LIST OF FILES

2011-2012
SENATE HEALTH AND SOCIAL SERVICES COMMITTEE
LIST OF FILES (PAGE 1)

1/24/11 REPORT TO THE LEGISLATURE: 2010 ALASKA VICTIMIZATION SURVEY

2/01/11 OVERVIEWS: ALASKA STATEWIDE INDEPENDENT LIVING COUNCIL; GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL EDUCATION; GOVERNOR'S STATEWIDE SUICIDE PREVENTION COUNCIL

2/02/11 PRESENTATION: DENALI FAMILY SERVICES

2/07/11 OVERVIEW: DEPARTMENT OF HEALTH & SOCIAL SERVICES; ALASKA HEALTH CARE COMMISSION REPORT

2/23/11 PRESENTATIONS: ALASKA MENTAL HEALTH TRUST; LONG TERM CARE OMBUDSMAN; ALASKA COMMISSION ON AGING

3/09/11 REPORT ON HOMELESSNESS: ALASKA COALITION ON HOUSING AND HOMELESSNESS; ALASKA HOUSING FINANCE CORPORATION; NEIGHBOR WORKS ANCHORAGE; RURAL CAP

1/31/12 PRESENTATION: ALZHEIMER'S RESOURCE OF ALASKA

2/01/12 PRESENTATIONS: ALASKA HEALTH CARE COMMISSION REPORT AND DEPARTMENT OF HEALTH & SOCIAL SERVICES OVERVIEW 2012

2/08/12 PRESENTATION: ALASKA CHILDREN'S JUSTICE ACT TASK FORCE

2/15/12 PRESENTATION BY NCSL: SUICIDE AWARENESS

2/29/12 ALASKA'S HOSPITALS AND NURSING HOMES

3/05/12 OVERVIEW: GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL EDUCATION

3/19/12 PRESENTATION: ALASKA BRAIN INJURY NETWORK

4/09/12 PRESENTATION: ALASKA E-HEALTH NETWORK (HEALTH INFORMATION MANAGEMENT AND SYSTEMS SOCIETY

AKEELA PRESENTATION 2011

ALASKA CHILDREN'S ALLIANCE UPDATE ON CAC'S 2011

CONFIRMATIONS 2011

2011-2012
SENATE HEALTH AND SOCIAL SERVICES COMMITTEE
LIST OF FILES (PAGE 2)

CONFIRMATIONS 2012

CONGENITAL CMV INFORMATION

NEIGHBOR WORKS ANCHORAGE, FUNDING REQUEST 2012

OVERVIEW: ALASKA'S CITIZEN REVIEW PANEL

TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE INFORMATION

SB 5

SB 8

SB 12

SB 14

SB 15

SB 17

SB 22

SB 27

SB 52

SB 55

SB 74

SB 82

SB 118

SB 119

SB 127

SB 134

SB 151

SB 172

SB 202

2011-2012
SENATE HEALTH AND SOCIAL SERVICES COMMITTEE
LIST OF FILES (PAGE 3)

SB 221

SCR 1

SCR 7

HB 15

HB 16

HB 21

HB 218

HB 310

HCR 1

HCR 3

HCR 5

HCR 20

1/24/11 REPORT TO THE LEGISLATURE: 2010 ALASKA VICTIMIZA-TION SURVEY

<TARGET><BILL></BILL><SUBJECT>1-24-11 REPORT TO THE LEGISLATURE 2010 ALASKA VICTIMIZATION SURVEY</SUBJECT><COMM>SHSS27</COMM></TARGET>

2010 Alaska Victimization Survey

Report to the Alaska State Legislature 1/24/11

University of Alaska Anchorage Justice Center
André B. Rosay

Council on Domestic Violence and Sexual Assault
Lauree Morton

UAA UNIVERSITY of ALASKA ANCHORAGE

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety * Prevention * Accountability

Presentation Overview

- Update on recent statistics from Uniform Crime Reports
- 2009 Senate Judiciary Committee recommendation for victimization survey
- FY10 Alaska Victimization Survey
- FY11 Alaska Victimization Surveys

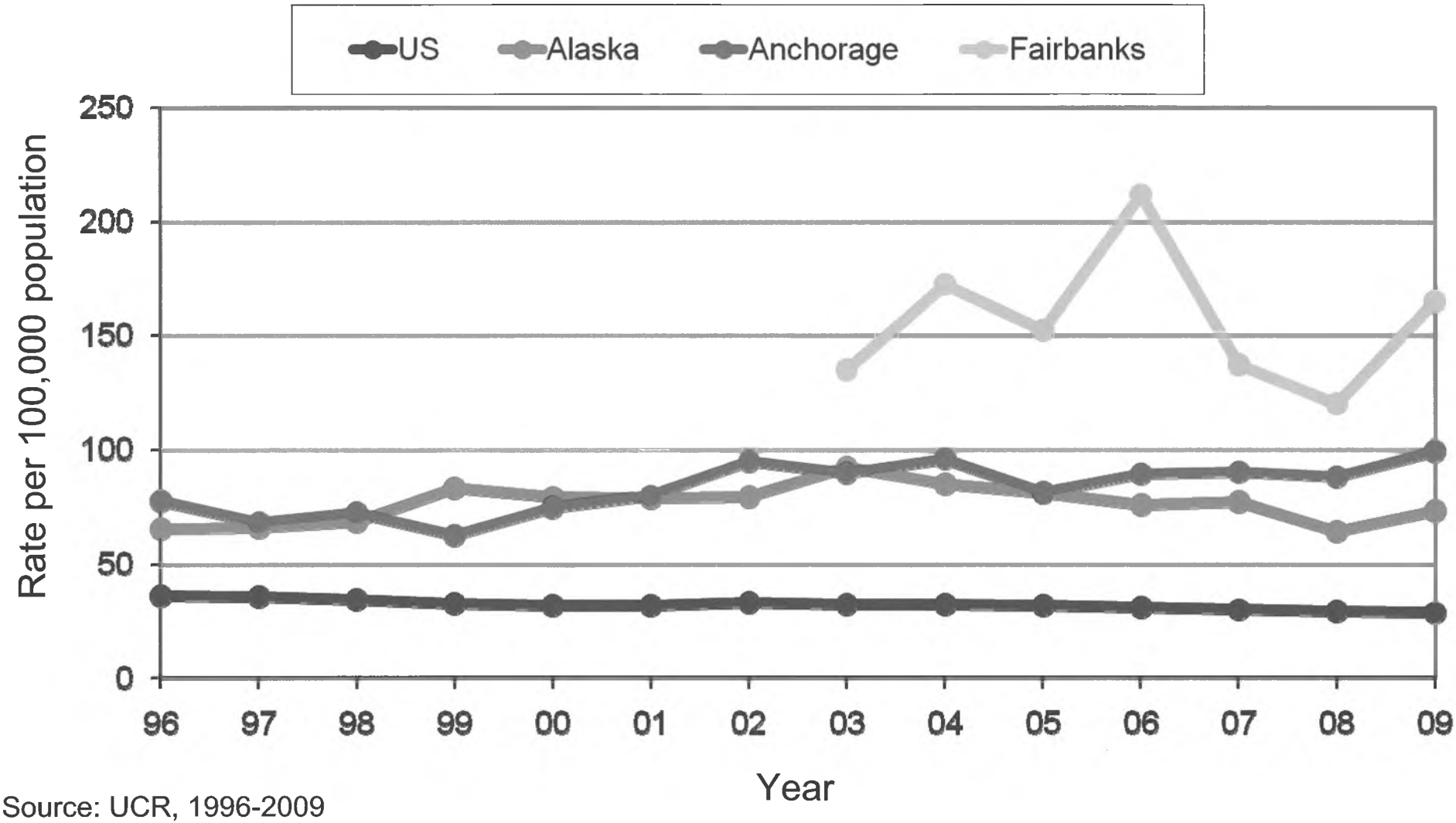
CDVSA
Council on Domestic Violence & Sexual Assault
Safety * Prevention * Accountability

Forcible Rape in Uniform Crime Reports

- **Forcible rape is defined as the carnal knowledge of a female forcibly and against her will**
- **UCR statistics show the number of forcible rapes reported to police each year**
- **Important limitations:**
  - Not all police agencies participate in the UCR program
  - These statistics only include rapes reported to police
  - These statistics exclude:
    - Statutory rapes
    - Incapacitated rapes
    - Rapes with male victims
    - Other sex offenses
    - Rapes with more serious offenses (e.g., homicide)

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

UCR Forcible Rape Statistics: 1996-2009



Source: UCR, 1996-2009

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT

UCR Forcible Rape Statistics

	2007 to 2008	2008 to 2009
U.S.	-2.3%	-2.1%
Alaska	-16.9%	+12.3%
Anchorage	-2.7%	+11.6%
Fairbanks	-12.5%	+27.1%

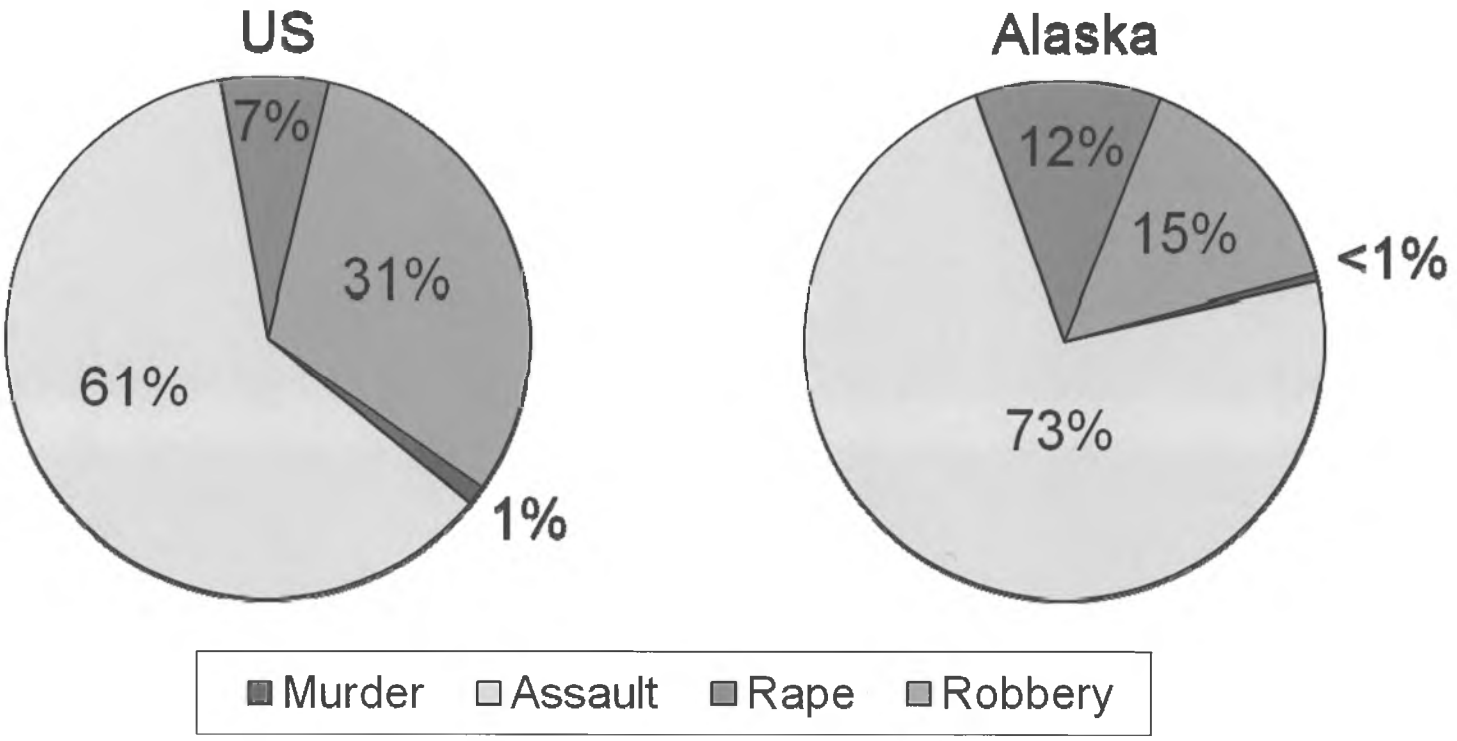
- Changes in UCR forcible rape statistics may be attributable to:
  - Changes in victimization rates,
  - Changes in reporting,
  - Changes in both victimization rates and reporting.

Source: UCR, 2007-2009

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Composition of Violent Crime: 2009

Forcible rape is still a more common form of violent crime in Alaska than in the U.S.



Source: UCR, 2009; Interpretation: 7% of violent crime reported to police in the US is attributable to rape; 12% of violent crime reported to police in Alaska is attributable to rape.

CDVSA
Council on Domestic Violence & Sexual Assault
Safety • Prevention • Accountability

Senate Judiciary Committee Recommendations

Alaska State Legislature

Senator Hollis French, Chair
State Capitol, Room 417
Juneau, Alaska 99801
Phone: (907) 465-3892
Fax: (907) 465-6595

Committee Members:
Senator Bill Wielechowski
Senator Dennis Egan
Senator Lesil McGuire
Senator Gene Therriault

Senate Judiciary Committee

Report and Recommendations: Reducing Sexual Assault in Alaska

"The legislature should fund a victimization survey to determine the actual rate of both reported and unreported sexual assaults in Alaska" (Senate Judiciary Committee, 2009).

Source: http://www.aksenate.org/french/101609_Senate_Judiciary_report_on_sexual_assault.pdf

Council on Domestic Violence and Sexual Assault

Council Vision:

Alaska, free from domestic and sexual violence

Council Mission:

Provide safety for Alaskans victimized or impacted by domestic Violence and sexual assault through a system of statewide crisis intervention, perpetrator accountability and prevention services.

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

FY10 Alaska Victimization Survey

- Designed to establish a baseline with statewide intimate partner and sexual violence estimates.
- Modeled after the National Intimate Partner and Sexual Violence Surveillance System (CDC, NIJ, DoD) and administered by RTI.
- Utilized a statewide random digit dial dual frame phone survey (both land and cell phone lines).
- Maximized respondent safety and confidentiality.

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Alaska Victimization Survey Questions

- Begin with less sensitive questions
- Use behaviorally specific questions:
  - *Avoid terms which respondents must define: "victim," "rape," "sexual assault," or "domestic violence." Instead, ask about behaviors and define when necessary. Example: "by vaginal sex, we mean that a man or boy put his penis in your vagina."*
- Attribute behaviors to perpetrators rather than respondents:
  - *Avoid asking "did you have vaginal sex with others? Instead, ask "did others have vaginal sex with you?"*
- Respondents were thankful for the survey (94% completed the entire 25 min. survey).

CDVSA
Council on Domestic Violence & Sexual Assault
Safety ★ Prevention ★ Accountability

Survey Respondents

- Survey respondents were limited to English-speaking adult women residing in a household with at least one land or cell phone line.
- Includes 871 adult women throughout Alaska, surveyed in May/June 2010.
- Sample provides an excellent representation of the Alaska population of adult women.
- Sampling weights were used to control for selection, non-response, and coverage.

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Survey Respondents

- Average age = 46 (ranges from 18 to 80+)
- 72% White, 15% Alaska Native
- 5% Hispanic
- 49% were married
- 35% had a high school degree or less
- 56% reported a household income <$50,000
- Geographically representative (68% are from Anchorage Municipality, Fairbanks North Star Borough, Matanuska-Susitna Borough)

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Intimate Partner Violence Definitions

- Intimate partner violence includes two measures:
  - *A – Threats of physical violence.*
  - *B – Physical violence.*
  - *Both include intimate partners only, defined as romantic or sexual partners.*
  - *Measures are then combined into a single 'intimate partner violence' composite.*
- Threats of physical violence by intimate partners:
  - *Have your romantic or sexual partners made threats to physically harm you?*

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety ★ Prevention ★ Accountability

Intimate Partner Violence Definitions

- Physical violence by intimate partners:
  - *Have your romantic or sexual partners…*
    - *Slapped you?*
    - *Pushed or shoved you?*
    - *Hit you with a fist or something hard?*
    - *Kicked you?*
    - *Hurt you by pulling your hair?*
    - *Slammed you against something?*
    - *Tried to hurt you by choking or suffocating you?*
    - *Beaten you?*
    - *Burned you on purpose?*
    - *Used a knife or gun on you?*

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Intimate Partner Violence Estimates

Lifetime Estimates	Estimated %	Estimated N (out of 247,238)
Intimate Partner Violence[1]	47.6%	117,685
A. Threats	31.0%	76,644
B. Physical Violence	44.8%	110,763

1 – Includes both threats of physical violence and physical violence by intimate partners.

- *47.6% of adult women in Alaska (or 117,685) experienced intimate partner violence in their lifetime,*
  - *31.0% (or 76,644) experienced threats of physical violence,*
  - *44.8% (or 110,763) experienced physical violence.*

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety * Prevention * Accountability

Intimate Partner Violence Estimates

Past Year Estimates	Estimated %	Estimated N (out of 247,238)
Intimate Partner Violence[1]	9.4%	23,240
A. Threats	5.8%	14,340
B. Physical Violence	8.6%	21,262

1 – Includes both threats of physical violence and physical violence by intimate partners.

- *9.4% of adult women in Alaska (or 23,240) experienced intimate partner violence in the past year,*
  - *5.8% (or 14,340) experienced threats of physical violence,*
  - *8.6% (or 21,262) experienced physical violence.*

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Sexual Violence Definitions

- Sexual violence includes two measures:
  - *A – Alcohol or drug involved sexual assault.*
  - *B – Forcible sexual assault.*
  - *Measures are not limited to intimate partners.*
  - *Measures are then combined into a single 'sexual violence' composite.*
- Alcohol or drug involved sexual assault:
  - *When you were alcohol or drug intoxicated and unable to consent, has anyone…*
    - *Had vaginal sex with you?*
    - *Made you receive anal sex?*
    - *Made you perform oral sex?*
    - *Made you receive oral sex?*

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

Sexual Violence Definitions

- Forcible sexual assault:
  - *Has anyone used physical force or threats to physically harm you to…*
    - *Make you have vaginal sex?*
    - *Make you receive anal sex?*
    - *Make you perform oral sex?*
    - *Make you receive oral sex?*
    - *Put their fingers or an object in your vagina or anus?*
    - *Try to have vaginal, oral, or anal sex with you?*

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT

Sexual Violence Estimates

Lifetime Estimates	Estimated %	Estimated N (out of 247,238)
Sexual Violence[1]	37.1%	91,725
A. Alcohol or Drug Involved Sexual Assault	26.8%	66,260
B. Forcible Sexual Assault	25.6%	63,293

1 – Includes both alcohol or drug involved sexual assault and forcible sexual assault.

- *37.1% of adult women in Alaska (or 91,725) experienced sexual violence in their lifetime,*
  - *26.8% (or 66,260) experienced at least one alcohol or drug involved sexual assault,*
  - *25.6% (or 63,293) experienced at least one forcible sexual assault.*

CDVSA
Council on Domestic Violence & Sexual Assault
Safety • Prevention • Accountability

Sexual Violence Estimates

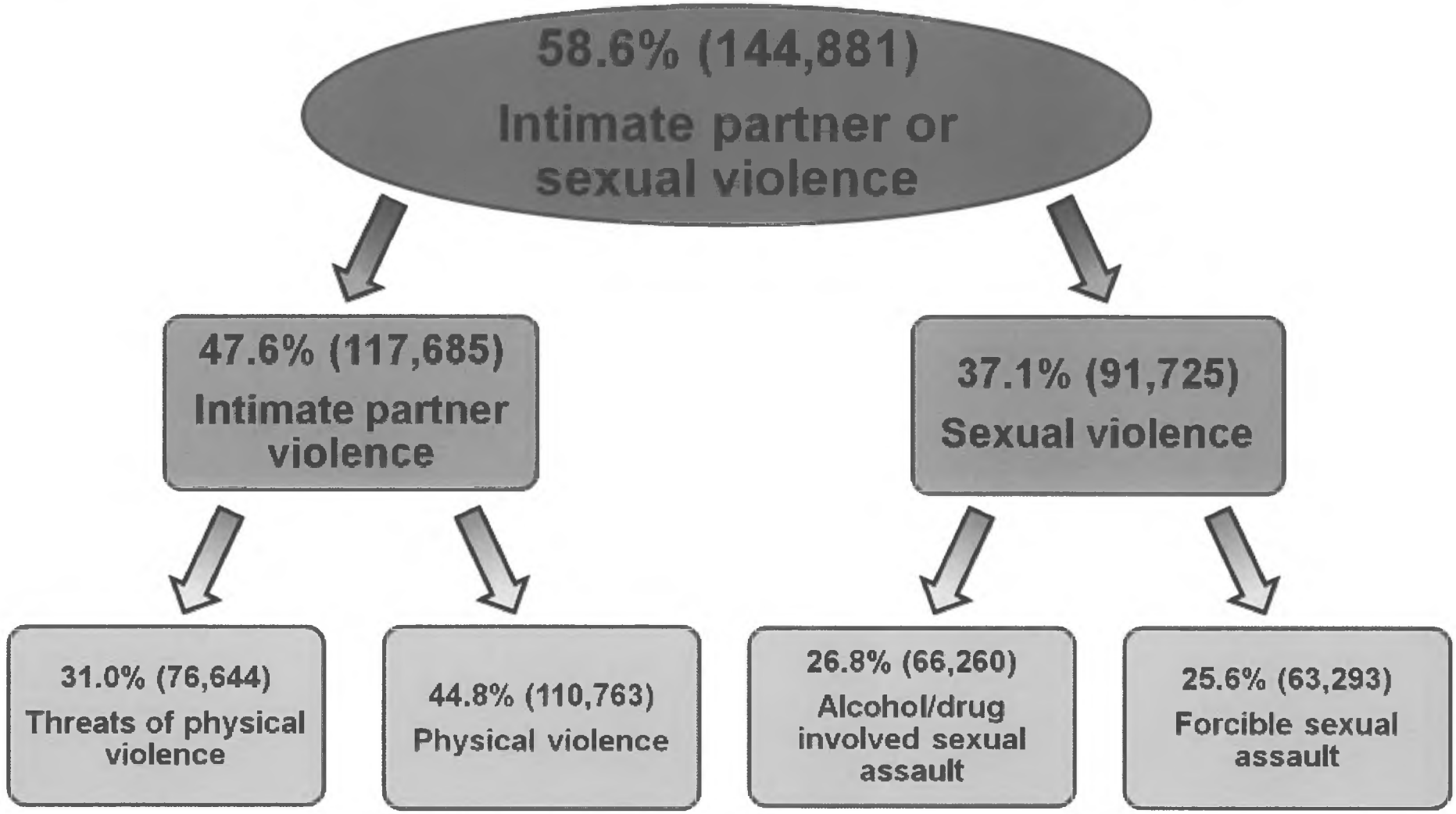
Past Year Estimates	Estimated %	Estimated N (out of 247,238)
Sexual Violence[1]	4.3%	10,631
A. Alcohol or Drug Involved Sexual Assault	3.6%	8,901
B. Forcible Sexual Assault	2.5%	6,181

1 – Includes both alcohol or drug involved sexual assault and forcible sexual assault.

- *4.3% of adult women in Alaska (or 10,631) experienced sexual violence in the past year,*
  - *3.6% (or 8,901) experienced at least one alcohol or drug involved sexual assault,*
  - *2.5% (or 6,181) experienced at least one forcible sexual assault.*

CDVSA
Council on Domestic Violence & Sexual Assault
Safety ★ Prevention ★ Accountability

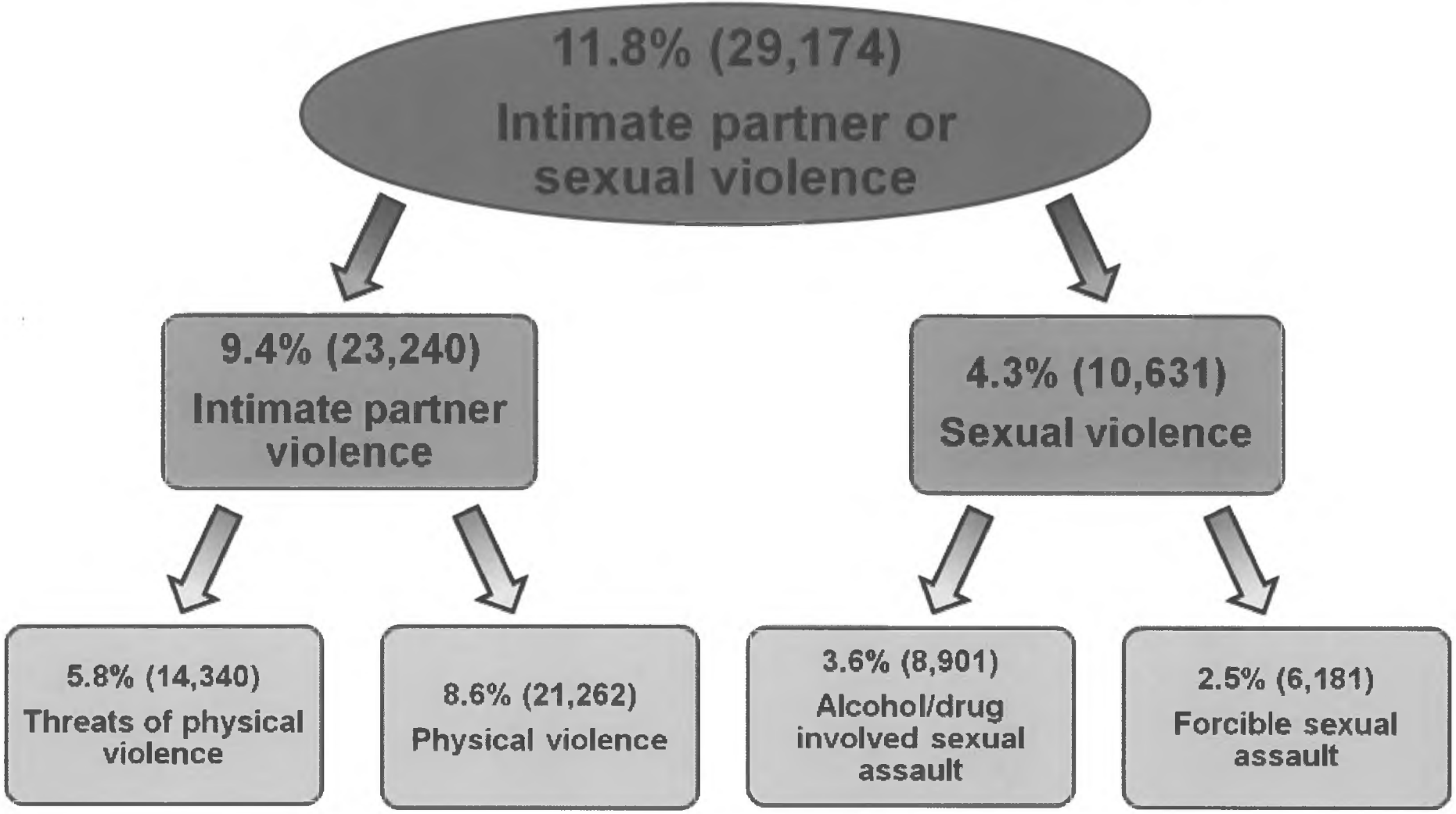
Summary of Lifetime Estimates



Note: percentages do not sum because some respondents experienced multiple victimizations.

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety ★ Prevention ★ Accountability

Summary of Past Year Estimates



Note: percentages do not sum because some respondents experienced multiple victimizations.

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT

Important Limitations

- Survey only provides a statewide average and masks regional differences. Regional estimates may vary significantly.
- Survey excluded non-English speaking women, women without phone access, and women not living in a residence (e.g., shelters, hospitals, homeless, prisons). Estimates may be significantly higher among women excluded from the survey.

CDVSA
Council on Domestic Violence & Sexual Assault
Safety • Prevention • Accountability

Important Limitations

- Measured *number of victims*, not *number of victimizations*. The number of victimizations is higher than the number of victims.
- Survey did not measure all forms of intimate partner violence or sexual violence. Estimates are therefore conservative.
- Estimates may also be conservative because of the continuing stigma of reporting intimate partner and sexual violence.

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

A Special Thank You!

We sincerely thank the women who invested time and effort to participate in the 2010 Alaska Victimization Survey.

They re-lived horrendous experiences – experiences no one should be subjected to – to help the rest of us understand the extent of intimate partner and sexual violence in Alaska. Thank you!

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety * Prevention * Accountability

FY10 Alaska Victimization Survey

- Survey provides the first statewide, comprehensive, and behaviorally specific measures of violence against Alaskan women
- Establishes a new baseline for Alaska that can be repeated to monitor progress and document change
- National comparisons and comparisons with other states will soon be available
- Results will be used to guide policy and practice

CDVSA
COUNCIL ON DOMESTIC VIOLENCE & SEXUAL ASSAULT
Safety • Prevention • Accountability

FY11 Alaska Victimization Surveys

- Surveys will soon begin in Anchorage and Fairbanks
- Surveys will include at least one rural location
- FY11 surveys will include two new questions:
  - Location of victimization (in/out of Alaska)
  - Child witnesses to violence
- FY11 surveys are again funded by the Council on Domestic Violence and Sexual Assault
- Continuing funding is needed and requested in the FY12 Governor's budget

Contacts

University of Alaska Anchorage Justice Center
André B. Rosay (Anchorage)
(907) 786-1821
afabr@uaa.alaska.edu

Council on Domestic Violence and Sexual Assault
Lauree Morton (Juneau)
(907) 465-4356
lauree.morton@alaska.gov

UAA Justice Center
UNIVERSITY of ALASKA ANCHORAGE

UAA Justice Center Research on Violence Against Women

Prepared for the joint meeting of the Senate Health and Social Services Committee
and the Senate Judiciary Committee, Alaska State Legislature
Monday, January 24, 2011, 1:30 PM

Index

SEXUAL ASSAULT

Sexual Assaults Reported to Alaska State Troopers
André B. Rosay, Greg Postle, Darryl S. Wood, and Katherine TePas
Vol. 25, 1-2 (Spring-Summer 2008), *Alaska Justice Forum* Reprint No. 2

Case Attrition of Sexual Violence Offenses: Empirical Findings
Darryl S. Wood and André B. Rosay
Vol. 25, 1-2 (Spring-Summer 2008), *Alaska Justice Forum* Reprint No. 1

Revisiting Alaska's Sex Offender Registration and Public Notification Statute
Deborah Periman
Vol. 25, 1-2 (Spring-Summer 2008), *Alaska Justice Forum* Reprint No. 10

Sexual Assaults in Anchorage
Vol. 22, 4 (Winter 2006), *Alaska Justice Forum* Reprint No. 7

Sexual Assault Case Processing: A Descriptive Model of Attrition & Decision Making
G. Matthew Snodgrass
Vol. 23, 1 (Spring 2006), *Alaska Justice Forum* Reprint No. 6

Forcible Rapes and Sexual Assaults in Anchorage
André B. Rosay
Vol. 20, 4 (Winter 2004), *Alaska Justice Forum* Reprint No. 8

Disposition of Sexual Assault Cases
Vol. 20, 4 (Winter 2004), *Alaska Justice Forum* Reprint No. 9

DOMESTIC VIOLENCE

Predicting Legal Resolutions in Domestic Violence Cases
Marny Rivera, André B. Rosay, Darryl S. Wood, Katherine TePas
Vol. 26, No. 3 (Fall 2009), pp. 1, 8-12, *Alaska Justice Forum*

Attrition in Cases of Violence Against Women Reported to the Alaska State Troopers
Darryl Wood, André B. Rosay , Marny Rivera, Katherine TePas
Vol. 26, No. 3 (Fall 2009), pp. 2-4, *Alaska Justice Forum*

Reducing Violence Against Women in Alaska
Vol. 26, No. 3 (Fall 2009), p. 5, *Alaska Justice Forum*

Animal Abuse and Domestic Violence/Further Reading about Animal Abuse and Domestic Violence
Vol. 26, No. 3 (Fall 2009), p. 6, *Alaska Justice Forum*

Assaults in Domestic Violence Incidents Reported to Alaska State Troopers
Marny Rivera, André B. Rosay, Darryl S. Wood, Greg Postle and Katherine TePas
Vol. 25, 3 (Fall 2008), *Alaska Justice Forum* Reprint No. 4

STALKING

Stalking Victimization: Comparison between Alaska and U.S. Data
Khristy Parker
UAA Justice Center *Research Overview*, No. 11 (January 2011)

Stalking in Alaska
André B. Rosay, Greg Postle, Katherine TePas, and Darryl Wood
Vol. 24, 1 (Spring 2007), *Alaska Justice Forum* Reprint No. 3

ALASKA JUSTICE FORUM
REPRINTS

February 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 2

Sexual Assaults Reported to Alaska State Troopers

André B. Rosay, Greg Postle, Darryl S. Wood, and Katherine TePas

Originally published in the *Alaska Justice Forum* 25(1–2): 1, 6–9 (Spring-Summer 2008).
http://justice.uaa.alaska.edu/forum/25/1-2springsummer2008/d_ast.html

For other articles and publications related to sexual violence and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This study examined 989 cases with a sexual assault or sexual abuse of a minor charge reported to Alaska State Troopers in 2003 and 2004, and excluded any sexual assault cases reported to local or municipal departments.*

- *Forty-eight percent of reports came from C Detachment (Western Alaska - Kodiak to Kotzebue), and 58% were reported from communities off the road system.*
- *In 69% of cases, the identity of at least one suspect was known. While most suspects (87%) were adults, most victims (73%) were juveniles. Sixty-one percent of victims were Alaska Native and 38% were White. Intra-racial victimizations were much more prevalent than inter-racial victimizations. The most common suspect was a friend or acquaintance of the victim, followed by a relative. Forty-three percent of suspects and 27% of victims had used alcohol.*
- *Sexual penetration occurred in 60% of assaults. Weapons were very rarely used. Most assaults occurred inside private residences. Nineteen percent of victims experienced general physical pain and 10% suffered bruising or swelling. Most victimizations were reported quickly to Troopers and Troopers were quick to respond. Ninety-six percent of victims were interviewed, with 48% interviewed on the day of the report and 80% interviewed within one week of the report.*
- *Forty-six per cent of reported cases were referred for prosecution, 60% of referred cases were accepted for prosecution, and 80% of accepted cases resulted in a conviction. Overall, however, only 22% of reported cases resulted in a conviction. In some cases, the conviction may be for a non-sexual offense. The highest level of attrition occurred from report to referral.*

Most research on sexual assault and the sexual abuse of minors in the state of Alaska has been focused on Anchorage; little has been known about the characteristics of these problems in other communities. The Justice Center, working with the Alaska State Troopers and the Alaska Department of Law, has completed the first thorough review of sexual assault incidents reported to Troopers in 2003 and 2004. The results delineate a first draft of the problem in Alaska's smaller communities, for the population primarily served by the Troopers.

The final sample in this study included 989 cases with a sexual assault or sexual abuse of a minor charge, reported to Troopers in 2003 and 2004, and closed by the time of the study. It is important to note that this study did not include any sexual assault cases reported to local or municipal departments. In addition, this study did not include cases specific to child pornography or online enticement of minors.

Report Characteristics

Almost half of the reports included in the study (48%) came from C Detachment, which covers western Alaska, from Kotzebue to Kodiak (Table 1). The C Detachment headquarters is in Anchorage, with the remaining posts in Aniak, Bethel, Dillingham, Emmonak, King Salmon, Kodiak, Kotzebue, Nome, and St. Mary's. The Bethel post handled 17 percent of all sexual assault and sexual abuse of minor cases reported to Troopers in 2003 and 2004. Thirty percent of the reports came from the Alaska Bureau of Investigation (ABI), whose Major Crime Unit is responsible for investigating sexual assaults and other person offenses statewide. The Alaska Bureau of Investigation has posts in Anchorage, Palmer, Fairbanks, and Soldotna. ABI posts in Palmer and Fairbanks handled 16 percent of all sexual assault and sexual abuse of minor cases reported to Troopers in 2003 and 2004. Together, C Detachment and ABI handled 78 percent of all reports. Forty-two percent of the reported cases originated in communities connected to the State of Alaska highway system, and 58 percent were reported from communities off the road system.

Most reports (86%) were made directly to troopers. The remaining 14 percent were reported to Village Police Officers, Village Public Safety Officers, or Tribal Police Officers. Few of the initial complaints (21%) were made by the victims themselves. Most initial reports to law enforcement (79%) were made by a third party. In over two-thirds of the cases (69%), the identity of at least one suspect was known.

The 989 cases in this study included a total of 1,645 sexual assault charges and 258 non-sexual assault charges (Table 2). The most common sexual assault charges were second degree sexual abuse of a minor, first degree sexual assault, second degree sexual assault, and first degree sexual abuse of a minor—all felonious assaults (Unclassified or Class B). Together, these four offenses accounted for 81 percent of all sexual assault charges. The most common non-sexual assault charges included assaults (in the

Table 1. Total Number of Reports by Detachment

Column percentages.

Detachment	Reports N	Reports %
C	476	48.1 %
ABI	299	30.2
D	79	8.0
E	54	5.5
A	39	3.9
B	24	2.4
ABWE	18	1.8
Total	**989**	

Source of data: *AST data (2003–2004)*

© 2009 Justice Center, University of Alaska Anchorage

Table 2. All Sexual Assault Charges

Column percentages.

Charge	Number N	%
Sexual abuse of a minor 2nd degree	481	29.2 %
Sexual assault 1st degree	366	22.2
Sexual assault 2nd degree	292	17.8
Sexual abuse of a minor 1st degree	193	11.7
Sexual assault 3rd degree	130	7.9
Sexual abuse of a minor 3rd degree	99	6.0
Sexual abuse of a minor 4th degree	78	4.7
Sexual assault 4th degree	6	0.4
Total	**1,645**	

Source of data: *AST data (2003–2004)*

second, third, or fourth degree), burglary (in the first or second degree) and kidnapping. Together, these three offenses accounted for 50 percent of all non-sexual assault charges.

Despite the geographical distance that is often present between victims and Troopers, most victimizations were reported quickly to Troopers, and Troopers were quick to respond. Sixty-two percent of cases were reported within 72 hours, which, at the time of the study, was the benchmark for initiating a call to the Sexual Assault Response Team (SART) and collecting evidence with a sexual assault evidence kit. Seventy-seven percent of suspects were interviewed by Troopers (recall that the identity of the suspect was known in 69% of cases). Fifty-seven percent of suspect interviews occurred within one week of the report. Ninety-six percent of victims were interviewed, with 48 percent interviewed on the day of the report and 80 percent interviewed within one week of the report. Ninety-one percent of victim interviews were conducted in-person. On average, cases were closed 18 weeks after they were reported (Table 3). More specifically, 30 percent of cases were closed within three weeks, 50 percent were closed within eight weeks, and 75 percent were closed within 24 weeks.

Table 3. Case Closure Codes

Column percentages.

Closure code		Reports N	%
CA	Closed by arrest	316	32.0 %
CR	Closed, referred	255	25.7
CI	Closed by investigation	232	23.5
CU	Closed, unfounded	150	15.2
CD	Closed, declined	29	2.9
CE	Closed, exception	7	0.7
	Total	**989**	

Source of data: *AST data (2003–2004)*

A majority of cases (61%) were closed and referred for prosecution. These included cases closed by arrest (32%), closed and referred (26%), and closed but declined (3%). The remaining cases were closed after investigation (23%), closed as unfounded (15%), or closed by exception (1%). These latter groups of cases (excluding those closed by exception) were all closed without a suspect being arrested and in some cases without a suspect being identified. Cases that were closed as unfounded were more likely to be reported by third parties who were concerned that a sexual assault may have occurred.

Suspect and Victim Characteristics

From the 989 reports included in this study, we gathered information on 1,050 suspects and 1,082 victims. Most suspects (97%) were male and most (87%) were adults. Conversely, most victims (89%) were female and most (73%) were juveniles. The average age of suspects—29.2—was 13 years greater than the average age of victims—16.2 (Table 4).

Figure 1 displays the number of victim-suspect combinations on the horizontal axis, by victim age on the vertical axis, for five different suspect age groups, in horizontal bars. The top five age group combinations were (1) suspects 31 years old or older and victims 0 to 12 years old (N=137); (2) 16 to 20-year-old suspects and 13 to 15-year-old victims (N=113); (3) 21 to 30-year-old suspects and 13 to 15-year-old victims (N=89); (4) suspects 31 years old or older and victims 31 years old or older (N=76); and (5) suspects 31 years old or older and 13 to 15-year-old victims (N=75). Together, these five age group combinations accounted for 48 percent of the assaults for which both the age of the suspect and victim were known.

Table 4. Demographic Characteristics of Suspects and Victims

Column percentages.

	Suspects N	%	Victims N	%
Age group				
0 to 12	35	3.7 %	380	35.9 %
13 to 15	87	9.2	303	28.6
16 to 20	210	22.2	165	15.6
21 to 30	236	24.9	101	9.5
31 or older	380	40.1	110	10.4
Total	**948**		**1,059**	
Race				
Native	566	59.1 %	638	60.5 %
White	349	36.5	400	37.9
Black	35	3.7	13	1.2
Other	7	0.7	4	0.4
Total	**957**		**1,055**	

Source of data: *AST data (2003–2004)*

Most suspects were Native (59%) or White (37%) and most victims were also Native (61%) or White (38%) (Table 4). Intra-racial victimizations were much more prevalent than inter-racial victimizations, with 91 percent of Native victims assaulted by Native suspects and 84 percent of White victims assaulted by White suspects. Slightly less than half (43%) of the suspects had used alcohol; few (7%) had used drugs. Substance use was most frequent among suspects age 21 to 30, followed by suspects age 31 to 40 and suspects age 16 to 20. Among victims, 27 percent had used alcohol and 5

Figure 1. Victim-Suspect Age Combinations

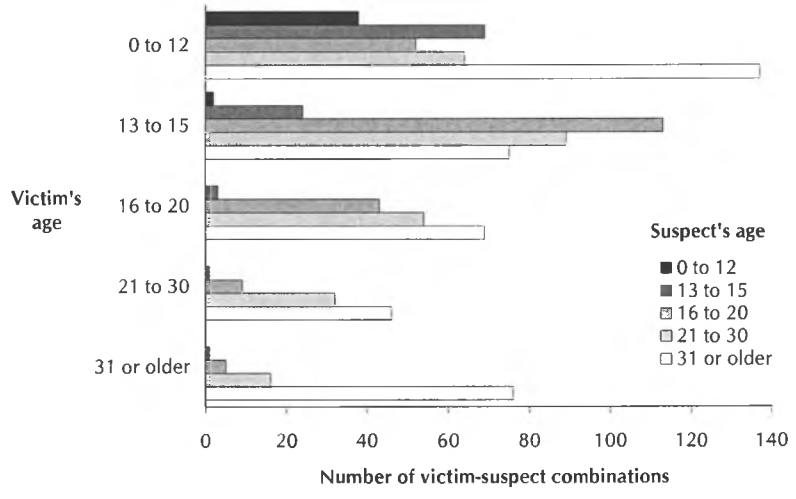


Table 5. Nature of Victim and Suspect Relationship

Column percentages.

	All victims		Minor victims		Adult victims	
Relationships	N	%	N	%	N	%
Friends or acquaintances	477	46.4 %	328	43.3 %	152	57.1 %
Relatives	360	35.1	308	40.6	45	16.9
Current or former partners	124	12.1	80	10.6	44	16.5
Authority figure (to victim)	44	4.3	36	4.7	17	6.4
Strangers	22	2.1	6	0.8	8	3.0
Total	**1,027**		**758**		**266**	

* The "relatives" category in this table includes in-laws, immediate, and extended family members. However, married couples were excluded from the "relatives" category.

Source of data: *AST data (2003–2004)*

percent had used drugs. Substance use was most frequent among victims age 13 to 15, followed by victims age 21 to 30 and victims age 31 or older.

Most victims (all but one) were not homeless, nor were most suspects (99%). Most victims (71%) were not living with the suspect at the time of the assault, but overwhelmingly, the victims reported knowing the suspect in some fashion (98%) (Table 5). Only 2 percent of all victim-suspect relationships involved complete strangers. Nearly half (46%) involved friends or acquaintances, 35 percent involved relatives, 12 percent involved current or past intimate partners (including married couples), and 4 percent involved suspects that were in a position of authority over their victims. Together, friends, relatives, and intimate partners accounted for 94 percent of the victim-suspect relationships in the study sample.

The nature of the victim-suspect relationship varied substantially by the age of the victim. In particular, minor victims were substantially more likely be assaulted by relatives than adult victims. While only 17 percent of adult victims were assaulted by relatives, 41 percent of minor victims were assaulted by relatives. Minor victims were slightly less likely to be assaulted by friends or acquaintances (43%) than adult victims (57%) and slightly less likely to be assaulted by current or former partners (10%) than adult victims (17%).

Assault Characteristics

The five most common ways that victims and suspects came into contact with each other prior to the assault were by living together (32%); the suspect inviting the victim somewhere (20%); the suspect attacking the victim indoors (15%); the victim inviting the suspect somewhere (10%); and the victim and suspect meeting up with each other at a party (9%). Together, these five pickup methods were used in 86 percent of the assaults (Table 6).

The five most common pickup and assault locations were identical, differing only in terms of rank. These locations included mutually shared residences (25% of pickups and 25% of assaults), the suspect's residence (25% of pickups and 30% of assaults), the victim's residence (20% of pickups and 17% of assaults), someone else's residence (14% of pickups and 14% of assaults), and outdoors (10% of pickups and 7% of assaults). Private residences accounted for 84 percent of pickup locations and 87 percent of assault locations (Table 7).

The reported use of weapons by suspects was very rare in this sample of sexual assault cases. The one major exception, however, was suspects' use of their hands and/or arms to restrain or strike their victims during the assaults. In slightly less than one-third of the incidents, suspects used their hand and/or arms to restrict victims' movement or to assault victims physically beyond the sexual assault. Other weapons such as knives, guns, drugs, or blunt objects were reported to have been used in less than 1 percent of the incidents.

Sexual penetration, as defined by Alaska law, was documented in 60 percent of the assaults. On average, suspects engaged in just over two sexual acts (2.16) per assault (Table 8).

As a result of the assault, 19 percent of victims experienced general physical pain. In addition, 10 percent suffered bruising or swelling. Lacerations, bite marks, and bone fractures were rarely reported or documented (less than 3% of victims). Overall, very few victims received any type of emergency medical treatment for injuries suffered as a result of the sexual assault. Only 4 percent of victims received emergency medical care for genital injuries; 2 percent received emergency medical care for non-genital injuries; and less than 1 percent received emergency medical care for alcohol or drug intoxication.

Evidence Collection

Detailed information was gathered on the availability and collection of several types

Table 6. Method of Pickup

Column percentages.

	Incidents	
Method	N	%
Lived together	234	32.4 %
Suspect invited victim	146	20.2
Attacked indoors	109	15.1
Victim invited suspect	71	9.8
Met at a party	63	8.7
Suspect performing service	33	4.6
Jumped outdoors	23	3.2
Entered suspect's vehicle	20	2.8
Met elsewhere	13	1.8
Met in a bar	10	1.4
Total	**722**	

Source of data: *AST data (2003–2004)*

Table 7. Location of Pickup and Assault

Column percentages.

	Pickup		Assault	
Location	N	%	N	%
Suspect's house	221	25.1 %	271	29.7 %
Victim and suspect's house	221	25.1	232	25.4
Victim's house	175	19.9	159	17.4
Other's house	122	13.8	130	14.2
Outdoors	89	10.1	61	6.7
Bar	17	1.9	3	0.3
Vehicle (victim or suspect's)	16	1.8	38	4.2
Work (victim or suspect's)	12	1.4	8	0.9
Hotel	8	0.9	11	1.2
Total	**881**		**913**	

Source of data: *AST data (2003–2004)*

Table 8. Sexual Acts

Row percentages.

Sexual acts	No N	No %	Yes N	Yes %	Total
Touching of the external female genitalia	365	47.7 %	400	52.3 %	**765**
Penile penetration of victim's vagina	582	60.1	387	39.9	**969**
Touching of victim's breasts	483	65.0	260	35.0	**743**
Kissing	563	70.9	231	29.1	**794**
Digital penetration of victim's vagina	597	75.3	196	24.7	**793**
Touching of penis (suspect's or victim's)	714	85.6	120	14.4	**834**
Touching of victim's anus	626	86.1	101	13.9	**727**
Victim performed oral sex on suspect	759	86.9	114	13.1	**873**
Suspect performed oral sex on victim	736	88.0	100	12.0	**836**
Penile penetration of victim's anus	786	91.7	71	8.3	**857**
Digital penetration of victim's anus	816	97.4	22	2.6	**838**

Source of data: *AST data (2003–2004)*

Table 9. Collection of Evidence and Forensic Exams

Row percentages.

Evidence	No N	No %	Yes N	Yes %	Total
Physical evidence from victim	720	78.2 %	201	21.8 %	**921**
Victim sexual assault evidence collection kit	733	79.9	184	20.1	**917**
Physical evidence from scene	796	84.1	150	15.9	**946**
Physical evidence from suspect	820	87.0	122	13.0	**942**
Photographs of scene	797	87.3	116	12.7	**913**
Suspect sexual assault evidence collection kit	874	92.9	67	7.1	**941**
DNA forensic exams	827	85.6	139	14.4	**966**
Trace/latent forensic exams	944	97.7	22	2.3	**966**
Computer forensic exams	942	97.5	24	2.5	**966**

Source of data: *AST data (2003–2004)*

of evidence, including physical evidence, electronic data, and photographic documentation.

Physical evidence from the victim (e.g., clothing) and victim sexual assault evidence collection kits were the most commonly collected types of evidence, gathered in 22 percent and 20 percent of cases respectively (Table 9). Suspect sexual assault kits were collected in only 7 percent of cases, and physical evidence from the suspect was gathered in only 13 percent of cases. In the majority of cases, there was no physical evidence recovered from the scene (84% of cases) and in 87 percent of cases, the scene was not photographed. Search warrants were obtained in 36 percent of cases. The most common warrants were for the victims' medical records (26% of cases) and glass warrants (13% of cases). Forensic exams of evidence were requested in only 16 percent of cases, with forensic DNA exams the most commonly requested (14% of cases).

Photographs of suspect injuries and the recovery of a weapon were the least common types of evidence collected (also the least available) during investigations.

Overall, evidence collection appeared to be somewhat low, although the statistics represent only what was included in the reports (Table 10). This is an important limitation with this study because evidence was counted as collected only if it was included in the report. This is particularly problematic with photographs. In some cases, photographs were taken, but were kept separately from the report (i.e., stored electronically but not printed to include with the report). In these cases, we counted the evidence as not collected because it was not found within the report. The statistics reported here therefore underestimate how frequently evidence was collected by Troopers.

Future analyses will be necessary to determine how these types of evidence impact legal resolutions. Two main factors determine the applicability and availability of evidence: one, the nature, or severity, of the reported incident; two, the timeliness of the report. Both factors impact what evidence is applicable and what evidence is available to be collected.

Legal Resolutions

We examined data from the Alaska Department of Law (DOL) to determine the legal resolution for cases in the study which were referred to DOL. We did not examine referrals to other agencies, such as the Division of Juvenile Justice. From the sample of 989 reported cases, 46 percent (N = 452) were referred to DOL for prosecution. Sixty percent of the cases referred to DOL (N = 273) had at least one charge accepted and filed with the court for prosecution (Table 11). Of those cases with at least one charge accepted by DOL, 80 percent resulted in a conviction. The highest level of attrition occurred from report to referral. Once cases were referred, the likelihood of at least one charge being accepted and resulting in a finding of guilt was quite high.

Additional analyses showed that attrition was less likely in cases with one or more

Table 10. Applicability and Collection of Evidence

Row percentages.

	Applicable?					Collected, if applicable?				
	No		Yes			No		Yes		
Evidence	N	%	N	%	Total	N	%	N	%	Total
SART exam photos	692	77.1 %	206	22.9 %	**898**	45	21.8 %	161	78.2 %	**206**
Electronic data	898	94.0	57	6.0	**955**	15	26.3	42	73.7	**57**
Victim injury photos	680	75.7	218	24.3	**898**	99	45.4	119	54.6	**218**
Weapon	929	97.5	24	2.5	**953**	18	75.0	6	25.0	**24**
Trace/latent	827	88.5	97	10.4	**934**	77	79.4	20	20.6	**97**
Suspect injury photos	864	90.9	86	9.1	**950**	69	80.2	17	19.8	**86**

Source of data: *AST data (2003–2004)*

Table 11. Number of Cases by Stage

Stage	N	% of reported	% of referred	% of accepted
Reported	989	100.0 %	—	—
Referred	452	45.7	100.0 %	—
Accepted	273	27.6	60.4	100.0 %
Convicted	219	22.1	48.5	80.2

Source of data: *Alaska Department of Law*

witnesses than in cases without witnesses and was less likely among rural cases than among urban cases (rural cases were defined as those emerging from locations not connected to the State of Alaska highway system). (See "Case Attrition of Sexual Violence Offenses: Empirical Findings" in this issue.)

From the 989 reports, a total of 1,171 charges were referred to DOL. Sixty-six percent of these charges were accepted by DOL. Thirty-one percent were declined with a required dismissal and 3 percent were declined without a required dismissal. The most frequently cited reasons for not accepting charges as referred were evidentiary reasons, with the two most common evidentiary reasons being inadequate corroboration and insufficient evidence.

Because evidentiary reasons were the most common reasons for not accepting charges that were referred and because evidence collection was somewhat low, it is imperative that we improve the capacity to collect evidence, when it is available. In "Sexual Assault Nurse Examinations in Alaska," also in this issue of the *Forum*, the importance of documenting non-genital injuries is discussed. In this study, victim injury photos were taken in only 55 percent of applicable cases. Again, this estimate may be low because some victim injury photos are kept separately from the reports. Nonetheless, there is room for improving evidence collection and resources should be provided for these improvements.

The findings presented here constitute a first look at the problem of sexual assault in smaller communities across the state—those served predominately by the Troopers. Further research will undoubtedly provide a more detailed picture.

André B. Rosay is an Associate Professor and the Interim Director of the Justice Center. Greg Postle is a doctoral student at the University of Delaware. Darryl Wood is an Assistant Professor at Washington State University Vancouver. Katherine TePas is a Program Coordinator with the Alaska State Troopers. *This project was supported by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice (Grant No. 2005-WB-GX-0011) and by the Violence Against Women Office, Office of Justice Programs, U.S. Department of Justice through the Alaska Council on Domestic Violence and Sexual Assault (Grant Numbers 2003-WR-BX-0210 and 2004-WF-AX-003).* *Points of view in this article are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

ALASKA JUSTICE FORUM
REPRINTS

February 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 1

Case Attrition of Sexual Violence Offenses: Empirical Findings

Darryl S. Wood and André B. Rosay

Originally published in the *Alaska Justice Forum* 25(1–2): 1, 18–20 (Spring-Summer 2008).
http://justice.uaa.alaska.edu/forum/25/1-2springsummer2008/b_attrition.html

For other articles and publications related to sexual violence and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This report examined the legal resolutions for 1,184 contact sexual violence cases reported to Alaska State Troopers in 2003 and 2004, and excluded results from other law enforcement agencies. We determined whether cases were founded with an identifiable suspect, were referred to the Alaska Department of Law for prosecution, were accepted for prosecution, and if the case resulted in a conviction. We only examined whether any conviction on any charge was obtained. In some cases, the conviction may be for a non-sexual offense.*

- *Seventy-five percent of cases were founded with at least one identifiable suspect, 51% of founded cases were referred to the Alaska Department of Law for prosecution, 60% of referred cases were accepted for prosecution, and 80% of accepted cases resulted in a conviction on at least one charge. The greatest point of attrition was from the founding to the referral decision.*
- *For the most part, cases of Alaska Native victims were as likely, or even more likely, to be processed by the criminal justice system relative to the cases of non-Native victims.*
- *Cases of sexual violence in the most rural portions of Alaska had an equal or greater chance of being subject to legal sanction when compared with cases from Alaska's less rural areas, and were as likely or more likely to receive full enforcement and prosecution. Unfortunately, the percentage of founded cases that resulted in a conviction never exceeded 30%.*

The State of Alaska's response to violence in Alaska Native villages has faced increased scrutiny over the past decade, with criticism coming from a number of sources, including the Alaska Advisory Committee to the U.S. Commission on Civil Rights, the Alaska Inter-Tribal Council (in *AITC v. Alaska*, 110 P.3d 947, 2005), and, most recently, Amnesty International. In general, allegations have been made that the state discriminates on a geographic and racial basis in the provision of criminal justice services to Alaska Native villages that are isolated from the main road system. For example, in *AITC v. Alaska* (2005), plaintiffs argued that their equal protection rights were violated by the state's deployment of police resources in a discriminatory fashion that favored those living along the main highway system. Similarly, in a 2007 report on police and court responses to violence against American Indian and Alaska Native women (*Maze of Injustice: The Failure to Protect Indigenous Women from Sexual Violence in the USA*), Amnesty International singled out Alaska for what it considers to be a discriminatory, two-tiered deployment of police into the isolated areas of the state, said to be indicative of the state's "failing to exercise due diligence when it comes to sexual violence against . . . Alaska Native women." Amnesty International argued that with this two-tiered deployment of police resources, villages without a trooper post receive less effective police response than villages with a trooper post.

The evidence put forth in the many critical reports is based primarily upon the written and oral testimony of criminal justice agency personnel as well as Alaska Native crime victims, political leaders, and legal advocates. Although compelling, the case made against the state is largely anecdotal, failing to demonstrate a *systematic* lack of criminal justice system response to sexual violence against Alaska Natives. In this article we consider information gathered from the case files of the Alaska State Troopers (AST) and the Alaska Department of Law (DOL) to determine if there is an empirical basis for claims of unequal enforcement of sexual violence statutes. Specifically, we consider multiple decision-making points within the criminal justice process to compare the outcomes of cases involving Alaska Native victims with cases of non-Native victims.

The results presented below allow for an examination of case attrition of instances of sexual violence reported to AST and prosecuted by DOL. *Case attrition* is a term used to describe the process by which only a portion of offenses reported to the police are eventually dealt with through criminal prosecution. At each specific decision-making point the number of cases deemed worthy of official attention is reduced, with some cases carried forward for additional processing while others are no longer subject to prosecution.

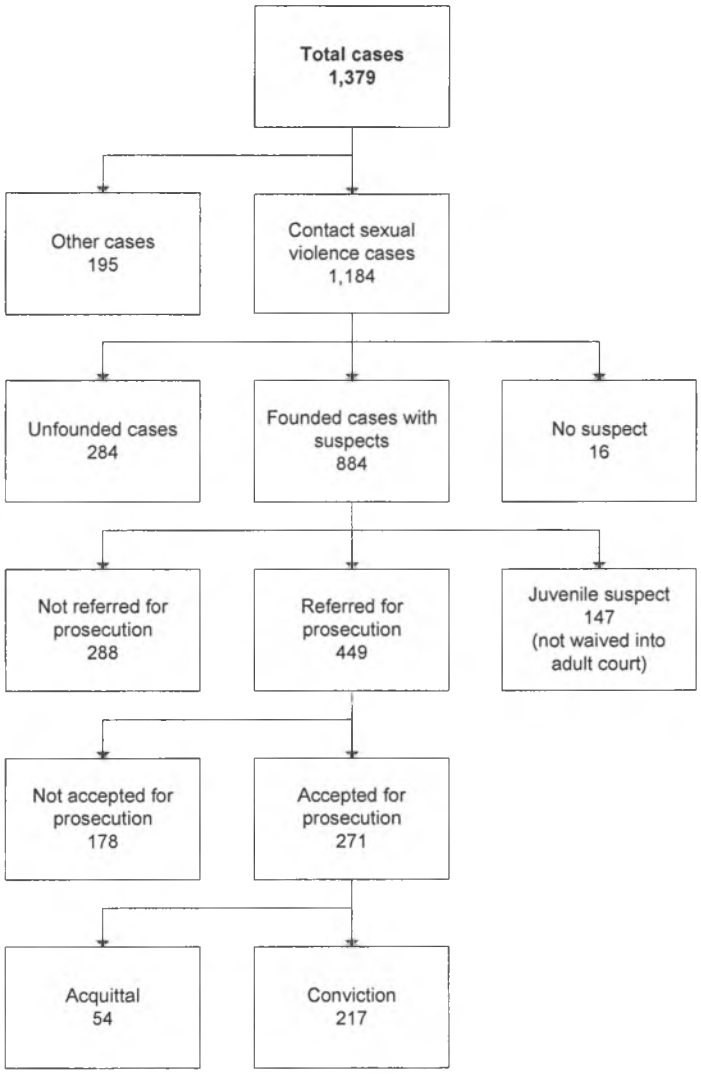
The attrition of sexual violence cases reported to AST in 2003 and 2004 is shown in Figure 1. Overall, there were 1,379 reports of sexual offenses made to AST during those two years. Of those original reports, 1,184 were contact sexual violence cases involving forcible rape, sexual assault, or sexual abuse of a minor. Among the other 195 cases were offenses that occurred outside of AST's geographic area of responsibility, offenses that occurred before 2003, offenses committed by children too young to form criminal intent, and non-contact sexual offenses such as indecent exposure or possession of child pornography.

In the next step in the process the police decide if the reported offense is *founded* (i.e., that it actually occurred) and if there is a suspect responsible for the offense to be subject to prosecution. Roughly three-fourths (74.7%) of the 1,184 reported contact sexual violence cases were deemed by AST to have occurred and to have at least one identifiable suspect.

After the police decide that an offense has indeed occurred and also identify a suspect, the next decision is whether to refer the case for prosecution in criminal court. Half (50.8%) of the 884 founded cases with identified suspects were referred to DOL for prosecution in adult criminal court. The

© 2009 Justice Center, University of Alaska Anchorage

Figure 1. Processing of Sexual Violence Cases Reported to the Alaska State Troopers, 2003–2004



cases excluded from the analysis at that point included those juvenile cases that were not waived into adult court (a sixth—16.6%—of founded cases with suspects) and those that were not referred for reasons such as a lack of evidence or uncooperative victims (a third—32.6%—of founded cases with suspects).

Once referred by the police, prosecutors decide which cases to prosecute; three-fifths (60.4%) of contact sexual violence cases referred by AST to DOL were accepted for prosecution. Cases that are prosecuted eventually result either in a conviction or an acquittal. Of the cases of sexual violence accepted for prosecution by DOL, most (80.1%) resulted in a conviction. Ultimately, only 18 percent of reported cases, 25 percent of founded cases with suspects, and 48 percent of cases referred by AST to prosecution resulted in a conviction—i.e., guilty plea or conviction at trial.

Apart from this general consideration of the winnowing of reported sexual violence offenses as they proceed through the system, it is also possible to examine relative case attrition of offenses involving Alaska Natives versus those of non-Natives. Doing so allows for a determination of the extent to which there is systematic under-enforcement of laws against contact sexual violence in cases with Alaska Native victims. Greater degrees of attrition of Alaska Native victims' cases when compared to that for non-Native victims would lend credence to the anecdotal evidence used in reports critical of the state's provision of policing and prosecution to Alaska Native communities.

Comparisons of attrition of cases of sexual violence are made on a number of levels. First, case attrition for offenses involving Alaska Native victims is compared with attrition of non-Native victims' cases. Next, case attrition in communities located in the rural regions of Alaska is compared with case attrition in communities located outside of the state's rural regions. Finally, the attrition of cases that occurred in isolated villages is compared with the attrition of cases that occurred in less-isolated locations. At each of these levels comparisons are made on the basis of the total of all contact sexual violence offenses, and for rape/sexual assault and sexual abuse of a minor (SAM) separately. Four different decisions are considered: the Troopers' decision on whether reported cases are founded; the Troopers' decision to refer founded cases for prosecution; the prosecutors' decision

Table 1. Attrition of Sexual Violence Cases Reported to Alaska State Troopers, Alaska Native vs. Non-Native Victims, 2003-2004

	Total sexual violence					Rape/sexual assault					Sexual abuse of a minor				
	Alaska Native		Non-Native			Alaska Native		Non-Native			Alaska Native		Non-Native		
Decision	N	%	N	%		N	%	N	%		N	%	N	%	
Founded	512	82.4 %	351	82.0 %		268	87.3 %	148	78.7 %	*	244	77.7 %	203	84.6 %	*
Referred†	289	67.7	159	56.8	*	153	69.9	65	56.0	*	136	65.4	94	57.3	
Accepted	185	64.0	85	53.5	*	105	68.6	29	44.6	*	80	58.8	56	59.6	
Convicted	149	80.5	67	78.8		80	76.2	21	72.4		69	86.3	46	82.1	

†Percentages based on founded cases with adult suspects.

*Difference between Alaska Native and non-Native victims is statistically significant at the $p < .05$ level.

Table 2. Attrition of Sexual Violence Cases Reported to Alaska State Troopers, Bush Stratum vs. Non-Bush Stratum, 2003-2004

	Total sexual violence					Rape/sexual assault					Sexual abuse of a minor				
	Bush		Non-Bush			Bush		Non-Bush			Bush		Non-Bush		
Decision	N	%	N	%		N	%	N	%		N	%	N	%	
Founded	447	76.1 %	453	75.9 %		233	81.5 %	197	75.2 %		214	71.1 %	256	76.6 %	
Referred†	242	65.9	207	55.9	*	129	69.7	89	56.0	*	113	62.1	118	55.9	
Accepted	167	69.0	104	50.2	*	95	73.6	39	43.8	*	72	63.7	65	55.1	
Convicted	136	81.4	81	77.9		72	75.8	29	74.4		64	88.9	52	80.0	

†Percentages based on founded cases with adult suspects.

*Difference between bush and non-bush regions is statistically significant at the $p < .05$ level.

to accept referred cases for prosecution; and the final court decision in cases accepted for prosecution—i.e., whether a conviction was obtained. These results are presented as a comparison between Alaska Native and non-Native victims in terms of the number and percentage of cases that were chosen to be carried forward in the criminal justice process. The results of chi-square tests of statistical significance—a test which measures the likelihood that differences in the percentage of cases carried forward are the result of chance alone and not indicative of an underlying association—are also provided.

Differences in the processing of cases involving Alaska Native and non-Native victims are shown in Table 1. For the most part, these results indicate that the cases of Alaska Native victims are as likely, or are even more likely, to be processed by the criminal justice system relative to the cases of non-Native victims. For the total of all sexual violence offenses, cases involving Alaska Native victims were just as likely as cases with non-Native victims to be founded or to result in a conviction and they were more likely to be referred by AST to prosecutors and to be accepted by DOL for prosecution. Considering only cases involving the offenses of rape and sexual assault, there were statistically significant differences between Alaska Native and non-Native victims at the founding decision and at the decisions to refer cases and accept cases for prosecution; at each of these decision-making points the cases of Alaska Native victims *were more likely* to be carried forward. In terms of SAM cases, those cases involving Alaska Native victims were less likely to be founded. Otherwise, none of the differences in the processing rates of Alaska Native and non-Native victims' SAM cases were statistically significant.

A second set of analyses was conducted to consider the processing of cases occurring in the largely Alaska Native communities of the most rural areas of the state. The dichotomy for these analyses was drawn between cases occurring either inside or outside of what the Department of Health and Social Services in its Alaska Behavioral Risk Factor Surveillance System has termed the "Bush Stratum"—comprising the boroughs and census areas north and west of the Railbelt. Comparisons of case processing from these bush communities with cases from non-bush communities are reported in Table 2. These results indicate that cases of sexual violence that occur in the most rural portions of Alaska have, depending upon the decision, an equal or greater chance of being subject to legal sanction when compared with cases from Alaska's less rural areas. Similar to what was found when comparing attrition in Alaska Native victims' cases versus non-Native victims' cases, victims from bush communities of sexual violence in general and of rape/sexual assault *were more likely* to have their cases referred to prosecutors by AST and to have DOL accept those cases for prosecution.

The final set of analyses considers attrition of cases coming from the most isolated villages compared to places that are less isolated. For these analyses a village was considered isolated if it lacked a local AST post or if Troopers were unable to reach the village by automobile. The premise of this dichotomy is that travel to villages that cannot be reached by highway is more difficult and, because of that hindrance, it could be expected that conducting investigations would be more difficult—thus increasing case attrition. From the perspective behind the allegations against the state, it is in these disconnected villages that lack a locally-posted police agency certified by the Alaska Police Standards Council where the greatest disparities in the enforcement and prosecution of cases of sexual violence would be expected to occur.

The results comparing attrition of cases occurring in villages defined as isolated with cases occurring in places more easily reached are presented in Table 3. As with the previously discussed comparisons of cases, case attrition in isolated villages is no more prevalent than in places that are better connected to AST posts. The results presented in Table 3 indicate that cases from isolated villages are instead *actually more*

Table 3. Attrition of Sexual Violence Cases Reported to Alaska State Troopers, Isolated vs. Non-Isolated Communities, 2003-2004

	Total sexual violence					Rape/sexual assault					Sexual abuse of a minor				
	Isolated		Non-Isolated			Isolated		Non-Isolated			Isolated		Non-Isolated		
Decision	N	%	N	%		N	%	N	%		N	%	N	%	
Founded	437	76.4 %	463	75.7 %		230	81.9 %	200	74.9 %	*	207	71.1 %	263	76.5 %	
Referred†	243	66.8	206	55.2	*	132	71.0	86	54.4	*	111	62.4	120	55.8	
Accepted	166	68.3	105	51.0	*	94	71.2	40	46.5	*	72	64.9	65	54.2	
Convicted	132	79.5	85	81.0		70	74.5	31	77.5		62	86.1	54	83.1	

†Percentages based on founded cases with adult suspects.

*Difference between isolated and non-isolated regions is statistically significant at the $p < .05$ level.

likely to receive full enforcement. Cases of rape/sexual assault in isolated villages *were more likely to be founded, more likely to be referred for prosecution by AST, and more likely to be accepted for prosecution by DOL.* Likewise, across the total of all sexual violence offenses, cases from isolated villages were referred and accepted for prosecution at a rate *greater than* cases from non-isolated locations. No differences were found in the attrition of SAM cases.

Overall, the results presented in this article provide little empirical support for allegations of discrimination in the processing of sexual violence cases by AST or DOL on a racial or geographic basis. With the exception of SAM cases against Alaska Native victims being less likely to be founded, *cases of sexual violence against Alaska Native victims were just as likely or actually more likely to receive full enforcement and prosecution when compared with cases against non-Native victims.* On the basis of geography, cases occurring in locations with predominately Alaska Native populations believed to be underserved by AST were actually more likely to be dealt with by AST or DOL when compared with cases from outside those geographic areas. Our results indicate that the anecdotal evidence found in reports critical of the state's response to sexual violence against Alaska Natives does not accurately reflect the actual processing of cases of rape, sexual assault, and SAM reported to AST and prosecuted by DOL. Ultimately, these results do not support claims of unequal enforcement by the state in response to the victimization of the Alaska Native population. However, Alaska continues to experience high rates of forcible rape, and the prosecution of sexual violence continues to be difficult: the percentage of AST-founded cases that resulted in a conviction never exceeded 30 percent.

Darryl Wood is an Assistant Professor at Washington State University Vancouver. André B. Rosay is an Associate Professor and the Interim Director of the Justice Center. *This project was supported by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice (Grant No. 2005-WGB-GX-0011). Points of view in this article are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

ALASKA JUSTICE FORUM
REPRINTS

March 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 10

Revisiting Alaska's Sex Offender Registration and Public Notification Statute

Deborah Periman

In Alaska and throughout the country sex offender registration requirements have become more inclusive. Almost all convicted sex offenders now must register for very extended periods; the registry is available over the Internet; and more details on the current status of the offender are available to the public. The intent of the registries is to protect the public from convicted offenders, but it can be argued that the increasingly stringent demands placed on offenders may, in fact, be counter-productive. The severity of the registration requirements may prohibit the rehabilitation of offenders and their reintegration into the community, and the increasing burden on law enforcement to monitor and maintain very broad registries may prevent police from focusing on the more serious sexual predators.

Originally published in the *Alaska Justice Forum* 25(1–2): 2-5 (Spring/Summer 2008).
http://justice.uaa.alaska.edu/forum/25/1-2springsummer2008/c_asora.html

For other articles and publications related to sex offenders and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This article examines the background and judicial interpretation of Alaska's sex offender registration and public notification statute, the new federal requirements for state sex offender registries and public notice under the Adam Walsh Child Protection and Safety Act, and weaknesses in both Alaska's existing system and the enhanced requirements of the new federal legislation. These weaknesses include:*

- *Absence of incentives for offenders to seek therapy or treatment;*
- *Failure to provide for individualized risk assessment that would differentiate between those offenders who pose a negligible or very low risk of re-offending from those who pose a continuing public risk – a failure that causes unwarranted marginalization of low risk offenders and diminishes the overall effectiveness of the public notification system;*
- *Public notice provisions so broad as to substantially impede offenders' reintegration into their families, their community, and the workforce, and potentially chilling family reporting;*
- *Internet posting requirements associated with severe stigmatization and public harassment, and concomitant emotional destabilization and isolation of offenders – factors that may actually increase the risk of recidivism and community harm.*

Because the Walsh Act conditions state receipt of Byrne Grant funds on compliance with its enhanced registration and notice requirements, there is little Alaska can do to remedy the above weaknesses and still remain eligible for Byrne funds. However, the article concludes with a recommendation for limited changes to our statute that would minimize, to the extent possible, its adverse effect on offenders' ability to find employment; omit the lowest risk offenders from internet posting requirements; and provide those incentives for treatment permissible under the Walsh Act.

Author's Note

This is an extremely abbreviated look at a complex federal initiative and at how specified aspects of the initiative relate to weaknesses in Alaska's sex offender registry. Issues of federalism and due process are not addressed, nor does this piece attempt to identify how the statutory elements of sex and kidnapping offenses under Alaska's code fit within the Walsh Act offender tiers. Finally, the reader should draw no inferences regarding Alaska's overall level of compliance with the Walsh Act requirements. A longer version of this piece, with complete legal citations, is available on the Justice Center website at http://justice.uaa.alaska.edu/workingpapers/.

Background

The Alaska Sex Offender Registration Act, which was enacted in the wake of extensive publicity over the tragic rape and murder of Megan Kanka in New Jersey, rests on specific legislative findings that (1) "sex offenders pose a high risk of reoffending after release from custody" and (2) release of information about sex offenders to the public "will assist in protecting public safety" (1994 Alaska Sess. Laws 41, § 1).

The state legislature's findings were premised on testimony reflecting the commonly held belief that sex offenders as a class are different from other offenders—that they will inevitably reoffend and that they are not receptive to treatment. In light of this testimony, the legislature did not attempt to distinguish among types of offenders or to evaluate which offenders were most likely to recidivate. Instead, it simply divided all offenders into two groups, aggravated and nonaggravated offenders, based on the severity of the offense. These two categories cover offenders ranging from the 18-year-old who has consensual sex with a 14-year-old to the perpetrator of a violent rape and murder.

The registration statute that emerged was, at the time of its enactment, one of the most stringent in the country. In a 2003 case closely watched by state and federal lawmakers, the U.S. Supreme Court upheld its terms against an *ex post facto* challenge. Justice John Paul Stevens, dissenting, summarized the statute's effect:

> In Alaska, an offender who has served his sentence for a single, nonaggravated crime must provide local law enforcement authorities with extensive personal information—including his address, his place of employment, the address of his employer, the license plate number and make and model

© 2009 Justice Center, University of Alaska Anchorage

> of any car to which he has access, a current photo, identifying features, and medical treatment—at least once a year for 15 years. If one has been convicted of an aggravated offense or more than one offense, he must report this same information at least quarterly for life. Moreover, if he moves, he has *one* working day to provide updated information. Registrants may not shave their beards, color their hair, change their employer, or borrow a car without reporting those events to the authorities. Much of this registration information is placed on the Internet. In Alaska, the registrant's face appears on a webpage under the label "Registered Sex Offender." His physical description, street address, employer address, and conviction information are also displayed on this page. (*Smith v. Doe*, 538 U.S. 84, 111 (2003))

At the time of its passage, Alaska's statute far exceeded the minimum requirements imposed on the states by the federal Jacob Wetterling Act. This legislation, adopted in 1994, required every state to enact a sex offender registration program meeting certain minimum guidelines or face a reduction in federal grant funding for law enforcement (42 U.S.C.A. § 14071 (West 2008)).

Unlike Alaska, many states attempted to tailor the reach of their registration statutes to the actual risk posed by individual offenders. The Connecticut legislature, for example, adopted a system using individualized clinical assessment to determine which offenders would be subject to registration requirements. Offenders were required to register only if such assessment demonstrated that they were found to pose a high risk of recidivism. This type of classification system has come to be known as an *offender-based* system, reflecting the emphasis on the individual. Alaska's system, in contrast, is *offense-based*, with classification resting solely on the conviction and no individual risk assessment undertaken.

Alaska was one of the relatively few states to require Internet dissemination of registration information for all offenders. Other states attempted to strike a balance between the stigmatization and collateral consequences of public notification and the risk of recidivism. New Jersey, for example, classified its offenders by risk and required no public disclosure for those who posed the least risk of reoffending, a percentage estimated at 45 percent of the entire sex offender class. Widespread disclosure was required only for those at the highest risk of reoffending (approximately five percent) of the whole.

Some of the flexibility afforded states under the original Wetterling Act was reduced through subsequent amendment; the flexibility to utilize individualized risk assessments will disappear almost completely as the provisions of the Adam Walsh Child Protection and Safety Act, PL 109-248, become binding on the states. This act represents an extensive revision and expansion of federal sex offender legislation. One of its many purposes is to standardize and increase minimum registration requirements nationwide. It imposes on the states highly detailed requirements for sex offender registration and public notification—requirements the states must in general implement by July 27, 2009. A state's failure to meet the implementation deadline will trigger a mandatory ten percent reduction in Byrne Justice Assistance Grant funding.

Key provisions of the Walsh Act include broadening the classes of sex offenses for which registration is required and extending it to cover juvenile offenses; requiring covered offenders to consistently remain registered in any jurisdiction in which they live, work, or attend school; expanding the scope of registration information required; imposing a national requirement for periodic in-person appearances by registrants; standardizing the required duration of registration; and widening the availability of information concerning registrants available to the public through required Internet posting. The act adopts an offense-based, three-tiered classification for offenders. It does not authorize the states to implement an offender-based classification using individualized risk assessment, nor, with limited exceptions, does it authorize the states to implement ameliorative programs that would allow offenders to avoid or shorten registration based on treatment and rehabilitation. The net effect of the new federal legislation will be to bring all cooperating states closer to Alaska's registration and publication requirements.

Alaska's Statute and its Federal Counterpart Rest on Disproved Assumptions

The myth of the incorrigible sex offender, all but guaranteed to reoffend, has been largely refuted. A study by the Alaska Justice Statistical Analysis Center of sex offenders released from Alaska corrections facilities in 2001 found that non-sex offenders were more likely to be rearrested than sex offenders. (See "Recidivism of Alaska Sex Offenders Released from Corrections Facilities in 2001" in this issue of the *Forum*.) With respect to sex crimes specifically, the study found no statistically significant difference between the rates at which sex offenders were rearrested for a new sex crime and the rates at which non-sex offenders were arrested for a first sex crime. These patterns are consistent with the results of studies elsewhere finding that sex offenders as a class are somewhat less likely than other categories of offenders to re-offend.

Moreover, recent studies conclude that treatment programs are, in fact, effective in reducing the overall rate of recidivism for many offenders. A Canadian study published in late 2007, for example, found that high-risk sex offenders who participated in a community-based treatment project had lower rates of reoffending of any type than did offenders who did not participate (Wilson, et al., 2007). Although sex offender treatment remains a controversial issue, these results are consistent with the general findings of studies conducted over the last decade or so—studies that refute the earlier belief that sex offenders are impervious to treatment.

The foregoing is particularly true with respect to juvenile offenders. Although offenders as young as 14 are subject to registration and public notification requirements under the Walsh Act, research establishes that recidivism rates for juvenile sex offenders are substantially lower than the rates for other types of juvenile offenders. Juvenile offenders have, in addition, proven highly amenable to treatment.

Problems with the Existing System

The Walsh Act and its antecedents rest on the premise that state registration and notification systems advance public safety, but empirical evidence disproves this premise. Studies show that after more than ten years of national registration and public notice, sex offender registries have made no discernable difference in sex offender recidivism rates (Tewksbury & Lees, 2007). (Although the registries have not curbed the commission of sex offenses, it should be noted that law enforcement officials in Alaska do view the offender database as a useful investigatory tool after an offense occurs.)

The weaknesses of Alaska's registration and notice system are well documented. Supreme Court Justice Ruth Bader Ginsberg, in a dissenting opinion in *Smith v. Doe*, 538 U.S. 84, 116–117 (2003), put it simply—the statute is excessive in relation to its purpose:

> The Act applies to all convicted sex offenders, without regard to their future dangerousness. And the duration of the reporting requirement is keyed

not to any determination of a particular offender's risk of reoffending, but to whether the offense of conviction qualified as aggravated." Moreover, "the Act makes no provision whatever for the possibility of rehabilitation: offenders cannot shorten their registration or notification period, even on the clearest demonstration of rehabilitation or conclusive proof of physical incapacitation. However plain it may be that a former sex offender currently poses no threat of recidivism he will remain subject to long-term monitoring and inescapable humiliation.

Of course, no matter how excessive the reach of the statute in relation to its goals, many would argue that the disabilities imposed on low-risk or rehabilitated offenders are warranted if the system serves to protect even one child. The difficulty, however, is that Alaska's registration and notification system, and others like it, do not demonstrably make the public safer. To the contrary, they are likely to trigger a host of consequences antithetical to the public interest.

Unemployment, Instability and Enhanced Risk of Recidivism

After ten-plus years of national experimentation with sex offender registries, the destabilizing effects of being listed on a sex offender registry are well understood. They include profound humiliation and social isolation, loss of employment and housing, and destruction of family ties. Registrants and their families have experienced vigilantism in the form of harassment, threats of violence, physical attacks and arson.

In *Doe v. State*, 92 P.3d 398, 410 (Alaska 2004), the Alaska Supreme Court made note of the severity of these consequences. Citing examples of Alaska registrants who had lost their jobs, been forced to move their residences, and received threats of violence, the Court observed that "the potentially destructive practical consequences that flow from registration and widespread governmental distribution of disclosed information" are grave. "[O]utside Alaska, there have been incidents of suicide by, and vigilantism against, offenders on state registries, and offenders listed on registries often have unique difficulties locating places to reside and work. Offenders are sometimes subjected to protests and group actions designed to force them out of their jobs and homes." Registrants have suffered neighborhood rallies staged to protest their presence, bricks thrown through windows, and harassing calls to employers.

Of these negative consequences, employment difficulties are perhaps most significant. The Ninth Circuit Court of Appeals concluded that Alaska's system of putting offenders' employment information on the Internet is likely to make registrants "completely unemployable" (*Doe v. Otte*, 259 F.3d 979, 988 (9th Cir. 2001), *rev'd.*, *Smith v. Doe*, 538 U.S. 84 (2003)). The system "creates a substantial probability that registrants will not be able to find work, because employers will not want to risk loss of business when the public learns that they have hired sex offenders." The court cited the experience of one Alaska business owner who suffered community hostility and damage to his business after print ads from the Alaska sex offender registry web site were publicly distributed and posted on a bulletin board.

It may be tempting to dismiss these adverse consequences as the just result of the offender's own conduct, but these consequences also disserve the community in several important ways. First, study after study has identified stress as one of the antecedents to sex offender relapse. Chronic torment and hostility from the public, fractured social relationships, lack of stable housing, and unemployment are likely to cause the registered offender heightened stress, anxiety and resentment, all of which may erode an offender's self-restraint (Cohen & Jeglic, 2007). Lack of social support, in particular, and the accompanying stress on the offender has been identified as a key trigger in sex offense recidivism (Levensen & Cotter, 2005).

These problems are particularly acute for juvenile offenders. Young persons subject to registration have been harassed at school; some have dropped out. The stigma associated with the public notice system causes a loss of social networks, which in turn increases the risk of anti-social behaviors.

The extreme length of the registration period may exacerbate these problems. Under the Walsh Act, states must require a minimum of 25 years registration for mid-level offenses and lifetime registration for the most serious offenses. Studies show, however, that offenders who view punishment as too severe or inescapable may be more likely to reoffend and that many offenders subject to the lifetime registration requirement feel states have opened the door to endless harassment and stigmatization.

The majority of offenders surveyed report that they have experienced first-hand social or psychological effects resulting from the public registries. The consequent shame, isolation, fear, and hopelessness all interfere with an offender's reintegration and recovery.

Lifetime Registration as a Disincentive to Therapy or Recovery

In Alaska, a sex offender "cannot escape the [registration] Act's grasp no matter how clearly he may demonstrate that he poses no future risk to anyone, and no matter how final the judicial determination that he has been successfully rehabilitated..." (*Otte*, 259 F.3d at 994). Alaska's failure to provide any avenue for relief from or mitigation of the registration requirement is one of its statute's failings.

In a recent sampling of individual sex offender perceptions, several offenders observed that the ability to have a risk evaluation completed while on the registry would provide an incentive and motivation "to pursue treatment, to avoid problematic situations, and . . . [maintain] a crime free lifestyle" (Tewksbury & Lee, 2007, p. 400). Another study looking at the social and psychological effects of registration on sex offenders found many experiencing feelings of despair and hopelessness in the absence of individualized assessment. One respondent stated, "no one believes I can change, so why even try?" (Levensen & Cotter, 2005, p. 52).

As written, the statute fails to recognize the possibility of rehabilitation and provides offenders considering treatment no hope that their efforts might eventually reduce the stigma associated with the registry's public notification system.

Mandatory Internet Publication and Chilled Reporting

The inability to avoid publication of an offender's personal information on the internet and the ensuing social obloquy may also discourage family members of some offenders from reporting offenses. The spouse of an offender, particularly of an offender who may be the family's primary source of economic support, faces a terrible dilemma in reporting: While the report may protect the spouse herself or himself, or a child, the report may consign the entire family to a lifetime of poverty, to loss of the family home if the offender is evicted, and to shared shame and harassment once the offender's personal information is placed on the Internet. Studies suggest that reporting may be equally difficult for the parent or sibling of an offender. Thus, to the extent that mandatory Internet publication acts as a disincentive to reporting intra-family offenses, Alaska's notification statute ill-serves Alaska's abused children and spouses.

Obfuscation of More Dangerous Offenders

The extraordinarily broad reach of

Alaska's publication requirement has ramifications beyond its collateral consequences to the offender and his or her family. Indiscriminate posting of information on all offenders tends to obscure from the public pertinent information relating to very dangerous sexual predators. Including low-risk offenders also places an unnecessary administrative burden on state officials responsible for establishing and maintaining the posting, with a concomitant increase in public expense. In addition, the greater the number of postings, the more difficult and expensive it is for the state to ensure accuracy and respond to noncompliant offenders.

Possible Changes

During the 2008 session, the Alaska legislature passed and the governor signed into law CSSB 185, which extends the reach of existing sex offender registration requirements. The new law adds the requirement that offenders provide the Department of Corrections with every email or instant messaging address or other Internet communication identifier they use—information mandated by the Walsh Act. This type of legislative fine-tuning, however, will not solve the most fundamental problems with the statute—overbreadth and the absence of treatment incentives.

Recent data show that those states whose legislation is most narrowly drawn to focus on the highest-risk offenders are most likely to achieve their legislative goals. A sex offender registration system is most effective where it uses actuarial risk-assessment measures to ascertain which sex offenders are at the highest risk of reoffending, distinguishes among offenders based on risk, and imposes the disabilities of registration and publication only on those most likely to recidivate. This type of registration and publication system allows the public to readily identify the most dangerous individuals and allows law enforcement to focus its resources on the most likely threats to the community (Cohen & Jeglic, 2007).

Unfortunately, the Walsh Act, with its offense-based tier structure, has foreclosed to a significant extent the states' ability to implement a true risk assessment scheme and retain eligibility for full Byrne Grant funding. There are, however, a few windows left open for small improvements to Alaska's statute.

Minimize the impact on employment. For reasons stated above, Internet publication of an employer name and address is one of the consequences of registration most likely to de-stabilize an offender socially and psychologically. The risk of consigning an offender to a lifetime of unemployment may also be a factor in deterring some family reporting.

The public interest associated with making employment available to released offenders is implicitly recognized under the new federal guidelines. The Walsh Act authorizes the states to exclude from their websites the name (though not the address) of a sex offender's employer. To facilitate offender reintegration and to protect the economic welfare of offenders' families, Alaska could avail itself of this option. While it is argued that knowing the name of an offender's employer enhances public safety, there is no empirical evidence to support this claim.

Omit the lowest risk offenders from internet publication. Another option granted the states under the new federal guidelines pertains to offenders classified under the statute as "Tier I Sex Offenders." Tier I offenders include those whose registration offense is not punishable by imprisonment for more than one year, whose offense is receipt or possession of child pornography, or whose offense is a sexual assault against an adult that involves sexual contact only.

The Walsh Act provides the states discretion to omit offenders in this category (other than those convicted of specified offenses against a minor) from placement on the state sex offender web site. With respect to this grant of discretion, Alaska legislators should do one of two things: Either adopt an individualized risk assessment program for offenders within this category and exclude from web publication those deemed to pose a low community risk or simply exclude these offenders as a class. The first approach would strike the optimal balance between the competing goals of providing adequate public notice and promoting offender reintegration and rehabilitation. It would also be much more expensive to administer, leaving the second approach a reasonable alternative with respect to these low-level offenders.

Include the limited treatment incentives authorized under the Walsh Act. The new federal requirements also offer states some latitude to include treatment incentives in their registration statutes. The Walsh Act generally requires the states to register Tier I offenders for 15 years, Tier II offenders for 25 years, and Tier III offenders for life. However, Section 115(b) provides that Tier I offenders' registration periods may be reduced by five years if they maintain a clean record within the statutory definition of that term, which includes successful completion of an approved treatment program. No reduction is authorized for offenders classified as Tier II or Tier III (73 Fed. Reg. at 38068). (Tier III offenders whose conviction stemmed from a delinquency proceeding are eligible for a reduction in term. In Alaska, however, a conviction triggering registration is defined as a conviction of an adult or a juvenile charged as an adult (AS 12.63.100(3).)

This window of opportunity for offering reduction of the registration period as a treatment incentive is very small. Nevertheless, in light of recent data showing that treatment is often effective in deterring future offenses, Alaska should take advantage of this limited opportunity to encourage released offenders to seek treatment.

Conclusion

There are ways to refine the current sex offender registration system to ensure that it better protects the public. The revulsion and anger that most of us feel toward those convicted of sex crimes should not blind us to the safety interest served by affording released offenders treatment incentives and the opportunity to live stable and socially productive lives. Within the confines of the federal funding mandates, Alaska can strike a more effective balance between warning the public of the most dangerous sexual predators and promoting the reintegration and rehabilitation of the larger class of offenders.

Deborah Periman is an assistant professor with the Justice Center.

For Further Reading

Cohen, M. and E. Jeglic. 2007. "Sex Offender Legislation in the United States: What Do We Know?" *International Journal of Offender Therapy and Comparative Criminology* 51(369): 376.

Levensen, J. and L. Cotter. 2005. "The Effect of Megan's Law on Sex Offender Reintegration." *Journal of Contemporary Criminal Justice* 21(49): 62.

Tewksbury, R. and M. Lees. 2007. "Perceptions of Punishment: How Registered Sex Offenders View Registries." *Crime & Delinquency* 53(380): 403.

Wilson, R., J. Picheca, and M. Prinzo. 2007. "Evaluating the Effectiveness of Professionally-Facilitated Volunteerism in the Community-Based Management of High Risk Sexual Offenders: Part Two—A Comparison of Recidivism Rates." *The Howard Journal* 46(4): 327.

ALASKA JUSTICE FORUM
REPRINTS

March 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 7

Sexual Assaults in Anchorage

Originally published in the *Alaska Justice Forum* 22(4): 2-3 (Winter 2006).
http://justice.uaa.alaska.edu/forum/22/4winter2006/b_sxassault.html

For other articles and publications related to sexual assault and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This study examined the characteristics of all sexual assaults reported to the Anchorage Police Department from 2000 through 2003. Key descriptive findings are summarized.*

- *Victims tended to be young and female, with Native women victims in over 45% of reported sexual assaults.*
- *In a majority of the assaults – over 62% - the assailant was not a stranger to the victim. The most common non-stranger relationships included friends and acquaintances.*
- *A majority of the assaults occurred indoors, with 45% taking place at the residence of one or both of those involved.*
- *Sixty-five percent of victims had used alcohol prior to the assault and 74% of suspects had also.*
- *While assaults occurred all over the Municipality of Anchorage, they happened with more frequency in Spenard, Fairview, and Downtown.*

Information from four years of police files shows that the problem of sexual assault in Anchorage has discernible contours: most assaults take place indoors, between people who are not strangers to each other, with either or both parties having consumed alcohol. The attached tables, figures and map provide an overview of reported sexual assaults in the city from 2000 through 2003. The data come from a recently-completed report by the Justice Center that updates an earlier study released in 2003. The new study was undertaken by the Center in collaboration with the Anchorage Police Department.

The Justice Center study revealed that victims have tended to be young and female, with Native women victims in over 45 percent of reported sexual assaults. In a majority of the assaults—over 62 percent—the assailant was not a stranger to the victim. A majority of the assaults occurred indoors, with 45 percent taking place at the residence of one or both of those involved. Over 65 percent of the victims had used alcohol prior to the assault and close to 74 percent of suspects had also. While assaults occurred all over the city, they happened with more frequency in certain areas of town—particularly in Spenard, Fairview, and Downtown.

The data presented here are already two years old, but figures released by the FBI's Uniform Crime Reporting (UCR) program indicate that the rate of reported forcible rape (a more tightly defined offense than that reflected in the tables presented here) in the Municipality of Anchorage was 96.1 per 100,000 people in 2004. The national rate was only 32.2. These UCR figures are not directly comparable to those presented in the Justice Center study, but they show that the

Table 1. Race of Victims in Sexual Assaults Reported to Anchorage Police, 2000-2003

Race	Percentage of Anchorage population, 2001[1]	Sexual assault victims N	%	Rate per 1,000 population[2]
White	77.6 %	556	45.5 %	2.77
Native	10.6	550	45.0	20.08
Black	7.2	75	6.1	4.04
Hispanic	6.0	17	1.4	1.10
Asian	7.3	22	1.8	1.17
Pacific Islander	1.3	1	0.1	0.30
Total		**1221**		

1 Includes both males and females (95.2% of victims were female), categories are not mutually exclusive
2 Rate is computed as a four-year rate. To obtain average annual rates, divide by four. Population estimates are 2001 estimates and include both males and females.

Source of data: *Anchorage Police Department & U.S. Census Bureau*

Table 2. Race of Suspects in Sexual Assaults Reported to Anchorage Police, 2000-2003

Race	Percentage of Anchorage population, 2001[1]	Sexual assault suspects N	%	Rate per 1,000 population[2]
White	77.6 %	483	39.6 %	2.40
Native	10.6	272	22.3	9.93
Black	7.2	319	26.1	17.18
Hispanic	6.0	95	7.8	6.16
Asian	7.3	46	3.8	2.44
Pacific Islander	1.3	4	0.3	1.20
Total		**1219**		

1 Includes both males and females (99.5% of suspects were male), categories are not mutually exclusive.
2 Rate is computed as a four-year rate. To obtain average annual rates, divide by four. Population estimates are 2001 estimates and include both males and females.

Source of data: *Anchorage Police Department & U.S. Census Bureau*

Alaska Justice Forum Reprints presents selected articles originally published in the *Alaska Justice Forum*. Complete issues of the *Forum* are available at http://justice.uaa.alaska.edu/forum/.
Justice Center ♦ University of Alaska Anchorage ♦ 3211 Providence Drive ♦ Anchorage, AK 99508 ♦ (907) 786-1810 ♦ ayjust@uaa.alaska.edu

© 2009 Justice Center, University of Alaska Anchorage

sexual assault rate in Anchorage continues to be extremely high. With the problem of sexual assault, it is also important to note that national data show that many assaults are not reported to the police, so it is possible that the figures collected represent only a limited picture of the problem.

André Rosay of the Justice Center was the principal investigator for the study. The complete results from this recent update can be found at http://justice.uaa.alaska.edu/research/2000/0107sxassaultupdate/index.html. The earlier study is available at http://justice.uaa.alaska.edu/ research/2000/0107sxassault/. A lengthier article on the 2003 study, "Forcible Rapes and Sexual Assaults in Anchorage," appeared in the Winter 2004 issue of the *Alaska Justice Forum.*

This project was supported by Grant No. 2004-WG-BX-0003 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Table 3. Alcohol Use by Victims of Sexual Assaults Reported to Anchorage Police, by Year: 2001-2003

Row percentages.

	Alcohol use		No alcohol use		
Year	N	%	N	%	Total
2001	167	62.3 %	101	37.7 %	**268**
2002	171	63.6	98	36.4	**269**
2003	194	69.8	84	30.2	**278**
Total	**532**	**65.3 %**	**283**	**34.7 %**	**815**

Source of data: *Anchorage Police Department*

Table 4. Alcohol Use by Suspects of Sexual Assaults Reported to Anchorage Police, by Year: 2001-2003

Row percentages.

	Alcohol use		No alcohol use		
Year	N	%	N	%	Total
2001	157	76.2 %	49	23.8 %	**206**
2002	152	72.7	57	27.3	**209**
2003	136	72.0	53	28.0	**189**
Total	**445**	**73.7 %**	**159**	**26.3 %**	**604**

Source of data: *Anchorage Police Department*

Figure 1. Locations of Sexual Assaults Reported to Anchorage Police, 2000-2003

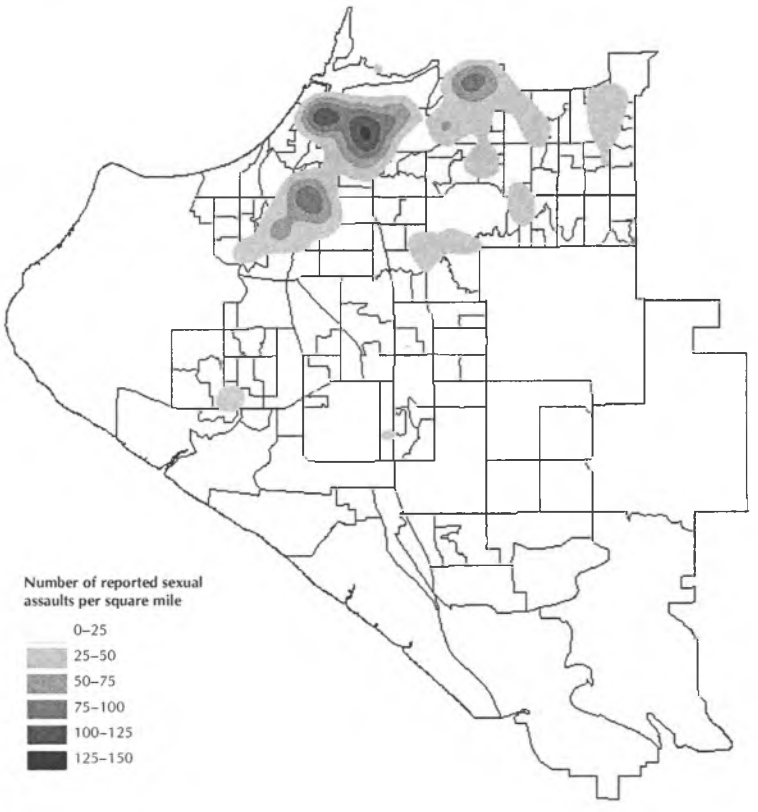


Table 5. Victim-Offender Relationship in Sexual Assaults Reported to Anchorage Police, 2001-2003

Relationship	N	% of total	% of non-stranger
Total non-stranger	**645**	**62.2 %**	**100.0 %**
Acquaintance	330	31.8	51.2
Friend	135	13.0	20.9
Family	83	8.0	12.9
Intimate	97	9.4	15.0
Stranger	**392**	**37.8 %**	–.–
Total	**1037**		

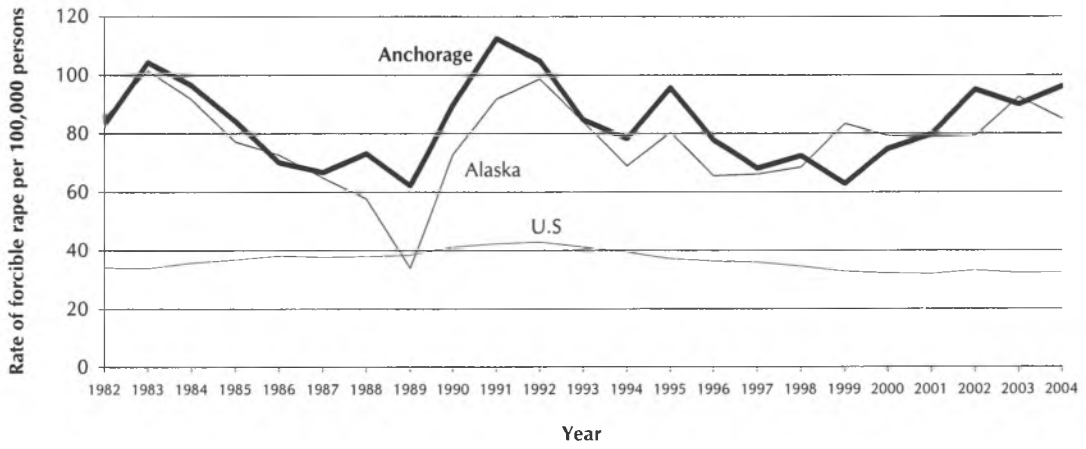
Source of data: *Anchorage Police Department*

Table 6. Assault Location Type for Sexual Assaults Reported to Anchorage Police, 2000-2003

Location	N	%
Victim's house	250	19.5 %
Suspect's house	256	20.0
Victim and suspect's house	75	5.9
Other's house	141	11.0
Hotel	102	8.0
Bar	13	1.0
Outdoors	250	19.5
Other	111	8.7
Unknown	83	6.5
Total	**1281**	

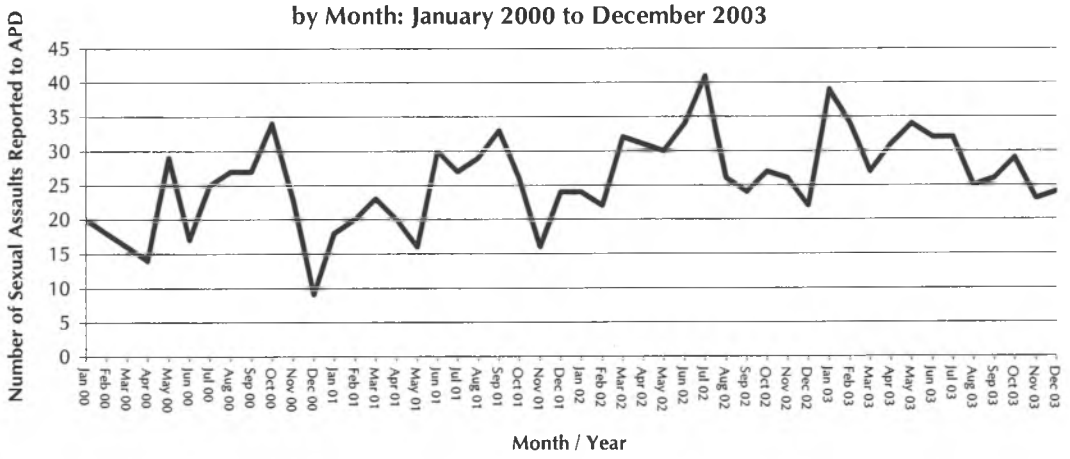
Source of data: *Anchorage Police Department*

Figure 2. Rates of Forcible Rape in the U.S., Alaska, and Anchorage: 1982 - 2004



Source of data: *Uniform Crime Reports, Federal Bureau of Investigation*

Figure 3. Number of Sexual Assaults Reported to the Anchorage Police Department by Month: January 2000 to December 2003



Source of data: *Anchorage Police Department*

ALASKA JUSTICE FORUM
REPRINTS

March 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 6

Sexual Assault Case Processing: A Descriptive Model of Attrition and Decision Making

G. Matthew Snodgrass

Originally published in the *Alaska Justice Forum* 23(1): 1, 4-8 (Spring 2006).
http://justice.uaa.alaska.edu/forum/23/1spring2006/a_sxassaultcases.html

For other articles and publications related to sexual assault and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This study examined the outcomes of sexual assault cases reported to the Anchorage Police Department between January 2000 and December 2003. The data include 1,052 cases involving one suspect and one victim (85% of all reported sexual assaults). Cases and charges were tracked through the Alaska Department of Law to determine what was referred, accepted, and convicted.*

- *Overall, 18% of cases were referred for prosecution. The most common referred charge was a sexual assault in the first degree. Seventy-nine percent of referred charges were sexual assault charges.*
- *Overall, 12% of cases were accepted for prosecution. The greatest point of attrition was from report to referral. Once referred, 68% of cases were accepted for prosecution. Sixty-eight percent of charges were accepted by the Department of Law as referred. The most common reasons for not accepting a charge as referred were evidentiary reasons. The most common accepted charge was also a sexual assault in the first degree. Seventy-five percent of accepted charges were sexual assault charges.*
- *Overall, 11% of cases resulted in a conviction. Once accepted, 87% of cases resulted in a conviction. Although convictions were common in accepted cases, accepted charges were often dismissed. While 87% of accepted cases resulted in a conviction, 59% of accepted charges were dismissed. Ninety percent of guilty findings were a result of plea bargaining. With plea bargaining, some charges were dismissed but a conviction was still secured. Fifty-six percent of convicted charges were sexual assault charges. The most common convicted charge was for assault, followed by sexual assault in the second degree.*

A recent Justice Center examination of sexual assault case processing shows that close to 60 percent of cases referred by the Anchorage Police Department to the Alaska Department of Law result in a conviction on some charge—although not necessarily the original charge. The number of cases referred, however, is less than 20 percent of those reported.

Anchorage has a very high incidence of reported rape. Between 2000 and 2003, the rate of reported forcible rape in Anchorage was 163 percent higher than in the U.S. as a whole. Over the past twenty years, Anchorage has been consistently at or near the top of U.S. metropolitan statistical areas for rates of reported forcible rape.

The Justice Center examined the outcomes of all sexual assaults involving one suspect and one victim reported to the Anchorage Police Department (APD) between January 2000 and December 2003. In this article we summarize how the Alaska Department of Law disposed of these reported assaults, detail case and charge outcomes and discuss the reasons given by prosecutors for these outcomes.

Overall, 1,235 sexual assaults were reported to APD from January 2000 through December 2003. We sampled all 1,074 sexual assaults committed by one suspect against one victim (87.0% of all sexual assaults reported from January 2000 to December 2003). Data were collected on 1,052 (98%) of these reports. Of these 1,052, 188 (17.9%) were referred for prosecution and had reached final disposition prior to data collection. Offenses in these 1,052 reports included sexual assaults, forcible rapes, attempted sexual assaults, and attempted forcible rapes. As defined by the Federal Bureau of Investigation's Uniform Crime Reports, forcible rape is "the carnal knowledge of a female forcibly and against her will." Sexual assault is a less restrictive state-defined offense that does not consider the gender of the parties involved and does not require carnal knowledge.

For this article, we consider three stages of prosecution: referral, acceptance, and conviction. These stages can be thought of as formal decision points at which prosecutors record what has transpired with the case, and why that outcome resulted. Referral is the forwarding of charges by APD to the DOL. This is the initial stage of prosecution and the first stage at which prosecutors officially become aware of a report. Once a case has been referred to the DOL, it is screened for acceptance. More specifically, prosecutors will screen each charge within each case for acceptance. The prosecutor's initial screening decision for each charge is recorded with a screening disposition code which indicates in what fashion the charge did or did not move forward. At this decision point, in addition to disposition codes, reason codes are given to charges that are not accepted as referred by law enforcement. The reason code indicates the formal reason that prosecutors gave for the disposition of the charge in that manner.

Acceptance can be considered the second stage of prosecution, or the second formal prosecutorial decision point. At this stage prosecutors formally agree to move forward with criminal prosecution. Once a final outcome has been established, a final disposition code and potentially a reason code are attached to each individual accepted charge within a case. The final disposition code indicates the final outcome of an accepted charge. The reason code associated with this final disposition reflects the prosecutor's reason for the final disposition of the charge. A conviction is an accepted charge result-

© 2009 Justice Center, University of Alaska Anchorage

Table 1. Number of Cases By Stage

Stage	N	% of reported	% of referred	% of accepted
Reported	1052	100.0 %	—	—
Referred	188	17.9	100.0 %	—
Accepted	127	12.1	67.6	100.0 %
Convicted	111	10.6	59.0	87.4

Source of data: Alaska Department of Law

ing in a finding of guilt. A finding of guilt can occur through plea bargaining or being found guilty beyond a reasonable doubt by either judge or jury.

Table 1 describes the number of cases reported, referred, accepted, and convicted. Of the 1,052 reported cases, 188 (17.9%) were referred to DOL and 127 (67.6%) were accepted. Finally, 111 (87.4%) of these 127 cases resulted in a conviction. Obviously, the point with the greatest attrition is from report to referral.

For the purposes of this article, two separate levels of analysis are used: a case-level analysis and a charge-level analysis. For case-level analysis, a case as a whole is the unit of analysis. With this level of analysis, we are concerned only with the most serious outcome at a particular stage. The second level of analysis, at the charge level, considers individual charges within a case, using the individual charge as the unit of analysis. Using this level of analysis, we are concerned with all charges at each decision point, not simply the single charge that received the most serious outcome. This distinction is important for understanding many of the results of this project.

Table 2. Referred Charges

Charge	N	%
Sexual assault 1	180	41.5 %
Sexual assault 2	99	22.8
Sexual assault 3	11	2.5
Sexual abuse of a minor 1	20	4.6
Sexual abuse of a minor 2	28	6.5
Sexual abuse of a minor 3	3	0.7
Sexual abuse of a minor 4	1	0.2
Assault	38	8.8
Kidnapping	17	3.9
Other charge	37	8.5
Total	**434**	

Source of data: Alaska Department of Law

Table 3. Class of Referred Charges

Class	N	%
Unclassified felony	211	48.6 %
Class A felony	12	2.8
Class B felony	135	31.1
Class C felony	36	8.3
Class A misdemeanor	35	8.1
Class B misdemeanor	4	0.9
Non-classified violation	1	0.2
Total	**434**	

Source of data: Alaska Department of Law

From referral to acceptance, there is often cross-movement of charges within a case. While it is necessary that at least one charge be referred for any case to be accepted, the number of charges within a case need not be static from referral to acceptance or from acceptance to conviction. Law enforcement may refer many charges to prosecutors, but upon review of the case, prosecutors agree to move forward with prosecution on a subset of the referred charges (i.e., the number of accepted charges is less than the number referred). Similarly, it is possible that when law enforcement refers only a single charge to prosecutors, upon review, prosecutors feel that additional charges are appropriate (i.e., they create an accepted charge that was not referred).

Referral

As mentioned earlier, of the 1,052 reported sexual assault cases, 188 (17.9%) resulted in a referral to the DOL. Fewer than half (41.5%) of the referred cases included one charge; 76.5 percent had three or fewer charges. Overall, the 188 referred cases contained 434 referred charges. Table 2 shows the distribution of these 434 referred charges by charge type. One hundred and eighty (41.5%) of the referred charges were sexual assaults in the first degree. Further, 290 (66.8%) of the 434 referred charges were sexual assaults of some degree. Fifty-two (12.0%) of the referred charges were for sexual abuse of a minor; 38 (8.8%) were assault charges; 17 (3.9%) were kidnapping charges; and 37 (8.5%) were other charges. Examples of other charges included contributing to the delinquency of a minor, driving under the influence, and possession of child pornography.

Table 4. Disposition of Referred Charges

Disposition	N	%
Accepted as referred	296	68.2 %
Accepted—same class	7	1.6
Accepted—higher level	19	4.4
Accepted—lesser felony	6	1.4
Accepted—lesser misdemeanor	2	0.5
Prosecution declined—dismissal required	9	2.1
Prosecution declined—no dismissal required	95	21.9
Total	**434**	

Source of data: Alaska Department of Law

Table 3 is a breakdown of referred charges by class. Over 90 percent (n = 394) of the referred charges were felonies. Almost half of the charges (48.6%) were referred as unclassified felonies, that is, the gravest crimes under Alaska statutes, carrying with them the harshest penalties. Under the statutes, sexual assault is taken very seriously. Further, when a report results in a referral, the charges referred for prosecution are at a high level of class severity and carry with them some of the most significant penalties exacted by the justice system.

All charges referred to the DOL receive screening disposition codes. Table 4 indicates the disposition codes that were attached to the 434 referred charges. Prosecutors agreed to prosecute 68.2 percent of charges as referred by law enforcement. "Prosecution declined" disposition codes were attached to 24.0 percent (n=104) of

Table 5. Reason for Not Accepting Charge as Referred

Reason	N	%
Witness reason	24	17.4 %
Evidentiary reason	63	45.7
Discretionary reason	45	32.6
Procedural/other reason	6	4.3
Total	**138**	

Source of data: Alaska Department of Law

Table 6. Charge Progression from Referral to Acceptance

	Accepted		
Referred	Yes	No	Total
Yes	330	104	**434**
No	83	0	**83**
Total	**413**	**104**	**517**

Source of data: Alaska Department of Law

Table 7. Accepted Charges

Charge	N	%
Sexual assault 1	151	36.6 %
Sexual assault 2	79	19.1
Sexual assault 3	13	3.1
Sexual abuse of a minor 1	27	6.5
Sexual abuse of a minor 2	32	7.7
Sexual abuse of a minor 3	7	1.7
Sexual abuse of a minor 4	1	0.2
Assault	38	9.2
Kidnapping	12	2.9
Other charge	53	12.8
Total	**413**	

Source of data: Alaska Department of Law

referred charges. Interestingly, 92.2 percent (n=400) of charges were either accepted as referred by law enforcement or declined.

Here we make claims about charges, not cases. As stated earlier, a majority of cases (58.5%) have more than one charge. It is therefore possible that at least one charge in a case progresses forward, while others are dismissed.

Only charges that were not accepted as referred receive reason codes. Thus, in our sample, the 138 charges not accepted as referred received reason codes. Reasons for not accepting charges as referred are shown in Table 5. What is important to note is the proportion of reasons, by type, given by prosecutors for a charge not being accepted as referred. At this stage, evidentiary reasons were the most typical reasons (45.7%) for not accepting a charge as referred. Discretionary reasons were the second most common reasons for not accepting a charge as referred—32.6 percent.

Transition between Referral and Acceptance

Of the 434 charges that were referred for prosecution, 330 (76.0%) were accepted, either as referred or as a different charge, while the remaining 104 (24.0%) were dropped. Also, 83 new charges were created by prosecutors from referral to acceptance. This means that there were a total of 517 charges at some stage of prosecution within these 188 cases (see Table 6).

We now briefly focus on the 104 charges that were declined for prosecution and the 83 new charges that were added by prosecutors. Half (n=52) of the 104 charges not accepted by the DOL were sexual assaults in the first degree and an additional 21.2 percent (n=22) were sexual assaults in the second degree. Over half of the charges that were not accepted by prosecutors were unclassified felonies and an additional 27.9 percent were class B felonies. Of the 83 charges added by prosecutors, 32 (38.6%) were sexual assault charges, 20 were sexual abuse of a minor charges, 6 were assault charges, 2 were kidnapping charges, and 23 were other charges. New charges added by prosecutors were most commonly class B felonies or unclassified felonies.

Acceptance

We now turn our attention to the 413 charges that moved forward from referral to acceptance. Within the case-level analysis, 127 cases of the original 188 moved forward from referral to acceptance (see Table 1). Stated differently, prosecutors agreed to move forward on 67.6 percent of the cases referred to them. Of the 127 accepted cases, 28.3 percent contained one charge and 70.8 percent contained three or fewer charges. Overall, 413 charges moved forward between referral and acceptance. Table 7 shows the charge type of these 413

Table 8. Referred Charges Versus Accepted Charges, for Charges that were Both Referred and Accepted

		Accepted charge									
Referred charge	**Total**	Sexual assault 1	Sexual assault 2	Sexual assault 3	Sexual abuse of a minor 1	Sexual abuse of a minor 2	Sexual abuse of a minor 3	Sexual abuse of a minor 4	Assault	Kidnapping	Other charge
Sexual assault 1	**128**	**123**	2	1	–	–	–	–	2	–	–
Sexual assault 2	**77**	12	**62**	2	1	–	–	–	–	–	–
Sexual assault 3	**9**	1	1	**7**	–	–	–	–	–	–	–
Sexual abuse of a minor 1	**19**	–	–	–	**18**	1	–	–	–	–	–
Sexual abuse of a minor 2	**24**	–	–	–	1	**23**	–	–	–	–	–
Sexual abuse of a minor 3	**1**	–	–	–	–	–	**1**	–	–	–	–
Sexual abuse of a minor 4	**1**	–	–	–	–	–	–	**1**	–	–	–
Assault	**31**	–	–	–	–	1	–	–	**30**	–	–
Kidnapping	**10**	–	–	–	–	–	–	–	–	**10**	–
Other charge	**30**	–	–	–	–	–	–	–	–	–	**30**
Total	**330**	**136**	**65**	**10**	**20**	**25**	**1**	**1**	**32**	**10**	**30**

Source of data: Alaska Department of Law

Table 9. Class of Accepted Charges

Class	N	%
Unclassified felony	179	43.3 %
Class A felony	18	4.4
Class B felony	116	28.1
Class C felony	46	11.1
Class A misdemeanor	40	9.7
Class B misdemeanor	6	1.5
Nonclassified misdemeanor	1	0.2
Misdemeanor probation or SIS revocation	7	1.7
Total	**413**	

Source of data: Alaska Department of Law

Table 10. Referred Charge Class Versus Accepted Charge Class for Charges That Were Both Referred and Accepted

		Accepted class					
Referred class	**Total**	Unclassified felony	Class A felony	Class B felony	Class C felony	Class A misdemeanor	Class B misdemeanor
Unclassified felony	**151**	**144**	1	3	1	2	–
Class A felony	**10**	2	**8**	–	–	–	–
Class B felony	**106**	11	3	**87**	5	–	–
Class C felony	**29**	1	1	3	**24**	–	–
Class A misdemeanor	**30**	–	–	1	1	**28**	–
Class B misdemeanor	**4**	–	–	–	–	–	**4**
Total	**330**	**158**	**13**	**94**	**31**	**30**	**4**

Source of data: Alaska Department of Law

charges. As with referral, the most common accepted charge was sexual assault in the first degree—36.6 percent (n=151) of the accepted charges. Further, 58.8 percent of all accepted charges were sexual assaults in some degree.

Table 8 shows exactly how charges moved from the referral stage to the accepted stage, for the 330 charges which were both referred and accepted. What is interesting here is the remarkable consistency with which charges fall on the table's diagonal: A charge referred and accepted as the same charge type will fall on a diagonal line from the upper-left to lower-right corners. We see that the vast majority of charges (92.4%) fall on this diagonal.

Table 9 provides the charge class frequencies for the 413 charges that were accepted by the DOL. Most charges were accepted as unclassified felonies. Furthermore, 86.9 percent of the charges in our sample were accepted at the felony level. Knowing that the vast majority of charges are accepted as referred, we could reasonably expect charge class to remain relatively constant from referral to acceptance—as Table 10 shows. For charges that were both referred and accepted, there is a great degree of class congruency between referral and acceptance.

Table 11. Disposition of Accepted Charges

Disposition	N	%
Jury trial—guilty as charged	10	2.4 %
Jury trial—not guilty	17	4.1
Pled as charged	52	12.6
Plea—amended charge	72	17.4
Dismissed by prosecutor	243	58.8
Dismissed by court	9	2.2
Probation/SIS revoked	4	1.0
No true bill	3	0.7
Final disposition outstanding	3	0.7
Total	**413**	

Source of data: *Alaska Department of Law*

Final Disposition

Once a final outcome has been determined for a charge, prosecutors attach a final disposition code. Table 11 shows the final disposition codes that were attached to the 413 accepted charges in our sample. What is immediately apparent is the large of proportion of charges that are dismissed by prosecutors. Of the 413 accepted charges, 243 (58.8%) were dismissed by prosecutors. Taken as a whole, 61.7 percent of accepted charges were later dismissed, including those for which no true bill was returned. Another point becomes clear from Table 11: For 124 of the 138 accepted charges that resulted in a finding of guilt, the conviction was a result of plea bargaining. This means that plea agreements were responsible for 89.9 percent of guilty findings in our sample. To state this differently: Only 10 percent of guilty findings were a result of court action.

Charges that were dismissed by prosecutors or charges for which prosecutors allowed a plea to an amended charge are given a final disposition reason code. These reasons are shown in Table 12. The most striking result in Table 12 is the degree to which discretionary reasons are cited by prosecutors. Of the reasons given by prosecutors for dismissing a charge or allowing a plea to an amended charge, 70.5 percent were discretionary in nature. Among discretionary reasons for charge dismissal can be the choice of another charge as more accurate, the consolidation of charges, or the suspect pleading to the essence of the offense.

Table 12. Reason for Accepted Charges Being Dismissed or Allowing Plea to an Amended Charge

Reason	N	%
Witness reason	53	16.8 %
Evidentiary reason	34	10.8
Discretionary reason	222	70.5
Procedural/other reason	6	1.9
Total	**315**	

Source of data: *Alaska Department of Law*

Conviction

Of the 127 cases that were accepted by DOL, 16 cases (12.6%) resulted in no conviction. Most cases (87.4%) resulted in a conviction on at least one charge. When examining the charge-level analysis, 138 (33.4%) of the 413 accepted charges resulted in a finding of guilt. Table 13 is a frequency table of convicted charge types. Table 14 presents the changes in the types of charges between acceptance and conviction. We see much more variation about the diagonal than we did in earlier crosstabulations.

Table 13. Convicted Charges

Charge	N	%
Sexual assault 1	12	8.7 %
Sexual assault 2	35	25.4
Sexual assault 3	10	7.2
Sexual abuse of a minor 1	2	1.4
Sexual abuse of a minor 2	14	10.1
Sexual abuse of a minor 3	3	2.2
Sexual abuse of a minor 4	1	0.7
Assault	30	21.7
Kidnapping	2	1.4
Other charge	29	21.0
Total	**138**	

Source of data: *Alaska Department of Law*

Table 14. Accepted Charges Versus Convicted Charges, for Accepted Charges that Resulted in a Conviction

		Convicted charge									
Accepted charge	**Total**	Sexual assault 1	Sexual assault 2	Sexual assault 3	Sexual abuse of a minor 1	Sexual abuse of a minor 2	Sexual abuse of a minor 3	Sexual abuse of a minor 4	Assault	Kidnapping	Other charge
Sexual assault 1	**41**	**12**	18	1	–	–	–	–	5	–	5
Sexual assault 2	**31**	–	**17**	5	–	–	–	–	7	–	2
Sexual assault 3	**4**	–	–	**4**	–	–	–	–	–	–	–
Sexual abuse of a minor 1	**5**	–	–	–	**2**	2	–	–	–	–	1
Sexual abuse of a minor 2	**15**	–	–	–	–	**12**	2	–	–	–	1
Sexual abuse of a minor 3	**1**	–	–	–	–	–	**1**	–	–	–	–
Sexual abuse of a minor 4	**1**	–	–	–	–	–	–	**1**	–	–	–
Assault	**18**	–	–	–	–	–	–	–	**17**	–	1
Kidnapping	**3**	–	–	–	–	–	–	–	1	**2**	–
Other charge	**19**	–	–	–	–	–	–	–	0	–	**19**
Total	**138**	**12**	**35**	**10**	**2**	**14**	**3**	**1**	**30**	**2**	**29**

Source of data: *Alaska Department of Law*

Table 15. Class of Convicted Charges

Class	N	%
Unclassified felony	10	7.2 %
Class A felony	7	5.1
Class B felony	36	26.1
Class C felony	34	24.6
Class A misdemeanor	42	30.4
Class B misdemeanor	5	3.6
Misdemeanor probation or SIS revocation	4	2.9
Total	**138**	

Source of data: Alaska Department of Law

Table 16. Accepted Charge Class Against Convicted Charge Class, for Charges that Resulted in a Conviction

		Conviction class						
Accepted class	Total	Unclassified felony	Class A felony	Class B felony	Class C felony	Class A misde-meanor	Class B misde-meanor	Misdemeanor probation or SIS revocation
Unclassified felony	**44**	**10**	5	13	10	6	–	–
Class A felony	**7**	–	**2**	1	2	1	1	–
Class B felony	**47**	–	–	**22**	11	13	1	–
Class C felony	**16**	–	–	–	**11**	5	–	–
Class A misdemeanor	**18**	–	–	–	–	**17**	1	–
Class B misdemeanor	**2**	–	–	–	–	–	**2**	–
Misdemeanor probation or SIS revocation	**4**	–	–	–	–	–	–	**4**
Total	138	10	7	36	34	42	5	4

Source of data: Alaska Department of Law

This is an indication that charge types are shifting between acceptance and conviction. Given that a large proportion of cases are disposed of by plea bargaining, this is not surprising.

There is a shift in charge class similar to the shift in charge type we observed between acceptance and conviction. Table 15 presents the convicted charge class, and Table 16 demonstrates the way charge class shifted between acceptance and conviction.

Sexual assaults in some degree formed 60.8 percent of charges that were accepted but failed to result in a conviction.

Conclusions

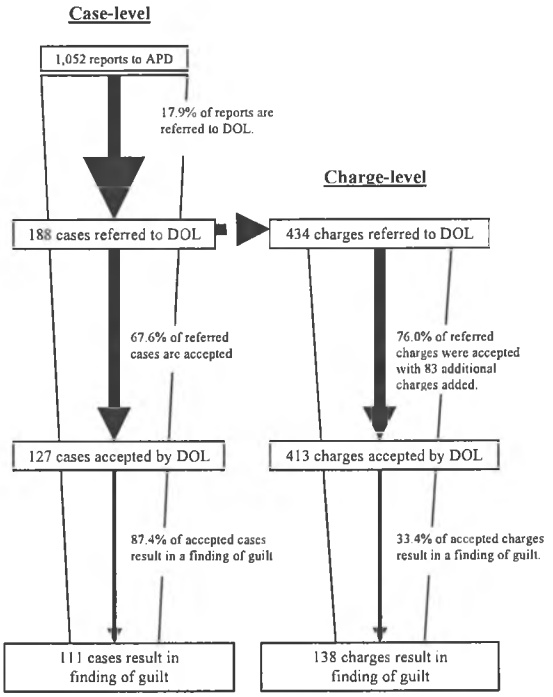
As we have seen, the picture of sexual assault case processing that emerges depends, in large part, on the level of analysis. Conclusions about the prosecution of sexual assaults by the DOL vary substantially depending on which level of analysis we consider. Figure 1 succinctly illustrates the points and rates of attrition for sexual assault cases and charges at the three formal prosecutorial decision points considered in this project. Figure 1 shows that a higher proportion of charges than offenders are being removed from the system at each decision point. Furthermore, results indicate that most offenders whose cases reach prosecutors are being held accountable in some degree; that is, they receive criminal sanctions. Another fact becomes clear when looking at Figure 1: The point of highest attrition is prior to prosecutorial involvement, with 82.5 percent of reported sexual assaults not referred for prosecution. This is by far the largest filtering that occurs at any formal decision point studied in this research. However, determining what precisely is happening between report and referral is beyond the scope of the present project.

In addition to the rates of attrition shown in Figure 1, there is a substantial change in the types of charges that flow through the three decision points examined in this research (Tables 8, 10, 14, and 16). The distribution of charges by type is relatively constant from referral to acceptance, but there is a demonstrable shift in the distribution between acceptance and conviction. The most dramatic shift is observed for the sexual assault in the first degree charges. At referral, charges for sexual assault in the first degree constitute 41.5 percent of all charges. At acceptance, this proportion is relatively unchanged at 36.6 percent. However, sexual assault in the first degree constitutes only 8.7 percent of convicted charges.

Upon first inspection, this result may be startling, but it becomes readily explainable when viewed in light of previous results. We stated earlier that the vast majority (89.9%) of convictions in our sample are a result of plea bargaining, which commonly results in convictions on less serious charges. We could therefore reasonably expect that many charges in our sample would result in convictions on charges that are less severe than those originally referred or accepted.

While the reason codes may not capture all possible reasons for charge dispositions, they offer useful insight into prosecutorial decision making. A comparison of reason codes between those given from referral to acceptance (Table 7) and those given from acceptance to conviction (Table 12) shows that there is a perceptible shift in the reasons attached to case dispositions at the respective decision points. From referral to acceptance, evidentiary reasons account for 47.5 percent of reasons given for a referred charge not being accepted as referred. From acceptance to conviction, this proportion drops substantially to 10.8

Figure 1. Case and Charge Movement Between Decision Points



Source of data: Alaska Department of Law

percent of reasons given by prosecutors. The opposite happens for the proportion of total reasons that are discretionary in nature. Between referral and acceptance, discretionary reasons account for 32.6 percent of the reasons given by prosecutors. This proportion jumps to 70.5 percent of reasons given for a dismissal or plea agreement to an amended charge.

Overall, we began with a total 1,074 sexual assaults reported to the Anchorage Police Department between January 2000 and December 2003 involving one suspect and one victim. Data were collected on 1,052 (98%) of these 1,074 reports. These 1,052 reports to APD resulted in the referral of 188 cases and 434 charges to DOL. These 188 referred cases resulted in the acceptance of 127 cases that included 413 charges. Prosecutors obtained convictions in 111 cases on 138 charges. Thus, the majority of cases resulted in a conviction on at least one charge. For referred cases, a majority of respondents were held accountable for their actions to some degree.

It remains true, however, that a heavy majority of reported sexual assaults are not referred for prosecution. More examination of this point in case processing—between reporting and referral—is urgently needed.

Since the greatest source of case and charge attrition is from report to referral, enhancing offender accountability may depend on increasing the proportion of reported sexual assaults that are referred to the Department of Law.

G. Matthew Snodgrass is a researcher in an ongoing study of sexual assaults in Anchorage. *The study is being directed by André Rosay of the Justice Center. The complete report on which this article is based is available at http://justice.uaa.alaska.edu/research/2000/0611sexassault/0611sxcaseprocess.html.* *This project was supported by Grant No. 2004-WG-BX-0003 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

ALASKA JUSTICE FORUM
REPRINTS

March 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 8

Forcible Rapes and Sexual Assaults in Anchorage

André Rosay

Originally published in the *Alaska Justice Forum* 20(4): 1, 9–11 (Winter 2004).
http://justice.uaa.alaska.edu/forum/20/4winter2004/a_rapes.html

For other articles and publications related to sexual assault and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This study examined the characteristics of all sexual assaults reported to the Anchorage Police Department from 2000 through 2003. Key descriptive findings are summarized.*

- *Victims tended to be young and female, with Native women victims in over 45% of reported sexual assaults.*
- *In a majority of the assaults — over 62% — the assailant was not a stranger to the victim. The most common non-stranger relationships included friends and acquaintances.*
- *A majority of the assaults occurred indoors, with 45% taking place at the residence of one or both of those involved.*
- *Sixty-five percent of victims had used alcohol prior to the assault and 74% of suspects had also.*

Alaska generally, and Anchorage specifically, have been plagued by a high incidence of forcible rapes and sexual assaults. For the first time, solid data on victim and suspect characteristics, time and location of assaults and other details have been assembled and studied. These data contradict some of the more common assumptions regarding Anchorage's rape problem.

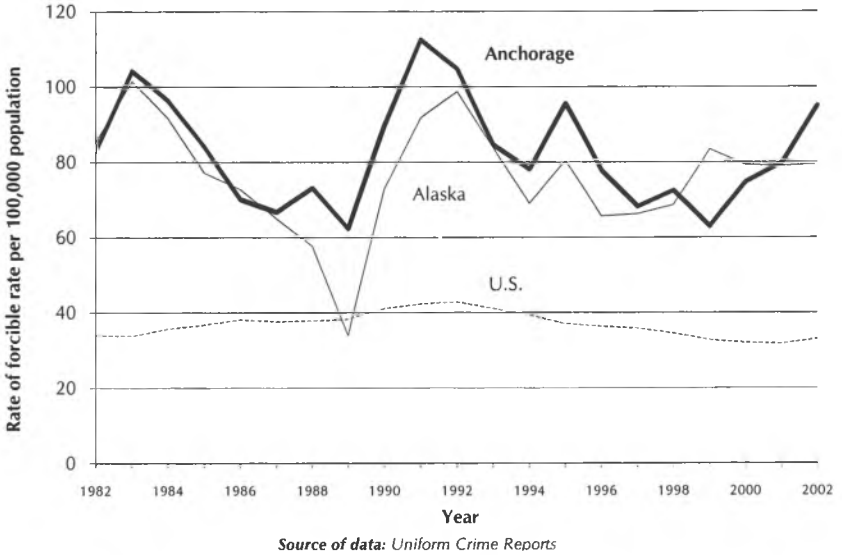
The data are important to designing effective rape prevention efforts. The Anchorage Police Department has recently secured new funding sources directed at reducing the occurrence of forcible rapes and sexual assaults: a $2 million federal grant and a $500,000 municipal grant. The question now is how to best allocate these resources. As discussed in the criminological literature, problem-oriented policing offers a promising approach.

Problem-oriented policing is a strategy in which police (1) define the problems to be solved, (2) diagnose these problems to identify their causes, (3) develop and implement interventions that address these causes, and (4) assess the efficacy of their interventions.

As defined in the Federal Bureau of Investigation's Uniform Crime Reporting (UCR) Program, forcible rape is "the carnal knowledge of a female forcibly and against her will." Attempted forcible rapes are also included in the UCR's measure. Figure 1 displays the rates of forcible rape reported to police from 1982 to 2002 for the United States, Alaska, and Anchorage. In 2002, the state of Alaska had the highest rate of reported forcible rape among the 50 states (79.4 per 100,000) and Anchorage had the second highest rate of reported forcible rape among metropolitan statistical areas in the U.S. (95.0 per 100,000). In 2002, the rates of reported forcible rape were 141 percent higher in Alaska and 188 percent higher in Anchorage than in the U.S.

In addition to forcible rapes, Anchorage also has a high rate of reported sexual assaults (although national comparisons are not available). The definition of a sexual assault is less restrictive than that of a forcible rape: sexual contact with another person, male or female, without the consent of that other person. In 2002, there were 254 forcible rapes and 85 sexual assaults reported to the Anchorage Police Department, for a total of 339 forcible rapes and sexual assaults. Furthermore, according to analysis done by Callie Marie Rennison for the Bureau of Justice Statistics, national statistics indicate that only 36 percent of forcible rapes, 34 percent of attempted forcible rapes, and 26

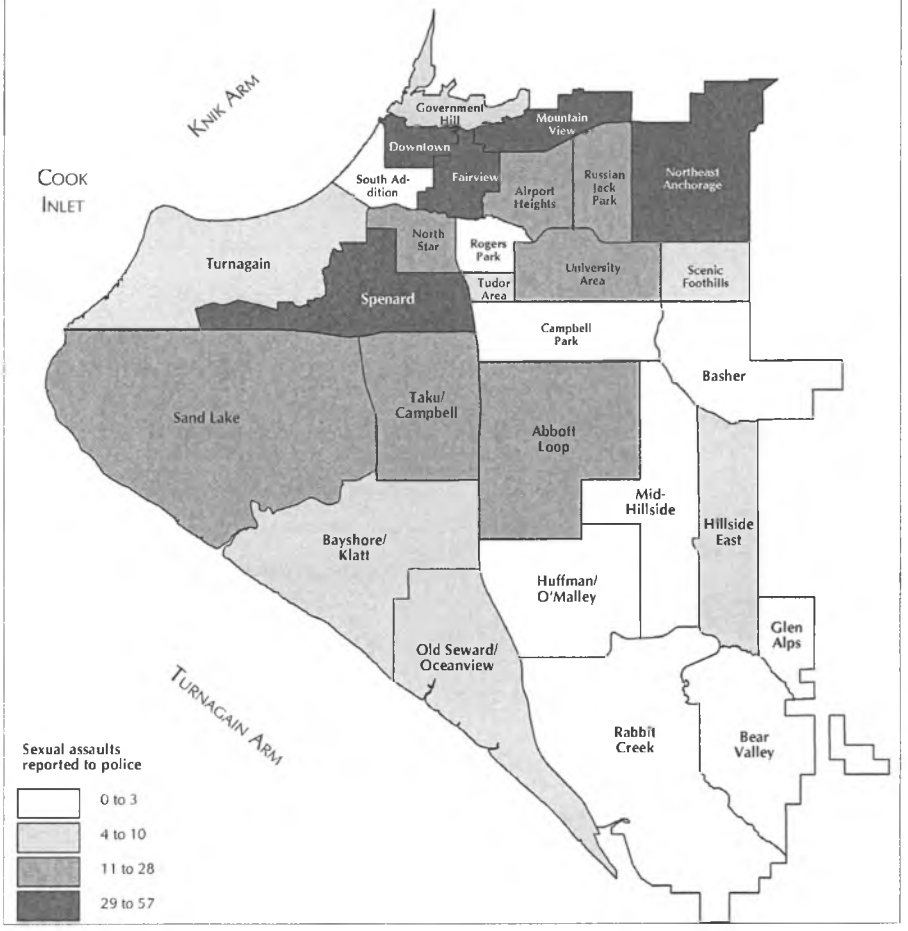
Figure 1. Rates of Forcible Rape in the U.S., Alaska, and Anchorage, 1982-2002



Source of data: *Uniform Crime Reports*

© 2009 Justice Center, University of Alaska Anchorage

Figure 2. Sexual Assaults Reported to Anchorage Police by Community Council Area, 2000-2001



percent of sexual assaults are reported to the police. In light of this, the forcible rape and sexual assault problem in Anchorage is probably worse than that indicated by police statistics.

A joint project of the UAA Justice Center and the Anchorage Police Department has focused on gaining a better understanding of the parameters of the rape problem in Anchorage. Researchers collected data from all sexual assaults and rapes reported to the Anchorage Police Department in 2000 and 2001. These data contain detailed information on the assaults, victims, and suspects. The findings presented here reflect a quantitative perspective on those assaults that have been reported. It is important to note again that many sexual assaults go unreported.

The key findings from this study suggest that interventions will be successful in Anchorage only insofar as they take into account:

- Geographical and temporal concentration of reported sexual assaults and rapes;
- Demographic characteristics of victims and suspects;
- Types of victim-suspect relationships;
- Locations of assaults; and
- Use of alcohol.

Like all criminal activity, sexual assaults and rapes are neither geographically nor temporally random. In the data studied, reported sexual assaults and rapes were most likely to occur in five community council areas—Downtown, Fairview, Spenard, Mountain View, and, to a lesser extent, Northeast Anchorage (see Figure 2). More specifically, 10.1 percent of the sexual assaults and rapes reported in 2000 and 2001 occurred Downtown, 10.1 percent in Fairview, 13.4 percent in Spenard, 10.1 percent in Mountain View, and 9.0 percent in Northeast. Of the 424 assault locations reported in 2000 and 2001, 52.7 percent were in these five community council areas. Temporally, reported sexual assaults and rapes were most likely to occur on the weekends and from 10 PM to 6 AM. More precisely, 49 percent of sexual assaults and rapes reported in 2000 and 2001 occurred on weekends and 60 percent occurred between 10 PM and 6 AM.

Knowing where and when sexual assaults

Table 1. Race of Victims of Sexual Assaults Reported to Anchorage Police, 2000-2001

Race[1]	Victims[2] N = 539 N	%	Percentage of Anchorage population, 2001[3]	Sexual assault rate per 1,000 population[4]
Caucasian	257	47.7 %	77.6 %	1.28
Native	243	45.1	10.6	8.86
Hispanic	8	1.5	6.0	0.52
African-American	27	5.0	7.2	1.45
Asian	8	1.5	7.3	0.42
Pacific Islander	0	0.0	1.3	0.00

[1] Categories are not mutually exclusive.
[2] Detail adds to greater than total N because victims may be of more than one race.
[3] Includes both males and females (95.5% of victims were female).
[4] Base population includes both males and females.
Source of data: *2000 and 2001 data (N = 539); U.S. Census Bureau, 2001 Supplementary Survey (Anchorage, AK MSA) <www.census.gov/acs/www/Products/Profiles/Single/2001/SS01/Tabular/380/38000US03801.htm>.*

Table 2. Race of Suspects in Incidents of Sexual Assault Reported to Anchorage Police, 2000-2001

Race[1]	Suspects[2] N = 567 N	%	Percentage of Anchorage population, 2001[3]	Sexual assault suspects per 1,000 population[4]
Caucasian	231	40.7 %	77.6 %	1.15
Native	126	22.2	10.6	4.60
Hispanic	47	8.3	6.0	3.05
African-American	137	24.2	7.2	7.38
Asian	30	5.3	7.3	1.59
Pacific Islander	4	0.7	1.3	1.20

[1] Categories are not mutually exclusive.
[2] Detail adds to greater than total N because suspects may be of more than one race.
[3] Includes both males and females (99.4% of suspects were male).
[4] Base population includes both males and females.
Source of data: *2000 and 2001 data (N = 539); U.S. Census Bureau, 2001 Supplementary Survey (Anchorage, AK MSA) <www.census.gov/acs/www/Products/Profiles/Single/2001/SS01/Tabular/380/38000US03801.htm>.*

and rapes occur is an important step in defining the problem to be solved. These results provide reliable evidence of the geographical and temporal concentration of sexual assaults and rape—rather than unreliable evidence based on hunches, experience, or common sense. This evidence suggests that police efforts to combat sexual assaults and rape ought to be concentrated on the weekends from 10 PM to 6 AM in Downtown, Fairview, Spenard, Mountain View, and Northeast.

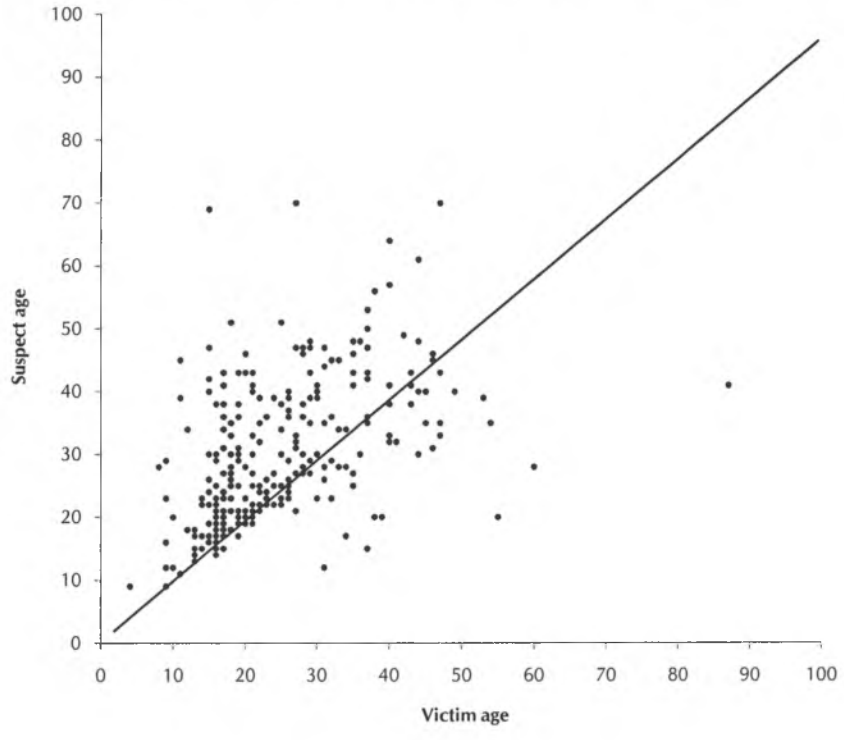
At the same time, police efforts to combat sexual assault and rape need to take into consideration the demographic characteristics of both victims and suspects. The vast majority (95.5%) of victims were female, with most (93.2%) residing in Anchorage. Almost all suspects (99.4%) were male and, again, most (94.3%) resided in Anchorage. Most victims were Caucasian or Native, with Native victims vastly overrepresented (see Table 1). For reported sexual assaults and rapes, Natives were 7.6 times more likely than others to be a victim.

Suspects were more racially diverse than victims (see Table 2). Most suspects were Caucasian, but Native and African-American suspects were overrepresented in proportion to the general population.

The age of victims and suspects is shown in Figure 3. On average, victims were 5 years younger than suspects. For victims, the highest rate of reported sexual assault and rape was for 15-to-19-year-olds (6.76 per 1,000) while for suspects, the highest rate of reported sexual assault and rape was for 20-to-24-year-olds (3.75 per 1,000).

Figure 3. Victim and Suspect Age in Sexual Assault Cases Reported to Anchorage Police, 2000-2001

Analysis includes only those cases with one victim and one suspect (N = 264).



With these demographics characterizing those involved in sexual assaults, interventions should primarily focus on Anchorage residents rather than visitors. Furthermore, it is clear that victim-focused interventions must occur at an earlier age than suspect-focused interventions. The daily routines of 15-to-19-year-olds are substantially different than those of 20-to-24-year-olds. In particular, 15-to-19-year-olds are likely to be in school during the week, making schools an attractive intervention partner for victim-focused interventions. Developing suspect-focused interventions in schools, however, makes little sense as most suspects are beyond school age.

It would also make little sense to develop interventions without considering the relationships between victims and suspects. These relationships are described in greater detail in Table 3. According to the 2002 National Crime Victimization Survey, only 32.5 percent of sexual assaults nationwide and rapes are stranger assaults. In Anchorage, however, stranger assaults are far more common. In 2000 and 2001, 44.3 percent of victims who reported a sexual assault or rape to police did not know the offender beforehand. Among non-stranger assaults, the most common were assaults between casual acquaintances (30.4%) and those between well-known friends (27.1%). Unfortunately, little is known about the differences between stranger and non-stranger assaults. Consequently, the implications of this important finding are still unclear. It is likely, however, that important differences between stranger and non-stranger assaults do exist, requiring separate approaches to reduce occurrence. For example, it is possible that non-stranger assaults are more likely to occur in private places than stranger assaults.

Though we have not yet investigated these differences, our analyses clearly reveal that most sexual assaults reported to police (over 67.7%) occurred indoors (see Table 4). The most common indoor locations included the victim's residence and the suspect's residence. Of the sexual assault locations, 45.3 percent were the victim's residence or suspect's residence (or both), and an additional 9.9 percent took place in some other residence. In comparison, fewer sexual assaults occurred outdoors (22.0%). Common outdoor locations included fields, woods, parks, roads, streets, and parking lots. Few assaults occurred in vacant lots (5.3%), city parks (1.9%), or along park trails (0.5%). Overall, our data show that

Table 3. Victim-Offender Relationship in Incidents of Sexual Assault Reported to Anchorage Police, 2001

Suspect's relationship to victim	N	% of total	% of non-stranger
Total non-stranger	**181**	**55.7 %**	**100.0 %**
Spouse	8	2.5	4.4
Parent	2	0.6	1.1
Sibling	5	1.5	2.8
Grandchild	1	0.3	0.6
Stepparent	3	0.9	1.7
Other family	9	2.8	5.0
Acquaintance	55	16.9	30.4
Friend	49	15.1	27.1
Neighbor	2	0.6	1.1
Babysitter	2	0.6	1.1
Boy/girlfriend	22	6.8	12.2
Ex-spouse	5	1.5	2.8
Employer	1	0.3	0.6
Otherwise known	17	5.2	9.4
Stranger	**144**	**44.3 %**	**–.–**
Total	**325**		

only 4.3 percent of reported sexual assaults *originated* in parks, fields, or woods and that only 7.3 percent *occurred* in these places. Most of these places were vacant lots. Moreover, while only one assault was reported as occurring in a bar, the original pick-up in 54 cases (13.6%) occurred in a bar—a finding that should be seen in relation to the figures on alcohol involvement in sexual assaults.

Consequently, strategies that target outdoor places, particularly ones that target parks or trails, will not appreciably affect the rates of sexual assault and rape in Anchorage. Although the municipality's Trail Watch Program instituted in September 2003 may reduce the fear of crime among trail users (and may reduce other forms of crime), it will probably have negligible effects, if any, on the occurrence of sexual assaults and rapes if these patterns continue. Different strategies must be used to lower the rates of sexual assault and rape in Anchorage, since most rapes occur indoors, in residences.

Finally, interventions must take into account that alcohol use was very frequent among both suspects and victims. During 2000 and 2001, 76.2 percent of suspects and 59.9 percent of victims had used alcohol. Table 5 displays victim and suspect alcohol use for 176 cases (cases with only one victim and one suspect and cases where both victim and suspect alcohol use was known). Both the suspect and the victim had used alcohol in 59.7 percent of these cases. Only the suspect had used alcohol in 13.1 percent of these cases. Only the victim had used alcohol in 1.7 percent of these cases and neither the suspect nor the victim used alcohol in 25.6 percent of these cases. Stated differently, almost 75 percent of these cases involved alcohol—either by the suspect, the victim, or both.

Overall, we have come a long way towards defining the problems to be solved, diagnosing these problems, and identifying their causes. Though the analyses are neither finished nor definitive, we nonetheless now have some reliable information that can be used to enhance the success of community and police rape prevention efforts. We ought to make sure that all interventions take into consideration that:

- Reported sexual assaults and rapes occur mostly on the weekends from 10 PM to 6 AM in Downtown, Fairview, Spenard, Mountain View, and Northeast;
- The highest victimization rates are for 15-to-19-year-olds while the highest offending rates are for 20-to-24-year-olds;
- 44.3 percent of victims are assaulted by strangers;
- 59.6 percent of known assault locations are private residences; and
- Alcohol use is very frequent among both suspects and victims.

It must be understood that police alone cannot solve the sexual assault and rape problem that has plagued Anchorage for well over 20 years. The data suggest that effective solutions to this problem need to be both suspect-focused and victim-focused (as well as event-focused). Many have dismissed the idea of victim-focused interventions for fear that it leads to victim blaming. The reality, however, is that we can educate about sexual assault and rape without blaming victims for sexual assault and rape: we educate homeowners about burglary prevention without blaming them for burglaries and we educate business owners about shoplifting without blaming them for shoplifting.

André Rosay is an assistant professor with the Justice Center. *The Justice Center report on which this article was based,* ***Descriptive Analysis of Sexual Assaults in Anchorage, Alaska****, is available on the Justice Center website, http://www.uaa.alaska.edu/just/. This project was supported by Grant No. 2000-RH-CX-K039 awarded by the Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

Table 4. Location Type for Pick-Up and Assault of Victims of Sexual Assault Reported to Anchorage Police, 2000-2001

	Pick-up		Assault	
Location type	N	%	N	%
Indoors	**389**	**71.9 %**	**397**	**67.7 %**
Victim's residence	110	20.3	129	22.0
Suspect's residence	66	12.2	121	20.6
Victim's and suspect's residence	12	2.2	15	2.6
Other residence	44	8.1	58	9.9
Bar	54	13.6	1	0.2
Hotel	33	6.1	57	9.7
Doctor's office	14	2.6	16	2.7
Other indoors	56	10.4	18	3.1
Outdoors	**104**	**19.2 %**	**129**	**22.0 %**
Road, street	62	11.5	52	8.9
Parking lot	15	2.8	31	5.3
Vacant lot	14	2.6	29	4.9
Park	7	1.3	11	1.9
Trail	2	0.4	3	0.5
Other outdoors	4	0.7	3	0.5
Unknown	**48**	**8.9 %**	**42**	**7.2 %**
Total	**541**		**586**	

Note: Totals differ because there was sometimes more than one assault location for the same pick-up.

Table 5. Victim and Suspect Alcohol Use in Incidents of Sexual Assault Reported to Anchorage Police, 2001

Analysis includes only those cases in which one victim and one suspect were involved.

Alcohol use by suspect	Alcohol use by victim: Yes	No	Total
Yes	105	23	128
No	3	45	48
Total	108	68	176

ALASKA JUSTICE FORUM
REPRINTS

March 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 9

Disposition of Sexual Assault Cases

It is not possible to correlate the figures on reported sexual assaults in Anchorage in 2000-2001 presented in the first article in this issue of the *Alaska Justice Forum* with figures on felony case processing as examined in the Judicial Council felony study, but the Judicial Council felony case study does contain figures specifically related to cases involving sexual offenses that give an idea of how these cases are handled.

According to the Judicial Council study, a sexual offense constituted the most serious charge in 12 percent of the cases studied. Table 1 shows the dispositions for these cases. The data reveal that disposition charges are often lower, sometimes at the misdemeanor level. A majority of all cases, however, resulted in a conviction on a felony charge—and on a sexual offense charge, a disposition that results in placement on the sexual offender registry.

The statistical analysis presented in the Judicial Council study shows that cases involving sexual offenses were handled even-handedly, with no effects associated with ethnicity in charge reduction, pre-disposition incarceration or sentence. Some disparities did appear in association with case location and with type of attorney.

See table on page 2.

Originally published in the *Alaska Justice Forum* 20(4): 8 (Winter 2004).
http://justice.uaa.alaska.edu/forum/20/4winter2004/d_rapedisposition.html

For other articles and publications related to sexual assault and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This article summarizes findings on cases involving sexual offenses from the Alaska Judicial Council study* ***Alaska Felony Process: 1999*** *(February 2004). (The full Judicial Council report is available online at http://www.ajc.state.ak.us/reports/Fel99FullReport.pdf.) The study examined the original single most serious charge and determined its final disposition. Twelve percent of felony cases included a sexual offense as the original single most serious charge. Charges for sexual abuse of a minor were more likely to be convicted as sexual offenses than sexual assault charges (and were less likely to be convicted as misdemeanors).*

- *The most frequent original single most serious charges included sexual abuse of a minor in the second degree (Class B felony), sexual assault in the second degree (Class B felony), sexual assault in the first degree (Unclassified felony), and sexual abuse of a minor in the first degree (Unclassified felony).*
- *Eighty-one percent of charges for sexual abuse of a minor in the second degree were convicted as sexual offense charges. Forty-one percent were convicted as sexual abuse of a minor in the second degree. Thirteen percent were convicted as misdemeanors.*
- *Fifty-five percent of charges for sexual assault in the second degree were convicted as sexual offense charges. Seventeen percent were convicted as sexual assault in the second degree. Thirty-four percent were convicted as misdemeanors.*
- *Fifty percent of charges for sexual assault in the first degree were convicted as sexual offense charges. Nine percent were convicted as sexual assault in the first degree. Twenty-two percent were convicted as misdemeanors.*
- *Eighty-four percent of charges for sexual abuse of a minor in the first degree were convicted as sexual offense charges. Twenty-one percent were convicted as sexual abuse of a minor in the first degree. Five percent were convicted as misdemeanors.*

Alaska Justice Forum Reprints presents selected articles originally published in the *Alaska Justice Forum*. Complete issues of the *Forum* are available at http://justice.uaa.alaska.edu/forum/.
Justice Center ♦ University of Alaska Anchorage ♦ 3211 Providence Drive ♦ Anchorage, AK 99508 ♦ (907) 786-1810 ♦ ayjust@uaa.alaska.edu

© 2009 Justice Center, University of Alaska Anchorage

Table 1. Charge Changes for Single Most Serious Charge

Original single most serious charge / Final disposition of single most serious charge	N	% of each disposition	Percent convicted of misdemeanor
Sexual abuse minor 1 (unclassified)	**43**	—	**4.7 %**
Sexual abuse minor 1	9	20.9 %	
Attempted sexual abuse minor 1	8	18.6	
Sexual abuse minor 2	15	34.9	
Sexual abuse minor 3	2	4.7	
Sexual assault 1	1	2.3	
Sexual assault 2	1	2.3	
Assault 4 (misd.)	1	2.3	
Contributing to delinquency of minor (misd.)	1	2.3	
Dismissed/acquitted	*5*	*11.6*	
Sexual assault 1 (unclassified)	**46**	—	**21.7 %**
Sexual assault 1	4	8.7 %	
Attempted sexual assault 2	2	4.3	
Attempted sexual assault 1	1	2.2	
Burglary 1	1	2.2	
Perjury	1	2.2	
Sexual assault 2	13	28.3	
Sexual assault 3	2	4.3	
Alcohol to minor (misd.)	1	2.2	
Assault 4 (misd.)	6	13.0	
Attempted sexual assault 3 (misd.)	1	2.2	
Harassment (misd.)	1	2.2	
Criminal mischief 3 (misd.)	1	2.2	
Dismissed/acquitted	*12*	*26.1*	
Attempted sexual abuse minor 1 (Class A)	**1**	—	**0.0 %**
Attempted sexual abuse minor 1	1	100.0 %	
Attempted sexual assault 1 (Class A)	**2**	—	**0.0 %**
Attempted sexual assault 1	1	50.0 %	
Dismissed/acquitted	*1*	*50.0*	
Exploit minor (Class B)	**1**	—	**0.0 %**
Exploit minor	1	100.0 %	
Sexual abuse minor 2 (Class B)	**95**	—	**12.6 %**
Sexual abuse minor 2	39	41.1 %	
Attempted sexual abuse minor 2	20	21.1	
Attempted sexual assault 2	3	3.2	
Coercion	2	2.1	
Probation revocation F	1	1.1	
Sexual assault 3	1	1.1	
Sexual abuse minor 3	6	6.4	
Sexual abuse minor 1	1	1.1	
Sexual assault 2	2	2.1	
Alcohol to minor (misd.)	1	1.1	
Assault 4 (misd.)	3	3.2	
Attempted sexual assault 3 (misd.)	1	1.1	
Attempted sexual abuse minor 3 (misd.)	2	2.1	
Contributing to delinquency of minor (misd.)	4	4.2	
Criminal trespass (misd.)	1	1.1	
Dismissed/acquitted	*6*	*6.3*	
Sexual assault 2 (Class B)	**47**	—	**34.0 %**
Sexual assault 2	8	17.0 %	
Attempted sexual assault 2	8	17.0	
Burglary 2	1	2.1	
Sexual assault 3	6	12.8	
Assault 4 (misd.)	6	12.8	
Attempted sexual abuse minor 3 (misd.)	2	4.3	
Criminal trespass (misd.)	1	2.1	
Harassment (misd.)	3	6.4	
Reckless endangerment (misd.)	1	2.1	
Sexual abuse minor 4 (misd.)	1	2.1	
Sexual assault 4 (misd.)	1	2.1	
Violation domestic violence pretective order (misd.)	1	2.1	
Dismissed/acquitted	*8*	*17.0*	
Attempted sexual abuse minor 2 (Class C)	**2**	—	**0.0 %**
Attempted sexual abuse minor 2	2	100.0 %	
Attempted sexual assault 2 (Class C)	**3**	—	**33.3 %**
Attempted sexual assault 2	2	66.7 %	
Harassment (misd.)	1	33.3	
Indecent exposure 1 (Class C)	**3**	—	**33.3 %**
Indecent exposure 1	2	66.7 %	
Indecent exposure 2 (misd.)	1	33.3	
Sexual abuse minor 3 (Class C)	**21**	—	**42.9 %**
Sexual abuse minor 3	8	38.1 %	
Probation revocation F	1	4.8	
Alcohol to minor (misd.)	2	9.5	
Assault 4 (misd.)	2	9.5	
Attempted sexual abuse minor 3 (misd.)	3	14.3	
Contributing to delinquency of minor (misd.)	1	4.8	
Resist arrest (misd.)	1	4.8	
Dismissed/acquitted	*3*	*14.3*	
Sexual assault 3 (Class C)	**6**	—	**16.7 %**
Sexual assault 3	2	33.3 %	
Assault 3	1	16.7	
Attempted sexual assault 2	1	16.7	
Assault 4 (misd.)	1	16.7	
Dismissed/acquitted	*1*	*16.7*	

Source: *Alaska Judicial Council*

ALASKA JUSTICE FORUM

A PUBLICATION OF THE JUSTICE CENTER

Fall 2009 | UNIVERSITY of ALASKA ANCHORAGE | Vol. 26, No. 3

Predicting Legal Resolutions in Domestic Violence Cases

Marny Rivera, André B. Rosay, Darryl S. Wood, and Katherine TePas

Introduction

The adoption of such policies as mandatory arrest, pro-arrest, and no-drop prosecution has changed the arrest and prosecution practices in domestic violence cases. Pro-arrest refers to arrest being preferred, but not required. No-drop prosecution allows the prosecutor, with or without the cooperation of the victim, to decide if the evidence merits going forward. Prosecution and conviction practices were the focus of a meta-analysis by Joel Garner and Christopher Maxwell in *Criminal Justice Review* 34(1) in 2009. They looked at 135 published reports emphasizing prosecution and/or conviction of intimate partner and other forms of domestic violence. These researchers found that 34 percent of reports to law enforcement of intimate partner violence (IPV) were prosecuted, and 59 percent of arrests for IPV were prosecuted. Overall, 51 percent of prosecuted cases resulted in conviction. They concluded that prosecution for IPV was not rare, but acknowledged that prosecution rates varied considerably across jurisdictions. They also acknowledged that the data in their 2009 study did not provide enough information to identify factors that predict prosecution and conviction of IPV. Identification of such predictive factors is important because these factors may explain jurisdictional variation in the prosecution of domestic violence cases, and may also suggest policies and practices for enhancing prosecution rates.

HIGHLIGHTS INSIDE THIS ISSUE

- An examination of attrition in criminal justice processing of cases of intimate partner violence against women (page 2).
- A summary of two sets of recommendations to reduce violence against women in Alaska (page 5).
- A look at the relationship between animal abuse and domestic violence (page 6).
- A comparison between leading causes of death in the U.S. and Alaska among different age groups (page 7).

Table 1. Number of Cases by Stage, for Cases with only One Suspect and One Victim

Stage	N	% of reported	% of referred	% of accepted
Reported	1,095	100.0 %	—	—
Referred	874	79.8	100.0 %	—
Accepted	753	68.8	86.2	100.0 %
Convicted	591	54.0	67.6	78.5

Source of data: *Alaska State Trooper data (2004)*

A recent analysis of prosecution for assaults in domestic violence incidents reported to Alaska State Troopers (AST or Troopers) found that prosecution rates in Alaska were even higher than the national average prosecution rates reported by Garner and Maxwell. Data from the study of assaults in domestic violence incidents reported to AST included detailed characteristics associated with these incidents, as well as prosecution data from the Alaska Department of Law. These data allowed for the computation of prosecution and conviction rates, as well as an analysis of characteristics predicting prosecution of domestic violence assaults. The results of those analyses are presented here following a summary of domestic violence statutes in Alaska and descriptive statistics for the characteristics examined as predictors of prosecution and conviction.

Summary of Alaska's Assault Statutes

The findings here come from a study of 1,281 Trooper reports (not including reports to local or municipal police) of assaults in domestic violence incidents in 2004 that resulted in at least one assault charge. Alaska's criminal code defines assault in terms of first, second, third, and fourth degrees (Alaska Statutes §§11.41.200, 11.41.210, 11.41.220, and 11.41.230). First, second, and third degree assault are class A, B, and C felonies, respectively, and fourth degree assault is a class A misdemeanor. The main distinctions between the degrees of assault relate to the level of intent and seriousness of resulting physical injury.

In this study we focus on assaults in domestic violence incidents between household members. *Household member*, as broadly defined in Alaska Statue §18.66.990, includes adults or minors who are current or former spouses, living together or who have lived together, dating or who have dated, engaging in or who have engaged in a sexual relationship, related to each other up to the fourth degree of consanguinity, related or formerly related by marriage, or who have a child together. Unrelated individuals residing together as roommates, and live-in caregivers, also fall under this definition.

The Sample

A subsample of 1,095 cases involving one victim and one suspect was used to conduct analyses to predict legal resolutions. Of the 1,095 cases, 874 (80%) were *referred* for prosecution and 753 (86% of referred cases) were *accepted* for prosecution. The conviction rate was 54 percent for reported cases, 68 percent for referred cases, and 79 percent for accepted cases. (See Table 1.)

Report Characteristics

Several report characteristics were examined as predictors of prosecution: time between the assault incident and the report

*Please see **DV cases**, page 8*

Table 2. Coding for and Frequencies of Report Characteristics Predicting Legal Resolutions

Variables	Reports N	Reports %	Variables	Reports N	Reports %
Time to report			**Time to case closure**		
One or more days = 0	175	16.1 %	Twenty or more days = 0	538	49.2 %
Zero days (day of incident) = 1	914	83.9	Zero through median of 19 days = 1	555	50.8
Person reporting the assault			**Total charges per report**		
Victim = 0	639	58.4 %	One = 0	659	60.2 %
Other = 1	456	41.6	More than one = 1	436	39.8
Detachment			**Number of witnesses per report**		
Other (A, E, or I) = 0	190	17.4 %	Zero = 0	464	42.4 %
B, C, or D = 1	905	82.6	One or more = 1	631	57.6
First agency notified					
AST = 0	870	79.5 %			
VPSO, VPO, local police or other = 1	225	20.5			

Source of data: *Alaska State Trooper data (2004)*

DV cases

(continued from page 1)

of the incident to law enforcement, person reporting the assault, Trooper detachment area receiving the report, agency reported to, time to case closure, total charges per report, and number of witnesses per report. The majority of cases (84%) were reported on the same day as the incident and the victim reported the incident in 58 percent of cases. Most reports (83%) were made in Trooper detachments B (Southcentral Alaska), C (Western Alaska), or D (Interior Alaska). In 80 percent of cases, AST was the first agency notified of the domestic violence assault. In the remaining 21 percent of cases the report was most often received by a Village Public Safety Officer (VPSO) or Village Police Officer (VPO), and less often by a local police department. (Percentages may total to more than 100% due to rounding.) Over half (51%) of the cases were closed between zero and 19 days (the median time to closure for all cases). The majority of domestic violence assaults (60%) involved a single charge, and in 58 percent of cases there was only one witness. (See Table 2).

Table 3. Coding for and Frequencies of Victim Characteristics Predicting Legal Resolutions

Variables	Reports N	Reports %	Variables	Reports N	Reports %
Race of victim			**Present upon Trooper arrival**		
Minority = 0	527	48.1 %	No = 0	43	3.9 %
Caucasian = 1	568	51.9	Yes = 1	1,038	96.1
Victim gender			**Victim was interviewed**		
Male = 0	802	26.6 %	No = 0	32	2.9 %
Female = 1	290	73.4	Yes = 1	1,056	97.1
Age of victim			**Victim cooperated with Troopers**		
33 or older = 0	520	47.9 %	No = 0	151	14.1 %
Infant to 32 = 1	566	52.1	Yes = 1	920	85.9
Victim used alcohol or drugs			**Victim suffered injuries**		
No = 0	687	66.1 %	No = 0	439	40.1 %
Yes = 1	353	33.9	Yes = 1	656	59.9
Victim consulted someone prior to assault					
No = 0	794	73.1 %			
Yes = 1	292	26.9			

Source of data: *Alaska State Trooper data (2004)*

Victim Characteristics

In over half of the cases, the victim was Caucasian (52%) and under 32 years of age (52%). The victim was female in 73 percent of the cases. Most victims (66%) did not use alcohol or drugs prior to the assault in domestic violence incident. Seventy-three percent of the victims contacted no one prior to reporting the assault to law enforcement. In the majority of cases (96%), the victim was present upon Trooper arrival. The victim was interviewed in 97 percent of cases, and most victims (86%) cooperated with the AST investigation. In 60 percent of cases victims suffered documented injuries as a result of the assault in domestic violence incident, but in 40 percent of cases victims did not suffer injuries or their injuries were not documented in the report. (See Table 3.)

Suspect Characteristics

Just over half of the suspects (52%) were Caucasian. Seventy-nine percent were male and 52 percent were in the 12 to 32 years age group. Fifty-eight percent of suspects used alcohol or drugs prior to the assault. Most suspects (77%) were present upon the Trooper's arrival at the scene and were interviewed as part of the Trooper's investigation. The suspect admitted guilt or gave a full confession in 57 percent of cases. In 7 percent of cases the suspect was known to have violated a Domestic Violence Protection Order (DVPO), conditions of release, or conditions of probation. (See Table 4.)

Victim-Suspect Characteristics

In terms of victim-suspect relationship, 67 percent of assaults in domestic violence

Table 4. Coding for and Frequencies of Suspect Characteristics Predicting Legal Resolutions

Variables	Reports N	Reports %	Variables	Reports N	Reports %
Race of suspect			**Present upon Trooper arrival**		
Minority = 0	530	48.4 %	No = 0	249	23.0 %
Caucasian = 1	565	51.6	Yes = 1	835	77.0
Suspect gender			**Suspect was interviewed**		
Female = 0	234	21.4 %	No = 0	248	22.7 %
Male = 1	860	78.6	Yes = 1	843	77.3
Age of suspect			**Suspect admitted guilt or gave a full confession**		
12 to 32 = 0	560	51.5 %	No = 0	360	42.8 %
33 and older = 1	527	48.5	Yes = 1	481	57.2
Suspect used alcohol or drugs			**Suspect violated DVPO, conditions of release, or probation**		
No = 0	415	42.0 %	No = 0	1,012	92.7 %
Yes = 1	574	58.0	Yes = 1	80	7.3

Source of data: *Alaska State Trooper data (2004)*

Table 5. Coding for and Frequencies of Victim-Suspect Characteristics Predicting Legal Resolutions

Variables	Reports N	Reports %
Nature of relationship		
Other family = 0	357	32.7 %
Intimate partners = 1	763	67.3
Living arrangements		
Common = 0	802	75.3 %
Separate = 1	263	24.7
Victim suspect race combination		
Intraracial = 0	925	84.6 %
Interracial = 1	169	15.4
Victim suspect age combination		
Intraage group = 0	447	41.2 %
Interage group = 1	638	58.8

Source of data: *Alaska State Trooper data (2004)*

incidents involved intimate partners while 33 percent involved other family members. Victims and suspects shared common living arrangements in 75 percent of cases. Most assaults in domestic violence incidents (85%) were intraracial—that is between a victim and a suspect of the same race—and 15 percent of cases were interracial—between persons of different races. In 59 percent of cases the victim and suspect were in a different age group. (See Table 5.)

Incident Characteristics

A number of incident characteristics were examined as predictors of prosecution. In 64 percent of cases the victim and suspect came into contact by invitation (either from the victim or the suspect) while in 36 percent of cases the suspect made a forced entry. In 41 percent of cases, a child was present at the time of the assault in domestic violence incident. Suspects used a weapon in five percent of cases. Twenty-eight percent of victims responded aggressively to the domestic violence assault. Victims remained at the scene following 75 percent of assaults in domestic violence incidents. Alcohol and/or drug use was a reported precipitating factor that led to the assault in domestic violence incident in 22 percent of cases, and jealousy was a reported precipitating

Please see ***DV cases****, page 10*

Table 6. Coding for and Frequencies of Incident Characteristics Predicting Legal Resolutions

Variables	Reports N	Reports %	Variables	Reports N	Reports %
Method of contact			**Precipitating factors 1**		
By invitation = 0	93	63.7 %	Not alcohol or drugs = 0	743	77.9 %
Forced entry = 1	53	36.3	Alcohol or drugs = 1	211	22.1
Child present			**Precipitating factors 2**		
No = 0	487	59.0 %	Not jealousy = 0	824	86.4 %
Yes = 1	338	41.0	Jealousy = 1	130	13.6
Use of any weapon			**Location of assault**		
No = 0	1,032	95.5 %	Public = 0	139	12.9 %
Yes = 1	49	4.5	Private = 1	939	87.1
Victim response characteristics 1			**Physical assault**		
Not aggressive = 0	772	72.1 %	No = 0	120	11.0 %
Aggressive = 1	298	27.9	Yes = 1	967	89.0
Victim response characteristics 2			**Any stalking behavior**		
Stayed = 0	802	74.5 %	No = 0	1,022	93.3 %
Left = 1	275	25.5	Yes = 1	73	6.7

Source of data: *Alaska State Trooper data (2004)*

DV cases
(continued from page 9)

factor in 14 percent of cases. The majority of assaults in domestic violence incidents (87%) took place in a private location and involved physical assaults (89%). Stalking behavior was reported in 7 percent of cases. (See Table 6.)

Predicting Legal Resolutions

Several characteristics of domestic violence incidents were examined as potential predictors of referral, acceptance for prosecution, and conviction: reports to law enforcement of the domestic violence incident, suspects, victims, victim-suspect relationships, and incidents. The analyses involved a three-phase procedure for each type of legal resolution (referral, acceptance, and conviction). In the first phase, individual characteristics within each category were analyzed as predictors of the three legal resolutions using bivariate logistic regression. In the second phase, significant individual predictors of legal resolutions in each category (reports, suspects, victims, etc.) were analyzed using multivariate logistic regression. In the third phase, characteristics found to be significant predictors from phase two, were analyzed across all five categories using multivariate logistic regression to produce a full model of predictors.

Referral

Characteristics that did not predict referral of cases for prosecution. The full model used to predict referral of cases for prosecution included several predictor characteristics found to be significant when analyzed with other characteristics from their respective categories (i.e., reports, suspect, victims, etc.), but not all of these were found to be significant predictors of referral when examined individually and included in the full model. Characteristics analyzed in the full model that did not significantly predict referral of cases for prosecution included: the person who reported the incident (victim or other), the first agency notified (AST, VPSO, VPO, or local police department), the total number of charges associated with the report (one or more than one), victim use of alcohol or drugs, victim injuries, the racial combination of the victim and suspect (intraracial or interracial), the victim's response characteristic (stayed or left the scene), the type of assault (physical or not physical), and precipitating factors to the assault in domestic violence incident (did or did not involve alcohol and/or drugs, did or did not involve jealousy).

Characteristics significantly predicting referral of cases for prosecution. The characteristics predicting referral of domestic violence incidents for prosecution are presented in order of greatest impact to least impact on referral. Each of these characteristics was found to significantly predict referral of domestic violence incidents for prosecution when the other predictive characteristics included in the model were held constant. Cases where the victim was interviewed by a Trooper were 5.8 times more likely to be referred for prosecution than cases where the victim was not interviewed by a Trooper. Cases involving domestic violence incidents that took place between a suspect and victim who were intimate partners were 2.9 times more likely to be referred for prosecution than cases where the victim and suspect were not intimate partners (i.e., family members such as siblings, parent/child, or extended family, etc.). When the suspect was reported to have used alcohol or drugs prior to the domestic violence incident, cases were 2.5 times more likely to be referred for prosecution than in cases with no report of a suspect's use of alcohol and/or drugs. Cases that were closed relatively quickly (less than or equal to a median of 19 days) were 2.3 times more likely to be referred for prosecution than cases that took longer to close. Cases in which the victim and suspect lived together were 2.1 times more likely to be referred for prosecution than cases where the victim and suspect were not cohabiting. Cases with relatively older suspects (older than the mean of 32 years) were two times more likely to be referred for prosecution than cases with younger suspects. (See Table 7.)

Table 7. Characteristics Significantly Predicting Referral for Prosecution

Variable	b	SE(b)	P	Exp(b)
Victim was interviewed	1.757	0.603	0.004	5.794
Intimate partner relationship	1.071	0.205	0.000	2.918
Suspect used alcohol or drugs	0.905	0.226	0.000	2.473
Time to case closure less than or equal to median	0.826	0.199	0.000	2.284
Common living arrangement	0.722	0.239	0.003	2.058
Suspect 33 years or older	0.707	0.203	0.000	2.028

Log Likelihood = 621.10; χ^2 = 117.10; $p < .05$.

Source of data: *Alaska State Trooper data (2004)*

Acceptance

Characteristics that did not predict acceptance of cases for prosecution. Characteristics analyzed in the full model that did not significantly predict acceptance of cases for prosecution included: the time between the incident and the report (one or more days or the same day on which it occurred), the first agency notified (AST, VPSO, VPO, or local police department), the suspect's use or non-use of alcohol or drugs, the victim's gender (female or male), the victim's race (minority or Caucasian), the victim and suspect relationship (intimate partners or other family), the victim and suspect's living arrangement (common or separate), and a precipitating factor to the assault in domestic violence incident (did or did not involve alcohol and/or drugs, did or did not involve jealousy).

Characteristics significantly predicting acceptance of cases for prosecution. The characteristics that significantly predicted whether cases were referred for prosecution were *not* the same characteristics that predicted whether referred cases were *accepted* for prosecution. Each of the following characteristics was found to significantly predict acceptance of domestic violence incidents for prosecution when the other predictive characteristics included in the model were held constant. One of the strongest predictors of acceptance

Table 8. Characteristics Significantly Predicting Acceptance for Prosecution

Variable	b	SE(b)	P	Exp(b)
Suspect admitted guilt or gave a full confession	0.784	0.327	0.003	3.114
Total charges greater than one	0.988	0.351	0.005	2.686
Person reporting was not the victim	0.841	0.351	0.017	2.318
Victim suffered injury	0.839	0.324	0.010	2.315
Child was present	0.825	0.354	0.020	2.282
Suspect male	1.136	0.381	0.016	2.191

Log Likelihood = 243.91; χ^2 = 64.02; $p < .05$.

Source of data: *Alaska State Trooper data (2004)*

for prosecution was whether the suspect admitted guilt or gave a full confession. Cases where suspects admitted guilt or gave a full confession were 3.1 times more likely to be accepted for prosecution, and cases with relatively more charges (cases with more than one charge) were 2.7 times more likely to be accepted for prosecution than cases with only a single charge. When the initial report of domestic violence was made by a person other than the victim, cases were 2.3 times more likely to be accepted for prosecution. Cases in which the victim suffered injury were 2.3 times more likely to be accepted for prosecution than cases in which the victim did not suffer injury. Cases in which a child was reportedly present were 2.3 times more likely to be accepted for prosecution than cases with no report of a child's presence. If the suspect was male, the case was 2.2 times more likely to be accepted for prosecution than if the suspect was female. (See Table 8.)

Table 9. Characteristics Significantly Predicting Conviction

Variable	b	SE(b)	P	Exp(b)
Reported to VPSO, VPO, or other	0.862	0.363	0.018	2.367
Suspect used alcohol or drugs	0.841	0.230	0.000	2.319
Total charges greater than one	0.584	0.237	0.014	1.794
Suspect admitted guilt or gave a full confession	0.561	0.228	0.014	1.752

Log Likelihood = 93.21; χ^2 = 33.57; $p < .05$.

Source of data: *Alaska State Trooper data (2004)*

Conviction

Characteristics that did not predict conviction. One characteristic analyzed in the full model that did not significantly predict conviction was the suspect's age (12 to 32 years *or* 33 years and older).

Characteristics significantly predicting conviction. The characteristics that predicted conviction in cases of domestic violence incidents included some characteristics that predicted referral and acceptance. It is important to note that the term "conviction" used in this article refers to *any* conviction for *any* charge (not necessarily a domestic violence charge), and includes plea bargains, guilty pleas, and convictions resulting from a bench or jury trial. Each of the following characteristics was found to significantly predict conviction of domestic violence incidents when the other predictive characteristics included in the model were held constant. Cases first reported to a VPSO, a VPO, or a local police department were 2.4 times more likely to result in a conviction than cases first reported to AST. Cases in which the suspect was reported to have used alcohol or drugs prior to the domestic violence incident were 2.3 times more likely to result in conviction than cases with no report of a suspect's alcohol or drug use. Cases were 1.8 times more likely to result in a conviction if there was more than one charge involved, or if the suspect admitted guilt or gave a full confession. (See Table 9.)

Conclusion

Based on our analyses, a number of report, victim, suspect, victim-suspect, and incident characteristics predict prosecution of assaults in domestic violence incidents reported to AST. The identification of these characteristics creates an opportunity to modify policy and/or practice in a way that enhances prosecution of these types of assaults. In the development of policy and/or practice changes, the impact of characteristics predicting prosecution at *each level* (referral, acceptance, and conviction) is equally important to consider: cases must progress through the initial stages of prosecution in order to result in conviction. Therefore, the majority of characteristics that predicted conviction also predicted acceptance or referral of cases.

The presence of certain characteristics seemed to increase the gravity of a case and heighten the likelihood of prosecution. Cases more likely to be prosecuted include those in which the victim was injured, there was more than one charge, and/or the report to law enforcement was made by someone other than the victim. Policies for investigation of assaults in domestic violence incidents should ensure extensive documentation of victim's injuries, corroboration of the victim's description of events, and discovery of all associated, justified charges. A victim's injuries and a report by someone other than the victim can corroborate the victim's description of events. Victim interviews and suspect admission of guilt also made prosecution more likely. Rates of victim interviews by Troopers were high (97%), but additional efforts could be made to interview a larger percentage of known suspects. (77% of suspects were interviewed.) It is important to train law enforcement officers to conduct thorough suspect interviews and interrogations and to employ reliable interviewing techniques that encourage suspects to admit guilt or give a full confession.

Other cases more likely to result in prosecution involved suspects who used alcohol or drugs prior to the assault in domestic violence incident. Therefore, it is essential for Troopers to document suspects' substance use every time it is indicated. Also, cases involving male suspects and assaults between intimate partners who live together were more likely to be prosecuted than other cases. As noted previously, the definition of domestic violence in Alaska statute covers a range of relationships. Troopers make arrests for assaults in domestic violence incidents where the victim-suspect relationship is one of several identified in the statute. However, it is more likely that domestic violence assaults between intimate partners who live together will be prosecuted than assaults between persons involved in other statutorily defined relationships. This may suggest a tendency on the part of prosecutors to view intimate partner domestic violence as an offense warranting more urgent prosecution

Please see ***DV cases****, page 12*

UAA **Alaska Justice Forum**

Editor: Barbara Armstrong
Editorial Board: Allan Barnes, Sharon Chamard, Ron Everett, Pamela Kelley, Alan McKelvie, Brad Myrstol, Deborah Periman, Marny Rivera, André Rosay
Typesetting and Layout: Melissa Green

Justice Center, André Rosay, Director

Published quarterly by the

Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508
(907) 786-1810
(907) 786-7777 fax
ayjust@uaa.alaska.edu
http://justice.uaa.alaska.edu/

© 2009 Justice Center,
University of Alaska Anchorage
ISSN 0893-8903

The opinions expressed are those of individual authors and may not be those of the Justice Center.

The University of Alaska provides equal education and employment opportunities for all, regardless of race, color, religion, national origin, sex, age, disability, or status as a Vietnam-era or disabled veteran.

UAA University of Alaska Anchorage

Alaska Justice Forum
Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508

Non-Profit Organization
U.S. Postage
PAID
Anchorage, Alaska
Permit No. 107

Return service requested

DV cases

(continued from page 11)

than other forms of domestic violence.

In terms of conviction, assaults in domestic violence incidents that took place in communities with a VPSO or a VPO had a greater likelihood of resulting in conviction than other cases. This supports similar findings identifying predictors of prosecution and conviction in sexual assault cases reported to AST, as well as findings noted by Wood, et al. (see "Attrition in Cases of Violence Against Women Reported to the Alaska State Troopers" in this issue), and findings by Wood and Rosay (see "Case Attrition of Sexual Violence Offenses: Empirical Findings" in the Spring/Summer 2008 issue of the *Alaska Justice Forum*). Increased likelihood of prosecution and conviction for cases first reported to a VPSO or a VPO highlights the importance of the VPSO and VPO programs. This finding suggests that the resources provided by these first responders (i.e., reduced response time and enhanced investigation) increases conviction of assaults in domestic violence incidents. The impact of VPSO and VPO programs on conviction, as well as factors that make intimate partner violence different from other forms of domestic violence, should be examined further. Additional studies could assist in better understanding the variation in prosecution of domestic violence assault cases and the policies and practices that enhance prosecution and conviction rates.

Marny Rivera is an Assistant Professor of the Justice Center. André Rosay is the Director of the Justice Center. Darryl Wood is an Assistant Professor at Washington State University Vancouver. Katherine TePas is a Program Coordinator with the Alaska State Troopers. *This project was supported by Grant No. 2005-WG-BX-0011 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

Attrition in Cases of Violence Against Women Reported to the Alaska State Troopers

Darryl S. Wood, André B. Rosay, Marny Rivera, and Katherine TePas

The statutory requirement that arrests be made for all crimes involving domestic violence (Alaska Statute 18.65.530) is an important dimension of the state's efforts to reduce violent victimization occurring among intimate partners. This policy is rooted in research that suggests mandatory arrest has a specific deterrent effect in cases of misdemeanor assault committed by males against their female intimate partners. Although there is reason to believe mandatory arrest may reduce re-victimization in its own right, the impact of the policy upon further criminal justice system intervention is largely unknown. On the one hand, it is possible that caseload pressures make it difficult for prosecutors to continue with zero-tolerance in intimate partner violence (IPV) cases. But it is also possible that mandatory arrest sets the tone for continual rigorous enforcement of IPV assault cases throughout the remainder of the criminal justice process. In this article we consider police, prosecutor, and court decision-making about IPV cases initially dealt with by the Alaska State Troopers (AST or Troopers) in 2004.

Information gathered from AST and Alaska Department of Law (DOL) case files was analyzed for this article to examine IPV assault case processing decisions. Two basic types of analyses were conducted. We first charted the processing of IPV assault cases as they made their way from the Troopers through the court system. We also used commonly employed categories (i.e., Alaska Native vs. Non-Native and isolated location vs. non-isolated location) to determine if there were variations in the processing of IPV cases relative to the victims' race or geographic location. Together, these analyses allow us (1) to understand how likely it is that IPV assault cases from the Troopers' area of responsibility are fully prosecuted, and (2) to begin to determine if particular aspects of the criminal justice environment have an impact upon the likelihood that IPV assault cases are dealt with fully.

The results presented in this article allow us to consider the attrition of cases of IPV assault reported to the Troopers and prosecuted by the DOL. For our purposes here, *case attrition* refers to the manner in which criminal cases are screened out of the criminal justice process as they are considered at successive decision making points. By definition, for a specific offense type, the number of cases resulting in conviction is smaller than the number of prosecutions which, in turn, is smaller than the number of arrests. Put another way, the greater the proportion of cases screened out of the process, the higher the rate of case attrition.

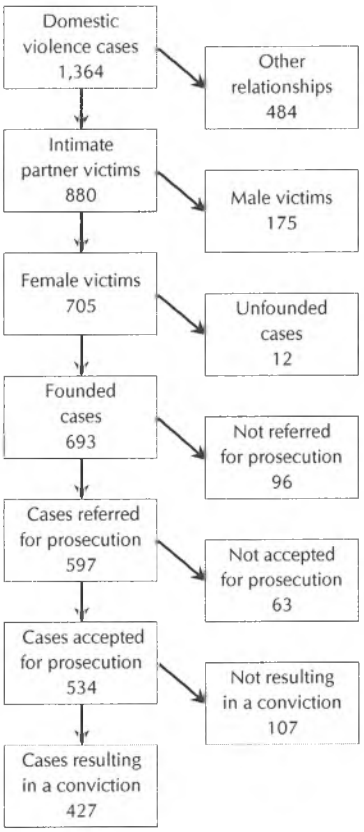
This article focuses upon IPV rather than *domestic violence* because the former is more indicative of the particularly pernicious power-based relationship violence that police and prosecutors have perpetually struggled against and that has served as the impetus for mandatory arrest policies. Under Alaska state law (§18.66.990), domestic violence is inclusive of all violent offenses committed by one household member against another household member where *household members* are broadly defined to include individuals who are related to one-another through common ancestry or marriage, unrelated individuals who are roommates or live-in caretakers, and individuals who are or were intimate partners (i.e., suspects and victims involved together in marital, dating, and/or sexual relationships). From a conceptual standpoint, it makes sense to consider IPV assault separately because it is qualitatively different compared to other types of violence that fall under the umbrella of domestic violence (e.g., child abuse, elder abuse, teenage brothers engaged in fisticuffs) in terms of its etiology and in terms of the nature and severity of official responses.

Likewise, the results presented below focus only on assault cases involving female victims because of the dissimilarities in the IPV assault committed against men compared to that committed against women. (IPV is not a purely heterosexual phenomenon. The analyses presented below include the cases of three women who reported being assaulted by their female partners.) Even though both women and men are violent toward one another when in intimate relationships, the character of women's violence against their male partners is substantially different than men's violence against their female partners in terms of its purpose and its potential for physical harm. Generally speaking, men are much more likely than women to employ physical violence in an instrumental fashion, using it as one method among many to maintain power and control over an intimate partner. Furthermore, the likelihood of physical harm is substantially higher in IPV assault against female victims relative to that of male victims because of the physiological differences between the sexes in terms of size and strength. Given these differences we would expect the victim's sex to have a differential impact on the probability that cases would be screened out during the criminal justice process.

Overall Attrition of IPV Cases

In Figure 1 we consider IPV assault cases reported to AST in 2004 as they made their way through the criminal justice process. First, we see that IPV assault cases made up a majority of the assaults classified as domestic violence. Roughly two-thirds of reported domestic violence cases (65%) involved an assault by one member of an intimate relationship against another member. The remainder of the domestic violence cases included victims and suspects that were connected by some other form of

Figure 1. Processing of Cases of Intimate Partner Violence Against Women Reported to the Alaska State Troopers, 2004



household membership. Of the IPV assault cases reported to police, the large majority (80%) involved a female victim.

Nearly all of the IPV assault cases against female victims that came to the Troopers' attention were *founded* (i.e., deemed to have actually occurred and classified as "crimes known to the police"). Less than two percent of the time was an IPV assault case against a female victim classified as unfounded after further investigation by AST. Some comparison figures are found in Alaska Department of Public Safety data, *Crime Reported in Alaska, 2004*. When compared to the founding rates for all assault cases reported to AST in 2004 regardless of victim-suspect relationship, IPV assault cases against female victims were more likely than simple assaults to be founded (87%) and just as likely as aggravated assaults to be founded (97%).

After establishing that an assault did occur, the next two steps in the process involve decisions about carrying a case forward for prosecution. An investigating Trooper first has to decide whether to refer the case to DOL and then, once referred, a DOL attorney has to choose to accept the case and proceed with prosecution. We see in Figure 1 that a large majority (86%) of IPV assault cases that were known to AST were referred to DOL for prosecution and a slightly larger proportion of those referred cases were accepted by DOL attorneys for further adjudication. Ultimately, of the cases that DOL attorneys accepted for prosecution, most (80%) resulted in a conviction.

To put these rates of prosecution and conviction into context, comparisons can be drawn with similar rates found for other U.S. jurisdictions as published in a recent meta-analysis by Joel Garner and Christopher Maxwell in *Criminal Justice Review* 34(1) in 2009. By any measure, it appears that there is substantially *less* case attrition for IPV assaults reported to AST than any other place in the U.S. where it has been studied. For example, across the studies considered by Garner and Maxwell, the proportion of IPV assault cases known to the police that were not accepted for prosecution was 72 percent. In comparison, only 23 percent of the IPV assault cases known to AST in 2004 were not accepted for prosecution. When the basis of comparison is acquittals per prosecutions, we see that DOL attorneys were much less likely to lose IPV assault cases than what has been reported elsewhere; only 20 percent of the IPV assault cases prosecuted by DOL resulted in acquittal while, on average, half of the cases prosecuted elsewhere in the U.S. did not result in conviction. Overall, of the IPV assaults known to the police, the cases dealt with by AST and DOL were much more likely to result in conviction than what has been found in other U.S. jurisdictions. In 2004, 61 percent of all IPV assault cases known to AST ultimately resulted in a conviction whereas the average conviction rate for founded cases in Garner and Maxwell's meta-analysis was 14 percent. Comparatively speaking, the AST/DOL conviction rate in 2004 was four times greater than is typical in the U.S. With such an extreme difference, it is no wonder that the prosecution and conviction rates shown in Figure 1 rank among or above the highest rates found in individual studies reviewed by Garner and Maxwell. While the DOL rate of prosecuted cases resulting in conviction was surpassed in a few jurisdictions, the AST/DOL rate of prosecutions per founded case and the AST/DOL rate of convictions per founded case were higher than what was reported in any of the American studies considered by Garner and Maxwell. Based upon these comparisons, it is fair to say that the case attrition rate of IPV assaults dealt with by AST and DOL in 2004 was among the lowest anywhere in the U.S.

Comparisons of Attrition by Victim Race and Location

To consider disparities in prosecution rates, we made comparisons of case attrition in terms of the victims' race and in terms of the geographic location where the IPV assault took place. Given the scrutiny placed on the State of Alaska's response to violence against Alaska Native women in rural villages (e.g., *AITC v. Alaska,* 110 P.3d 947, 2005 or Amnesty International's *Maze of Injustice*), these comparisons were made between the cases of Alaska Native and non-Native victims and between the cases that occurred in isolated villages versus cases that occurred in places that are less remote. These results have been used to argue that there is unequal enforcement by the State of Alaska in cases of IPV assault against Alaska Native women.

To test this assertion, we first examined the differences in case attrition of cases of Alaska Native victims compared to cases of non-Native victims. The first two rows of figures in Table 1 allow comparisons between the cases of female Alaska Native and non-Native IPV assault victims in terms of the proportion of all cases reported that were founded, that were referred for prosecution, that were accepted for prosecution, and that resulted in a conviction. With a lack of statistically significant differences between the two groups, it appears that Alaska Native victims' reports of IPV assault are just as likely as non-Native victims' reports of IPV assault to be founded and referred for prosecution by AST, to be accepted for prosecution by DOL, and to result in conviction in state court. In the third and fourth rows of Table 1 the two groups are compared in terms of the proportion of founded cases that resulted in referral for prosecution, acceptance for prosecution, and conviction. Although there was little difference between the referral and acceptance rates for founded cases reported by the two groups of victims, founded IPV assault cases against Alaska Native victims were actually more likely to result in a conviction relative to founded IPV

Please see ***Attrition****, page 4*

Table 1. Attrition of Cases of Intimate Partner Assault Against Women Reported to the Alaska State Troopers, Alaska Native vs. Non-Native Victims, 2004

Total possible cases		Number & percent founded		Number & percent referred		Number & percent accepted		Number & percent convicted	
Alaska Native	Non-Native	Alaska Native	Non-Native	Alaska Native	Non-Native	Alaska Native	Non-Native	Alaska Native	Non-Native
All cases reported									
333	372	325	368	275	322	251	283	213	214
100.0%	100.0%	97.6%	98.9%	82.6%	86.6%	75.4%	76.1%	64.0%	57.5%
Founded cases									
325	368			275	322	251	283	**213**	**214**
100.0%	100.0%			84.6%	87.5%	77.2%	76.9%	**65.5%**	**58.2%**
Referred cases									
275	322					251	283	**213**	**214**
100.0%	100.0%					91.3%	87.9%	**77.5%**	**66.5%**
Accepted cases									
251	283							**213**	**214**
100.0%	100.0%							**84.9%**	**75.6%**

Note: **Bold** type indicates difference between Alaska Native and non-Native victims is statistically significant at the $p < .05$ level.

Attrition

(continued from page 3)

assault cases against non-Native victims. The fifth and sixth rows of figures in Table 1 let us compare the rates of acceptance for prosecution and conviction for those cases that were referred by AST to DOL for prosecution. Once again, the difference in the acceptance rates of referred cases was not statistically significant whereas the conviction rates of the referred cases of Alaska Native victims was higher than the referred cases of non-Native victims. A similar result is found in the bottom two rows of Table 1 in which a greater proportion of cases of Alaska Native victims that were accepted for prosecution resulted in conviction when compared to the corresponding proportion for non-Native victims. Overall, the results of Table 1 indicate that Alaska Native and non-Native IPV assault victims' cases are processed at similar rates and that the only exception is that IPV assault cases are more likely to result in a conviction when the victim is Alaska Native.

Table 2. Attrition of Cases of Intimate Partner Assault Against Women Reported to the Alaska State Troopers, Victims from Isolated vs. Non-Isolated Communities, 2004

Total possible cases		Number & percent founded		Number & percent referred		Number & percent accepted		Number & percent convicted	
Isolated	Non-isolated	Isolated	Non-isolated	Isolated	Non-isolated	Isolated	Non-isolated	Isolated	Non-isolated
All cases reported									
221	484	215	478	179	418	170	364	**149**	**278**
100.0%	100.0%	97.3%	98.8%	81.0%	86.4%	76.9%	75.2%	**67.4%**	**57.4%**
Founded cases									
215	478			179	418	170	364	**149**	**278**
100.0%	100.0%			83.3%	87.4%	79.1%	76.2%	**69.3%**	**58.2%**
Referred cases									
179	418					**170**	**364**	**149**	**278**
100.0%	100.0%					**95.0%**	**87.1%**	**83.2%**	**66.5%**
Accepted cases									
170	364							**149**	**278**
100.0%	100.0%							**87.6%**	**76.4%**

Note: **Bold** type indicates difference between victims from isolated and non-isolated communities is statistically significant at the $p < .05$ level.

To consider the effect of geographic isolation on case attrition, we made comparisons in terms of whether the IPV assault occurred in a village that was difficult for AST to reach to conduct an investigation. Villages were considered isolated if they did not have a local AST post or if they could not be reached by the Troopers from a post via automobile. The results of these comparisons are made in Table 2. In many ways, the results for an isolated/non-isolated comparison mirror the results presented in Table 1 regarding the differences in the processing of Alaska Native and non-Native victims' cases. First, the results indicate that isolation did not have an effect on the proportion of cases that were founded or that were referred for prosecution. In other words, it appears that the difficulty of reaching a village to make an investigation did not make it less likely that an IPV assault case would be carried forward by AST to DOL for prosecution. Next, there is some indication that DOL is more likely to accept IPV assault cases that occurred in isolated villages as compared to those cases that occurred in non-isolated locales; we see in Table 2 that there was a statistically significant difference in the proportion of cases referred by AST that were accepted for prosecution and that it was the cases from the isolated villages that were least likely to be screened out at that point. Finally, the results in Table 2 indicate that the conviction rate for cases that occurred in isolated villages was higher than for cases from non-isolated villages for all possible bases of calculation (i.e., convictions per reported case, convictions per founded case, convictions per case referred for prosecution, and convictions per case accepted for prosecution). Taken as a whole, it appears that the isolation of a village where an IPV assault occurs does not increase the likelihood of case attrition. If anything, these results indicate that IPV assault cases from isolated villages are not neglected by the State of Alaska but are instead more likely to be fully prosecuted.

Conclusion

Although Alaska's mandatory arrest law is the only policy specifically requiring official response to IPV cases, it appears that the law's spirit of full-enforcement guided other decisions regarding IPV cases as they continued through the criminal justice process in 2004. And while attrition still occurred in the IPV cases handled by AST and the DOL, it happened at a rate that was substantially less than what has been found outside of Alaska. By most standards, the fact that at any given decision point there was less than a one-in-five chance that a case would be screened out of the criminal justice process is an indication that IPV is taken seriously in rural Alaska and that AST and the DOL are willing and able to deal with the cases brought to their attention. Furthermore, this appears to be as true for Alaska Native victims as it is for non-Native victims and it does not seem to be affected by the difficulties of travel to conduct investigations.

Darryl Wood is an Assistant Professor at Washington State University Vancouver. André Rosay is the Director of the Justice Center. Marny Rivera is an Assistant Professor of the Justice Center. Katherine TePas is a Program Coordinator with the Alaska State Troopers. *This project was supported by Grant No. 2005-WG-BX-0011 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

Table 3. Prosecution and Conviction Rates for Cases of Intimate Partner Assault Against Women Reported to the Alaska State Troopers in 2004 vs. Rates Reported in National Meta-Analysis.*

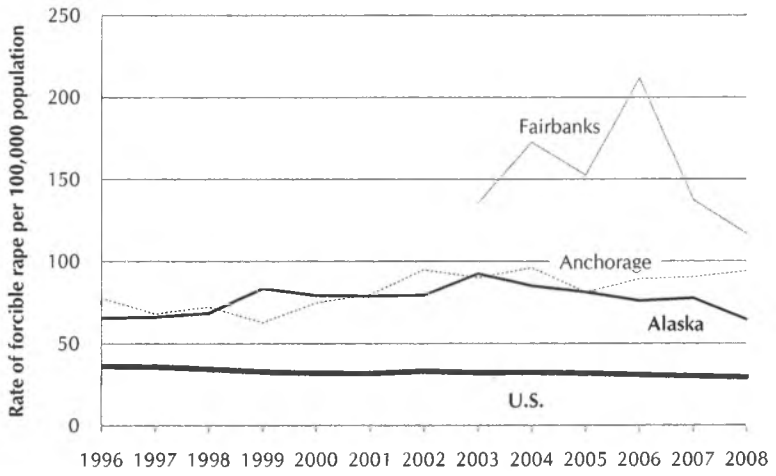
Case source and outcome	AST/DOL rate	U.S. rate	Range of U.S. rates
Known assaults accepted for prosecution	77%	28%	3% to 62%
Prosecuted assaults resulting in conviction	80%	50%	8% to 99%
Known assaults resulting in conviction	61%	14%	4% to 31%

*Adapted from H. Garner, J.H. & Maxwell, C.D. 2009. Prosecution and conviction rates for intimate partner violence. *Criminal Justice Review*, *34*(1), 44-79.

Reducing Violence Against Women in Alaska

Alaska has long been plagued by astonishingly high rates of violence against women. National statistics on forcible rapes reported to law enforcement provide one example. Relative to the average U.S. rate from 2003 to 2008, the average Alaska rate was 2.6 times higher, the average Anchorage rate was 2.9 times higher, and the average Fairbanks rate was 5.0 times higher. Alaska has the highest rate of forcible rape reported to law enforcement out of all U.S states. While changing these trends is a daunting task, several initiatives are currently being considered. In chronological order, they include recommendations from the Alaska Senate Judiciary Committee and initiatives from Governor Sean Parnell.

Figure 1. Rates of Forcible Rape Reported to Law Enforcement in the U.S., Alaska, Anchorage, and Fairbanks, 1996–2008



Source of data: *Uniform Crime Reports, 1996–2008*

Alaska Senate Judiciary Committee Recommendations to Reduce Sexual Assault in Alaska

Four major areas are outlined in the recommendations: (1) getting better data on sexual assault, (2) increasing the number of successful prosecutions, (3) addressing the alcohol and sexual assault nexus, and (4) reducing recidivism by known sex offenders.

A brief summary of the recommendations follows:

- Improve data systems to track sexual assault cases statewide from report to conviction.
- Fund a victimization study to determine the actual rates of both reported and unreported sexual assaults.
- Increase the number of villages with local law enforcement through the Village Public Safety Officer (VPSO) program.
- Consider grant funding for local hospitals to provide qualified Sexual Assault Nurse Examiners (SANEs) and continue to support the cost of existing programs.
- Review ways to increase the State Crime Lab's ability to process DNA evidence in a timely way.
- Continue to support, as a state, programs and policies to reduce alcohol consumption.
- Address alcohol use specifically, and its potential negative impact on personal safety, in education programs about sexual assault awareness and prevention.
- Continue to fund and expand Alaska sex offender management programs.
- Expand Alaska's Internet Crimes Against Children Task Force which locates offenders who are looking for victims using the internet.

Governor Sean Parnell's Initiative to Reduce Domestic Violence and Sexual Assault

Three major areas are outlined in the initiative: (1) putting abusers behind bars, (2) helping victims heal, and (3) preventing abuse.

A brief summary of the recommendations follows:

- Launch a public education campaign encouraging Alaska's men to "Choose Respect."
- Increase law enforcement presence in every community that desires it, with new Village Public Safety Officers (VPSOs) and Alaska State Troopers.
- Fund specialized domestic violence/sexual assault training across multiple disciplines.
- Toughen penalties for sexual assault crimes, and toughen guidelines for prosecutors.
- Strengthen sex offender registry requirements.
- Expand prisoner re-entry programs to reduce recidivism among offenders.
- Increase support for victims of abuse including funding for shelters and the availability of *pro bono* legal services.
- Create a position within the Alaska Department of Law to coordinate state, federal, tribal, and non-profit domestic violence and sexual assault programs.
- Work with youth, community leaders, private sector, and religious organizations to raise awareness and develop prevention strategies.

For additional information, see the UAA Justice Center's violence against women webpage: (http://justice.uaa.alaska.edu/vaw/), the Alaska Senate Judiciary Committee's "Report and Recommendations: Reducing Sexual Assault in Alaska" (http://www.aksenate.org/french/101609_Senate_Judiciary_report_on_sexual_assault.pdf), and Governor Sean Parnell's "Choose Respect" Initiative (http://gov.state.ak.us/pdf/DVSA%20Fact%20Sheet%20final.pdf).

Visiting Faculty

Dr. Adrienne Freng, Associate Professor in the Department of Criminal Justice at the University of Wyoming, joins the Justice Center as Visiting Faculty for the Spring 2010 semester. Dr. Freng received her Ph.D. in sociology from the University of Nebraska-Lincoln. Her research areas include juvenile justice, gangs, Native American justice issues, and research methods. Dr. Freng's experience includes serving as a counselor in a group home for delinquent boys and as an intern probation officer.

Animal Abuse and Domestic Violence

Concern that acts of animal abuse are connected with or are predictors of domestic violence prompted a number of specific research studies in the 1990s. This early work focused on describing interviews with women in battered women's shelters and highlighted the frequency with which women reported abuse of pets by their partners. The interviews documented a high rate of pet abuse and appeared to indicate that animal abuse in the home and concern for pets affected *if* and *when* a woman sought assistance at a shelter—particularly because shelters did not normally accept pets.

As more attention was given to animal abuse and its impact in the context of domestic violence assaults, additional studies were undertaken. Frank Ascione discussed the limitations of some of these past studies in his article, "Emerging Research on Animal Abuse as a Risk Factor for Intimate Partner Violence" in the Civic Research Institute's 2007 publication, *Intimate Partner Violence*. He noted that although twelve different studies found (1) a high rate of pet ownership by domestic violence victims in shelters, (2) a substantial rate of children's exposure to pet abuse, and (3) clear indications that domestic violence victims' concern for pets affected their decision to stay in or leave a relationship with a batterer, more research is needed that includes women in domestic violence situations who have not chosen to go to a shelter, in addition to women in shelters. In response to the concern expressed by battered women for their pets, many areas developed "safe haven" programs for free fostering of pets of victims of domestic violence. Anchorage is currently the only area in Alaska with a "safe haven" program. It is administered by Friends of Pets, a local nonprofit animal welfare group, in collaboration with the Abused Women's Aid in Crisis (AWAIC) shelter. Another local nonprofit, the Eva Foundation Pet's Program, provides post-shelter transition services to domestic violence victims and their pets.

In addition, since 2006 ten states have enacted domestic violence protective orders covering pets: California, Colorado, Connecticut, Illinois, Louisiana, Maine, Nevada, New York, Tennessee, and Vermont.

Research involving a larger sample population of women was reported by Ascione, et al. in 2007 in *Violence Against Women*, "Battered Pets and Domestic Violence: Animal Abuse Reported by Women Experiencing Intimate Partner Violence and Nonabused Women." The findings of this study agreed with earlier research about the high rate of pet abuse reported by victims of intimate partner violence (IPV). Responses showed that women in domestic violence shelters were nearly 11 times more likely to report that their partner had engaged in pet abuse than women who said they had not experienced intimate partner violence. This study again stressed the need for further research on co-occurring pet abuse and IPV with larger and more diverse populations, i.e., urban, suburban, and rural victims of intimate partner violence, as well as non-victims of IPV.

Catherine Simmons and Peter Lehman addressed some of these issues in a 2007 *Journal of Interpersonal Violence* article, "Exploring the Link Between Pet Abuse and Controlling Behaviors in Violent Relationships." In their study of 1,283 women who owned pets and were sheltered at an urban domestic violence center in Texas between 1998 and 2002, they concluded that "[m]en who abuse the family pet appear to be more dangerous than men who do not." The authors did not find that pet abuse was always a form of controlling behavior in incidents of domestic violence assault. However, they did conclude:

> Despite the limitations of this study, it is clear that animal cruelty is an important factor for domestic violence workers to address in assessment and treatment of both victim and perpetrator populations. Batterers who also abuse their pets are both more controlling and use more dangerous forms of violence than batterers who do not. Therefore, addressing whether pet abuse has occurred in the home can help workers in the domestic violence field better understand the behavior of the batterer and the overall risk they present to their partner.

Animal abuse is one factor in the complex dynamic of intimate partner violence, and can be used by law enforcement and domestic violence advocates in assessing risk. In 2008, the Anchorage Police Department (APD) began a program to target animal abuse and to look at its connection to domestic violence. Detective Jackie Conn was assigned as the liaison to the Anchorage Animal Care and Control Center and received training from the Law Enforcement Training Institute National Cruelty Investigations School and from the First Strike program developed by the Humane Society of the United States to raise awareness about the connection between animal cruelty and other violent crime. Detective Conn now trains APD personnel in recognizing animal abuse, and relating it to the possible presence of other types of abuse in the home. She works closely with Alaska Department of Law Assistant District Attorney Joan Wilson who is regularly assigned the prosecution of animal abuse

Further Reading about Animal Abuse and Domestic Violence

Arkow, Phil. (Summer 2007). "Expanding Domestic Violence Protective Orders to Include Companion Animals." *American Bar Association Commission on Domestic Violence ENewsletter* 8. (http://www.abanet.org/domviol/enewsletter/vol8/expertArkow.html).

Ascione, Frank R. (2007). "Emerging Research on Animal Abuse As a Risk Factor for Intimate Partner Violence." In Kathleen A. Kendall-Tackett and Sarah M. Giacomoni, editors, *Intimate Partner Violence*, pp. 3-1 – 3-17. Kingston, NJ: Civil Research Institute. (http://amrric.org/sites/default/files/docs/resources/Chapter%203%20Intimate%20Partner%20Violence%20Ascione.pdf)

Ascione, Frank R.; Weber, Claudia V.; Thompson, Teresa M.; Heath, John; Maruyama, Mika; and Hayashi, Kentaro. (Apr 2007). "Battered Pets and Domestic Violence: Animal Abuse Reported by Women Experiencing Intimate Violence and by Nonabused Women." *Violence Against Women* 13(4): 354–373. (http://vaw.sagepub.com/cgi/content/abstract/13/4/354).

Ascione, Frank R.; Weber, Claudia V.; and Wood, David S. (1997). "The Abuse of Animals and Domestic Violence: A National Survey of Shelters for Women Who Are Battered." *Society & Animals: Journal of Human-Animals Studies* 5(3). (http://www.psyeta.org/sa/sa5.3/Ascione.html).

Faver, Catherine A. and Strand, Elizabeth B. (Dec 2003). "To Leave or to Stay: Battered Women's Concern for Vulnerable Pets." *Journal of Interpersonal Violence* 18(12): 1367–1377. (http://jiv.sagepub.com/cgi/content/abstract/18/12/1367).

Lockwood, Randall. (2006). *Animal Cruelty Prosecution: Opportunities for Early Response to Crime and Interpersonal Violence*. Alexandria, VA: American Prosecutors Research Institute. (http://www.ndaa.org/pdf/animal_cruelty_06.pdf).

Simmons, Catherine A. and Lehman, Peter. (Sep 2007). "Exploring the Link Between Pet Abuse and Controlling Behaviors in Violent Relationships." *Journal of Interpersonal Violence* 22(9): 1211–1222. (http://jiv.sagepub.com/cgi/content/abstract/22/9/1211).

cases. For the period 2002–2009, 121 misdemeanor animal cruelty cases under Alaska Statute 11.61.140 and 11.61.145 were referred and 94 prosecuted. During the same period, one felony case was referred and prosecuted. Case statistics are also being compiled to better understand the relationship between domestic violence and animal abuse.

Leading Causes of Death

A look at recent data on leading causes of death in Alaska and the U.S. shows that malignant neoplasms (cancer) and heart disease rank as the top two causes. Although intentional self-harm (suicide) and assault (homicide) do not rank in the U.S. top ten leading causes of death, they have ranked as leading causes of death in Alaska for many years. A comparison of rankings of suicide and homicide as causes of death for specific age groups in Alaska and the U.S. reveals some similarities in trends.

In 2008 in Alaska, suicide was ranked number 6 among the top ten causes of death for the entire population. Suicide has been ranked number 5 or 6 consistently for the past decade. Homicide has been reported as the number 8 cause of death in 1999, number 10 in 2001, and number 10 again in 2007. The rankings for the leading causes of death by specific age group in Alaska show that suicide and homicide are in the top five for each age group up to the age of 44. In Alaska, and the nation as a whole, people aged 15–34 are more likely to die in an accident, at the hands of another, or by suicide, than by cancer or heart disease. For the period 2005–2007, suicide and homicide were the second and third leading causes of death for both 15–24 and 25–34 year olds. Suicide was the second leading cause of death for 35–44 year olds, and homicide was fifth. Among 45–54 year olds, suicide was the fourth leading cause of death.

Nationally, suicide and homicide are not among the ten leading causes of death according to the most current final data available: 2006. However, suicide ranked number 11 in causes of death for the overall population for 2006; homicide ranked 15.

In the U.S. in 2006, homicide and suicide were the second and third leading causes of death, respectively, for 15–24 year olds, while for 25–34 year olds, suicide ranked second and homicide third. Suicide was the fourth leading cause of death for 35–44 year olds, and the fifth leading cause for 45–54 year olds. These rankings mirror those of Alaska for those aged 15–44, where both suicide and assault were in the top five leading causes of death. Suicide was one of the top five causes of death for 45–54 year olds.

This high ranking of suicide as a cause of death for 15–44 year olds is also seen globally. According to the World Health Organization, suicide is among the top three leading causes of death in 15-44 year olds. For the worldwide population, the top two leading causes of death are coronary heart disease, and stroke and other cerebrovascular diseases.

The leading causes of death for the overall population continue to be related to diseases of the body; however, the growing rate of suicide among young people and the suicide rate among other age groups, as well as the rate of homicide, are the focus of national and international study and prevention programs.

Table 1. Five Leading Causes of Death by Age Group, U.S. (2006) and Alaska (2005–2007)

	U.S. (2006)		Alaska (2005–2007)		
Rank	Cause	Deaths	Rank	Cause	Deaths
	0–4 years				
1	Congenital anomalies	6,334	1	Conditions originating in the perinatal period	68
2	Short gestation	4,841	2	Unintentional injury	49
3	Unintentional injury	2,757	3	Congenital malformations	43
4	SIDS	2,323	4	SIDS	18
5	Maternal pregnancy complications	1,683	5	Assault (homicide)	7
	5–14 years				
1	Unintentional injury	2,258	1	Unintentional injury	48
2	Malignant neoplasms	907	2	Congenital malformations	6
3	Homicide	390	3	Malignant neoplasms	5
4	Congenital anomalies	344	4	Intentional self-harm (suicide)	4
5	Heart disease	253	5	Assault (homicide)	3
			5	Diseases of the heart	3
	15–24 years				
1	Unintentional injury	16,299		Unintentional injury	150
2	Homicide	5,717		Intentional self-harm (suicide)	101
3	Suicide	4,189		Assault (homicide)	34
4	Malignant neoplasms	1,664		Malignant neoplasms	14
5	Heart disease	1,076		Diseases of the heart	10
	25–34 years				
1	Unintentional injury	14,954		Unintentional injury	162
2	Suicide	4,985		Intentional self-harm (suicide)	72
3	Homicide	4,725		Assault (homicide)	29
4	Malignant neoplasms	3,656		Malignant neoplasms	19
5	Heart disease	3,307		Diseases of the heart	17
	35–44 years				
1	Unintentional injury	17,534	1	Unintentional injury	161
2	Malignant neoplasms	13,917	2	Intentional self-harm (suicide)	85
3	Heart disease	12,339	3	Malignant neoplasms	82
4	Suicide	6,591	4	Diseases of the heart	68
5	HIV	4,010	5	Assault (homicide)	26
			5	Chronic liver disease and cirrhosis	26

	U.S. (2006)		Alaska (2005–2007)		
Rank	Cause	Deaths	Rank	Cause	Deaths
	45–54 years				
1	Malignant neoplasms	50,334	1	Malignant neoplasms	328
2	Heart disease	38,095	2	Diseases of the heart	204
3	Unintentional injury	19,675	3	Unintentional injury	184
4	Liver disease	7,712	4	Intentional self-harm (suicide)	78
5	Suicide	7,426	5	Chronic liver disease and cirrhosis	59
	55–64 years				
1	Malignant neoplasms	101,454	1	Malignant neoplasms	546
2	Heart disease	65,477	2	Diseases of the heart	309
3	Chronic lower respiratory disease	12,375	3	Unintentional injury	93
4	Unintentional injury	11,446	4	Chronic lower respiratory diseases	73
5	Diabetes mellitus	11,432	5	Diabetes	69
	65+ years				
1	Heart disease	510,542	1	Malignant neoplasms	1,347
2	Malignant neoplasms	387,515	2	Diseases of the heart	1,249
3	Cerebrovascular	117,010	3	Cerebrovascular diseases	390
4	Chronic lower respiratory disease	106,845	4	Chronic lower respiratory diseases	358
5	Alzheimer's disease	71,660	5	Alzheimer's disease	179
	Total population				
1	Heart disease	631,636	1	Malignant neoplasms	2,341
2	Malignant neoplasms	559,888	2	Diseases of the heart	2,055
3	Cerebrovascular	137,119	3	Unintentional injury	979
4	Chronic lower respiratory disease	124,583	4	Cerebrovascular diseases	506
5	Unintentional injury	121,599	5	Chronic lower respiratory diseases	467

Homicide Suicide

Source of data: *National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control (2006); Alaska Bureau of Vital Statistics (2005–2007)*

ALASKA JUSTICE FORUM
REPRINTS

February 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 4

Assaults in Domestic Violence Incidents Reported to Alaska State Troopers

Marny Rivera, André B. Rosay, Darryl S. Wood, Greg Postle, and Katherine TePas

Originally published in the *Alaska Justice Forum* 25(3): 1, 7–12 (Fall 2008).
http://justice.uaa.alaska.edu/forum/25/3fall2008/a_dvassaults.html

For other articles and publications related to domestic violence and violence against women, see:
http://justice.uaa.alaska.edu/vaw/index.html

Abstract: *This study examined 1,281 cases with an assault charge involving domestic violence reported to Alaska State Troopers in 2004, and excluded any cases reported to local or municipal departments.*

- *Eighty-two percent of reports were handled by three detachment areas: 32% in C – Western Alaska, 29% in D – Interior Alaska, and 22% in B – Southcentral Alaska. Troopers received 80% of the reports, while 20% were received by Village Police Officers, Village Public Safety Officers, or Tribal Police Officers. Eighty-one percent of the assault charges were in the fourth degree. Eighty-four percent of assaults were reported within 24 hours, and 89% of victims and 81% of suspects were interviewed on the day of the report.*
- *Seventy-six percent of suspects were male and 24% were female. On average, suspects were 33 years old and victims were 32 years old. The majority of assaults in domestic violence incidents (86%) were intra-racial. Fifty-seven percent of suspects and 32% of victims used alcohol. Overall, alcohol was involved in 59% of domestic violence incidents reported to Troopers.*
- *Most assaults in domestic violence incidents (75%) occurred between victims and suspects who were staying or living together. The most common forms of violence (disclosed by victims and documented by officers) included pushing, grabbing, or shoving the victim (in 48% of incidents), punching the victim (in 29%), and slapping or hitting the victim (in 28%). Weapons such as knives or guns were rarely used. The most common injuries included bruising (for 38% of victims), lacerations or bite marks (for 27%), bloody nose or lips (for 10%), and black or swollen eyes (for 10%). Forty-three percent of incidents occurred in the presence of children.*
- *Eighty percent of cases were referred to the Alaska Department of Law for prosecution, 68% were accepted for prosecution, and 54% resulted in a conviction. Overall conviction rates were slightly lower for female suspects, but conviction rates were generally not affected by victim gender or victim-suspect relationship.*

Researchers, criminal justice system professionals, victim advocates, and policymakers agree that domestic violence is an undeniable urban and rural problem in Alaska and the nation. Detailed data on domestic violence incidents in the state are sparse, except for ongoing data collection by the Municipality of Anchorage. Now, a recent joint study by the Justice Center, the Alaska State Troopers, and the Alaska Department of Law looks for the first time at reports of assaults in domestic violence incidents made to Troopers for populations outside of Anchorage. Focusing on reports made in 2004 from communities served primarily by the Troopers, the study reviews a final sample of 1,281 cases with an assault charge involving domestic violence. Only reports to the Troopers were included in this study; reports to local or municipal police were not reviewed.

Some preliminary findings mirror national and Anchorage statistics: the majority of domestic violence assault incidents occur between victims and suspects of the same race, and the victim's home is the most common location of the domestic violence incident. On the other hand, both Anchorage data and the data from this study show a much higher use of alcohol by suspects and victims in Alaska than is reported nationally.

Report Characteristics

The majority of reports to Troopers (82%) were handled by three detachment areas: C—Western Alaska (32%), D—Interior Alaska (29%), and B—Southcentral Alaska (22%) (Table 1). While fifty-eight units received at least one report in 2004, over 90 percent of reports came from roughly 18 units or geographic areas (Table 2). Fairbanks Alaska State Trooper (AST) Enforcement and Investigation Units received the highest number of reports (23%) with Palmer AST Enforcement and Investigation Units and Soldotna AST Enforcement and Investigation Units having the second and third highest percentage of reports (19% and 9% respectively). Units in Nome received seven percent of reports while units in Bethel, Aniak, Kotzebue, and Kodiak each received four or five percent of all reports.

Troopers received 80 percent of reports while the remaining 20 percent were received by Village Police Officers, Village Public Safety Officers, or Tribal Police Officers. Reports of assaults in domestic violence incidents were most likely to come from victims (57%), though third parties, including family members, friends, officials, strangers and others, initiated 43 percent of reports.

The 1,281 cases in this study included a total of 1,803 assault charges and 604 other

Table 1. Total Number of Reports by Detachment

Detachment	Reports N	Reports %
C	409	31.9 %
D	367	28.6
B	275	21.5
E	171	13.3
A	49	3.8
ABI	10	0.8
Total	**1,281**	

Source of data: *Alaska State Troopers (2004)*

© 2009 Justice Center, University of Alaska Anchorage

Table 2. Total Number of Reports by Unit for Units with at Least One Percent of all Reports

Detachment	Reports N	Reports %
Fairbanks AST Enforcement and Investigation	295	23.0 %
Palmer/Wasilla AST Enforcement and Investigation	237	18.5
Soldotna AST Enforcement and Investigation	117	9.1
Nome AST Enforcement, VPSO. and WAANT	88	6.9
Bethel AST Enforcement and VPSO	60	4.7
Aniak AST Enforcement	58	4.5
Kotzebue AST Enforcement and VPSO	56	4.4
Kodiak AST Enforcement , VPSO and ABWE	55	4.3
St. Marys AST Enforcement	33	2.6
Ketchikan AST Enforcement	28	2.2
Glennallen AST Enforcement	24	1.9
Homer AST Enforcement	23	1.8
Galena AST Enforcement	19	1.5
King Salmon AST Enforcement	17	1.3
Northway AST Enforcement	17	1.3
Tok AST Enforcement	15	1.2
Juneau AST Enforcement	13	1.0
Talkeetna AST Enforcement	13	1.0
Total	**1,168**	**91.2 %**

Source of data: *Alaska State Troopers (2004)*

charges. The most common assault charges (81%) were for fourth degree assaults and fewer charges were leveled for third through first degree felony assaults. Thirty-one percent of cases involved other charges. The most common other charges included interfering with a report of a crime involving domestic violence, criminal mischief, reckless endangerment, misconduct involving a weapon, DUI/reckless driving, resisting arrest, misconduct involving a controlled substance, and criminal trespass.

The time interval between the incident, the report to Troopers, and the Troopers' response was short, even with transportation and distance issues. The majority of reports (84%) were made the day of the domestic violence assault incident and 97 percent of reports were made within one week.

Suspect and Victim Characteristics

From the 1,281 cases included in this study, we gathered information on 1,356 suspects and 1,523 victims, though information was not always available for every suspect or every victim. Over three-quarters of the suspects were male while only 24 percent were female. Victim ages ranged from under one year to eighty-four years old. Most victims were in the following age groups: 21–30 years (26%), 31–40 years (22%), and 41–50 years (19%). Suspect ages ranged from 10 years old to eighty-eight years old. The majority of suspects were adults (94%). Starting with the group of suspects 21 or older, the number of suspects in each age group decreased as age increased. More specifically, 21–30 year olds made up 31 percent of suspects, 31–40 year olds made up 28 percent of suspects, 41–50 year olds made up 19 percent of suspects, and suspects 51 years or older made up 7 percent of suspects. Most suspects were White (50%) or Native (47%) and most victims were also White (51%) or Native (47%) (Table 3).

The average age of suspects (33) was quite similar to the average age of victims (32). Thirty-nine percent of assaults in domestic violence incidents took place between suspects and victims in the same age group while 61 percent took place between suspects and victims in different age groups. The age groups most commonly shared by suspects and victims involved in assaults in domestic violence incidents included 21 to 30 year olds (38%), 31 to 40 year olds (27%) and 41 to 50 year olds (19%).

In contrast to the age groups of suspects and victims, the majority of assaults in domestic violence incidents (86%) were intraracial (occurring between suspects and victims of the same race). Of all intraracial assaults in domestic violence, 51 percent occurred between White suspects and White victims and 48 percent occurred between Native suspects and Native victims.

We examined alcohol and substance use among victims. Over a third of female victims (35%) and 27 percent of male victims used alcohol prior to the assault in domestic violence incident, but only two percent of female victims and less than one percent of male victims used illicit drugs (Table 4). We also examined alcohol and substance use among suspects. Fifty-eight percent of male suspects and 54 percent of female suspects used alcohol prior to the assault. Only three percent of male suspects and two percent of female suspects used an illicit drug prior to the assault. Overall, alcohol was involved in 59 percent of domestic violence incidents reported to Troopers. Nationally, for the period 2001–2005, 42 percent of victims reported the presence of alcohol or drugs during a domestic violence incident, while in Anchorage for the period 1989–2002 there was documented involvement of alcohol in 49 percent of the reported cases.

Many of the suspects (79%) remained at the location of the assault. Specifically, 76 percent of male suspects and 86 percent

Table 3. Demographic Characteristics of Suspects and Victims

Column percentages.

	Suspects N	Suspects %	Victims N	Victims %	Intragroup N	Intragroup %
Age group						
1 to 10	3	0.2 %	54	3.6 %	2	0.3 %
11 to 17	94	6.1	174	11.5	23	3.9
18 to 20	122	8.0	131	8.6	32	5.5
21 to 30	477	31.2	397	26.2	225	38.3
31 to 40	433	28.3	326	21.5	160	27.3
41 to 50	288	18.8	284	18.7	114	19.4
51 or over	113	7.4	151	10.0	31	5.3
Total	**1,530**		**1,517**		**587**	
Race						
Native	722	46.9 %	720	47.3 %	628	48.1 %
White	767	49.8	770	50.6	667	51.1
Black	38	2.5	26	1.7	10	0.8
Other	12	0.8	6	0.4	—	—
Total	**1,539**		**1,522**		**1,305**	

Source of data: *Alaska State Troopers (2004)*

Table 4. Male and Female Victim and Suspect Characteristics

Row percentages.

Characteristic	Female N	Female %	Female Total	Male N	Male %	Male Total
Victims						
Gender	1,047	69.6 %	**1,047**	458	30.4 %	**458**
Used alcohol	347	34.7	**1,001**	118	26.9	**438**
Used drugs	16	1.6	**1,021**	2	0.4	**451**
Present when AST arrived	998	96.9	**1,030**	424	95.1	**446**
Interviewed	985	94.1	**1,047**	416	93.3	**446**
Suspects						
Gender	319	23.6 %	**319**	1,034	76.4 %	**1,353**
Used alcohol	159	53.7	**296**	553	58.0	**953**
Used drugs	7	2.3	**299**	26	2.7	**970**
Present when AST arrived	259	86.0	**301**	775	76.2	**1,017**
Interviewed	269	88.8	**303**	775	75.8	**1,023**

Source of data: *Alaska State Troopers (2004)*

of female suspects were still at the scene of the assault when Troopers arrived. Troopers were able to interview 76 percent of male suspects and 89 percent of female suspects.

Eighty-one percent of suspects were interviewed on the day of report. Ninety-six percent of all suspect interviews occurred within one week of the report. Troopers interviewed 95 percent of the victims, with 89 percent being interviewed on the day of the report, and 98 percent of the interviews being completed within one week.

The total number of charges per suspect (including both assault and other charges), the number of assault charges, and the number of other charges are summarized in Table 5. On average, each suspect received a total of 1.78 charges, including an average of 1.33 assault charges and 0.45 other charges. Of the 1,356 suspects, 200 (15%) had multiple assault charges and 401 (29%) had at least one other charge. As a result, 580 (43%) of the suspects therefore had a total number of charges greater than one. Overall, the 1,356 suspects generated a total of 2,407 charges, including 1,803 assault charges and 604 other charges.

Table 5. Number of Total, Assault, and Other Charges per Suspect

Column percentages.

Number	Total charges N	Total charges %	Assault charges N	Assault charges %	Other charges N	Other charges %
0	0	0.0 %	0	0.0 %	955	70.4 %
1	776	57.2	1,055	77.8	274	20.2
2	344	25.4	216	15.9	82	6.0
3	121	8.9	54	4.0	25	1.8
4	63	4.6	18	1.3	16	1.2
5	26	1.9	7	0.5	3	0.2
6 or more	26	1.9	6	0.4	1	0.1
Total	**1,356**		**1,356**		**1,356**	

Source of data: *Alaska State Troopers (2004)*

Table 6. Suspects with Domestic Violence Protection Orders or who Violated Conditions of Release or Probation

Row percentages.

Characteristic	No N	No %	Yes N	Yes %	Total
DVPO for this victim	1,330	98.7 %	17	1.3 %	**1,347**
Violated conditions of release	1,320	97.9	28	2.1	**1,348**
Violated conditions of probation	1,280	95.6	59	4.4	**1,339**

Source of data: *Alaska State Troopers (2004)*

Despite the number and types of offenses suspects were charged with as a result of the assaults in domestic violence incidents, few suspects (just over 1%) had an existing domestic violence protection order filed against them by the victim at the time of the offense (Table 6). Likewise, few suspects were violating conditions of release or probation. Specifically, two percent of suspects were documented as violating a condition of release with their current charges. Another four percent of suspects violated documented conditions of their probation with the current charges. It is important to note that the percentage of suspects violating conditions of release may be greater than those reported here, because these conditions are not always documented in APSIN (Alaska Public Safety Information Network) and are not readily available to Troopers, or for our analysis.

Incident Characteristics

The presence of children during a domestic violence incident continues to be a serious concern. In this study, the victim's or suspect's children under the age of 18 were witnesses to 43 percent of the incidents (Table 7). In Anchorage during 1999–2002, 42 percent of domestic violence incidents occurred with children under the age of 18 present. Nationwide, in 43 percent of the incidents with female victims during 2001–2005, children under the age of 12 were residing in the household where the incident took place. Studies discussed by John L. Worrall in *Crime Control in America: An Assessment of the Evidence* highlight concern regarding children who are present during domestic violence. Exposure to such violence is associated with both child abuse and later delinquency.

Most assaults in domestic violence incidents (75%) occurred between victims and suspects who were staying or living together at the time of the incident. For the remaining quarter of incidents that occurred between suspects and victims who did not stay or live together, 34 percent occurred between victims and suspects who met in a

Table 7. Presence of Children During Assault

Victim and/or suspect's child present	N	%
No	654	57.0 %
Yes	493	43.0
Total	**1,147**	

Source of data: *Alaska State Troopers (2004)*

public place, and 32 percent resulted from invitation by the suspect or victim. In 25 percent of incidents (where suspects and victims were not living together) the suspect was uninvited or forced entry, and in nine percent of these incidents the suspect entered through an open window or unlocked door.

The use of a traditional weapon such as a knife or a gun was extremely rare; each weapon was used in fewer than four percent of assaults in domestic violence incidents. While still fairly infrequent, suspects were more likely to throw something at the victim (9% of incidents) or hit the victim with an object (10%) rather than use a traditional weapon. Nationwide in 2001–2005, 19 percent of domestic violence incidents with a female victim reported a traditional weapon present, while 31 percent of incidents with a male victim reported a weapon.

We also gathered information about the presence of nine specific violent acts and seven types of threats in the assaults in domestic violence incidents. Only forms of violence that were documented as a result of victim disclosure or officer inquiry, rather than all forms of violence that occurred, were included for analysis. The three most common forms of violence disclosed by victims or documented as a result of officer inquiry included pushing, grabbing or shoving the victim (48%), punching the victim (29%), and slapping or hitting the victim (28%). Documented sexual assault of the victim occurred in only one percent of the cases.

Documented injuries to victims and emergency medical treatment data were also collected and analyzed. The percentage of victims who sustained the most common types of documented injuries included the following: bruising (38%), lacerations or bite marks (27%), bloody nose or lips (10%) and black or swollen eyes (10%). Overall, few victims (12%) received any type of emergency medical treatment for their injuries.

Legal Resolutions

Mandatory arrest in domestic violence cases has been in effect in Alaska since 1996. This law places additional requirements on law enforcement when investigating a domestic violence report and provides criteria for assessing whom to arrest if there are cross complaints "arising from the same incident." (See "Mandatory Arrest in Domestic Violence Cases" accompanying this article.)

Most of the cases (96%) were closed and referred for prosecution including cases that were closed by arrest (79%), and those closed and referred (13%). The remaining cases were closed after investigation (2%) or closed as unfounded (2%) in cases where a suspect was not arrested. On average, it took 6.30 weeks to close a case after it was reported, and 87 percent of cases were closed within 90 days.

An important component of this study involved tracking assaults in domestic

Mandatory Arrest in Domestic Violence Cases

Alaska's mandatory arrest statute was passed as part of the Domestic Violence Prevention and Victim Protection Act of 1996 with the support of prosecutors, law enforcement, and advocates for domestic violence victims in the state. Alaska Statute 18.65.530, "Mandatory arrest for crimes involving domestic violence, violation of protective orders, and violation of conditions of release," sets out conditions for arrest and minimum sentencing requirements. A law enforcement officer is required to make an arrest with or without a warrant:

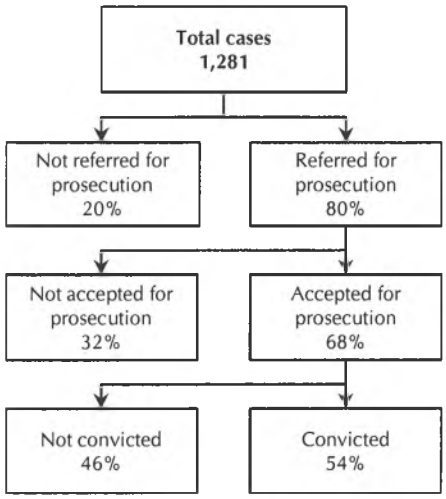
> if the officer has probable cause to believe the person has, either in or outside the presence of the officer, within the previous 12 hours, (1) committed domestic violence, except an offense under AS 11.41.100-11.41.130, whether the crime is a felony or misdemeanor; (2) committed the crime of violating a protective order in violation of AS 11.56.740; (3) violated a condition of release imposed under AS 12.30.025, 12.30.027, 12.30.029....

The statute provides criteria for an officer to use when determining who is the "principal physical aggressor." A "principal physical aggressor" evaluation must be made in domestic violence cases if there are cross complaints "arising from the same incident." In rare circumstances, an officer may determine that no arrest should be made. An "authorization not to arrest" must first be granted by a prosecutor from "the jurisidiction in which the offense under investigation arose," and the officer must later report in writing why an arrest was not made. A prosecuting attorney is on call and available by phone to law enforcement in all parts of the state to provide an officer with an authorization, if needed.

Under Alaska law, there is a 20-day minimum sentence if the defendant is in violation of a domestic violence protection order, a 30-day minimum sentence if the defendant has a prior conviction for assault or domestic violence assault, and a 60-day minimum sentence if the defendant "has been previously convicted two or more times of a crime against a person or a crime involving domestic violence, or a combination of those crimes." Aggravating factors that can increase the length of the normal minimum sentence required by the statute include the presence of a child under the age of 16 during a felony crime involving domestic violence, as well as a domestic violence offense committed at a shelter or facility providing services to domestic violence and sexual assault victims. In addition, recent legislative changes have upgraded certain misdemeanor assaults to a Class C felony and have added a new provision to the animal cruelty statute dealing with "intent to intimidate, threaten or terrorize another person." Some domestic violence convictions also carry federal legal consequences. Under federal law it is "unlawful to sell or dispose of a firearm" to a person convicted of a qualifying domestic violence misdemeanor.

The terms "domestic violence and "crime involving domestic violence" have a broad meaning under AS 18.66.990(3) & (5). "Acts of domestic violence" as defined under the statute go beyond physical assault; acts of domestic violence also include burglary, criminal trespass, arson or criminally negligent burning, criminal mischief, terrorist threatening, violating a protective order, and harassment. In addition, the statute defines domestic violence as an offense committed "by [one] household member against another household member." The definition of household member encompasses more than persons living in the same residence. It includes many people who do not live together: "adults or minors who are current or former spouses, adults or minors...who have lived together, adults or minors who are dating or have dated, adults or minors who are engaged in or who have engaged in a sexual relationship, adults or minors who are related to each other up to the fourth degree of consanguinity..., adults or minors who are related or formerly related by marriage, persons who have a child of [their] relationship, and minor children in a relationship that is described [in the statute]."

Figure 1. Processing of Domestic Violence Cases Reported to Alaska State Troopers, 2004



violence incidents from reports to Troopers through case resolution by the Department of Law. Because we only examined referrals to the Department of Law (and excluded, for example, referrals to the Division of Juvenile Justice), the following statistics are not directly comparable to the ones reported in the previous paragraph.

When examining case processing with Department of Law data, we find that after Troopers close a case, the next decision is whether to refer the case for prosecution. Results show that 80 percent of the 1,281 cases reported to Troopers were referred for prosecution, 68 percent were accepted for prosecution, and 54 percent resulted in a conviction (Figure 1). Once cases were referred for prosecution, they had a high likelihood of being accepted for prosecution. Specifically, 84 percent of referred cases (N=1,030) were accepted for prosecution, and 67 percent resulted in a conviction (Table 8). Cases accepted for prosecution (N=869) had an 80 percent conviction rate.

In addition to examining case resolution rates for all assaults in domestic violence incidents reported to Troopers, we reviewed case resolution rates separately for male and female suspects comparing cases that had at least one male suspect to cases that had at least one female suspect. In our sample of 1,281 cases, 974 cases included at least one male suspect and 259 included at least one female suspect. Cases with at least one female suspect were slightly less likely to be referred for prosecution, to be accepted for prosecution, and to result in a conviction than cases with at least one male suspect. Of the 259 reported cases with at least one female suspect, 75 percent were referred for prosecution (versus 82% with a male suspect), 56 percent were accepted for prosecution (versus 73% with a male suspect), and 44 percent resulted in a conviction (versus 58% with a male suspect) (Figure 2).

Once referred for prosecution, 89 percent of cases with at least one male suspect (N=707) and 76 percent of cases with at least one female suspect (N=146) were accepted for prosecution. Once accepted for prosecution, the likelihood of cases resulting in a conviction did not vary greatly by suspect gender. Upon acceptance for prosecution, 80 percent of cases with at least one male suspect (N=568) and 78 percent of cases with at least one female suspect (N=114) resulted in a conviction (Table 9).

In addition to examining case resolution rates separately for male and female suspects, we examined case resolution rates separately for male and female victims. In our sample of 1,281 cases, 352 cases included at least one male victim and 925 included at least one female victim. Cases with at least one female victim were as likely to be referred for prosecution, as likely to be accepted for prosecution, and as likely to result in a conviction as cases with at least one male victim. Of the 925 reported cases with at least one female victim, 80 percent were referred for prosecution (versus 81% with a male victim), 59 percent were accepted for prosecution (versus 65% with a male victim), and 54 percent resulted in a conviction for both female and male victims (Figure 3 and Table 10). Although cases involving male suspects had higher case processing and conviction rates, case processing rates were quite similar for victims of both genders. No discernable pattern was found in case processing rates for domestic violence victims based on their gender.

Another variable examined in relation to case processing of assaults in domestic violence incidents was the relationship between the victim and the suspect. We examined the relationship between the victim and suspect separately for male and female victims. Most of the assaults in domestic violence incidents occurred between intimate partners. The most likely relationship identified was current or former intimate partner as seen in 67 percent of assaults in domestic violence incidents with female victims and 38 percent with male victims. The next most likely relationship was parents or children comprising 16 percent of the assaults in domestic violence incidents with female victims and 25 percent with male victims. Another 12 percent of assaults in domestic violence incidents with female victims and 22 percent with male victims took place between other

Table 8. Number of Cases by Stage

Column percentages.

Stage	N	% of reported	% of referred	% of accepted
Reported	**1,281**	100.0 %	—	—
Referred	**1,030**	80.4	100.0 %	—
Accepted	**869**	67.8	84.4	100.0 %
Convicted	**692**	54.0	67.2	79.6

Source of data: *Alaska Department of Law*

Figure 2. Processing of Domestic Violence Cases Reported to Alaska State Troopers, 2004: Male/Female Suspects

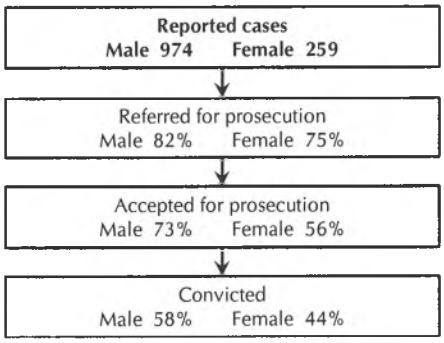


Figure 3. Processing of Domestic Violence Cases Reported to Alaska State Troopers, 2004: Male/Female Victims

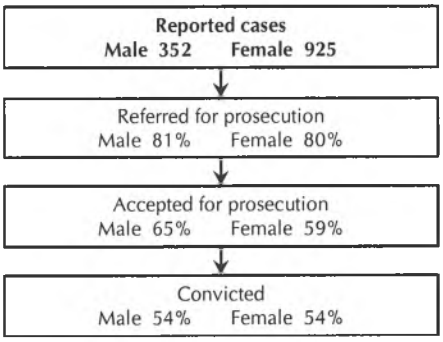


Table 9. Number of Cases by Stage for Cases with Male or Female Suspects

Column percentages.

	N	% of reported	% of referred	% of accepted
Male suspects				
Reported	**974**	100.0 %	—	—
Referred	**798**	81.9	100.0 %	—
Accepted	**707**	72.6	88.6	100.0 %
Convicted	**568**	58.3	71.2	80.3
Female suspects				
Reported	**259**	100.0 %	—	—
Referred	**193**	74.5	100.0 %	—
Accepted	**146**	56.4	75.6	100.0 %
Convicted	**114**	44.0	59.1	78.1

Source of data: *Alaska State Troopers (2004) and Alaska Department of Law*

Table 10. Number of Cases by Stage for Cases with Male or Female Victims

Column percentages.

	N	% of reported	% of referred	% of accepted
Male victims				
Reported	**352**	100.0 %	—	—
Referred	**284**	80.7	100.0 %	—
Accepted	**228**	64.8	80.3	100.0 %
Convicted	**191**	54.3	67.3	83.8
Female victims				
Reported	**925**	100.0 %	–	–
Referred	**743**	80.3	100.0 %	–
Accepted	**639**	59.1	86.0	100.0 %
Convicted	**500**	54.1	67.3	78.2

Source of data: *Alaska State Troopers (2004) and Alaska Department of Law*

family members (including siblings and extended family). Six percent of assaults in domestic violence incidents with female victims and 13 percent with male victims took place between roommates. Overall, most assaults occurred between intimate partners, and this was particularly true for female victims.

An examination of case processing for the different relationship types revealed some differences in the earlier stages of case processing. Regarding referral rates for assaults in domestic violence incidents, 88 percent of cases involving roommates, 86 percent of cases involving intimate partners, 72 percent of cases involving other family members, and 63 percent of cases involving parents or children were referred for prosecution (Table 11). Cases involving victims and suspects who were roommates or intimate partners were more likely to be referred for prosecution than cases involving other family members or parents and children. Of all referred cases, 87 percent of cases involving intimate partners, 82 percent of cases involving parents or children, 81 percent of cases involving other family members, and 74 percent of cases involving roommates were accepted for prosecution. Referred cases involving intimate partners were most likely to be accepted for prosecution, and cases involving roommates were least likely to be accepted for prosecution. Although some differences were found in referral and acceptance rates for different relationship types in assaults in domestic violence incidents, conviction rates for accepted cases were remarkably similar. Eighty-one percent of cases involving intimate partners, 81 percent of cases involving other family members, 80 percent of cases involving parents or children, and 77 percent of cases involving roommates resulted in a conviction, once accepted for prosecution. Despite differences in referral and acceptance rates for assaults in domestic violence incidents involving various relationships between victims and suspects, conviction rates for accepted cases were similar across the different relationship types.

In another examination of assaults in domestic violence incidents, we assessed the combined influence of gender and relationship on case processing. In this examination, cases were classified as intimate partner violence or non-intimate partner violence incidents. Incidents of intimate partner violence were defined as taking place between intimate partners and involving a male suspect and a female victim. Non-intimate partner violence incidents included all other combinations of suspect and victim gender and the various relationship types. (Few cases—1.5%—involved same-sex intimate partner violence. The characteristics of these cases will be included in a future study.) Results showed higher case processing rates for intimate partner violence incidents in the earlier stages of case processing. Specifically, 85 percent of intimate partner violence incidents and 75 percent of non-intimate partner violence incidents were referred for prosecution (Table 12). Once referred, 90 percent of intimate partner violence incidents and 79 percent of non-intimate partner violence incidents were accepted for prosecution. Again, no discernable differences were found in conviction rates for intimate partner and non-intimate partner violence incidents once they were accepted for prosecution. Eighty-one percent of accepted cases involving intimate partner violence incidents resulted in a conviction, and 79 percent of accepted non-intimate partner violence incidents resulted in a conviction. Conviction rates based on the total number of reports to Troopers of intimate partner violence incidents were

Table 11. Nature of Victim and Suspect Relationships and Legal Resolutions

Column percentages.

	N	Intimate partner	Parents or children	Other family	Room-mates
Referred	**1,029**	86.1 %	63.4 %	71.8 %	87.9 %
Accepted	**869**	86.5	81.5	81.1	74.1
Convicted	**692**	80.5	80.0	80.8	76.7

Source of data: *Alaska State Troopers (2004) and Alaska Department of Law*

Table 12. Legal Resolutions for Intimate Partner and Non-Intimate Partner Violence

Column percentages.

		% of reported		% of referred		% of accepted	
	N	Intimate partner	Non-intimate partner	Intimate partner	Non-intimate partner	Intimate partner	Non-intimate partner
Reported	**1,279**	100 %	100 %	—	—	—	—
Referred	**1,028**	85	75	100 %	100 %	—	—
Accepted	**862**	76	59	90	79	100 %	100 %
Convicted	**692**	62	47	72	62	81	79

Source of data: *Alaska SANE data and Alaska Department of Law*

higher (62%) than for all reported cases to Troopers of non-intimate partner violence incidents (47%).

A more detailed examination of legal resolutions explored differences in case processing rates for male and female victims in various relationships with suspects. Just as cases with male suspects tended to have higher case processing rates at each stage of prosecution, male victims tended to experience higher case processing rates across different relationship types. One exception to this trend was higher rates of acceptance for referred cases involving intimate partners with female victims (76%) relative to male victims (67%). Similarly, cases involving intimate partners with female victims had higher conviction rates (61% of accepted cases) than cases with male victims (53% of accepted cases) (Table 13). In sum, cases of assaults in domestic violence incidents investigated by Troopers had relatively high referral, acceptance and conviction rates overall, despite variation in rates by gender of the suspects and victims and relationships between them.

The findings presented in this article provide an initial description of case processing and conviction rates for assaults in domestic violence incidents in smaller communities across the state of Alaska. The full report containing more detailed descriptive analyses is published on the Justice Center website. Future studies may focus on comparisons of the data from the Anchorage analysis, this study, and nationwide reports. An important area to examine in more depth is factors affecting legal resolutions. More complex analyses involving multiple predictor variables are required to understand the many influential factors in case processing and conviction of assaults in domestic violence incidents. A growing body of data about domestic violence incidents will enable policymakers to focus on improving ways to deal with this critical issue.

Table 13. Nature of Victim and Suspect Relationships and Legal Resolutions for Female and Male Victims

Column percentages.

	N	Intimate partner	Parents or children	Other family	Room-mates
Female victim					
Referred	**663**	85.3 %	60.8 %	69.6 %	88.2 %
Accepted	**580**	76.2	44.6	57.6	55.9
Convicted	**454**	60.6	34.6	41.3	35.3
Male victim					
Referred	**229**	89.4 %	67.1 %	74.4 %	87.5 %
Accepted	**177**	66.9	61.0	59.0	75.0
Convicted	**148**	53.1	51.2	53.8	65.6

Source of data: *Alaska State Troopers (2004) and Alaska Department of Law*

Figures for national and Anchorage domestic violence incidents are from the Bureau of Justice Statistics (2007) and the Municipality of Anchorage (2006).

Marny Rivera is an Assistant Professor of the Justice Center. André B. Rosay is an Associate Professor and the Interim Director of the Justice Center. Darryl Wood is an Assistant Professor at Washington State University Vancouver. Greg Postle is a doctoral student at the University of Delaware. Katherine TePas is a Program Coordinator with the Alaska State Troopers. *This project was supported by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice (Grant No. 2005-WG-BX-0011) and by the Violence Against Women Office, Office of Justice Programs, U.S. Department of Justice through the Alaska Council on Domestic Violence and Sexual Assault (Grant Numbers 2003-WF-BX-0201 and 2004-WF-AX-0033). Points of view in this article are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

UAA Justice Center
University of Alaska Anchorage

UAA Justice Center
Research Overview

January 2011 No. 11

Stalking Victimization: Comparisons between Alaska and U.S. Data

This research overview presents information on stalking victimization in the United States. Alaska-specific data include Alaska State Trooper cases from 1994–2005 as published in the *Alaska Justice Forum* in 2007. Nationwide data are from the U.S. Bureau of Justice Statistics (BJS) 2009 "Special Report on National Crime Victimization Survey (NCVS), Stalking Victimization in the United States"; the survey was conducted in 2006. It is important to note that Alaska does not yet have stalking victimization estimates. This research overview looks at data that are currently available for Alaska and notes contrasts and similarities with nationwide data. Only adult cases were considered for this purpose.

It is also important to emphasize that Alaska data are only from stalking victimizations that were reported to law enforcement. By comparison, the national NCVS data are from all stalking victimizations, those reported to law enforcement and those not reported to law enforcement. Finally, it is important to emphasize that the Alaska data are only from stalking victimizations reported to Alaska State Troopers (the data do not include victimizations reported to municipal or other law enforcement agencies in Alaska).

Gender of Victim and Offender

- Alaska data show that 89% of stalking victims were female and 11% were male while 88% of offenders were male and 9% were female. In comparison, NCVS data show that nationally 74% of stalking victims were female and 26% male (Table 1).

Table 1. Gender of Victims and Offenders

Column percentages

	Victims		Offenders	
	Alaska	U.S.	Alaska	U.S.
Male	10.6 %	26.0 %	88.0 %	60.2 %
Female	89.4	74.0	9.3	28.4
Don't know	—	—	2.8	11.3

Note: Percentages exceed 100% due to rounding errors.

- In Alaska, nearly 90% of female stalking victims and 74% of male stalking victims were victimized by male offenders. According to the NCVS, nationally, 67% of female victims and 41% of male victims were victimized by male offenders (Table 2).

Table 2. Gender of Stalking Offender, by Victim Gender

Column percentages except where noted.

	Victim gender					
	Alaska			U.S.		
Offender gender	Male	Female	**All offenders**	Male	Female	**All offenders**
Male	73.9 %	89.6 %	**88.0 %**	41.3 %	66.9 %	**60.3 %**
Female	26.1	7.3	**9.3**	42.5	23.5	**28.4**
Don't know	0.0	3.1	**2.8**	16.1	9.6	**11.3**
All victims	**10.7 %** (row percentages)	**89.4 %**		**25.96 %** (row percentages)	**74.02 %**	

Note: Percentages may not total to 100% due to rounding.

Age of Victim and Offender

- In Alaska, the most common age group for both stalking victims (39%) and offenders (34%) was 30–39 years. NCVS data show that nationally, the most common age group for stalking victims (28%) was 21–29 years while the most common age of offenders (22%) was 30–39 year-olds (Table 3).

Table 3. Ages of Victims and Offenders

Column percentages.

	Victims		Offenders	
	Alaska	U.S.	Alaska	U.S.
18-20	9.4 %	9.3 %	4.4 %	7.3 %
21-29	20.4	27.7	20.4	21.7
30-39	39.2	22.2	33.7	22.3
40-49	23.8	21.2	30.4	18.7
50 and older	7.2	19.5	11.0	15.7
Unknown	0.0	0.0	0.0	14.3

- NCVS data show that stalking victims are most likely to be victimized by an offender in their own age group (Table 4).
- Victims in Alaska, similarly to victims nationwide, are most likely to be victimized by offenders in the same age group. However, in Alaska, victims aged 50 years and older are most likely to be victimized by an offender in the 30–39 year-old age group (Table 4).

Table 4. Age of Stalking Offender, by Victim Age

Column percentages except where noted.

	Victim age					
Offender age	18-20	21-29	30-39	40-49	50 or older	All offenders
Alaska						
18-20	**41.2 %**	2.7 %	0.0 %	0.0 %	0.0 %	**4.4 %**
21-29	29.4	**40.5**	18.3	9.3	0.0	**20.4**
30-39	17.6	32.4	**42.3**	18.6	61.5	**33.7**
40-49	5.9	18.9	29.6	**53.5**	23.1	**30.4**
50 or older	5.9	5.4	9.9	18.6	**15.4**	**11.0**
Unknown	0.0	0.0	0.0	0.0	0.0	**0.0**
All victims	**9.4 %**	**20.4 %**	**39.2 %**	**23.8 %**	**7.2 %**	
			(row percentages)			
United States						
18-20	**46.7**	5.7	2.3	3.0	1.0	**7.3**
21-29	26.2	**48.5**	14.1	9.0	3.9	**21.7**
30-39	5.7	23.2	**38.3**	17.1	16.6	**22.3**
40-49	7.5	7.8	21.2	**34.9**	19.1	**18.7**
50 or older	2.7	5.9	10.1	22.1	**35.3**	**15.7**
Unknown	11.2	8.9	14.2	14.0	24.1	**14.3**
All victims	**9.3 %**	**27.7 %**	**22.2 %**	**21.2 %**	**19.5 %**	
			(row percentages)			

Race of Victim and Offender

- Overall, nearly 86% of all Alaska victims were White and 13% were Alaska Native/American Indian. NCVS data show that nationally 84% of stalking victims were White (Table 5).
- Offenders in the Alaska cases were most likely to be White (79%) or Alaska Native (20%). Nationally, offenders were most likely to be White (73%) or Black (12%) in stalking cases (Table 5).

Table 5. Race of Victims and Offenders

Column percentages

	Victims		Offenders	
	Alaska	U.S.	Alaska	U.S.
White	86.0 %	84.1 %	78.7 %	73.3 %
Black	1.0	10.7	1.0	12.2
Alaska Native/American Indian	12.6	—	20.3	—
Some other race	0.5	5.2	—	9.2
Unknown	—	—	—	5.2

Note: Due to rounding errors, percentages may not total 100.

— Alaska data identified Alaska Native as an individual cateogory. NCVS data includes "Alaska Native/American Indian" data with "Some other race."

- Alaska stalking victims are more commonly stalked by offenders of the same race. NCVS data show that, like in Alaska, Whites are more likely to be victimized by White offenders and Blacks are more likely to be victimized by Black offenders (Table 6).
- NCVS data show that victims of other races were most commonly victimized by White (45%) offenders (Table 6).

Table 6. Race of Stalking Offender, by Victim Race

Column percentages except where noted.

	Victim race								
	Alaska					U.S.			
Offender race	White	Black	Native	Other	All offenders	White	Black	Other	All offenders
White	**88.2 %**	0.0 %	19.2 %	100.0 %	**78.7 %**	82.8 %	12.5 %	45.4 %	**73.3 %**
Black	0.0	**100.0**	0.0	0.0	**1.0**	5.2	65.6	16.0	**12.2**
Alaska Native/ American Indian	11.8	2.0	**80.8**	0.0	**20.3**	—	—	—	—
Some other race	—	—	—	—	—	7.6	11.8	29.8	**9.2**
Unknown	—	—	—	—	—	4.3	10.1	8.8	**5.2**
All victims	**86.0 %**	**1.0 %**	**12.6 %**	**0.5 %**		**84.1 %**	**10.71 %**	**5.22 %**	
		(row percentages)					(row percentages)		

Note: Percentages may not total to 100% due to rounding.

— Alaska data identified Alaska Native as an individual cateogory. NCVS data includes "Alaska Native/American Indian" data with "Some other race."

Victim-Offender Relationship

- Alaska stalking victims most commonly were victimized by ex-boy/girlfriends (30%), acquaintances (29%), and current spouses (16%). NCVS data show that nationally most stalking victimization was committed by an acquaintance (20%), friend (16%), or ex-boy/girlfriend (13%) (Table 7).
- In Alaska, 8% of stalking victims had unknown relationships with the offender. Nationwide, 10% of victims had unknown relationships with their offenders.

Stalking Behaviors

- Alaska stalking victims were most likely to be stalked by offenders showing up at places and/or waiting for the victim (64%), receiving unwanted phone calls and text messsages (51%), and/or by being followed or spied upon (Table 8).
- NCVS data show that the most common types of stalking behaviors were unwanted phone calls and text messages (66%), spreading rumors (36%), and following or spying upon victims (34%) (Table 8).

Table 7. Relationship Between Victims and Offenders

	Alaska	U.S.
Stranger	7.5 %	9.7 %
Current spouse	15.5	5.6
Ex-spouse	6.5	8.4
Current boy/girlfriend	2.5	3.2
Ex-boy/girlfriend	29.5	13.1
Other family	3.5	9.0
Friend	6.5	16.4
Acquaintance	28.5	19.7

Note: Fifteen percent of NCVS data represent unknown relationships between the victim and offender.

Table 8. Nature of Stalking Behaviors Experienced by Victims

	Alaska	U.S.
Unwanted phone calls and text messages	50.5 %	66.2 %
Unwanted letters and email	16.7	30.6
Spreading rumors	2.7	35.7
Following or spying	39.6	34.3
Showing up at places	64.0	31.1
Waiting for victim	64.0	29.0
Leaving unwanted presents	9.9	12.2

Note: "Showing up at places" and "Waiting for victim" were combined for Alaska due to data detail limitations. Percentages may total more than 100% because multiple behaviors may have been reported.

Data Sources

Rosay, A., Postle, G., TePas, K., and Wood, D. (2007). "Stalking in Alaska." *Alaska Justice Forum* 24(1): 1, 7–12. Available online at http://justice.uaa.alaska.edu/forum/24/1spring2007/a_stalking.html.

Baum, K., Catalano, S. & Rand, M. (2009). "Stalking Victimization in the United States: National Crime Victimization Study." *Bureau of Justice Statistics Special Report*, NCJ 224527. Available online at http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1211.

Rosay, A.; Wood, D.; Postle, G.; and TePas, K. (2007). *Descriptive Analysis of Stalking Incidents Reported to Alaska State Troopers: 1994-2005.* Anchorage, AK: Justice Center, University of Alaska Anchorage. available online at http://justice.uaa.alaska.edu/research/2000/0601intimatepartnerviolence/0601.01.stalking.html.

Secondary data analysis on Alaska State Trooper data was performed by the author with the assistance of Dr. André B. Rosay.

Research compiled by Khristy Parker, Research Assistant

UAA University of Alaska Anchorage
UAA is an EEO/AA employer and educational institution.

© 2011 Justice Center, University of Alaska Anchorage

ALASKA JUSTICE FORUM
REPRINTS

February 2009 JUSTICE CENTER ♦ UNIVERSITY of ALASKA ANCHORAGE No. 3

Stalking in Alaska

André B. Rosay, Greg Postle, Katherine TePas, and Darryl Wood

Originally published in the *Alaska Justice Forum* 24(1): 1, 7–12 (Spring 2007).
http://justice.uaa.alaska.edu/forum/24/1spring2007/a_stalking.html

For other articles and publications related to stalking and violence against women, see:
http://justice.uaa.alaska.edu/vaw/

Abstract: *This study examined 267 cases with a stalking charge reported to Alaska State Troopers from 1994 to 2005, and excluded any cases reported to local or municipal departments. We also examined the legal resolutions for cases that were reported from1999-2004.*

- *Over 50% of reports occurred in B detachment (Southcentral Alaska) and D detachment (Interior Alaska). Three units (Fairbanks AST Enforcement, Palmer AST Enforcement, and Soldotna AST Enforcement) handled 49% of reports. Thirty-five percent of the charges were for stalking in the first degree and 65% were for stalking in the second degree.*
- *Most suspects (91%) were male and most victims (89%) were female. Most suspects (78%) were White and most victims (86%) were also White. On average, suspects were 36 years old while victims were 33 years old. Twenty percent of suspects had used alcohol, but only 2% of victims had used alcohol. Fifty-four percent of suspects were, or had been, in a romantic relationship with the victim. An additional 35% of suspects were friends or acquaintances of the victim.*
- *The most common forms of stalking included standing outside or visiting the victim's home (in 54% of charges), making unsolicited phone calls to victims (in 51% of charges), following the victim (in 39% of charges), threatening to physically assault the victim (in 36% of charges), harassing the victim's family and friends (in 28% of charges), trying to communicate with the victim in other ways (in 27% of charges), standing outside or visiting the victim's work (in 20% of charges), physically assaulting the victim (in 19% of charges), sending the victim unsolicited mail (in 15% of charges), and vandalizing the victim's home (in 13% of charges). Forty-five percent of behaviors occurred primarily at the victim's home, while 27% occurred primarily in cyberspace.*
- *Seventy-five percent of the cases reported between 1999-2004 were referred for prosecution, 55% were accepted for prosecution, and 40% resulted in a conviction on at least one charge. Cases with suspects who violated protective orders were 20% more likely to be referred for prosecution, were 19% more likely to be accepted, and were 41% more likely to result in a conviction.*

Although the available data are limited, a recent Justice Center examination of Alaska State Trooper case files has revealed that the crime of stalking is probably greatly underreported by victims as well as underrecognized by law enforcement and hence not charged often enough in Alaska. A charge of stalking can be applied in a wide range of situations, and its parameters as a crime can be somewhat ambiguous for both victims and law enforcement. The available data show that a stalking charge is often made in conjunction with other charges, particularly when there has been a prior relationship—which is often the case, with stranger stalking fairly rare.

Stalking, by its nature and its legal definition, induces fear. Statistics from the National Violence Against Women Survey showed that even after the stalking ended, 68 percent of victims thought their personal safety had gotten worse, 42 percent were very concerned about their personal safety, 30 percent were very concerned about being stalked, and 45 percent carried something to defend themselves. Psychological counseling was sought by 30 percent of female victims and 20 percent of male victims.

Moreover, other studies have shown links between stalking and intimate partner homicide among female victims. For example, according to an analysis published in *Homicide Studies* in 1999, 76 percent of female intimate partner homicide victims had been stalked by their intimate partner in the past. Furthermore, 89 percent of female intimate partner homicide victims that were physically abused had also been stalked by their intimate partner in the past. Of all female intimate partner homicide victims, 54 percent had previously contacted police to report they were being stalked.

With funding from the National Institute of Justice, the Justice Center is working with the Alaska State Troopers and the Alaska Department of Law to learn more about the characteristics of stalking in Alaska.

In the first quantitative examination of the crime, data from all stalking incidents reported to Alaska State Troopers from 1994 to 2005 were collected to gather descriptive information. The research provides a first overview of a specific crime whose characteristics are not widely known beyond the justice community. The Alaska statutes defining the crime of stalking are presented on page 5.

Methodology

To conduct this study, Justice Center researchers examined the total 267 cases with a stalking charge reported to Alaska State Troopers from 1994 to 2005. (Alaska stalking statutes went into effect in 1993.) The final sample for analysis comprised 210 cases (Table 1) covering a total of 222 stalking charges, 211 suspects, and 216 victims. Case outcome data were gathered directly

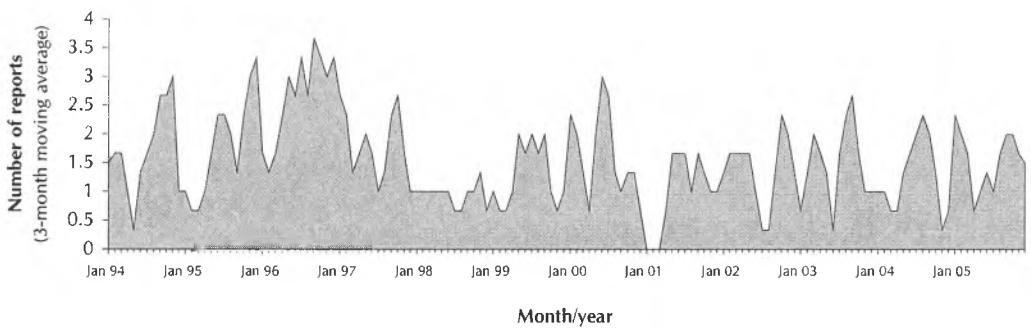
Table 1. Case Closure Codes in Alaska Stalking Cases, 1994–2005
Column percentages

	Reports	
Closure code	N	%
Closed by arrest	140	66.7 %
Closed, declined	6	2.9
Closed by investigation	34	16.2
Closed, referred	22	10.5
Closed, unfounded	8	3.8
Total	**210**	

Source of data: *Alaska State Troopers data (1994-2005)*

© 2009 Justice Center, University of Alaska Anchorage

Figure 1. Number of Stalking Reports in Alaska by Month and Year, 1994–2005



Source of data: *Anchorage State Troopers data (1994–2005)*

from the Alaska Department of Law for a sub-sample of the stalking cases—only those reported from 1999 to 2004 ($N = 92$).

Results

For the first four years included in this investigation (1994 to 1997), the number of reports averaged 22 per year. After that, the average number of reports dropped significantly, to 15 per year. Figure 1 displays the trend of reporting over time, from January 1994 to December 2005, using a three-month moving average. Seasonal variations from January to December in the trend of reporting were not quite statistically significant, but 23 percent of the reports were made in the months of June and October.

Over 50 percent of reports occurred in B and D detachments. B detachment includes five Alaska State Trooper posts (Wasilla, Palmer, Glennallen, Big Lake, and Talkeetna) while C detachment includes nine Alaska State Trooper posts (Coldfoot, Galena, Fairbanks, Nenana, Healy, Cantwell, Delta Junction, Tok, and Northway; see Figure 2). The units with the highest number of stalking reports included Fairbanks AST Enforcement (with 19% of reports), Palmer AST Enforcement (with 18% of reports), and Soldotna AST Enforcement (in E Detachment, with 12% of reports). Together, these three units had 49 percent of all stalking reports. Additional details are shown in Table 2.

Most cases (67%) were closed by arrest, meaning that at least one person was criminally charged, by a physical arrest, summons, warrant, or criminal complaint (see Table 1). Other cases (10%) were closed with a referral to the district attorney for a charging decision. Sixteen percent of cases were closed after the investigation because there were no suspects or because evidence was lacking. Only four percent of cases were closed unfounded (because there appeared to be no basis for the complaint). Finally, only three percent of cases were closed because the prosecution declined to pursue the case, even though a suspect was known.

The 210 stalking incidents reported to troopers from 1994 to 2005 included a total of 222 stalking charges. Seventy-seven (35%) of the 222 stalking charges were for stalking in the first degree (AS §11.41.260) and 145 (65%) were for stalking in the second degree (AS §11.41.270). For each stalking charge, thirty different forms of behavior were examined, shown in Table 3. On average, four forms of stalking behaviors were found per charge. The most common forms of stalking behaviors included standing outside or visiting the victim's home (found in 54% of charges), making unsolicited phone calls to victims (found in 51% of charges), following the victim (found in 39% of charges), threatening to physically assault the victim (found in 36% of charges), harassing the victim's family and friends (found in 28% of charges), trying to communicate with the victim in other ways (found in 27% of charges), standing outside or visiting the victim's work (found in 20% of charges), physically assaulting the victim (found in 19% of charges), sending the victim unsolicited mail (found in 15% of charges), and vandalizing the victim's home (found in 13% of charges).

Figure 2. Alaska State Trooper Locations

Source: Alaska State Troopers May 2006

Table 2. Total Number of Stalking Reports in Alaska by Unit, 1994–2005

Column percentages

Unit	N	%	Unit	N	%	Unit	N	%
Anchorage AST Enforcement	7	3.3 %	Girdwood AST Enforcement	3	1.4 %	Northway AST Enforcement	1	0.5 %
Aniak AST Enforcement	1	0.5	Glennallen AST Enforcement	6	2.9	Mat-Su Regional Office	1	0.5
Bethel AST Enforcement	7	3.3	Healy AST Enforcement	1	0.5	Palmer AST Enforcement	37	17.6
Big Lake AST Enforcement	1	0.5	Homer AST Enforcement	7	3.3	Palmer AST Investigations	5	2.4
Cooper Landing AST Enforcement	1	0.5	Juneau AST Enforcement	1	0.5	Seward AST Enforcement	4	1.9
ABI Child Abuse Investigation Unit	1	0.5	Ketchikan AST Enforcement	7	3.3	Soldotna AST Enforcement	25	11.9
Cantwell AST Enforcement	3	1.4	Ketchikan AST Investigations	1	0.5	St. Marys AST Enforcement	2	1.0
ABI Cold Case Investigations	1	0.5	Klawock AST Enforcement	9	4.3	Talkeetna AST Enforcement	3	1.4
Cordova ABWE	1	0.5	Kodiak AST Enforcement	9	4.3	Tok AST Enforcement	1	0.5
Delta Junction AST Enforcement	7	3.3	Kotzebue AST Enforcement	6	2.9	Unalakleet AST Enforcement	1	0.5
Fairbanks AST Enforcement	40	19.0	Ninilchik AST Enforcement	1	0.5			
Fairbanks AST Investigations	4	1.9	Nome AST Enforcement	2	1.0			
Galena AST Enforcement	2	1.0	Nome V.P.S.O.	1	0.5	**Total**	**210**	

Source of data: *Alaska State Troopers data (1994-2005)*

The primary location for stalking behaviors was most often the victim's residence. As shown in Table 4, 45 percent of stalking behaviors occurred primarily at the victim's home. Cyberspace was also a common location for stalking behavior, with 27 percent of charges occurring primarily in cyberspace. An additional 10 percent of charges occurred primarily on public roads and parking lots.

The 210 stalking incidents reported to troopers from 1994 to 2005 included a total of 211 suspects and 216 victims. Most suspects (91%) were male and most victims (89%) were female. As shown in Table 5, most suspects (78%) were white and most victims (86%) were also white. On average, suspects were 36 years old while victims were 33 years old; with 13 percent of suspects and 20 percent of victims under 21, 18 percent of suspects and 22 percent of victims between 21 and 30, 37 percent of suspects and 33 percent of victims between

Table 3. Stalking Behaviors in Alaska Stalking Cases, 1994–2005

Row percentages

	Yes		
Behaviors	N	%	**Total**
Followed victim	86	39.4 %	**218**
Sent victim unsolicited mail	33	14.9	**222**
Made unsolicited phone calls to victim	112	50.5	**222**
Sent victim unsolicited electronic mail	7	3.2	**222**
Sent victim unsolicited text messages	0	0.0	**222**
Tried to communicate in other ways	60	27.0	**222**
Photographed victim without permission	3	1.4	**219**
Abused victim's pets	3	1.4	**221**
Threatened to harm victim's pets	0	0.0	**222**
Physically assaulted victim	42	18.9	**222**
Threatened to physically assault victim	78	35.8	**218**
Sexually assaulted victim	13	5.9	**222**
Threatened to sexually assault victim	8	3.6	**222**
Harassed victim's children	13	5.9	**221**
Threatened victim's children	13	5.9	**220**
Harassed victim's family and friends	62	27.9	**222**
Vandalized victim's home	28	12.7	**221**
Vandalized victim's car	14	6.4	**220**
Vandalized other property	11	5.0	**222**
Stood outside/visited victim's home	120	54.1	**222**
Stood outside/visited victim's work	44	20.0	**220**
Left unwanted items for victim	3	1.4	**222**
Sent victim presents	20	9.0	**222**
Opened victim's mail	1	0.5	**222**
Filed false police reports against victim	1	0.5	**222**
Contacted victim's employer	4	1.8	**222**
Contacted or filed report with children services	1	0.5	**222**
Installed spyware on victim's computer	2	0.9	**222**
Installed/utilized GPS on victim's car	0	0.0	**221**
Relocated residence to follow victim	10	4.5	**222**

Source of data: *Alaska State Troopers data (1994-2005)*

Table 4. Primary Location for Stalking Behavior in Alaska Stalking Cases, 1994–2005

Column percentages

	Charges	
Location	N	%
Cyberspace	60	27.0 %
Victim's house	99	44.6
Other residence	8	3.6
Work / school	17	7.7
Public places	16	7.2
Roads / parking lots	22	9.9
Total	**222**	

Source of data: *Alaska State Troopers data (1994-2005)*

Table 5. Race of Suspects and Victims in Alaska Stalking Cases, 1994–2005

Column percentages

	Suspects		Victims	
Race	N	%	N	%
White	160	78.0 %	183	85.9 %
Native	42	20.5	27	12.7
Black	3	1.5	2	0.9
Other	0	0.0	1	0.5
Total	**205**		**213**	

Source of data: *Alaska State Troopers data (1994-2005)*

Table 6. Age of Suspects and Victims in Alaska Stalking Cases, 1994–2005

Column percentages

	Suspects		Victims	
Age	N	%	N	%
11 to 20	27	13.2 %	43	20.1 %
21 to 30	38	18.5	47	22.0
31 to 40	75	36.6	70	32.7
41 to 50	47	22.9	41	19.2
51 to 60	13	6.3	6	2.8
61 or over	5	2.4	7	3.3
Total	**205**		**214**	

Source of data: *Alaska State Troopers data (1994-2005)*

31 and 40, and 31 percent of suspects and 25 percent of victims over 40. One in five suspects (20%) had used alcohol, but very few victims (2%) had. Drug use was very infrequent (1% or less) for both suspects and victims.

Table 7. Relationship Between Suspects and Victims in Alaska Stalking Cases, 1994–2005

Column percentages

Relationship to victim	Suspects N	%	% of non-stranger
Stranger	15	7.5 %	—
Current spouse	31	15.5	16.8 %
Ex-spouse	13	6.5	7.0
Current boy/girlfriend	5	2.5	2.7
Ex-boy/girfriend	59	29.5	31.9
Other family	7	3.5	3.8
Friends	13	6.5	7.0
Acquaintances	57	28.5	30.8
Total	**200**		

Source of data: *Alaska State Troopers data (1994-2005)*

Table 8. Number of Total, Stalking, and Non-Stalking Charges per Suspect in Alaska Stalking Cases, 1994–2005

Column percentages

	N	%	cumulative %
Total charges			
Zero	0	0.0 %	0.0 %
One	89	42.2	42.2
Two	65	30.8	73.0
Three	32	15.2	88.2
Four	9	4.3	92.4
Five	6	2.8	95.3
Six or more	10	4.7	100.0
Total suspects	**211**		
Stalking charges			
Zero	0	0.0 %	0.0 %
One	202	95.7	95.7
Two	7	3.3	99.1
Three	2	0.9	100.0
Total suspects	**211**		
Non-stalking charges			
Zero	94	44.5 %	44.5 %
One	63	29.9	74.4
Two	29	13.7	88.2
Three	9	4.3	92.4
Four	6	2.8	95.3
Five	4	1.9	97.2
Six or more	6	2.8	100.0
Total suspects	**211**		

Source of data: *Alaska State Troopers data (1994-2005)*

Relationships between suspects and victims are shown in Table 7. Half (54%) of the suspects were, or had been, in a romantic relationship with the victim, as an ex-boyfriend or ex-girlfriend (29%) or current spouse (15%). In addition, 35 percent of suspects were friends or acquaintances of the victim, with acquaintances as the more prominent category. Very few suspects (4%) were currently living with the victim. Slightly over half of the relationships (55%) had ended prior to the stalking, and 58 percent had ended by the time the stalking was reported to law enforcement (these statistics were not calculated for strangers or family members).

Most suspects (55%) were not charged solely with a stalking offense. Stalking charges were often accompanied by other charges (Tables 8 and 9). On average, suspects had a total of 2.32 charges, including an average of 1.05 stalking charges and an average of 1.27 other charges. Overall, the 211 suspects were charged with 489 offenses (i.e., 222 stalking offenses and 267 non-stalking offenses). The most common additional non-stalking charges included assault, violating a protective order, and harassment. In addition to these additional charges, 38 percent of suspects had at least one aggravating factor (Table 10). The most common aggravating factors included violating protective orders and prior arrests for stalking the victim—present for 20 percent and 12 percent of suspects respectively. In addition, 22 percent of suspects had a prior arrest for stalking, assaulting, or harassing the victim. More specifically, 12 percent of suspects had a prior arrest for stalking the victim, 8 percent had a prior arrest for assaulting the victim, and 5 percent had a prior arrest for harassing the victim. Almost three quarters (74%) of the victims had previously contacted law enforcement to report harassing behavior by the suspect (e.g., to seek a protective order).

Overall, 75 percent of the 92 cases reported between 1999 and 2004 were referred; 55 percent were accepted; and 40 percent resulted in a conviction (Table 11). The likelihood of referring, accepting, and convicting varied substantially by legal factors (Table 12)—whether suspects violated protective orders, violated conditions of release, violated conditions of probation, had prior arrests for assaulting the victim, had prior arrests for harassing the victim, had multiple stalking charges, or had additional non-stalking charges. In general, these legal factors enhanced the likelihood of referral, acceptance, and conviction.

In particular, violating protective orders and having additional non-stalking charges were important legal factors. Cases with

Table 9. Additional Non-Stalking Charges in Alaska Stalking Cases, 1994–2005

Column percentages

Charge	Non-stalking charges N	%
Assault	60	22.5 %
Violating protective order	56	21.0
Harassment	31	11.6
Criminal trespass	23	8.6
Burglary	15	5.6
Criminal mischief	15	5.6
Violating conditions of release	10	3.7
Sexual assault / abuse	10	3.7
Other public administration offense	10	3.7
Other	7	2.6
Misconduct involving controlled substance	6	2.2
Misconduct involving weapon	5	1.9
Driving offense	5	1.9
Theft	4	1.5
Reckless endangerment	4	1.5
Coercion	4	1.5
Kidnapping	2	0.7
Total	**267**	

Source of data: *Alaska State Troopers data (1994-2005)*

Table 10. Aggravating Factors in Alaska Stalking Cases, 1994–2005

Row percentages

Factors	No N	%	Yes N	%	Total
Violated protective order	165	80.5 %	40	19.5 %	**205**
Violated conditions of release	188	90.8	19	9.2	**207**
Violated conditions of probation	185	90.7	19	9.3	**204**
Had prior arrest for stalking victim	175	87.9	24	12.1	**199**
Had prior arrest for assaulting victim	181	91.9	16	8.1	**197**
Had prior arrest for harassing victim	190	95.0	10	5.0	**200**

Source of data: *Alaska State Troopers data (1994-2005)*

Table 11. Case Outcomes by Stage in Alaska Stalking Cases, 1999–2004

Column percentages

Stage	N	% of reported	% of referred	% of accepted
Reported	92	100.0 %	—	—
Referred	69	75.0	100.0 %	—
Accepted	51	55.4	73.9	100.0 %
Convicted	37	40.2	53.6	72.5

Source of data: *Alaska Department of Law (1999-2004)*

suspects who violated protective orders were 20 percent more likely to be referred for prosecution, were 19 percent more likely to be accepted, and were 41 percent more likely to result in a conviction. Cases that included additional non-stalking charges were 27 percent more likely to be referred, were 84 percent more likely to be accepted,

Table 12. Percent Referred, Accepted, and Convicted in Alaska Stalking Cases by Legal Factors, 1994–2005

Cell percentages

Legal factors		N	% referred	% accepted	% convicted
Violated protective order	No	72	73.6 %	54.2 %	37.5 %
	Yes	17	88.2	64.7	52.9
Violated conditions of release	No	82	74.4	52.4	36.6
	Yes	8	100.0	100.0	87.5
Violated conditions of probation	No	83	74.7	54.2	39.8
	Yes	5	100.0	80.0	60.0
Had prior arrest for stalking victim	No	78	73.1	50.0	34.6
	Yes	6	100.0	100.0	100.0
Had prior arrest for assaulting victim	No	76	72.4	50.0	38.2
	Yes	8	100.0	87.5	37.5
Had prior arrest for harassing victim	No	84	75.0	53.6	38.1
	Yes	2	100.0	100.0	100.0
Had multiple stalking charges	No	88	76.1	56.8	40.9
	Yes	4	50.0	25.0	25.0
Had additional non-stalking charges	No	40	65.0	37.5	22.5
	Yes	52	82.7	69.2	53.8

Source of data: *Alaska State Troopers data & Alaska Department of Law (1999-2004)*

Stalking Cases

The following individual case summaries, drawn from the sample studied in the accompanying article "Stalking in Alaska" illustrate a range of situations and circumstances in which the Alaska State Troopers issued a stalking charge. The details were taken from the AST case file. The initials of those involved have been changed.

B.W. reported receiving phone calls from S.M.; she reported being frightened for herself and for her family. S.M. had previously pled "no contest" to harassment charges and had been ordered to have no contact with her. At the time of the reported phone calls, he was on probation for the previous harassment offense. During the phone calls, S.M. stated that he was in trouble and needed B.W., that he loved her and found her perfect. In response to this report, the troopers charged him with first degree stalking.

***

T.K. reported that she was being stalked and harassed by her boyfriend's ex-wife, M.D. An order forbidding contact between M.D. and her former husband, P.D., was in place, but there was no provision forbidding contact with the girlfriend T.K. The two former spouses were involved in a child custody case.

T.K. reported that M.D. was making threatening phone calls; that she had destroyed T.K.'s personal property—including cutting up clothes—and had followed T.K. and P.D. to a mall and attempted to force her way into their vehicle. On another occasion she had followed the couple on a berry-picking trip.

M.D. was charged with second-degree stalking, criminal mischief involving personal property and misdemeanor assault.

***

N.C. called the troopers to report that P.M., her ex-boyfriend, was in her home yelling and causing a disruption. Another man, who was spending the night, and two of N.C.'s children were present in the house at the time P.M. arrived. She also reported that P.M. had been following her to her workplace and other locations. She had reported to the troopers at least once before. She said she had previously obtained protective orders against P.M. but had let them drop.

N.C.'s employer and a co-worker confirmed that P.M. would regularly appear at the workplace.

N.C. stated that she had made it clear that she no longer wanted a relationship with P.M. He maintained that they still had an active sexual relationship and that he often came to her house late at night. The two have a child together.

P.M. was charged with third degree assault, fourth degree criminal trespass, and second degree stalking.

L.K. reported that her ex-husband S.K. had telephoned her several times that day, leaving threatening messages on her voice mail. He had been served with a protective order two days previously. L.K stated that S.K. could be violent and that he had been trying to obtain a gun.

When contacted by AST, S.K. said he had only been trying to contact his daughter. He was charged with violating a protective order and stalking in the second degree.

***

E.R. called to report that her ex-boyfriend V.L. was pounding on her door and refused to leave. He ran off just before the troopers arrived and was caught shortly afterward.

He had been previously arrested for a crime involving domestic violence against E.R., stalking and criminal trespass. She had had several protective orders against him. She stated that he was violent when drinking and had assaulted her in the past.

The couple had lived together off and on for nine years but not for three years prior to this incident, although they had recently been sexually intimate and he had done work on her property. She stated she had told him she did not want a relationship with him.

For this incident, V.L. was charged with fourth degree assault and second degree stalking.

***

I.W. reported to the VPSO that she was being harassed and threatened by her ex-boyfriend J.T. He had been sending her obsessive letters for some time and was threatening to kill her. (*Copies of some of the letters are in the AST file.)* The two have two children together. They had last lived together three years previously, and she had indicated she no longer wanted a relationship with him.

It appeared that he had followed her from one community to another over a period of time. There had been previous incidents in other towns, including at least one in which the local police were called when J.T. attempted to take one of the children from I.W.

A witness confirmed that J.T. had made threats to kill others if I.W. would not be intimate with him again.

J.T. was charged with second degree stalking.

and were 139 percent more likely to result in a conviction. In other words, cases that included additional non-stalking charges were 2.4 times more likely to result in a conviction than cases that did not include additional non-stalking charges.

It is important not to over-interpret these results because some categories are represented by extremely low sample sizes (e.g., only two suspects had a prior arrest for harassing the victim). Nonetheless, it is interesting to see the variation in the likelihood of cases being referred, accepted, and convicted. For example, although only six cases had suspects who had a prior arrest for stalking the victim, all six were referred for prosecution, all six were accepted, and all six resulted in a conviction. By comparison, only 34.6 percent of other cases resulted in a conviction. When suspects had a prior arrest for stalking the victim, they were 2.9 times more likely to be convicted.

Comparisons with National Data

Few national statistics on stalking are available. The current primary source of information on the offense is the National Violence Against Women Survey (NVAWS). While the numbers are not directly comparable, in looking at the NVAWS statistics and the Alaska figures presented here, we can note several points. First, stalking seems even more underreported and, possibly, underrecognized by law enforcement in Alaska than in the country as a whole. Second, it is likely that this is particularly true among Alaska Natives. Third, it is likely that the prosecution of stalking is more effective in Alaska than nationally.

Based on NVAWS results, an estimated 2.2 percent of men and 8.1 percent of women in the United States have been stalked at some point in the past (for a total of over two million men and over eight million women). Annual stalking estimates (rather than lifetime estimates) are obviously much lower, with 1.0 percent of women and 0.4 percent of men stalked per year. Nationally, this equates to over one million women and over 370,000 men stalked in a given year. Although we must do so with great caution, we can use these statistics to estimate the prevalence of stalking in Alaska.

Using the annual NVAWS statistics that 1.0 percent of women and 0.4 percent of men are stalked (derived from a sample of 8,000 women and 8,000 men), and assuming that annual rates in Alaska would be similar to annual rates in the U.S., we can estimate that around 2,100 adult women and 900 adult men are stalked in Alaska in a given year (see Table 13). Further NVAWS estimates suggest that nationally 55 percent of female stalking victims and 48 percent of male stalking victims report to law enforcement. If similar reporting patterns emerged in Alaska, around 1,100 women and over 530 men in Alaska would report a stalking incident in a given year (see Table 14). Alaska's numbers are much lower than those for the rest of the country, something that may be a factor of underreporting by victims or underrecognition by law enforcement.

More accurate estimates of stalking prevalence and reporting patterns will be available only through additional research; nonetheless, even in the absence of this additional research, it is clear that stalking is greatly underreported in Alaska. In 2005, only 17 stalking incidents were reported to the Alaska State Troopers, and statewide from all jurisdictions only 30 stalking cases were referred to the Alaska Department of Law.

The underreporting may be particularly true among Alaska Natives. NVAWS statistics show that "American Indian/Alaska Native women reveal significantly more stalking victimization than women of other racial and ethnic backgrounds." While 8.2 percent of white women reveal being stalked at some point in their lifetime, 17.0 percent of American Indian/Alaska Native women revealed being stalked at some point in their lifetime. American Indian/Alaska Native women (and men) were the most likely persons to indicate having been stalked at some point in their lifetime—over two times more likely than for whites. This was true for both women and men. (It is important to note that the NVAWS figures do not represent actual reports to law enforcement, but rather self-disclosure of incidents that may or may not have been reported to the police.) By comparison, according to the study, the rates of stalking reported to Alaska State Troopers were 6.6 times higher for white women than for Native women and were 9.1 times higher for White men than for Native men (see Table 15)—rates contradicting national figures. Although these statistical extrapolations are fraught with untested assumptions, it is nonetheless clear that stalking is under-

Table 13. Annual Estimates of Stalking Incidents in Alaska by Gender (With and Without Anchorage)

	Alaska (with Anchorage)			Alaska (without Anchorage)		
Gender	Number of adults	Estimated prevalence	95% confidence interval	Number of adults	Estimated prevalence	95% confidence interval
Women	210,104	2,101	1,681 to 2,521	118,645	1,186	949 to 1,424
Men	226,111	904	678 to 1,130	133,158	533	399 to 666
Total	436,215	3,005	2,359 to 3,651	251,803	1,719	1,348 to 2,090

Source of data: *NVAWS (1998); U.S. Census (2000, SF1)*

Table 14. Annual Estimates of Stalking Reports to Law Enforcement in Alaska by Gender (With and Without Anchorage)

	Alaska (with Anchorage)			Alaska (without Anchorage)		
Gender	Number of victims	Estimated # of reports	95% confidence interval	Number of victims	Estimated # of reports	95% confidence interval
Women	2,101	1,156	1,071 to 1,240	1,186	652	605 to 700
Men	904	434	371 to 497	533	256	218 to 293
Total	3,005	1,590	1,442 to 1,737	1,719	908	823 to 993

Source of data: *NVAWS (1998); U.S. Census (2000, SF1)*

Table 15. Number of Adults and Number of Stalking Reports in Alaska by Gender and Race (Without Anchorage)

	White			Native		
Gender	Number of adults	Number of reports	Rate of reports per 100,000	Number of adults	Number of reports	Rate of reports per 100,000
Women	150,925	165	109.3	150,925	25	16.6
Men	30,554	18	58.9	30,554	2	6.5
Total	**167,513**	**183**	**109.2**	**167,513**	**27**	**16.1**

Source of data: *U.S. Census (2000, SF1); Alaska State Troopers data (1994-2005)*

reported in Alaska, particularly for Alaska Natives.

But, while stalking may be underreported in Alaska, prosecution seems to be somewhat more effective. The Alaska Department of Law secured convictions in the cases accepted more often than occurred nationally: while NVAWS results showed that 54 percent of accepted cases resulted in a conviction, 72 percent of the 51 cases accepted by the Alaska Department of Law between 1999 and 2004 resulted in a conviction.

Reporting and Early Intervention

While we do not have any data on why stalking is so underreported, law enforcement hypothesizes that stalking may be underrecognized by victims. NVAWS statistics show other factors may also come into play. Of the victims that did not report to police, 20 percent believed it was not a police matter, 17 percent believed that police could not help, and 16 percent were afraid of reprisal from the stalker. Of the victims that did report to police, 50 percent were not satisfied with police actions and 46 percent thought that police actions did not improve the situation.

Law enforcement might be trained to capitalize on opportunities for early recognition of stalking patterns. Efforts might also be undertaken to raise public awareness of stalking as a crime and report it as such and to further train law enforcement to recognize the signs of stalking. This will increase the likelihood that suspects who violate stalking statutes are reported to law enforcement and are appropriately charged.

André B. Rosay is an associate professor with the Justice Center. Greg Postle is a researcher with the Justice Center. Katherine TePas is a program coordinator with the Alaska State Troopers. Darryl Wood is an associate professor with the Justice Center. *The project discussed in this article was supported by Grant No. 2005-WG-BX-0011 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

Alaska Victimization Survey

Detailed Responses to Intimate Partner Violence and Sexual Violence Questions

André B. Rosay, Ph.D.
Marny Rivera, Ph.D.
Brad Myrstol, Ph.D.
Justice Center, University of Alaska Anchorage

Darryl Wood, Ph.D.
Washington State University Vancouver

With the Council on Domestic Violence and Sexual Assault

JC 1004

Alaska Victimization Survey Questions

Intimate Partner Violence

Now I'm going to ask you some questions about times when any romantic or sexual partner has physically hurt you. Remember that you can skip questions you don't want to answer and you can stop at any time. How many of your romantic or sexual partners have…

1. Made threats to physically harm you?
2. Slapped you?
3. Pushed or shoved you?
4. Hit you with a fist or something hard?
5. Kicked you?
6. Hurt you by pulling your hair?
7. Slammed you against something?
8. Tried to hurt you by choking or suffocating you?
9. Beaten you?
10. Burned you on purpose?
11. Used a knife or gun on you?

Alcohol or Drug Involved Sexual Assault

Sometimes sex happens when a person is unable to consent to it or stop it from happening because they were drunk, high, drugged, or passed out from alcohol, drugs, or medications. This can include times when they voluntarily consumed alcohol or drugs or they were given drugs or alcohol without their knowledge or consent. Please remember that even if someone uses alcohol or drugs, what happens to them is not their fault. When you were drunk, high, drugged, or passed out and unable to consent, how many people have…

1. Had vaginal sex with you? By vaginal sex, we mean that a man or boy put his penis in your vagina.
2. Made you receive anal sex, meaning they put their penis into your anus?
3. Made you perform oral sex, meaning that they put their penis in your mouth or made you penetrate their vagina or anus with your mouth?
4. Made you receive oral sex, meaning that they put their mouth on your vagina or anus?

Forcible Sexual Assault

Some people are threatened with harm or physically forced to have sex when they don't want to, for example, by being pinned or held down, or by the use of violence. How many people have used physical force or threats to physically harm you to…

1. Make you have vaginal sex?
2. Make you receive anal sex?
3. Make you perform oral sex?
4. Make you receive oral sex?
5. Put their fingers or an object in your vagina or anus?
6. Try to have vaginal, oral, or anal sex with you, but sex did not happen?

Weighted Proportions of Alaskan Women Reporting Intimate Partner Violence

Measures of Intimate Partner Violence	Past 12 Months	Lifetime
Partner(s) made threats to physically harm you	5.8%	31.0%
Partner(s) slapped you	3.1%	27.2%
Partner(s) pushed or shoved you	7.9%	39.3%
Partner(s) hit you with a fist or something hard	2.9%	22.2%
Partner(s) kicked you	2.0%	13.3%
Partner(s) hurt you by pulling your hair	2.1%	17.3%
Partner(s) slammed you against something	4.2%	25.4%
Partner(s) tried to hurt you by choking or suffocating you	1.5%	13.8%
Partner(s) beat you	2.0%	17.1%
Partner(s) burned you on purpose	0.6%	2.9%
Partner(s) used knife or gun on you	0.9%	9.7%
Intimate partner violence (composite with all items)	9.4%	47.6%
Physical violence (composite without threats)	8.6%	44.8%

Note. CI = confidence interval.

Weighted Proportions of Alaskan Women Reporting Sexual Violence

Measures of Sexual Violence	Past 12 Months	Lifetime
While intoxicated[a] and unable to consent…		
Someone had vaginal sex with you	2.0%	18.3%
Someone made you receive anal sex	1.0%	6.9%
Someone made you perform oral sex	1.7%	11.5%
Someone made you receive oral sex	1.6%	8.4%
Alcohol or drug involved sexual assault (composite)	3.6%	26.8%
With physical force or threats of physical harm…		
Someone made you have vaginal sex	1.5%	17.9%
Someone made you receive anal sex	0.4%	3.3%
Someone made you perform oral sex	0.9%	7.7%
Someone made you receive oral sex	0.9%	5.3%
Someone put fingers or an object in your vagina/anus	0.9%	9.4%
Someone tried to have vaginal/oral/anal sex with you	1.2%	13.0%
Forcible sexual assault (composite)	2.5%	25.6%
Sexual violence (composite)	4.3%	37.1%

Note. CI = confidence interval.

[a] Includes being drunk, high, drugged, or passed out from alcohol, drugs, or medications.

2/01/11 OVERVIEWS: AK STATEWIDE INDEP LIVING COUNCIL; GOV'S COUNCIL ON DISABIL & SPEC EDUC; GOV'S STATE SUICIDE PREVEN COUNCIL

<TARGET><BILL></BILL><SUBJECT>2-01-11 OVERVIEWS ALASKA STATEWIDE INDEPENDENT LIVING COUNCIL; GOVERNOR'S COUNCIL ON DISABILITIES and SPECIAL EDUCATION; GOVERNOR'S STATEWIDE SUICIDE PREVENTION COUNCIL</SUBJECT><COMM>SHSS27</COMM></TARGET>

Gavel the meeting to Order on Tuesday, February 1st at 3pm. For a joint House and Senate Health and Social Service Meeting

Let the Record reflect that there is a quorum:

Present are:

- Representative Cissna
- Representative Dick
- Representative Herron
- Representative Millet
- Representative Miller
- Representative Seaton
- And myself Representative Keller

Today will be Hearing from the Department of Health and Social Services for a continuation of their overview presentation. Commissioner Streur.

After the Department is finished we will hear from the other presenters scheduled for today:

- Statewide Independent Living Council –Andi Nations
- Governor's Council on Disabilities and Special Education- Millie Ryan
- Governor's Statewide Suicide Prevention Council

Are there any questions from the members of the committee?

No more Activities:

With that we have concluded today's business. Meeting adjourned.

We will meet again Tuesday, February 8th, 3pm in this room.

An Overview of The Alaskan Independent Living Network

Presented to the Alaska Senate
Health and Social Services Committee
By the Alaska Statewide
Independent Living Council and
The Alaskan Centers for Independent Living
February 2, 2011

Independent Living Philosophy

- All Alaskans, regardless of disability
  - Should have the control over choices
  - Are in charge of their lives and know best what they need
- The independent living movement is
  - Grassroots
  - Local control
  - Giving communities and individuals the right and responsibility to make choices they deem best

Vital Components of the Independent Living Philosophy

- Consumer control and choice
- Peer support
- Self-help
- Self-determination
- Equal access
- Individual and systems advocacy
- Empowerment
- Independence
- Home and community-based services
- Integration as fully contributing, valued members of society

Alaskan Independent Living Partners

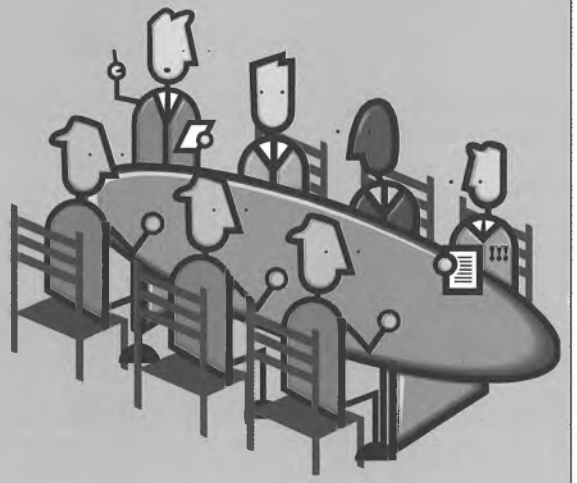
- Alaskans with disabilities, their friends and families
- Centers for Independent Living
- Alaska Statewide Independent Living Council
- Partner agencies and service providers

Alaska Statewide Independent Living Council (SILC)

- Alaska SILC is a non-profit corporation
- Established by Rehabilitation Act of 1992
- In 1995 established under Alaska Statute AS 47.80.300
- For budgetary purposes, falls under
  - **Alaska Department of Labor and Workforce Development Division of Vocational Rehabilitation**
- Mission
  - **To ensure that Alaskans with disabilities live independently and are fully integrated into the mainstream of society**

Alaska SILC Composition and Responsibilities

- Council members are appointed by the Governor
- **Main responsibilities**
  - ➢ to develop, implement and evaluate the State Plan for Independent Living
  - ➢ expand and improve the IL network



Alaskan Centers for Independent Living

- **Access Alaska**
  Southcentral and Interior regions
- **Southeast Alaska Independent Living Center(SAIL)**
  Southeast region
- **Independent Living Center(ILC)**
  Kenai Peninsula, Kodiak Island and Valdez/Cordova census area
- **Arctic Access**
  Nome census area and Northwest Arctic Borough

Regional Service Areas

- ACCESS ALASKA ANCHORAGE
- SOUTHEAST ALASKA INDEPENDENT LIVING (SAIL)
- ACCESS ALASKA FAIRBANKS
- KENAI PENINSULA INDEPENDENT LIVING CENTER
- ARCTIC ACCESS

Each Center for Independent Living

- Unique
- A private, non-profit organization
- Offers services based on community needs and choice
- Supported by a board of directors made up of a majority of people with disabilities
- Non-residential
- Consumer-controlled
- Cross-disability
- Cross-age
- Designed and operated by Alaskans with disabilities

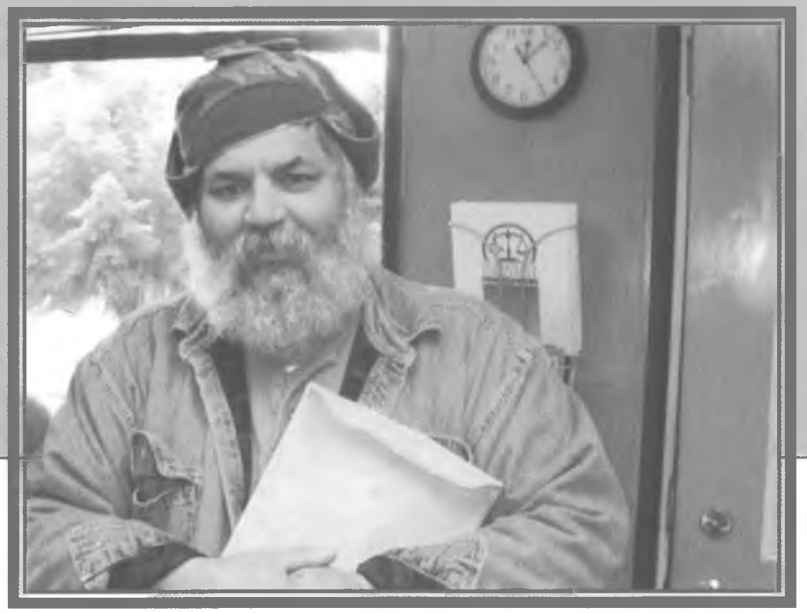
Each Center for Independent Living Offers Five Core Services

1. Information and referral
2. Peer counseling and support
3. Individual and systems advocacy
4. Independent living skills training
5. Deinstitutionalization

Assistive Technology

Centers for Independent Living

- Housing
- Transportation
- Health Care
- Financial Assistance
- Access to Home and Community Based Services
- Employment
- Recreation
- Many more!



Independent Living Partners

- Governor's Council on Disability and Special Education
- Alaska Mental Health Trust Authority
- State of Alaska Advisory Board on Drug and Alcohol Abuse
- The Alaska Commission on Aging
- Alaska Deaf Council
- The Alaska Center for the Blind
- Alaska Brain Injury Network
- State Vocational Rehabilitation Committee
- AgeNet
- The Alaska Mobility Coalition
- Consortia for Native American Rehabilitation
- Association of Programs for Rural Independent Living

Pocket Talker Made a Difference in Darrell's Life!

Overview

Governor's Council on Disabilities & Special Education

House HSS Standing Committee

February 1, 2011

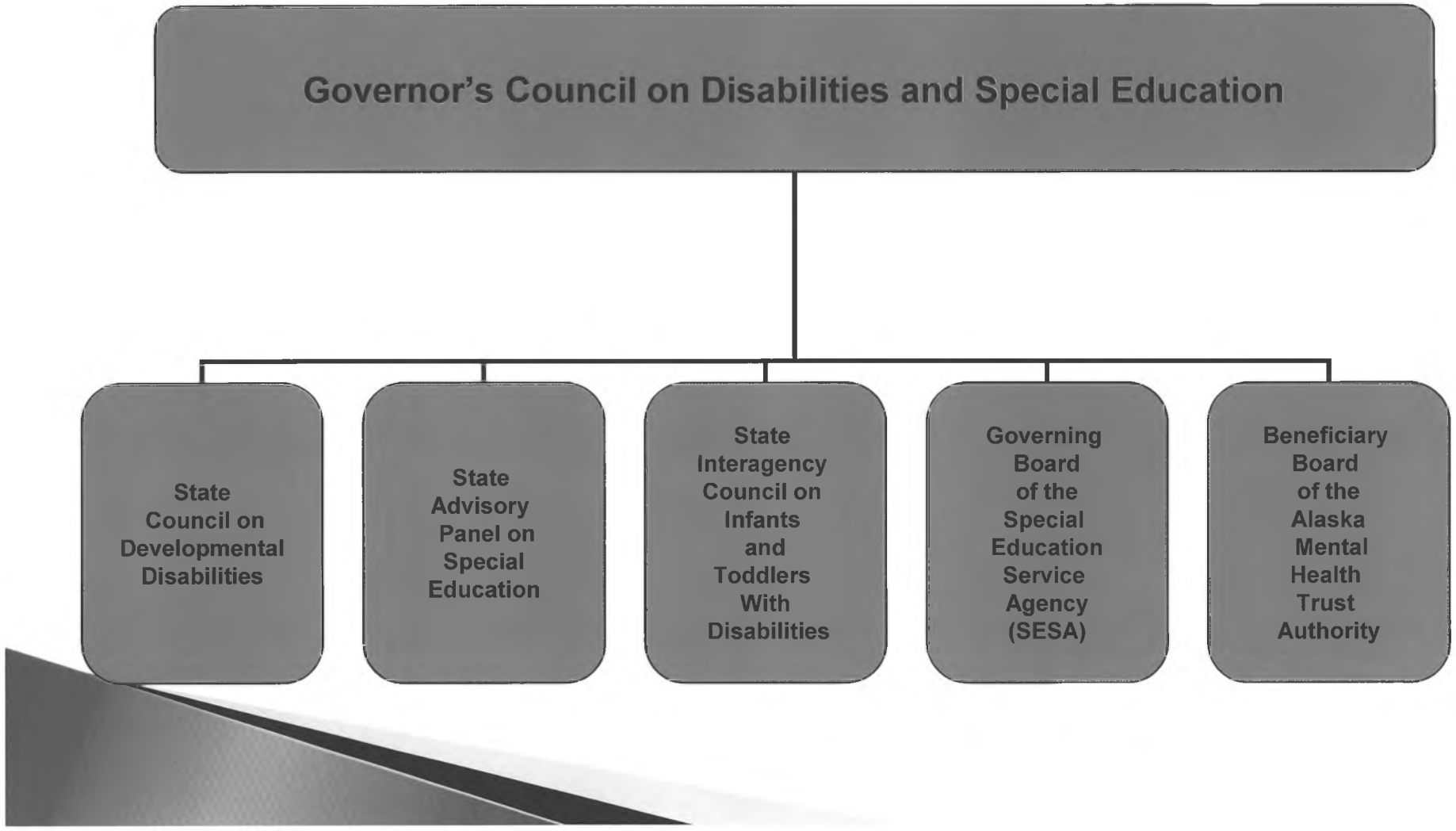
Council Mission

- Create change that improves the lives of people with disabilities
  - Capacity building
  - Systems change
  - Advocacy

Council Members

- 27 members appointed by the Governor
- Primary consumers or self-advocates
  - Individuals with disabilities
- Secondary consumers
  - Parents or family members of people with disabilities
- State agency representatives
- Other representatives designated in federal law
  - Center for Human Development
  - Disability Law Center
  - Non-profit agencies
  - Public education systems
  - Higher education

Council Responsibilities



Tools Used to Achieve Mission

- Gathering community and stakeholder input
- Conducting research and data gathering
- Preparing policy papers and reports about issues impacting people with disabilities
- Providing testimony about how legislation will impact people with disabilities
- Providing advice to the Governor, legislature and agencies on policy that impacts people with disabilities
- Helping self-advocates and families learn about and connect with the political process
- Educating and providing information to the media and general public

Example of Council in Action

- Heard considerable public testimony about the lack of services for people with autism
- Convened ad hoc committee on autism to develop recommendations for administration and legislature
- Researched work done in other states and evidence-based practices

Example of Council in Action

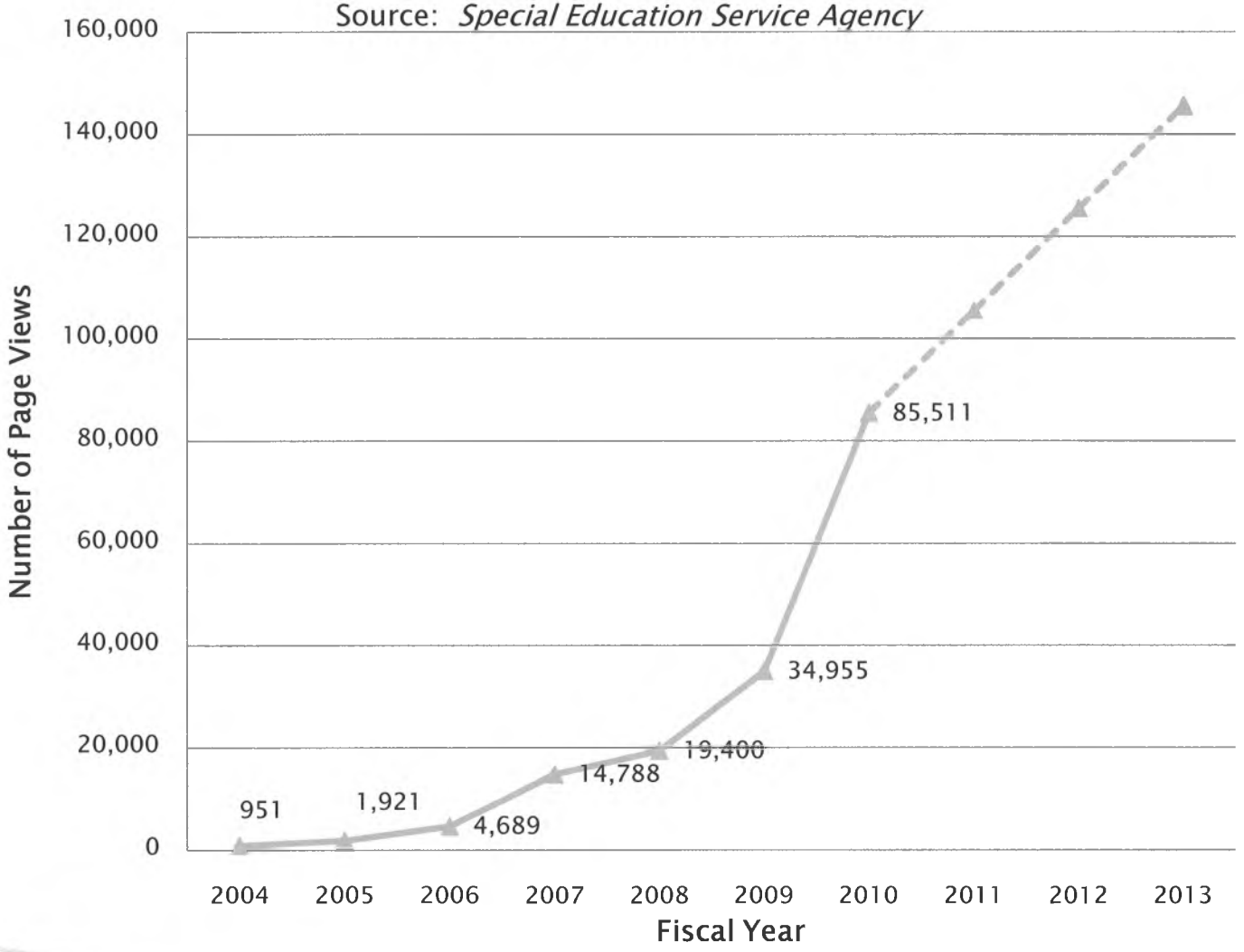
- Boiled recommendations into 5-Part Autism Initiative
  - Universal screening
  - Expanded diagnostic capacity
  - Enhanced awareness, I&R and training
  - Workforce development capacity building
  - Funding for time-limited intensive services

Outcomes

- Use of Ages & Stages Questionnaire and Modified Checklist for Autism in Toddlers (M-CHAT) in *Child Find* and well baby check-ups
- Secured federal grant to develop rapid rural response system (Division of Public Health)
- $500.0 legislative increment for diagnostic and screening clinics
- Added Advanced Nurse Practioneer to list of medical personnel that can diagnosis autism (State Board of Education & Early Development)
- Legislative increment and MHTAAR funding for Alaska Autism Resource Center
- Legislative increment and MHTAAR funding for workforce development capacity

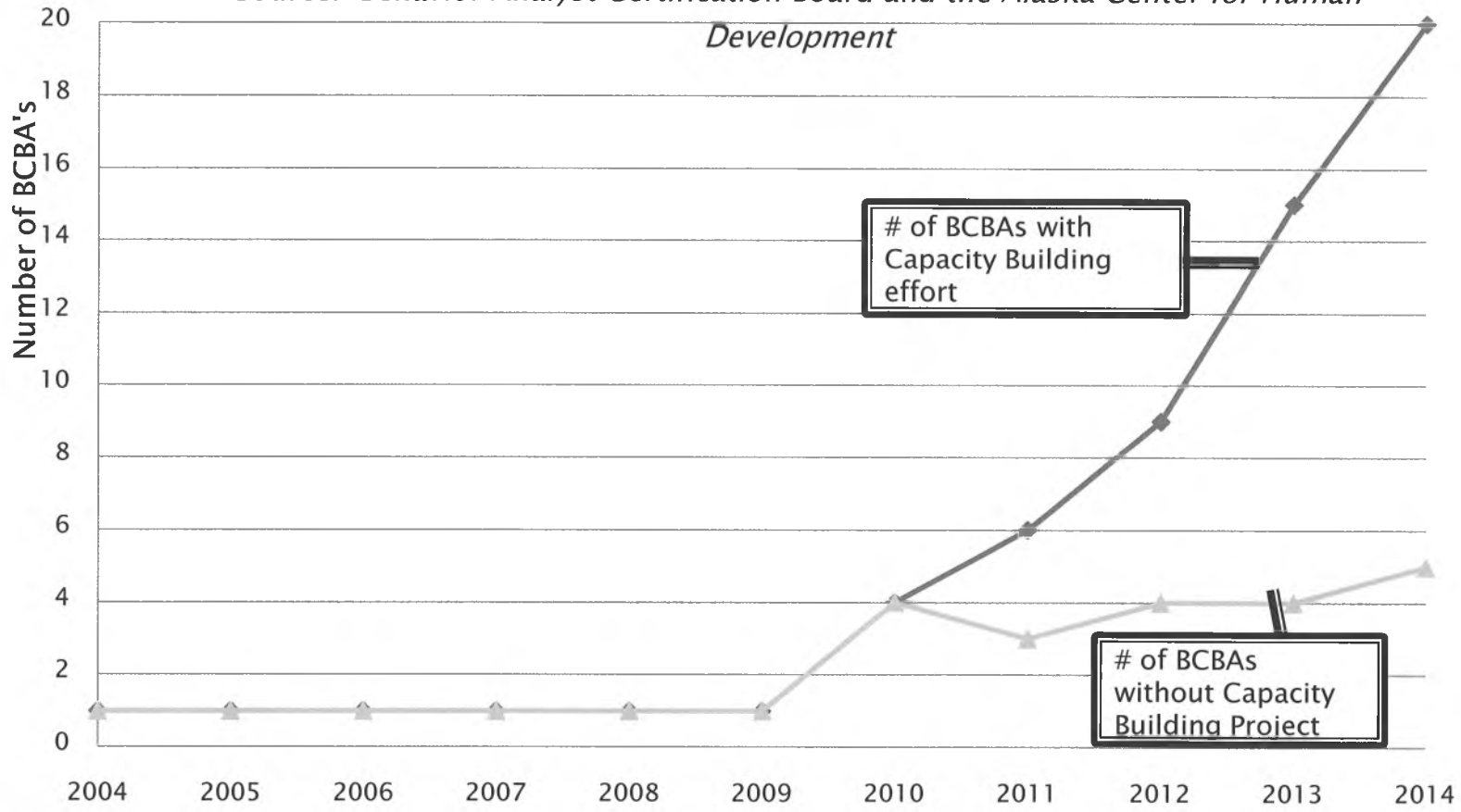
Number of AARC Web Site Page Views by Fiscal Year

Source: *Special Education Service Agency*



Number of Board Certified Behavior Analysts (BCBAs) Practicing in Alaska

Source: *Behavior Analyst Certification Board and the Alaska Center for Human Development*



Complex Behaviors Hub

- Current Situation
  - 1st in the country with no publicly or privately funded institutions for people with developmental disabilities
  - However, 11 individuals with developmental disabilities are in out-of-state institutions
    - Longest placement (3+ years)
    - 5 out-of-state placements (2+ years)
    - Shortest placement (4 months)
  - 12 individuals are in the process of being sent out of state
- Policy Recommendation: Establish Complex Behaviors Hub
  - Comprehensive diagnostic and testing capacity
  - Individualized triage services
  - Technical assistance to providers throughout Alaska
  - Case-specific consultation and training services

Special Education Service Agency

- Current Situation
  - Established under State Statute (AS 14.30.600) in 1986
    - Provide itinerant outreach services to students with low incidence disabilities
      - Students who are dead, deaf-blind, cognitively impaired, hearing impaired, blind and visually impaired or who have orthopedic disabilities, other health impairments, severe emotional disabilities, multiple disabilities
    - Provide special education instruction support and training of local school district special and general education personnel
    - Other services appropriate to special education services
  - Formed as a not-for-profit corporation
  - Operates under a sunset provision
  - Receives Low Incidence Disabilities funding from EED based on prior year's statewide total enrollment at a flat rate ($15.75) set in 1986
  - Receives federal and state grants and contracts

Special Education Service Agency

- Policy Recommendations
  - Remove the sunset provision from SESA's authorizing statute
    - Recommended by most recent audit
    - SESA performs a valuable effective and efficient service to local school districts that they cannot provide themselves and does not duplicate services
  - Change the funding formula for SESA
    - 0.39 – 0.40% of Current Year Base Student Allocation (BSA) X Total Average Daily Membership (ADM) from Previous Year
      - SESA already has trouble meeting its statutorily mandated duties; if there is a reduction in grants and contracts, this situation will get even worse and negatively impact students and school districts

2010 Harris Poll Findings

- Only 21% employed compared to 59% of general population
- Much more likely to be living in poverty
- Much less likely to socialize
- Only 54% use the Internet compared to 85% of the general population
- More likely to have gone without needed health care (19% vs. 10%)

Upcoming Challenges

- Developing actions and policies that will improve the lives of thousands of Alaskans with disabilities in the future
- Properly equipping Alaskans with disabilities with tools, skills and opportunities they need to successfully live the same everyday lives as Alaskans without disabilities

Thank You!

Questions?

Progress Made on Action Plan and Timeline for Implementing the Five-Part Autism Initiative

	FY07	FY08	FY09	FY10	FY11	FY12
Infrastructure Development						
▪ Develop strategic plan for autism services – Ad Hoc Committee on Autism	Done					
▪ Oversee strategic plan implementation – Ad Hoc Committee on Autism		In progress and ongoing				
▪ Identify and secure variety of funding resources – Governor's Council on Disabilities & Special Education (GCDSE)	Secured legislative increments and Trust funding for diagnostic evaluations, Alaska Autism Resource Center and workforce development capacity building; some examples of pooled funding; autism insurance reform bill introduced					
▪ Coordinate services/continued infrastructure development – Autism Alliance		In progress and ongoing				
Universal Screening						
▪ Conduct Child Find – Infant Learning Programs/School Districts	Ongoing – in addition, federal funds from the *Combating Autism Act* were secured to develop a rapid rural response systems to meet the needs of children living in rural and remote areas, who are typically diagnosed 1-3 years later than children living in urban areas					
▪ Develop plan to establish universal screening at well child clinics – Early Childhood Comprehensive Systems Grant	Done					
▪ Pilot universal screening at 3 pediatric clinics conducting well child clinics – Early Childhood Comprehensive Systems Grant		Pilot findings are being used for expansion to other sites and there is an enhanced Early Periodic Screening, Diagnosis and Treatment (EPSDT) fee for using Ages & Stages Questionnaire and Modified Checklist for Autism in Toddlers (M-CHAT)				
▪ Develop plan for diagnostic clinic expansion – Ad Hoc Committee on Autism	Done					
▪ Expand diagnostic clinics in Anchorage and regional hubs – Providence Hospital		The number of communities with screening and diagnostic clinics has increased from 3 in FY07 to 15 in FY 10 and 50% of referrals to the main clinic in Anchorage are coming from outside the Anchorage bowl				
Diagnostic Clinic Expansion						
▪ Provide multi-disciplinary team services – Providence Hospital		Ongoing - Recent autism diagnostic clinic data shows a 44% increase in children served over the 2007 baseline, which suggests that adding services and a provider were effective expansion tactics.				
▪ Conduct regional screening and diagnostic clinics – Providence Hospital		Ongoing				
▪ Coordinate clinic program and related		Ongoing				

activities – Division of Public Health						
▪ Increase parent navigation services – Stone Soup Group (SSG)		Ongoing - Parent navigators are meeting the very specific needs of each of the families they serve				
Resources, Referral and Training						
▪ Conduct public awareness activities – Special Education Service Agency(SESA)	Ongoing –in FY10, information was provided to 2,600 people. In addition, the Division of Public Health is using federal funds from the *Combating Autism Act* are being used to develop outreach materials specifically targeted to reach those living and working in rural and remote areas					
▪ Provide information and referral services – SESA	Ongoing – the number of website page views has increased from 14,788 in 2007 to 85,511 in FY10					
▪ Provide overview training on service delivery strategies – SESA	Ongoing – in FY10, overview training was provided to 1,500 Alaskans.					
▪ Provide consultation services to families, infant learning program providers, school districts and service providers – SESA	Ongoing					
▪ Provide expanded support to parent of children with autism spectrum disorders – SSG			Ongoing – Stone Soup Group is offering Structured play dates, helping families use generic resources (e.g., Boy Scouts), offering shadowing services and providing training in use of positive reinforcement			
Workforce Training (Specific, Hands-On, Intensive Interventions)						
▪ Contract with experts in a variety of evidence-based, intensive autism interventions to provide training – Center for Human Development at the University of Alaska Anchorage			Ongoing – primarily with Northern Arizona University and University of Kansas, two programs providing cutting edge, evidence-based training over through distance education			
▪ Coordinate face-to-face and distance delivery training to develop state expertise in evidence-based, intensive autism interventions – Center for Human Development			The number of individuals who are board certified as Applied Behavior Analysts increased from 1 in FY07 to 6 in FY 10, with a total of 20 expected by the end of FY14. In addition, approximately 100 people per year are participating in summer autism institutes.			
Time-Limited Intensive Early Intervention						
▪ Conduct policy analysis – GCDSE	Done					
▪ Develop time-limited early intervention program – GCDSE and Department of Health & Social Services (DHSS)		This is taking longer than expected; the ad hoc committee on autism will develop a funding and resources plan in early March				
▪ Implement and monitor autism program				Some examples of pooled funding exist.		

Mending the Net: Suicide Prevention in Alaska

Annual Report FY2010

Governor Sean Parnell

Statewide Suicide Prevention Council

William Martin, Chair 2010-2011

431 North Franklin Street, Suite 204

Juneau, Alaska 99801

Acknowledgements

The Statewide Suicide Prevention Council recognizes the contributions of the following people to the FY2010 Annual Report:

Brenda Moore, chair of the Council from 2008-2010, for her tireless efforts to guide and support the Council in the activities on which it is reporting;

Andrew Jessen, Research Analyst III, Bureau of Vital Statistics, Division of Public Health, Department of Health and Social Services, for assisting with the effective use of suicide data in this report;

Brian Laurent, MPA Candidate, Boise State University, for his analysis of funding patterns and the creation of the maps used in the report;

Patrick Sidmore, Research Analyst III, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, for analyzing incidence and unemployment data used in the report, assuring accuracy in reporting, and creating charts and graphs for the report;

Thomas Chard, Planner II, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, for his work with the Council in the activities reported;

Tim Spengler, Legislative Analyst II, Legislative Research, for his work on the November 12, 2010 report, "Suicide Rates, Prevention Funding, and Prevention Efforts in Alaska;"

Martha Moore, Public Health Specialist II, Alaska Trauma Registry, Division of Public Health, Department of Health and Social Services, for assisting with the effective use of suicide attempt data in this report;

the **Alaska Mental Health Board** and **Advisory Board on Alcoholism and Drug Abuse**, for providing support (financial, staff, and moral) in advocacy, education, outreach, and planning in the activities on which the Council is reporting; and

Eric Morrison, Council Assistant, and **Kate Burkhart**, Executive Director, for their work on the report.

A Letter from the Chair

On behalf of the Statewide Suicide Prevention Council, thank you for your interest in learning about the state of suicide prevention in Alaska. What you will learn from our report is both inspiring and disappointing. Despite substantial efforts by communities and organizations statewide, and millions of dollars of funding, over the last ten years, the number of suicides in Alaska and the rate of suicide has not decreased. What has changed is that people in Alaska are talking — and talking a lot — about how suicide affects us and how we can prevent it.

Years ago, no one talked about suicide. There was stigma and fear. Now, even though there is still stigma and there is still fear, people are showing greater courage and speaking out. I am grateful for the leaders in our tribal organizations and communities who are standing up with the Council to speak about suicide and how to prevent it. I have seen more and more openness to talking about suicide, more awareness of how important talking about suicide is to healing from its wounds.

One of our biggest achievements of FY2010 was the Statewide Suicide Prevention Summit we hosted, with the help of the Alaska Native Tribal Health Consortium and many partners. Since then, there have been listening sessions and public meetings all over Alaska. Suicide prevention providers have come together to better support each other, share ideas, and take care of each other. The message that every life has value is being spread in communities all over our state. My hope is that, in the coming year, the Council will continue to support and encourage people to speak out, to share their loss and grief, to heal, and to come together to prevent suicide.

Thank you again for your interest in the Council's work.

Gunalchéesh,

William Martin, Chair

Mending the Net: Suicide Prevention in Alaska

Annual Report FY2010

INTRODUCTION

The Statewide Suicide Prevention Council was established by the Alaska Legislature in 2001, in response to what was characterized as "an on-going epidemic" of suicide.[1] The Council, after a legislative audit in 2008, was extended by the Legislature to June 30, 2013.[2]

The Council is responsible for advising legislators and the Governor on ways to improve Alaskans' health and wellness by reducing suicide, improving public awareness of suicide and risk factors, enhancing suicide prevention efforts, working with partners and faith-based organizations to develop healthier communities, creating a statewide suicide prevention plan and putting it in action, and building and strengthening partnerships to prevent suicide.[3]

Each year, the Council provides an annual report on its activities and the impact of suicide prevention efforts over the past year. The FY2010 report takes its title from the theme of the Suicide Prevention Summit, "Mending the Net." Many individuals and organizations are working to prevent suicide all over Alaska — but often, these dedicated people feel disconnected and unsupported. Focus is often placed on practices or strategies that may or may not fit a community's needs. Creative community-based solutions often operate in isolation.

By "mending" the suicide prevention systems' "net," the Council hopes to increase the effectiveness of local suicide prevention efforts, support the spread of effective ideas to other Alaskan communities, recognize the work of every person trying to prevent suicide, and honor the losses to families and communities caused by suicide.

The Council has increased its efforts related to its statutory duties. The State of Alaska, tribal organizations, and communities all over the state have continued to work to prevent suicide. Even so, Alaska is still faced with an "on-going epidemic." Therefore, in addition to fulfilling the yearly reporting requirements, this Annual Report will include a look back at the last ten years of data and will offer the opportunity to look with fresh eyes at how Alaskans can work together to prevent suicide.

[1] SB198 Sponsor Statement, Senator Rick Halford, April 24, 2001.
[2] HB123, sponsored by Representative Anna Fairclough, passed in April 2009 and was signed into law on August 5, 2009.
[3] AS 44.29.350. The Council's statutory authority is included in Appendix A.

HISTORY OF THE COUNCIL

The Statewide Suicide Prevention Council was established in 2001 after a series of "suicide clusters" throughout Alaska led state leaders to more closely examine the issue. Former Department of Health and Social Services Commissioner Karen Perdue requested funding in March of 2001 to support communities experiencing high rates of suicide and to examine Alaska's suicide prevention strategies. The passage of SB 198, on May 7, 2001 established the Council. The Council had its first meeting on November 12, 2001 in Anchorage.

The Council has twelve voting members from the public and four non-voting members from the Legislature. The twelve voting members are appointed by the Governor to four-year terms. Members include:

- one person representing the Department of Health and Social Services;
- one person representing the Department of Education and Early Development;
- one person from the Advisory Board on Alcoholism and Drug Abuse;
- one person from the Alaska Mental Health Board;
- one person recommended by the Alaska Federation of Natives;
- one person who works for a high school;
- one person who is active in a youth organization;
- one person who has experienced the death by suicide of a member of their family;
- one person who resides in a rural Alaska community not on the road system;
- one person who is a member of the clergy;
- one person who is enrolled in grades 9-12 of a secondary school in Alaska;
- and one public member.

The President of the Alaska State Senate and the Speaker of the House appoint the four non-voting members of the council. The Senate President appoints one majority and one minority member of the Senate, and the Speaker appoints one majority and one minority member of the House of Representatives.

2010-2011 Council Chair Bill Martin with Vice-Chair Barbara Jean Franks

SUICIDE IN ALASKA

Suicide was considered an "epidemic" when the Council was created. Back then, in 2000, the age-adjusted rate of suicide for all Alaskans was 21.2/100,000 — an average of 135 lives lost each year.[4] In 2000, the suicide rate in rural Alaska was nearly three times that in urban Alaska.[5] Not much has changed since then. In 2009, the (provisional) age-adjusted rate was 20.2/100,000 with 140 lives lost.[6]

Conversations about suicide rates versus numbers can be confusing. The **number** of suicides is the actual number of people who have been confirmed to have died by committing suicide.[7] The **rate** is the number of deaths by suicide divided by the total population. That means that, if 100 people die by suicide in Alaska, the rate is 100/6.92314 or 14.4/100,000 (which should not be confused with percentage).[8] A **crude rate** is a basic division of the number of deaths by the population (the example given is a crude rate). An **age-adjusted rate** is a weighted average that accounts for the distribution of people of different ages in different regions (some communities are "younger" or "older" than others). It reflects the rate that would occur if every region had the same mix of people of different age ranges.

Why does it matter whether we talk about rates or numbers?

The impact of suicide on a community isn't always clear if you just look at one or the other. For example, in 2008 there were 33 suicides in the Interior Region and 75 in the Anchorage/Mat-Su/Kenai Peninsula region.[9] Based solely on those numbers, you might think that suicide is a bigger problem in Anchorage/Mat-Su/Kenai Peninsula area. Except, the age-adjusted suicide rate in the Interior Region in 2008 was 33.7/100,000 and for the Anchorage/Mat-Su/Kenai Peninsula area it was 17.6/100,000.[10] If you look at that alone, you would come to the opposite conclusion. This is why it's important to look at **both** numbers and rates.

[4] Data from the Alaska Bureau of Vital Statistics.
[5] FY2002 Statewide Suicide Prevention Council Annual Report at 5 (available online at www.hss.state.ak.us/suicideprevention/pdfs_sspc/2002sspcannualreport.pdf).
[6] Data from Alaska Bureau of Vital Statistics. All data for 2009 is considered provisional and subject to change until all deaths by suicide have been confirmed.
[7] This does not take into account those people who may have committed suicide but whose death was classified accidental (i.e. accidental overdose, firearm accident, etc.) or due to other causes (i.e. exposure, etc.)
[8] The Alaska Department of Labor and Workforce Development July 1, 2009 population estimate is 692,314, which is 6.92314 when divided by 100,000. For more information, go to http://almis.labor.state.ak.us/?PAGEID=67&SUBID=115 .
[9] Data from Alaska Bureau of Vital Statistics.
[10] Data from Alaska Bureau of Vital Statistics.

It's also important to consider the local impact of suicide. Between 2000 and 2009, there were 1,369 confirmed suicide deaths in Alaska; at least one suicide occurred in 176 Alaskan communities.[11]

Suicide Data

Over the last ten years, the rate of suicide has remained consistently high. The statewide age-adjusted rate has been 20/100,000 people or higher for eight of the ten years. Some regions have had age-adjusted rates much higher than that.

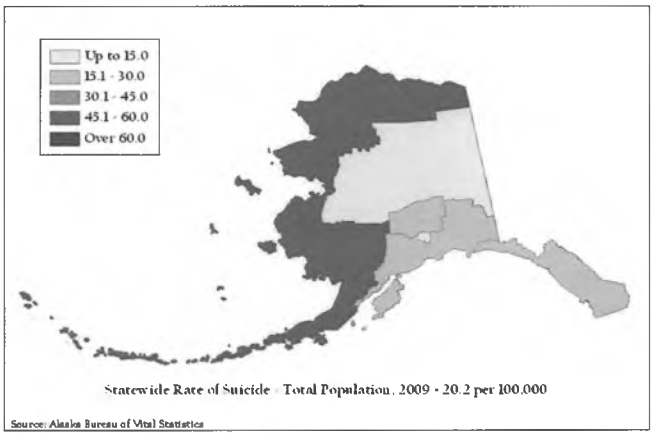
Suicides By Region of Residence: Age-Adjusted Rates'

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
North Slope Borough	103.3*	**	**	**	**	**	**	**	**	**
Northwest Arctic Borough	**	**	93.5*	**	**	**	102.1*	**	99.4*	**
Nome	63.5*	63.2*	118.2*	**	63.7*	106.0*	65.0*	**	59.9*	84.9*
Bethel/Wade Hampton	62.5*	**	36.7*	57.8*	96.2	60.2*	46.0*	55.0*	75.4*	55.8*
Dillingham/Bristol Bay/Lake and Peninsula Borough	**	**	**	**	**	**	**	**	0.0	**
Kodiak Island Borough	**	0.0	**	**	0.0	**	**	**	**	**
Aleutians	**	**	0.0	**	**	**	**	0.0	**	**
Anchorage/Mat-Su Borough/Kenai Peninsula	17.6	14.1	18.3	18.6	20.4	16.0	16.6	20.7	17.6	16.7
Valdez-Cordova	**	**	**	**	**	**	**	**	**	**
Interior	18.4	19.2*	17.0*	19.8*	19.7	13.9*	17.3*	21.3	33.7	12.9*
Southeast	13.4*	15.2*	19.5*	7.8*	14.3*	10.6*	14.0*	25.0*	23.3*	27.4*
Total	21.1	16.5	20.9	20.5	23.3	19.5	20.0	23.1	24.7	20.2

Data provided by Bureau of Vital Statistics. 2009 data is provisional.
Rates based on fewer than 20 occurrences are not statistically reliable and should be used with caution.
****** *Rates based on fewer than 6 occurrences are not reported.*

The table above shows age-adjusted rates (weighted averages). The crude rates (the simple number of suicide deaths divided by the population) by economic region are a little different. This map shows the regional breakdown.[12] The Southwestern Region and the Northern Region had crude rates of 60/100,000 people or higher — three times the statewide crude rate of 20.2/100,000 people. The Interior Region and Municipality

Crude Rate of Suicide by Alaska Department of Labor Economic Region per 100,000 Population, 2009



[11] Data from Alaska Bureau of Vital Statistics.

[12] For a map of the Department of Labor and Workforce Development's economic regions, see Appendix B. The Department of Labor and Workforce Development uses six regions, but we have separated the Municipality of Anchorage and the Mat-Su Borough to better understand any differences in the communities.

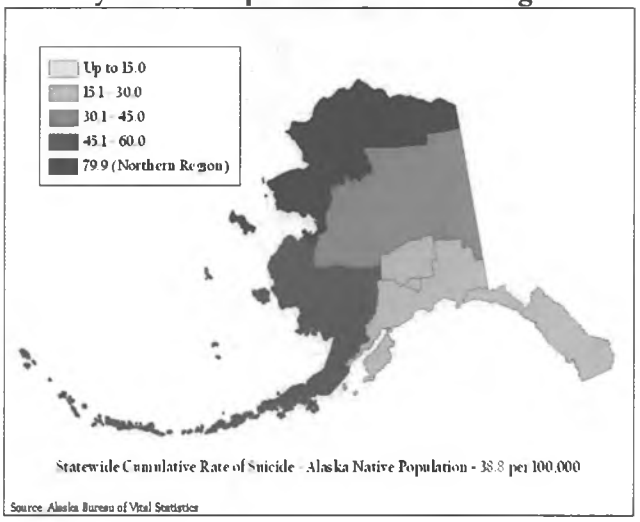
of Anchorage had crude rates below the statewide rate.

Suicide and Ethnicity

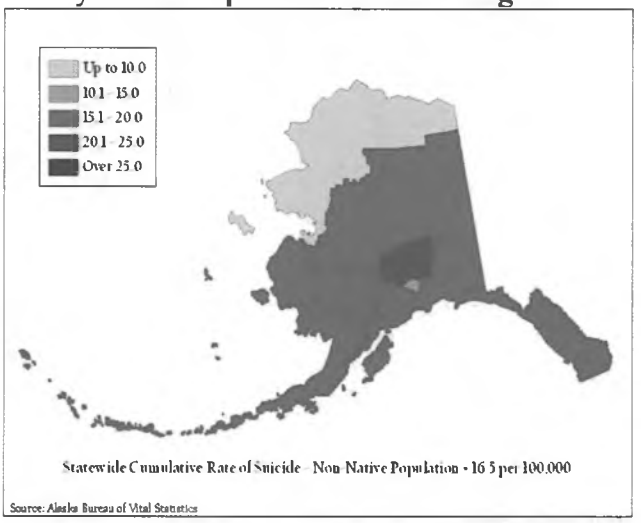
Suicide rates among Alaska Native peoples are higher than for any other ethnicity in the state, and are the highest of any ethnicity in the United States. In 2009, the age-adjusted rate for Alaska Native peoples was 32.8/100,000 people.[13] For White or Caucasian people, the age-adjusted rate was 17.7/100,000.[14] That is a difference of nearly 2:1.

Looking at Alaska suicide rates over time shows that same disparity, with a cumulative crude rate of 38.8/100,000 for Alaska Native peoples and 16.5/100,000 for non-Native peoples. Alaska Native individuals are twice as likely to commit suicide as individuals of other ethnicities.

Crude Rate of Alaska Native Suicide by Alaska Department of Labor Region



Crude Rate of Non-Native Suicide by Alaska Department of Labor Region



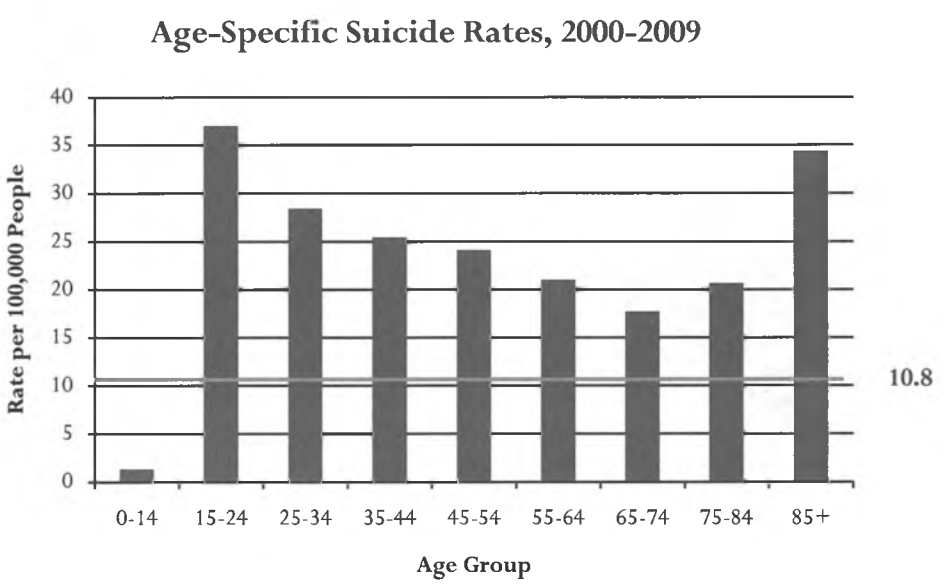
Looking at the suicide rates according to ethnicity tells one side of the story. The actual numbers of suicides tell another. In 2009, twice as many White or Caucasian Alaskans (89) committed suicide as Alaska Natives (44).[15] Since 2001, 847 White or Caucasian Alaskans have committed suicide and 411 Alaska Natives have committed suicide.[16] What this tells us is that suicide is not confined to one ethnic group. Suicide is an **Alaskan** problem.

[13] Data provided by the Bureau of Vital Statistics.
[14] Data provided by the Bureau of Vital Statistics.
[15] Data provided by the Bureau of Vital Statistics.2009 data is provisional.
[16] Data provided by the Bureau of Vital Statistics.

Suicide and Age

In Alaska, young people age 15-24 continue to have the highest rates of suicide. The age-specific suicide rate for young men age 15-24 is 56.1/100,000 and for young women is 16.6/100,000.[17] For Alaska Natives, the rate for this age group is 141.6/100,000 for young men and 50.3/100,000 for young women.[18] For White or Caucasian young men, the rate is 33.8/100,000.[19] For White or Caucasian young women, it is 6.1/100,000.[20]

The rates for other age groups[21] are less dramatic, but no less important. For all age groups above 0-14, the age-specific rate is above the 2007 national rate of 10.8.[22]



From review of the suicide rates over time, it appears that risk of suicide decreases as Alaskans age, at least until age 75. For the most senior group (age 85+), the high rate of 34.4 should be taken in the context of a small number of suicides (13) among a relatively small population. The age groups of 75-84 and 85+ bear further scrutiny over the next 10 years, as Alaska's senior population continues to grow.[23]

---

[17] Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.
[18] Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.
[19] Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.
[20] Data is for the period 2000-2009, provided by the Bureau of Vital Statistics. This rate is based on fewer than 20 occurrences and is therefore statistically unreliable. It is offered for comparison purposes only and should be used with caution.
[21] Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.
[22] 2007 rate, reported on the Alaska Scorecard at www.hss.state.ak.us/dhcs/healthplanning/scorecard/assets/scorecard.pdf
[23] The Alaska Commission on Aging reported that the population of Alaskans over age 65 grew by 19.6% between 1997 and 2007. February 17, 2009 Press Release, online at http://www.hss.state.ak.us/acoa/assets/SeniorGrowth.pdf

Suicide and Substance Abuse

Alcohol and drugs play a role in the suicide problem in Alaska, but are not a cause of suicide. We know this from three sources of Alaska-specific information. First, the Alaska medical examiner's office performs a post mortem examination (autopsy) in some — but not all — suicide deaths. From those exams, there is an indication that alcohol and/or drug use was involved in the majority of suicide decedents examined. The Alaska Suicide Follow-Back Study reported that, of the 33% of suicide decedents tested for drugs and/or alcohol, 44% tested positive for alcohol and 48% one or more other drugs.[24]

The Alaska Psychiatric Institute reports that alcohol and/or drug use is involved in an average of 48.44% of all admissions to the state psychiatric hospital. To be admitted to API under the law, a person must be a danger to himself or to another person, so not all of these admissions involved the risk of suicide. However, the data does show that substance abuse is a factor in a significant number of psychiatric emergencies requiring hospitalization.

The Alaska Trauma Registry tracks hospitalizations for poisonings – of which overdoses on alcohol and/or drugs account for the majority. In 2005, the Alaska Trauma Registry published a review of suicide hospitalizations for 2001-2002.[25] During that time, 77% of hospital visits resulting from suicide attempts (or other self-harm) involved an overdose on medications. Of those medication overdoses, 64% were prescription medications. Tylenol was the most common medication on which children age 0-19 years overdosed.

Do numbers and rates tell the whole story?

Rates and numbers are helpful in describing the problem of suicide in Alaska, but the stories of people who have survived a loss to suicide provide an important context for understanding the true impact of the problem.

- "We have an epidemic, a Hurricane Katrina and a Gulf oil spill but in a magnitude much more devastating because it is humanitarian." (Nick Tucker, Sr., Emmonak)

- "Over the past few years, a large number of people took their lives and caused a lot of pain to our friends and family. We try to move on in our lives but the pain never leaves." (Kyle M., Galena)

[24] The Alaska Suicide Follow-Back Study at 16. This study reviewed data on all 426 suicides that occurred between 2003 and 2006. It is available online at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/aipc_suicide_followback207.pdf .
[25] Alaska Suicide Hospitalizations 2001-2002, Alaska Injury Prevention Center, July 2005 at 4. Available online at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/hospitalsuicides01-02.pdf .

- "The war that engulfs us today is a war fought on the battlefield of substance abuse. Self-hatred. Suicide. Rape. Child molestation. This is a war within ourselves." (Elizabeth Hensley, Alaska Federation of Natives 2009 Convention)

- "It's a lot for a small town to go through. It's amazing that a lot more people's spirits haven't been broken by this." (James Hoelscher, Hooper Bay)

- "Everybody in Southeast has lost friends and loved ones to suicide, so it's pretty hard to talk about it." (Bill Martin, Juneau)

- "The process of waiting for my son's body to be sent to Anchorage from Bethel and to be sent back to here was the longest four to five days I have ever felt. The emotions we went through cannot be described in human terms. I tried to do something and I would feel lost while I was doing it. I tried working on my (fish) nets but found myself lost in my mind. We should never ever put our parents through this no matter how low we feel or how mad we may be." (Harley Sundown, Scammon Bay)

Photographs courtesy of Thomas Chard

There is empirical information that supports what Alaskans say about the tragic consequences of suicide. Suicide claims more lives in the United States than homicide. Suicide is one of the top ten causes of death in Alaska. Between 2000 and 2008, 4.26% of all deaths in Alaska were due to suicide. In the Wade Hampton Census Area (which includes Hooper Bay, Emmonak, Chevak, Scammon Bay, Mountain Village, Nunam Iqua, and nine other villages), 14% of all deaths were due to suicide. In the Northwest Arctic Borough,

which includes Kotzebue, 13.54% of all deaths were due to suicide. In Anchorage, 3.49% of all deaths in that time period were due to suicide.

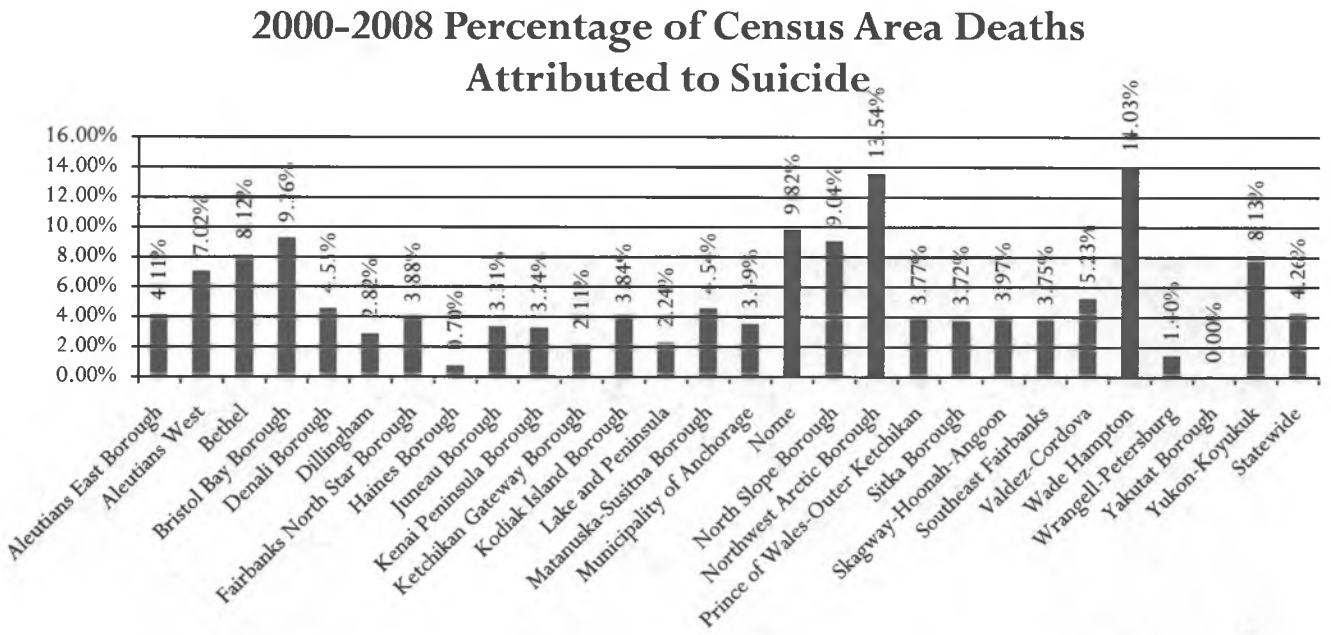


Chart created by Alaska Mental Health Board staff. **Sources:** *Alaskan Bureau of Vital Statistics, Detailed Causes of Death by Census Area & Department of Labor and Workforce Development Population Estimates.*
For more information, go to http://laborstats.alaska.gov/?PAGEID=67&SUBID=171 ,
http://www.hss.state.ak.us/dph/bvs/death_statistics/Detailed_Causes_Census/default.htm

Does unemployment affect suicide rates?

The availability of jobs and economic opportunities has a lot to do with personal feelings of self-worth and the health of a community. Research has documented a connection between unemployment, poverty and other social determinants and low self-esteem, anxiety, and isolation.[26] Unemployment and economic distress are factors that can increase the risk of suicide.[27] Review of Alaska's unemployment data shows a weak connection between unemployment and suicide rates.

The average state unemployment rate in 2009 was 8%.[28] For the census areas in economic regions with the highest suicide incidence rate, the average annual unemployment rates in 2009 varied from very low to very high. Bristol Bay Borough had the lowest unemployment rate in 2009 at 4.3%. Wade Hampton had the

[26] *Mental Health, Resilience, and Inequalities*, Dr. Lynne Friedli, World Health Organization 2009 (available online at www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf).
[27] *Getting Through Tough Economic Times*, A SAMHSA Guide (available online at www.samhsa.gov/economy/#suicide).
[28] All unemployment data for 2009 provided by the Department of Labor and Workforce Development, online at http://almis.labor.state.ak.us/?PAGEID=67&SUBID=188

highest 2009 unemployment rate at 21.2%. Unemployment rates in regions with lower suicide rates are equally variable, ranging from 6.6% in Anchorage to 15.7% in the Yukon-Koyukuk Census Area.

Looking at unemployment rates for 2000-2008, there is a weak statistical correlation between unemployment rates and suicide rates.[29] There is no clear connection between an increase in the unemployment rate and an increase in the suicide rate, as there were periods of time when suicide rates fell in regions experiencing increases unemployment. What this means is that unemployment, while **not a cause of suicide**, is apparently a factor in suicide incidence — and there is room for more research and study of the impact of the health of the economy on the suicide rate.

Photographs courtesy of the Alaska Department of Commerce, Community and Economic Development

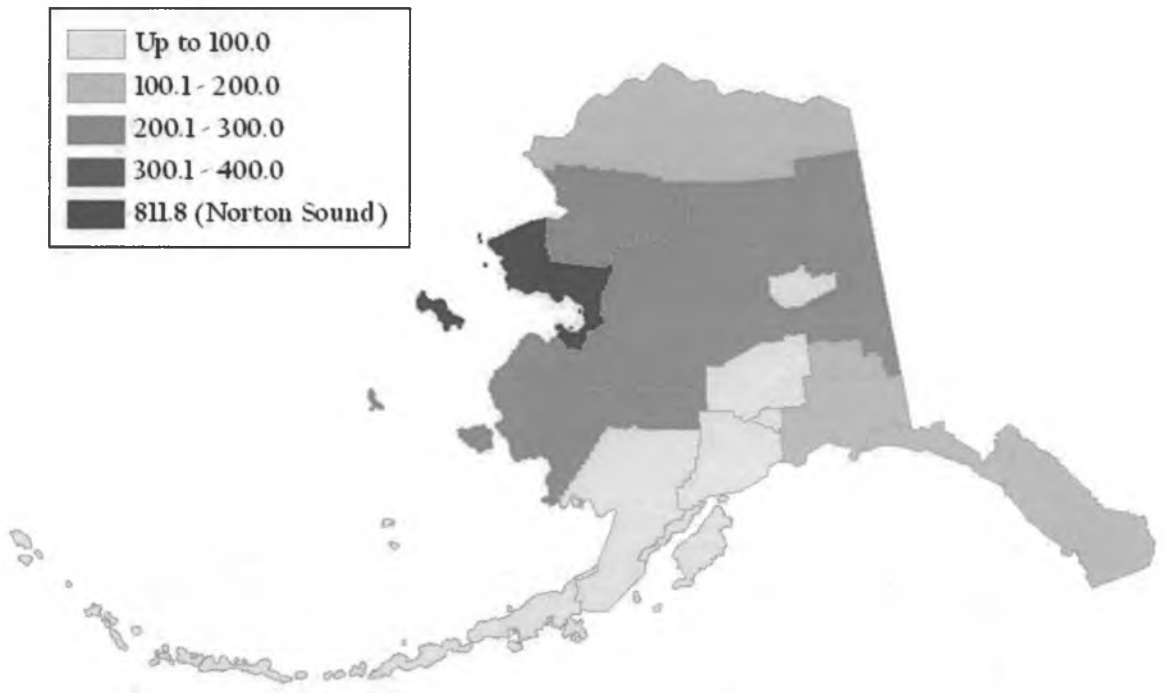
Suicide Attempts

The number of attempted suicides is just as important as completed suicides. The Alaska Department of Health and Social Services tracks this information through the Alaska Trauma Registry. In 2007 (the most

[29] Analysis of unemployment rates and suicide rates for 2000-2008 was conducted by Alaska Mental Health Board staff.

recent year's data available), the suicide attempt rate was 99.3/100,000 people.[30] That's nearly five attempted suicides to each completed suicide.

In 2007, the Norton Sound area (Nome, St. Lawrence Island, and the Seward Peninsula) had the highest rate of non-fatal suicide attempts. That same year, Fairbanks, Anchorage, Mat-Su and the Aleutians had a rate of less than 100 non-fatal attempts per 100,000 people.



Statewide Rate of Non-Fatal Suicide Attempts - Total Population, 2007 - 99.3 per 100,000

Source: Alaska Division of Public Health

Depression and suicidal ideation occurs with alarming frequency among Alaska's high school students. This information is collected every two years through the Youth Risk Behavior Survey, an anonymous survey developed by the Centers for Disease Control and Prevention. In 2009, the survey was administered in alternative high schools as well as traditional high schools. The information was alarming.

[30] Data provided by the Alaska Trauma Registry, Division of Public Health.

2009 Youth Risk Behavior Survey Data

2009	Traditional High Schools % of students surveyed	Alternative High Schools % of students surveyed	National Average % of students surveyed
Depression, hopelessness	25.2%	37.5%	26.1%
Considered attempting suicide in the past 12 months	13.9%	18.1%	13.8%
Attempted suicide at least once in the last 12 months	8.5%	11.3%	6.3%
Suicide attempt resulted in injury, poisoning, or overdose requiring medical treatment	2.6%	4.4%	1.9%

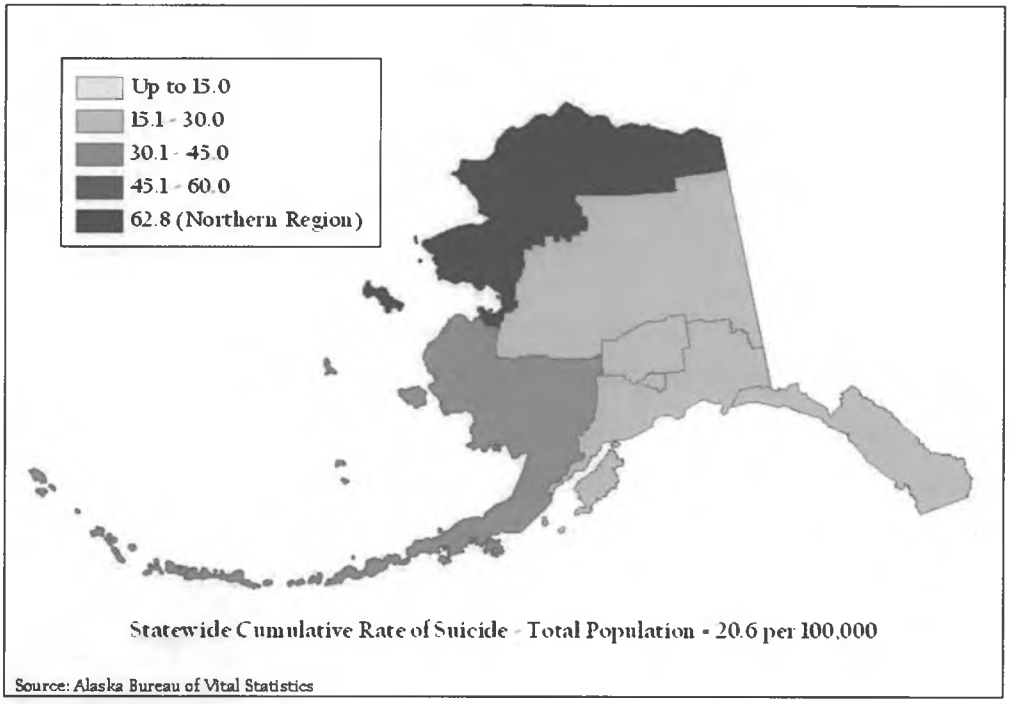
Alaska data provided by the Division of Public Health, Chronic Disease Prevention and Health Promotion (available online at http://www.hss.state.ak.us/dph/chronic/school/YRBSresults.htm).
National data reported by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, June 4, 2010 (available online at http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf).

In 2009 Alaskan high school students, especially those attending alternative high schools, presented a much higher incidence of suicidal ideation, suicide attempts, and suicide attempts requiring medical treatment than students nationally.

What does the data tell us?

In 2009, more people died by suicide in the Anchorage area than any other region. However, rural Alaska had higher rates of suicide, indicating a more dramatic impact on communities. We typically look at the suicide rates by year, and measure from year to year whether it is getting better or worse. However, since some regions have a low number of suicides, we don't always have rates for every region. Also, looking year by year doesn't show the long-term effects of suicide on communities. If you look at the cumulative rate since 2001, the statewide rate remains consistent — 20.6/100,000 people. But the rate by region varies considerably.

Cumulative Crude Rate of Suicide by Alaska Department of Labor Economic Region per 100,000 Population, 2001-2009



Source: Alaska Bureau of Vital Statistics

The Alaska Trauma Registry reports data using different geographical regions than the census boroughs or economic regions used by the Alaska Bureau of Vital Statistics and Department of Labor and Workforce Development.

The 2001-2009 crude rate for the majority of the state is between 15.1 and 30 per 100,000 people. This is the case for the Anchorage area, where most of Alaska's population resides.[31] However, the rate for the Northern Region (which includes the North Slope Borough, Northwest Arctic Borough, and Seward Peninsula) is 62.8/100,000. Less than 5% of the state population lives in that region.[32] This is a good

[31] According to the Alaska Department of Labor and Workforce Development, the 2009 population for the Anchorage Mat-Su region was 374,902 (54% of the state population). Data available at http://laborstats.alaska.gov/?PAGEID=67&SUBID=247 .
[32] According to the Alaska Department of Labor and Workforce Development, the 2009 population for the Northern Region was 23,664. Data available at http://laborstats.alaska.gov/?PAGEID=67&SUBID=247 .

example of how looking solely at rates can be misleading. The number of people who died by suicide in that period of time in the Anchorage area was 626; in the Northern Region it was 152.[33] Again, we see that looking solely at rates — or solely at numbers — is not enough.

⌘⌘⌘

Suicide Prevention Efforts

In Alaska, suicide prevention efforts are supported by the State of Alaska, the tribal health system and Alaska Native Tribal Health Consortium, the federal government, and local communities. Some suicide prevention efforts are large-scale professionalized prevention programs. Others are community driven efforts staffed by volunteers.

Until 2009, very little effort was put into linking the state and tribal suicide prevention systems with other community efforts. Many prevention providers were unaware of other suicide prevention projects in other parts of Alaska. In FY2010, the Council and its partners, the Alaska Mental Health Board, the Department of Health and Social Services Division of Behavioral Health, the Advisory Board on Alcoholism and Drug Abuse, and others prioritized strengthening the connections between suicide prevention efforts. Thus, the Council can better report the scope of suicide prevention in Alaska (though is not yet able to comprehensively identify every suicide prevention program or project in the state).

Careline

Careline, located in Fairbanks, is the statewide suicide hotline. Careline's focus is the safety of the caller and helping the caller access appropriate services to preserve that safety. Careline partners with community mental health centers and clinicians statewide to ensure callers' mental health needs are appropriately addressed.

Careline offers telephone-based crisis intervention and online chat for people who would rather connect with a counselor that way. When someone calls in crisis, the trained counselor assesses the person's safety by identifying whether or not the person is at imminent risk of suicide.

In 99% of calls, the Careline counselors are able to provide effective interventions to keep the callers safe until they can access services they need. In the 1% of cases that are judged to be so acute that the caller is found to be in "imminent risk of death," Careline engages with local emergency services to provide immediate interventions to preserve the caller's safety.

[33] Data provided by the Bureau of Vital Statistics.

Careline provides prevention materials through its website, at community events, and through partners like the Council, Alaska Mental Health Board, and community coalitions. As an agency, Careline has used social media like Facebook to reach out to individuals and to link prevention providers to better serve people in crisis.

Careline reported a 55% increase in total call volume in the second half of FY2010, compared to the same period in FY2009.[34] Of calls received, 223% more involved suicidal ideation.[35] Careline staff attributes this increase in suicide-related calls to increased outreach through partnerships with the Alaska Native Tribal Health Consortium, Alaska Mental Health Trust Authority, NAMI chapters, military Family Advocacy Centers, and statewide outreach efforts. A 23% increase in calls involving addiction and a 54% increase in calls from individuals experiencing mental illness occurred in this same time period.[36]

Careline has received state funding from the Department of Health and Social Services and the Alaska Mental Health Trust since 2006.

Suicide Prevention ~ State Funded

In FY2010, the Department of Health and Social Services made 28 grants totaling $2,663,743 for suicide prevention. These grants were funded with General Funds, receipts from the Alcohol Excise Tax, and federal grant funds received by the State of Alaska. While many more comprehensive community prevention grants were made to address substance abuse, violence, etc. — all contributing factors to suicide — only 28 grants targeted suicide (in whole or in part). Grantees in FY2010 included:

- Juneau School District (Juneau, Douglas)
- Iditarod School District (McGrath)
- Central Peninsula Hospital (Kenai)
- Big Brothers Big Sisters (Fairbanks, Juneau, Sitka)
- City of Nulato (Nulato)
- Mt. Edgecumbe High School (Sitka)
- Mat-Su Health (Palmer, Wasilla)
- PeaceHealth (Prince of Wales Island)
- Stone Soup Group (Statewide)

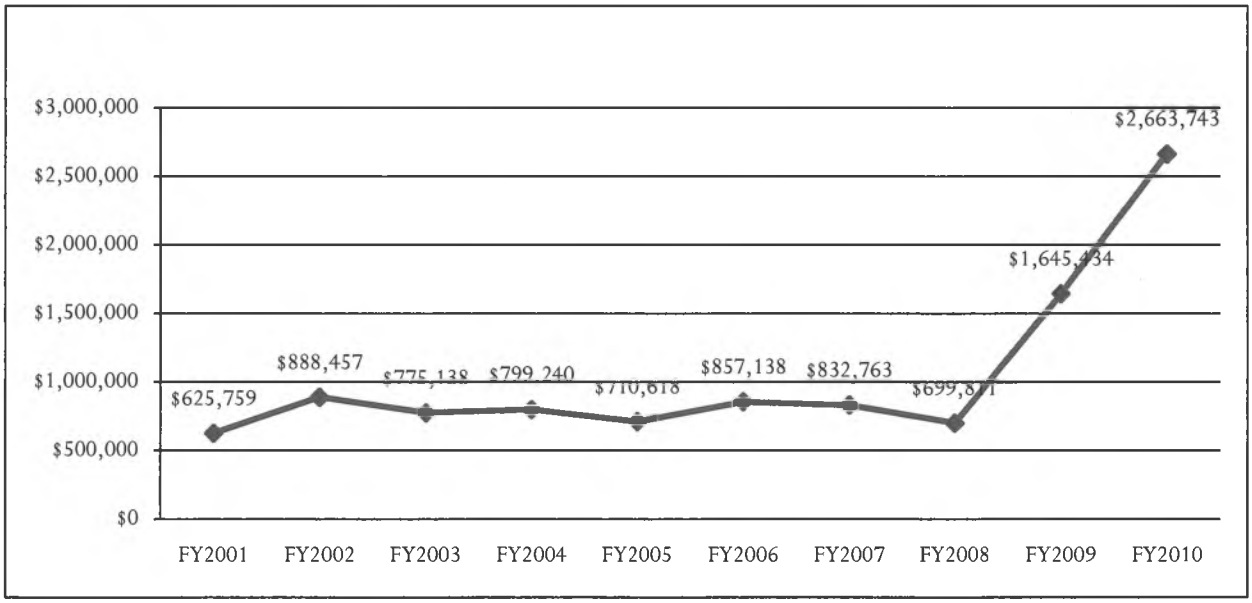
Examples of suicide prevention projects funded through these grants include community coalitions, creation of community resources, public education and outreach. The Juneau School District (which has received grant funding since FY2008) has implemented a school-based screening and intervention program using the Signs of Suicide Prevention Program. This is an evidence based prevention program that addresses depression, suicide risk, and self-harm. Of Juneau alternative high school students screened in September 2009, 40% met the diagnostic criteria for major depression.[37] In the two traditional high schools, 23% and 31% of students screened presented with characteristics of a major depressive episode and/or suicidal ideation. In Juneau, the grantee has added additional interventions and referrals to address contributing factors like poverty, domestic violence, and access to health care to provide a more comprehensive

[34] Data reported by Careline Executive Director Kimberlee Jones to the Statewide Suicide Prevention Council, August 24, 2010.
[35] Data reported by Careline Executive Director Kimberlee Jones to the Statewide Suicide Prevention Council, August 24, 2010.
[36] Data reported by Careline Executive Director Kimberlee Jones to the Statewide Suicide Prevention Council, August 24, 2010.
[37] Reported by Juneau Douglas School District for FY2010.

response to students at risk for suicide. In cooperation with the local suicide prevention task force, the grantee created a valuable internet-based community resource guide: JuneauSuicidePrevention.org.

Since 2001, the State of Alaska has invested over $10 million in suicide prevention. Funding remained consistent from year to year, until 2009 when available grant funds were substantially increased. This was made possible by the State of Alaska's receipt of a Garrett Lee Smith Grant from the federal government.[38]

Cumulative Suicide Prevention Grants Funded by State of Alaska, FY2001-FY2010



The distribution of grant funds has changed over the last ten years. Before 2006, large numbers of communities received small grants of less than $20,000 per year to engage in community driven suicide prevention efforts.[39] These small grant projects included Alaska Native culture camps, "alternative activities" that promoted healthy relationships between adults and youth, community wellness and suicide prevention coalitions, and a natural helper programs for youth in the Lower Yukon School District.

Since FY2006, the number of grantees has dropped steadily as the amount of the awards has risen. In FY2001, grants were made to 48 communities. In FY2010, only 28 grants were made, even though **four times as much money** was available for grants.

Beginning in FY2006, the Department of Health and Social Services adopted a funding mechanism that blended and braided multiple funding streams available for prevention programs and implemented the

---

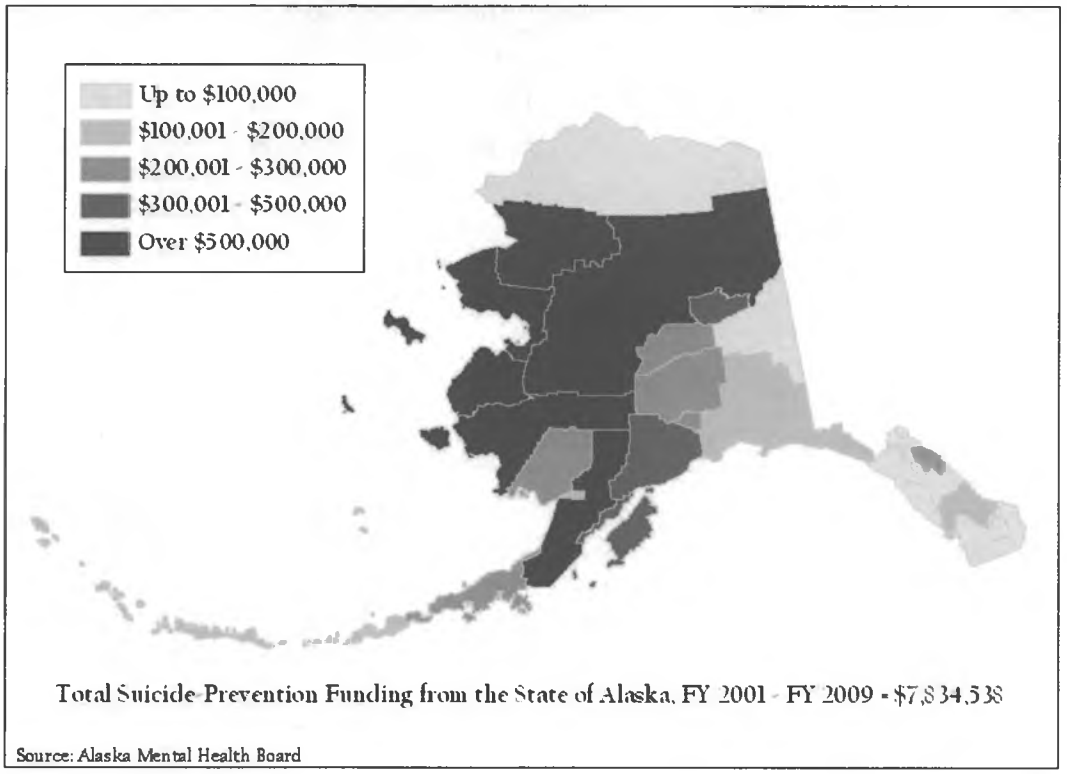
[38] $1.5 million was awarded by the Substance Abuse and Mental Health Services Administration to the State of Alaska, payable in $500,000 increments over three years (2008-2010).

[39] For a full list of grantees between 2001 and 2009, see "Suicide Rates, Prevention Funding, and Prevention Efforts in Alaska," Legislative Research Report (November 12,2010) at Attachment D (available online at http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2011/11-015m.pdf).

Strategic Prevention Framework model established by the federal Substance Abuse and Mental Health Services Administration. This model is a public health model that emphasizes community readiness and planning, as well as outcomes, in prevention efforts. Community collaborations are a major part of prevention projects funded under the Strategic Prevention Framework model. This model is more complicated than what was previously used (before FY2006), and requires more from grant writers and managers, as well as community coalitions and partnerships, than the previous structure.

With the evolving funding mechanisms, and the move to a more competitive grant process in FY2006, the distribution of funding has depended more on communities' sophistication in grant writing and management — and their willingness to apply for funding. The map below shows how this funding has been distributed from FY2001-FY2009.

Suicide Prevention Funding from the State of Alaska, by Borough and Census Area FY2001-FY2009



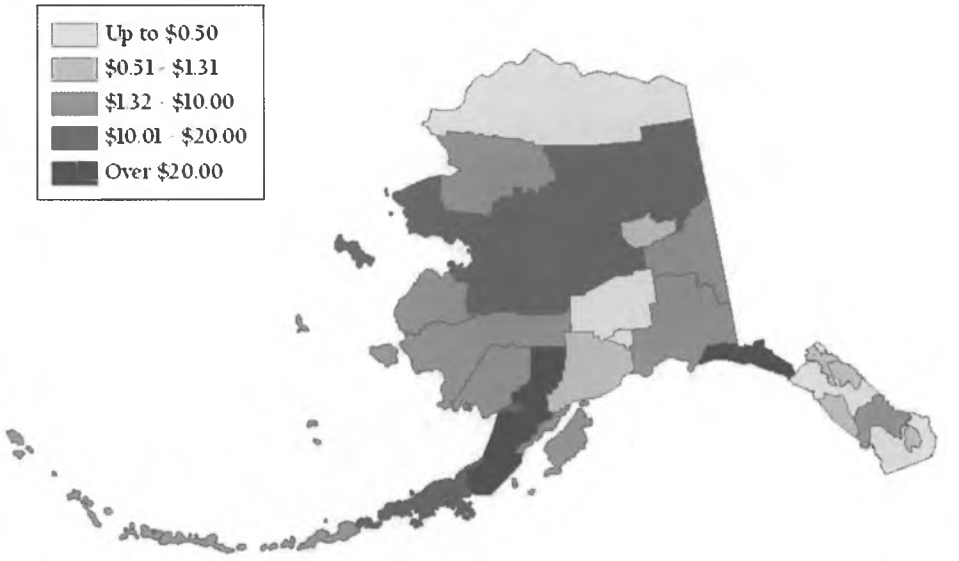
Source: Alaska Mental Health Board

Because not all communities apply for suicide prevention grants, not all regions receive suicide prevention funding from the State of Alaska. Between FY2001 and FY2009, the State of Alaska spent $1.31 per capita per year on suicide prevention.[40] Annual per capita per year spending ranged from $0.08 per capita — in

[40] Average annual per capita numbers were calculated by dividing each geographic area's nine-year funding total by the corresponding nine-year population total. The State of Alaska provided $7.8 million in suicide prevention grants between FY2001 and FY2009. The denominator in this equation is 5,964,093, the sum of the statewide population figures from each of

the North Slope Borough (which received the benefit of less than $5,000 in suicide prevention funding from statewide projects like Careline over this time period), Municipality of Anchorage, Hoonah-Angoon Census Area, and Municipality of Skagway — to $35.24 per capita in the Lake and Peninsula Borough.

Annual Per Capita Suicide Prevention Funding from the State of Alaska, by Borough and Census Area FY2001-FY2009



Annual Statewide Per Capita Suicide-Prevention Funding from the State of Alaska, FY 2001 - FY 2009 = $1.31

Sources: Alaska Mental Health Board; Department of Labor and Workforce Development

Analysis[41] of the distribution of suicide prevention funding shows that incidence is not clearly affected by the amount of funding received. Between FY 2001 and FY 2009, grantees in the Southwest Region received $2.6 million in grant funds (approximately one-third the total provided by the State of Alaska). That region had the second-highest cumulative suicide rate during the same period. However, funding peaked in FY2004 (the year when the region experienced its highest suicide rate of 67.9/100,000). Since FY2005, funding has decreased annually. This region received only $72,931 in FY 2009. Incidence of suicide has come down in the Southwest Region from its peak in FY2004 (during years of decreasing funding), though the rate is still twice the statewide average.

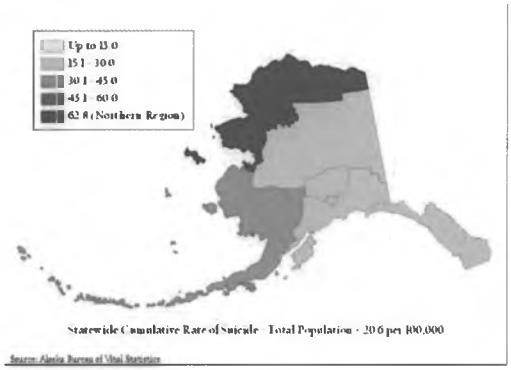
Grantees in the Interior Region received $1.6 million (20% all funding provided by the State of Alaska) in suicide-prevention funding between FY 2001 and FY 2009. Grants averaged about $100,000 per year from FY 2001 to FY 2005. The average from FY2006 to FY2008 was about $180,000 per year. In FY 2009, the

---

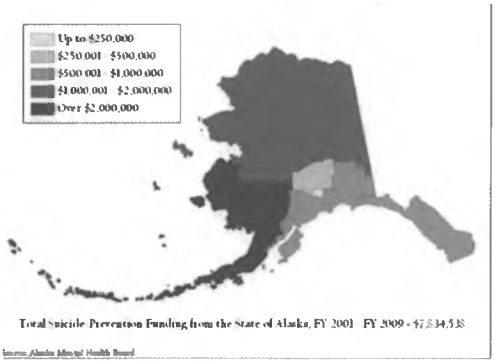
the nine years in the study period. Dividing the former number by the latter gives us $1.31. This means that the State of Alaska distributed the equivalent of $1.31 annually for every Alaska resident between FY 2001 and FY 2009.

[41] Analysis provided by Brian Laurent, former research analyst with the Alaska Department of Labor and Workforce Development and MPA candidate at Boise State University. Because FY2010 grant information was not available until December, 2010, it was not available at the time the analysis was performed.

Cumulative Crude rate of Suicide by Department of Labor Economic Region, FY2001-FY2009



Suicide Prevention Funding from State of Alaska by Department of Labor Economic Region, FY2001-FY2009



$580,989 in grant funds went to the Interior Region. The suicide rate in this region was lower than the statewide rate between 2002 and 2007. In 2008, it spiked to 30.7/100,000 people. In 2009, it fell to 13.8 /100,000 people.

In the Northern Region, which had the highest cumulative suicide rate between 2001 and 2009, grantees received 18.8% of total funding from the State of Alaska ($1.5 million). The amount of grant funding received fell by 37.2% in FY2008 and 51.6% in FY2009, when grantees in this region received $70,500 (the lowest in the state outside of Anchorage).[42]

Funding in the Southeast Region was consistent from FY 2001 to FY 2008. Average annual funding was about $41,000. In FY 2009, grants to the region totaled $406,247 (more than the previous eight years combined). The suicide rate in the Southeast Region increased from 2001 to 2009. Between 2001 and 2006, the rate was between 8.4 and 18.1/100,000 people (below the statewide average). The suicide rate since 2006 has ranged from 23.1 to 27.4 per 100,000/people.

Further detail and disparities can be discerned in an analysis of funding by the smaller regional designations used by the Department of Health and Social Services. For example, the department of Labor's "Northern Region" includes the North Slope and Northwest Arctic boroughs, and the Norton Sound Region. The Norton Sound Region had extreme rates of non-fatal suicide attempts suicide in 2008 and 2009, specifically in the Alaska Native community. This region received close to $900,000 between FY2001 and FY2009. Conversely, the North Slope Borough, with a suicide-attempt rate close to double the statewide average, received less than $5,000.[43]

Suicide Prevention ~ Federally Funded

Seventeen tribal organizations received prevention grants from the Indian Health Service as part of the Methamphetamine and Suicide Prevention Initiative. These grants, totaling over $5 million over three years) were funded as part of the 2009 Recovery Act. The intent of these grant programs is to expand

[42] The Municipality of Anchorage received no suicide prevention grant funds from the State of Alaska in FY 2009. The only grant awards that went to Anchorage between FY2001 and FY2009 were part of larger statewide grants. It received no specifically allocated funds during this period. All funds attributed to the region were apportioned, based on population, from statewide suicide prevention grants.

[43] Like the Municipality of Anchorage, none of the North Slope Borough's suicide prevention funds were to grantee organizations in the borough. All were apportioned, based on population, from statewide grants to organizations like Careline.

community prevention efforts to reduce methamphetamine use and incidence of suicide. Grantees include the Alaska Native Tribal Health Consortium, Southcentral Foundation, Maniilaq Association, Ketchikan Indian Community, Arctic Slope Native Association, Chugachmiut, Bristol Bay Area Health Corporation, and others.

Photograph courtesy of Southcentral Foundation

These grants have funded a variety of projects. Southcentral Foundation is using its grant for the Lead the Change project, a contest that provides outreach, awareness, and education and technical assistance to help youth produce short video messages focused on protective factors that reduce risk for suicide. Rather than a stark suicide prevention message, videos focused on positive aspects of life and hopefulness. The FY2010 winner was a team of youth from Wendler Middle School in Anchorage.

In addition to the current IHS Methamphetamine and Suicide Prevention Initiative grantees, several tribal organizations have received federal Garrett Lee Smith funding. As mentioned above, Maniilaq in the Kotzebue region was awarded a three year Garrett Lee Smith Grant in 2006, which supported a digital storytelling project for students in schools in twelve regional villages and efforts to improve suicide prevention practices in local agencies.

Kawerak, Inc. in the Norton Sound region also received a three year Garrett Lee Smith Grant in 2008. It is funding the Bering Strait Suicide Prevention Program, focusing on all youth age 12-18 and young Alaska Native men age 19-30 in the region's 15 villages. This prevention program includes a "Peer Helpers" project to provide peer support for youth.

Southcentral Foundation received a three year Garrett Lee Smith Grant in 2009. The grant will fund a screening, referral, and case management program targeting high risk Alaska Native youth age 10-24. Suicide prevention and intervention training and youth engagement in media outreach and awareness campaigns are also anticipated.

Suicide Prevention ~ Tribal Health

Tribal health organizations all over Alaska have worked to prevent suicide among their client/customer populations. Along with individual tribal health organizations, the Alaska Native Tribal Health Consortium (ANTHC) has been engaged in ongoing efforts to reduce suicide among Alaska Native peoples. These include a Suicide Prevention Initiative begun in 2009, ongoing suicide prevention and intervention training

(discussed below), assisting regional tribal health organizations with community readiness, and projects to reduce access to "lethal means" (guns, etc.) of suicide. Examples of these efforts are described below.[44]

Bristol Bay Area Health Corporation (BBAHC), a tribal health organization serving Dillingham and 34 regional villages, developed a gun locker program in partnership with ANTHC and the local housing authority. BBAHC targeted access to guns as a "lethal means" of suicide, because firearms are involved in 2/3 of suicides by men in Alaska.[45] In the course of this project, BBAHC has installed over 300 gun safes in homes throughout the region.[46]

In FY2010, ANTHC and its partners worked to develop a culturally relevant postvention resource for Alaska Native peoples. *Doorway to a Sacred Place* is a tool for communities after a suicide or other tragedy has occurred. It incorporates traditional ways of knowing to provide resources for healing — which in turn can prevent suicide contagion, or the domino effect of suicides that so many rural communities have experienced. *Doorway to a Sacred Place* is expected to be finalized and ready for use in FY2011.

Southcentral Foundation offers a suicide prevention program called Denaa Yeets' — "Our Breath of Life" in Athabascan. This program provides case management, information and referrals to services to Alaska Native adults who are at risk of suicide. Denaa Yeets' also provides supportive services to the family members of clients.

Suicide Prevention ~ Training

There are multiple prevention and intervention models available in Alaska. Training is provided through the State of Alaska, ANTHC, and other organizations.

ASIST, which stands for Applied Suicide Intervention Skills Training, is an evidence based suicide prevention model used all over the world. ANTHC has supported trainings throughout the tribal health system in Alaska. At the end of FY2010, there were 585 Alaskans who had been trained in the ASIST model. Communities like Barrow have emphasized training in identifying warning signs of suicide and appropriate responses and referrals.

ASIST Training in Barrow
Photograph courtesy of Audrey Suganna

CISM, Critical Incident Stress Management, is another suicide prevention model. It is most effective after a suicide or other tragic event. The Alaska Police and Fire Chaplain's Ministries, as well as other organizations offer training in this model. CISM is a comprehensive model that focuses on how individuals and communities can debrief and react to a suicide or other crisis in a healing way. By partnering together, organizations have expanded the

[44] Contact the Injury Prevention Program at the Alaska Native Tribal Health Consortium (907-729-3799) for a more comprehensive review of tribal health organizations' suicide prevention efforts.
[45] Reported by the Division of Public Health Epidemiology, Department of Health and Social Services, September 14, 2010 (available online at http://www.epi.alaska.gov/bulletins/docs/b2010_28.pdf).
[46] Reported to the Statewide Suicide Council by Eric Holland, deputy director of Behavioral Health, BBAHC, November 13, 2009.

reach of this model. For example, ANTHC, the Chaplain's Ministry, and the Arctic Slope Native Association partnered to train 50 individuals in CISM in FY2010. Participants included public safety officers and behavioral health providers.

Gatekeeper is another suicide prevention and intervention model. Training in this model is offered by the State of Alaska through the Division of Behavioral Health, Department of Health and Social Services. Anyone can be trained as a Gatekeeper. The model focuses on teaching people to listen and connect with someone, assess that person's risk for suicide, and act appropriately when someone is in crisis. Gatekeeper trainings include a basic overview of suicide, active listening skills, how to assess someone's risk of suicide, and how to be comfortable intervening to keep someone safe. Knowledge of local and statewide resources is also provided, to help Gatekeepers make referrals to the right services when someone is in need.

⌘⌘⌘

Council Activities

The Council held meetings in Dillingham, Anchorage and Toksook Bay in FY2010. At all of these meetings, extensive public comment was provided to council members. Council members have characterized the Toksook Bay meeting in May, 2010 as one of the most meaningful and informative meetings held so far. Not only was much of the meeting held in Yupik (with English translation), but a significant amount of time was spent listening and learning from the local elders.

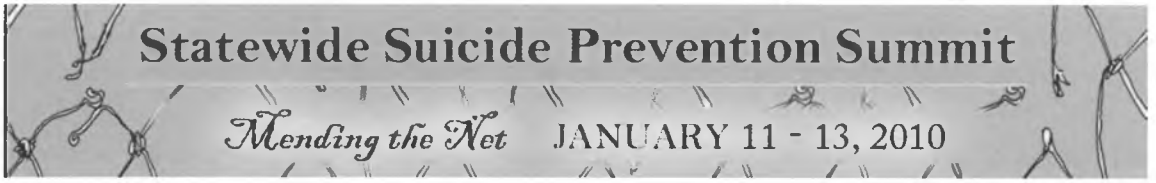
Photographs courtesy of Teri Tibbett

The Council provided anti-stigma and public education materials to communities around the state and online. In addition to conducting regular business, the Council worked with the Division of Behavioral Health, the Alaska Mental Health Board, and the Advisory Board on Alcoholism and Drug Abuse to develop a transition plan for co-locating the Council with the Boards beginning in FY2011.

The Council's major achievements, however, involved extensive efforts to identify and connect suicide prevention stakeholders to "mend" and strengthen the suicide prevention system "net." These efforts, the first ever Suicide Prevention Summit in January 2010 and the development of the web portal StopSuicideAlaska.org, were only possible because of the Council's partnerships with the Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust.

Alaska Suicide Prevention Summit

In January, 2010 the Statewide Suicide Prevention Council and the Alaska Native Tribal Health Consortium partnered with several state agencies to convened the first ever Alaska Suicide Prevention Summit (Summit). More than 60 individuals, representing agencies and communities statewide, gathered to review and assess the state of Alaska's suicide prevention system and to determine what immediate, short-term and long-term steps can be taken to strengthen the system.



The tribal health system and state-funded health system both support suicide prevention efforts in Alaska. Often these suicide prevention systems operate along parallel tracks rather than in concert. The Summit was the first time that the tribal health suicide prevention system and the state-funded suicide prevention system have come together to identify their unique and common strengths, and how together these systems could build upon those strengths to fill in the gaps in our suicide prevention efforts overall. The Summit started a more collaborative partnership between the tribal and state prevention systems, to begin to have a more meaningful impact on Alaska's suicide rate.

Summit participants identified the strengths and weakness of the suicide prevention systems in Alaska. **Partnerships**, where they occur, between the state and tribal suicide prevention systems were identified as strengths. After the Summit, the level of cooperation between tribal and state entities, as well as other stakeholders, has increased dramatically:

- ANTHC, Southcentral Foundation, and NAMI-Anchorage are partnering to form and host a support group for survivors of suicide in Anchorage.

- SSPC, ANTHC, the Alaska Mental Health Board, the Alaska Mental Health Trust, non-profit organizations, and many survivors of suicide partnered in advocacy to secure funding for suicide prevention, postvention, and technical assistance. Through this partnership, an increment of $200,000 general funds per year was appropriated for postvention funding.
- Alaska Children's Services and the Alaska State Troopers are partnering to deliver Gatekeeper training to state troopers statewide between 2010-2012.
- The Alaska Federation of Natives identified suicide and suicide prevention as a major focus of the 2010 convention.

Photograph courtesy Thomas Chard

Summit participants identified many different avenues of **health promotion** that is now or could more fully be part of suicide prevention efforts. These include a wide range of efforts undertaken at the individual, community, and state levels. Elders and cultural leaders model healthy lifestyles and encourage connections with youth to foster leadership and growth. Depression and substance abuse screening in clinics and other primary care settings, like Anchorage Neighborhood Health Center, help people access treatment and recovery services before they are in crisis. This is an especially effective model for rural and older populations. The tribal health system offers many health promotion programs that help Native Alaskans and people living in rural communities. These include primary and dental health programs, as well as substance abuse prevention and overall wellness programs. These services are culturally appropriate for the target populations. The Rural Human Services program provides culturally relevant education for the behavioral health aides, family service workers, and other human services providers in Alaska's villages and rural communities. This helps expand the wellness promotion services available throughout the state.

Summit participants identified the power of **young Alaskans** as a strength. The Statewide Suicide Prevention Council includes a youth member with full voting privileges. The new youth suicide prevention effort coordinated by Central Council of Tlingit and Haida Indians has a youth advisory board. These are just two examples of how suicide prevention organizations reach out to and include the perspectives of young people in their work.

Current suicide prevention efforts were also identified by Summit participants as system strengths. Some are evidence based practices implemented in clinical settings, some are community based, and some are built on other models. **School-based screenings** of students, like the model in Juneau discussed above, are an effective way of identifying children at risk of suicide before they are in crisis. In some districts, there are student clubs and support groups related to mental wellness that help de-stigmatize mental illness and the seeking of help for a crisis.

Community coalitions involve partnerships between local agencies and individuals interested in preventing suicide emphasize the importance of diverse stakeholder participation. They include multi-disciplinary collaborations between public health, primary care, and behavioral health systems. Since the Summit, a new coalition – SPEAK – has formed in Ketchikan and is an active part of the community's larger wellness coalition.

Careline, Alaska's 24/7 crisis call line, was identified as a strength. Careline and the Alaska Native Tribal Health Consortium offer dynamic and information web pages with prevention resource information. The Juneau Suicide Prevention Task Force and SPEAK in Ketchikan have equally effective webpages with local information and resources. All of these websites link back to each other, to help make sure people can access all the information they need. The Anchorage gay, lesbian, bisexual organization, Identity, Inc., provides a toll-free helpline.

Both the tribal and state systems emphasize the importance of **locally developed prevention solutions**, to ensure that each community has a relevant and respectful way of addressing the problem of suicide as it occurs in their community. The wide availability and acceptance of ASIST, CISM, Gatekeeper, and other suicide prevention and intervention models were identified as strengths. The Rural Human Services program includes a suicide prevention curriculum. The Alaska National Guard is a partner in providing ASIST trainings in communities statewide.

While many strengths were noted, weaknesses and gaps were also identified. Few Alaska communities have an active **support groups for survivors of suicide**. Survivors of suicide can find support groups in only six of the 143 communities: Anchorage, Barrow, Bethel, Fairbanks, Juneau, and Wasilla. Not all of these meet regularly. There are two active support groups and one developing support group in Anchorage, where the largest number of suicides occur each year. In the four census areas with suicide rates of 30 or more per 100,000 people, there are only two communities with support groups for survivors of suicide (Barrow has an active group and Bethel is developing a group). In the Nome census area, where the rate has been the highest, there are no active support groups for survivors of suicide. Increasing access to support for survivors, whether in person or through other means, was identified as a next step for participants and the state as a whole.

Many different models for support services are available, based on specific community needs and capacity. Cultural healing circles help individuals, families and communities deal with the feelings that come immediately after a loss to suicide. They also can provide ongoing support to survivors of suicide. Fairbanks Counseling and Adoption developed the structure for the Fairbanks group directly with participants to ensure that the group provides meaningful support and assistance to people who attend.

Summit participants spoke often of suicide as a taboo subject in families and communities. The pervasiveness of this silence on the issue of suicide was reflected in experiences individual and communal, in public and private space. Family members' deaths left unexplained for generations, ostracism of survivors, suicide deaths listed as accidental by local physicians, media outlets avoidance of even the term "suicide" – these are just a few of the ways that the long-standing culture of silence weakens the suicide prevention system. Contributing to the social norm that suicide is not a subject openly discussed is the fact that, in

many communities, the lack of confidentiality presents an obstacle to developing trust necessary to seek services. Stigma and labeling of both the person who has committed suicide, as well as those affected by the loss to suicide, further impairs access to services and their effectiveness.

Since the Summit, the number of public forums to discuss suicide and its impact on Alaska's communities and families has exploded. Media coverage in newspapers large and small, and by television news programs, has also increased. State and federal policymakers have taken greater interest in the state of the suicide prevention system in Alaska.

IF, FOR NOTHING ELSE, FY2010 IS RECOGNIZED AS THE YEAR THE COUNCIL HELPED ALASKANS END THE SILENCE ABOUT SUICIDE, IT WILL HAVE BEEN A SUCCESSFUL YEAR.

Summit participants identified a lack of cohesion among the different prevention systems (tribal, faith-based, state, federal, local) as a weakness. Efforts to bridge the gaps between these systems were begun immediately after the Summit, and continue today. Other weaknesses included:

- Lack of support services for populations made vulnerable by loss of structure (veterans, transition age youth, immigrants, individuals displaced due to economic or environmental hardships);
- Lack of effective prevention and intervention programs to address bullying;
- Lack of age appropriate services for individuals age 18-25 years;
- Lack of follow up services for individuals who have attempted suicide; and
- Lack of communication among and support for suicide prevention providers.

The Council, along with the Alaska Mental Health Board, prioritized the lack of communication among and support for suicide prevention providers as a weakness that could be addressed in FY2010. Together, they implemented initiatives to improve "net"-working among suicide prevention providers statewide.

StopSuicideAlaska.org

The Alaska Mental Health Board had in, 2009, successfully advocated for a one-time increment of $75,000 in Alaska Mental Health Trust receipts for a web-based suicide prevention resource. This funding, with the input from the Summit, led to the development of StopSuicideAlaska.org.

StopSuicideAlaska.org is not a website. It is a web portal that provides a forum for community groups and stakeholders to come together, share information and ideas, and support each other in suicide prevention efforts. Design and content development was the focus for FY2010, with StopSuicideAlaska.org going live in FY2011.

Given the time necessary to develop and launch the suicide prevention web portal, a companion page for StopSuicideAlaska.org was created on Facebook. Like Careline, the Council has begun to use social media outlets like Facebook to improve outreach efforts and strengthen communication with stakeholders.

Set up in May, 2010, the StopSuicideAlaska.org page on Facebook had nearly 100 members by the end of June (it now has 275 members from all over Alaska). Research, data, news, upcoming events, and words of strength and support are now constantly streaming to stakeholders through these online resources.

Outreach and Education

The Council receives a small grant from the Alaska Mental Health Trust for anti-stigma efforts. In FY2010, this funding supported print media based awareness ads. The Council also provided education, materials, and in-person discussion at a booth at the Alaska Federation of Natives convention (October, 2010). Council members spoke at regional and community events to help raise awareness about suicide, its warning signs, and the effect it has on the people left behind. Council member Barbara Franks coordinated the National Survivors of Suicide day event at the University of Alaska Anchorage in November 2009 (the second survivors' event at UAA).

⌘⌘⌘

Looking Ahead

After a year spent assessing the suicide prevention system, gathering stakeholders together, and identifying its own resources, the Council is ready to look forward at the next five (or even ten) years. Council members will use all the public comment received, the information from the Summit participants, as well as the data and information compiled and reported on here to develop a true state suicide prevention plan for Alaska. That plan will include strategies and recommendations for the State of Alaska, as well as communities and individuals, to prevent suicide.

With the August 2010 hire of a full-time assistant, and the co-location with the advisory boards most closely related to the issue of suicide, the Council can now maximize its resources to better serve the people of Alaska. Strengthening relationships with the tribal suicide prevention system, as well as non-traditional partners like law enforcement and members of the clergy, will ensure that the work of the Council stays fresh and relevant. With the help of the Governor's Office, the Council has begun active recruitment of diverse and energetic candidates for membership. Use of social media, the StopSuicideAlaska.org web portal, and other easily access communication channels will provide ongoing information and feedback from the public — and ensure that the Council stays connected to the people it serves.

⌘⌘⌘

Conclusion

This Annual Report is offered to inform Alaskans about the problem of suicide in our state, and to show how many people all over the state are working very hard to prevent suicide. A substantial financial investment in suicide prevention is being made by the State of Alaska, tribal health organizations, and the federal government. An even greater personal, emotional and spiritual investment is being made by each and every Alaskan dedicated to preventing suicide. And yet, Alaska still experiences suicide at a rate twice the national average.

We hope that this Annual Report starts conversations — in the Legislature, in classrooms, in assembly chambers, in doctors' offices, and in living rooms — about how we can better prevent suicide. The Council deliberately avoided coming to conclusions or providing answers in this report. Instead, we invite you to join us as we plan for the future and share the message that every life is valuable across Alaska.

THE MEMBERS OF THE STATEWIDE SUICIDE PREVENTION COUNCIL
William Martin, Chairman
Barbara Jean Franks, Vice-Chair
Bernard Gatewood, Officer-at-large
Melissa Stone, Recorder/Treasurer
Brenda Moore
Phyllis Carlson
Meghan Crow
Alana Humphrey
Sharon Norton
Pastor Lowell Sage, Jr.
Senator Johnny Ellis
Senator Fred Dyson
Representative Anna Fairclough
Representative Woodie Salmon
Representative Berta Gardner

APPENDIX A

STATUTORY AUTHORITY

AS 44.29.300 Council Established

(a) There is established in the Department of Health and Social Services the Statewide Suicide Prevention Council, consisting of 16 members, as follows:

(1) two members of the senate, appointed by the president of the senate, one of whom shall be a member of the majority and one of whom shall be a member of the minority;

(2) two members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the majority and one of whom shall be a member of the minority;

(3) 12 members appointed by the governor, as follows:

(A) two persons who are employed in the executive branch of state government, one of whom shall represent the Department of Health and Social Services and one of whom shall represent the Department of Education and Early Development;

(B) one member of the Advisory Board on Alcoholism and Drug Abuse;

(C) one member of the Alaska Mental Health Board;

(D) one person recommended by the Alaska Federation of Natives, Inc.;

(E) one person who is an employee of a secondary school;

(F) one person who is active in a youth organization;

(G) one person who has experienced the death by suicide of a member of the person's family;

(H) one person who resides in a rural community in the state that is not connected by road or the Alaska marine highway to the main road system of the state;

(I) one person who is a member of the clergy;

(J) one person who is enrolled in grade nine, 10, 11, or 12 of a secondary school in the state; and

(K) one public member.

(b) Members of the council appointed under (a)(1) and (2) of this section are nonvoting members.

AS 44.29.310 Term of Office

(a) The governor shall appoint the members of the council under AS 44.29.300(3)(D) - (J) for staggered terms of four years.

(b) The governor shall fill a vacancy of a member on the council appointed under AS 44.29.300(3)(D) - (J) by appointment for the unexpired part of the vacated term.

(c) Members of the council serve at the pleasure of the governor. The governor shall replace a member who, by poor attendance or lack of contribution to the council's work, demonstrates ineffectiveness as a member. In this subsection, "poor attendance" means the failure to attend three or more consecutive meetings.

AS 44.29.330 Officers and Staff

(a) The council, by a majority of its membership, shall annually elect a presiding officer and other officers it considers necessary from among its membership.

(b) The council may employ a coordinator to assist the council. The coordinator is in the partially exempt service. The coordinator shall be directly responsible to the council in the performance of the coordinator's duties. The council shall annually review the performance of the coordinator.

(c) The council may appoint an advisory panel to provide further advice on suicide prevention. The advisory panel serves at the pleasure of the council. Members of the advisory panel are not entitled to compensation, per diem, or reimbursement of travel expenses.

AS 44.29.340 Meetings

(a) The council may meet and vote, by teleconference or otherwise, as often as considered necessary by the presiding officer of the council.

(b) Seven voting members of the council participating in a meeting in person or by teleconference constitute a quorum for the transaction of business and the exercise of the powers and duties of the council.

AS 44.29.350 Duties

The council shall serve in an advisory capacity to the legislature and the governor with respect to what actions can and should be taken to

(1) improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities;

(2) broaden the public's awareness of suicide and the risk factors related to suicide;

(3) enhance suicide prevention services and programs throughout the state;

(4) develop healthy communities through comprehensive, collaborative, community-based and faith-based approaches;

(5) develop and implement a statewide suicide prevention plan;

(6) strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

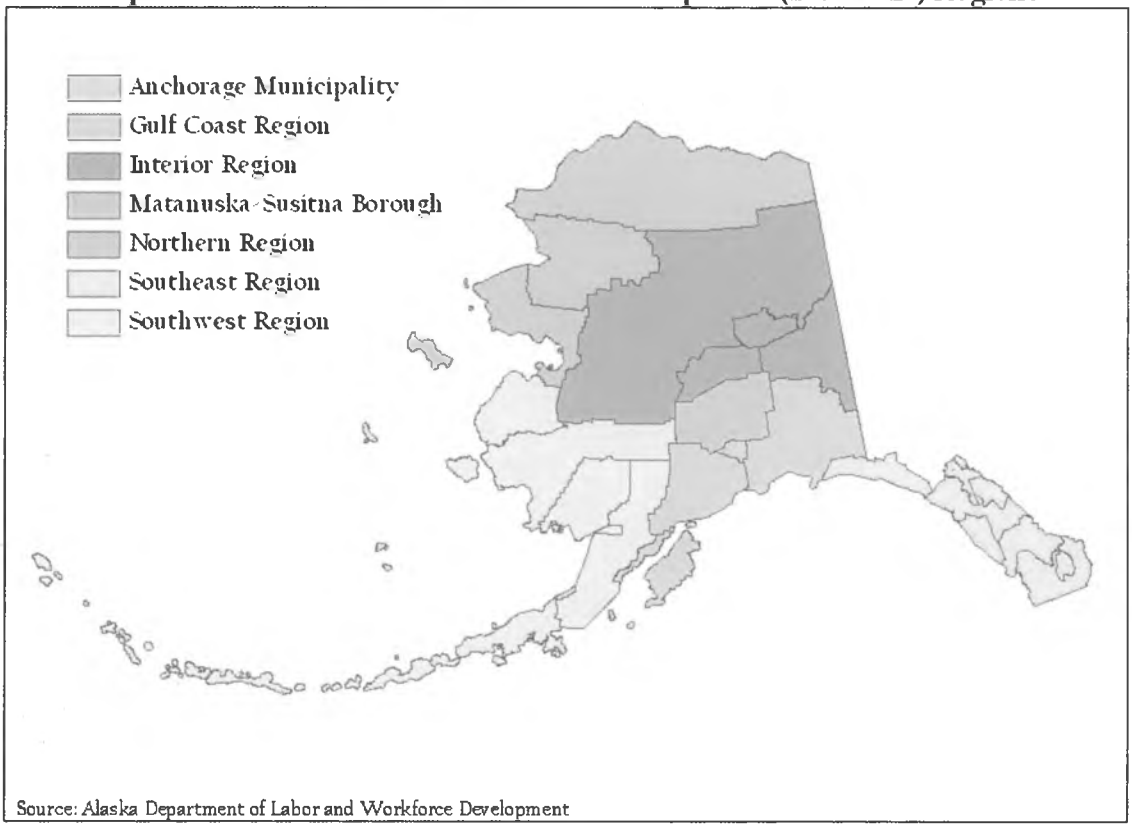
AS 44.29.360 Annual Report

The council shall annually report its findings and recommendations in a report to the governor, the president of the senate, and the speaker of the house of representatives by March 1 of each year.

APPENDIX B

MAP OF REGIONS USED BY THE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Department of Labor and Workforce Development (DOLWD) Regions



Source: Alaska Department of Labor and Workforce Development

This report was web published, resulting in reduced paper and waste and savings of approximately $3,000.00.
Printed copies, free and available upon request, are prepared in-house at a cost of approximately $3.00 per copy.

Governor Sean Parnell

Statewide Suicide Prevention Council

Kate Burkhart, Executive Director
Eric Morrison, Council Assistant
431 North Franklin Street, Suite 204
Juneau, Alaska 99801
http://www.hss.state.ak.us/suicideprevention/

2/02/11 PRESENTA-TION: DENALI FAMILY SERVICES

<TARGET><BILL></BILL><SUBJECT>2-02-11 PRESENTATION DENALI FAMILY SERVICES</SUBJECT><COMM>SHSS27</COMM></TARGET>

More about Denali Family Services
&
Little Steps Preschool

Brief History of the Organization

Denali Family Services (DFS) was incorporated in May 1995 as *Alternatives Child and Family Guidance Clinic.* At that time, the agency operated as an outpatient psychological and psychiatric provider with a child protection visitation program. In December of 1995, Denali Family Services was accepted as an Alaska Youth Initiative (AYI) provider. As an AYI provider, DFS was allowed to serve the most acute children with mental illness residing outside of psychiatric residential settings. By 1996, the agency grew from approximately 15 employees to 98 employees and provided wrap-around services for the "severely emotionally disturbed" (SED). In 1997, DFS became a child placement agency with the ability to recruit, license, train, and supervise foster homes and place children in those homes. In 2002, the agency joined in a partnership with Life Quest to provide therapeutic foster care services for that agency's AYI clients. Also, in July 2002, *Alternatives* changed its name to *Denali Family Services* to better communicate to the community the focus of its services. Denali's mission is "Supporting Children and Families through Individualized Community Based Services."

Denali Family Services (DFS) provides mental health rehabilitation services from a wrap-around model to approximately 300 clients at any one time. Approximately half of the clients we serve are under the age of twelve, with the remaining 50% in the adolescent range, particularly older teens who are aging out of the system and for many there is no natural support network. DFS provides a full range of support services, which include all of the rehabilitation services, including psychiatric care. By providing such a wide array of supports within DFS, we are able to meet the mental health needs for most of the families within our agency through a unified team, without fragmentation of services. However, the transition from adolescence to adulthood

also marks, for many of our adolescents, a transition from one system of care to another and teens aging out of the system find themselves with little or no assistance in navigating the systems designed for adults.

DFS maintains an active foster care program, licensing treatment foster homes, placing children in those homes and working in partnership with the foster parents and the DFS clinical staff to ensure the child is making progress toward his/her treatment goals. The foster care program accepts a number of placements of children in OCS custody who are returning to Alaska after receiving residential treatment in the Lower 48. Denali Family Services believes in providing as much support as possible to foster parents. DFS is one of only a few agencies that provide liability insurance coverage for foster parents. Because the behaviors of the children placed in their homes can often become destructive, foster parents need a way to have some insurance covering loss to their home or household belongings due to the omission or commission of an act by a child placed in their home. This has been viewed by foster parents as an extremely positive benefit.

Finally, DFS operates a therapeutic pre-school, "Little Steps." The goal of this program is to provide a safe structured environment where children may work on developing social competency. Little Steps, located at 545 5th Avenue in Anchorage, provides developmentally appropriate activities for children ages twelve months through five years.

Little Steps Preschool is a licensed preschool dedicated to serving young children and their families. A part of Denali Family Services (DFS), the Center operates from 7:30 am to 5:30 pm, Monday through Friday year-round. This program is the only one in Alaska that accepts children meeting the criteria for *severely emotionally disturbed (SED)* as well as typically developing children and places special emphasis on their social/emotional development. In addition to the program director and teaching staff, Little Steps has a full-time, master's level clinician located at the preschool. In order for Little Steps to best meet the needs of all of the children, the program maintains low child to staff ratios. The program is currently licensed for 60 children, is operating at capacity and presently has a one-year waiting list.

Legislative request: A one year waiting list at Little Steps in Anchorage has prompted the agency to locate a larger facility and to find suitable space in the Valley where a similar waitlist exists without a Little Steps program in operation. Finding space that can be remodeled for a preschool at a reasonable cost and that will meet child care regulations is a challenge. DFS hopes to purchase a building in at least one of the two locations. We realize capital funding is limited and we are asking for assistance from the Legislature on a down payment – not on the total purchase.

Request amount: $400,000.

LITTLE STEPS PRESCHOOL

...A GUIDED TOUR

WHAT WE ARE

- "Little Steps" is a therapeutic preschool and the only early development program in the State serving both typically developing children and children who have been diagnosed with serious emotional issues.
- Little Steps is one of only six demonstration projects in the country utilizing the Pyramid project design for enhancing the learning environment for children.
- In addition to a high staffing ratio (1 staff for every 3 children), a clinician is on site fulltime.

The early years are the "critical" years.

- Our current site has the capacity to serve 60 children.
- We have a waiting list of almost 70 children in Anchorage.
- We have a similar waitlist in the Valley and are hoping to open a "Little Steps-too" in the summer of 2011.

United Way volunteers hung Bamboo blinds to add privacy for the children.

What makes Little Steps special?

- 12 AMAZING CLASSROOM TEACHERS
- A WONDERFUL COOK
- A SPUNKY ADMINISTRATIVE ASSISTANT
- AN ALL KNOWING CLINICIAN
- …AND OF COURSE OUR WEEKLY CONSULTATIONS WITH 'DR MIKE'

Classroom Break Down

- Little Steps has four classrooms:
  - 1 for 12-24 months old
  - 1 for 2-3 year olds
  - 2 for 3-5 year olds

1'S and 2'S classroom

2'S and 3'S classroom

Individualized plans & positive behavioral support : keys to positive growth & development

3-5 year old classroom

A recipe for success:

- A positive workforce
- Providing children with structure and resources for social and emotional development

Little Steps utilizes "evidence-based practice"

- Early childhood research has shown that learning problem solving techniques early lead to positive successes in school and as adults.

To serve the children in our communities, we need:

- To open a program in the Valley
- To double our capacity in Anchorage

Program Expectations....

Healthy, creative, enthusiastic learners who communicate effectively become responsible & ethical members of our communities!

COME VISIT US SOMETIME!!

FAX: 907-465-6615

Letter Requesting ACTION on (Alaska State) Senate Bill 3

Name: Scott Heyworth

Address: PO Box 100531

Anch. AK 99510

Phone Number: (907) 277-9981

Senate Bill 3, "An Act providing for funding for school lunch and breakfast," is sponsored by Senator Bill WIELECHOWSKI and 9 other Senators (including Majority leaders Johnny ELLIS, Bettye DAVIS, and Hollis FRENCH.) This bill will directly impact the lives of 10,000 Alaskan children by increasing the reimbursement rates for school lunches by 15 cents and school breakfasts by 35 cents. This is the second time WIELECHOWSKI has sponsored such a bill and as a citizen of the Great State of Alaska I ask that it be passed because . . .

We are the richest State in the U.S.A. - $40 Billion + Cash!!
Surely we can help feed our hungry children !! ??!!
Pass SB 3 this session! Please.

Thank you for taking my thoughts into consideration. **Yes, we "ARE" – ending child hunger in America!**

Signature

1/17/11
Date

This letter campaign is organized by local citizens and is not affiliated with any politicians, political organizations or political action committees.

2/07/11 OVERVIEW: DEPARTMENT OF HEALTH & SOCIAL SERVICES; ALASKA HEALTH CARE COMMISSION REPORT

<TARGET><BILL></BILL><SUBJECT>2-07-11 OVERVIEW DEPARTMENT OF HEALTH and SOCIAL SERVICES; ALASKA HEALTH CARE COMMISSION REPORT</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

AGENDA

MONDAY, FEBRUARY 7, 1:30 PM

Butrovich Room #205

1:30 PM – Call to Order

Time:

Members Present:

PRESENTATIONS:

- DEPARTMENT OF HEALTH & SOCIAL SERVICES OVERVIEW/COMMISSIONER WILLIAM STREUR & Assistant Commissioner Alison Elgee

- ALASKA HEALTH CARE COMMISSION REPORT/UPDATE – DEBORAH ERICKSON, EXEC. DIRECTOR & DOCTOR WARD HURLBURT

ADJOURNMENT:

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

2011 Alaska Department of Health & Social Services Overview

William J. Streur, Acting Commissioner
Alison Elgee, Assistant Commissioner

Alaska Department of Health and Social Services
Organization Chart

Acting Commissioner William J. Streur

Chief Medical Officer/ Director Public Health
Ward B. Hurlburt, M.D.

- Public Health Nursing
- Epidemiology
- Chronic Disease Prevention & Health Promotion
- Emergency Programs
- Women's Children's & Family Health
- Bureau of Vital Statistics
- State Laboratory
- State Medical Examiner's Office
- Certification & Licensing

Boards, Commissions and Workgroups
- Alaska Council on Emergency Medical Service
- Regional Health Information Org.
- Electronic Health Record workgroups

(Acting Commissioner) for Medicaid & Health Care Policy
William J. Streur

HEALTH CARE SERVICES
Director: Kimberli Poppe-Smart

- Medicaid Director
- Medicaid Policy & Planning
- Medicaid financing
- Medicaid reform
- Medicaid Management Information System
- Rate Review
- Tribal Health
- Health Facility Survey
- Health Planning & Systems Development

Boards & Commissions
- Medical Care Advisory Committee
- Pharmacy/Therapeutics Committee

Public Information
Clay Butcher
Communications Manager

Legislative Relations
[illegible]

Special Assistant
[illegible]

Alaska Health Care Commission
Deborah Erickson,
Exec. Dir.

Boards & Commissions
(Behavioral Health)
- Alaska Mental Health Board
- Advisory Board on Alcoholism and Drug Abuse

(Senior & Disabilities Services)
- Governor's Council on Disabilities and Special Education
- Alaska Commission on Aging

Deputy Commissioner for Family, Community & Integrated Services
Patrick B. Helley

ALASKA PIONEER HOMES
Director: Dana Cole

Boards & Commissions
- Alaska Pioneer Homes Advisory Board

BEHAVIORAL HEALTH
Director: Melissa Stone

Boards & Commissions
- Suicide Prevention Council

CHILDREN'S SERVICES
Acting Director: Christy Lawton

Boards & Commissions
- Alaska Children's Trust

JUVENILE JUSTICE
Director: Barbara Hoffman

Boards & Commissions
- Juvenile Justice Advisory Committee

PUBLIC ASSISTANCE
Director: Dana Fitzgerald

SENIOR & DISABILITIES SERVICES
Director: Laurie Mayer

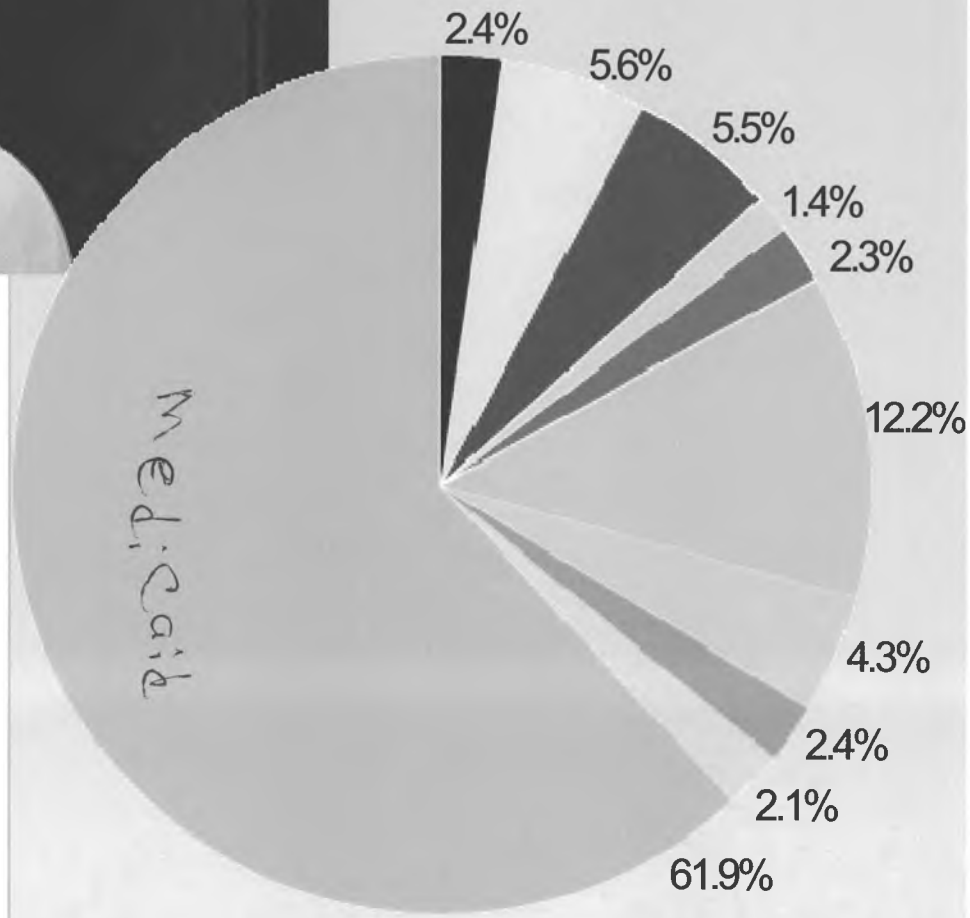
Assistant Commissioner for Finance Management Services
Alison M. Elgee

- Performance/Quality Assurance
- Audits (including Legislative Audits)
- Hearings & Appeals
- Facilities
- Administrative Services
- Budget
- Revenue
- Fiscal
- Grants & Contracts
- Information Technology
- Regulations
- Legal Services Coordination

Mission: to promote and protect the health and well-being of Alaskans

Department of Health & Social Services
Budget Highlights

Alaska Pioneers Homes	59,671.9
Behavioral Health	136,651.4
Office of Children's Services	133,317.6
Health Care Services	33,567.5
Juvenile Justice	55,619.2
Public Assistance	298,499.3
Public Health	104,882.0
Senior & Disabilities Services	57,657.6
Finance & Management Services	51,748.7
Medicaid Services	1,513,491.9
	2,445,107.1



Mission: to promote and protect the health and well-being of Alaskans

Department of Health & Social Services
Alaska Pioneer Homes

State of Alaska > Health & Social Services > Alaska Pioneer Homes

Dave Cote

Division of Alaska Pioneer Homes Director

"While preserving dignity and individuality, the Pioneer Homes are committed to providing a safe and compassionate environment to residents, with a focus on people's abilities and potential for personal growth."

News

October, 2010

The Alaska Pioneer Homes Advisory Board Southeast Tour October 2010 – Board President Banarsi Lal with Gov. Sean Parnell, first lady Sandy Parnell, and Alaska Pioneer Homes Director Dave Cote.

Our Statewide Homes

Our Main Number

1-888-355-3117

- **Anchorage**
- **Fairbanks**
- **Juneau**
- **Ketchikan**
- **Palmer**
- **Sitka**
- **Pioneer Homes Pharmacy**

508 N Hbeds

Mission: assist older Alaskans to have the highest quality of life by providing assisted living in a safe home setting which promotes positive relationships, meaningful activities, and physical, emotional, and spiritual growth

Department of Health & Social Services
Behavioral Health

State of Alaska > Health & Social Services > Behavioral Health

Melissa Witzler Stone
Director

"Partners promoting healthy communities."

Mission & Values

FRONTLINE BEHAVIORAL HEALTH
Telebehavioral Healthcare Services

Current Events & Announcements

New! **Alaska Suicide Prevention Web Portal: www.stopsuicidealaska.org.**
Check out this new statewide resource, post an event, start a group page, share resources, join a discussion, get involved!

Contact James gallanos for more information james.gallanos@alaska.gov or 907-465-8536 or 1-877-393-2287.

- Epidemiology Report on Suicides in Alaska recently released

Suicide Awareness Conference Listening Session
Indian Health Services along with the Department of the Interior are holding listening sessions across the country to learn more about the impact, causes, and current efforts to reduce and prevent suicide among Alaska native and American Indian communities. Meeting will be held in Anchorage, Egan Convention Center, 555 West

334 FT ime 11 part time

Sections

- Home
- Division Contacts

Programs

- Alaska Psychiatric Institute
- Policy & Planning
- Prevention & Early Intervention
- Program Integrity
- Treatment & Recovery

Resources

- Advisory, Advocacy, & Planning Boards
- Division Initiatives
- Documents & Publications

Mission: to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships

STATE of ALASKA
Department of Health and Social Services

Department of Health & Social Services
Office of Children's Services

State of Alaska > Health & Social Services > Office of Children's Services

Christy Lawton, Acting Director

Help us keep our children safe

OCS Practice Model

- Office of Children's Services Practice Model
  - Intake Program
  - Initial Assessment Program
  - Family Services Program
  - Resource Families Program
  - Service Array Program
- Alaska Child & Family Services Review Program Improvement Plan
  - Data Profile – Performance Gauges

Mission, Goals & Strategies

- Strengthening families:

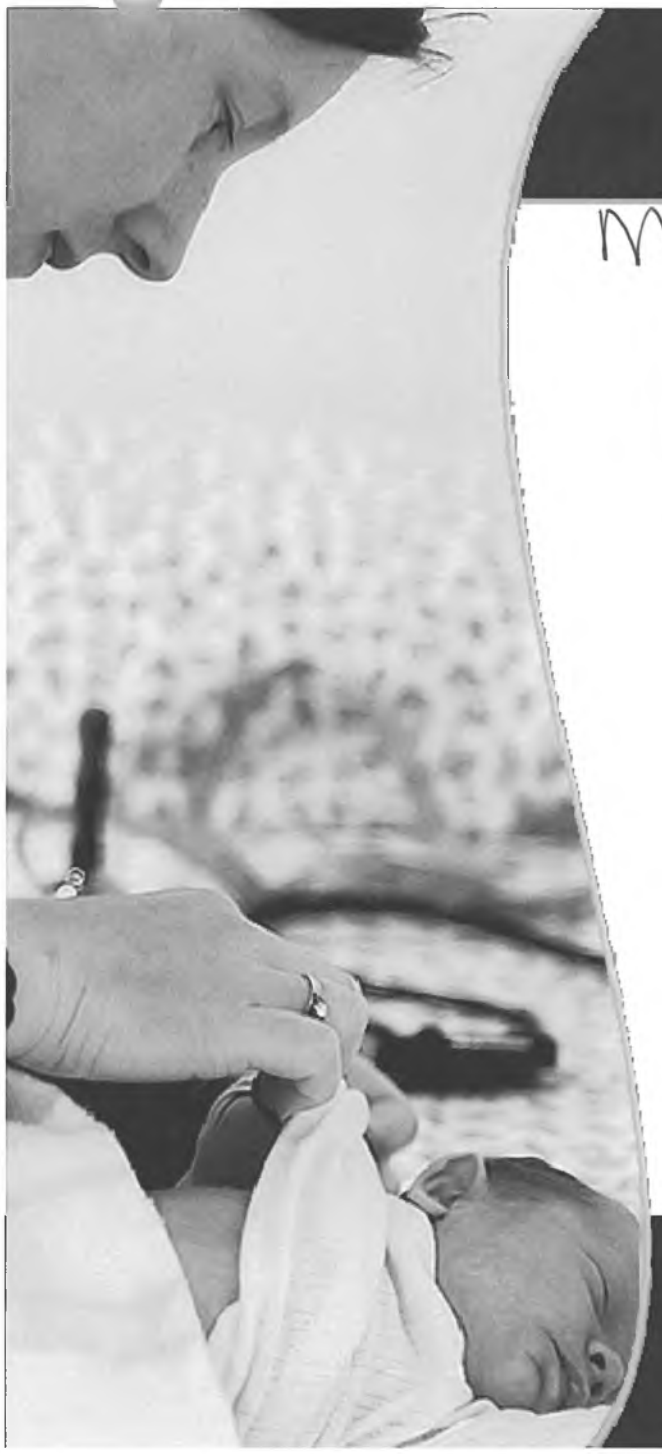
Of Interest

- Foster Care Rate Schedule
- State of Alaska Social Services Block Grant, State Fiscal Year 2011
- Parent's Rights Brochure
- Become a Foster Parent (Commercial)
- Alaska 2-1-1
- Requesting Adam Walsh Checks from Alaska
- The Pipeline - An OCS Newsletter

5th Reg for western alaska

Mission: to protect and serve Alaska's children and families

STATE of ALASKA
Department of Health and Social Services



Department of Health & Social Services
Health Care Services

MMIS

Health Care Services
Providing health coverage to Alaskans in need

State of Alaska > Health & Social Services

Kimberli Poppe-Smart
Director

Useful Links

- Contacts
- Director's Office
- Alaska Scorecard: Key Issues Impacting Trust Beneficiaries
- Directory of Alaska's Health Care Sites
- Certificate of Need
- Certification
- Community Health Centers
- Critical Access Hospitals (CAH)
- Health insurance – Alaska's Uninsured
- Help Beyond Medicaid
- HIPAA Information
- Medicaid State Plan
- Medical Care Advisory Committee
- Orthodontia guidelines
- Payment Error Rate Measurement (PERM)

Programs

- Alaska Crash Outcomes Pilot Project
- Adult Dental Care Program
- Alaska Office of Rural Health
- Alaska Primary Care Office
  - Loan repayment programs
  - Community Health Centers
  - Health Prof. Shortage Areas
  - Medically Underserved Areas
- Case Management Services
- Certificate of Need
- Chronic & Acute Medical Assistance (CAMA)
- Community Health Aide Training and Supervision (CHATS) Grants
- Comprehensive Integrated Mental Health Plan (Moving Forward)

Mission: to provide health coverage to Alaskans in need

STATE of ALASKA
Department of Health and Social Services

Department of Health & Social Services
Juvenile Justice

State of Alaska > Health & Social Services > Juvenile Justice

Barbara Henjum
Director

479 Staff

Of Interest

- Come work for us! Check out our new recruitment videos!
- AJJAC 2010 Annual Report
- Gang Reduction & Intervention Network (GRAIN) assesses Fairbanks gang activity with survey
- Fact Sheet: Preventing abuse at McLaughlin Youth Center Our plan for addressing victimization in state youth facilities
- Juvenile Justice's Year in Review
- DJJ FY09 Statistics
- Disproportionate Minority Contact in Alaska
- Success Stories
- *Threat Security and Safety: An Assessment of Security Needs for Alaska's Juvenile Detention Facilities*
- Restorative Justice System
- Information for Victims of Juvenile Crimes
- Who's Who in the DJJ State Office

16 P. probation officer

Our Locations

- Map of DJJ Locations
- List of DJJ Locations
- Youth Facilities
- Probation Services

What We are Doing

- Statistics
- Publications
- Performance Measures
- Capital Projects

About Us

- The Director
- DJJ Report Card
- DJJ Contacts
- AJJAC and DMC
- JOMIS

Mission: We are committed to holding youths accountable for their actions while also protecting communities, repairing the harm to victims and working to ensure that youths gain necessary skills to function successfully in society

Department of Health & Social Services
Public Assistance

State of Alaska > Health & Social Services

Ron Kreher
Acting Director

Director's Office

Our Mission

Proposed Regulations and Public Notices

Fraud Control

Online Manuals

Headlines...

- **9/24/10 Press Release: Tainted baby formula found in Alaska**
- **9/24/10 Abbott Voluntary Recall of Certain Similac Brand Powder Infant Formulas**
- **9/23/10 Abbott recall of powdered Similac infant formula - Fact Sheet (PDF)** Concentrate liquid and Ready-To-Feed products are not affected.
- **Text4Baby** is a new resource for pregnant mothers. This is a service designed to provide free, health –related text messages to pregnant women and new mothers. Women who sign up for this service by texting BABY to

For Employers

- Job Start - Money for your Business!
- Tax Credits for Employers
- Calendar of Job Fairs

For Customers

- Contact Us!
- Work for us!
- AK Job Centers Phone/Fax/TDD
- Alaska Quest Card
- Prescription Drug Resource List
- Printable Application for Public Assistance
- Printable Application for Senior Benefits
- What changes should be reported
- Program Manuals

Programs

- Adult Public Assistance
- Child Care
- Chronic and Acute Medical Assistance
- Denali Kidcare
- Family Nutrition
- Food Stamps
- General Relief Assistance
- Heating Assistance
- Medicaid
- SeniorBenefits
- Temporary Assistance

Get Help...

- ...finding a job?
- ...with Child Care?
- ...with Child Support?
- ...with heating bills?
- ...with Food Assistance?
- ...for elderly or disabled?

S3S Staff Processing time decreased

Mission: We promote self-sufficiency and provide basic living expenses to Alaskans in need

STATE of ALASKA
Department of Health and Social Services

Department of Health & Social Services
Public Health

Prevention. Promotion. Protection.

State of Alaska > Health & Social Services > Public Health

Ward B. Hurlburt, M.D., MPH
Chief Medical Officer
Director, Division of Public Health

Learn more about Alaska's public health centers... *your partners in good health.*

Announcements

- Subscribe to **Public Health Announcements**
- Tests results released from sulfolane garden project
- 2011 Alaska Immunization Program Conference Science+Safety+Cents: Making it All Add Up
- Behavioral Risk Factor Surveillance System: Survey Highlights 2009
- 'Expedited partner therapy' a new tool to reduce STDs in Alaska
- Expedited Partner Therapy Recommendations for Alaska Providers
- An Assessment of Expedited Partner Therapy for Enhanced Gonorrhea and Chlamydia Control in Alaska
- Obesity Facts: Availability of Snacks in Alaska Schools
- 2011 Clinic Schedule

Public Health

- Public Health Home
- Certification & Licensing
- Chronic Disease Prevention & Health Promotion
- Emergency Programs: Preparedness, EMS and Trauma
- Epidemiology
- Laboratories
- Public Health Nursing
- State Medical Examiner
- Vital Statistics
- Women's, Children's & Family Health

Useful Links

- About the Division

SOA staff

Mission: To protect and promote the health of Alaskans

Department of Health & Social Services
Senior & Disabilities Services

tate of Alaska > Health & Social Services > Senior & Disabilities Services

eniors • Adults with Physical Disabilities and Seniors on Medicaid Waivers • Persons with Developmental Disabilities • ulnerable Adults • Assisted Living Providers

Duane Mayes
Director

About Us

- SDS Org Chart
- Our Service Principles

CMS Review

- SDS met a major benchmark. set with the Centers for Medicare and Medicaid Services (CMS): staff completed past-due Medicaid waiver participant re-assessments by Oct. 15. Medicaid waiver programs are still accepting new applicants. **Please follow this link for more information.**
- **Please follow this link for more information on the Corrective Action Plan**

Headlines

- **SDS E-Alerts Moving to Listserv.** To keep receiving SDS E-Alerts through the

Sections

- **Adult Protective Services**
- **Aging and Disability Resource Centers**
- **Care Coordination Training and Resource Materials**
- **Developmental Disabilities**
- **Grant Services**
- **Medicare Information Office**
- **Nursing Facility Transition Program**
- **Personal Care Assistant Program**
- **Systems Development and Support**
- **Provider Certification and Training**
- **Quality Assurance Program**
- **Research and Analysis Team**

Waivers

Mission: We serve Seniors • Adults with Physical Disabilities and Seniors on Medicaid Waivers • Persons with Developmental Disabilities • Vulnerable Adults • Assisted Living Providers

Department of Health & Social Services
Financial Management Systems

Alison Elgee
Assistant Commissioner

Announcements

- Budget Presentation Materials
- DHSS FY10 Operating Grants
- DHSS FY11 Budget Overview
- Facilities Funding Allocation Plan '10
- Capital Grants Status Report '10

Reports & Publications

- Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2009-2029
- Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2008-2028
- Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2007-2027
- Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2006-2026
- Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2005-2025

Sections

- Home
- Assistant Commissioner
- Audit
- Budget
- Facilities
- Grants & Contracts
- Human Resources
- Information Services
- Revenue & Finance
- Hearing & Appeals

Links

- Commissioners Office
- Division Contacts
- Program Overview
- Safety Plan
- Legislative Reports
- Streamline Newsletter

Conclusion

- Questions?

Alaska Department of Health & Social Services

Vision: *All individuals and families are healthy, safe & productive.* • **Mission:** *To promote and protect the health and well-being of Alaskans.*

Substance Abuse & Mental Health

Substance abuse and mental illness affect every family and community in Alaska. They are a contributing factor in suicides, crime, unemployment, domestic violence, child abuse, school dropouts, juvenile delinquency, emergency room visits, physical health, etc. We need to prevent, intervene early, treat and help people recover from substance abuse through public/private partnerships, performance-based standards and funding, and long-term strategies.

Major strategies include:

- Prevention and Health Promotion: Implement strategies to change common influences among children, youth, adults and communities to develop healthy attitudes, beliefs and behaviors. Target areas include underage drinking, binge drinking, heavy drinking, suicide, and domestic and sexual violence.
- Early Intervention: Integrate primary care with behavioral health (mental health and substance abuse); screen all youth in the juvenile justice system for substance abuse; universal screening for behavioral health conditions; implementation of general mental health services.
- Treatment: Develop and implement family-based treatment services; increase access to substance abuse services; implement involuntary treatment and secure detoxification services; ensure adequate response to behavioral health emergencies; increase use of tele-behavioral health; promote integration of behavioral health and primary care.
- Recovery: Support array of recovery services using performance-based standards and funding. Continue to integrate mental health and substance abuse services into a behavioral health system.

Health and Wellness

Many Alaskans lead less happy and less productive lives, and many die prematurely each year, because of disability and death caused by obesity, tobacco, alcohol abuse, injuries, diabetes, cancer, heart disease, and vaccine-preventable diseases. The economic impact of chronic disease alone in Alaska is staggering: an estimated $600 million is spent annually on direct medical services and $1.9 billion in lost productivity. Most of this is attributable to personal choice involving diet, physical activity and tobacco use — and is preventable. We can do a better job of screening, diagnosing and treating these conditions.

Major strategies include:

- Prevention and Health Promotion: Implement evidence-based, population-based health promotion efforts to reduce obesity, chronic disease, and injuries. Increase primary prevention approaches, including those targeting increased self responsibility. Educate about and improve methods for screening, diagnosis, and early treatment of conditions and behaviors most detrimental to the physical and mental health of Alaskans.
- Disease Control: Detect epidemics and control the spread of infectious diseases, in particular influenza, tuberculosis, hepatitis C, HIV and sexually transmitted diseases, through screening, testing, diagnosis and treatment. Immunize children and adults against vaccine-preventable diseases.
- Access: Use Public Health nurses to ensure all possible resources are made available in Alaska communities. Expand medical examiner services statewide. Increase community partnerships to improve local capacity for primary care and preventive health services.
- Emergency Response and Preparedness: Build capacity in Alaska's statewide trauma system. Work with communities to prevent health emergencies and prepare for pandemics and natural disasters.
- Environmental Health Impacts: Provide medical, toxicological, and public health expertise to individuals and communities to enable them to reduce hazards from environmental exposures. Develop credible, science-based, Alaska-specific information about environmental exposure levels and potential impact to human health.

Health Care Access and Delivery

Through the state-run Medicaid program, health insurance coverage is provided to approximately 18 percent of Alaska's population. Similar to other states, Alaska's Medicaid program is being challenged to meet increasing demands for costs and services. However, Alaska's rate of growth of the more medically needy in the Medicaid population is out-pacing most other states. A compounding factor unique to Alaska is the fragmentation of the health care delivery system that exists related to geography, active Tribal and Veterans Affairs health care systems, and other factors. By utilizing technology tools, strengthening statewide policies and embracing state priorities for action with partners such as the Health Care Commission, and supporting health care workforce development, the health care delivery system and access to care will align with increasing demand.

Major strategies include:

- Technology for Sustainable and Effective Health Care Delivery:
  - Implement a new Medicaid Management Information System for enhanced, effective program management through timely, data-driven decisions that improve health care utilization analysis and promote decisions that support sustainability of the program.
  - Reduce erroneous payments, and monitor payment trends for more accurate projections in an environment of rapidly increasing costs.
  - Create a health information exchange that will facilitate the communication of health information sharing, improve continuity of care and potentially reduce costs related to duplicate testing and referrals.
  - Convert providers throughout the state to electronic health records to make records more accessible for health care service delivery, to more effectively and efficiently monitor health care use and quality of care.
- Workforce development:
  - Partner with the University of Alaska and others to create new training opportunities for health professionals throughout the state.
  - Create professional residency programs for "hard to attract" health care fields such as psychiatry.
  - Develop alternative approaches to health care delivery in rural Alaska.
- Enhanced Management of High Health Needs
  - Improve coordination of care for individuals with the highest needs and chronic health conditions.
  - Analyze care management options and implement the Health Care Commission's recommendations for managing care, cost containment and improving health outcomes and quality.

Sustainable Long-Term Care Delivery System

Medicaid is the primary payer for long-term care services for the elderly and disabled. In Alaska, those services are delivered in a fragmented fee-for-service environment. Alaska has been very successful in making services available in homes and communities, thereby delaying or avoiding the higher cost and more restrictive institutional care for many individuals. Challenges remain, however, in the availability of home and community-based services in rural areas; long-term institutional care for the individuals with very high needs that cannot be met in the community; standardization of the quality of care delivered; and comprehensive oversight of the health and welfare of these participants.

Major strategies include:

- Identification and Coordination of Health and Welfare Needs
  - Implement quality assurance strategies that set forth standards of performance for home and community-based care providers and remediation responses for failure to meet those standards.
  - Integrate automated solutions that provide for real-time care plan development and amendment to meet change in condition of the participant and to conduct risk assessments.
- Align cross-division efforts to manage provider enrollment, certification, compliance and performance oversight.
- Train and oversee the performance of care coordinators who have the role of continuous monitoring of health and welfare needs of waiver program participants.
- Integrate recipient feedback on analysis of the efficacy of home and community based programs.

- Develop integrated pro-active and reactive programs of safety related to complaints and reports of harm received by Adult Protective Services, Long Term Care Ombudsman, Licensing and Certification and Senior and Disabilities Services.
- Increase utilization of Aging and Disability Resource Centers as referral sources to meet the needs of those receiving services in their home and community settings.

- Promote a service array that meets the needs of underserved who require long term care services
  - Collaborate with providers to develop sustainable options for institutional care that meets the needs of those very complex individuals whose needs may not be safely met in the community setting;
  - Improved coordination of services to individuals utilizing the general relief program to promote greater self-responsibility and self-reliance where appropriate;
  - Provide continued support to individuals who do not qualify for waiver services but need supports through continued grant opportunities;
  - Create sustainable solutions through partnerships with the Pioneer Homes, Senior and Disabilities Services, Medicaid and Behavioral Health to address the needs of individuals with long-term needs related to complex behavioral issues and cognitive deficits such as Alzheimer's disease and other dementias.
- Develop Integrated and Comprehensive Model of Care
  - Evaluate opportunities provided by the federal government to manage the benefits of dually eligible individuals.
  - Design a risk-based long-term care management program to improve care coordination and incorporate disease management strategies.

Vulnerable Alaskans

We must work to ensure that Alaska families are safe and communities are equipped to help our citizens thrive. When our neighbors struggle, appropriate supports should be in place to prevent progressively worsening circumstances. By focusing on family-centered services we can better meet the needs of our most vulnerable citizens and their families. Developmentally disabled children and adults should have access to quality services and supports, and individuals and families should receive the kind of financial and vocational supports they need to be contributing members of society.

Major Strategies Include:

- Protective Services: Provide effective and timely protective services to vulnerable children and adults experiencing, or at risk for, neglect, abuse and exploitation in an environment where more timely and effective reporting by providers and community members is occurring. Forge relationships with community partners to develop proactive measures to reduce and eliminate risks to the health and welfare of vulnerable children and adults.
- Domestic Violence and Sexual Assault: Strengthen behavioral health programs to address family violence prevention and to provide treatment for alcohol and substance abuse, often an underlying cause of DVSA.
- Suicide Prevention: Target suicide prevention efforts to those individuals and communities most in need.
- Bring the Kids Home Initiative: Continue efforts to develop the infrastructure within the state to support the needs of children who have previously been sent out of state to receive services and to keep youth in state.
- Families First Initiative: Expand this project which is designed to help families leave the public assistance rolls and find employment through coordination of services between state agencies to assure that services are designed to meet family needs vs. individual program requirements.

Alaska Health Care Commission's 2010 Report

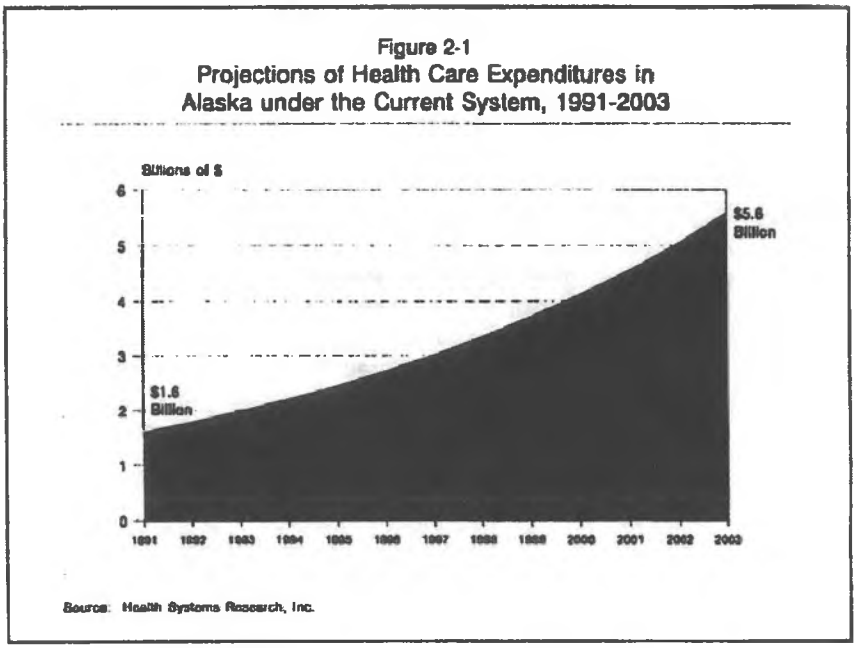
Presentation to the Senate HSS Committee

Deborah Erickson, Executive Director
Ward Hurlburt, MD, MPH, Chair

February 7, 2011

A Brief History of Health Reform Attempts in Alaska...

1987 – 1988	Governor's Interim Health Care Commission
1991 – 1993	Health Resources & Access Task Force
1993 – 1994	Commonwealth North (CWN) Report
2003 – 2005	CWN Alaska Health Care Roundtable
2007	Alaska Health Strategies Planning Council



From Health Resources and Access Task Force 1993 Report

3

Significance of Health Care to SOA

- State Operating Budget ($7.3 B (FY 11; w/o debt))
  - **Medicaid** **$1.4 B** **(DHSS $2.3 B)**
  - Education 1.4 B
  - Transportation .7 B
  - University of Alaska .8 B
  - Public Safety .2 B
  - Courts .1 B
  - Corrections .3 B

4

Alaska Health Care Commission

- Created by Governor Palin under Admin Order # 246
  - Convened February 2009 – January 2010
  - Released 2009 Report 1/15/10
  - Terminated with release of report
- SB 172 established Commission in statute (AS 18.09.010)
  - Passed by the Legislature April 2010
  - Signed into Law by Governor Parnell June 2010
  - New members appointed September 2010
    - Transition clause retained former members
  - Convened October 2010
  - Released 2010 Report 1/15/11

5

Alaska Health Care Commission

AS 18.09.010

Purpose:

Foster development of a statewide plan to address quality, accessibility and availability of health care for all citizens of the state

Duties:

- State health planning and coordinating body
- Foster development of:
  - Comprehensive statewide health care policy
  - Strategy for improving the health of Alaskans
- Annual Report due to Governor and Legislature January 15

6

Membership

11 Voting Members *(New seats added by SB 172 italicized)*

- DHSS Chief Medical Officer – designated Chair ***Ward Hurlburt, MD, MPH***
- Tribal health community ***Valerie Davidson***
- Statewide chamber of commerce ***Wayne Stevens***
- Alaska State Hospital & Nursing Home Association ***Patrick Branco***
- Health care provider ***Larry Stinson, MD***
- Health insurance industry ***Jeff Davis***
- Health care consumer ***Keith Campbell***
- *Primary care physician* ***T. Noah Laufer, MD***
- *Alaska Mental Health Trust Authority* ***Emily Ennis***
- *Community health centers* ***David Morgan***
- *U.S. Dept. of Veterans' Affairs health care industry* ***Col. Paul Friedrichs, MD***

3 Ex-Officio Members

- House of Representatives ***Wes Keller***
- Senate ***Donny Olson, MD***
- Office of the Governor ***Linda Hall***

7

8

Develop Vision

Vision

*Alaska's health care system produces improved **health** status, provides **value** for Alaskan's health care dollar, delivers consumer and provider **satisfaction**, and is **sustainable**.*

Reform Goals

I. Increased Access
II. Controlled Costs
III. Improved Quality
IV. Prevention-Based

(II. and III. } VALUE)

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

9

Describe Current State

I. Description of System (2009 Report)

II. Overview of Federal Reform/Impact on AK (2010)

III. Analysis of Current Conditions (planned for 2011)
   A. Cost Analysis (total expenditures; services & payers; cost drivers)
   B. Price Comparison Study
   C. Health Status Assessment

IV. Analysis of Current Conditions (potential for 2012?)
   D. Quality of Care Study (utilization, efficiency, appropriateness, effectiveness of care)

10

Describe Current State

I. Description of System (2009 Report)
- How Health Care in Alaska is Delivered & Funded
- Issues Identified:
  - High, Rising & Unsustainable Cost of Care
  - Inadequate Insurance Coverage
  - Logistical Challenges
  - System Fragmentation & Duplication
  - Workforce Shortages & Maldistribution
  - Health Status, Health Behaviors & Demographics
  - Leadership Challenges
  - Health Information Technology Development
  - Specific Medicare Access Problem

11

Describe Current State

III. Analysis of Current Conditions (planned for 2011)

A. **Cost Analysis (total expenditures; services & payers; cost drivers)**

B. **Price Comparison Study**

C. Health Status Assessment

IV. Analysis of Current Conditions (potential for 2012?)

D. **Quality of Care Study (efficiency, appropriateness, effectiveness of care)**

Variables Contributing to Cost of Health Care

Cost (total expenditures) =

Price (per process) x **Utilization**

Utilization =

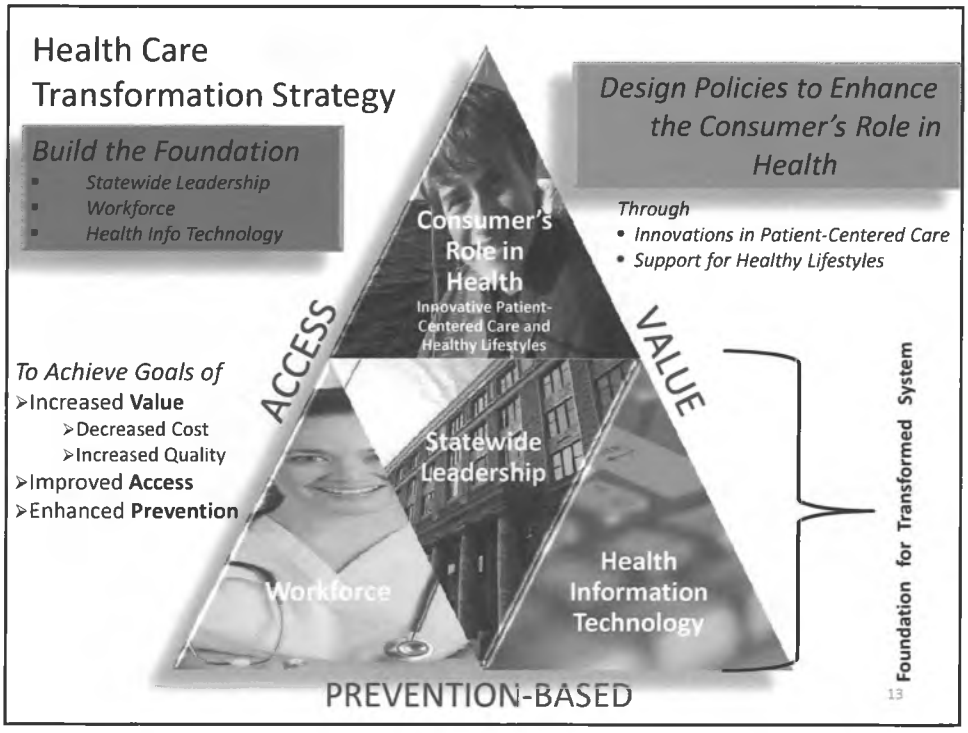
Conditions

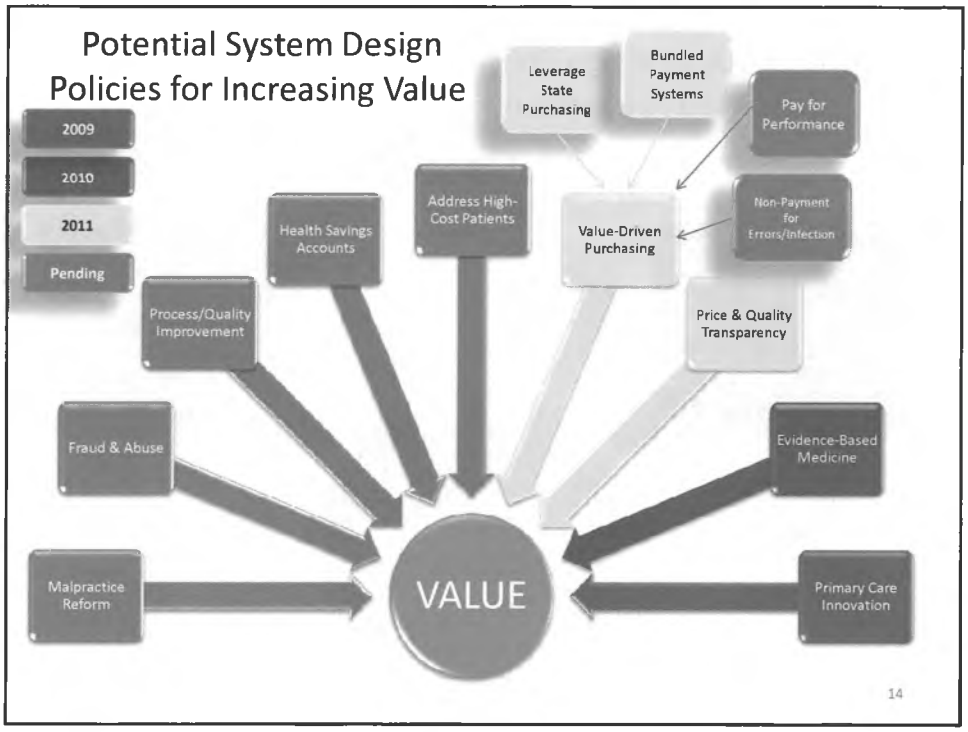
X **# Episodes of Care** /Condition

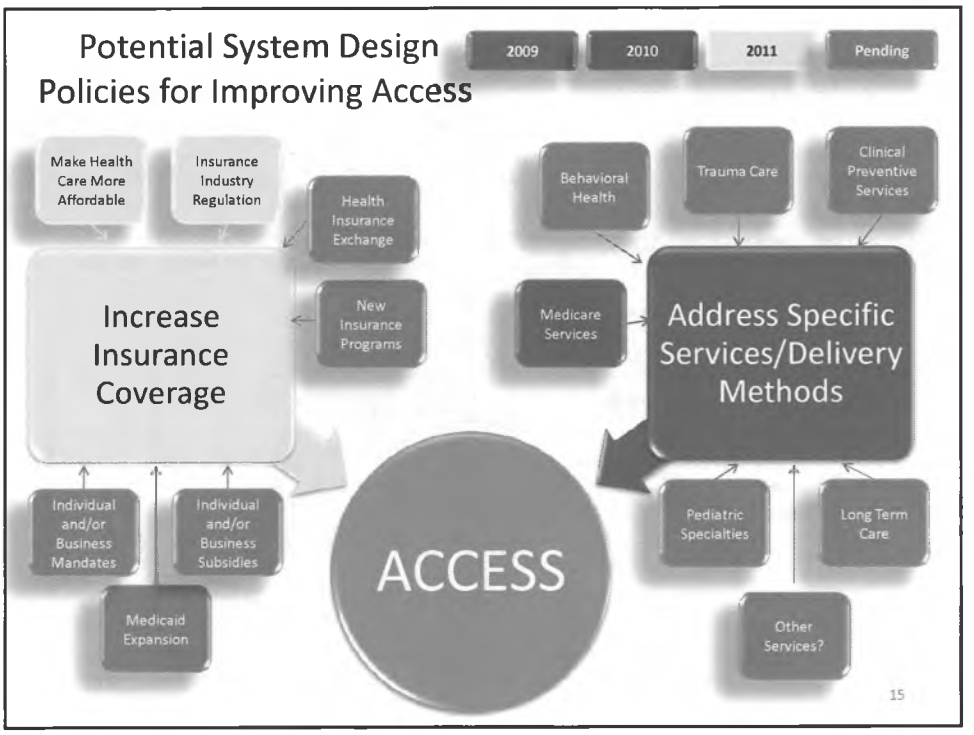
X **# of Services** (by type)/Episodes of Care

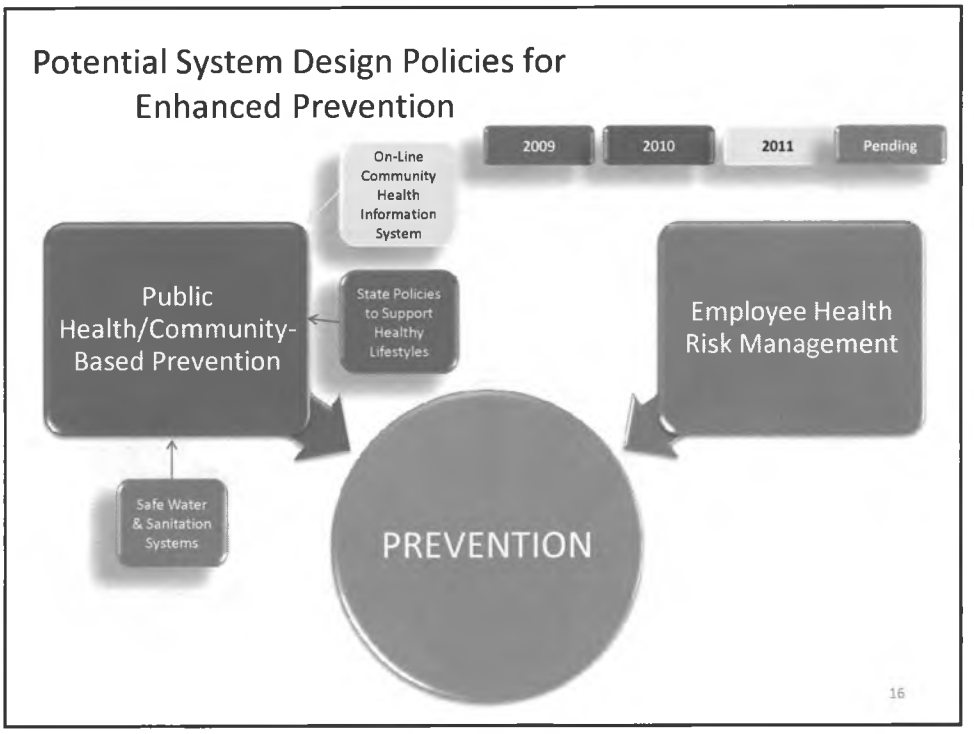
X **# of Processes** /Service

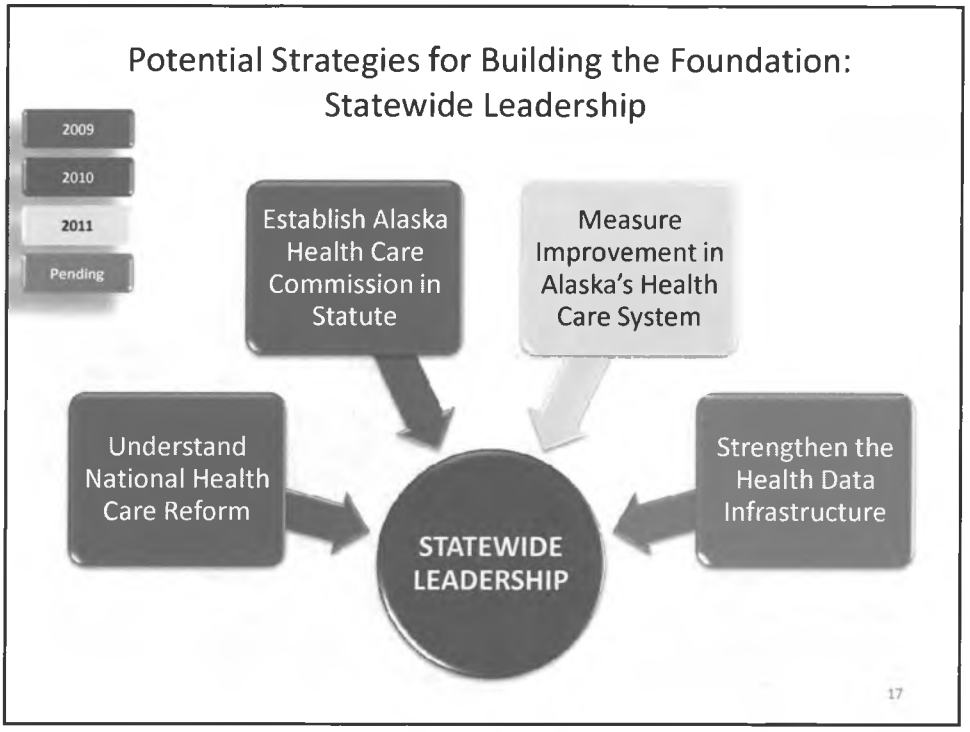
12

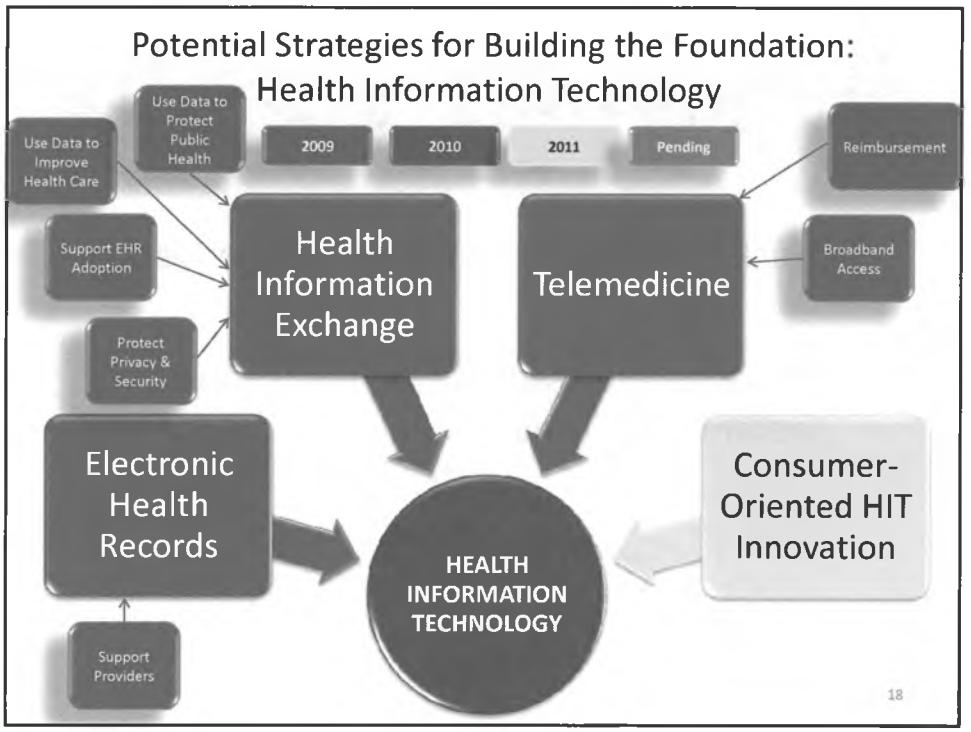

Health Care Transformation Strategy
Build the Foundation
Statewide Leadership
Workforce
Health Info Technology
Design Policies to Enhance the Consumer's Role in Health
Through
Innovations in Patient-Centered Care
Support for Healthy Lifestyles
Consumer's Role in Health
Innovative Patient-Centered Care and Healthy Lifestyles
ACCESS
VALUE
Statewide Leadership
Workforce
Health Information Technology
Foundation for Transformed System
To Achieve Goals of
Increased Value
Decreased Cost
Increased Quality
Improved Access
Enhanced Prevention
PREVENTION-BASED
13


Potential System Design Policies for Increasing Value
2009
2010
2011
Pending
Leverage State Purchasing
Bundled Payment Systems
Pay for Performance
Address High-Cost Patients
Health Savings Accounts
Value-Driven Purchasing
Non-Payment for Errors/Infection
Process/Quality Improvement
Price & Quality Transparency
Fraud & Abuse
Evidence-Based Medicine
Malpractice Reform
VALUE
Primary Care Innovation
14

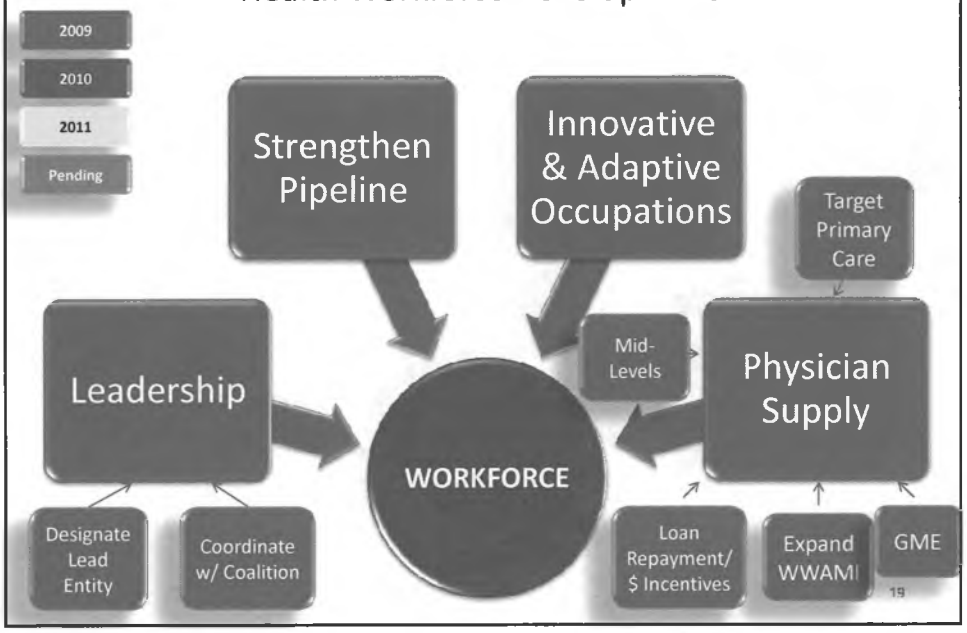

Potential System Design Policies for Improving Access
2009
2010
2011
Pending
Make Health Care More Affordable
Insurance Industry Regulation
Health Insurance Exchange
New Insurance Programs
Increase Insurance Coverage
Individual and/or Business Mandates
Individual and/or Business Subsidies
Medicaid Expansion
Behavioral Health
Trauma Care
Clinical Preventive Services
Medicare Services
Address Specific Services/Delivery Methods
Pediatric Specialties
Long Term Care
Other Services?
ACCESS
15


Potential System Design Policies for Enhanced Prevention
2009
2010
2011
Pending
On-Line Community Health Information System
Public Health/Community-Based Prevention
State Policies to Support Healthy Lifestyles
Safe Water & Sanitation Systems
Employee Health Risk Management
PREVENTION
16


Potential Strategies for Building the Foundation:
Statewide Leadership
2009
2010
2011
Pending
Establish Alaska Health Care Commission in Statute
Measure Improvement in Alaska's Health Care System
Understand National Health Care Reform
Strengthen the Health Data Infrastructure
STATEWIDE LEADERSHIP
17


Potential Strategies for Building the Foundation:
Health Information Technology
Use Data to Protect Public Health
Use Data to Improve Health Care
2009
2010
2011
Pending
Reimbursement
Support EHR Adoption
Health Information Exchange
Telemedicine
Broadband Access
Protect Privacy & Security
Electronic Health Records
Consumer-Oriented HIT Innovation
HEALTH INFORMATION TECHNOLOGY
Support Providers
18

Potential Strategies for Building the Foundation: Health Workforce Development



Measure Progress

- ✓ Track Implementation of Recommendations
- ✓ Measure Improvement in Health Care System Over Time

20

Potential Health Care System Improvement Measures

I. Increase Access
- Percent of Alaskans Uninsured
- Percent of Alaskans who have a specific source of on-going care
- *Measure of insurance affordability?*
- *Indicator of workforce supply?*

II. Control Costs
- Annual growth rate in total health system expenditures in Alaska
- Annual growth rate in Alaska's Medicaid expenditures
- Impact on Alaska's state budget: Annual change in spending and revenue; net savings
- *Measure of provider revenue based on value rather than volume*

III. Safe, High-Quality Care
- Percent of population receiving key preventive services
- Percent of Alaskans with chronic conditions controlled
- Percent reduction in gap between benchmark and actual levels of quality
- Percent reduction in gap between benchmark and actual levels of safety

IV. Focus on Prevention
- Percent of Alaskan homes with safe water and wastewater systems
- Percent of Alaskans reporting health risks
  - Percent of Alaskans who smoke cigarettes
  - Percent of Alaskans who are obese or overweight
  - Percent of Alaskans who are binge drinkers
- Percent of Alaskans with moderate to severe depression
- Death rate among Alaskans due to injury (intention and unintentional)

21

2010 Report

- **Introduction** – Background, Purpose, Planning Framework, 2010 Activities
- **Description of Current Condition of Alaska's Health Care System**
  - Summarizes 2009 Information and Findings
  - New 2010 Information: Federal Reform in AK
  - Study Plans for 2011
    - Health Care Spending & Cost Drivers in Alaska
    - Health Care Pricing & Reimbursement in Alaska
    - Health Status of Alaskans
    - Services: Long Term Care; Trauma Care
- **Recommendations for Health Care Transformation**
  - Status of Implementation of 2009 Recommendations
  - New 2010 Recommendation: Evidence-Based Medicine
  - Strategies for Consideration in 2011:
    - Price & Quality Transparency
    - Value-Driven Purchasing (Payment Bundling; Leverage State Purchasing)
    - Insurance Regulations
    - On-Line Community Health Information System
    - Measure Improvement in Alaska's Health Care System
    - Consumer-Oriented Health Information Technology Innovation

22

Status of 2009 Recommendations

2010 Activities to Strengthen Consumer's Role

- Support Healthy Lifestyles and Create Culture of Wellness
  - *"Choose Respect" Initiative launched by Gov. Parnell March 2010*
  - *Alaskans taking on Childhood Obesity Collaborative MOA July*
  - *Alaska Food Policy Council Created*
  - *$375.0 GF appropriated to DHSS/DPH for Obesity Prevention/Control*
  - *StopSuicideAlaska web portal created*
- Develop Patient-Centered Primary Care Model
  - *DHSS received federal grant for PC Medical Home pilots*
  - *Southcentral Foundation PCC 1st practice in AK to achieve NCQA recognition – others following suit*
  - *AK Primary Care Association launched initiative to support member clinic transition to Patient-Center Medical Home model*

23

Status of 2009 Recommendations

2010 Activities to Foster Statewide Leadership

- Invest in Health Policy Infrastructure to Respond to National Reform
  - *SOA engaged in lawsuit regarding constitutionality*
  - *Commission tracking; high-level impact analysis*
- Establish Permanent State Health Policy Body
  - *Commission established in statute (AS 18.09.010) with passage of SB 172*
  - *Members appointed September 2010; Convened October 2010*

24

Status of 2009 Recommendations

2010 Workforce Development Activities

- Make health care workforce development a priority
- Strengthen the pipeline of future workers
- Explore strategies for innovation and adaptation
- Designate single, coordinating entity for workforce planning

  - *Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan" – adopted by the Alaska Workforce Investment Board May 2010*
  - *Alaska Department of Labor & Workforce Development received federal grant to develop strategic plan for health workforce development*

Status of 2009 Recommendations

2010 Workforce Development Activities

- Increase Supply of Primary Care Physicians by
  - Supporting educational loan repayment/financial incentive program
  - Expand WWAMI as resources allow
  - Support primary care residency program development (continue supporting family medicine residency, support development of pediatric, psychiatry, and internal medicine residencies)

  - *Legislation to develop state loan repayment/financial incentive program did not pass in 2010*
  - *Pediatric and psychiatry residency programs planned – ready for implementation in 2012*
    - *Psychiatry residency will require state financial support*

Status of 2009 Recommendations

2010 Activities to Deploy Health Information Technology

- Support Health Information Technology (HIT) Adoption & Utilization; Ensure Privacy & Security
  - *DHSS awarded $3 M contract to Alaska eHealth Network (AeHN) to develop Alaska's Health Information Exchange (HIE) – AeHN is designated entity responsible for privacy & security*
  - *AeHN awarded HIE vendor contract to Orion Health*
  - *AeHN received $3.6 M federal grant to establish HIT Regional Extension Center*
  - *Alaska EHR Alliance selected two EHR vendors for Alaska providers*
  - *2009 Provider EHR Survey Updated*
  - *Two hospitals began offering EHRs at reduced prices for affiliated providers*
  - *University of Alaska created two HIT certificate training programs*
  - *DHSS planned implementation of Medicaid EHR Incentive Program*
- Expand Broadband Telecommunication Infrastructure
  - *Connect Alaska chartered – new non-profit formed to expand broadband in Alaska*
  - *1st web-based statewide broadband availability map launched in September*
  - *$117 M in federal grants received by broadband service providers to expand and improve connectivity in rural Alaska*
  - *257 rural health clinics in Alaska received FCC subsidies for telecommunications/Internet access*
- Develop Reimbursement Mechanisms for Telemedicine

Status of 2009 Recommendations

2010 Activities to Improve Medicare Access

- Improve the supply of primary care providers
- Support Federally Qualified Health Center (FQHCs) and Rural Health Clinics (RHCs)
- Request relief from Federal Reimbursement Inequities and Administrative/Audit Burden
- Develop Programs of All-Inclusive Care for the Elderly (PACE)
  - *New Medicare Clinics started/planned*
    - *Mat-Su Community Medicine opened in Wasilla in November*
    - *Providence Senior Care Center scheduled to open in January 2011*
    - *Alaska Medicare Clinic, Inc. received $1 M state capital grant to support start-up*
  - *Clinic/Capacity Expansion supported: Anchorage Neighborhood Health center received new $6 M state capital grant (in addition to $10 M received earlier) plus new $8 M federal grant to support clinic*
  - *Health care organizations in Anchorage are studying feasibility of PACE*
  - *Sen. Begich included amendment in the Affordable Care Act*

New 2010 Recommendations

Foster the Use of Evidence-Based Medicine

- Encourage and support State health care programs to
  - engage in application of high grade evidence-based medicine (EBM) in benefit design and provider payment methods
- Require/Direct State health care programs to
  - Coordinate development and application of EBM policies
  - involve health care providers and consumers in decision-making related to application of EBM to public policy
  - Incorporate data on patient compliance in developing provider payment methods and benefit design
- Implement a web-based data system for public health information

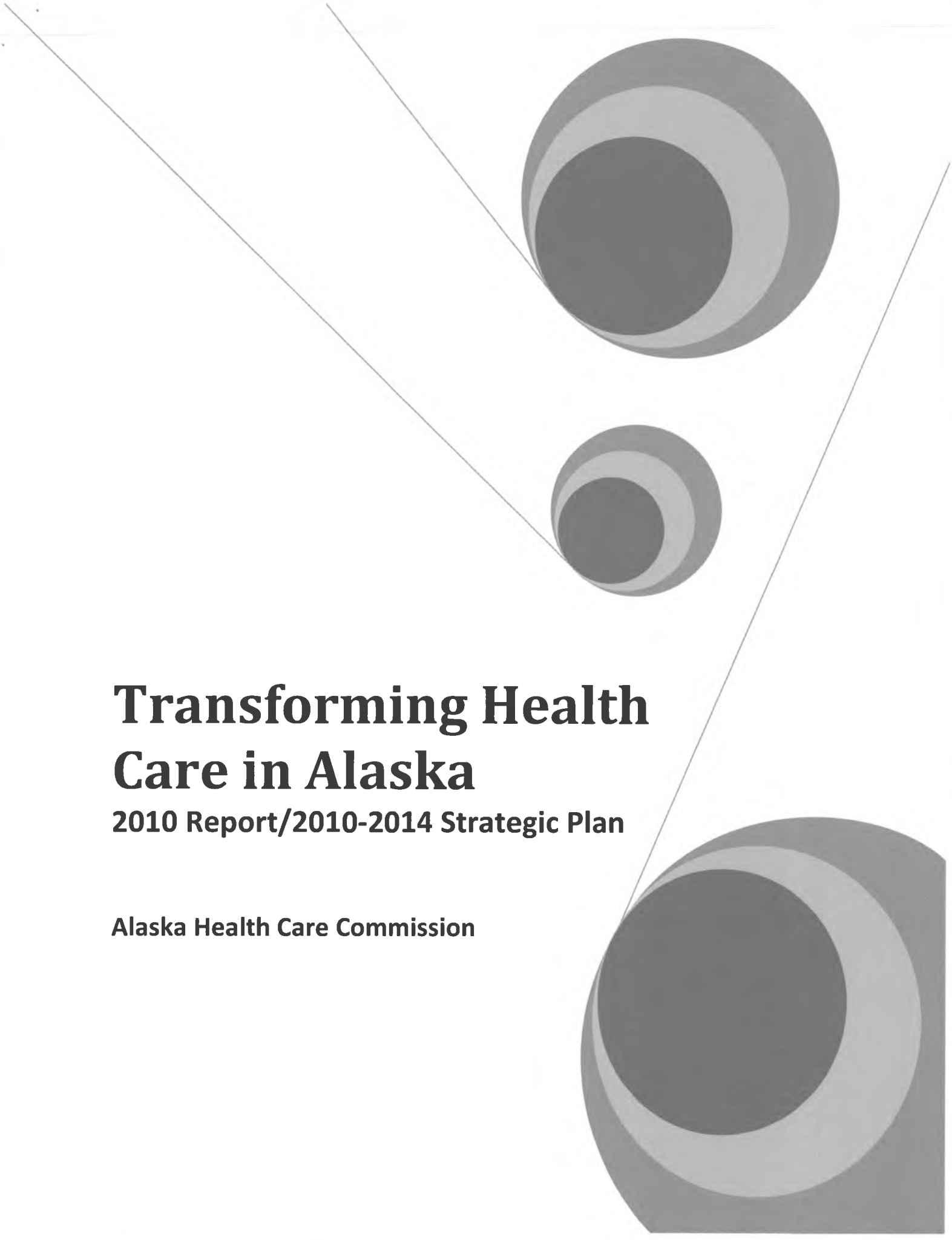
Thank You

For more information please visit the Commission's web site at:

http://hss.state.ak.us/healthcommission/

Question? Comments?

30



Transforming Health Care in Alaska

2010 Report/2010-2014 Strategic Plan

Alaska Health Care Commission

Transforming Health Care in Alaska

2010 Report/2010-2014 Strategic Plan

Alaska Health Care Commission

Ward Hurlburt, MD, MPH, Chair
Patrick Branco
C. Keith Campbell
Valerie Davidson
Jeffrey Davis
Emily Ennis
Paul Friedrichs, MD
T. Noah Laufer, MD
David Morgan
Wayne Stevens
Lawrence Stinson, MD
Ex Officio Members:
Linda Hall
Senator Donny Olson, MD
Representative Wes Keller

Deborah Erickson, Executive Director

Prepared for
Governor Sean Parnell and
The Alaska Legislature
In accordance with AS 18.09.070

January 2011

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA HEALTH CARE COMMISSION

SEAN PARNELL, GOVERNOR

3601 C Street, Suite 902
Anchorage, Alaska 99503
PHONE: (907) 269-7800

January 15, 2011

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present this report of the Alaska Health Care Commission in accordance with AS 18.09.070. SB 172 was signed into law on June 21, 2010 establishing the Alaska Health Care Commission in statute (AS 18.09.010). Commission members were appointed on September 15 and the new Commission convened for the first time October 14. While the new Commission only just started their work during the last quarter of 2010 there is much to report.

The Commission was able to spend time this past quarter studying progress made during 2010 related to the Commission's 2009 recommendations and also learning about federal health reform and its implications for Alaska. The Commission will remain focused on developing Alaskan solutions to Alaska's health care challenges, but is tracking implementation of federal reform to understand how it may be affecting Alaska's health care environment. To that end, the Commission learned about provisions in the new federal law and also compiled information about action taken so far in Alaska. The Commission also contracted with the Institute for Social & Economic Research to study potential impacts of the impending changes to Alaska's health care system and Alaska's economy. This report documents what the Commission has learned.

Our greatest concern is the continuing escalation in health care costs, which is making health insurance increasingly unaffordable for Alaska's families and businesses and driving government spending for health care programs to new heights. During 2011we will continue digging deeper into understanding this problem through new studies on health care spending trends and cost drivers, and comparisons of pricing and reimbursement for health care services in Alaska compared to other states. We will also focus on studying potential solutions, such as primary care innovation and price and quality transparency. In addition we will continue studying needs and opportunities for improving health status, supporting health workforce development, and deploying health information technology. These plans are included in this report.

We are grateful for the foresight of the Alaska Legislature and Governor Parnell in establishing the Commission in statute and providing resources to support continuing work to address the challenge of transforming Alaska's health care system so that it is sustainable, provides value for Alaskans' health care dollar, meets the needs of patients and providers, and focuses on health.

Sincerely,

Ward B. Hurlburt, MD, MPH
Chair, Alaska Health Care Commission
Chief Medical Officer & Public Health Director
Department of Health & Social Services

Deborah Erickson
Executive Director
Alaska Health Care Commission

Table of Contents

Executive Summary ii

Part I: Introduction 1

A. Purpose of this Report 1

B. Background on the Commission 1

C. Summary of 2010 Activities 3

D. 2010 – 2014 Strategic Plan Framework 4

E. The Commission's Vision for Transformation of Alaska's Health Care System 5

F. Core Transformation Strategy 7

Part II: Understanding Alaska's Health Care System Challenges 8

A. Summary of 2009 Findings 8

B. 2010 Analysis: Overview & Impact of the Federal Health Care Law 14

C. Issues Prioritized for Study in 2011 26

Part III: Alaska Health Care System Transformation Strategies 29

A. Status of Implementation of 2009 Commission Recommendations 29

B. 2010 Commission Recommendations 36

C. Strategies under Consideration for Study in 2011 41

End Notes 46

APPENDICES *Available on the Commission's Web Site* at: *http://hss.state.ak.us/healthcommission/*

Appendix A: Commission's Health Care Transformation Strategies

Appendix B: State of Alaska Federal Health Care Reform Review Documents

Appendix C: Economic Impact of the Federal Patient Protection and Affordable Care Act (report by Mark A. Foster & Associates/Institute for Social & Economic Research)

Appendix D: Voting Records, Summary of Public Comments, Meeting Summaries, and Ethics Reports

Executive Summary

Background

The Alaska Health Care Commission was established in Chapter 9 of Title 18 in Alaska Statute this year with the implementation of SB 172, which was signed into law by Governor Parnell in June 2010. Commission members were appointed in September and the new Commission convened for the first time in October. The new body continued the work of the original Commission which was organized and met during 2009 under Governor's Administrative Order #246. This report reflects work accomplished since the launch of the new Commission in the last quarter of 2010, describes how it builds on and continues the work begun in 2009, and lays the groundwork for 2011 activities.

The Commission's process for transforming Alaska's health care system began with identification of a vision, goals and values of the ideal system, and is now in a continuing cycle of learning about current challenges, designing policies for achieving the vision, and evaluating progress. The core of the transformation strategy rests on building a strong foundation for the system through health workforce development, deployment of health information technology, and statewide leadership. The focus of the core transformation strategy is to strengthen the consumer's role in health through innovations in patient-centered care and by fostering healthy lifestyles.

Understanding Alaska's Health Care Challenges

To better understand why Alaska's health care system is not achieving the vision, the Commission started in 2009 by describing how health care in Alaska is delivered and funded (Appendix A of the 2009 report). Particular concerns identified in the 2009 report included that:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services;
- Fragmentation and duplication in Alaska's health care system creates inefficiencies;
- Alaska suffers from shortages and maldistribution of health care workers;
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services;
- The State of Alaska does not have an infrastructure and capacity to provide leadership for health care system improvement;
- Use of modern health information technology is taking hold in Alaska, but much remains to be done; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care.

In 2010 the Commission added to learning about Alaska's health care system challenges by compiling information on the new federal health care reform law. In addition to reviewing and providing summaries of the law's provisions and noting activities related to implementation in Alaska that occurred during 2010, the Commission also contracted with the Institute for Social & Economic Research to provide an analysis of the potential economic impact of the law on Alaska.

In 2011 the Commission will continue studying current challenges in Alaska health care delivery and financing with a focus on health care spending trends and cost drivers, pricing and reimbursement for health services, and health conditions contributing to utilization of services. The Commission will also review the status of statewide planning for long term care and for trauma system improvement.

Alaska Health Care System Transformation Strategies

The Commission's 2009 recommendations for health care system transformation still stand – the Commission is building on those recommendations to develop a mosaic of strategies intended to increase value, improve access and support prevention. These strategies focus on enhancing the consumer's role in health through supporting healthy lifestyles and fostering innovations in health care delivery, building statewide leadership for health policy development, strengthening the supply and distribution of health care workers, promoting the use of health information technology, and improving access to primary care for Medicare enrollees.

2010 saw a number of developments related to the Commission's 2009 recommendations.

- **Consumers' Role/Healthy Lifestyles:** Governor Parnell launched a domestic violence and sexual assault initiative aimed at preventing harm through creating a culture of respectful relationships. The Commissioners of the Departments of Health & Social Services (DHSS) and Education & Early Development collaborated to convene a task force targeting obesity prevention and control among Alaska's school children. The legislature invested in the state's obesity and control program, and Alaska's first food policy council was created to improve the supply and distribution of Alaska-produced foods and improve the nutrition literacy of Alaskans.
- **Consumer's Role/Primary Care Innovation:** DHSS received federal grant funds that will be used to pilot test and evaluate patient-centered medical homes for children; a number of Alaska health care organizations are implementing the patient-centered medical home model in their practices and seeking NCQA recognition; and the Alaska Primary Care Association began an initiative to support Alaska's 142 community health center sites' movement towards adoption of innovative care models.
- **Statewide Leadership:** Creation of the Alaska Health Care Commission in AS 18.09.010 this year implemented the recommendation for a permanent state health planning and policy body. No new resources were allocated to support analysis and implementation of federal health care reform due to the state challenge regarding constitutionality of the new law and questions regarding severability of the challenged provisions from the whole law; however, state agencies and other organizations are tracking federal implementation, complying with legally mandated requirements, and investigating optional provisions that align with existing policies and programs.
- **Health Workforce Development:** The Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan," which was adopted by the Alaska Workforce Investment Board in May, and received a federal grant to develop a strategic plan for implementing the comprehensive plan. None of the proposed bills that would have created and funded a state health professions educational loan repayment and financial incentive program passed during the 2010 session, but a federal grant with matching funds from stakeholders enabled the creation of such a program for at least one year. Two new primary care residency programs for training pediatricians and psychiatrists in Alaska are closer to reality with progress made in planning during the year.
- **Health Information Technology:** DHSS awarded the State Health Information Exchange (HIE) Entity grant to the Alaska eHealth Network (AeHN) in April, and in November AeHN awarded a contract to Orion Health to build the system. AeHN also received a federal grant to establish a regional health IT extension center to provide technical assistance to health care providers. The Alaska EHR Alliance established preferred vendor agreements with two electronic health record (EHR) vendors to simplify the selection process and guarantee reduced pricing for Alaska providers. Broadband telecommunications service providers received $117 million in federal grants to support expansion in rural communities; and Connect Alaska, a new non-profit formed to expand broadband access, was created and launched Alaska's first statewide interactive online broadband availability map.

- **Medicare Access:** A new clinic intended to alleviate the primary care access problem for seniors in the Mat-Su was opened this year, and two new clinics devoted to providing health care for seniors in Anchorage were planned during 2010 and will open early in 2011: The Senior Care Center at Providence, which is subsidized by Providence Health & Services, and the Alaska Medicare Clinic, which is subsidized by a FY 11 state capital grant. In addition the Anchorage Neighborhood Health Center will open doors of a new clinic doubled in size with more room and staff to accommodate additional Medicare recipients and medical clinic space devoted to seniors.

New 2010 Recommendations made by the Commission relate to the significance of **Evidence-Based Medicine** for improving the quality of health care by emphasizing the need for critical assessment skills in understanding and applying findings from medical research to clinical practice and to health care policies. The importance of protecting the practitioner's and the patient's role in making clinical decisions is emphasized. The importance of shared decision-making and also patient compliance is recognized to balance reliance on the medical system to improve quality. The need for reliable data and information to guide decision-making is also noted.

The Commission has identified a number of additional strategies to study and consider for 2011 recommendations. For improving value – by increasing quality and controlling costs – the Commission will analyze additional strategies for fostering patient-centered primary care, mechanisms for providing transparency in health care pricing and quality, bundled payment systems, and the possibility of leveraging state purchasing power to drive quality improvement. For supporting community efforts to foster healthy lifestyles, the Commission will consider the need for an on-line interactive public health information system. To strengthen statewide leadership, the Commission will finalize a set of indicators for measuring improvement in Alaska's health care system over time.

Part I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the 2010 findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Alaska Statute 18.09.070. This report builds on the work of the original Alaska Health Care Commission (created by Governor Palin under Administrative Order #246) which in their 2009 Report presented a 5-year strategic planning framework as a "roadmap" for strengthening Alaska's health care delivery system. The 2009 report was described as a living document meant to evolve each year as problems of health care quality, cost and access are studied, potential solutions are analyzed, and implemented strategies are evaluated. This new report documents the continuation of that process.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission's 2010 activities, and a description of the Commission's strategic planning framework;
- Part II: information on the challenges of delivering and accessing health care in Alaska, and plans for additional study of current challenges in 2011;
- Part III: the Commission's recommendations for transformation of Alaska's health care system, including a status report on implementation of the Commission's 2009 recommendations, findings and recommendations on the one new strategy studied this year, and strategies that will be considered in 2011;
- Appendices: information on the new federal health care law and its implementation in Alaska, an analysis of the potential economic impact on Alaska of the new federal health care law, and additional information by and about the Commission.

B. Background on the Commission

The Alaska Health Care Commission was first established by Governor Palin on December 4, 2008 under Administrative Order #246. Original Commission members were appointed on January 27, 2009 and the Commission met throughout 2009, producing a report on their findings and recommendations in January 2010. The Commission created under A.O. #246 terminated with the production of that report.

The Alaska Health Care Commission was established in state statute (AS 18.09.010) this year with the passage of Senate Bill (SB) 172 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. SB 172 was passed by the Alaska Legislature on April 17, 2010 and subsequently signed into law by Governor Parnell on June 21, 2010.

Duties of the Commission prescribed by AS 18.09.070:

I. Serve as the state health planning and coordinating body;
II. Provide recommendations for and foster the development of a:
    1. Comprehensive statewide health care policy;

2. Strategy for improving the health of Alaskans that
    i. Encourages personal responsibility for disease prevention, healthy living and acquisition of health insurance;
    ii. Reduces health care costs;
    iii. Eliminates known health risks, including unsafe water and wastewater systems;
    iv. Develops a sustainable health care workforce;
    v. Improves access to quality health care; and,
    vi. Increases the number of insurance options for health care services.

III. Submit a report to the Governor and the Legislature by January 15 of each year regarding the Commission's recommendations and activities.

Former Commission members were reappointed under the transition clause included in SB 172, and new members were appointed by Governor Parnell September 15, 2010. Legislative representatives were reappointed by their respective bodies. Short biographies for each of the Commission members are provided on the Commission's web site at www.hss.state.ak.us/healthcarecommission. The members of the Commission are:

Ward Hurlburt, MD, MPH: Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.
Patrick Branco: Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of Ketchikan General Hospital; Ketchikan.
C. Keith Campbell: Representing consumers; retired hospital administrator and former AARP Chair; Seward.
Valerie Davidson: Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.
Jeffrey Davis: Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.
Emily Ennis: Representing the Alaska Mental Health Trust Authority; Executive Director of Fairbanks Resource Agency; Fairbanks.
Col. Paul Friedrichs, MD: Representing the U.S. Department of Veterans Affairs health care system; Commander of the Air Force/Veterans' Affairs Joint Venture Hospital at Elmendorf; Anchorage.
T. Noah Laufer, MD: Representing primary care physicians; family medicine physician and president of Medical Park Family Care; Anchorage.
David Morgan: Representing community health centers; Reimbursement Director for the Southcentral Foundation; Anchorage.
Wayne Stevens: Representing the Alaska State Chamber of Commerce; President & CEO of the Alaska State Chamber of Commerce; Juneau.
Lawrence Stinson, MD: Representing Alaska health care providers; anesthesiologist and co-owner of Advanced Pain Centers of Alaska; Anchorage.
Linda Hall (Ex-Officio): Representing the Governor's Office; Director of the Alaska Division of Insurance; Anchorage.
Representative Wes Keller (Ex-Officio): Representing the Alaska House of Representatives; Wasilla.
Senator Donny Olson (Ex-Officio): Representing the Alaska Senate; Golovin.

C. Summary of 2010 Activities

The formal work of the Commission was paused for the first 9 months of 2010 following termination of the 2009 Commission until the new body was established in statute and members were appointed in September. The group was then able to hold two face-to-face meetings during 2010, one in October and one in November. At these first meetings the new members were introduced to the work of the 2009 Commission, and the group received updates on several issues studied during the previous year. Despite the short timeframe available for developing this year's annual report, the Commission:

1. Revised their Core Transformation Strategy
2. Developed recommendations for a key strategy to improve value: Evidence-based Medicine
3. Identified issues to be analyzed in 2011
4. Prioritized new policy options for study and recommendation development in 2011.

2010 Accomplishments

Meetings and public hearings: During 2010 the Commission held three face-to-face meetings, all in Anchorage: January 8 (this was the last meeting of the 2009 Commission to incorporate changes based on public comment, finalize and approve the 2009 report to the Governor and legislature); October 14-15; and November 16-17. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend in person but interested in listening to the meeting or providing public testimony. Summaries of the meetings and the Commission's voting record are included in Appendix D of this report. Public hearings were held during both the October and November meetings, and a summary of comments received from the public is also included in Appendix D.

Administration: In their first months the new Commission reviewed meeting rules, updated and approved changes to the by-laws, approved a budget for SFY 2011, and received ethics training from the State's ethics attorney. A copy of the Commission's meeting rules, by-laws, SFY 2011 budget, and ethics handbook are available on the Commission's website (see website address below).

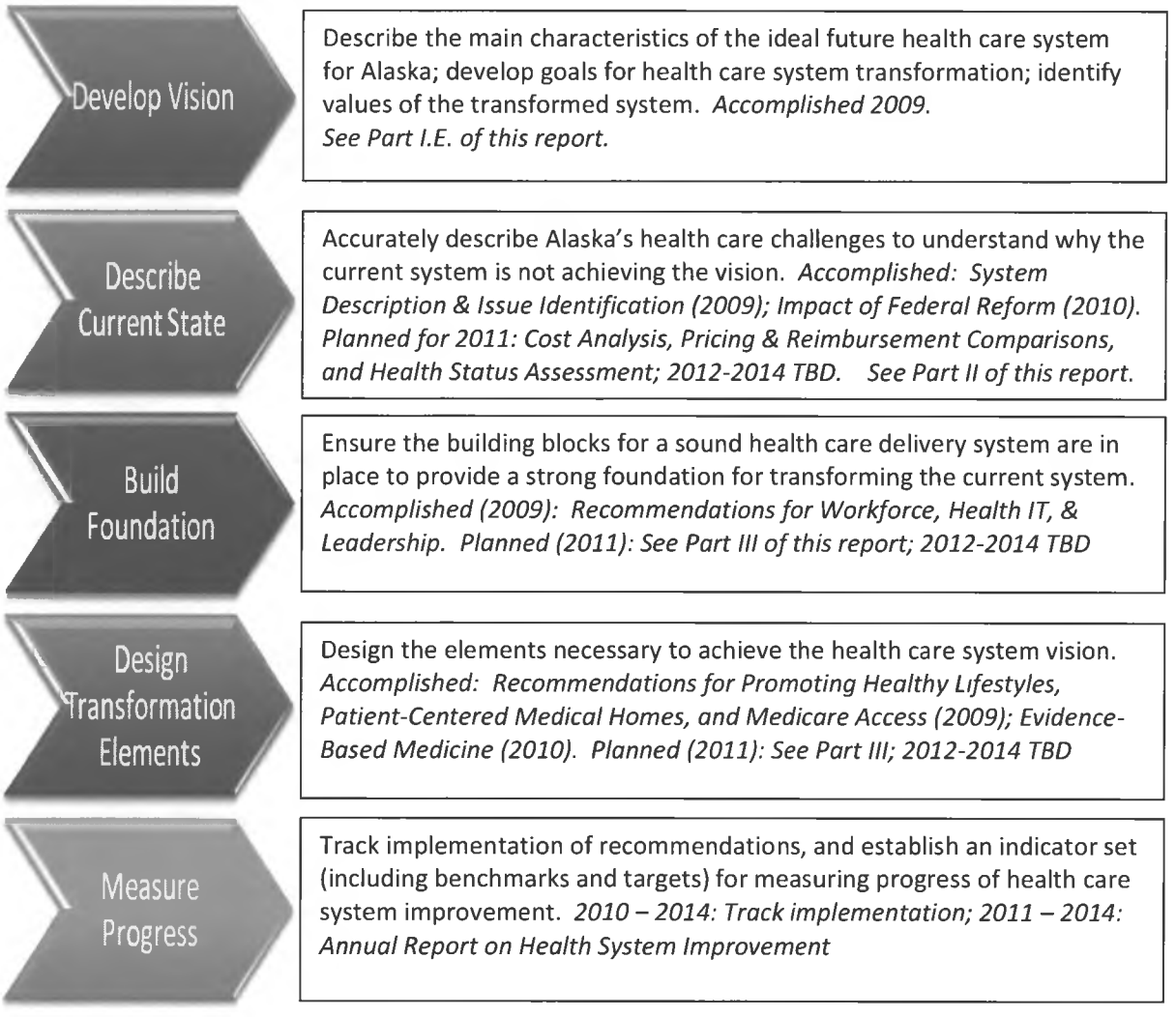
Communication and coordination: The Commission updated and maintained a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (http://hss.state.ak.us/healthcommission/). A listserv established in 2009 to maintain communication with system stakeholders and members of the public interested in receiving periodic updates was also updated, expanded and utilized. The Commission also maintained an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (also available on the website).

Products: The main product from 2010 is this annual report, which includes analysis and recommendations related to the value-improvement strategy of evidence-based medicine, and an overview and analysis of potential impact of the new federal health care law (P.L. 111-148, the Affordable Care Act) on Alaska.

D. 2010 – 2014 Strategic Plan Framework

In 2009 the initial Commission developed a 5-year strategic planning framework to guide the process for improvement of Alaska's health care system. The new Commission is following the same process, depicted graphically below with a brief note about the status of implementing each process step. Note that except for the first step of developing a vision the process is not sequential - the steps in the process are being implemented concurrently and continually.

Strategic Planning Process & Implementation Status



E. The Commission's Vision for Transformation of Alaska's Health Care System

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and behavioral, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the state of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, some are private business. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment. A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of their consumers.

Vision

Alaska's Health Care System

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The first step in the Commission's journey toward transformation of Alaska's health care system was to design a picture of the ideal system. The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system is one that is sustainable over time.

Health Care Goals

I. Improved Access
II. Contained Cost
III. Safe, High Quality Care
IV. Prevention-Based

The Commission also identified four goals for a transformed health care system to support a targeted approach to identification of improvement strategies and performance measurement.

I. **Access:** Access to affordable health care coverage and to a viable and vital health care delivery system is improved.
II. **Cost:** The cost of health care is controlled so that the medical inflation rate in Alaska is below the national rate.
III. **Quality:** Alaskans can be assured that health care services they receive in Alaska meet the highest quality and safety standards.
IV. **Prevention:** A focus on preventive services, both clinical preventive services for individuals and community prevention policies, will support improved health status and control costs by reducing the burden of preventable disease and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission agreed to the following set of values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.
Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.
Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.
Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.
Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

F. Core Transformation Strategy

The figure below depicts in graphic form the core strategies identified by the Commission for transforming Alaska's health care system to achieve their vision, and the relationship of those strategies to one another and to the planning process.

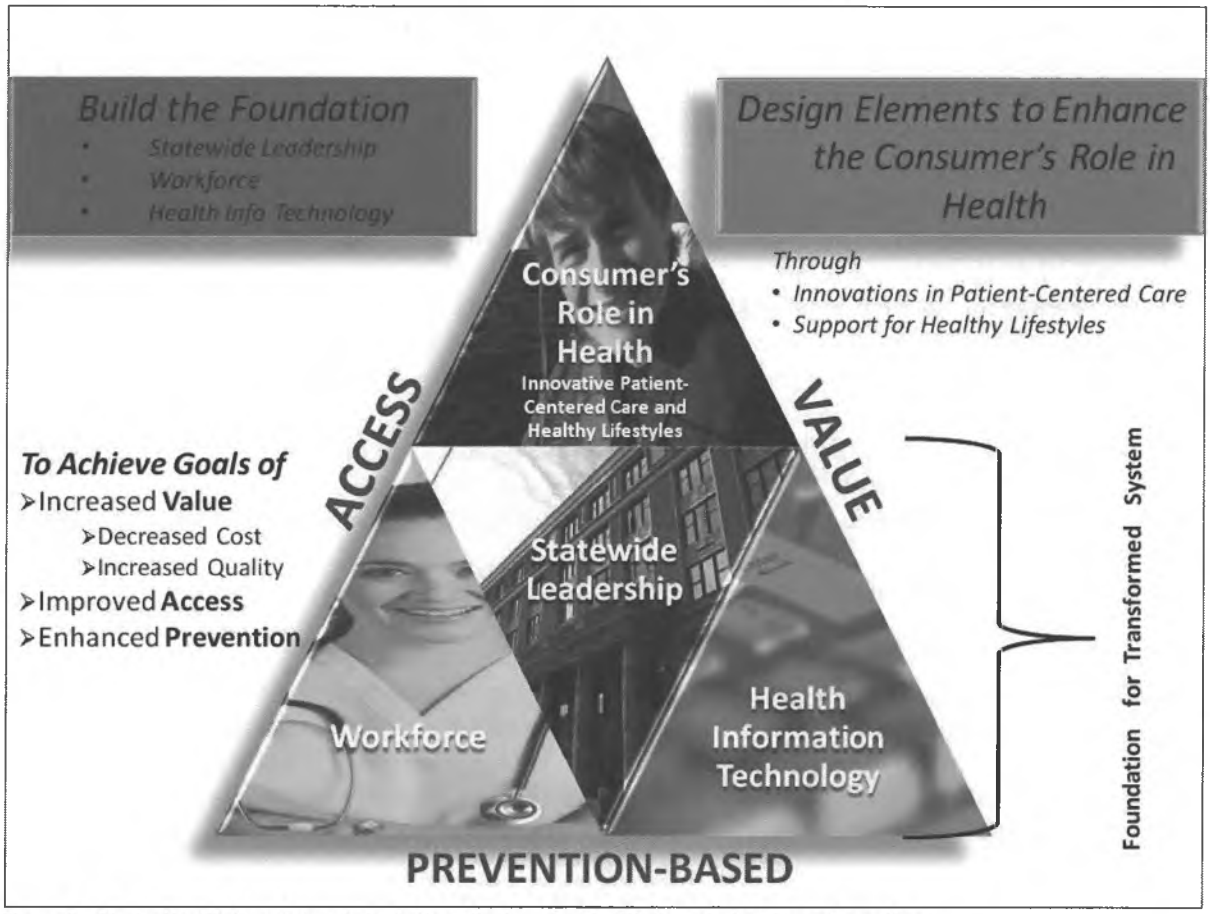


Figure 1: Alaska Health Care Commission's Core Strategy for Health Care System Transformation

Understanding and supporting the consumer's role in health care is the central focus of Commission's strategic approach to transformation of Alaska's health care system. Two aspects of the consumer's role are critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and an innovative patient-centered system depend. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

Part II: Understanding Alaska's Health Care System Challenges

A. Summary of 2009 Findings

To better understand why Alaska's health care system is not achieving the Commission's vision, the 2009 Commission started by describing how health care in Alaska is delivered and funded (Appendix A of the 2009 report). The commission also received numerous presentations and reviewed existing reports to identify a series of challenges that contribute to the current problems in the system. Particular concerns identified in the 2009 report included that:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services;
- Fragmentation and duplication in Alaska's health care system creates inefficiencies;
- Alaska suffers from shortages and maldistribution of health care workers;
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services;
- The State of Alaska does not have an infrastructure and capacity to provide leadership for health care system improvement;
- Use of modern health information technology is taking hold in Alaska, but much remains to be done; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care

Health Care Costs: Health care spending in the U.S. has been growing faster than the economy for decades, doubling from 8% of the nation's GDP in 1970 to 16% in 2006 and projected to increase to 20% by 2016. Per capita national health care expenditures in the U.S. increased 850% over the past three decades. High costs for health care contribute to higher prices for goods and services produced in the U.S., challenging our ability to maintain a competitive edge in the global market place.

In 1993 the Alaska Health Resource & Access Task Force projected health care spending in Alaska would "sky-rocket" from slightly below $1.9 billion in 1991to nearly $5.6 billion in 2003. In 2009 spending was estimated at over $6 billion. State general fund expenditures for Medicaid grew more than five-fold between FY 91 and FY 08 from a little over $80 million to over $408 million. In 2005 government paid 64% of Alaska's health care bills, private employers paid 17%, and individual Alaskans paid 19%.

Alaska has the highest annual Medicaid expenditure level per enrollee in the U.S. Alaska has also ranked 1st in the nation for cost of workers' compensation premium rates since 2005, with medical costs making up 72% of total benefit claims in Alaska in 2008 compared to the national average of 58%. Signs that prices for health care are higher in Alaska than other states include differences in reimbursement rates between our Medicaid and Workers Comp programs and those of other states. A comparison of Alaska's Medicaid rates to Washington state's indicate our fees are two to three times higher. Alaska's Workers' Comp medical fee schedule rates were the highest in the nation in 2006 – on average 3.5 times higher than Massachusetts (the state with the lowest rates).

Health Insurance Coverage: Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. In Alaska health insurance premiums for working families grew by 90.8% between 2000 and 2009. In comparison, the median earnings of Alaska's workers rose 17% during the same period. The average annual premium for individual health coverage rose from $2,923 to $5,626 during that same period. The percentage of income spent on health care in Alaska increased steadily from 11% in 1991 to 19% in2004.

14% of Alaskans are uninsured or do not have access to military, Veteran's Administration or Indian Health Service beneficiary health care services. 84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed in small businesses that do not offer health benefits or offer coverage they cannot afford. Nearly all Alaskan firms with more than 100 employees provide health benefits, while less than a quarter of Alaska's smallest businesses (<10 employees) offer insurance. The seasonal nature of Alaska's workforce is an important factor in employer health coverage – data on coverage does not account for those who are insured only part of the year. There is also insufficient data on Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still cannot afford care.

Logistical Challenges: The dispersion of Alaska's relatively small population over a large geographic area increases the cost and complexity of delivering care here. Approximately 75% of Alaska's communities are not connected by road to a community with a hospital, and nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.[i] Transportation costs associated both with patient travel and also with moving supplies, staff and equipment to operate clinics and hospitals in rural Alaska can be formidable.

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state – a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner Program, and the use of telehealth technologies.

Health System Fragmentation and Duplication: Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. Health care organizations within the same sector (military, tribal health system, or private sector) do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

Some communities have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four hospitals – one military, one tribal, one for-profit, and one non-profit (plus two psychiatric hospitals). The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs.

Health Care Workforce Shortages: Demand for health care workers rose sharply over the past decade. Alaska's health care employment sector experienced 40% job growth between 2000 and 2007, compared to 13% for all other industries, outpacing the state's population growth during that same period by five times.[ii] The supply of new workers produced by Alaska's training and education programs plus those imported from outside Alaska cannot keep up.

Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations are experiencing vacancy rates of 15% - 20%. Pharmacist, therapist and certain nurse specialist positions are also experiencing high vacancy rates. Behavioral health occupations have a somewhat lower vacancy rate overall, but made up the highest proportion of vacancies with 1,033 vacant positions in 2007.[iii]

Health Status, Health Risk Behaviors and Changing Demographics: Health conditions and demographics drive utilization of health care services and spending for health care services. Alaska experiences high rates of chronic disease, behavioral health conditions, and injuries. Three health risk behaviors (tobacco use, poor diet, and inactivity) are the primary contributors to development of chronic diseases such as heart disease, diabetes, lung disease, and cancer. Tobacco use in Alaska has been declining due to significant investment of resources in prevention and control, but increases in Alaska's rates of obesity are alarming. The total population of Alaska is steadily increasing, and the number of Alaskans aged 65 and older has more than doubled over the past two decades and is projected to nearly triple again by the year 2030.

Statewide Leadership for Health Care System Improvement: Over the two decades preceding the creation of the Commission four groups had been formally convened to address the problems of access to and cost of health care. All of those entities had been ad-hoc in nature and met over periods ranging from 6 months to 2 years. Existing resources for health care planning are fragmented, and also insufficient for analyzing the complexity of pending federal health care reforms for their impact on Alaska. Lack of sustainable capacity and a coordinated, long-term approach to health care planning and policy development hampers the ability to provide statewide leadership for health care system improvement.

Health Information Technology: There is significant governmental and private sector interest in deploying the use of health information technology to improve efficiency and effectiveness of health care. President Bush established the Office of the National Coordinator for Health Information Technology in 2004, and in 2009 Congress appropriated more than $20 billion for the development and adoption of health information technology under the HITECH Act. The Alaska Legislature passed SB 133 during the 2009 session to create a statewide health information exchange (HIE) system for Alaska. Two non-governmental organizations in the state – the Alaska eHealth Network and the Alaska EHR Alliance formed in recent years to support implementation of electronic health records (EHRs) in physician practices and foster the development of a HIE.

There is also a history of innovative uses of telecommunications technologies for delivering health care in Alaska, and now growing support for development and utilization of these technologies. The Alaska Federal Health Care Access Network provides telehealth applications to 248 sites throughout Alaska. Other telemedicine programs involved in improving access to health care in the state include the Alaska Rural Telehealth Network, Providence's REACH system and eICU, the Alaska Psychiatric Institute's Telebehavioral Health Care Services Program, and the Southeast Alaska Regional Health Consortium

Telebehavioral Health Program. Insufficient access to broadband telecommunication services hampers further development and deployment of telehealth in some rural communities.

Medicare Enrollee Access to Primary Care: A study conducted by the Institute for Social & Economic Research in 2008 confirmed anecdotal information that many Alaskan Medicare beneficiaries living in urban communities, particularly Anchorage, have trouble finding a primary care physician to take them as a patient. The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.

Finding Statements from 2009 Report: Following are the Finding Statements included in the 2009 report associated with each of the core strategies that were studied and for which recommendations were developed.

Strengthen the Consumer's Role – Support Healthy Lifestyles

- Chronic disease is the leading cause of death and disability in the U.S. and Alaska.
- The majority of health care spending in the U.S. is for chronic disease.
- Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.
- Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.
- Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.
- Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

Strengthen the Consumer's Role – Foster Innovative Primary Care Models

- Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Develop Statewide Leadership – Response to National Health Care Reform

- National health care reform proposals under consideration by Congress will have a significant impact on Alaska's state and local governments, health care system, business community, citizens, and families.

Develop Statewide Leadership – State Health Policy Board

- The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Develop the Health Care Workforce

- Health care in Alaska is big business and represents a significant employment sector.
- Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

- Health care worker shortages in Alaska are widespread and costly.
- A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).
- Alaskans have been particularly innovative in meeting their health care workforce needs.
- Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Workforce – Physician Supply

- The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.
- Alaska has a shortage of primary care physicians[1].
- New physicians face disincentives to entering primary care specialties.
- Providers stay to practice where they train.
- Mid-level medical practitioners (Nurse Practitioners and Physician's Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

Deploy Health Information Technology

- Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:
  - Increased health care efficiency and effectiveness; and
  - Improved clinical quality and patient safety.

Deploy Health Information Technology – Electronic Health Records

- Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:
  - Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
  - The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers in small practices;
  - Systems that are not user-friendly from the provider's perspective, i.e., are difficult, inflexible and time-consuming to use;
  - Costs associated with on-going operation and maintenance; and,
  - Antiquated and nonstandard eligibility and claims processing systems.

[1] The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission's definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.

- Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records by providers. Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

Deploy Health Information Technology – Ensure Privacy & Security

- Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

Deploy Health Information Technology – Telehealth/Telemedicine

- Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.
- Barriers to adoption and use of telemedicine include:[2]
  - Insufficient telecommunications connectivity in some rural Alaskan communities;
  - Inadequate access to training for providers and their staff;
  - Medical licensure restrictions across state borders;
  - Misalignment of payment systems between costs and benefits.

Improve Access to Primary Care for Medicare Beneficiaries

- Alaska's Medicare-eligible population is growing.
- Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.
- One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.
- Health care providers report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.
- Care for Medicare patients is often more complex and time-intensive than for the general patient population.
- Mid-level practitioners are increasingly being used to solve the Medicare access problem.
- Health care providers report Medicare's physician and mid-level practitioner reimbursement schemes are not rational and not reliable.
- Health care providers commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

[2] The order of the bullets in this finding is not meant to imply priority order of significance.

B. 2010 Analysis: Overview & Impact of the Federal Health Care Law

For their 2010 report the Commission compiled summary information on the new federal health care law and Alaska's response to enacted provisions to-date. The Commission is not charged with developing recommendations on the implementation of federal reform, but plans to track implementation in order to understand how the law may affect the health care landscape in Alaska as they continue developing state-specific solutions to Alaska's health care challenges. As part of this effort the Commission contracted with the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage to provide a report on the projected economic impact of the new law on Alaska.

An overview of the law, brief information on enactment status in Alaska to-date, and a summary of preliminary estimates of the health care and economic impact to Alaska are provided in this section. Additional information and the full ISER report are included in Appendices B and C.

Overview & Status in Alaska

Federal health care reform is enacted under three new federal laws passed in March and April 2010:

- P.L. 111-148: The Patient Protection and Affordable Care Act (PPACA)
- P.L. 111-152: The Health Care and Education Reconciliation Act
- P.L. 111-159: The TRICARE Affirmation Act

PPACA is structured as follows (the names of these titles do not reflect the exact names assigned in the legislation – they are modified to be more descriptive):

Title I	Private Health Care Coverage
Title II	Public Health Care Coverage (primarily Medicaid changes)
Title III	Health Care Delivery and Payment (primarily Medicare changes)
Title IV	Prevention and Public Health
Title V	Health Care Workforce
Title VI	Fraud, Waste and Abuse
Title VII	Pharmaceuticals
Title VIII	CLASS Act (Community Living Assistance Services & Supports)
Title IX	Taxes and Fees
Title X	Amendments (changes made to the original bill (Titles I-IX) prior to passage)

This overview describes PPACA as amended by Title X and the two subsequent laws. The provisions described in this overview take effect at various points over the next eight to ten years. A number of key provisions took effect during 2010. Most of the more significant changes take effect in 2014.

Title I – Private Health Care Coverage

The private health care coverage provisions set forth in Title I impose a series of new rules on health insurance plans, create state-based Health Insurance Exchanges, create a number of new health insurance programs, require individuals and employers to participate in purchasing health coverage or pay a penalty, and provide subsidies for low-income individuals, small businesses, and employers providing health insurance for early retirees.

New health insurance rules include prohibitions against pre-existing condition exclusions, lifetime and annual limits, and coverage rescissions. They also require expansion of coverage to dependents up to 26 years of age and require benefit packages to include clinical preventive services. Health insurers are required to guarantee issuance and renewal of coverage. A minimum Medical Loss Ratio (MLR) will be imposed, requiring insurance companies to pay out 85% of their premium revenue in medical claims (80% for insurers covering the individual and small group market). New community rating rules will limit variations in rates to certain ratios based only on age, region, family composition and tobacco use. Risk adjustment will be required in individual and small group markets and in the Exchange. This title also imposes a series of new administrative simplification and standardization requirements on insurance plans. Grants are made available to States to conduct premium rate reviews, and to establish an Office of Health Insurance Consumer Assistance to assist and advocate for consumers with private coverage in the individual and small group markets.

A Health Insurance Exchange will be established for every state by 2014. The Exchanges are intended to provide an electronic web-based marketplace where individuals and small businesses of under 100 employees (and eventually large businesses) will be able to comparison shop for health plans. State governments are given the option of designing and establishing the Exchanges, and federal planning grants are provided to States choosing to develop their own Exchange. States are also given the option of partnering with other States to create regional or multi-state Exchanges. The Exchanges may be administered by a government agency or non-profit entity, and are required to be self-sustaining within one year of implementation. The federal government will establish Exchanges for the states in which the State government chooses not to participate.

Other health insurance programs and entities that are established in Title I include 1) a temporary high risk health insurance pool program, intended to offer coverage to those with pre-existing conditions until the prohibition on exclusions takes effect (for children for plan years starting after 9/23/10; for adults for plan years starting after 1/1/14); 2) a temporary (2010 – 2014) early-retiree reinsurance program that will subsidize health plans provided by employers offering insurance to retirees not yet qualified for Medicare; 3) a Health Care Cooperative program, which will create non-profit member-operated health insurance companies in each state; 4) Health Choice Compacts, which will allow insurance companies to sell plans across state lines for those States that have entered into a compact agreement; and 5) Multi-State Health Plans that the federal Office of Personnel Management will establish in every state.

Individuals will be required to have a qualified health plan or pay a tax penalty. The tax penalty will be $695/year (family penalty capped at 3-times the individual penalty, or $2,085) or 2.5% of household income (whichever is greater), and will be phased in starting in 2014 reaching the full amount noted here in 2016 (and indexed to CPI thereafter). Exemptions to the individual mandate apply for financial hardship, religious objections, American Indians/Alaskan Natives (due to the federal government's trust obligation under treaty to provide their health care), and if the lowest cost coverage option exceeds 8% of household income.

U.S. citizens and legal immigrants with incomes between 133% - 400% of federal poverty level (FPL) whose employer does not offer coverage with a value of at least 60%, or for which the employee's contribution is 9.5% of income, will be eligible for subsidies in the form of premium credits. Amounts of the credits will be tied to the cost of certain plans in the region and set on a sliding scale based on income level. The premium credits will be advanceable and available for purchase of insurance through

the Exchange. In addition to premium credits, cost sharing subsidies will be provided to individuals and households whose income is between 100% - 400% FPL.[3]

Larger employers (over 50 full-time employees (FTEs)) will be required to offer their employees a qualified health plan or pay a tax penalty. Employers offering health plans will face penalties if one or more of their employees choose to purchase coverage through an Exchange and receives a federal subsidy (under certain conditions). Employers who do not offer coverage will be required to pay $2,000/FTE (first 30 FTEs are excluded from calculation) if one or more of their employees receive a subsidy through the exchange. Employers who do offer coverage will be required to pay $2,000/FTE or $3,000/subsidized employee (whichever is less) if one or more of their employees receive a subsidy.

Small employers (for this provision defined as 25 or fewer employees with average annual wages of less than $50,000) that purchase health insurance for employees will receive a tax credit of up to 35% of the employer's contribution (25% for non-profit employers) if that contribution is at least 50% of the premium cost for 2010 through 2013. Starting in 2014 the tax credit increases to 50% (35% for non-profits), but then ends two years later. The full tax credits are available for the smallest businesses (10 FTEs or less and average annual wages less than $25,000) and phases out as business size increases.

Status in Alaska:

- *State Lawsuit Challenging the Individual Mandate: Alaska is participating in the 20-state Florida-led lawsuit against the federal government over the enactment of PPACA. One of the two main complaints asserted in the suit is regarding the federal government's constitutional authority to require individuals to purchase health insurance. The lawsuit was heard in a Florida district court in December, and is expected to proceed to the appellate courts and eventually be heard by the U.S. Supreme Court in 2012 or 2013.*
- *High Risk Pool: The State of Alaska supported and facilitated the application by the state's existing high risk pool, the Alaska Comprehensive Health Insurance Association, for the new federal high risk pool. $13 million was allocated for Alaska's federally-subsidized pool, and coverage began September 1, 2010. Television and other media have been used to advertise the availability of the subsidized insurance program. 24 Alaskans had enrolled as of December 17.*
- *Early Retiree Reinsurance Program: The following Alaskan employers and unions had been approved for participation in this program by the US DHHS as of December 20: Alaska Electrical Health and Welfare Fund, Alaska Pipe Trades UA Local 367 Health & Security, Alaska Teamster-Employer Welfare Trust, Alaska USA Federal Credit Union, Alyeska Pipeline Service Company, Municipality of Anchorage, State of Alaska Retirement and Benefits Plan, Tongass Timber Trust.*
- *Health Insurance Rate Review: The State of Alaska chose not to apply for the state Health Insurance Rate Review grant made available in July (and again in October) citing onerous grant requirements, lack of state statutory authority to pre-approve health insurance rates for most health insurance plans, and sufficient existing capacity to review health insurance rates. At this date it is unknown whether state legislation will be introduced during the 2011 legislative session to adopt new federal insurance standards in state law.*
- *Consumer Information & Assistance: The State of Alaska chose not to apply for the state Consumer Information and Assistance grant made available in September citing concerns over sustainability of capacity created with one-time funds, and insufficient need (the Alaska Division*

[3] The Hyde amendment applies to the use of federal funds in these programs, and prohibits the use of federal subsidy funds for the purchase of coverage for abortion (except in the case of rape or incest or to save the life of the mother).

of Insurance currently has sufficient capacity to respond to consumer inquiries and complaints in its existing consumer assistance program).

- *Health Insurance Exchange: The State of Alaska chose not to apply for the state Health Insurance Exchange planning grant made available in September At this date it is unknown whether state legislation will be introduced during the 2011 legislative session to establish an Alaska health insurance exchange.*

Title II – Public Health Care Coverage

PPACA changes the role of the Medicaid program in the health care system by moving the program from one that covers certain safety-net populations to one that covers all individuals under certain income limits so that it becomes the floor for all insurance coverage in the country. The law expands Medicaid eligibility to everyone under 65 years of age, including childless adults, whose incomes are under 138% of FPL (the new minimum eligibility level is 133% but PPACA also imposes a required 5% income disregard effectively increasing the level to 138%). A maintenance of effort requirement took effect on enactment of the law in March to prohibit States from reducing eligibility for adults between now and when the expansion takes effect in 2014. The maintenance of effort requirement for children is in place until September 30, 2019.

The federal government will absorb 100% of the increased cost associated with the expansion population during the first four years, then States will begin sharing in the cost at phased in levels until the State share is 10% in 2020. States have the option of expanding eligibility prior to 2014, but would do so at their regular match rate (about 50% for Alaska). Of significance is a policy change in PPACA that requires States to change to a new eligibility determination method based on modified adjusted gross income. A number of new enrollment procedure changes are included as well, along with a requirement for States to integrate Medicaid enrollment into the Health Insurance Exchange.

A number of provisions add new requirements for covered services, such as freestanding birth center and comprehensive tobacco cessation services for pregnant women; and also makes available new State options to add services, such as family planning for low income individuals. Changes are made to certain payments and reimbursements, such as a new prohibition against federal Medicaid payments to States for services related to health care acquired conditions, and a change to the prescription drug rebate. Optional programs to test new payment methodologies include hospital bundled payment and Accountable Care Organization demonstration projects. There are also incentives and options intended to increase home and community based services in lieu of facility-based services for individuals requiring long term care.

Status in Alaska:

- *Medicaid Maintenance of Effort: the Alaska Medicaid program is required to maintain eligibility standards, methods and procedures for adults until January 2014 and for children until October 2019.*
- *Medicaid Expansion:*
    - *As noted above, Alaska is participating in the 20-state Florida-led lawsuit against the federal government over the enactment of PPACA. One of the challenges under the lawsuit is regarding the unfunded federal mandate imposed by the Medicaid expansion.*
    - *Preliminary estimates released by the Alaska Department of Health & Social Services (DHSS) this summer project that the 2014 expansion will cover approximately 30,000 new enrollees[iv]. The Urban Institute, applying Alaska data to a national model, projects*

the expansion will add between 42,794 to 59,914 new Medicaid enrollees (33,106 – 49,061 of whom will have been previously uninsured)[v].
    - *DHSS is not currently planning to apply for the early expansion option.*
- *New Service Requirements: The Alaska Medicaid program previously exercised the option to cover all the services now mandated under provisions enacted in Title II, including freestanding birth centers and comprehensive tobacco cessation services for pregnant women. These changes are not expected to impact Alaska, other than by eliminating the flexibility the state once had to remove these services from the covered services list, and by requiring a new billing methodology for freestanding birth centers.*
- *Maternal, Infant, and Early Childhood Home Visiting Program: The following organizations were awarded grants under this program in 2010:*
    - *AK Department of Health & Social Services (DHSS): $584,256*
    - *Southcentral Foundation: $345,000*
    - *Fairbanks Native Association: $250,000*
    - *Kodiak Area Native Association: $236,000*
- *Personal Responsibility Education Program (PREP): DHSS was awarded two grants in 2010 totaling $849,985 under this program, which focuses on fostering healthy relationships and preventing teen pregnancy. DHSS chose not to apply for an abstinence education grant made available under this title as the relatively small amount allocated to Alaska would not fund the grant requirements, a match was required, and the same services will be provided under the PREP program.*
- *Aging & Disability Resource Centers (ADRC): DHSS applied for but did not receive the ADRC grant made available under Title II in 2010.*
- *Money Follows the Person Rebalancing Demonstration: DHSS did not apply for a planning grant made available for this program, and does not intend to apply to participate in the demonstration project (grant application due in January 2011).*
- *Medical Home for Medicaid Enrollees with Chronic Conditions: Federal planning funds for this demonstration project will be made available in January through Medicaid match at the state's pre-ARRA FMAP rate. DHSS has not yet made a decision regarding whether to plan for and participate in this demonstration.*

Title III – Health Care Delivery and Payment Changes

Title III intends to control health care costs and improve quality through a series of delivery system and payment changes driven primarily through the Medicare program. Increases in Medicare costs will be limited by restructuring payments to Medicare Advantage plans, reducing annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers. Providers organized as Accountable Care Organizations will be allowed to participate in cost savings they achieve for the Medicare program as long as they meet certain quality thresholds. The Center for Medicare and Medicaid Innovation is created to test new payment and service delivery models, and the Independent Payment Advisory Board is created to develop proposals for reducing per capita rate of growth in Medicare if spending exceeds target growth rates. The Secretary of HHS is vested with broad authority to implement payment reform models that prove to be effective at improving quality and reducing the rate of cost growth.

Medicare will reduce payments to hospitals for excess preventable hospital readmissions and for hospital-acquired conditions. Bonus payments will be made to hospitals in counties with the lowest

Medicare spending. Medicare will establish a Hospital Value-Based Purchasing Program to pay hospitals based on performance on certain quality measures. Plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers will be developed. A Medicare pilot program to test payment bundling for acute inpatient hospital, physician, outpatient hospital, and post-acute care services for an episode of care that begins three days prior to a hospitalization and ends 30 days following discharge is created. A home health demonstration program intended to prevent hospitalization and improve cost, patient outcomes and satisfaction is also created.

The Medicare Part D "doughnut hole" is phased out starting with a $250 rebate check provided to all Medicare beneficiaries entering this drug coverage gap in 2010 and phasing down the coinsurance rate until it is eliminated altogether in 2020. A program to strengthen trauma center capacity is created, along with a demonstration program to develop models for regional emergency care systems.

Status in Alaska:

- *MIPPA (Medicare Improvements for Patients & Providers Act) Medicare Outreach: DHSS was awarded $65,454 for Medicare Outreach to low-income and rural Alaskans.*
- *The only other major provision under Title III known to have taken effect in Alaska during 2010 was the issuance of the $250 rebate checks to Medicare enrollees in the prescription drug "doughnut hole." A few of the provisions impacting Medicare reimbursement also began taking effect in 2010.*

Title IV – Prevention and Public Health

Title IV establishes or reauthorizes and funds a series of programs intended to reduce the burden of disease in the population. It establishes the National Prevention, Health Promotion & Public Health Council and a Prevention and Public Health Fund to coordinate and support prevention, wellness, and public health activities. National committees to develop and disseminate recommendations on effectiveness of clinical and community preventive services are authorized.

Medicaid and Medicare coverage of preventive services is expanded. The Fair Labor Standards Act is amended to require employers to provide reasonable break times and private locations for employees who are nursing mothers to express breast milk. Chain restaurants will be required to disclose the nutritional content of the food items they sell.

"Community Transformation" and "Healthy Aging, Living Well" grants aimed at reducing chronic disease rates and addressing health disparities through wellness activities are funded, and a worksite wellness program to provide technical assistance and funding to small businesses is also established. A grant program to support school-based health centers is created. A grant program to support oral health promotion and disease prevention is created. Programs to improve immunization coverage and continue federal support of public health epidemiology and laboratory capacity are authorized or reauthorized.

Status in Alaska:

- *Much of the new funding appropriated to the new National Prevention & Public Health Fund was diverted by the US DHHS to fund workforce programs authorized but not funded under Title V.*
- *The following grants were awarded to the Alaska Division of Public Health under provisions in Title IV during 2010:*

- *Strengthening Public Health Infrastructure ($100,000)*
- *HIV/AIDS Surveillance – Lab Reporting ($41,909)*
- *Epidemiology & Laboratory Capacity ($473,908)*
- *Behavioral Risk Factor Surveillance System Supplemental ($68,265)*

- *Strengthening Tribal Public Health Infrastructure: The Alaska Native Tribal Health Consortium and the SE Alaska Regional Health Consortium were each awarded $100,000 under this new program.*
- *School-Based Health Centers Capital Program: None of the three school-based health centers (Juneau-Douglas High School/Juneau, Mt. Edgecumbe High School/Sitka, and Clark Middle School/Anchorage) applied to participate in this 1-year equipment grant opportunity.*

Title V – Health Care Workforce

Title V establishes a National Workforce Advisory Committee and requires a national health care workforce assessment be conducted. There are a number of new scholarship and educational loan repayment programs created and existing programs are expanded, with certain emphases on primary care and preventive specialties, nursing, oral health, public health, geriatrics, and behavioral health. It increases the National Health Services Corps and eliminates the cap on the number of commissioned officers in the Public Health Service Regular Corps, and also expands the use of the Reserve Corps (renamed Ready Reserve Corps) in times of a public health emergency. It also expands Area Health Education Centers.

The number of Medicare-funded physician training positions (Graduate Medical Education (GME) for residency training) will be increased by redistributing unused positions with priority given to primary care and general surgery, and by expanding eligible training sites to allow for outpatient health center-based residency training programs. A number of provisions also support the development of training programs in different patient care models, such as medical homes, chronic disease management, and integration of primary and specialty health care into behavioral health care settings. This Title also includes a provision for a 10% bonus payment under Medicare to primary care physicians and general surgeons practicing in health professional shortage areas.

Status in Alaska:

- *State Health Care Workforce Development: The Alaska Workforce Investment Board (AWIB)/ Department of Labor & Workforce Development (DOLWD) in collaboration with the Alaska Health Workforce Planning Coalition received a $150,000 grant in September to develop a strategic plan for health workforce development in Alaska.*
- *Health Occupations Training for Low Income and TANF Recipients: DOLWD also collaborated with DHSS to apply for funding for this program but did not receive a grant. The Cook Inlet Tribal Council was awarded $1,463,627 in September under the tribal organizations provision for this program.*
- *Primary Care Service Integration in Behavioral Health Centers: Alaska Island Community Services (in Wrangell) was awarded a grant of $296,836 under this program in September.*
- *Primary Care Residency Expansion: This grant opportunity became available in July, but did not support planning and development for new residency programs and therefore was not a potential funding stream for development of the new psychiatric or pediatric residency programs in Alaska. The Alaska Family Medicine Residency Program chose not to apply due to concerns over sustainability as the grant would only support addition of new residency slots for one year.*

- *Physicians Assistant Training Program: The UAA Physicians Assistant Training Program was not eligible to apply under the grant opportunity made available by this program in July (only accredited PA schools were eligible, and the PA program at UAA is accredited under the University of Washington's MEDEX program).*
- *Family-to-Family Health Information Centers: This program, initially created in 2005, was reauthorized under PPACA. Stone Soup Group, an Anchorage-based non-profit, was previously funded under this program and received a continuation grant of $96,700 in July to provide information and training to families of special needs children.*
- *No Alaskan organizations are known to have applied for the following grant opportunities made available under provisions in Title V during July:*
    - *Personal and Home Care Aide State Training Program (competitive 6-grantee demonstration project)*
    - *Advanced Nursing Education Expansion Program*
    - *Nurse Managed Health Clinics*
    - *Nursing Assistant and Home Health Aide Program*

Title VI – Fraud, Waste and Abuse

Title VI will require transparency related to financial relationships between health care provider and supplier entities. New provider enrollment processes for Medicare and Medicaid are created, as well as a new database for sharing provider data among federal programs and between federal and State programs. Providers and suppliers will be required to establish compliance programs, and face increased penalties for false claims. State Medicaid programs are required to implement the Medicare RAC (Recovery Audit Contractor) Program.

The Elder Justice Act is created under this title, which addresses prevention and intervention in the abuse and neglect of individuals aged 60 or older, creating an Elder Justice Coordinating Council, and providing funding to State Adult Protective Services and Long Term Care Ombudsman programs. A medical malpractice demonstration program is also created, which will provide grants to States to test alternatives to tort litigation. This title also establishes a non-profit Patient-Centered Outcomes Research Institute to identify priorities for a national comparative outcomes research project agenda.

Status in Alaska:

- *Medicare RAC Program Expanded to Medicaid: AK DHSS submitted a request to US DHHS to extend the deadline for Alaska's compliance with this new requirement from April 1, 2011 to October 1, 2011. The department currently has a contract in place with Myers and Stauffer to conduct audits of Medicaid providers required under state law (AS 47.05.200). This contract is up for annual renewal 10-1-11. The department's intent is to align the state audit program as much as possible with the new RAC program. It will not be possible however to fully integrate the two Medicaid audit programs, as the state program pays the audit contractor a flat fee, while the federal RAC program requires audit contractors be paid on a contingency fee basis.*
- *Nationwide Program for Long Term Care Worker Background Checks: The DHSS/Division of Public Health's Section of Certification & Licensing received a grant of $1 million in October under this program.*
- *Other Provisions: Additional changes enacted under this Title that will potentially impact the Alaska's Medicaid program are currently under analysis by DHSS, including extension of the*

period for collection of overpayments, termination of provider participation in Medicaid if terminated under Medicare, and required participation in the National Correct Coding Initiative.

Title VII - Pharmaceuticals
Title VII authorizes the FDA to approve generic versions of biologic drugs, and expands the 340B program, which is a program limiting the cost of covered outpatient drugs to certain federal grantees.

Status in Alaska:

- *Unknown*

Title VIII – CLASS Act
The Community Living Assistance Services and Supports Act will establish a national, voluntary long term care insurance program starting in 2011. The program requires five-year vesting, and will provide a cash benefit of no less than $50 per day to help aged or disabled individuals to stay in their home. The benefit may also be used to cover nursing home costs. Premiums will be paid through payroll deductions.

Status in Alaska:

- *The federal government is required to establish this new national program in 2011.*

Title IX – Taxes and Fees
New taxes and fees imposed in order to finance the new programs established under PPACA started in 2010 with a 10% excise tax on indoor tanning. There are a series of new taxes and fees imposed on the health care industry and health care products, such as an annual fee on the pharmaceutical industry (starting at $2.8 billion in 2012 and increasing over time), an annual fee on the health insurance industry (starting at $8 billion in 2014 and increasing over time), and a 2.3% sales tax on medical devices starting in 2013. The tax deduction for employers receiving Medicare Part D retiree subsidies is eliminated.

The Medicare payroll tax is increased starting in 2013 by 0.9% (from 1.45% to 2.35%) for individuals who make over $200,000/year ($250,000/year for married couples filing jointly). The payroll tax increase applies only to the employee, not the employer share of the tax. There is also a new 3.8% tax imposed on the unearned income for high-income individuals in that same tax bracket. The revenue from that tax is intended to flow to the Medicare program. Starting in 2018 a new excise tax will be imposed on employer-sponsored high-value insurance plans. Otherwise known as the "Cadillac tax", this tax will be imposed on plans valued at more than $10,200 for individual plans and $27,500 for family coverage, and will be assessed at 40% of the amount over those thresholds.

Status in Alaska:

- *The one Title IX provision that took effect in 2010 was the new federal 10% sales tax on indoor tanning.*

Title X - Amendments

There are a few stand-alone provisions included in Title X (not amending other sections of PPACA). Of significance to Alaska's health care system is a provision that expands funding for Community Health Centers and another that permanently reauthorizes the Indian Health Care Improvement Act. There is one provision specific to Alaska that created the Federal Interagency Task Force to Improve Access to Health Care in Alaska, which was charged with assessing access to health care for beneficiaries of federal health care systems in Alaska.

Status in Alaska:

- *Federal Interagency Task Force to Improve Access to Health Care in Alaska: The Task Force was convened in July, conducted a site visit in August, and issued its report and disbanded in September. A copy of the Task Force's report is available on the Commission's website.*
- *Community Health Center Construction/Renovation: Two Alaska CHCs received grants in October In the first round of funding made available under this program – the Anchorage Neighborhood Health Center ($8 million) and the SE Alaska Regional Health Consortium ($1,299,147).*
- *The Alaska Native Health Board sponsored workshops during 2010 for its member tribal health care organizations and partners on changes made under the Indian Health Care Improvement Act reauthorization and associated amendments.*

Economic Impact of the Federal Affordable Care Act (ACA) on Alaska

Executive Summary of October 2010 Presentation to Commission (included in Appendix C), by Mark A. Foster & Associates/Institute for Social & Economic Research.

Overview – How much might it cost by 2019?

- The Medicaid Expansion *and* Individual Mandate may result in a *net* increase of roughly 60,000 insured individuals in Alaska by 2019; reducing the number of uninsured by about 50% over baseline projections
- The *net effect on overall Alaska health care spending* in 2019 may be an increase of roughly 3%, consisting of:
    - An increase of roughly 4% associated with an increase in utilization of medical care by the newly insured and those whose existing insurance coverage will be increased to comply with new requirements
    - An increase to close the Medicare prescription drug "donut hole"
    - Decreases associated with:
        - Medicare reductions in allowable growth rates – including hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, hospice, and home health
        - Insurance and provider discounts imposed or negotiated
        - Reductions in utilization associated with the shift of financial resources away from health insurance and toward income in response to the 40% excise tax on high cost plans

Changes in Funding Sources in Alaska, 2019 – Who Pays?

- Federal support for the Medicaid Expansion *and* subsidies for households <400% of federal poverty level (FPL) are the primary sources of funding for the insurance expansion – totaling roughly $800 million in Alaska in 2019
- The increased federal support for the insurance expansions will be offset by:
    - Reductions in the overall level of spending on Medicare including:
        - Increments for closing the Medicare prescription drug benefit "donut hole"[<$10M], and
        - Decrements associated with reductions in rate updates and changes in payments for hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, hospice, and home health [$60M]
        - Increased Medicare taxes on high income families [$90M]
        - New 40% excise tax on high cost health plans (approx 50% of health plans in Alaska in 2019 may be subject to the excise tax) [$280M]
        - New fees on drugs, medical devices, health insurance, changes in tax deductions and Health Savings Accounts (HSA) rules [$80M]

Impact on Households

In aggregate, Alaskan households may spend on the order of 1-2% more on health care, which is the net effect of several factors including:

- Subsidies
    - Federal support of coverage expansions – including insurance premium support, cost sharing subsidies, and Medicaid expansion
- Insurance Mandate
    - Increased costs for households who purchase insurance to comply with the mandate; even after subsidies and cost support, households can be expected to pay on the order of 8-9% of income on health insurance
    - Penalties of 2.5% of income for households who decline to purchase health insurance
- Taxes and Fees
    - 40% excise tax on high cost health plans
    - New fees on drugs, medical devices, health insurance providers, changes in tax deductions and Health Savings Accounts rules

The net effect of the ACA on households varies considerably by income level, whether previously insured, and the age of householder. Low and moderate-income level older households and high medical expense households tend to be net beneficiaries. Healthier, higher-income households with no insurance or high deductible plans tend to be net payers. Previously insured households <400% of federal poverty guidelines ($110,280 for a family of four in 2010) are slated to receive insurance subsidies that increase as household incomes decrease. With some limited exceptions, uninsured households above 138% of federal poverty level can be expected to spend roughly 8-9% of their income (after subsidies) to purchase health insurance or spend up to 2.5% of their income as a penalty for noncompliance with the individual mandate. In the individual and small group market, young singles (not covered under their parents' plans) and young families can expect to pay more under health insurance reform while those over 55 can expect to pay less due to a mandate to limit age differentials (previously market rates for insurance tended to more closely track the actuarial costs by age group).

Impact on Private Business

In aggregate, Alaskan businesses may see a reduction in spending on health care of around 3%, which is the net effect of several factors including:

- A reduction in the number of firms offering health insurance with employees migrating to the new Exchange for subsidized coverage; sign-up rates in the new Exchange are likely to be higher for low to moderate wage employees (<400% of FPL) who are in line to receive larger subsidies as a portion of their income in the Exchange
- Firms with 50 or more employees may offer insurance or be required to pay an assessment when their employees use subsidies in the new Exchange

Impact on key economic sector competitiveness

Resource development and export sectors with high wages and benefits appear likely to experience the 40% excise tax on high cost plans sooner than their competitors in other states. Large fishing and tourism enterprises may be faced with challenging "pay or play" penalties due to the high cost of medical care. Small fishing and tourism enterprises may not see the same proportion of small business tax credits due to a relatively small proportion of employees with "low wages" as compared to other states.

C. Issues Prioritized for Study in 2011

1. Health Care Costs

Health care costs are higher in Alaska compared to other states[vi], but a thorough understanding of the underlying reasons why costs vary is required prior to making specific policy recommendations to address the problem. Is it due to an insufficient supply of providers and insufficient competition between providers? Is there higher utilization of medical services in our state, and if so is it due to waste in the system or due to a higher prevalence of complex health conditions? How does fragmentation of the health care delivery system affect overall costs? Are payers unable or unwilling to negotiate the lowest possible price for services?

An important aspect of understanding variations in cost and underlying cost drivers is understanding how cost shifting occurs when one payer or set of payers underpays a health care provider (pays less than the costs the provider incurs to deliver the service). Prices charged are typically higher than the cost of care to make up for capped reimbursement by some payers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are unable to pay. Further analysis of cost drivers and cost shifting is needed to support development and implementation of successful strategies to control cost and improve value.

The high and continued escalation in health care costs in Alaska was a primary concern of the Commission in 2009, and they identified the need for additional analysis to better understand what is driving those costs as a top priority for future study. To understand the main variables influencing cost the Commission was introduced to this simple formula in 2009:

Cost (total spending) = **Price** (paid)/process unit x **Utilization**

During 2010 they were introduced to a more detailed breakdown of the utilization variable:

Utilization =
of **health conditions**
x # of **episodes of care**/condition
x # of **services (by type)**/episode of care
x # of **process units**/service

This formula is providing a framework to guide plans for studying the cost of health care in 2011.

A. Health Care Spending and Cost Driver Analysis – In order to better understand the current cost of health care in Alaska in terms of total spending in the state for health care services the Commission has contracted with the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage to conduct an analysis. ISER conducted similar analyses in the past – once in 1992 and more recently in 2005 (published in March 2006 with 2005 data).[vii] ISER will provide updated information on current spending by payer and service category, will expand past analyses of cost drivers, and will also include an analysis of opportunity costs of high health spending. The final report, expected in April 2011, will include:

- A review of historical spending trends, health insurance and health provider costs, and distribution of public and private payers;
- A ten-year spending forecast;

- An analysis of cost drivers, including:
    - Demand
        - Demographic trends
        - Technology
        - Nature and extent of insurance coverage
        - Tax treatment of benefits
        - Supply sensitive and preference sensitive demand considerations
    - Supply
        - Inefficient organization
        - Physician supply
    - Other factors (e.g., institutional factors, research)
- An analysis of opportunity costs of health spending (in Alaska and compared to the U.S.), including health spending trends as a percentage of GDP compared to other sectors, implications of health spending trends in terms of potential cuts to other public programs and/or tax increases, and description of what higher spending in Alaska buys.

B. Health Care Price and Reimbursement Study - The Commission will contract with a health care actuarial consulting firm with expertise in the analysis of system-wide health care pricing and reimbursement to conduct a study comparing health care provider third party and private-pay charges and reimbursement in Alaska to charges and reimbursement for the same services in Washington and Oregon, and to also benchmark those charges against public coverage such as Medicare, Medicaid, Workers Compensation, TriCare, and the Veteran's Administration. Specific analyses to be requested will include:

- Comparisons of billed and allowed non-facility provider charges, on a per unit basis, for the top 25 most commonly used codes;
- Comparisons of billed and allowed non-facility provider charges, on a per unit basis, for the top 25 most commonly used codes by specific major specialties, including but not limited to family practice, pediatrics, internal medicine, ob/gyn, orthopedics, urology, gastroenterology, cardiology, neurology, general surgery, cardiothoracic surgery, interventional cardiology, ENT, ophthalmology, diagnostic imaging, and chiropractic;
- Comparisons of facility-based provider charges.

The range of billed and allowed charges for each grouping of codes by specialty, as well as the mean and the 50th and 80th percentile, will be included. The consultant will also be asked to identify the major drivers of the pricing and reimbursement differences between Alaska and the other states.

In addition, to assist the Commission in better understanding the challenges Alaska physicians face in delivering Medicare services under the current reimbursement structure, the consultant will be asked to include an analysis of variations in the cost of providing primary care (including compensation, materials and overhead) to Medicare recipients in Alaska compared to other regions of the study, and a description of the major factors driving differences resulting in under-reimbursement of Alaskan physicians by the Medicare program.

The Commission intends to award this contract in January 2011 and hopes to take delivery of the final report by July 2011.

C. Health Status Assessment - The Commission is interested in learning how the "health conditions" variable in the cost equation is driving utilization of and spending for health care services, and has asked the Department of Health & Social Services to provide information on the health status of the Alaskan population, including health trends and health disparities, with comparisons to national averages. The Commission anticipates the information will include data on chronic and infectious disease, injury (both intentional and unintentional), health risk behaviors (including substance abuse), mental illness, and disabling conditions. The Commission hopes to receive the state health status report by July 2011.

3. Long Term Care

Alaska's long term care system is recognized as being one of the most balanced in the nation in terms of supporting people to live in their home and in community settings as opposed to institutions. However, the growing cost of providing long term care services is a critical issue facing Alaska's Medicaid program, and Alaska's senior population is projected to triple over the next twenty years. Current challenges in addition to escalating costs and concerns over system capacity include the need to improve quality in assisted living and other home and community based services, and inadequate services for individuals with maladaptive or severe behavior issues. During 2011 the Commission will compile recent long term care studies, plans and other information available, and will invite a presentation by state leaders grappling with the long term care challenges in our state.

4. Trauma System

Injury is the leading cause of death for Alaskans who are one to 44 years of age. A trauma system that provides rapid appropriate response and treatment is critical to reducing death and disability due to injury. The Department of Health & Social Services made trauma system development a priority two years ago and commissioned a study by the American College of Surgeons Committee on Trauma. Progress has been made since the release of the Committee's November 2008 report. For example HB 168, establishing the Uncompensated Trauma Care Fund to incentivize hospitals to meet trauma center standards, passed during the 2010 legislative session and was signed into law in June; and, DHSS created and filled a Trauma System Coordinator position to support development of a trauma system strategic plan. During 2011 the Commission will learn about the status of trauma system improvement in our state.

Part III: Alaska Health Care System Transformation Strategies

A. Status of Implementation of 2009 Commission Recommendations

The Commission intends their recommendations from prior years to continue standing as current recommendations unless and until they decide to modify or eliminate them based on further study. To that end the Commission will track, consider and report on implementation of our prior year recommendations over time. During 2010 progress was made related to all of the 2009 Commission recommendations. Following is a summary of these developments.

A. <u>Strengthen the Consumer's Role in Health and Health Care</u>

1. Support healthy lifestyles and create cultures of wellness
2. Develop patient-centered primary care models through payment reform, removal of barriers, and support for pilot projects

Healthy Lifestyles

State agencies operate a number of programs aimed at supporting healthy lifestyles, including programs to prevent and control specific diseases and conditions and also risk behaviors such as: obesity, tobacco use, alcohol & drug abuse (including Fetal Alcohol Spectrum Disorders), suicide, unintentional injuries, domestic violence & sexual assault, child abuse, infectious disease, chronic disease, autism, and metabolic and other genetic disorders. Following are significant new efforts initiated and resources invested during 2010.

- Governor Parnell launched "Choose Respect" in March 2010, a new initiative to stop the epidemic of domestic violence and sexual assault in Alaska. As an early phase of this initiative, the Governor proposed and won passage of several new laws during the 2010 legislative session targeted at sexual and domestic violence offenders. The Governor's initiative is now aiming to prevent domestic violence and sexual assault from occurring in the first place by working towards creating a culture that emphasizes respect for others and zero tolerance of violence against women and children.

- The Alaska Department of Health & Social Services (DHSS) implemented two new initiatives related to obesity and chronic disease prevention and control:

    - Alaskans Taking on Childhood Obesity: DHSS collaborated with the Alaska Department of Education & Early Development (DEED) to create "ATCO" – a Task Force convened by the Commissioners of the two state agencies and including the Anchorage School District, Alaska Association of School Boards, and the Alaska Native Tribal Health Consortium to develop recommendations regarding strategies to reverse the trend of increasing rates of overweight and obesity among Alaska's children. The two state agencies (DHSS and DEED) formalized their agreement to collaborate in school-based obesity prevention and reduction efforts in a Memorandum of Agreement signed by Commissioner Hogan and Commissioner LeDoux in July.

    - Alaska Food Policy Council (AFPC): DHSS collaborated with the Alaska Division of Agriculture, US Department of Agriculture, Farm Bureau, Alaska Center for the Environment, and Alaska Root Sellers to create the first food policy council in Alaska. The goal of the new council is to expand

Alaska's food production, improve supply and distribution of locally grown and produced products, decrease hunger, support the use of traditional and local foods, and increase nutrition literacy of consumers.

- DHSS also received an annual operating budget increase of $375,000 in state general funds in the SFY 11 budget to support the Division of Public Health's Obesity Prevention & Control Program. The new state funding will not support new efforts, but replaces federal funding received through hard earmarks and under ARRA to support obesity prevention and control over the past decade. Without the new state funds and with federal support drying up the program may have been discontinued.

- The Statewide Suicide Prevention Council launched a new web portal in November, **www.StopSuicideAlaska.org**, offering information and resources for individuals and groups in Alaska to support efforts to prevent suicide and help with recovery after a loss.

Patient-Centered Primary Care

During 2010 DHSS received a federal grant under CHIPRA (Children's Health Insurance Program Reauthorization Act) that will provide funding for piloting and evaluating patient-centered medical home care models to improve children's health care in primary care clinics in Alaska. The department released a grant Request for Proposals in November and intends to make grant awards to pilot sites in January 2011.

In June of this year the Southcentral Foundation's (SCF) Primary Care Center became the first practice in Alaska to achieve NCQA (National Committee for Quality Assurance) recognition as a patient-centered medical home (level III; effective 2010-2013). In July the University of Alaska Anchorage was awarded a 2-year federal grant to evaluate SCF's adoption of the medical home model in terms of its impact on the cost and quality of care.

This past year the Providence Family Medicine Center/Alaska Family Medicine Residency Program transitioned to a patient-centered medical home care model. The new Providence Senior Care Center, scheduled to open in January 2011, is building its practice based on the same model.

The Alaska Primary Care Association (APCA) launched an initiative in 2010 to support their members' efforts to transform their clinics and practices to a medical home model. APCA contracted with Primary Care Development Corporation to hold a learning session for member clinics and organizations on how to become a recognized medical home. APCA is currently investigating opportunities for developing a set of "Alaskanized" patient-centered medical home standards that will be based on national standards but modified to accommodate special features of health care delivery in Alaska (such as mid-level practitioner led clinics in rural communities too small to support physician practices).

B. <u>Foster Statewide Leadership to Support Health Care Transformation</u>

1. Invest in the health policy infrastructure needed to respond to national reform
2. Establish a permanent state health planning and policy body in statute

National Reform

Following passage of the federal health care reform laws in March and April Governor Parnell directed the State Attorney General to join the Florida-led multi-state lawsuit challenging the law on two primary points: 1) the constitutionality of the federal government's authority to require individuals to purchase

health insurance or pay a penalty, and 2) the imposition of an unfunded mandate on state government by expansion of the Medicaid program.

Due to the Administration's constitutional challenge to the new federal laws, state agencies are proceeding cautiously regarding implementation of new programs created by the laws. State agency staff have been working to assess requirements imposed on state government and to consider options to participate in potential funding opportunities. Decisions to participate in optional programs and regarding how to implement required provisions are being made on a case-by-case basis by program managers and agency executives based on alignment with current policies and programs.

Information that has been made public to-date by state and federal agencies on analyses and implementation of the new laws in Alaska is included in this report in Part II.B and Appendix B.

State Health Planning & Policy Body

The Alaska Legislature passed SB 172 establishing the Alaska Health Care Commission in statute on the final day of the legislative session in April. The bill was transmitted to the Governor in June and signed into law June 21. The new law is very similar to Governor Palin's order that established the original Commission (Administrative Order #246). The most substantive change is the addition of four new voting member seats. SB 172 also included a transition clause to automatically appoint former members appointed under A.O. #246 to the new Commission. New Commission members were appointed September 15 and the Commission convened for the first time in October of this year.

C. Develop the Health Care Workforce

1. Make workforce a priority on health care reform and economic development agendas
2. Strengthen the pipeline of future health care workers
3. Support workforce innovation and adaptation as patient care models evolve
4. Direct workforce planning to be more coordinated
5. Increase the supply of primary care physicians by
    - Supporting educational loan repayment and financial incentives for recruitment
    - Expanding the WWAMI Alaska medical school program as resources allow
    - Supporting primary care residency program development and operation

Health Workforce Planning

The Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan," which was adopted by the Alaska Workforce Investment Board in May 2010. In September the Department of Labor & Workforce Development (DOLWD) received a federal grant to develop a strategic plan for health workforce development in Alaska. DOLWD is using these funds to support the work of the Coalition to develop an action plan based on the new comprehensive statewide plan. The Coalition anticipates the action plan will be drafted by the spring of 2011. The Coalition also launched a new website this year (https://sites.google.com/site/alaskahealthworkforcecoalition/) and has been holding monthly planning meetings.

Educational Loan Repayment & Financial Incentives

A number of bills introduced in the 26th legislature (2009-2010) would have created and funded a state educational loan repayment and financial incentive program to support recruitment of health care professionals to serve underserved areas and populations in Alaska, but none of these bills passed.

During 2010 the Department of Health & Social Services started a loan repayment program, SHARP (Supporting Healthcare Access through loan Re-Payment), funded with a 1-year $600,000 federal grant and additional funds provided by the Alaska Mental Health Trust Authority and health care organizations. The annual loan repayment benefit provides up to $35,000 for Tier-1 professions or $20,000 for Tier-2 professions for two years, and is paid directly to the practitioner's lender. Eligible practitioners are primary care physicians, nurse practitioners, physician's assistants, dentists, dental hygienists, psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, licensed professional counselors, and marriage and family therapists serving in identified high-needs areas and facilities. The first grants issued under this program were awarded in June to 14 practitioners based in Anchorage, Bethel, Dillingham, Kenai, Homer, Petersburg, Talkeetna, Tok and Wrangell, as follows: $230,000 to five behavioral health providers, $140,000 to two dental care providers, and $361,771 to seven primary medical care providers.

Primary Care Residency Programs

Of the three new residency programs noted as a need in the Commission's 2009 recommendations, there was significant progress made related to planning and development for two during 2010:

- Alaska Pediatric Residency: The new pediatric residency program will be a three-year branch program of the UW Children's Hospital Pediatric Residency Program. Residents will complete a four-month rotation in Alaska during each of the three years in training; will train in Anchorage, Fairbanks and Juneau; and will have opportunities for placement in both urban and rural and tribal health system and private industry sites. The new pediatric residency program will support 12 residents starting in 2012. Planners do not anticipate requesting funding from the State of Alaska for support. Financial support will be provided by Southcentral Foundation, Providence Health and Services System, Banner Health System, SouthEast Alaska Regional Health Consortium, and the Seattle Children's Hospital.

- Alaska Psychiatry Residency: The new psychiatry residency program will be a four-year branch program of the University of Washington Psychiatry Residency Program. Residents will spend their first two years training in Seattle, and the last two years in Alaska. The program could begin as early as the summer of 2012, and at full capacity 11 residents will be enrolled in the program each year. Residents will train with both urban and rural providers of psychiatric care, and their training will emphasize primary care integration, telepsychiatry and rural/remote consultation. Financial support will be provided by Southcentral Foundation, Anchorage Community Mental Health Trust, Fairbanks Memorial Hospital, Providence Health and Services System, and the Alaska Psychiatric Foundation. Planners anticipate requiring State of Alaska funding in addition to industry and other support to start and maintain operation of this program.

D. Deploy Health Information Technology

1. Support health information technology adoption and utilization
2. Ensure public health connectivity
3. Ensure resulting information is used for optimization of medical care
4. Ensure privacy and security
5. Facilitate broadband telecommunications service access
6. Improve reimbursement for telemedicine

In April 2010 the Alaska Department of Health & Social Services awarded a $3 million four-year contract to the Alaska eHealth Network (AeHN) to serve as the state's official Health Information Exchange (HIE) management entity. In November AeHN awarded a contract to Orion Health to provide the technology for Alaska's statewide exchange. Initial pilots to begin connecting hospitals and clinics in certain test sites are slated to begin in April 2011. The program creates a system for securely moving electronic health records (EHRs) between participating health care providers; provides connectivity to referral providers in Alaska and the lower 48; supports telemedicine (high-resolution image transfer, videoconferencing, and Voice-over-Internet applications); and creates a system to track chronic disease across the state, coordinate care programs and improve patient health.

Also in April AeHN received a federal grant of $3,632,357 to establish a Regional Health IT Support Center (also known as the Regional Extension Center, or "REC") to provide technical assistance to health care providers in the selection and implementation of EHRs. One of AeHN's goals is to assist smaller providers with implementing EHR systems and achieving "meaningful use" (standards for qualifying for incentive payments and avoiding penalties). Services include EHR readiness assessment, vendor selection and contracting assistance, practice workflow redesign, training, and IT support ("geek team"). Alaska's REC began offering services in September.

Following a 2009 survey of Alaskan providers on EHR adoption that identified difficulty in selecting an EHR vendor as a top barrier, the Alaska EHR Alliance launched an 8-month process to select two EHR vendors to endorse for Alaska's providers. In April 2010 the Alliance selected e-MDs and Greenway Medical Technologies as the preferred vendors. Under the endorsement Alaska providers are offered reduced pricing and access to pre-negotiated contracts to simplify the EHR selection process, in addition to the assurance that the vendors were carefully vetted from an initial field of 250 potential vendors by a team of Alaska health care system stakeholders. This project was funded by AeHN through a grant from the State of Alaska.

The Alaska EHR Alliance also updated their 2009 survey of Alaskan providers in January 2010 by contacting clinics that reported not having EHRs in the 2009 survey. Of the 94 clinics that responded to the follow-up survey, 24 had acquired new EHRs in the past year and an additional 18 were planning to do so.

In addition to the contracts negotiated by the Alliance with e-MDs and Greenway, two Alaska hospitals began offering EHRs at a reduced price to affiliated physicians this year. Central Peninsula Hospital in Soldotna offers eClinical Works and Providence offers Epic as remote-hosted EHRs, providing hosting, maintenance and subsidies to independent physician practices choosing to adopt their systems.

The University of Alaska partnered with Dakota State University this year to create Alaska's first Health Information Technology Workforce Training Program. The program offers two certificates available through the UAS Sitka Campus providing noncredit continuing education courses via online delivery. The two certificates, one for Health IT Redesign, Planning, and Management, and the other for Health IT Implementation and Technical Support, fulfill the requirements for roles defined by the federal Office of the National Coordinator (ONC) for Health IT. This program is federally funded by the American Recovery and Reinvestment Act of 2009 (ARRA).

In July CMS published final regulations to implement the Medicare and Medicaid EHR Incentive Programs created by ARRA. These programs will begin providing financial incentives to health care providers making "meaningful use" of electronic health records in 2011. Federal regulations also issued

in July implement the EHR Certification Program. Authorized testing and certification bodies are now certifying EHR technologies as meeting compliance standards required for achieving meaningful use.

Significant 2010 developments related to expansion of broadband availability and support in Alaska include:

- The creation of Connect Alaska at the beginning of the year. Connect Alaska is a subsidiary non-profit of Connected Nation (a national non-profit formed to expand broadband across the U.S.), and received a $1.9 million federal NTIA (National Telecommunications and Information Administration) grant through the Denali Commission to map broadband connectivity in Alaska.
- The launch of Alaska's first statewide broadband availability map in September. Connect Alaska, in partnership with the Alaska Department of Commerce, Community and Economic Development, developed the web-based interactive map with funding from the federal NTIA grant (appropriated under ARRA). The map will be continually updated, and is available at www.connectak.org.
- Receipt of $117 million in federal grants and loans by broadband service providers to expand and improve broadband connectivity to rural SW Alaska communities (and also Tanana and Cordova).
- Receipt by 257 health clinics in rural Alaska of FCC subsidies for telecommunication and internet access costs.

E. Improve Access to Primary Care for Medicare Beneficiaries

1. Increase the supply of primary care providers
2. Support Federally Qualified Health Centers and Rural Health Clinics
3. Request relief from federal reimbursement inequities and administrative burdens
4. Develop a PACE (Program of All-Inclusive Care for the Elderly) program

Expansion of clinical capacity intended to help alleviate the primary care access problem for Medicare beneficiaries is the main area of progress during 2010 related to the Commission's recommendations. One new clinic that accepts Medicare patients opened this year, and two new clinics were planned during 2010 and will open in early 2011:

- Mat-Su Community Medicine, currently staffed by one physician who is board certified in both pediatrics and internal medicine, opened in November. The new clinic accepts Medicare patients, and is being subsidized by Mat-Su Regional Medical Center.

- Providence Senior Care Center will open in January 2011. It will initially be staffed by two internal medicine physicians and one nurse practitioner with hopes to add two additional internists by the summer. Care delivery will be based on the patient-centered medical home model. The Center will accept patients 55 years of age and older, and estimates that approximately 70% of the patients will be Medicare enrollees. Providence Health & Services is subsidizing the start-up and operation of this clinic.

- Alaska Medicare Clinic, Inc., a new non-profit, received a $1 million state grant in the FY 2011 capital budget to support start-up costs for a new clinic devoted solely to Medicare enrollees. This clinic will be directed by a physician and primarily staffed with mid-level practitioners, nurses and medical assistants. It will not use a patient-centered medical home care model, but planners have developed a streamlined care delivery process. Administrative operations will also be streamlined since the practice will be limited to a single payer and a specific patient population. Clinic organizers are hoping to open in February.

In addition to these new clinics the Anchorage Neighborhood Health Center (ANHC), a Federally Qualified Health Center, is implementing a project to relocate and expand clinic capacity from 20,000 ft^2 to 42,000 ft^2. During 2010 ANHC received a new $6 million state capital grant (in addition to $10 million in state capital funds received in prior year budgets), and also an $8 million federal grant under the Patient Protection & Affordable Care Act (PPACA), to support this $28 million project. The new facility will have 3 medical pods, one dedicated to seniors, and use a patient-centered medical home model. August 2012 is the scheduled move-in date for the new facility.

Health care organizations in Anchorage are continuing to study the feasibility of creating a PACE program, but are not yet prepared to begin active planning with the Department of Health & Social Services on a reimbursement model, which will be the next step towards development of a CMS waiver to develop a PACE program for Alaska.

Individuals commenting at recent public hearings of the Commission have noted a provision included in the federal Patient Protection & Affordable Care Act through an amendment offered by Sen. Begich that intends to provide state governments an avenue for subsidizing Medicare payments to providers with state-funded grants (P.L. 111-148, Sec. 5606 added by Sec. 10501). It is unclear whether this provision overcomes the legal restriction prohibiting providers from accepting supplemental payment for Medicare services.

Continuing Work Needed on 2009 Recommendations

While progress has been made during 2010 in every area the 2009 Commission addressed more effort is needed to implement the initial set of recommendations, including on-going work to:

- Develop policies and capacity to encourage and support healthy lifestyles;
- Foster the development of innovative patient-centered primary care models including integration of primary medical care and behavioral health services;
- Track implementation of federal health reform legislation;
- Create sustainable capacity for health workforce planning and development;
- Improve health professions recruitment and retention through a state educational loan repayment and financial incentive program;
- Develop and support graduate medical education programs for training psychiatry, pediatric, and internal medicine residents in Alaska;
- Support health information technology deployment; and,
- Achieve improvements in federal Medicare policies.

The Commission will continue tracking progress made on the 2009 recommendations and will periodically review and potentially refine and add to these recommendations over time.

B. 2010 Commission Recommendations

Note: The numbering system for Strategies, Findings, and Recommendations continues from 2009.

A.3. Consumer's Role/Value: Foster the use of Evidence-Based Medicine

Finding A.3.a: Waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending.

Finding A.3.b: Evidence-based medicine can increase the effectiveness of medical treatment, improve the quality of health care, and reduce health care costs.

Finding A.3.c: Public and private health care sectors have demonstrated an increasing interest in applying evidence-based medicine to policy and practice in response to high and rising costs and variations in quality of health care.

Finding A.3.d: Involvement of health care providers and patients in decision-making is essential to the successful application of evidence-based medicine to clinical practice and public and private payer policies.

Finding A.3.e: Existing mechanisms to assess patients' compliance with evidence-based medical recommendations are limited.

Finding A.3.f: Assessing the outcomes of health care interventions is challenging due to limitations on collecting and sharing data among patients, clinicians, payers, and government agencies.

> *"Evidence-based medicine is the practice of medicine in which the physician finds, assesses, and implements methods of diagnosis and treatment on the basis of the best available current research, their clinical expertise, and the needs and preferences of the patient."*
>
> Mosby's Medical Dictionary, 8th edition, 2009 Elsevier

Health care expenditures are consuming an increasing proportion of Alaska's and the United States' gross domestic product (GDP) each year, but there is no indication that higher spending is producing better health outcomes for individuals or populations. Furthermore, there is growing evidence that a significant proportion of health care delivered in the United States is ineffective, inappropriate, or unnecessary, potentially wasting hundreds of billions of dollars. An oft-cited estimate is that waste in the health care system due to misused medical resources represents as much as 30% of health care spending. There is a costly gap between the care patients need and the care they actually receive.[viii]

Highlighting the problem of inconsistent and inappropriate use of health services is the Dartmouth Atlas of Health Care[ix] and numerous other studies, which have consistently demonstrated wide variations in practice patterns across geographic regions of the United States. The tests and treatment patients receive varies based on the location in the country where the care is provided. Moreover, research has documented those regions of the country where there is overuse of health care resources and higher spending actually have lower quality of care and worse health outcomes.[x xi xii]

Coinciding with increased recognition of the gap in the quality of care is an evolution in the nature of medical practice toward shared decision-making. A generation ago patients typically relied on their physician to make decisions for them regarding their care. The physician would determine the best

course of treatment based on their training, continuing education and journal reviews, and clinical experience. Today health care decision making is becoming a shared process that includes the provider's clinical judgment but also takes account of the patient's personal values and preferences and presents them with choices based on the best available scientific evidence of what course of treatment might work best for them.

A growing trend in clinical practice that is demonstrating improvement in quality and cost of care and that also supports better patient engagement in decision-making about their care is "evidence-based medicine." Evidence-based medicine (EBM) is a model of clinical practice intended to improve the quality, safety and effectiveness of care by applying scientific evidence of effectiveness and benefit to individual medical decisions. It uses the best available, high-grade evidence to support the clinician's and patient's decision-making process.

The practice of EBM dates back to ancient times, with accounts of efforts to study and understand the health outcomes of different treatment regimens found from Ancient Greece and China and even documented in the Bible.[xiii] Archie Cochrane, a physician and epidemiologist from Scotland, is acknowledged as the father of modern EBM. His 1972 text "Effectiveness and Efficiency: Random Reflections on Health Services" is noted as having had a profound influence on the practice of medicine and on the evaluation of medical interventions. His work led to the founding of the Cochrane Collaboration which is an international, nonprofit, independent organization dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide.

The term "evidence-based medicine" is relatively new. It came into use in the early 1990s and was first formally defined by David Sackett in 1996 as "the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients."[xiv] More recently David Eddy integrated the definition to include application of evidence to policy development with his definition published in 2005, defining EBM as a set of principles and methods intended to ensure that, to the greatest extent possible, population-based policies and individual medical decisions are consistent with evidence of effectiveness and benefit.[xv]

Numerous public and private organizations have demonstrated increasing interest in supporting the use of evidence-based medicine to improve health care quality and contain costs, for example:

- The Blue Cross Blue Shield Association established the Technology Evaluation Center (TEC) in 1985 to provide health care decision makers with timely, rigorous and credible assessments that synthesize the available evidence on the diagnosis, treatment, management, and prevention of disease. Current TEC clients include Kaiser Permanente and the Centers for Medicare and Medicaid Services.[xvi]

- The Veterans Health Administration established the Quality Enhancement Research Initiative in 1998 to support the application of new research findings into routine clinical practice to improve the quality of health care for Veterans.[xvii]

- The Agency for Healthcare Research and Quality (AHRQ), the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care in the United States, established the Effective Health Care Program in 2003 (under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) to support the production of health care effectiveness research for clinicians, consumers, and policymakers.[xviii]

- The Oregon Center for Evidence-based Policy was created at the Oregon Health & Science University in 2003. Current projects of the Center include 1) the Drug Effectiveness Review Project (DERP), which supports the application of the best available evidence on effectiveness and safety comparisons between drugs in the same class to public policy and decision making; and, 2) the Medicaid Evidence-based Decisions Project (MED), which makes high quality evidence available to participating State Medicaid Programs to support benefit design and coverage decisions.[xix]

- Washington state enacted a set of statutory provisions between 2003 and 2006 authorizing the state's public payers (Medicaid, Workers' Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improve the quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.[xx]

- In 2006 the Institute of Medicine convened the "Roundtable on Evidence-Based Medicine", which is working through a series of workshops and publications to explore opportunities for achieving the Roundtable's goal that "by 2020, 90% of clinical decisions will be supported by accurate, timely, and up-to-date clinical information and will reflect the best available evidence."[xxi]

- The Patient Protection & Affordable Care Act (P.L. 111-148) enacted in 2010 established a private, non-profit Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by carrying out research projects that provide high-grade, relevant evidence on how diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed. Members of the Board of Governors of the new Institute were recently appointed by the U.S. Government Accountability Office (GAO).[xxii]

A critical aspect of EBM is the importance of understanding the quality of evidence and the appropriate application of evidence to an individual medical decision or population policy decision. Many unfortunate decisions have been made based on inadequate information or information derived from poor quality research or by those who misinterpreted the findings. The media is filled with stories of drugs being pulled off the market due to newly identified dangerous side-effects (e.g., Vioxx, Avandia, and Meridia), and commonly used medical therapies found to be potentially harmful (e.g., hormone replacement therapy) or no more effective compared to less invasive, less costly treatments (e.g., arterial stents). This has lead to significant confusion on the part of the public and skepticism regarding whether to ever believe any medical research at all.

Skepticism on the part of the public is not misplaced – an estimated 90% of published medical information is flawed.[xxiii] It is therefore essential that health care professionals understand how to translate evidence into practice. It is relatively easy to learn basic critical appraisal skills, and training in how to critically evaluate the medical literature and apply it is increasingly available. Methods for grading the quality of evidence and the strength of recommendations have been developed and are in wide use. A growing number of organizations evaluate clinical studies and make medical information based on high grade evidence available publicly. Other challenges to applying EBM in clinical practice, such as the overwhelming volume of research and information available to guide clinical decision making, should in time be more easily managed with the assistance and growing use of health information technologies by health practitioners and patients.

It should be noted that there has been some controversy around the term "evidence-based medicine." Some borne out of concern that the intent is to turn clinicians into automatons through imposed decisions based on required instructions ("cookbook medicine"). Others who have heard the term in recent use by public entities fear it is a government initiative, intended to take individual health care decisions out of the hands of providers and their patients. It is neither, and acknowledging these potential concerns and ensuring the appropriate use of EBM can guard against these concerns becoming realized.

> *"Evidence based medicine is not "cookbook" medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied."*
>
> *David Sackett, et al, 1996*[xxiv]

Resources available for health care are not infinite, and policy decisions regarding their use are made by health care payers in the public and private sector every day. Evidence-based medicine is a model of individual clinical practice and population policy decision-making that can serve to ensure limited resources are targeted to the most effective and efficient services. Application of evidence-based medicine to the public policy arena should not increase government control over health care decisions, but should ensure that government officials are being more responsible stewards of the public funds with which they are entrusted. The goal should always be to increase the quality of care and improve health care outcomes by ensuring information on which decisions are being made is valid and accurate.

The ideal health care system for Alaska should be designed to apply high-grade evidence in support of a collaborative health care choice for each patient and provider. The system should also be designed to support application of high-grade evidence by public officials who have the qualifications and training to critically appraise medical literature, and through a public process that is transparent and includes stakeholders in public policy decision-making regarding allocation of limited public medical care dollars.

In Alaska state government is a significant payer for health care services. State programs that purchase health care such as the Medicaid program, state employee and retiree health plans, corrections and Workers' Compensation could provide leadership in incentivizing improved quality and efficiency of care through the use of evidence-based medicine. Public policies based on the application of evidence-based medicine should enhance the consumers' role in health by fostering informed discussions between patients and providers with the goal of improving the health outcomes of medical decisions.

Recommendation A.3.a: The Commission recommends that the Governor and Alaska Legislature encourage and support State health care programs to engage in the application of high grade evidence-based medicine in making determinations about benefit design (covered services, prior authorization requirements, patient cost-sharing differentials) and provider payment methods.

Recommendation A.3.b: The Commission recommends that the Governor require State health care programs to coordinate development and application of evidence-based medicine policies to create a consistent approach to supporting improved quality and efficiency in Alaska's health care system.

Recommendation A.3.c: The Commission recommends that the Governor require State health care programs to involve health care providers and consumers in decision making related to the application of evidence-based medicine to public policy. The purpose of such involvement is to support a transparent process leading to policies that avoid restricting access to appropriate treatment and that foster informed discussions between patients and clinicians in which individualized, evidence-based choices improve the quality of health care.

Recommendation A.3.d: The Commission recommends that the Governor direct State health care programs to seek to incorporate data on patient compliance in developing new provider payment methods and benefit design.

Recommendation A.3.e: The Commission recommends that the Alaska Department of Health & Social Services implement a web-based data system for public health information.

C. Strategies under Consideration for Study in 2011

Note: The numbering system for Strategies continues from 2009 and 2010.

A.1. Consumers' Role/Prevention: Healthy Lifestyles - On-line Community-Based Health Data System
During 2009 the Commission learned that chronic disease is the leading cause of death and disability in the U.S. and Alaska, that the majority of health care spending is for chronic disease, and that individual behaviors such as tobacco use, poor diet and inactivity are now the leading determinants of the health status of the population and contributors to premature death. The Commission recommended that the State investigate strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Communities play an important role in creating local environments that support healthy lifestyles. Design of roads, walkways and public transportation systems; school policies regarding nutrition, physical education, and extracurricular activity; development of non-profit organization programs; local ordinances such as those pertaining to clean indoor air; and, organization of local medical services and systems are all examples of where communities can act to influence the health of their residents.

A critical resource for community health improvement planning is timely and relevant data on local health factors to guide identification and prioritization of program strategies, support alignment with health goals, and enable measurement of progress and evaluation of outcomes. During their November 2010 meeting the Commission heard from a representative of an Alaskan community health foundation about the need for and opportunity to develop a public access, web-based data and information system to support local health status reporting and improvement planning. The Commission identified this strategy as a priority for study during 2011.

A.2. Consumers' Role/Value: Primary Care Innovation - *Next Steps*
Primary care is the foundation of the health care delivery system – providing the main point of entry for secondary and tertiary care, and meeting the majority of patient needs for health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health conditions, and overall management of a patient's health care services. There is increasing evidence that access to high-quality primary care improves health outcomes and reduces costs. However, the rising demand for services from an aging population and increasing chronic disease, coupled with the decreasing supply of primary care physicians, is sweeping our primary care system toward a crisis.

In preliminary learning about innovative patient-centered primary care models during 2009 the Commission found that these models are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care. Key characteristics of patient-centered primary care include a stable trusting relationship between the patient and their health care practitioners; care that is provided by a multidisciplinary team; whole-person orientation (addressing all life stages, prevention and wellness, acute and chronic conditions, and both mind and body); care that is coordinated and/or integrated (including integration of primary medical care and behavioral health services); emphasis on quality and safety; and enhanced access (through open scheduling and modern communication options). The Commission recommended the State aggressively pursue development of these care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects.

During 2011 the Commission will engage in additional learning to identify more specific strategies for advancing the patient-centered primary care medical home model in Alaska, including strategies for integrating primary medical care with behavioral health services.

A.4. Consumers' Role/Value: Increase Price & Quality Transparency

Consumers need to know the price and quality of their health care options in order to make informed decisions and support their ability to participate more fully in their care, but the present system of health care pricing and reimbursement has been characterized as "forcing sick and anxious people to shop around blindfolded for cost-effective care."[xxv] Empowering consumers with information not only supports improved decision-making on their part, but drives the entire system to provide better care for less money. An infrastructure to support transparency of health care prices and quality for Alaskan consumers, compiling and analyzing data on pricing and quality measures for physician services and hospital care and producing public information through an accessible and understandable reporting mechanism, does not currently exist.

Creating a system to provide transparency is not as simple as it may sound however. Pricing of individual services might be misleading without a more comprehensive picture of the total cost of care for a given condition and the expected outcomes of various care options. And transparency to support a market-based approach is not the only solution to the health care cost and quality problem. Health care is different than other goods and services, and all the conditions required for a competitive market do not exist in the health care market. Consumers do not fully control all of their health care dollars, and they cannot participate fully in all aspects of clinical decision-making about their care. In addition, many health care decisions are made for consumers in urgent or emergent situations when the consumer is severely ill, injured or under too much emotional stress to participate in their care decisions.

The potential benefits of and barriers to developing a system providing price and quality information to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent with the goal of improving value (increasing quality/controlling costs). During 2011 the Commission will study national trends in price and quality transparency and identify opportunities for applying transparency strategies to improve value in Alaska's health care system.

A.5. Consumer's Role/Value: Bundled Payment Systems

The current fee-for-service payment system rewards health care providers for volume, not value. The financial incentives in this system lie entirely in the provision of more health care services and the sale of more health care commodities regardless of the quality of care provided, and may actually serve as a disincentive to creating health. Payment bundling is one value-driven payment method with the potential for rewarding quality over volume.

Payment bundling provides a global fee for a specified set of services. Development of this type of payment system could be phased in over time, starting with bundling of a limited set of hospital services related to certain acute care episodes (related to certain illness diagnoses for a specified period of time – for example, coronary artery bypass surgery and extending 30 days beyond discharge); and expanding over time to include physician inpatient care and post-acute care.

A particular challenge to implementing this strategy in Alaska is the lack of integrated care networks in our state. Hospitals would have to contract with physicians and other service providers required to deliver the suite of services potentially needed to treat the bundled diagnoses or procedures. Other challenges involve the lack of sophisticated information and accounting systems in many of Alaska's smaller hospitals, the need to identify standards to ensure changes in reimbursement do not negatively impact quality, mechanisms for avoiding "cherry-picking" of patients with the potential for fewer complications, and ways to reduce exposure to risk for providers. Research is required to guide implementation of new payment methods, and careful evaluation is required to assess cost-effectiveness, impact on quality of care and patient outcomes, and identification of unintended

consequences. During 2011 the Commission will analyze the opportunities for testing bundled payment systems in Alaska.

A.6. Consumer's Role/Value: Leverage State Purchasing Power

State government in Alaska represents a substantial payer for health care services. The state spent over $1.5 billion in FY 2009 in Medicaid expenditures, state employee and retiree claims (not counting benefit credits paid to union health trusts), state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. In 2011 the Commission will study potential benefits and barriers to collaboration between these state programs to develop shared value-driven purchasing strategies --- leveraging their purchasing power to drive improved health care quality and cost in Alaska.

A.7. Consumer's Role/Access: Insurance Industry Regulation/Deregulation

One cornerstone of the new federal health care legislation (the Affordable Care Act) is reform of the private insurance market through a series of new federal regulatory requirements. The federal government envisions these reforms will be implemented through and by state insurance regulators. There are questions and concerns regarding the impact of these new requirements on the insurance industry, on future prices for insurance premiums, and on the States' role in insurance regulation.

Only 23% of Alaskans have health insurance purchased on the private market. An additional 32% have insurance through their employers' self-insured plan (exempt from state regulation under federal law (ERISA)). The remaining 45% of Alaskans have insurance through a public plan (Medicaid/Medicare), have health care provided by the military or the tribal health system, or are uninsured. [xxvi] Consideration of insurance market reform strategies will require study of the potential impact on Alaska's health care system since less than a quarter of the population is covered by the state-regulated insurance market. During 2011 the Commission will study opportunities for improving access to and value of health care through insurance market regulation (and deregulation) in the context of the changes imposed by the Affordable Care Act.

B.3. Statewide Leadership: Measuring Health System Improvement

The Commission and State leaders in government, business and the health care industry need a mechanism for tracking how Alaska's health care system is performing over time, and whether Commission recommendations are having intended results in health system improvement. During 2011 the Commission will develop a set of indicators that are measurable and that best represent the status of our health care system relative to attainment of the four goals of increased access, controlled costs, improved quality, and prevention-focused. The Commission will also set benchmarks and targets for each measure, with the intention of reporting annually in future years on the progress of health system improvement. Following are examples of potential indicators.

<u>Potential Health Care System Transformation Measures:</u>

1. Increase Access
    - Percent of Alaskans insured
    - Percent of Alaskans who have a specific source of on-going care
    - *Measure of insurance affordability*
    - *Indicator of workforce supply*

2. Control Costs
    - Annual growth rate in total health system expenditures in Alaska
    - Annual growth rate in Alaska's Medicaid expenditures

- Impact on Alaska's state budget: new spending, net savings, new revenues
- *Measure of provider revenues based on value*

3. Safe, High-Quality Care
    - Percent of population receiving key preventive services or screenings
    - Percent of Alaskans with chronic conditions controlled
    - Percent reduction in gap between benchmark and actual levels of quality
    - Percent reduction in gap between benchmark and actual levels of safety
4. Focus on Prevention
    - Percent of Alaskan homes with safe water and wastewater systems
    - Percent of Alaskans reporting health risks
        - Percent of Alaskans who smoke cigarettes
        - Percent of Alaskans who are overweight or obese
        - Percent of Alaskans who are binge drinkers
    - Percent of Alaskans with moderate to severe depression
    - Death rate among Alaskans due to injury (intentional and unintentional)

C. Workforce Development - *Next Steps*

Alaskans' access to quality health care is dependent on the availability of a well trained health care workforce with sufficient numbers of workers in the right occupations and the right locations to meet the needs of the population. The Commission focused during 2009 on the physician workforce as just a first small step and only one component in what should be a comprehensive and sustained approach to development and implementation of a health care workforce strategy for Alaska. There are numerous organizations collaborating on various aspects of health care workforce planning and development, and further study and improvement of Alaska's health care workforce cannot occur in isolation but must consider and build on these other efforts, and a comprehensive approach to addressing Alaska's health care workforce needs must include strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of health care workforce planning, development and support infrastructure

During 2011 the Commission will coordinate with the Alaska Health Care Workforce Coalition to identify opportunities for sharing and leveraging resources to develop strategies for health workforce development in our state.

One specific workforce strategy that the Commission also intends to track during 2011 is improvement of the licensure process for health care professionals in Alaska.

Pending Strategies for Future Consideration

In addition to the policy options and other strategies for which recommendations were developed in 2009 and 2010 and those described above for consideration in 2011, the following options have been identified for study by the Commission at some point in the future. Most of these options were identified during 2009 and are briefly described in the Commission's 2009 report.

A. Consumer's Role in Health

I. Value (Cost & Quality)

- Move to value-driven purchasing
  - Pay-for-Performance
  - Medical error/infection reporting and non-payment
- Control fraud and abuse
- Reform the malpractice system
- Support process and quality improvement
- Increase consumer participation in payment for services
  - Health Savings Accounts
- Identify additional innovative patient-centered health care strategies to address
  - High-cost beginning and end of life care
  - Medicaid high-cost clients

II. Access

- Increase insurance coverage
  - New insurance programs
  - Health insurance exchange
  - Individual and/or business subsidies
  - Individual and/or business mandates
  - Medicaid Expansion
- Address availability of specific services
  - Behavioral health
  - Long term care
  - Trauma care
  - Clinical preventive services
  - Pediatric specialties

III. Prevention

- Safe water and sanitation systems
- Employee health risk management programs

B. Statewide Leadership

- Strengthen the Health Data Infrastructure

End Notes

[i] Healthy Alaskans 2010 Volume I. Alaska Department of Health & Social Services.
[ii] "Alaska's 10-Year Occupational Forecast," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.29, #1, January 2009.
[iii] 2007 Alaska Health Workforce Vacancy Study. Alaska Center for Rural Health, UAA. July 2007.
[iv] See State of Alaska Medicaid Budget Impact Analysis included in the "Summary of Medicaid Requirements Included in PPACA" presented by DHSS to the Senate HSS Committee August 3, 2010 and included in Appendix B.
[v] "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL", Prepared by the Urban Institute for the Kaiser Commission on Medicaid & the Uninsured, May 2010
[vi] Alaska Health Care Commission, "Transforming Health Care in Alaska: 2009 Report/2010-2014 Strategic Plan," January 2010.
[vii] Foster, M, Goldsmith, S. "Alaska's $5 Billion Health Care Bill – Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.
[viii] Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
[ix] www.dartmouthatlas.org
[x] Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
[xi] Fisher, ES, et al, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Annals of Internal Medicine, 138, 2003.
[xii] Wennberg JE, Fisher ES, Skinner JS, "Geography and the Debate Over Medicare Reform," Health Affairs, February 2002.
[xiii] Claridge, JA, Fabian, TC, "History and Development of Evidence-based Medicine," World Journal of Surgery, 29, 547-553, 2005.
[xiv] Sackett DL et al, "Evidence based medicine: what it is and what it isn't," British Medical Journal, 312:71-72, 1996.
[xv] Eddy, DM, "Evidence-Based Medicine: A Unified Approach," Health Affairs, Vol. 24, No.1, Jan/Feb 2005.
[xvi] http://www.bcbs.com/blueresources/tec/
[xvii] http://www.queri.research.va.gov/
[xviii] http://effectivehealthcare.ahrq.gov/index.cfm
[xix] http://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/
[xx] Franklin, GM, Budenholzer, BR, "Implementing Evidence-Based Health Policy in Washington State," N Engl J Med 361;18, October 29, 2009.
[xxi] Institute of Medicine. 2009. *Leadership Commitments to Improve Value in Healthcare: Toward Common Ground: Workshop Summary*. Washington, DC: The National Academy Press.
[xxii] http://www.gao.gov/press/pcori2010sep23.html
[xxiii] Ioannidis JPA. Why Most Published Research Findings are False. PLoS Med 2005; 2(8):696-701. PMID 17593900.
[xxiv] Sackett DL et al, "Evidence based medicine: what it is and what it isn't," British Medical Journal, 312:71-72, 1996.
[xxv] Reinhardt, UE, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," Health Affairs, Vol.25, No.1, Jan/Feb 2006.
[xxvi] Information provided by the Alaska Division of Insurance, November 2009.

2/23/11 PRESENTATIONS: ALASKA MENTAL HEALTH TRUST; LONG TERM CARE OMBUDSMAN; ALASKA COMMISSION ON AGING

<TARGET><BILL></BILL><SUBJECT>2-23-11 PRESENTATIONS ALASKA MENTAL HEALTH TRUST; LONG TERM CARE OMBUDSMAN; ALASKA COMMISSION ON AGING</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

AGENDA

WEDNESDAY, FEBRUARY 23, 1:30 PM
Butrovich Room #205

PRESENTATIONS:

- *AK MENTAL HEALTH TRUST – Subject: AK Health Workforce Plan (Presentation by: Alaska Health Workforce Coalition)*
- *LONG TERM CARE OMBUDSMAN (Presentation by: Diana Weber, LTC Ombudsman)*
- *ALASKA COMMISSION ON AGING (Presentation by: Denise Daniello, Exec. Dir)*

REMINDER

TONIGHT, 6 PM, LEGISLATORS ARE INVITED TO ATTEND THE KEY CAMPAIGN KICK-OFF DINNER AT THE CENTENNIAL HALL. ALSO TOMORROW MORNING AT 8 AM IN THE SENATE FINANCE CONFERENCE ROOM #532, BOTH SENATE AND HOUSE HSS ARE HOSTING THE ANNUAL KEY CAMPAIGN MEETING. I WOULD APPRECIATE MEMBERS SUPPORTING BOTH EVENTS.

Also, it's time for the Legislative Health Fair tomorrow from 8 to noon in the Terry Miller Building gym. All legislative family members are invited to the fair. PSA, thyroid, prostate screenings and more are available. Fasting is helpful.

ADJOURNMENT:

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

ALASKA HEALTH WORKFORCE PLAN

Prepared by the Health Workforce Planning Coalition for presentation to the Alaska Workforce Investment Board

May 2010

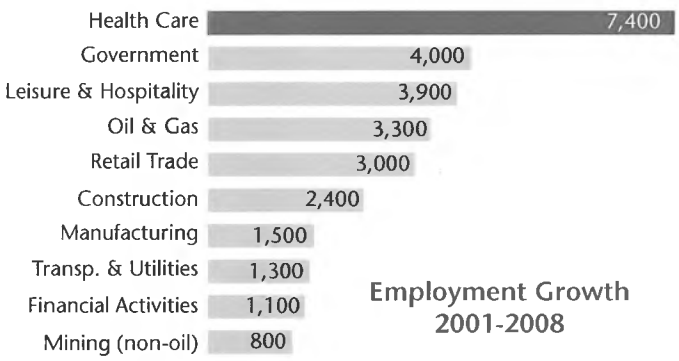
Executive Summary

Health care is one of the largest and most dynamic industries in Alaska, accounting for eight percent of total employment and around 16 percent of the value produced by the state's economy. Between 2000 and 2009, health care employment increased 46 percent, about five times as fast as the state's population and three times as fast as all other sectors of the economy.

This plan is a consensus of the strategies that must be employed to meet Alaska's most pressing health workforce needs. It is a result of a year-long, industry-led process with active involvement from education and governmental sectors. While there have been many large health workforce expansions and plans around specific occupations, this plan is the most comprehensive statewide effort to date, targeting key occupations with severe shortages.

This growth is expected to continue. Department of Labor and Workforce Development (DOLWD) data indicate a 30 percent growth rate between 2004 and 2014, twice that of the overall economy. Currently, 11 of the top 15 fastest growing jobs in Alaska are in this sector.

Additionally, federal health reform is expected to significantly increase the demand for providers.



Source: Alaska Department of Labor and Workforce Development, Research and Analysis

The Need:

While job growth is good news for the economy, it also places heavy strains on an industry already burdened by unacceptably high vacancy rates in key occupations. State rates for primary care professions, as determined by the 2009 Health Workforce Vacancy Study conducted by the Alaska Center for Rural Health, range from 12.9 percent for community health aides and practitioners to 37.4 percent for pediatric nurse practitioners. Though registered nurses had a comparatively moderate vacancy rate at 10.1 percent, this relatively large profession was calculated to have over 320 vacant positions.

The above vacancy rates are statewide averages; rates in rural Alaska are even more dramatic. These vacancy figures coupled with anticipated high increases in demand for workers indicate a significant skills gap in the health care workforce at the present time, a gap that without increased attention can only worsen.

The Promise:

Health care positions are found in all regions of the state, offering close-to-home employment for many Alaskans. Although some positions require advanced training, many jobs are entry-level, requiring limited preparation. Often, these entry-level positions are the start of a career ladder or lattice that can—with additional experience and education—lead to life-long, meaningful careers.

Through public and private postsecondary education institutions in the state, Alaskans currently have access to education and training in more than 80 health care occupations. This combination of local jobs, opportunity for advancement and access to in-state training makes the health care industry a primary mover in putting Alaskans to work.

The Strategy:

The Health Care Workforce Development Plan addresses the challenge of assuring a well-prepared and sufficient workforce to meet Alaskans' health care needs through four strategies: Engage, Train, Recruit, Retain.

Alerting Alaskans to the opportunities available in the health care field is a first step in securing the necessary workforce. Public information campaigns, K-12 career awareness and exploration and outreach to Alaskan job seekers are elements of the Engage strategy.

Preparation for a health care career often starts at the secondary level, where prerequisite math, science and communications skills are developed. Quality, standards-based postsecondary education delivered as close to home as possible is a next step

along a career path in health care. As the practice of health care changes through technology, health reform, or new care models, those employed in the industry must upgrade skill levels. Finally, experienced teachers must be available to deliver the necessary education and training at all levels. Strengthening secondary math, science and career education, expanding access to training programs in priority occupations, providing continuing education and securing the necessary faculty are elements of the Train strategy.

Although the plan speaks to significant expansion of health care career training and education in the state, the size and complexity of the industry indicate that recruitment from outside of Alaska will continue to be needed to fill some positions. Alaska can improve its competitiveness with others seeking similar skilled professionals by more widely disseminating information about employment opportunities and offering more post-graduate experiences within the state. State and federal-supported loan repayment and other financial and quality-of-life incentives can sway the decision to locate or stay in Alaska. Finally, more coordination in recruitment by health care providers could reduce costs. All of these approaches are elements of the Recruit strategy.

The final plank in the health care plan is to retain the workforce that has been educated and recruited. To do so requires successful transitioning from training into the world of work and employment that offers sufficient remuneration, adequate supervision and opportunities for professional growth. Assisting employers to provide these workplace elements make up the Retain strategy.

Plan Phases:

The Steering Committee considered several time horizons in developing the plan strategies: short term (within the next two years), medium term (within three to five years) and long term (five years or more in the future). A key focus of the plan is in training for and development of specific occupations. From data collected by the Departments of Labor and Health and Social Services, the University of Alaska and other sources, the planning group identified 15 occupational groupings encompassing 26 individual occupations and careers requiring action in the short term.

The following occupational groups are included in this plan:

Behavioral Health Aide/Village Counselor
Primary Care Physician
Advanced Nurse Practitioner
Substance Abuse Counselor
Registered Nurse
Community Health Aide/Practitioner
Social Worker
Oral Health Practitioner
Psychiatrist
Human Services Worker
Pharmacist
Therapist and Therapist Assistant
Nurse Educator
Health Informatics Staff
Direct Care Worker

Details for applying the plan to these priority occupational groups are found in Section 4. Here, the occupations are described with relevant data on vacancy rates, educational qualifications and training opportunities, followed by suggested strategies under the four broad strategies of Engage, Train, Recruit, Retain. Occupational and training data will be reviewed and updated annually, at which time—due to changes brought about by reform efforts, population shifts and/or adoption of new models of care—additional occupations may emerge as high priority.

The Role of AWIB:

Endorsement by the Alaska Workforce Investment Board (AWIB) of this health workforce plan is essential for assuring a coordinated approach to implementation. Representatives of the three key state departments involved in delivering plan elements—Health and Social Services, Labor and Workforce Development and Education and Early Development—sit on the Board as do representatives from health industry employers. The University of Alaska, the major training provider for health care careers, is also a member. This mix of government agencies, industry and training institutions provides a mechanism for collaborative efforts in addressing the workforce strategies outlined in the plan. In addition, AWIB's stewardship responsibilities for federal and state workforce development funds can direct needed resources to support the plan. Data collected from public and private training providers as part of the Board's oversight duties will allow for annual checks of progress toward meeting training goals and targets.

Purpose:

The heath care plan is anchored in collaboration and builds on earlier successful cooperative efforts, such as the expansion of the UA nursing program, the addition of slots at the University of Washington Medical School through WWAMI, participation in the National Health Service Corps and Indian Health Service loan repayment programs

and the creation of a Health Care Commission. Under the governance structure that is being developed to oversee plan implementation and monitoring, these collaborations will be made more formal through memoranda of understanding among stakeholders.

The Alaska Health Workforce Development Plan is indeed a call for action: a call that has already been heeded by industry, education and training institutions, state government and professional organizations. Successfully directing the energies and resources of these stakeholders through the steps outlined in the plan will not only increase the size and quality of the health care workforce but will be reflected in a higher standard of health for all Alaskans.

Table of Contents

Section 1
Steering Committee Members **2**

Section 2
Introduction **3**

Section 3
Overall Health Workforce Development Strategies **8**

Section 4
Occupation-Specific Strategies for Priority Occupations **23**

Section 5
Alaska Occupational Forecast **43**

Section 6
Appendix **44**
- Acronym List
- Documents Cited in the Plan

Steering Committee Members

Industry Members

Kitty Farnham
Regional Director Strategic Planning
Providence Health and Services
(907) 212-8423
Katherine.Farnham@providence.org

Jim Lynch
Chief Financial Officer, Chair, Alaska Workforce Investment Board
Fairbanks Memorial Hospital
(907) 458-5305
jim.lynch@bannerhealth.com

Dennis Murray
Director of Long Term Care and Workforce Development
Alaska State Hospital and Nursing Home Association
(907) 646-1444
dennis@ashnha.com

Ellen Maling
Manager, Regional Grants Program
Providence Health and Services
(907) 212-8386
Ellen.Maling@providence.org

State Agency Members

Helen Mehrkens
Administrator of Career and Technical Education
Department of Education & Early Development
(907) 465-8730
helen.mehrke0ns@alaska.gov

Patricia Carr
Section Chief, Health Planning & Systems Dev.
Dept. of Health and Social Services
(907) 465-8618
PCarr@health.state.ak.us

Kathryn Craft
Workforce Development Coordinator; Alaska Workforce Investment Board
Dept. of Health and Social Services
(907) 450-8048
kathryn.craft@alaska.gov

Louise Dean
Program Coordinator
Alaska Workforce Investment Board
(907) 269-7487
louise.dean@alaska.gov

Training & Education Members

Karen Perdue
Associate Vice President for Health
University of Alaska
(907) 450-8017
karen.perdue@alaska.edu

Jan Harris
Vice Provost for Health Programs
University of Alaska Anchorage
(907) 786-4595
anjch1@uaa.alaska.edu

Rick Rios
Coordinator, Office of Career & Technology Education
Anchorage School District
(907) 742-8942
Rios_Rick@asdk12.org

Consultant/Writer

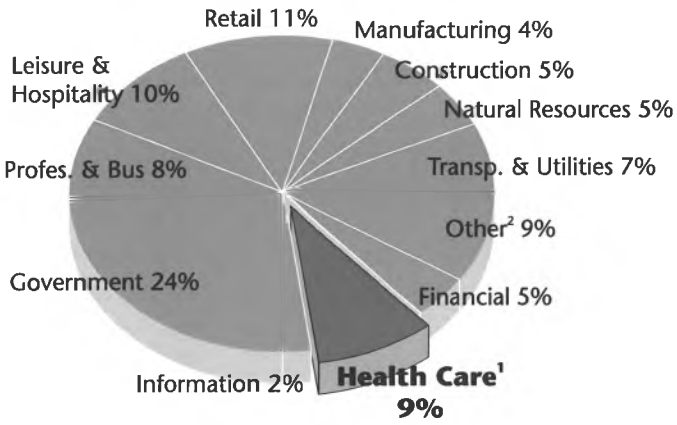
Mary Lou Madden
President
Madden Associates
(907) 523-7783
madden@alaska.com

Introduction

The health care industry is important to Alaska and Alaskans

Health care is one of the largest and most dynamic industries in Alaska, accounting for eight percent of total employment and around 16 percent of the value produced by the state's economy. One out of every 12 employed Alaskans works in the industry; one out of every six dollars spent in Alaska is spent on health care. The industry also accounts for a significant portion of economic growth. Between 2000 and 2009, health care employment increased 46 percent, about five times as fast as the state's population and three times as fast as all other sectors of the economy. With a payroll of more than $1.4 billion in 2008, it employed more people than state government, oil industry or most other industries.[1]

Health Care: One of the Biggest Players in Alaska's Labor Market



[1]Includes the private and public sectors, 2008
[2]Includes other services, private education services, social assistance and wholesale trade
Source: Alaska Department of Labor and Workforce Development, Research and Analysis

This growth is estimated to continue. Department of Labor and Workforce Development (DOLWD) data indicate a 30 percent growth rate between 2004 and 2014, twice that of the overall economy. Around 15 percent of the state's new jobs in that period will come from health care; currently, 11 of the top 15 fastest growing jobs in Alaska are in this sector.

While job growth is good news for the economy, it also place heavy strains on an industry already burdened by unacceptably high vacancy rates in key occupations. For example, state rates for primary care occupations as reported by 747 surveyed employers for a 2009 University of Alaska study[2] range from 12.9 percent (community health aide/practitioner) to 37.4 percent (pediatric nurse practitioner). Other troubling rates include occupational therapist and physical therapist at 22.8 and 15.8 percent respectively. Though registered nurses had a comparatively moderate vacancy rate at 10.1 percent, this relatively large profession was calculated to have over 320 vacant positions. These rates indicate a significant skills gap in the health care workforce at the present time, a gap that without increased attention can only worsen.

Recognizing these conditions, the Alaska Workforce Investment Board (AWIB) has targeted health care as one of the industries critical to Alaska's workforce and economic needs. The Alaska Health Care Commission and many other agencies and groups, such as the Department of Health and Social Services, The Alaska Mental Health Trust and the Alaska State Hospital and Nursing Home Association (ASHNHA), have identified health care workforce development is one of the most critical priorities in assuring health care access in Alaska.

The health care industry has unique features

Health care has unique features that distinguish it from other industries—features of Impact, breadth, scope and outlook. These characteristics add to the urgency of assuring that Alaska has a well prepared and sufficient health care work force.

Impact—The health care industry touches almost every Alaskan, from the newborn infant in Ketchikan General Hospital to the elder in Barrow's assisted living facility. The overall health of the state's citizenry is intimately tied to the adequacy and competence of the health care workforce. Meeting Alaska's targets for improved health as envisioned in Healthy Alaskans 2010[3] in the areas of health promotion, health protection, preventative services and access to health care requires attention to the development, upgrading and retention of workers who can address these targets.

Breadth—Health care industry employment can be found in almost every location in the state.

[1] Alaska Department of Labor and Workforce Development, *Alaska's Health Care Industry*, Alaska Economic Trends, March 2010, p.
[2] Alaska Center for Rural Health, University of Alaska Anchorage, *2009 Alaska Health Workforce Vacancy Study (Draft)*, January 2010.
[3] Alaska Department of Health and Social Services, Division of Public Health, *Healthy Alaskans 2010, Targets and Strategies for Improved Health*, November 2005

Although about half of the jobs are in hospitals and nursing homes, the other half are with small health care provider offices, outpatient and community health centers and home health care. The State of Alaska also provides many career opportunities in the health care field. This breadth indicates that job opportunities are available close to home for many Alaskans.

Scope—Perhaps no other industry employs front-line workers with such a wide range of educational backgrounds, from high school diploma or GED through post-doctoral specialization. Although the industry utilizes many highly-skilled professionals, a large portion of health care is provided by direct service workers, who assist Alaskans dealing with mental health problems, substance abuse, medical illnesses, developmental delays and disabilities, elder care and social stressors. Career ladders and lattices exist that can move workers to higher-level positions. This wide scope of employment allows many Alaskans to access the industry through entry-level jobs and to construct meaningful, life-long careers.

Outlook—Demand for health care is not cyclical, unlike that for most Alaskan industries. This has distinct advantages. As reported by DOLWD, health care is one of a handful of industries expected to grow in 2010—adding about 500 jobs—while most other sectors will continue to experience a decline.[4] Because it is not subject to sudden downward shifts in demand, the output from training programs can more easily be matched to current and future industry needs.

While health care is relatively free from the effects of economic fluctuations, it is highly susceptible to other influences. At least four factors are currently driving higher demand for health care services and therefore increasing the need for workforce development: reform efforts, demographics, changes in care models and technology.

Health care reform will greatly expand demand for care, adding coverage for tens of thousands of Alaskans who were previously un- or underserved. The increased demand from this population is likely to be in areas such as primary care, therapies and behavioral health that currently experience high job vacancy rates throughout the state. Reforms will also spur the growth of new classes of health care positions such as continuum of care managers and health information technicians.

An aging Alaskan population also contributes to increased demand for services. In the decade between 1996 and 2006, the number of Alaskans 65 years and older increased 50 percent, from 30,440 to 45,489. In the latter year, older Alaskans accounted for 6 percent of the total population. DOLWD estimates indicate that this age segment will reach around 134,400 persons by 2030, or about 16 percent of the population. This demographic shift has tremendous implications for workforce development, not only in numbers but also in types of workers needed, such as geriatric nurses, nurse practitioners, psychiatrists, licensed practical nurses (LPNs) and certified nursing assistants (CNAs).

Changes in care models and care objectives will also change the face of the workforce. For example, the move to more outpatient services increases the demand for home health care workers. An emphasis on prevention requires increases in occupations such as health educator and wellness trainer.

Technology influences the health care workforce in many ways. First, access to higher levels of medical technology within the state has an "import substitution" effect on demand as an increasing share of Alaskans can meet their health care needs locally rather than going out of state. Generally, this effect heightens the need for highly-trained specialists. Increasing uses of technology in all areas of care also require continuing skill attainment and development on the part of the existing workforce at all levels, from direct service worker through specialist. Implementation of electronic health records will require the creation of new job classes and related training. Finally, technology—in particular simulation and the Internet—can vastly increase access to health care career education and training.

Because of the above factors, several of the strategies identified for successful workforce development in health care will differ from those in other industries. Recruitment of health care providers that cannot be trained or trained in adequate numbers in the state will remain a central activity. Retention, while a significant concern in all industries, assumes greater importance when high turnover can affect Alaskans' access to critical medical and therapeutic services.

The health care workforce planning process is collaborative

To begin to address these workforce issues and to craft a statewide plan for workforce development, a Health Care Workforce Coalition made up of health care providers, agencies, educators and associations was formed in August, 2009. A steering team from the larger coalition, comprised of

[4] Alaska Department of Labor and Workforce Development, *Employment Forecast for 2010*. Alaska Economic Trends, January 2010, p. 11

representatives from industry, state government and the University of Alaska met regularly to work on the plan. The basic plan strategies were presented to the larger provider community for discussion and further refinement at the ASHNHA Health Care Workforce Summit in November, the Alaska Public Health Association Health Summit in December, 2009, and to various smaller groups. Audio-conferences with the Coalition allowed member input throughout plan development.

The planning group early on agreed on several underlying principles. First, although health care workforce development is a statewide issue, the need is especially acute in rural Alaska. The difficulties involved in training, recruiting and retaining health care workers in the more remote parts of the state require increased attention to distance education that trains people to work in their home community, financial and other incentives for attracting needed specialists, community involvement in recruitment and retention and opportunities for professional growth.

Second, because the training needs of the health care industry are substantial and relatively costly, the planning group recognized that particular care must be taken to assure that resources—both public and private—are allocated to areas of highest need, avoid needless duplication and utilize existing institutions wherever possible. The priority occupations treated in Section 4 of the plan have been identified as needing immediate attention for one or more of the following reasons: high vacancy rate, high number of vacancies or criticality to health care delivery. The governance structure that will be developed to oversee plan implementation will be a major tool for assuring coordinated, effective and efficient resource use.

Finally, the group agreed that all training under the plan must be directed at meeting industry standards, state and national licensing requirements and the quality benchmarks established by educational program accreditation agencies. These principles of access, efficiency and quality permeate the plan document.

Because the health care industry in the state is so diverse and covers so many disparate occupations, many of the overall strategies in the following plan are broad and general in nature. Several of the strategies and many of the action steps echo those in other industry plans, particularly the call for broad public awareness and support for developing a pipeline of new workers through the revitalization of K-12 career awareness and technical education programs. To achieve these goals will require a cooperative, coordinated effort by many industries and agencies.

Health care workforce planning builds on successful partnerships

The planning group acknowledged the considerable cooperative effort that has already been made in developing the health care workforce. For example, a strong partnership between industry and the University of Alaska School of Nursing succeeded in doubling the number of nursing graduates between 2003 and 2007. Industry/university collaboration has also led to the introduction, expansion or revision of more than 80 health care-related UA certificates and degrees over the past ten years. New UA programs such as the bachelor degree in nutrition are coming on line to address emerging critical needs.

A coordinated effort by industry resulted in a doubling of medical school slots for Alaska students at the University of Washington through the WWAMI program. Combined industry, government and association advocacy has also spurred the creation of a Health Care Commission and the introduction of several pieces of legislation to provide loan repayment and other financial incentives for health care professionals practicing in Alaska. The Behavioral Health Initiative partnered the University of Alaska, the Alaska Mental Health Trust Authority and the Department of Health and Social Services to address the severe workforce shortages experienced in the behavioral health field at all levels of licensure and credentialing.

Implementing the health care-specific strategies and action steps in the plan will require the continued participation and coordination of many partners: industry/employers, education and training providers, government and professional associations. Each group contains many stakeholders.

Industry/employers include the broad range of health care providers—public, private and nonprofit—that extend health care services to Alaska's residents. Among these are hospitals, health clinics, tribal health organizations, private practice offices, state and local public health agencies and mental/behavioral health programs and treatment centers.

Education and training providers include the University of Alaska, Alaska Pacific University, the Alaska Vocational Technical Center (AVTEC), the Alaska Technical Center (ATC), Yuut Elitnaurviat and other regional training centers, private training providers and out-of-state institutions that have partnered with an Alaskan institution to offer a specific program within the state.

Government agencies involved in health care workforce development include the state departments of Health and Social Services, Labor and Workforce Development, Education and Early Development and Commerce, Community and Economic Development (Licensing), the Alaska Mental Health Trust Authority and local government public health offices. With the passage of health care reform, the federal government is also assuming a larger role in supporting health workforce planning and training.

Professional organizations encompass a variety of groups such as the Alaska Public Health Association, the Alaska Primary Care Association, the Alaska Nurses Association and other health care membership organizations such as ASHNHA.

In addition to the above groups, health care is served by the Alaska Area Health Education Center (AHEC) network—a university-industry partnership directed at strengthening Alaska's health workforce serving rural and other underserved populations. The AHEC network plays an important role in encouraging Alaskans to pursue careers in health and behavioral health care, providing clinical rotation sites and delivering continuing education to health care practitioners.

In the following plan, the first partner category listed under "Responsible Parties" in any sub-strategy is assumed to be the prime mover for that particular strategy, although the support and involvement of other listed partner groups is essential for success.

Health care workforce planning is on-going

The plan is intended to encompass rather than replace the workforce development efforts of other professional groups and health care organizations. The strategies outlined in the plan become real through application to a specific occupation, as can be seen in Section 4 that links strategies to the top priority occupations identified by vacancy data and other information.

The plan is not complete; rather it is a work-in-progress that will be revisited and revised over time as occupation-specific action plans are developed, successes are achieved and circumstances change.

The health care workforce development plan embraces AWIB principles

In preparing the plan, the steering group was cognizant of the need to address the following principles found in Alaska's Future Workforce Strategic Policies and Investment Blueprint, which was adopted by AWIB in 2000 to serve as the comprehensive guide for alignment of public policy and resource investments in vocational and technical education and training programs statewide.[5]

The plan is needs driven, based on data provided by the Research and Analysis Section of DOLWD, the Alaska Center for Rural Health, the Office of the Associate Vice Provost for Health Programs, University of Alaska Anchorage and DHSS Health Planning and Systems Development Section. Occupational supply and demand data were distributed to participants of the ASHNHA, Alaska Public Health and Behavioral Health conferences and to members of the Alaska Medical Group Management Association and the Alaska Native Tribal Health Consortium to gain consensus on the priority occupations detailed in Section 4. Strong industry leadership and involvement in the planning process assured that both current and emerging workforce needs would be addressed.

The plan extends access to health care occupations by creating awareness of career opportunities, utilizing distance delivery and simulation in health workforce education and training programs and increasing financial support for pursing health care careers. As mentioned above, the need to strengthen training, recruitment and retention of health care workers in rural Alaska was at the forefront of the planning effort.

The plan is interconnected, extending the use of career pathways to link secondary and post-secondary education and expanding post-employment training and advancement. It incorporates the state's job center system both to advertise job openings and to counsel job-seekers into training for health care positions.

The plan is accountable. All of the training and education under the plan is based on industry standards and most programs lead to state or national certification. Programs offered under the plan that utilize state or federal workforce development funds will report annually on the outcomes of the training in terms of number of participants and completers, placement of graduates and gains in income.

The plan will be collaboratively governed. The governance structure to be developed in a sustainability plan will include industry, tribal health organizations, appropriate government agencies, the University of Alaska and other training partners. The plan closely aligns with the AWIB emphasis on training Alaskans for high demand, high wage jobs.

[5] Alaska Workforce Investment Board, *Alaska's Future Workforce: Strategic Policies and Investment Blueprint, 2002, p. 1*

The plan will be sustained. The sustainability plan will detail the linkages between plan strategies and the mission and operational responsibilities of the involved partners. These linkages will be made concrete through memoranda of understanding outlining such activities as shared staffing, joint grant applications and other mechanisms to assure that parties carry through with assigned responsibilities for implementing the plan. The sustainability plan will call for an annual review of accomplishments and modifications to the plan as new opportunities and challenges arise.

Endorsement by AWIB is a critical step in moving the plan forward and securing the financial and other support necessary to assure that plan strategies are actualized.

Overall Health Workforce Development Strategies

Strategy 1

Engage Alaskans in health care workforce development

Alaskans need information about career opportunities afforded by the health care industry in the state—careers that are in demand in all regions, provide stable employment and encompass all educational levels, from on-the-job training through postgraduate programs. Alaskans also should be aware of the link between a well-trained, sufficient health care workforce and the overall health of the state's citizenry. Finally, voters and policy makers need reliable information about public policy and financing options that can impact health care work force development.

This strategy can be implemented by:

- Conducting public awareness campaigns on general workforce development issues and the full continuum of jobs available
- Expanding career awareness and counseling that highlight health career pathways in Alaskan schools
- Developing targeted marketing for high need professions
- Utilizing the existing one-stop information system to disseminate information on training opportunities and job openings in Alaska to job seekers

Funding

- Industry/employers
- Private foundations (e.g., the Robert Wood Johnson nationwide nursing career promotion)
- Alaska School Foundation funding
- State General Fund
- Youth Workforce Development funds
- Alaska Native Health Corporations
- Alaska Mental Health Trust Authority (AMHTA)

Strategy 1.1 Create public awareness

Rationale: Health occupations comprise 11 of the 15 fastest growing occupations in the state and employers report difficulty in attracting qualified workers. The most recent Alaska Health Workforce Vacancy Study[6] identified a range of vacancy rates in various occupations, with generally higher rates in rural Alaska. The demand is expected to increase as a result of health care reform, changes in care models, demographic shifts and retirement of older workers. Alaskans need accurate and timely information not only for career counseling and planning but also to develop and support the policy and funding initiatives needed to address critical health care workforce shortages.

Action Steps

- Develop a consistent, multi-faceted public awareness campaign that highlights the link between an adequate health care workforce and the overall health of Alaskans
- Implement communication strategies for the full continuum of job opportunities, with particular emphasis on reaching rural, Alaskan Native and minority residents
- Provide opportunities for public dialog on policy and funding issues around health care workforce development

Timeline

- Short term

Responsible Parties

- Industry/employers
- Government (DHSS)
- Education and training providers
- Professional organizations and boards
- AHEC

Resources

- Publications and data
  - *Healthy Alaskans 2010*
  - *Alaska Health Care Data Book*
  - *Alaska Health Workforce Vacancy Study 2007 and 2009 update*
  - Alaska DOLWD employment projections

[4] Alaska Center for Rural Health, *2009 Alaska Health Workforce Vacancy Study*, (Draft) January 2010.

- Alaska Center for Rural Health studies and publications
- Securing an Adequate Number of Physicians for Alaska's Need, Physicians Task Force Report

- Funding
  - Industry
  - Private Foundations
  - State General Fund
  - State and federal grant funds
  - University of Alaska general funds
  - Alaska Native Health Corporations
- People
  - State and industry public information staff

Evaluation: Public awareness/communications plan is in place and being implemented as planned

Strategy 1.2 Expand career awareness and counseling

Rationale: Career decision-making begins early in a child's educational career. Research indicates that students begin to rule out certain career options as early as the third grade. Often career choices are guided by what a student is familiar with rather than a careful consideration of alternatives. Many health careers require substantial preparation at the secondary level in math and science. In addition, choices made while still in school, such as teenage drinking and drug use, are not only dangerous in themselves but can be lifelong barriers to entry into careers that require extensive background checks. A sound career awareness and guidance program beginning in early elementary grades can open up many more career options to Alaskan students and can assist them in developing both their secondary and postsecondary academic plans.

Action Steps

- Reinforce job readiness skills through the use of WorkKeys™, Youth Employability Skills (YES) or other programs that develop the soft skills necessary for success in the workplace
- Expand the use of health career pathways and DOLWD Health Career Guides in local school districts and for postsecondary academic counseling
- Identify "best practices" for use in elementary and middle schools to introduce students to careers in health care
- Establish an incentive program to encourage schools to adopt these practices
- Provide training for high school counselors and postsecondary academic advisors in using health care career pathways to advise students into health care occupations
- Secure sustainable state and industry funding for the Alaska AHEC network

Timeline

- Short term

Responsible Parties

- Government (DEED, K-12 districts)
- Industry/Employers
- AHEC
- Education and training providers

Resources

- Models
  - Best practices from Alaskan school districts
  - Alaska Career Information System (AKSIS)
  - Hot Jobs in Health Care (DOLWD) publications and teacher guides
  - State and national health career pathway models
- Funding
  - Alaska School Foundation Program (for K-12 district programs)
  - State and federal grant funds
  - Industry
  - Private Foundations
- People
  - K-12 and postsecondary career and academic advisors

Evaluation: By 2012, 50 percent of all Alaskan school districts will have incorporated healthcare career pathways into a career awareness/counseling program that begins in elementary school and continues through high school with demonstrated connections/transitions to postsecondary programs.

Strategy 1.3 Market high need professions

Rationale: There are several occupations in the health care industry that are in constant and high demand and that can be prepared for in Alaska. A full-scale media campaign, modeled after such nationwide efforts as the successful Robert Wood Johnson (RWJ) Nursing campaign, could attract considerable numbers of Alaskans into these careers.

Action Steps

- Identify two top priority, high demand professions across the full continuum, from direct service workers to doctors
- Prepare and widely disseminate ads, TV spots and other materials to encourage Alaskans to prepare for these professions
- Target under-represented minorities and populations for recruitment

Timeline

- Mid-term

Responsible Parties

- Industry/Employers
- Government (DHSS, DOLWD)
- Education and training providers
- Professional organizations
- AHEC

Resources

- Models
  - RWJ Nurse Campaign
  - The Alaska Mental Health Trust You Know Me anti-stigma campaign
- Publications
  - *Securing an Adequate Number of Physicians for Alaska's Need*, Alaska Physician Supply Task Force, August 2007
- Funding
  - Industry
  - Private Foundations

Evaluation: Enrollment in preparation programs for the selected occupations will double by 2015. Recruitment and enrollment of Alaskan Natives and underserved minorities will reflect the make-up of the total population.

Strategy 1.4 Attract Alaskan job seekers into health careers

Rationale: The health care industry offers many opportunities for job-seekers such as retiring active duty military, underemployed individuals, persons undergoing job loss/transitions, out-of-school youth and women returning to the workforce to prepare for and secure entry-level employment in a relatively short period of time. Many of these jobs are the first step in a career ladder than leads to long-term, stable and well-paid employment.

Action Steps

- Utilize the existing one-stop information system to disseminate information on health care training opportunities and job openings in Alaska
- Encourage health care providers to utilize the Alaska Labor Exchange System (ALEXsys) and 3RNet (Rural Recruitment and Retention Network) to post job openings
- Establish mechanisms for networking between DOLWD job counselors and local health care provider human resources offices
- Target market to persons who are undergoing transition due to economic downturn and/or job losses
- Increase coordination among vacancy posting services to disseminate information to a broad array of potential applicants

Timeline

- Short term

Responsible Parties

- Government (DHSS, DOLWD)
- Industry/Employers

Resources

- Information Systems
  - ALEXsys
  - AKCIS
  - EarnAndLearnAK.org
  - 3RNet (national)
  - Alaska Alliance for Direct Service Careers
- Funding
  - State and Federal Employment Security funds
  - Workforce Investment Act (WIA) Youth funds
  - Industry
  - Alaska Native Tribal Health Corporations
- People
  - DOLWD employment counselors

Evaluation: Health care job openings are posted in ALEXsys and 3RNet. Employment security counselors are aware of health care training and employment opportunities.

Strategy 2

Train Alaskans for health care employment

Almost three-quarters of the fifteen fastest growing occupations in Alaska are in the health care field. Taken as a group, these occupations are estimated to account for over 6,000 job openings between now and 2016[7]. These projections are based on the current level of health care provision and do not take into account the increased demand for health care workers that will result with the aging of the Alaskan population or from expansion of health care access. Filling these positions with Alaskans requires creating a pipeline for people seeking the necessary credentials, providing appropriate training and educational opportunities and allowing for those already employed to upgrade their skills and to advance professionally. Delivering training as close to home as possible through expanded distance education is essential to assuring that rural workforce development needs are addressed.

This strategy can be implemented by

- Strengthening secondary school offerings in mathematics, sciences, communications, job readiness and entry-level training in health care occupations
- Providing postsecondary health care occupational training and education programs that are effective, cost-efficient and lead to employment in Alaska
- Delivering post-employment training opportunities that allow practitioners to gain new skills and advance in their profession
- Developing the faculty needed at the secondary, postsecondary and continuing education levels to deliver education and training programs

Funding

- Alaska Public School Foundation Program
- University of Alaska general funds
- DOLWD
- State of Alaska General Fund
- Industry
- State and federal grants
- Private foundations
- The Alaska Mental Health Trust
- Alaska Native Tribal Health Consortium

[7] DOLWD, *Alaska's 10-year Occupational Forecast*, Alaska Economic Trends, January 2009, p. 22

Strategy 2.1 Strengthen secondary school offerings and programs

Rationale: Preparation for many health care careers begins at the secondary level, where fundamental academic and job readiness skills are acquired. Ideally, students with knowledge of what is required in their fields of interest will select the appropriate math, science and other high school courses that support their career interests. Individual learning plans based on career pathways greatly assist secondary students to easily transition to postsecondary education and training. Applied academics—where the student experiences real-life applications of math, science and communications—improve student success in these subjects. Training programs that lead to national certification can provide an avenue to post-high school employment and onto a career ladder.

Action Steps

- Encourage Alaska's secondary schools to develop and deliver foundation programs that support health career pathways, include advanced math, science and communications courses and articulate to postsecondary certificates and degrees (Career and Technical Education Programs of Study)
- Develop a framework to provide Work-based Learning Experiences (WBLEs) in health care settings that clearly delineates the responsibilities of the educational and health care provider and supports the interests of all parties in the health care setting
- Develop short-term exploratory programs in health care sciences that spark student interest in pursuing careers in the industry and that can be conducted with local resources in rural as well as urban settings
- Expand the use of health career academies modeled on the construction academies conducted throughout the state
- Deliver high school programs that lead to entry-level employment such as CNA and EMT or to certificates that are widely accepted, such as First Aid, CPR and OSHA Safety
- Expand the use of dual credit/Tech Prep/School-to-Apprenticeship/Early College programs that provide secondary students the opportunity to earn university credit
- Establish four additional career/technical magnet high schools that deliver training in health occupations and other careers
- Utilize distance education to expand access to students in small, rural high schools
- Work with health care providers and organizations to secure on-going support through scholarships, internships and mentoring programs

Timeline

- Short term

Responsible Parties

- Government (DEED, K-12 districts, DHSS)
- Education and training providers
- Industry/Employers
- AHEC

Resources

- Models
  - National health career pathways
  - Alaska-specific health career pathways
  - Tech Prep, early college and dual enrollment programs
  - Existing secondary career high schools and centers: Mat-Su Career and Technical High School, King Career Center, Hutchison Career Center
  - Construction academies
- Funding
  - Alaska State Foundation Program
  - Federal Perkins IV funding
  - Industry

Evaluation: Alaska's secondary schools have programs of study based on health career pathways. Four career/technical high schools are established and operational.

Strategy 2.2 Provide health care occupational training and education programs

Rationale: Between 2001 and 2009, aggressive program development at the University of Alaska added instruction and training in a variety of health occupations resulting in more than 80 certificates/degrees in primary care, nursing, and allied, behavioral and public health. The UA system now serves around 4,200 Alaskans each year who are preparing for and enrolled in health care training and education programs. Half of the programs are accessed by students via distance education technology. APU provides undergraduate degrees in behavioral health and health administration. AVTEC, regional training centers and several private training providers serve additional students, generally with entry-level training. Meeting the anticipated workforce needs, however, will require additional effort—to expand access to existing programs particularly to rural sites, to develop new programs where demand and cost-considerations dictate and to partner with out-of-state institutions when programming by an Alaskan institution is not feasible.

Action Steps

- Develop and deliver occupation specific training at all levels (work-based, certificate, Associate, Bachelor and graduate) for occupations that are high demand and/or are critical to health care delivery, as indicated in Section 4
- Continue to refine and develop the UA academic plan for health care occupation certificates and degrees
- Provide adequate financial support for training and education programs
- Increase access through program expansion, distance delivery and simulation
- Expand the capacity of community campuses of the UA system to support local students in health care programs
- Strengthen the dialog among employers, labor and education/training institutions concerning registered apprenticeship and other work-based learning opportunities in health care, create and evaluate pilot apprenticeship projects and disseminate the results
- Explore credit-for-experience or other mechanisms that allow practitioners to challenge introductory and lower level coursework in a certificate/degree program
- Develop partnerships with institutions in other states to provide certificate and degree programs in Alaska that cannot be cost-effectively delivered by in-state institutions
- Assure that all health care training and education programs delivered by any institution in Alaska meet industry standards, are accredited by a regional or national body and lead to certification or licensure as required for employment
- Periodically assess Alaska's capacity to deliver high need/high cost programs in-state and initiate programs that are deemed viable
- Research national and international best practices in health care professional training for possible adoption in Alaska

Timeline

- Short term for high priority occupations
- Mid and long term for other occupations

Responsible Parties

- Education and training providers (Alaska and elsewhere)
- Government
- Industry

Resources

- Programs
  - Existing health care occupational training programs at UA, APU, AVTEC, ATC, regional training centers and private training providers
  - Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) regional school of medicine based at University of Washington
  - Western Interstate Commission on Higher Education (WICHE) and Western Undergraduate Exchange (WUE)
  - Distance delivered programs in Alaska and in other states
- Funding
  - UA general funds
  - Tuition and fees (UA, APU, AVTEC ATC, other)
  - Technical and Vocational Education Program (TVEP) state dollars
  - Scholarships and loan repayment programs
  - State and federal grant funds (STEP/WIA)
  - Industry

- People
  - UA, APU, technical center and private provider faculty

Evaluation: Programs are available in-state that train Alaskans for high need occupations in a cost-effective manner. Training is available as close to home as possible for most Alaskans.

Strategy 2.3 Deliver post-employment training opportunities

Rationale: Changes in health care access, care models and technology mandate that the workforce engage in continuing education and acquisition of new skills. Professional development is most effective when it is based on developing or strengthening commonly-accepted competencies and promotes career advancement. Adopting core competencies for various health care occupations and utilizing these competencies to build on-the-job training and career ladders are proven methods of assuring comparable skill levels around the state. Greater economies of scale can be achieved by sharing professional development programs and resources among health care providers.

Action Steps

- Define priority occupations for competencies and career ladders and lattices
- Develop and adopt standardized core competencies in critical health care occupational clusters
- Assist in developing and supporting occupation-specific industry/education consortia that will address the professional development needs within the occupation, including competencies and career ladders
- Encourage health care providers—including state and local governments—to establish professional development programs and career ladders/lattices based on competencies
- Extend the use of registered apprenticeships and other work-based post-employment training for career development
- Provide post-employment academies and other intensive training to accelerate skills and achieve advanced certifications, including nursing specialties
- Utilize the AHEC network to provide continuing education to practitioners in underserved areas
- Establish mechanisms for sharing high-cost, effective training tools such as simulation and distance delivery among health care institutions around the state
- Increase opportunities for health care professionals to obtain continuing education and continuing medical education credits (CEUs/CMEs)

Timeline

- Short term for competencies, career ladders, apprenticeships and continuing education
- Short/mid-term for expansion of simulation

Responsible Parties

- Industry/Employers
  - Education and training providers
  - Professional associations
  - Government (licensing boards)
  - AHEC

Resources

- Models
  - Alaska Coalition of Educators-Health Care (ACE-HC) Nurse Competencies
  - Alaska Mental Health Trust Authority (AMHTA) Credentialing and Quality Standards Subcommittee (CQSS) – Alaska Core Competencies for Direct Care Workers
  - Providence Hospital Academies to accelerate skills and advanced certifications
  - Registered Apprenticeships
- Facilities
  - Community and university-based simulation facilities
- Funding
  - Industry
  - AMHTA
  - UA general funds
  - State and federal grants
- People
  - Education personnel in health care facilities
  - Training program faculty

Evaluation: Core competencies are developed and adopted for the major occupational groups in the health care workforce. Employers conduct professional development programs based on competencies. Training programs and resources are shared among Alaskan health care providers in all areas of the state.

Strategy 2.4 Develop needed faculty

Rationale: High quality education and training programs are built on strong faculty who not only know the content but who also have practical experience in the field. Increasingly, faculty members need to be conversant with technology and distance-delivery methodologies. Because the demand for persons who are skilled health care program educators is high throughout the country, Alaska will need to consider "grow your own" strategies to develop this workforce internally.

Action Steps

- Provide opportunities for secondary academic and career/technical teachers to increase their understanding of how academic skills are applied in various health care occupations using the Teacher-Industry Externship (TIE) program or other successful models
- Develop additional secondary faculty from industry and elsewhere that can deliver heath career-related instruction
- Prepare/secure the necessary postsecondary faculty through better utilization of national health care educator loan repayment programs, sabbaticals/release time for faculty pursuing the necessary credentials and/or aggressive recruitment
- Assure salaries, benefits and other incentives for faculty that are comparable to practicing health care professionals in their area of instruction
- Increase opportunities for health care professionals to serve as adjunct or part-time faculty by identifying and addressing current workplace and training institution policy or practice barriers
- Establish training and incentives for practicing professionals to assume responsibility for continuing education in their facilities, for example, as nurse educators
- Assist health care faculty and educators to effectively utilize technology, including simulation, and distance methodologies in their instruction

Timeline

- Short term for programs such as faculty externships and adjuncts
- Mid-term for master/doctoral degree-prepared faculty development

Responsible Parties

- Education and training providers
- Industry/Employers
- Professional Associations

Resources

- Models
  - Alaska Process Industry Careers Consortium Teacher Industry Externships (TIE) programs
  - ACE-HC
- Funding
  - K-12 Foundation Program
  - UA general funds
  - Industry
  - State and federal grants

Evaluation: Alaska has skilled and well-prepared faculty at all levels to deliver the training, education and continuing skill development necessary to support the health care workforce. The health care industry supports a teacher in industry program modeled after APICC's TIE program.

Strategy 3

Recruit qualified candidates to fill health care positions

Even with expansion of programs through in-state training facilities and distance delivery, Alaska's population and resources alone will not be able to fill all of the health care workforce needs. In some cases—such as medical education—preparation program are prohibitively expensive; in others—such as pharmacy—positions are critical but needed in relatively small numbers. For the foreseeable future, therefore, Alaska will need to attract health care providers to the state.

This strategy can be implemented by

- Promoting health care employment opportunities in the state
- Expanding post-graduate programs, residencies and fellowships
- Establishing financial and other incentives to attract needed professionals
- Coordinating recruitment among health care providers
- Creating a positive community, policy and economic environment for health care providers

Funding

- Industry
- State and federal loan repayment/incentive dollars
- State marketing dollars
- Federal grants and programs that address recruitment

Strategy 3.1 Promote health care employment opportunities in Alaska

Rationale: A widespread campaign to advertise health care opportunities in Alaska can assist in developing a pool of qualified applicants for open positions. An untapped resource is Alaskan students who have gone out-of-state for education in health care fields and who may return if provided information about career opportunities. Identifying institutions that have a high number of graduates practicing in Alaska for targeted recruitment can also increase the applicant pool. Greater use of existing resources such as the ALEXsys system and state marketing efforts can be a cost-effective means of attracting needed expertise to the state.

Action Steps

- Refine the ALEXsys system to more accurately identify the occupations and specialties that are being recruited
- Partner with state marketing groups to advertise health care provider opportunities in Alaska
- Reach out to Alaskan students who are pursing health care education outside of Alaska to inform them of opportunities in Alaska and encourage them to return after graduation
- Develop partnerships with institutions in other states with strong health care preparation programs and/or which have a large number of graduates already practicing in Alaska to directly recruit program completers

Timeline

- Short term

Responsible Parties

- Industry/Employers
- Government (DOLWD, DHSS, DEED, Alaska Commission on Postsecondary Education)
- Professional Associations
- Education and training providers (Alaska and other states)

Resources

- Models
  - *Status of Recruitment Resources and Strategies 2005-06 (DHSS)*
  - Seafood Marketing Institute
  - Office of Tourism marketing materials
- Funding
  - State employment security dollars
  - State marketing dollars
  - Industry
  - National Health Service Corps (NHSC) and Indian Health Service (IHS) Loan Repayment programs

Evaluation: ALEXsys information accurately reflects the nature and qualifications of open positions. Alaska's health care system and workforce needs are highlighted in the state's promotional materials. Recruiting networks are established with select institutions in other states.

Strategy 3.2 Expand post-graduate opportunities

Rational: Research indicates that health care professionals frequently choose to practice in an area where they have completed a rotation, residency, internship, fellowship or other postgraduate experience. In Alaska, the rate of return on its one residency program—the Alaska Family Medicine Residency—is extremely high: 70 percent of the 55 graduates have remained in Alaska.[8] There is widespread agreement that Alaska has additional capacity for residencies and rotations; however, at the current time, there are policy and fiscal barriers to such expansion.

Action Steps

- Change Medicaid and Medicare policy to allow increased support for in-state teaching hospitals and the use of residents
- Increase funding for Alaskan and rural rotations through AHEC and other agencies that support rotations
- Develop an American Psychology Association (APA) approved residency in conjunction with the UA PhD in psychology
- Establish residencies in psychiatry, pediatrics and internal medicine
- Support the development of a plan to expand graduate medical education (GME) to additional specialties and regions
- Implement strategies to identify medical interns and residents working with Alaskan physicians and to encourage them to practice in the state upon graduation

Timeline

- Short term for APA, pediatric, internal medicine and psychiatry residencies
- Mid term for other specialties
- Short term for changes in Medicaid/Medicare reimbursement policies

Responsible Parties

- Industry/Employers
- Education and training providers
- Government (DHSS, state legislature for Medicaid/Medicare policy changes)
- AHEC

Resources

- Programs
  - NHSC Student/Resident Experiences and Rotations in Community Health
  - AHEC network
  - Alaska Family Practice Medical Residency
  - Alaska Center for Rural Health Rural/Underserved Opportunities Program
- Funding
  - Medicaid and Medicare Graduate Medical Education (GME) funds
  - NHSC and IHS federal funding
  - Federal Health Resources and Services Administration (HRSA) for AHEC, NHSC and IHS funding
  - Industry
  - State funds

Evaluation: Medicaid/Medicare policies support the use of residents in Alaskan hospitals. Residency opportunities are available in all regions of the state. Rural rotations are available at all rural hospitals, in most community health centers and tribal clinics and in a number of private practices.

[8] DHSS, *Securing an Adequate Number of Physicians for Alaska's Need*, Report of the Alaska Physician Supply Task Force, August 2006, p. 42

Strategy 3.3 Improve coordination in recruitment among health care providers

Rationale: Recruitment in the health care industry is an expensive business. According to a 2005 study, state health care facilities—hospitals, community health centers and rural mental health centers—spent over $24 million on recruitment in the prior year. Many times, more than one institution is recruiting for a similar skill set. Often searches at one institution yield multiple qualified candidates, some of whom at least could be good fits for other open positions in the state. A more coordinated recruitment system would allow hiring agencies to spread the costs of recruitment, share promising recruitment practices and develop a pool of applicants that are interested in relocating to Alaska in general and rural Alaska in particular.[9]

Action Steps

- Inventory existing recruiting practices among health care providers and facilities to identify "best practices"
- Create and maintain a single website that links health care organizations and is a repository for open positions
- Actively market Alaska health care employment opportunities in selected regions and with selected institutions in other states
- Explore a coordinated recruitment consortium that can serve multiple agencies and can share applicant information/applicant pools
- Pilot the use of non-traditional recruitment strategies such as posting on Craig's List and other web sites

Timeline

- Short term

Responsible Parties

- Industry/Employers
- Government (DHSS)
- Professional associations and membership organizations

Resources

- Programs
  - 3RNET technical assistance and web page
  - DHSS Alaska Primary Care Office and State Office of Rural Health
  - ASHNHA
- Funding
  - Industry

Evaluation: A coordinated recruitment effort exists that shares information and recruiting resources.

Strategy 3.4 Establish incentives to attract needed professionals

Rationale: Financial incentives of various types—loan repayment, moving costs, housing assistance and tax breaks—can influence a provider's decision to practice in Alaska. Research on support-for-service programs indicates that these programs bring health care providers to needy communities where they remain in practice for many years. Of all types of programs, loan repayment and direct financial incentives that target the practitioner after training show the broadest success.[10] Currently, a small number of health care providers—primarily physicians—who locate to Alaska are eligible for a variety of federal loan repayment programs, but these programs have limited slots and are generally targeted at underserved areas of the state. Incentives are needed for additional categories of high-need health care professionals, for all areas of the state and for those for whom loan repayment is not appropriate.

Action Steps

- Maximize use of federal loan repayment programs through dissemination of information and application assistance to health care providers and potential applicants
- Continue to submit the Health Professional Shortage Area (HPSA) designation application to HRSA to assure that sites are eligible to have loan repayors through HRSA-funded National Health Service Corps and State Loan Repayment programs
- Create and fund a state-supported loan repayment program
- Provide funds for non-loan incentives
- Explore federal tax breaks and other economic incentives to practice in underserved areas

[9] Alaska DHSS, *Status of Recruitment Resources and Strategies 2005-06*, p. iii and Recommendations, pp. 40-41

[10] Donald E. Pathman, M.D., et al, *Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians*, Medical Care, Vo. 42, No. 6, p. 567

Timeline
- Short term for state loan repayment and incentive program
- Mid-term for tax incentives

Responsible Parties
- Government (DHSS, State Legislature, Alaska Congressional delegation)
- Industry/Employers

Resources
- Programs
  - HRSA NHSC Loan Repayment
  - National Institutes of Health loan repayment programs
  - Military LR
  - HRSA State Loan Repayment Program
  - HRSA Nursing Faculty Loan Repayment
  - IHS Loan Repayment Program
  - Alaska Mental Health Trust Authority
- Funding
  - Federal loan repayment, including stimulus funds
  - State dollars
  - Industry
- People
  - DHSS health Planning and Systems Development Section staff, including the Alaska Primary Care Office and the State Office of Rural Health
  - Alaska Native Tribal Health Consortium staff for IHS loan repayment

Evaluation: State loan repayment and incentive program is in place and funded. Federal loan repayment programs are utilized to maximum effect. Support system for non-loan incentives is in place.

Strategy 3.5 Create a positive environment for health care providers

Rationale: While financial considerations can greatly influence the success of recruiting efforts, other factors can also come into play. The ease with which a relocating professional can become licensed or certified in Alaska can significantly affect a successful placement. Hurdles such as multiple background checks for the same position and with the same state agency can sour an applicant. Community amenities such as quality schools, housing and opportunities for spousal employment are important, particularly when a family is relocating.

Action Steps
- Align state regulations and licensure requirements with clinical workforce needs
- Develop and support the utilization of tools that promote community-based approaches to recruitment and retention
- Create Alaskan-specific practice environment assessments and comparison tools for selected profession

Timeline
- Short term for alignment of licensure and regulatory requirements
- Mid-term for community-based approaches and practice environment assessments

Responsible Parties
- Government (DCCED, Division of Corporate, Business and Professional Licensing, DHSS Criminal Background Check Unit)
- Industry/Employers
- Professional organizations

Resources
- Models
  - National Health Service Corps Site Development Manual
  - Examples from other states, such as the Massachusetts Medical Society index for physicians
- Funding
  - State GF and professional fees for licensing
  - Industry/state funds for community grants
  - Professional organizations
  - Federal/state grant funds
  - Private foundations

Evaluation: State licensure requirements are in line with national standards and reflect the needs of the health care workplace. Communities are involved in and take appropriate responsibility for the recruitment of needed health care professionals.

Strategy 4

Retain a skilled health care workforce

While recruiting skilled health care workers is a major task, keeping this workforce is even more critical. Some health care occupations and some locations report annual double-digit turnover rates. A 2006 study by DHSS found that the average cost for a physician hire was $126,782. Urban costs for recruiting registered nurses were $10,527 per hire; rural costs for the same position topped $42,500.[11] Clearly, replacement of lost workers represents huge costs in terms of both recruitment and retraining—costs that can be avoided by better retention.

This strategy can be implemented by

- Supporting and disseminating effective orientation and on-boarding programs for new employees
- Providing opportunities for professional development and advancement
- Promoting positive work environments

Funding

- Industry
- Private Foundations
- State/federal grants

Strategy 4.1 Support and disseminate effective orientation programs for new employees

Rationale: Much of the turnover in the health care workforce occurs during the first year of employment, particularly among new graduates who are entering the profession. As health care worker shortages in Alaska and the nation continue to grow, the state's health care employers are hiring and are willing to hire newly-trained workers in ever higher numbers.[12] Even seasoned professionals who are new to Alaska or to more rural conditions require assistance to be successful in their positions. Both health care organizations and the wider community have a responsibility for assuring that entering employees receive the support they require to succeed.

Action Steps

- Assist employers to implement preceptorship/mentorship programs based on standardized core competencies
- Encourage employers to provide cultural awareness/competencies training
- Establish industry/education consortia to share competencies, models and best practices in inducting new employees
- Identify community support initiatives

Timeline

- Short term for competency-based preceptorship programs
- Mid-term for community-based initiatives

Responsible Parties

- Industry/Employers
- Professional Organizations

Resources

- Models
  - ACE-HC competency-based nurse preceptorship programs
  - AMHTA – Alaska Core Competencies for Direct Service Workers
  - AHEC network
- Funding
  - Industry
  - AMHTA
  - Professional organizations

Evaluation: Competency-based preceptorship/mentorship/apprenticeship programs are established in all health care facilities and available to new employees.

[11] DHSS, *Status of Recruitment Resources and Strategies 2005-2006*, June 2006, pp. 31-32

[12] Alaska Center for Rural Health, *2007 Alaska Health Workforce Vacancy Study Research Summary*, August 2007, p. 4

Strategy 4.2 Provide opportunities for professional development and advancement

Rationale: The health care industry provides many career pathways both for those who come to the industry with entry-level skills and for those with more advanced training who wish to specialize. Work-based training directed at competencies and tied to career ladders is an effective method for retaining employees and for developing an increasingly-skilled workforce. Sharing training and continuing education opportunities among health care facilities through state/regional workshops or distance delivery can increase the reach of limited resources. Professional networking opportunities can assist with on-going skill development, encourage collaboration and lessen the sense of isolation that frequently occurs in Alaska among health care professionals, particularly those serving in rural areas.

Action Steps

- Share existing competency-based career ladders among employers
- Identify emerging roles and competencies resulting from health care reform and changes in care models
- Encourage apprenticeships and work-based experiences tied to career ladders and lattices
- Sponsor in-state professional development events
- Expand access to continuing education coursework through the UA system
- Assist with networking among health care occupational groups

Timeline

- Short term

Responsible Parties

- Industry/Employers
- Education and training providers
- Professional organizations

Resources

- Models
  - ACE-HC nursing group
  - Alaska Primary Care Association
- Funding
  - Industry
  - State/federal grants
  - Private foundations

Evaluation: Competency-based career ladders are established for high demand occupational groupings. Appropriate work-based and credit-bearing training opportunities support the career ladders. Professional workshops and networking opportunities are available to practitioners throughout the state.

Strategy 4.3 Promote positive work environments

Rationale: Health care positions place a high degree of responsibility on individual workers and often demand long hours and non-standard shifts. A major cause of turnover among direct care workers is the lack of appropriate supervision that supports and develops the employee. For all health care providers, changes in care models, technology and record-keeping systems can increase stress levels if adequate information and training is not provided. Finally, although compensation is usually not at the top of the list of reasons for leaving the industry, salary and benefits for the entry-level workforce need to recognize the importance of these positions and their contributions to the quality of health care in Alaska.

Action Steps

- Strengthen supervisory and leadership skills in health care occupations and facilities
- Assure competitive salary rates and employee benefits for health care workers, particularly those in entry-level and direct care positions
- Provide training in supervision and leadership to front-line supervisory personnel
- Inventory and disseminate best practices such as flexible schedules
- Establish organizational models that reflect changes in care management and that utilize technology to improve patient care and employee effectiveness
- Explore cross-industry leadership training programs that can be delivered collaboratively to both urban and rural site

Timeline

- Short term for supervisory and leadership training
- Mid-term for new organizational models

Responsible Parties

- Industry/Employers
- Professional organizations
- Education and training providers

Resources

- Programs
  - ACE-HC Nurse leadership competencies
  - UA/APU management/supervisory training programs
  - State of Alaska supervisory training
  - Private sector consultants/training
- Funding
  - Industry
  - UA general funds
  - Fees and tuition for management/supervisory training courses and programs

Evaluation: Turn-over in Alaskan health care facilities is reduced to at least the national average. Employees receive appropriate supervision and competitive wages and benefits.

Occupation-Specific Strategies for Priority Occupations

The health workforce is exceedingly complex to describe, evaluate and project. While overarching strategies to engage, train, recruit and retain health care workers are useful—even essential—to address the overall workforce picture, individual occupations and professions require their own detailed action plans comprised of strategies tailored to their unique needs.

In order to begin to develop these action plans, the health workforce planning process included an initial assessment of occupational priorities for Alaska, utilizing data and information from a variety of sources including the following:

- DOLWD
- Ten-Year Projections
- Industry-Specific Studies
- Occupational Information, Ranking and Demographics
- DHSS
- Health Professional Shortage Area (HPSA) Analysis
- Physician Task Force Report
- Special Topics (e.g. dental, pharmacy, licenseholders, loan repayment/
- employee incentives options)
- University of Alaska (Alaska Center for Rural Health/Alaska's AHEC and Office of Health Programs Development)
- Vacancy Studies
- Recruitment Studies
- Special Topics (e.g. rural allied health, CHA/P, nursing, health information technology, pharmacy, geriatric education)

On the basis of the above information, which is compiled in the Occupational Forecast (Section 5), the planning group initially identified 35 occupations that appeared to be in most critical need of attention because of high vacancy rates, high number of vacancies and/or criticality to health care delivery. This initial listing was then distributed to various health-related groups either in a conference setting—Behavioral Health, Alaska State Hospital and Nursing Home Association (ASHNHA) and Alaska Public Health Association (ALPHA)—or through surveys to the participants/members of those groups as well as to the Alaska Medical Group Management Association (which represents many doctor's offices and clinics) and the Alaska Native Tribal Health Consortium. In all, 151 Alaskans participated in the survey prioritization process.

Conference and survey respondents were asked to select their top five from the list of priority occupations and to add occupations that they felt should be on the list. Results were reviewed by the coalition's Assessment and Priorities Committee. From these processes, occupations/occupational groupings were identified as those most in need of immediate attention. The 15 top priority groupings listed below include a total of 26 occupations and professions:

- Behavioral Health Aide/Village Counselor
- Primary Care Physician
- Advanced Nurse Practitioner
- Substance Abuse Counselor
- Registered Nurse
- Community Health Aide/Practitioner
- Social Worker
- Oral Health Practitioner
- Psychiatrist
- Human Services Worker
- Pharmacist
- Therapist and Therapist Assistant (Physical, Occupational, Speech-Language)
- Nurse Educator
- Health Informatics Staff
- Direct Care Worker

Once priorities were identified, an initial set of strategies for each occupation on the list was developed. These strategies were then circulated to educators and practitioners in the occupation for review, verification and revision.

The revised strategies for each of the 15 priorities, together with descriptions of the occupations and pertinent data, make up the remainder of this section. The format used is similar to that found in the Physician Supply Task Force report cited elsewhere in this plan. An estimated time frame for the strategies is provided: Short Term (within the next two years), Medium Term (within three to

five years) and Long Term (five years or more in the future).

Priority strategies will be identified in the next step of the planning process and action plans utilizing these strategies will be drafted in the coming months for each of the identified priority occupations. These plans will include the following sections: Strategy, Problem Statement, Action Steps, Target Outcomes, Timeframe, Benefits, Costs, Responsibility, Area of Impact, and Rationale. During action planning, budget projections will be made for each strategy.

It is anticipated that those responsible for working on strategies for a particular health occupation will maintain regular communication, collaborate, and share ideas, information and results. Also, it is expected that work will continue on occupations beyond those included in the plan until a full set of health occupations strategies is completed.

Industry Occupations by Priority

Priority 1 *Most critical; requires immediate attention*

Behavioral Health Aide/Village Counselor
Certified Nurse Assistant
Community Health Aide/Practitioner
Dental Health Aide/Therapist
Dental Hygienist
Dietitian/Nutritionist
Disabilities Specialist/Worker
Family Nurse Practitioner/Advanced FNP
Family Physician (M.D., D.O.)
General Internal Medicine Physician/Internist
Health Educator
Health Informatics Staff
Healthcare Managers/Supervisors
Home Health Aide
Human Services Worker
Medical Assistant
Nurse Educator
Nurse Manager/Executive
Nurse Specialist (e.g. Critical Care, ER, OB)
Occupational Therapist
Personal Care Assistant
Pharmacist
Pharmacy Technician
Physical Therapist
Physical Therapy Assistant
Physician Assistant
Psychiatric Nurse
Psychiatric Nurse Practitioner
Psychiatrist
Public Health Nurse
Registered Nurse
Social Worker (BSW, MSW, LCSW)
Sonographer
Speech-Language Pathologist
Substance Abuse Counselor

Priority 2

Accountant (Health Care)
Behavioral Health Case Manager
Behavioral Health Clinician
Billing/Coding Clerk/Technician/Specialist
Clinical Psychologist/Psychologist
Community Health Representative
Community Wellness Advocate
Compliance Officer/Auditor
Dental Assistant
Dentist
Geriatrician
Gerontologist
Health Information Administrator/Manager
Healthcare Quality Professional
Hospital Administrator
Licensed Practical Nurse
Limited Radiographer
Mammographer
Marital/Family Therapist
Medical Director
Medical Laboratory Technician
Medical Technologist
Nuclear Medicine Technologist
Nurse Case Manager
Nurse Midwife/Women's Health Nurse Practitioner
Nursing Home Manager
Occupational Therapy Assistant
Optician
Pediatric Nurse Practitioner
Pediatrician
Physician Specialist
Radiation Therapist
Radiographer/Radiologic Technician
Rehabilitation Counselor
Residential Aide
Safety Officer
Sanitarian
Speech Therapist
Surgical Technologist
Veterinary Technologist/Technician
Village Health Educator

Priority 3

Anesthesia Technologist/Technician
Anesthesiologist Assistant
Art Therapist
Athletic Trainer
Audiologist
Billing Supervisor
Biomedical/Health Researcher
Blood Bank Technology Specialist
Cardiovascular Technologist
Chaplain
Clinical Assistant (Lab)
Cytogenic Technologist
Cytotechnologist
Dance/Movement Therapist
Dental Laboratory Technician
Diagnostic Molecular Scientist
Echocardiography Technician
Electrocardiography Technician (EKG)
Electroencenphalography Technician (EEG)
Electroneurodiagnostic Technologist
Emergency Medical Services Technician (EMT/ETT)
Epidemiologist
Exercise Physiologist
Exercise Science Professional
Genetic Counselor
Health Advocate
Health Care Manager/Supervisor
Health Information Clerk/Technician
Histotechnologist
Horticultural Therapist
Kinesiotherapist
Low Vision Therapist
Magnetic Resonance Technologist (MRI/CT)
Massage Therapist
Medical Biller/Billing Clerk
Medical Coding Clerk/Specialist/Certified Coder
Medical/Dental Receptionist
Medical Dosimetrist
Medical Illustrator
Medical Librarian
Medical Transcriptionist
Music Therapist
Nurse Anesthetist
Orientation and Mobility Specialist
Ophthalmic Assistant
Ophthalmic Dispensing Optician
Ophthalmic Medical Technician/Technologist
Optometric Technician
Optometrist
Orthoptist
Orthotist and Prosthetist
Paramedic
Pathologist's Assistant
Perfusionist
Personal Fitness Trainer
Phlebotomist
Podiatrist
Polysomnographic Technologist
Privacy Officer/Specialist
Professional Counselor
Psychiatric Aide/Technician
Public Health Administrator
Respiratory Therapist
Surgical Assistant
Sterile Processing Technician
Therapeutic Recreation Specialist
Teacher of the Visually Impaired
Veterinarian
Veterinary Assistant/Lab Animal Caretaker
Vision Rehabilitation Therapist

Behavioral Health Aide/Village Counselor

Description:

Behavioral Health Aides/Practitioners are employed by Alaska tribal health organizations to address local mental health and substance abuse issues and to promote healthy individuals, families and communities in rural and remote Alaska Native Villages. Behavioral health aides work under the supervision of licensed professionals.

Overview:

Programs are in place to train behavioral health workers for rural and urban Alaska, and there is an articulated behavioral health pathway available through distance delivery. Attracting individuals to these demanding positions and retaining them is challenging.

Workforce Data:

There were an estimated 39 vacancies in 2009 (15% vacancy rate).[13]

Education and Training:

UAF Rural Human Services; Regional Alcohol and Drug Abuse Counselor Training (RADACT), Alaska Native Tribal Health Consortium (ANTHC) Behavioral Health Aide Training; certification by Community Health Aide Program Certification Board; behavioral health career ladder (BHA I, II, III and BHA Practitioner) with participation by many UA campuses and tribal health organizations; courses are a combination of distance delivered and in person.

Strategies	Timescale
Engage	
Develop awareness of behavioral health occupations, especially in rural Alaska, using public service announcements on radio and television and other methods.	Short
Conduct culturally appropriate anti-stigma campaigns.	Medium
Engage local elders and leaders in introducing children and adults to the role of a village counselor.	Short
Provide information about, access to and funding for training and career opportunities in behavioral health.	Medium
Support continued ANTHC/University of Alaska/Alaska Mental Health Trust Authority cooperative efforts on the further development of BHA training opportunities and outreach.	Short
Train	
Enlist the help of local Alaska Native elders and leaders to assist with teaching healthy lifestyles and coping skills development in elementary schools.	Short
Continue to provide competency-based, culturally sensitive education for behavioral health workers at the village level; expand as needed. Ensure local Alaska Native elders and leaders co-teach and story-tell.	Medium
Expand access to continuing education for the village behavioral health workforce by promoting UA cross-campus coordination.	Medium
Consider strengthening work-based learning approaches to BHA education.	Medium
Present training materials and information at the Annual BHA Forum.	Short
Recruit	
Identify youth with peer helping skills and abilities in consultation with Native elders and community leaders, and support and nurture their growth.	Medium
Educate the legislature and advocate for increases in funding for sustaining these positions across the state.	Medium
Ensure that BHA certifications and endorsements are reciprocal and can be used at all levels of the career ladder in all rural areas.	Medium

[13] Unless otherwise noted, vacancy data are taken from the *2009 Alaska Health Workforce Vacancy Study*, conducted by the Alaska Center for Rural Health at the University of Alaska Anchorage. Licensing data have been provided by the Division of Occupational Licensing at the Department of Commerce, Community and Economic Development and by Department of Health and Social Services. Non-resident and age data for the current workforce are from Department of Labor and Workforce Development studies and projections.

Provide support to the Tribal BHA Training Academy to recruit and support training staff.	Short
Provide recruitment materials through tribal health organization communication channels and at tribal events around the state	Short

Retain

Ensure Native elder and community leader support for behavioral health workers through mentoring, guidance and leadership.	Short
Make general and targeted skills enhancement available for village behavioral health workforce.	Medium
Improve supervision of village workers.	Medium
Develop community understanding of and support for behavioral health workers in local areas, including personal expressions of appreciation.	Short

Primary Care Physician

Description:

Primary Care Physicians diagnose, treat, and help prevent diseases and injuries that commonly occur in the genera population and may be trained as either Doctors of Medicine (MD) or Doctors of Osteopathy (DO). Areas of practice include Family Practice, General Internal Medicine, and Pediatrics. Obstetricians/Gynecologists are sometimes include in this group, as are General Surgeons.

Overview:

In 2005 a task force was convened to analyze and provide recommendations regarding Alaska's physician workforc These recommendations included expanding the size of the WWAMI medical school class, considering establishment o a medical school in Alaska, and various recruitment and retention measure. Several of these strategies, and some others represented in this section, have already commenced. Further planning is needed to develop strategies specific to each type of primary care physician.

Workforce Data:

In 2009, there were an estimated 67 family practice vacancies (11% vacancy rate) and 1,583 licensees, up 2% from 2007; 24% of the workforce is non-resident, 41% over age 50.

Education and Training:

Alaska WWAMI program (20 graduates per year); Alaska Family Medicine Residency (10 completers per year).

Strategies	Timescale
Engage	
Strengthen pipeline programs to medical and other health professions, particularly for minority and disadvantaged/under-represented populations.	Short
Support school districts in offering health occupations awareness and exploration activities.	Short
Incentivize consideration of family rather than specialty practice.	Medium
Engage hospitals/physicians in the community to help develop student awareness and interest.	Short
Train	
Expand the WWAMI program to include the second year in Alaska and additional students as resources allow.	Medium
Remove requirement to repay the public fund portion of medical education.	Short
Increase the use of distance delivery, simulation and other technologies to strengthen medical education in Alaska.	Medium
Implement a post-baccalaureate program to prepare college graduates and mid-career individuals for successful application to medical school.	Short

Provide excellent continuing medical education opportunities for family physicians throughout the state.	Medium
Develop a plan for Graduate Medical Education (GME) across the state that includes reducing barriers to financing GME.	Short
Explore community partnerships for GME programs, DO rotations, etc.	Medium
In conjunction with nurse practitioner and physician assistant programs, work to expand clinical practice opportunities for medical students and residents.	Short-Medium
Consider development of a medical school in Alaska.	Long
Infuse interdisciplinary teamwork, quality improvement and evidence-based practice concepts and applications in all health programs including medical.	Medium
Recruit	
Work collaboratively to recruit primary care physicians to Alaska.	Short
Offer information and incentives to attract physicians to Alaska, particularly to areas of shortage.	Medium
Establish a robust loan repayment and employment incentives program that rewards physicians in family practice.	Long
Retain	
Sustain and improve the practice environment in Alaskan communities.	Long
Assess and meet market wages and benefits for employed staff physicians.	Medium
Offer incentives for physicians and their families to remain in Alaskan communities.	Long

Advanced Nurse Practitioner (Family, Psychiatric/Mental Health)

Description:

Advanced nurse practitioners (ANPs) are Registered Nurses who have specialized formal, post-basic education and who function in highly autonomous and specialized roles working with all ages of patients.

Overview:

Nurse practitioner programs in the state have been in existence for many years. There is growing interest in these programs and class size in the UAA Family NP program has increased. Maintaining current enrollment and evolving the programs will require additional faculty. Recruitment, especially for other specialties, will continue to be required.

Workforce Data:

In 2009, there were an estimated 58 vacancies for Family Nurse Practitioners (17% vacancy rate) and 490 licensees, 9% increase from 2007. In that same survey, there were 2 vacancies (18% vacancy rate) reported for Psychiatric/Mental Health Nurse Practitioners.

Education and Training:

UAA Master of Science in Nursing Science, Family Nurse Practitioner track (15 graduates per year); Psychiatric/ Mental Health Nurse Practitioner Track (6 graduates every other year); these programs are offered primarily through distance delivery with some clnical intensives.

Strategies	Timescale
Engage	
Inform the public and prospective students about advanced practice nursing and the need for primary care providers in Alaska through media, role modeling, job shadows, and other means.	Short
Target nurses from minority and disadvantaged/underrepresented groups for encouragement and assistance in becoming advanced practice nurses.	Medium

Train

Hire more faculty for the UAA SON Advanced Nurse Practitioner programs.	Short
Identify additional practice sites for the education of advanced nurse practitioners in Alaska; consider innovative solutions such as offering a business tax credit to practices that agree to serve as a training site.	Short
Allow for evolution of advanced nursing practice education in Alaska toward national norms to ensure continued graduation and certification of Alaska ANPs, including the development of a Doctorate in Nursing Practice (DNP) program.	Medium
Provide continuing education in essential and advanced skills and knowledge for nurse practitioners across the state.	Medium
Update audio/video equipment to improve program delivery; add capacity for clinical simulation throughout the state.	Short

Recruit

Include advanced nurse practitioners in the professions eligible for loan repayment and other employment incentives.	Short
Examine the feasibility of subsidies for establishing advanced nursing practices in communities experiencing a primary care shortage; consider housing support.	Medium
Identify other strategies for external recruitment of ANPs through consortia of providers.	Medium

Retain

Sustain and improve the practice environment in Alaskan communities.	Medium
Ensure continuation of a robust scope of practice for advanced nurse practitioners in Alaska.	Short
Subsidize continuing education offerings by providing financial support for continuing education conferences to keep attendee costs affordable.	Medium

Substance Abuse/Behavioral Health Counselor

Description:

These positions counsel and advise individuals, families or groups with alcohol, tobacco, drug, or other co-occurring mental health and associated problems, such as domestic violence, criminal justice involvement, gambling, eating disorders, etc. Counselors may also provide life skills development and engage in education, harm reduction and prevention programs.

Overview:

There is an established process in Alaska for training and certifying these workers . As with other behavioral health fields, attracting and retaining individuals as substance abuse counselors is challenging.

Workforce Data:

There were an estimated 48 vacancies (15% vacancy rate) in 2009. An additional 110 positions are expected to be created in the ten-year period ending 2016. Currently, 8% of the workforce is non-resident; 39% is over 50 years of age.

Education and Training:

Alaska certifications and continuing education in the chemical dependency field; pertinent content included in behavioral health degree programs such as social work, psychology and human services. (Behavioral Health Technicians - 151 contact hours; Behavioral Health Counselor I - 304 contact hours; BH Counselor II - 6 years of work in chemical dependency or a bachelor's in human services or a minimum of 436 contact hours. An advanced BH Counselor II must have 6 years of full time work and experience supervised by a chemical dependency supervisor.)

Strategies	Timescale
Engage	
Develop awareness and educate the public about occupations and professions dedicated to decreasing the effects of alcohol, tobacco, substance use, eating disorders, and gambling in Alaska.	Short
Engage in a dialog with elders, local community leaders, businesses and civic organizations, as well as prospective students, about these roles.	Short
Train	
Inform practitioners at all levels about certification requirements and training opportunities such as Regional Alcohol and Drug Abuse Counselor Training (RADACT) and university programs.	Short
Encourage and assist substance abuse staff to receive required levels of training in the field.	Short
Ensure that Behavioral Health Technicians through Advanced Behavioral Health Counselors have access to the hours needed for training to keep their certification; provide financial assistance as necessary.	Short
Recruit	
Identify with community elders and leaders youth that show helping skills and abilities; ensure they have access to further their interest through formal education; support them as necessary to complete their training.	Medium
Work with all post secondary and vocational training programs to disseminate information to students who may be interested in an addiction treatment professional career.	Short
Partner with regional Native corporations to provide scholarships targeted to the addiction treatment field.	Medium
Create a Tech Prep pathway for high school students interested in this career area, allowing them to take one or more courses from the university as a way to build toward a career and future training.	Medium
Retain	
Create opportunities for certified Behavioral Health Technicians through Advanced Behavioral Health counselors to have daily access to not only a clinical supervisor but also to community leaders and advisors.	Short
Support the development and delivery of evidence-based continuing education critical to the professional development of counselors in the areas of substance abuse and related disorders, such as specific assessment tools, interventions and treatment modalities.	Short
Institute a loan repayment program for paraprofessionals in the addiction treatment field to enable them to seek postsecondary education that will allow them to assume leadership positions in their agencies.	Medium
Facilitate the development of a rural substance abuse and behavioral health counselor network to connect these individuals through video or live web-conferencing on a regular basis.	Medium
Ensure individuals just entering the behavioral health field have regular and consistent access to a clinical supervisor for support, using distance delivery as a prime method for education and/or transitioning into private practice.	Medium

Registered Nurse (RN)

Description:

RNs assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. They administer nursing care to ill, injured, convalescent, or disabled patients in many venues and may advise patients on health maintenance and disease prevention or provide case management. Licensing or registration is required in order to practice. DOLWD data include advance practice nurses in this category.

Overview:

Progress has been made on increasing the number of new graduate registered nurses in Alaska. Over time, the exte sion of the associate's degree program to many locations across the state, and improvement of the distance delivered RN to-bachelor's degree, will allow for significant headway in most regions. Distribution remains a challenge—though less than in the past—and should improve further as new training sites are added. A continuing challenge is the process of orienting new graduates into their workplace roles and augmenting their skills in specialty areas. Considering the size o this workforce, it is anticipated that recruitment from outside the state will continue to be a factor, especially for nurse specialists.

Workforce Data:

There were 307 estimated vacancies (10% vacancy rate) in 2009 with only 63 vacancies for new graduates. By 2016 DOLWD estimates that the state will have 6,328 nursing positions, up from 4,817 in 2006. There were 6,334 licensees in 2009, a 9% increase from 2007; 16% of the current workforce is non-resident, 40% over age 50.

Education and Training:

AAS and BS nursing degrees at UAA SON (180-200 graduates per year); currently 12 locations in Alaska, 2 more to be added in 2011.

Strategies	Timescale
Engage	
Inform the public about nursing as a career, including K-12 awareness activities and working with AHEC Centers.	Short
Expand awareness of nursing opportunities to include specialty, rural and long-term care areas, as well as advanced practice.	Short
Educate the public about career lattice opportunities, including the ability to grow into the profession from a direct services background. Include information to those with other bachelor's degrees.	Short-Mediu
Broaden the field of nursing applicants, reaching out to students with degrees in other fields.	Short
Train	
Encourage relevant knowledge and skills development during K-12 education.	Short
Sustain and improve UA School of Nursing basic programs; solidify AAS program at the community level; strengthen and market advanced and specialty education, including the nurse educator distance-delivered master's program.	Short-Mediu
Identify specialty priories; achieve statewide process for specialty training.	Medium
Continue development and support for accelerated specialty and rural generalist preceptorships and other post-employment continuing education opportunities; fund coordinating/development consortium; find funding for coordination/development consortium.	Medium
Engage all levels of nursing students in interdisciplinary teamwork and quality improvement/evidence-based practice education and clinical opportunities.	Short

Recruit	
Identify nursing specialists and nurse educators as beneficiaries of loan repayment and employment incentives programs.	Short
Use a coordinated approach to developing a strong pool of nursing candidates in the state.	Medium
Develop a comprehensive plan including financial incentives to attract nursing faculty to Alaska and engage local nurses in educational roles as preceptors and faculty members.	Medium
Retain	
Structure the workplace environment to maximize retention of incumbent nurses; consider factors such as shared governance, fair salary/benefits, highest attention to patient care quality and safety, reasonable and flexible workloads and schedules, etc.	Medium
Incentivize nursing staff to welcome and mentor new graduates and employees.	Short
Identify methods of attracting and retaining nurses later in their careers as productive members of the workforce.	Short
Encourage the delivery of continuing education that is financially feasible and readily available to nurses residing in rural settings.	Short

Community Health Aide/Practitioner (CHA/Ps)

Description:

A profession unique to Alaska, Community Health Aides and Practitioners provide preventive, primary and emergency care to rural Alaskans. CHA/Ps work under the supervision of licensed physicians employed by one of the tribally-managed hospitals or clinics and communicate regularly with these providers by telemedicine, telephone, email and other means.

Overview:

CHA/Ps are employed by the tribal system in Alaska. Certification is provided by the Community Health Aide Program Certification Board. Village councils typically participate in selection of individuals for CHA/P training.

Workforce Data:

In 2009, there were an estimated 43 vacancies (12.9% vacancy rate). Quarterly program surveys most recently revealed 103 vacancies out of 583 positions, for a 17.6% vacancy rate.

Education and Training:

Tribal Training Centers provide required session training, with field experience between sessions. UAF assists with advanced courses and provision of credits and degree progression for those interested in academic credentials.

Strategies	Timescale
Engage	
Include CHA/Ps in career awareness activities for K-12 and the public, especially in rural Alaska.	Short
Engage local elders and leaders in introducing children and adults to the role of health aides.	Short
Provide job shadowing and basic skills strengthening for those interested in these occupations; work with AHECs on this strategy.	Short
Train	
Continue to assess and seek support for provision of sufficient sessions to meet needs in the state.	Medium
Provide continuing education opportunities on a variety of pertinent topics.	Short
Provide smooth and subsidized access to university credits and relevant degrees, including a career ladder to the physician assistant program and other health professions.	Medium

Recruit	
Seek and encourage likely candidates for CHA/P positions to apply and proceed through levels of session training.	Short
Retain	
Provide respite for those working with little assistance in small villages.	Short
Ensure reasonable wages, benefits, and schedules.	Medium
Work to provide adequate supervision and support.	Medium
Consider housing stipends for community health aides and practitioners.	Short

Social Worker

Description:

Social workers provide services to improve client well-being and functioning. Particular focus is placed on assisting bulnerable populations and providing psycho-social supports to help clients cope with health/public health, behavioral health, abuse and neglect, education and basic need-related issues. Interventions may include individual, family and group therapy, crisis intervention, case management, advocacy, prevention and education.

Overview:

While the overall vacancy rate for social workers in the 2009 study was very low, there are critical pockets of vacancies, particularly in rural areas, that seriously affect critical functions. In some organizations, the inability to find social workers has resulted in positions being discontinued and filled by other types of workers. There may also be a need to provide additional resources to increase numbers of positions.

Workforce Data:

The 2009 vacancy rate was 3%, with 5 estimated vacancies. DOLWD data indicate a need for an additional 70 positions by 2016. Of the current workforce, 3% is non-resident, 33% is over age 50.

Education and Training:

Social work bachelor's degrees are delivered by UAA and UAF (distance), master's in social work at UAA (distance). Graduate about 58 per year (35 bachelors and 23 masters). Career pathway from rural human services certificate through associates in human services, bachelor's in social work, human services or psychology, master's in social work, now PhD in psychology.

Strategies	Timescale
Engage	
Include behavioral/mental health occupations in career awareness activities for K-12 students and educate the public on the role of the clinical social worker.	Short
Train	
Continue to develop and maintain a smoothly articulated career pathway in social work.	Short
Recruit	
Include clinical social workers in loan repayment and employment incentives programs, especially for Alaskan students.	Medium
Retain	
Increase numbers of positions in social work to lessen workload burden and associated burn out, decision errors and other problems.	Medium
Provide continuing education for social workers.	Short-Medium
Provide respite to decrease burn out.	Medium
Improve salary/benefits for social workers, as well as supervision and support.	Medium

Oral Health Practitioner

Description:

Dental Hygienists – The role of the dental hygienist is to assist members of the dental profession in providing oral health to the public. A person licensed in this profession may clean and remove stains from teeth, apply topical preventive agents (i.e. fluoride and sealants), and examine oral areas, head and neck for signs of oral disease. They may educate patients on oral hygiene and take and develop x-rays.

Dental Health Aides and Therapists (DHA/Ts) are only employed by Alaska's tribal organizations. They provide oral health care to individuals in remote communities without regular access to dentists. DHAs provide dental disease prevention and education services. Depending on level of training, DHAs may also provide additional basic level dental services. DHA Therapists are advanced practitioners who provide prevention services and a limited scope of basic restorative dental procedures such as cavity removal, fillings and simple extractions. DHATs practice under the direct, indirect or general supervision of a dentist.

Overview:

Dental Hygienists - Program expansions have recently been implemented in the UA system. The University will assess the effect in next few years and consider if additional changes are necessary. Recruitment to rural areas needs considerable attention.

DHA/T – The several levels of DHAs function similarly to dental assistants and dental health educators in non-tribal organizations. In many other developed nations, there is a tradition of a DHAT mid-level role, similar to physician assistants and nurse practitioners.

Workforce Data:

Dental Hygienists: In 2009, there were an estimated 41 vacancies statewide (8% vacancy rate); 16 (4.6%) urban and 24 (15.8%) rural. According to DOLWD estimates, an additional 210 will be needed over the 10-year period ending 2016. There were 444 licensees in 2009, up 4% from 2007. The current workforce is 7.5% non-resident, 26% over age 50.

DHA/T s: The DHA/T roles have only recently been developed in Alaska and their potential employment opportunities are evolving. The 2009 vacancy study, which included all tribal organizations except one small one, found an estimated 48 positions statewide, with 2 vacancies, a 4.2% rate.

Education and Training:

Dental Hygienists - Dental hygiene programs exist in Anchorage and Fairbanks; combined 17-20 graduates per year.

DHA/T - Training sessions for DHAs are organized by tribal health organizations. DHATs are educated in Anchorage and Bethel, in a partnership between ANTHC and the University of Washington MEDEX program. Formerly DHATs were educated in New Zealand. DHA/Ts receive certification from the Community Health Aide Program Certification Board.

Strategies	Timescale
Engage	
Include oral health practitioner occupations (Dental Hygienists and Dental Health Aides/Therapists, as well as Dentists) in career awareness activities with K-12 students and the public.	Short
Work with high schools, especially in rural areas, to provide adequate science education supportive of careers in oral health.	Medium-
Inform public about new expanded functions role for dental hygienists.	Short
Train	
Evolve educational programs for DHA/Ts.	Medium
Develop crosswalk of training in hygiene and dental assisting with that for dental health aides; collaborate where feasible.	Medium
Ensure continued funding for the cost intensive DHA/T program.	Short
Provide training in expanded dental hygiene functions.	Medium
Explore ways to give college credit for DHA/T program work.	Medium

Continue dental hygiene programs in Anchorage and Fairbanks; expand when resources and space permit; offer a Bachelor of Science in Dental Hygiene (BSDH) degree to prepare dental hygienists for entry into ADHP programs.	Medium
Recruit	
Identify and encourage likely candidates for DHA/T positions.	Short
Educate tribal dental directors about employment of DHAs and encourage appropriate support of training.	Short
Include dental hygiene in loan repayment and employment incentives programs, especially for Alaskan students.	Short
Include dental hygiene in efforts to recruit collaboratively, especially to rural Alaska.	Short
Retain	
Provide adequate compensation for oral health practitioners.	Medium
Improve supervision of village-based DHAs, including training for the dental team.	Medium
Provide meaningful, appropriate continuing education for Dental Hygienists and DHA/Ts.	Short
Improve workplace conditions and compensation and exercise other retention strategies for oral health practitioners.	Medium

Psychiatrist

Description:

A psychiatrist is a physician who specializes in the prevention, diagnosis, and treatment of mental, emotional and addictive disorders.

Overview:

While the total number of vacancies was fairly low in the 2009 study, the population of psychiatrists in Alaska ove age 50 is quite high. Considering the extent of behavioral health issues in the state, it is important to address this medical specialty.

Workforce Data:

The 2009 vacancy study estimated 11 vacancies (13% vacancy rate); 16% of current practitioners are non-resident, 57% over age 50.

Education and Training:

A psychiatry residency being worked on at this time with the University of Washington.

Strategies	Timescale
Engage	
Include behavioral/mental health occupations in career awareness activities for K-12 students and the public.	Short
Train	
Develop psychiatric residency in Alaska.	Medium
Expand the third year WWAMI psychiatry clerkship for medical students.	Medium
Create and maintain a robust psychiatry resident elective until a psychiatry residency is operational; add matriculating psychiatrists to the workforce.	Medium
Recruit	
Cover psychiatrists in loan repayment and employment incentives programs.	Medium
Include psychiatrists in efforts to recruit collaboratively for physicians.	Short

Retain	
Develop and deliver continuing education opportunities for psychiatrists, particularly those in more rural areas of the state.	Shortt
Create supportive practice environments; assist in establishing practices and transitioning into the workforce.	Short

Human Service Worker

Description:

The primary purpose of the human service worker is to assist individuals and communities to function as effectively as possible in the major domains of living.

Overview:

Human service workers hold jobs with many titles. Examples include: Case Worker, Family Support Worker, Life Skills Instructor, Probation Officer, Group Home Worker, Mental Health Worker, Community Outreach Worker, Residential Manager, and Care Coordinator. Human service workers are found in diverse settings such as group homes, correctional facilities, community mental health centers, and a wide variety of other social service programs. In rural Alaska, employment opportunities include regional health corporations and federal, state and local governmental agencies.

Workforce Data:

In a large workforce of about 1,000, the number of vacancies among human service workers was 176 in 2009 (12% vacancy rate). Non-residents made up 11% of the workforce in 2006; 26% of workers were over age 50. DOLWD projects a need for about 250 additional workers in the period from 2006-2016.

Education and Training:

Some human service workers require only a high school education. The University of Alaska provides various levels of human service education, from certificate to graduate coursework. Several campuses provide education in human services, and it is possible to access programs in this field via in distance education.

Strategies	Timescale
Engage	
Include behavioral/mental health occupations in career awareness activities for K-12 students and the public.	Short
Target under-represented and other non-traditional students for human services occupations.	Short
Train	
Develop and maintain a smoothly articulated career pathways in human services across UA campuses.	Short
Seek improvements in educational programs, including complying with national standards and trends, meeting accreditation requirements, and providing access via distance education.	Short
Recruit	
Provide incentives for students to enroll in human services programs, including financial aid and scholarships for part-time, working students, workplace learning and distance education.	Medium
Retain	
Deliver continuing education for human service workers.	Short
Provide respite and sufficient staffing to decrease burn out.	Medium
Strengthen supervision through education and incentives.	Medium
Improve salary/benefits for human service workers.	Medium

Pharmacist

Description:

Pharmacists dispense drugs prescribed by physicians and other health practitioners and provide information to patients about medications and their use. Pharmacists may advise physicians and other health practitioners on the selec tion, dosage, interactions, and side effects of medications.

Overview:

The demand for pharmacists in Alaska has diminished somewhat in the past two years, probably helped by the recession and the recent increase in the number of pharmacy schools in the rest of the country. With anticipated retire- ments and potential expanded functions for pharmacists, it is expected that attention will need to be paid to ensuring that the number and distribution of this profession are adequate to meet state needs. Recruitment and retention will be important, as well as expanding viable options for educating pharmacists in state.

Workforce Data:

There were an estimated 37 vacancies (8.6% vacancy rate) in 2009 and 471 licensees, up 12% from 2007. Of the current workforce, 26% is non-resident and 34% over age 50.

Education and Training:

Currently there is no program in Alaska. Several options for pharmacy education recommended by a consultant ar being discussed. An average of fewer than 10 Alaskans enroll in pharmacy schools in other states each year. The Creigh- ton University distance delivered pharmacy program is available for those who want to stay in state for school.

Strategies	Timescale
Engage	
Inform the public about pharmacy as a career; include in K-12 career awareness activities.	Short
Target college majors in chemistry, biology and biochemistry for information about opportunities in pharmacy.	Short
Consider pharmacy technology program at the high school level.	Medium
Train	
Develop a strategy for pharmacy education for Alaska.	Short
Explore partnership options through an RFP process.	Medium
Develop a clear pre-pharmacy track at all three UA Major Administrative Units (MAUs).	Short
Work with Creighton University to set aside slots and provide tuition discount for Alaska students.	Short
Recruit	
Continue successful recruitment efforts; target new schools for information about Alaska.	Medium
Include pharmacists in loan repayment and employment incentives programs.	Short
Retain	
Creative attractive workplaces and exercise other retention strategies.	Long
Assure continuing education opportunities for pharmacists, especially in rural areas.	Medium

Therapists

Description:

A Physical Therapist assesses, treats, plans, organizes, and participates in developmental, restorative, and rehabilitative programs that improve mobility, relieve pain, increase strength, and decrease or prevent deformity of patients suffering from disease or injury.

An Occupational Therapist assesses, treats, plans, organizes, and participates in developmental, restorative and rehabilitative programs that help restore vocational, homemaking, and daily living skills, as well as general independence, to disabled persons.

A Speech-Language Pathologist assesses and treats persons with speech, language, cognition, voice, and fluency disorders to develop or regain the ability to communicate. The therapist may select alternative communication systems and teach their use and work with those with swallowing disorders to optimize nutritional intake and decrease risk of aspiration.

A Physical Therapist Assistant assists physical therapists in providing physical therapy treatments and procedures. The PT Assistant may, in accordance with State laws, assist in the development of treatment plans, carry out routine functions, document the progress of treatment, and modify specific treatments in accordance with patient status and within the scope of treatment plans established by a physical therapist.

An Occupational Therapist Assistant assists occupational therapists in providing occupational therapy treatments and procedures. The OT Assistant may, in accordance with State laws, assist in development of treatment plans, carry out routine functions, direct activity programs, and document the progress of treatments.

A Speech Therapy Assistant assists speech-language pathologists in carrying out services for individuals requiring these services.

Overview

Therapist professions in Alaska are in short supply, and pressures will continue to grow on this workforce as the population continues to rapidly age. Training for these professions tends to be expensive and complex to deliver. At present, programs in two critical therapy professions (OT and Speech-Language) are offered in Alaska through partnership arrangements and partners are being sought for physical therapy. There is some need to expand the use of occupational therapists across the state, as well as assistants in both PT and OT. That has not been the typical practice pattern to date but could serve the state well. Local development of the assistant occupations is being considered, but will require resources. There will be a continued need for recruitment into the state and for attention to distribution within Alaska.

Workforce Data:

The 2009 vacancy study estimates the following for the various therapies: PT: 45 (rate 16%), OT: 29 (rate 23%), Speech-Language Pathologists: 16 (rate 10%), PTA: 17 (rate 28%). The current workforce has considerable non-resident and older workers: OT: 17% out-of-state workers; 32% age 50+; PT: 22% out-of-state, 22% age 50+; Speech-Language: 18% out-of-state, 44% age 50+; PTA: 11% out-of-state, 19% age 50+.

Education and Training:

There is an OTD program at UAA with Creighton University, currently admitting up to ten per year in Anchorage. UA is exploring partnerships for an Alaska-offered DPT. The University is also looking into requirements for development of PTA and OTA programs. There is a speech-language master's program available in Alaska, a partnership with East Carolina University's distance program, with post-baccalaureate bridge courses offered by UAA. There is a speech pathology assistant distance option available through the UAA Center for Human Development.

Strategies	Timescale
Engage	
Elevate public awareness of therapies occupations and professions.	Medium
Provide information to K-12 students, including job shadows, role models, and mentors.	Short
Advise students on educational opportunities within and outside Alaska.	Medium
Raise awareness and acceptance of the use of mid-level PTAs and OTAs in the Alaska healthcare community.	Long

Train

Maintain OT partnership with Creighton University and Speech-Language partnership with East Carolina University; develop PT partnership with an external institution.	Medium
Seek expanded/alternate approaches to therapies education in Alaska over time, where feasible and needed.	Long
Assist UA to move aggressively to develop programs for both PTA and OTA, with a goal of admitting a cohort of PTA students in the fall of 2011.	Short-Mediu
Consider potential for the speech therapy assistant program to be developed as an apprenticeship (may be registered or non-registered).	Short
Assist non-traditional students to enter professional programs; give credit for relevant past experience; provide mentors.	Medium

Recruit

Address wage disparity for mid-levels (PTAs and OTAs).	Medium
Identify schools in the Lower 48 that would like to offer clinical rotations in Alaska facilities and develop relationships, after giving first preference to students in programs in Alaska.	Medium
Include PTs, OTs and Speech Pathologists in loan repayment/employment incentive programs and recruitment collaborations.	Medium
Consider industry provision of financial assistance in exchange for service.	Medium
Develop additional appropriate clinical rotations for therapy students.	Medium

Retain

Assess retention factors for therapy professionals in Alaska; plan retention strategies.	Medium
Work on a re-entry strategy for those who have left the profession to raise children, etc.	Long
Provide affordable, high quality and pertinent continuing education in a format easily accessed by therapists, especially those in rural Alaska.	Medium

Nurse Educator

Description:

Nurse educators teach nursing students in basic and advanced nursing programs. They may also provide education to patients, families, communities and health care workers, in a variety of settings.

Overview

There is a national shortage of nurse educators and current faculty is older on average than the overall nursing work force. Recruitment and retention require attention to salary/benefits issues. Accreditation standards are high for school of nursing. Regular faculty are required to have earned master's or doctoral degrees. This is a challenging role, combinin expertise in clinical skills and instruction. UAA established a master's track several years ago and interest is increasing. Sustaining and marketing this program is important to allow Alaska to grow its own nurse faculty and to also prepare nurse educators to work with patients and communities.

Workforce Data:

Currently there are 4 faculty vacancies in the UA SON AAS program (vacancy rate 16%) . The overall nursing faculty vacancy rate is 7.8%. One to two additional FTEs are needed for the MS program. The average age of current faculty is 54.9 years: 4% at 30-39, 17% at 40-49, 49% at 50-59, and 30% at 60-69 years.

Education and Training:

UAA has an online master's degree track for nursing education.

Strategies	Timescale
Engage	
Expand awareness of nursing opportunities in the education of students, patients, families, others.	Short
Engage local nurses in educational roles as preceptors and faculty members.	Short
Encourage health care providers to identify members of the workforce to serve as educators.	Short
Train	
Market nurse educator distance-delivered master's program at UAA.	Short
Provide scholarships and other incentives for nurses to achieve advanced education and to participate as educators of the next generation of nurses.	Medium
Encourage continued involvement of current nursing faculty as preceptors of graduate nurse educator students.	Short
Recruit	
Identify nursing specialists and nurse educators as beneficiaries of loan repayment and employment incentives programs.	Short
Develop a comprehensive plan and provide incentives to attract nursing faculty to Alaska.	Medium
Encourage and incentivize aspirations for advanced degrees in nursing, including master's and doctoral degrees.	Short
Assess salaries for nursing faculty and find ways to enhance salary/benefits to improve recruitment and retention.	Short
Retain	
Provide incentives to nursing staff to welcome and mentor student nurses, new graduates and employees.	Short
Ensure School of Nursing workplace is collegial and congenial place to work; provide resources, mentoring and support needed to become/be an effective faculty member.	Short
Identify methods of attracting and retaining nurses later in their careers as productive members of the nurse educator workforce.	Medium
Establish faculty compensation at levels found in the industry.	Medium

Health Informatics Staff

Description:

Modern definitions of Health Informatics encompass the two broad interrelated fields of Health Information Management (HIMS) and Clinical Informatics. Personnel operate at many levels to design, develop, implement, use and manage information technology in health care organizations. Related HIMS occupational titles include medical records technicians, medical coders, and medical and health services managers. In the evolving field of Clinical Informatics, occupational titles are not yet standardized but encompass the spectrum of information technology (IT) titles in a clinical setting: clinical informatics specialist, programmer, and analyst.

Overview

Health Informatics is a swiftly growing and evolving field in Alaska. A combination of education and on-the-job training is usually required for these occupations. IT professionals need an augmented health background, and health professionals require IT knowledge. Alaska is presently working to develop a Health Information Exchange to enable the electronic sharing of patient records between medical providers and all medical providers are working to implement or enhance electronic health record systems and interface them with point-of-care medical devices such as glucometers, ventilators, EKGs, etc.

Workforce Data:

There are many types of workers involved in health informatics, from administrative assistants and billing/coding staff to health care and IT professionals. The common denominator is that they function in support of health IT, inclu ing electronic medical records. The future growth in jobs in this broad and complex field is not yet accurately measurec but it is expected to be dramatic due to the proliferation of hi-tech devices in direct patient care, and federal mandates expand the meaningful use of electronic health records.

Education and Training:

The University of Alaska has several programs in billing, coding, health records and related topics. A work group is planning to add HIT components to these existing programs and to expand coursework in this area, especially at certificate and associate degree levels. Collaborations with other universities and colleges are being developed in this area, particularly to make graduate level education available to Alaskans. Charter College also offers health informatio technology programming.

Strategies	Timescale
Engage	
Include health informatics careers when providing career awareness to K-12 students.	Medium
Inform existing health care workers and administrative staff about health informatics.	Short
Advise current students in health programs and computer science/IT programs to study HIT.	Medium
Train	
Assess HIT training needs with industry.	Short
Develop a comprehensive plan for HIT education needed by the Alaska health care industry.	Short
Participate in consortia to develop curricula and share HIT courses at all levels.	Short
Provide HIT-related coursework in-state for health and IT staff pertinent to individual knowledge gaps.	Medium
Recruit	
Encourage interested employees to gain additional education and skills in the area of HIT.	Medium
Retain	
Provide sufficient support and continuing education to health care staff to allow them to be comfortable as health informatics evolves and becomes more prevalent in the workplace.	Medium

Direct Care Worker

Description:

Direct care workers are the backbone of the health care delivery system, providing routine, personal healthcare and assistance with daily living in a variety of settings. Common titles for these workers are Personal Care Assistant or Atter dant, Home Health Aide, Nurse Aide or Certified Nurse Assistant (CNA), Disabilities Services Worker, Direct Suppor Professional, Direct Service Worker.

Overview

CNAs fall under the Board of Nursing in Alaska which ensures that educational standards are met by programs and that the CNA scope of practice is defined and enforced. In January 2010 a proposal was put forth by a collaborative Credentialing and Quality Standards group outlining core competencies for direct care workers in health and human services. These competencies are intended to be used to further educate and strengthen the direct care workforce in the state.

Workforce Data:

The direct care workforce in Alaska is quite large. In 2006, DOLWD identified 2,337 Personal and Home Care Aides, 1,859 Home Health Aides and 1,940 Nurses Aides, Orderlies and Attendants, for a total in these three occupations of 6,136 workers. 2009 vacancy data for Personal Care Attendants showed 33 positions (6%, vacancy rate) with 8% non-residents and 31% over 50 years of age. DOLWD projects a need for an additional 1,210 PCAs in the 2006-2016 timeframe. There were 12 vacancies for home health aides identified in 2009, a 16% vacancy rate. DOLWD projects needing an additional 830 HHAs by 2016. Certified Nurse Aides showed 116 vacancies, an 8% rate. DOLWD projects a need for 850 more nurse aides, orderlies and attendants by 2116. While only 6% of the current nurse aide workforce is non-residents, 21% is over 50 years of age. There is a high turnover in these entry-level occupations.

Education and Training:

There are a number of training providers for CNAs across the state, including university campuses, AVTEC and several hospitals (some in partnership with campuses and/or high schools). PCAs are required to have minimal training and, if hired directly by a consumer rather than an agency , there is very little required training or oversight. In part because home health aides do not have special certification in Alaska at this time, there is no specific training program for HHAs in the state.

Strategies	Timescale
Engage	
Encourage awareness of these entry-level careers, including providing programs at the high school level.	Short
Ensure potential and current workers understand this can be an entry point into a career ladder.	Short
Train	
Work with the Board of Nursing to remove barriers that impede the provision of CNA training programs in a large number of communities and in various training sites.	Short
Continue to work on common core curricula for PCA and CNA education, as well as advanced practice specialties with the Board of Nursing and others.	Short
Strengthen, support and expand the long-term care and direct/disabilities support apprenticeship programs, working with federal and state DOLWD staff.	Short
Continue work on standardization of occupational core competencies and strategies for implementation.	Medium
Recruit	
Increase efforts to attract underrepresented individuals to participate in the direct care workforce.	Short
Develop and support recruitment strategies that focus on the non-traditional and under-represented worker, i.e. retirees, family & friends, Alaskan Natives, etc.	Short
Retain	
Work on improving wages and benefits for direct care workers through a focus on credentialing.	Long
Provide continuing education to allow direct care workers to add to their competencies and advance in their field.	Medium
Increase skills of supervisors and ensure delivery of supervision of Direct Care Workers; integrate instruction on the supervision and support of direct care workers into the educational preparation for registered nurses or related occupations.	Medium
Seek opportunities to facilitate participation of direct care workers in educational programs and the annual conference to advance their credentials; augment career ladders.	Short

Notes

Alaska Occupational Forecast

Fold-Out Chart

Alaska Occupa Forecas 2006 to 2016, Vacancy Rates a Supply Data–H Occupa

DOL and l sources

Note:
*All Nurse Pr
**All Physician
***Physical and

Appendix

3RNET	Rural Recruitment and Retention Network
ACE-HC	Alaska Coalition of Educators in Health Care
AHEC	Area Health Education Center
AKCIS	Alaska Career Information System
ALEXsys	Alaska Labor Exchange System
AMHTA	Alaska Mental Health Trust Authority
ANTHC	Alaska Native Tribal Health Consortium
APICC	Alaska Process Industry Careers Consortium
APU	Alaska Pacifc University
ASHNHA	Alaska State Hospital and Nursing Home Association
AVTEC	Alaska Vocational Technical Center
AWIB	Alaska Workforce Investment Board
DCCED	Department of Commerce, Community and Economic Development
DEED	Department of Education and Early Development
DHSS	Department of Health and Social Services
DOLWD	Department of Labor and Workforce Development
HOSA	Health Occupations Student Association
HRSA	Health Resources and Services Administration
IHS	Institutes of Health
MAU	Major Administrative Unit
NHSC	National Health Service Corp
RWJ	Robert Wood Johnson Foundation
STEP	State Training and Employment Program
TIE	Teacher Industry Externships
UA	University of Alaska
VTEP	Technical Vocational Education Program (state funds)
WBLE	Work-based Learning Experiences
WIA	Workforce Investment Act
WICHE	Western Interstate Commission on Higher Education
WWAMI	Washington, Wyoming, Alaska, Montana and Idaho (regional school of medicine based at University of Washington)
YES	Youth Employment Skills

Alaska Occupational Forecast 2006 to 2016, Vacancy Rates and Supply Data–Health Occupations

DOL and UAA sources

SOC Code	Occupation	Employment			Openings			Alaska Mean Wage	Percent Non-Resident Workers	Percent Residents Age 50+
		2006	2016	Pct Chg	Growth	Replacement	Total for 10 Year Period			
	Healthcare Practitioners and Technical									
	Behavioral Health Aides/Village Counselors									
	Behavioral Health Case Managers									
	Behavioral Health Clinicians									
	Child, Family and School Social Workers	749	847	13.1	100	160	260	20.87	7.0%	26.2%
	Community Health Aides/Practitioners									
	Community Health Representatives									
	Critical Care/Emergency Room/Intensive Care Unit Nurses									
29-2021	Dental Hygienists	532	643	20.9	111	99	210	$44.38	7.5%	26.0%
29-1021	Dentists, General	121	135	11.6	14	16	30	$97.60	19.1%	43.3%
29-1031	Dietitians and Nutritionists	100	118	18	18	32	50	$27.41	6.1%	27.3%
29-2041	Emergency Medical Technicians and Paramedics	260	329	26.5	69	31	100	n/a	14.3%	14.3%
	Family Nurse Practitioners									
	Family Physicians/General Practitioner							66.53	23.7%	40.8%
29-1199	Health Diagnosing and Treating Practitioners, All Other	147	180	22.5	33	27	60	$37.88		
	Health Educator/Village Health Educator/Community Wellness Advocate	230	281	22.2	50	30	80	$19.84	5.0%	25.6%
	Health Information Managers									
29-2099	Health Technologists and Technicians, All Other	477	581	21.8	104	36	140	$25.20		
29-9099	Healthcare Practitioners and Technical Workers, All Other	344	413	20.1	69	71	140	$24.39		
	internists, General							$68.25	41.7%	41.9%
29-2061	Licensed Practical and Licensed Vocational Nurses	593	700	18	107	163	270	$23.01	15.5%	42.2%
	Marital/Family Therapists							$28.54		
29-2012	Medical and Clinical Laboratory Technicians	272	336	23.5	64	36	100	$20.16	15.6%	30.4%
29-2011	Medical and Clinical Laboratory Technologists	255	297	16.5	42	38	80	$30.23	17.9%	42.5%
	Medical and Public Health Social Workers (BA/BSW, MSW, LCSW)	188	221	17.6	30	40	70	$24.92	3.2%	33.1%
29-2071	Medical Records and Health Information Technicians	419	512	22.2	93	107	200	$18.41	9.4%	24.9%
	Mental Health and Substance Abuse Social Workers	321	401	24.9	80	70	150	$22.47	8.9%	37.0%
	Mental Health Counselors	232	287	24.8	60	30	90	$24.69	9.9%	36.7%
	Nurse Case Managers									
	Nurse Managers/Executives									
	Nurse Midwives/Women's Health Nurse Practitioners									
29-9011	Occupational Health and Safety Specialists	200	221	10.5	21	39	60	$38.64		
29-1122	Occupational Therapists	142	180	26.8	38	22	60	$33.38	17.2%	31.9%
29-2081	Opticians, Dispensing	126	145	15.1	19	41	60	$18.51	9.6%	30.9%
	Optometrists							$55.02	15.2%	35.7%
29-1051	Pharmacists	294	393	33.7	99	51	150	$53.18	26.1%	34.0%
29-2052	Pharmacy Technicians	460	622	35.2	162	138	300	$17.42	11.6%	13.1%
29-1123	Physical Therapists	307	410	33.6	103	37	140	$37.71	22.0%	21.6%
29-1071	Physician Assistants	352	460	30.7	108	52	160	$46.99	22.8%	43.8%
29-1060	Physicians and Surgeons	822	996	21.2	174	146	320	n/a		
	Psychiatric Nurses									
	Psychiatric Nurse Practitioners									
29-2053	Psychiatric Technicians	182	222	22	40	60	100	n/a	11.2%	28.9%
	Psychiatrists							$ 94.09	15.5%	57.4%
	Psychologists/Clinical Psychologists									
	Public Health Nurses									
29-2034	Radiologic Technologists and Technicians	400	501	25.3	101	49	150	$29.03	15.2%	30.7%
29-1125	Recreational Therapists	141	184	30.5	43	17	60	$20.78	10.4%	34.7%
29-1111	Registered Nurses	4,817	6,328	31.4	1,511	799	2,310	$35.01	16.0%	40.2%
	Rehabilitation Counselors	402	499	24.1	100	80	180	$23.15	6.4%	27.3%
29-1126	Respiratory Therapists	149	197	32.2	48	22	70	$28.75	19.1%	39.5%
	Social and Human Services Assistants/Human Services Workers	989	1131	14.4	1240	110	250	$16.10	11.3%	26.5%
	Sonographers							$35.23	32.6%	46.9%
	Speech Therapists									
29-1127	Speech-Language Pathologists	164	181	10.4	17	33	50	$34.87	17.9%	44.1%
	Sterile Processing Technician									
	Substance Abuse and Behavioral Disorder Counselors	259	320	23.6	60	50	110	$23.71	8.1%	39.4%
	Surgical Technologist							$20.55	23.1%	23.0%
29-2056	Veterinary Technologists and Technicians	119	135	13.5	16	44	60	$14.87		
	Healthcare Support									
31-9091	Dental Assistants	1,003	1,215	21.1	212	168	380	$20.11	11.5%	13.8%
	Disabilities Services Workers									
31-9099	Healthcare Support Workers, All Other	1,933	2,217	14.7	284	236	520	$17.80		
31-1011	Home Health Aides	1,859	2,515	35.3	656	174	830	$13.58	8.9%	26.4%
31-9011	Massage Therapists	181	221	22.1	40	20	60	$38.70	12.9%	19.2%
31-9092	Medical Assistants	800	1,132	41.5	332	98	430	$16.95	8.3%	13.8%
31-9094	Medical Transcriptionists	143	168	17.5	25	25	50	$19.43	9.8%	38.8%
31-1012	Nursing Aides, Orderlies, and Attendants	1,940	2,629	35.5	689	171	860	$15.53	6.3%	21.3%
	Pharmacy Aides							$15.17	15.0%	12.3%
	Physical Therapist Aides							$15.67	8.60%	9.30%
	Physical Therapy Assistants							$17.18	11.10%	18.80%
31-1013	Psychiatric Aides	120	133	10.8	13	7	20	$17.58	90.00%	29.90%
31-9096	Veterinary Assistants and Laboratory Animal Caretakers	195	219	12.3	24	16	40	$12.25		
	Personal Care and Service									
39-9021	Personal and Home Care Aides	2,337	3,146	34.6	809	401	1,210	n/a	8%	31%
	Management									
11-9111	Medical and Health Services Managers	903	1,076	19.2	173	167	340	$41.33	5.8%	42.0%
11-9151	Social and Community Service Managers	478	542	13.4	64	86	150	$29.15	7.5%	38.3%
	Office and Administrative Support - Not Only Healthcare									
43-3021	Billing and Posting Clerks and Machine Operators	1,118	1,209	8.1	91	139	230	$17.88	11%	18%
43-4199	Information and Record Clerks, All Other	1,808	1,722	-4.8	0	290	290	$19.51		
43-6013	Medical Secretaries	337	410	21.7	73	47	120	$15.76	10%	23%

Note:

*All Nurse Practitioners

**All Physicians

***Physical and Occupational Therapists

Appendix

3RNET	Rural Recruitment and Retention Network
ACE-HC	Alaska Coalition of Educators in Health Care
AHEC	Area Health Education Center
AKCIS	Alaska Career Information System
ALEXsys	Alaska Labor Exchange System
AMHTA	Alaska Mental Health Trust Authority
ANTHC	Alaska Native Tribal Health Consortium
APICC	Alaska Process Industry Careers Consortium
APU	Alaska Pacifc University
ASHNHA	Alaska State Hospital and Nursing Home Association
AVTEC	Alaska Vocational Technical Center
AWIB	Alaska Workforce Investment Board
DCCED	Department of Commerce, Community and Economic Development
DEED	Department of Education and Early Development
DHSS	Department of Health and Social Services
DOLWD	Department of Labor and Workforce Development
HOSA	Health Occupations Student Association
HRSA	Health Resources and Services Administration
IHS	Institutes of Health
MAU	Major Administrative Unit
NHSC	National Health Service Corp
RWJ	Robert Wood Johnson Foundation
STEP	State Training and Employment Program
TIE	Teacher Industry Externships
UA	University of Alaska
VTEP	Technical Vocational Education Program (state funds)
WBLE	Work-based Learning Experiences
WIA	Workforce Investment Act
WICHE	Western Interstate Commission on Higher Education
WWAMI	Washington, Wyoming, Alaska, Montana and Idaho (regional school of medicine based at University of Washington)
YES	Youth Employment Skills

Documents Cited in the Plan

Alaska Center for Rural Health, 2009 Alaska Health Workforce Vacancy Study, (Draft) January 2010.

Alaska Department of Health and Social Services, Division of Public Health, Healthy Alaskans 2010, Targets and Strategies for Improved Health, November 2005

Alaska Department of Health and Social Services, Securing an Adequate Number of Physicians for Alaska's Need, Alaska Physicians Supply Task Force Report, August 2006

Alaska Department of Health and Social Services, Status of Recruitment Resources and Strategies 2005-06, June 2006

Alaska Department of Labor and Workforce Development, Employment Forecast for 2010, Alaska Economic Trends, January 2010

Alaska Department of Labor and Workforce Development, Alaska's 10-year Occupational Forecast, Alaska Economic Trends, January 2009

Alaska Department of Labor and Workforce Development, Alaska's Health Care Industry, Alaska Economic Trends, March 2010

Alaska Workforce Investment Board, Alaska's Future Workforce: Strategic Policies and Investment Blueprint, 2002

Donald E. Pathman, M.D., et al, Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians, Medical Care, Vo. 42, No. 6

Notes

Alaska Commission on Aging
2010 SURVEY OF OLDER ALASKANS

(Do you have access to a computer? If so, you may complete this survey online by going to our website, www.alaskaaging.org, and clicking on the SURVEY button. Otherwise, mail your completed survey to us in the enclosed postpaid envelope, or send to Alaska Commission on Aging, P.O. Box 110693, Juneau, AK 99811-0693.)

1. Your Age: _____
2. Your Gender: ____ Female ____ Male
3. Your Race: (Check all that apply.)
   ____ African-American / Black ____ Asian / Pacific Islander
   ____ Alaska Native / American Indian ____ Caucasian / White
   ____ Other, please specify: _____
4. Your Zip Code: _____

5. How long have you lived in Alaska?
   ____ All my life (born here) ____ 11 to 20 years
   ____ More than 40 years ____ 5 to 10 years
   ____ 31 to 40 years ____ Less than 5 years
   ____ 21 to 30 years

6. Would you recommend your community as a good place to live for seniors?
   ____ Yes, unconditionally ____ Yes, with a few reservations ____ No

7. *Please rate the following senior concerns from 1 to 10 based on how much they affect Alaskan seniors in your opinion. A rating of 10 indicates the issue is of great importance. A rating of 1 indicates the issue is of minor importance. For example, if you feel that fuel costs are a very minor concern, you would circle "1"; if you feel it's a very important issue for seniors, you would circle "10". (You may use the same number more than once.*

	Minor Importance									*Great Importance*
Health care	1	2	3	4	5	6	7	8	9	10
Financial security	1	2	3	4	5	6	7	8	9	10
Fuel costs	1	2	3	4	5	6	7	8	9	10
Transportation	1	2	3	4	5	6	7	8	9	10
Having enough food to eat	1	2	3	4	5	6	7	8	9	10
Affordable, accessible housing options	1	2	3	4	5	6	7	8	9	10
Assisted living facilities providing 24-hour care	1	2	3	4	5	6	7	8	9	10
Availability of in-home services for seniors	1	2	3	4	5	6	7	8	9	10
Information about programs and services	1	2	3	4	5	6	7	8	9	10
Mental health and substance abuse problems	1	2	3	4	5	6	7	8	9	10
Help for isolated or depressed seniors	1	2	3	4	5	6	7	8	9	10
Senior center with a variety of programs and activities	1	2	3	4	5	6	7	8	9	10
Other, please specify: _____	1	2	3	4	5	6	7	8	9	10

8. Do you provide home care for a family member or friend? (Check all that apply.)
   ___ No ___ Yes, a friend age 60 or older
   ___ Yes, a spouse or partner age 60 or older ___ No, but I am a long-distance caregiver for an elder who lives elsewhere
   ___ Yes, a parent age 60 or older
   ___ Yes, a disabled family member under age 60 ___ Other, please specify: _____
   ___ Yes, one or more children or grandchildren under age 18

9. Do you visit your senior center?
   ___ Yes, regularly – at least twice a month
   ___ Yes, occasionally – once a month or less
   ___ No, I would like to but have difficulty getting to the senior center
   ___ No, I am not interested in what the senior center offers
   ___ There is no senior center in my community

10. Your estimated net MONTHLY household income from all sources: $ _____
11. Total number of people living in your household (including yourself): _____
12. Besides yourself, who lives in your household? (Check all that apply.)
   ___ Just myself
   ___ My spouse or partner
   ___ One or more adult children
   ___ One or more adult grandchildren
   ___ One or more grandchildren under age 18
   ___ Roommate(s) or renter(s)
   ___ Other, please specify: _____
13. Is your monthly income enough to meet all your monthly expenses?
   ___ Yes, with some left over for extras like vacations
   ___ Yes, but there is very little money left for extras in the budget
   ___ No, my income is not enough to pay for food, housing, fuel, clothing, medicine, and other necessities
14. At any time in the past 30 days, have you had difficulty paying for any of the following? (Check all that apply.)
   ___ Food to prepare meals
   ___ Medications or medical bills
   ___ Rent or mortgage payment
   ___ Energy costs – utilities, fuel oil, gas
   ___ Credit card bill
   ___ None of the above
   ___ Other, please specify: _____
15. What are the sources of your household's income? (Check all that apply.)
   ___ Social Security
   ___ Disability payments
   ___ Pension from employer or union
   ___ Wages from employment
   ___ Income from self-employment
   ___ Personal savings or investments
   ___ Senior Benefits program
   ___ Rental income
   ___ Permanent Fund Dividend
   ___ Native corporation dividends
   ___ Food Stamps
   ___ Adult Public Assistance
   ___ Cash from relatives
   ___ Rent subsidy (voucher, etc.)
   ___ Other, please specify: _____
16. What type of housing do you live in?
   ___ House/condo that I or a family member own (or have a mortgage on)
   ___ House/condo that I rent
   ___ Apartment in senior housing complex
   ___ Apartment that I rent, not in senior complex
   ___ Assisted living facility
   ___ Nursing home
   ___ Rooming house or hotel
   ___ Homeless shelter
   ___ Other, please specify: _____
17. Is your home in need of modification in order for you to be safe and comfortable (example: insulation, ramp installation, grab bars, elevator, etc.)?
   ____ Yes ____ No

18. Where do you expect to be living five years from now?
   ___ Same home as I live in now
   ___ Same community, but smaller living space
   ___ Living independently in a larger community in Alaska
   ___ Living independently in a smaller community in Alaska
   ___ Other, please specify: _____
   ___ Living independently in a different state
   ___ Move to an assisted living or nursing facility in Alaska
   ___Move to an assisted living or nursing facility outside Alaska

19. Are you currently employed or self-employed?
    ___Yes, full-time ___ No, but I am seeking work
    ___ Yes, part-time ___ No, I am retired
20. If you are currently still working, when do you expect to retire? (Skip this question if you are already retired.)
    ___ Within the next year or two
    ___ Within the next two to five years
    ___ More than five years from now
    ___ I can't afford to retire
    ___ I don't plan to retire even if I can afford to
21. Do you participate in subsistence activities (hunting, fishing, gathering) during subsistence season?
    ___ Yes, for an average of less than two hours a week
    ___ Yes, for an average of two to five hours a week
    ___ Yes, for an average of more than five hours a week
    ___ No
22. Do you do volunteer work in your community? (Check all that apply.)
    ___ Yes, with my church or house of worship
    ___ Yes, with a civic organization (example: Rotary)
    ___ Yes, with a charitable organization (example: Red Cross)
    ___ Yes, with a non-profit organization (example: senior center)
    ___ Yes, with a library, school, or educational institution
    ___ No, I do not volunteer because I don't have time right now
    ___ No, I do not volunteer at this time due to disability or ill health
    ___ No, I do not volunteer at this time due to difficulties with transportation
    ___ No, I do not volunteer at this time because I don't know how to find the right opening
    ___ Other, please specify: _____
23. Total hours per week you spend in volunteer work (estimate an average): _____
24. Where do you go when you have questions about the services available for seniors? (Check all that apply.)
    ___ Local senior center
    ___ Other local non-profit agency
    ___ Aging & Disability Resource Center
    ___ Independent Living Center
    ___ Pamphlets or handouts
    ___ Printed directory showing services by community
    ___ Dial 2-1-1
    ___ Internet search or specific website with service information
    ___ Senior housing staff
    ___ Hospital social services department
    ___ Check the phone book for possible information sources
    ___ Ask a friend or relative for help finding the information
    ___ Other, please specify: _____
25. What would be the BEST way for you to get the information you need about programs and services?
    ___ Toll-free number to call, with live answer
    ___ Toll-free number to call, with push-button options
    ___ Website with search features
    ___ Pamphlets, handouts, or printed directory
    ___ Speak to someone in person at senior center or other agency
    ___ Speak to someone in person in my housing complex or neighborhood
    ___ Other, please specify: _____

26. In the last TWO WEEKS, on how many occasions have you gotten together with family, friends, or a group you belong to for an event or activity, either outside your home or at your home? (For example: parties, movies, concerts, games, classes, dinners, senior center meals....)

___ None
___ Once
___ Two or three times
___ Four or five times
___ More than five times

27. In the past year, have you had trouble finding a primary care doctor to see you when you needed to see a doctor?

___ Yes, because of Medicare payment issues
___ Yes, because there are not enough doctors in my community
___ Yes, for another reason (tell us below)
___ No
___ Haven't needed to see a doctor in the last year
___ Other reason for trouble finding doctor: _____

28. Do you experience an illness or disability that limits the range of activities you can enjoy? (Check all that apply.)

___ No
___ Yes, a chronic disease such as heart disease, diabetes, etc.
___ Yes, a physical disability such as low vision, knee or hip problems, etc.
___ Yes, other physical health problems
___ Yes, Alzheimer's or other type of dementia
___ Yes, a mental or emotional problem such as depression, anxiety, etc.

29. *If you have used any of the following services in the past year, please tell us how satisfied you were. For example, if you were "very satisfied" with home-delivered meals you received, check "4." If you were "very unsatisfied," check "1". A "5" indicates that you didn't use the service in the past year, and a "6" means that the service isn't available in your community. Use the "additional comments" space to tell us how the service made a difference to you, or how it* could *be improved.*

1=very unsatisfied	*2=mostly unsatisfied*	*3=mostly satisfied*	*4=very satisfied*	*5=did not use*	*6= not available in my community*
Meals at a senior meal site	1	2	3	4	5	6
Home-delivered meals	1	2	3	4	5	6
Senior transportation	1	2	3	4	5	6
Information & referral	1	2	3	4	5	6
Care coordination	1	2	3	4	5	6
Chore service	1	2	3	4	5	6
Respite care	1	2	3	4	5	6
Personal care attendant	1	2	3	4	5	6
Adult day program	1	2	3	4	5	6
Caregiver support program	1	2	3	4	5	6

30. ***Additional Comments: Please add any specific comments you have on the services you have used, OR ANY OTHER TOPIC THAT IS IMPORTANT TO YOU. What is working well? What needs improvement?***

_____
_____
_____
_____
_____
_____

Experience our

Culture of Caring

Alaska Health Programs

Workforce Crisis

Alaska is experiencing a workforce crisis that affects home and community-based health and behavioral health services. Issues pertaining to wages and benefits, recruitment and retention, and training and education impact the accessibility and effectiveness of these services to all Alaskans, especially beneficiaries of the Alaska Mental Health Trust. These beneficiaries include people with:

- Mental illness
- Developmental disabilities
- Chronic alcoholism
- Alzheimer's disease and related dementia.

Growing Alaska's Workforce

To address these problems, The Trust has developed and funds the Workforce Development Focus Area, which aims to develop a capable, culturally competent workforce that can support the communities and families of Trust beneficiaries. The Trust has partnered with the University of Alaska, Alaska Department of Health & Social Services, Alaska Department of Labor & Workforce Development and service providers from across the state to address workforce issues.

For more information, contact Kathy Craft:
907-450-8048
kathryn.craft@alaska.gov

The TRUST
The Alaska Mental Health Trust Authority
www.mhtrust.org

Training Collaborative

The following organizations provide support, training and education for the workforce and provider agencies serving Trust beneficiaries.

Trust Training Cooperative (TTC)

The TTC promotes career development opportunities for direct service workers and their supervisors by ensuring that technical assistance and training is accessible and coordinated. To learn more, visit **www.trusttrainingcoop.org**. The TTC also provides a Learning Management System, a web-based, one-stop shop for professional training opportunities with an on-line training catalog, registration and tracking of a user's training, conferences and educational participation in an E-Portfolio. See **www.ttclms.org** for details.

Alaska Rural Behavioral Health Training Academy

Alaska Rural Behavioral Health Academy (ARBHA)
ARBHA's mission is to develop and provide training for the behavioral health workforce primarily working in or serving rural Alaska. This University of Alaska Fairbanks based program offers training activities statewide via face-to-face, telebehavioral health, and hybrid delivery models and modalities. While the ARBHTA serves an array of service providers, its target group includes mid and upper-level clinicians, supervisors, and program directors. For more information, visit **www.uaf.edu/arbhta**

Alaska Alliance for Direct Service Careers

Alaska Alliance for Direct Service Careers (AADSC)
AADSC works to improve the flow of information to direct service professionals and the organizations that employ them. AADSC is focused on increasing the awareness of the industry statewide; working to help agencies recruit via a statewide job bank; and helping agencies reduce turnover via technical assistance on recruitment and retention issues. For more information, visit **www.aadsc.org**

Office of Health
Programs Development
UNIVERSITY of ALASKA ANCHORAGE

Jan Harris, MSHA, FACHE
Vice Provost, Health Programs

T 907.786.4595 • F 907.786.6511
anjch1@uaa.alaska.edu
www.uaa.alaska.edu/hpd

Physical Address
Diplomacy Building, Suite 402
4500 Diplomacy Drive

Mailing Address
3211 Providence Drive
Anchorage, AK 99508-4614

Summary: HB 78 Incentives for Certain Medical Providers

Sponsored by Representative Bob Herron

Health Care Professions Loan Repayment & Incentive Program

The following organizations support the loan repayment and incentive solution as outlined in HB 78 Incentives for Certain Medical Providers:

Alaska State Medical Association • Alaska Dental Society • Alaska Primary Care Association • Alaska Osteopathic Medical Association • Alaska State Hospital and Nursing Home Association • Alaska Mental Health Trust Authority • Alaska Native Health Board • Alaska Pharmacists Association • Alaska Physical Therapy Association • AARP-Alaska • Advisory Board on Alcoholism and Drug Abuse • Alaska Behavioral Health Association • Alaska Mental Health Board • Alaska Mental Health Trust Authority • Alaska Public Health Association • Alaska Hygienists Association • Commonwealth North • Iliuliuk Family and Health Services, Inc. • Maniilaq Association • Municipality of Anchorage Senior Citizens Advisory Board • Mary Willard, DDS, Clinical Site Director, Alaska Native Tribal Health Consortium • Alaska Chapter National Association of Social Workers • Nome Eskimo Community • SEARHC • School of Social Work-UA • Dental Hygiene Program-UA • Sunshine Community Health Center

Problem:

Having a sustainable and competent practitioner workforce is vital to the health of Alaskans. However, Alaska is at a serious disadvantage as it competes in the national health care labor market. In other states, "support-for-service programs" (SFSPs) have shown substantial and long-standing success as a cost-effective strategy to address shortages (e.g., loan repayment and direct incentive). A key problem is that Alaska does not have a robust SFSP while 47 other states have one or more SFSPs.

Solution:

The Health Care Professions Loan Repayment and Incentive Program, as outlined in Representative Herron's HB 78 will make Alaskan health care employment competitive and attractive enough for practitioners to want to work in Alaska, particularly in hard-to-fill localities. State funds will be used to ensure that Alaskans with the greatest difficulty in obtaining care due to limited financial resources, cultural barriers, and geography will have access to professional health care services.

Program Description:

1) **Practitioner Eligibility**
   - DHSS Commissioner will annually prioritize the 10 eligible practitioner types:
     - Tier-1: Dentists, Pharmacists, Physicians (MD and DO)
     - Tier-2: Dental Hygienists, Nurse Practitioners, Nurses (RN), Physical Therapists, Physician Assistants, Psychologists, Social Workers (LCSW)
   - A practitioner's clinical duties must constitute at least 50% of duties to be eligible.
   - A part-time practitioner may participate and be eligible for pro-rated payments.
   - Preference may be given to current Alaskan residents.

2) **Payment Detail**

Placement Type		Regular		Hard-to-Fill
Tier 1:	up to	$35,000/year	up to	$47,000/year
Tier 2:	up to	$20,000/year	up to	$27,000/year

   - Duration of award is for a 3-year period of service.
   - Payments will be made every quarter following a completed full quarter of service.

3) **Site Eligibility**
   - DHSS Commissioner will rank eligibility of sites annually and determine any area and/or population in Alaska as a "shortage priority." These may include, but are not limited to, federally defined Health Professional Shortage Areas.
   - Preference will be given to sites that provide care to individuals regardless of insurance status, including persons who are uninsured or have Medicare and/or Medicaid.

4) **Oversight Entity**
   - Department of Health & Social Services will serve as the Oversight Entity.
   - DHSS Commissioner will appoint an advisory body to make recommendations regarding program administration including the identification of shortages, eligible sites, payment priorities and program evaluation.

5) **Program Evaluation**
   - By January 1, 2019, DHSS will submit a report to the Legislature on the program: the participation rates, costs, and the effect on the health care profession shortage areas.

6) **Fiscal Agent**
   - DHSS will serve as Fiscal Agent. DHSS will make loan repayments to the lending institution or eligible practitioners and will make incentive payments to eligible practitioners.

7) **Funding**
   - An in-cash "employer match" is required and is paid on a quarterly basis by eligible sites to DHSS. The level of required match will be adjusted according to the ability of the eligible site to contribute and may be set between 0% and 50%.
   - Program funds will not be used to offset current or expected provider supports.
   - The DHSS Commissioner will reserve funding for not fewer than three very-hard-to fill positions in each of the tier 1 and tier 2 categories.
   - The fiscal note has not yet been released but the expected funding for FY12 is $2.7 million to fund 90 participants for year 1 of their 3 years of service; that is, approximately 9 practitioners in each of 10 occupational categories.

For more information re: HB 78, please contact Shelley Hughes / Alaska Primary Care Association at Shelley@alaskapca.org or 907-841-1634.

Alaska Psychiatry Residency

- Alaska currently has a critical shortage of at least 25-30 psychiatrists, a deficit of 30%-40%. 40% of Alaska psychiatrists are 50 years of age or older and 29% may retire within five years.

- Four Anchorage health care organizations spent $2.9 million in 2009 for temporary psychiatrists.

- This critical shortage adversely impacts health care access, quality, cost, and outcomes across the continuum of care.

- A coalition of federal and state agencies, hospitals and providers, and the University of Alaska recommend partnering with the University of Washington to create the Alaska Psychiatry Residency.

- The Alaska Psychiatry Residency will emphasize primary care integration, telebehavioral health, and rural consultation.

- There will be 11 residents in training with three graduating annually. The final two years will be in Alaska increasing the likelihood graduates remain in Alaska.

- Stakeholders have promised $2.88 million for the first five years (FY12 – FY16) and more than $500,000 annually beginning year six (FY17). The Governor has included $202,000 in FY12.

- The balance remaining is $3.62 million across the first five years (FY12 – FY16) and $1.62 million annually beginning year six (FY17).

- Alaska is ineligible for new Medicare graduate medical education funding because a cap was imposed in 1997. Medicare is the largest funder of graduate medical education ($8.8 billion in 2007).

- Partners include:
  - Alaska Family Medicine Residency
  - Alaska Federal Health Care Partnership
  - Alaska Mental Health Trust Authority
  - Alaska Psychiatric Foundation
  - Alaska Psychiatric Institute
  - Alaska Veterans Affairs Healthcare System
  - Anchorage Community Mental Health Services
  - Fairbanks Memorial Hospital
  - Joint Base Elmendorf Richardson
  - North Star Behavioral Health Systems
  - Providence Health & Services Alaska
  - Southcentral Foundation
  - Southeast Alaska Regional Health Corporation
  - Tanana Chiefs Conference

2/19/2011

RRANN

Recruitment and Retention of Alaska Natives into Nursing

MEETING A NEED

In rural Alaska, the ongoing, well documented shortage of qualified nursing professionals is compounded by a need for nurses who speak indigenous Native languages and are attuned to the cultural traditions and sensibilities of their patients. Honoring the past while working toward the future, RRANN plays an integral part in meeting Alaska's burgeoning need for qualified nurses, and is the key to helping many individual Alaskans to achieve their dreams.

UAA recognizes that Alaska Native students, while deeply motivated to succeed, face unique challenges on their way to meeting their goals. The RRANN program was initiated to increase the number of Alaska Native and American Indian nurses in the state by providing assistance and support, beginning with advice on preparing for college, and following through to include creating a sense of community on campus.

In just its first two years, the program had already successfully doubled the percentage of Alaska Native nurses in the state. But there's still a long way to go.

"I can honestly say that if it had not been for the support of the RRANN program, I would have given up ... "

Michelle Cooper ('08, B.S. Nursing), RRANN graduate

"Recruitment and Retention of Alaska Natives into Nursing opened a door for me to be involved with the community at UAA. It made me feel like a part of a community, like I did in the Kotzebue community. I was able to form lasting relationships and share my culture with other nursing students. I also spent time talking to pre-major nursing students about the program, mentoring them and encouraging them not to give up. The only way to get through the program is to have a sense of community and support."

Marjorie Bolton-Baldwin ('10, B.S. Nursing), RRANN graduate

ACHIEVING A BALANCE

Alaska Natives and American Indians account for about 16 percent of Alaska's population, yet less than 3 percent of nursing professionals fall into that group. To address this disparity, RRANN offers help to prospective students in planning for admission to UAA, as well as information about nursing degree programs and course requirements. Through RRANN, students have access to tutoring, financial aid and on-campus housing options tailored to their needs.

"I now find myself encouraging others to enter the nursing field. I tell them, 'Your hard work will pay off in the end.'"

Andrea Moses ('08, B.S. Nursing) RRANN graduate, currently working at Alaska Native Medical Center

SHOWING THE WAY

In the RRANN program, individual success breeds success for the entire community, with program graduates not only serving as role models for new recruits, but also going on to actively mentor new students in the program.

"My incentive to become a nurse derived from my relationship with my grandmother ... I firmly believe there is more happiness in giving than receiving and I'm ready to spend the rest of my life giving to people as a nurse."

Debra Snider ('05, A.A.S. Nursing), RRANN graduate

"A lack of educational resources in rural Alaska puts many intelligent students at a disadvantage for pursuing their dreams of college and careers. RRANN's pre-nursing support services are designed to help level that playing field, and expand opportunities for success."

Jackie Pflaum, RNC, DNSC, RRANN Project Director/Associate Vice Provost for Health Professions Development

SUCCESS BY THE NUMBERS

Over 120 Alaska Native and American Indian students have graduated from UAA's nursing programs since the inception of RRANN. Looking toward the future, 35 RRANN students are currently in the clinical portion of their nursing studies and are on track to obtain their degrees in the next three years. At least 70 additional students are immersed in their pre-clinical studies.

"My goal is to return to rural Alaska and promote healthier lifestyles, as well as spread awareness about the various diseases that are devastating our villages."

Chelsea Royal, Upper Kuskokwim Athabaskan Pre-nursing Student, RRANN program

UAA
UNIVERSITY *of* ALASKA
ANCHORAGE

For more information about UAA's Office of Health Programs Development, visit http://www.uaa.alaska.edu/hpd/.
To learn how to support UAA's health programs, contact Ivy Spohnholz at (907) 786-1944 or anias2@uaa.alaska.edu

UAA

Health Programs

Health Sciences Building

Health Sciences Building Operating & Maintenance

$591.0 - Regents Budget

Health Sciences Building Staffing

$392.6 - Regents Budget

Above: UAA's HSB will open in August 2011. FY12 request ensures building is fully operational with funding to ensure there is adequate funding for utilities, cleaning and all-season ground maintenance. This is included in the govenor's budget.

Right: Also needed are four positions in support of interdisciplinery clinical simulation laboratories onsite and the distance delivery of simulation statewide. This is not included in the govenor's budget.

Demand for health care workers in Alaska is expected to grow faster than any other employment sector over the next decade. According to the Anchorage Economic Development Corporation's annual report regarding employment, 45 percent of Anchorage's net job growth occurred in health care since 2002 (that's 4,600 new jobs). The same report states that health care jobs increased by 500 in 2010 alone, and forecasts that growth of 300 more in 2011.

In response to the state's growing need for well educated and trained health care professionals, UAA will open its new Health Sciences Building (HSB) in August 2011.

About the HSB

This 66,000-square-foot facility will provide much-needed laboratory space as well as education and instructional space for the health sciences programs.

The building is situated across Providence Drive from the Anchorage campus and will house the following programs:

- medical
- nursing
- clinical laboratory
- physician assistant

Co-location of these programs will provide for efficiency of scale, as well as provide opportunities for interdisciplinary education.

The building will feature:

- Distance classrooms to connect students from rural communities
- Clinical and instructional laboratories and classrooms
- Faculty and staff offices
- Instructional spaces designed for interactive learning, simulation of real-life clinical situations and collaborative hands-on experiences

The facility will allow students an opportunity to integrate theory and practice, think critically and ensure patient safety.

This request covers maintenance and repair needs and the operations component, which are undeniably critical to the building's opening.

Also needed are several positions included in the FY12 High-Priority Program requests.

Alaska's AHEC Program

2011 Legislative Session Talking Points

Engage

Train

Recruit

Retain

Summary of request

Alaska's Area Health Education Centers, known as AHEC, with our supporting partners request $500,000 to continue healthcare workforce development activities. As part of the Federal AHEC funding awarded to Alaska in 2005, there is an expectation that states will pick up the funding as federal monies diminish – beginning in September 2011. ($125,000 x 4 Centers; excluding Northwest AHEC)

Background

AHEC is a statewide university-healthcare industry partnership focused on strengthening Alaska's health workforce across the spectrum from "pipeline to placement."

- Since 2005, host organizations have invested a 1:1 match with federal HRSA funds in the Alaska AHEC. **In FY2011, this investment totals more than $1.6 million dollars.** Partners are:
  - Yukon Kuskokwim Health Corporation (YK AHEC)
  - Providence Health & Services Alaska (South Central AHEC)
  - Fairbanks Memorial Hospital (Interior AHEC)
  - Southeast Alaska Regional Health Consortium (Southeast AHEC)
  - Ilisagvik College (Northwest AHEC)

Program highlights

- **Engaging Alaskans into health careers & guiding them into the workforce.**
  - In 2010, *Alaska's AHEC Program touched 4,907 K-12 students, adults, educators and parents in part through partnerships with*:
    - Secondary Career & Technical Education Programs i.e. Alaska Health Careers Academy
    - UAA & UAF programs i.e. U/DOC Della Keats, Pre-Med Summit, Alaska Summer Research Academy
    - Teacher-Industry Externships with UAA & Department of Labor
    - Health Occupations Students of America (HOSA)
    - Maintaining the http://www.healthcareersinalaska.info website
- **Training health professions students through on-site clinical rotations and exposing them to Alaska's hardest-to-fill vacancies**
  - Since 2005, *AHEC supported clinical rotations for 2,419 non-duplicated health programs students*
  - Multi-disciplinary support: allied health, behavioral health, physicians, pharmacy, nursing, therapies, and social work
- **Retaining Alaska's rural health workforce by assessing their needs and increasing access to Continuing Education opportunities**
  - In 2010, *AHEC supported over 6,000 contact hours of CE/CME*
  - Developing preceptor/mentor certification in coordination with UAS & the Alaska Coalition of Educators (ACE)

Contact: Katy Branch, Director, Alaska's AHEC Program Office, 907.786.6705 or ankeb@uaa.alaska.edu

UNIVERSITY
of ALASKA
Many Traditions One Alaska

Health Programs
PO Box 755010
Fairbanks, AK 99775-5010
Tel: 907-450-8016
Fax: 907-450-8002
www.akhealthcareers.org

Alaska's Health Workforce

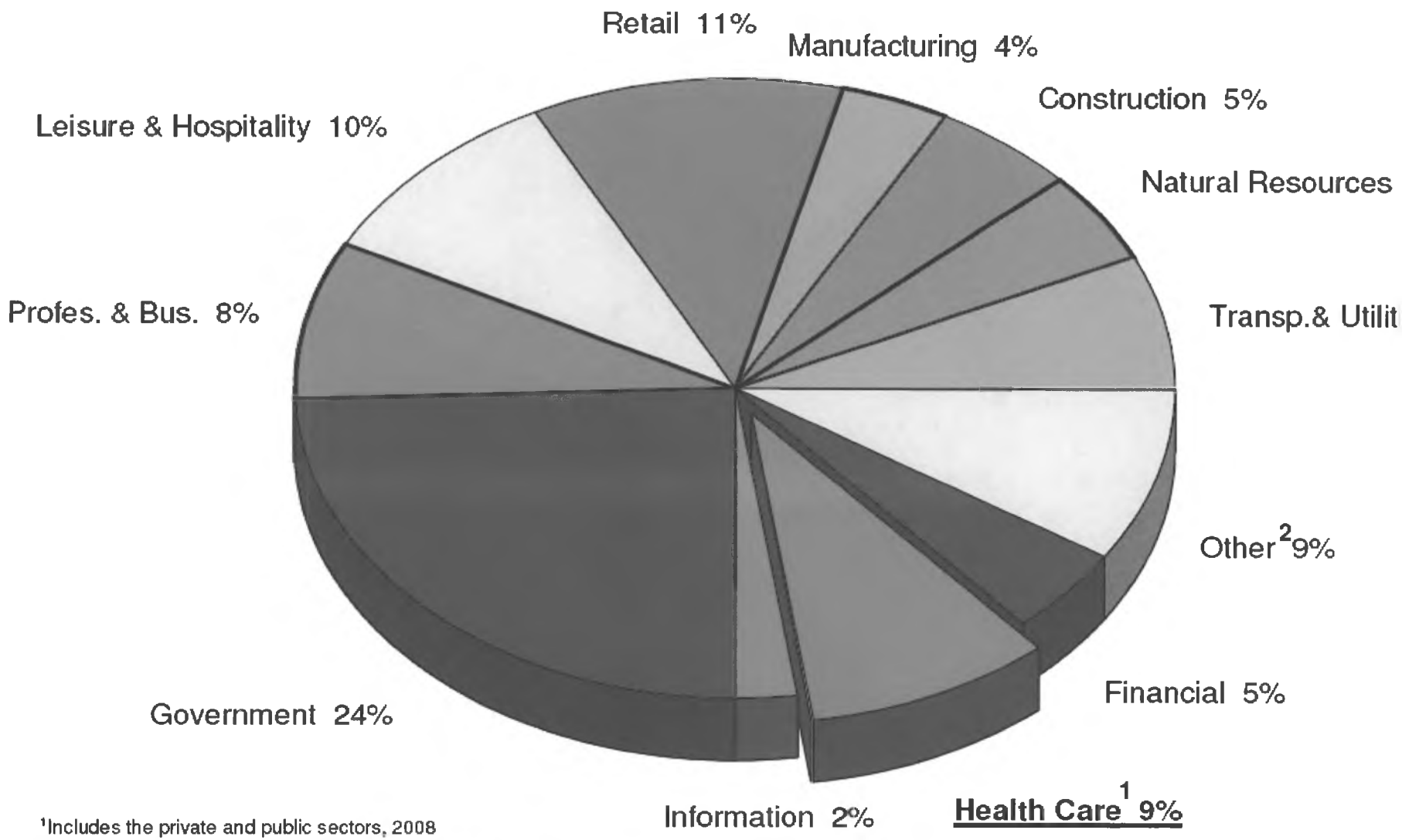
Alaska Health Workforce Coalition

January 2011

Health Care is a Vibrant Industry

- 11 of the 15 fastest growing Alaska jobs are in health care
  - Large employer ~ 10% of workforce in 2009
  - Payroll is more than $1.4 billion a year
  - Has wide geographic distribution; many healthcare organizations are the largest employers in their region
  - Is a labor-intensive industry; has a broad range of occupations and professions requiring from on-the-job training to post-doctoral education

Health Care-One Of The Biggest Players Alaska's Labor Market

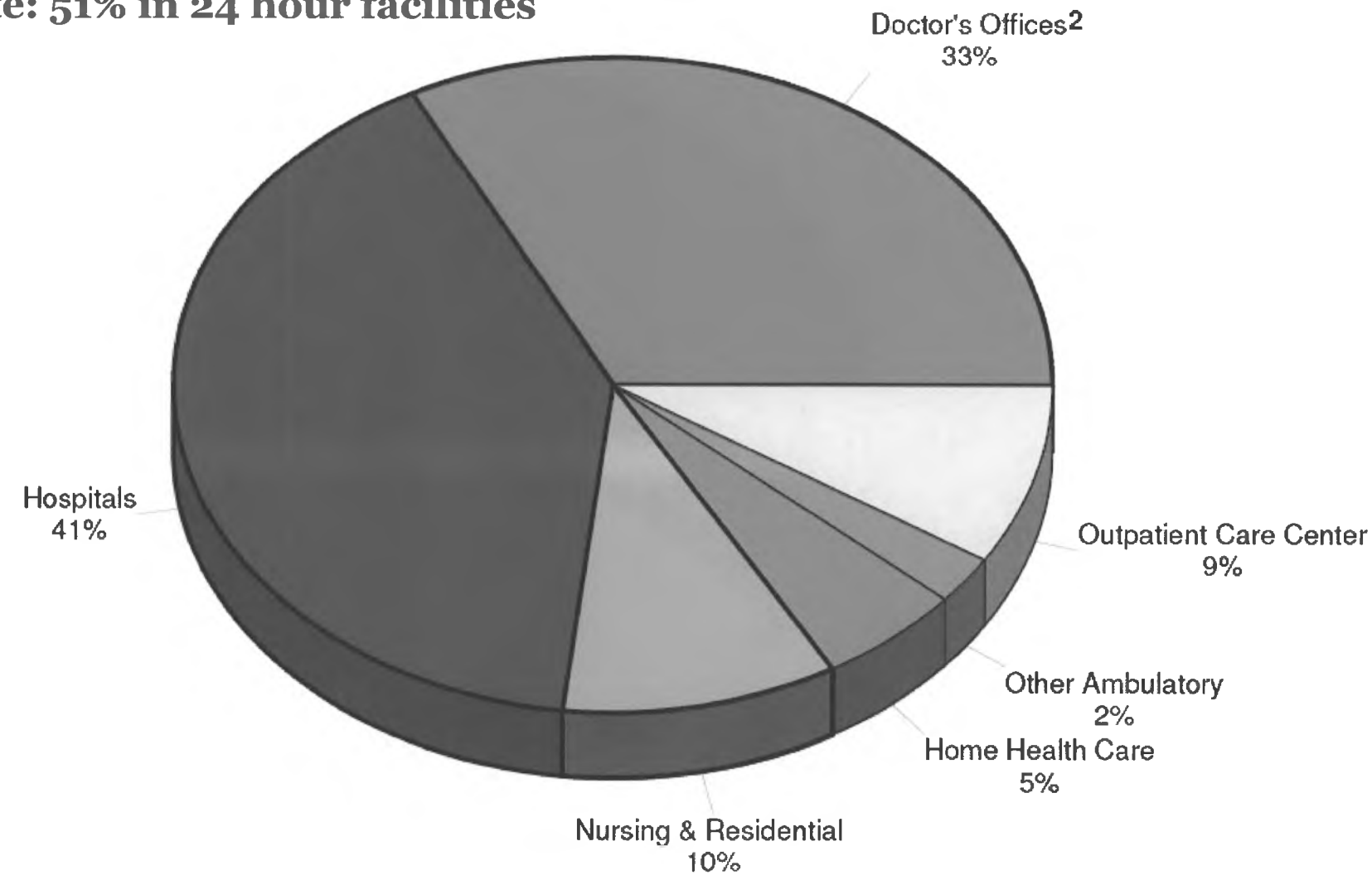


[1]Includes the private and public sectors, 2008

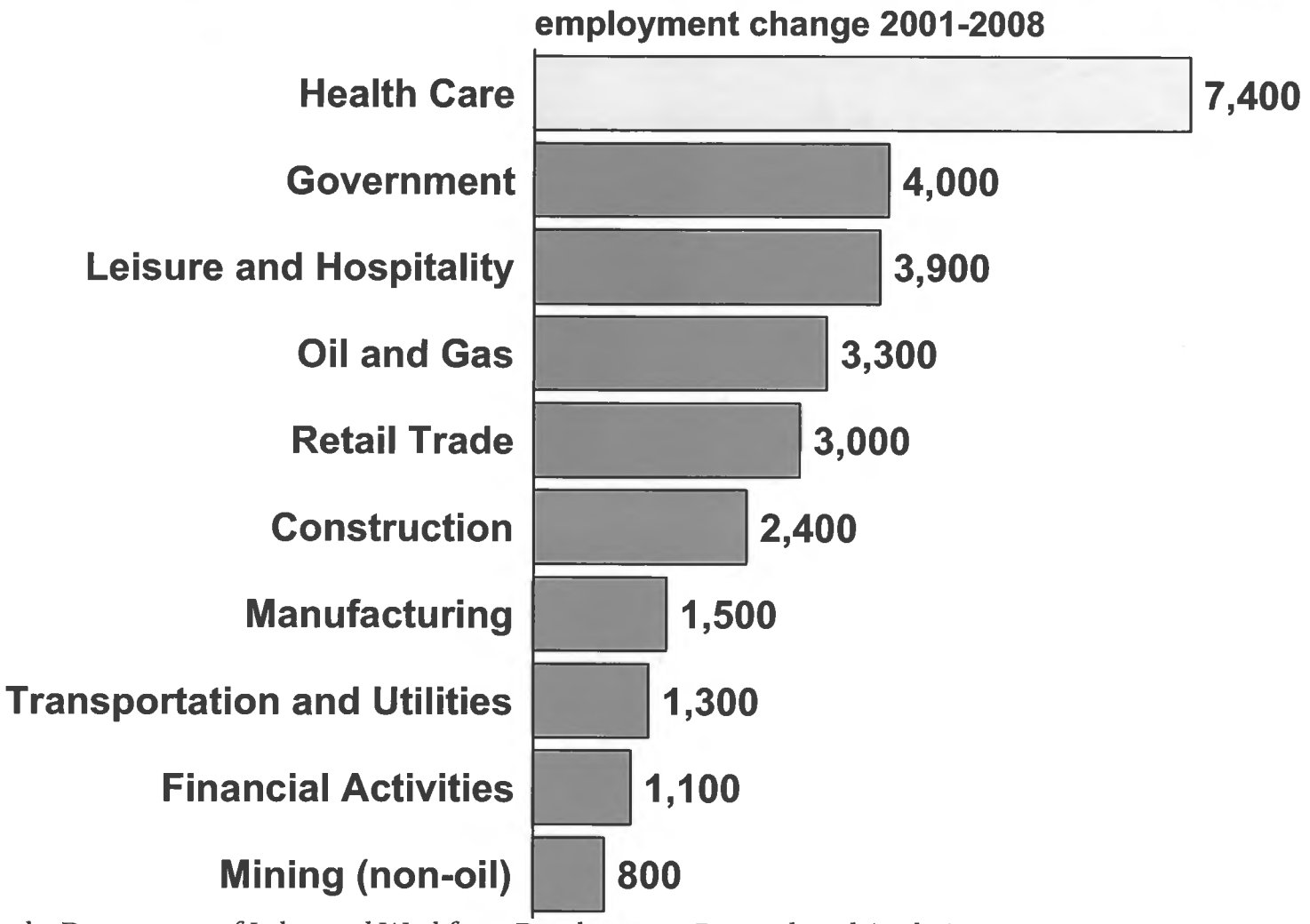
[2]Include other services, private education services, soical assistance and wholesale trade

Where Alaska's Health Care Services Job Are-2009[1]

Note: 51% in 24 hour facilities



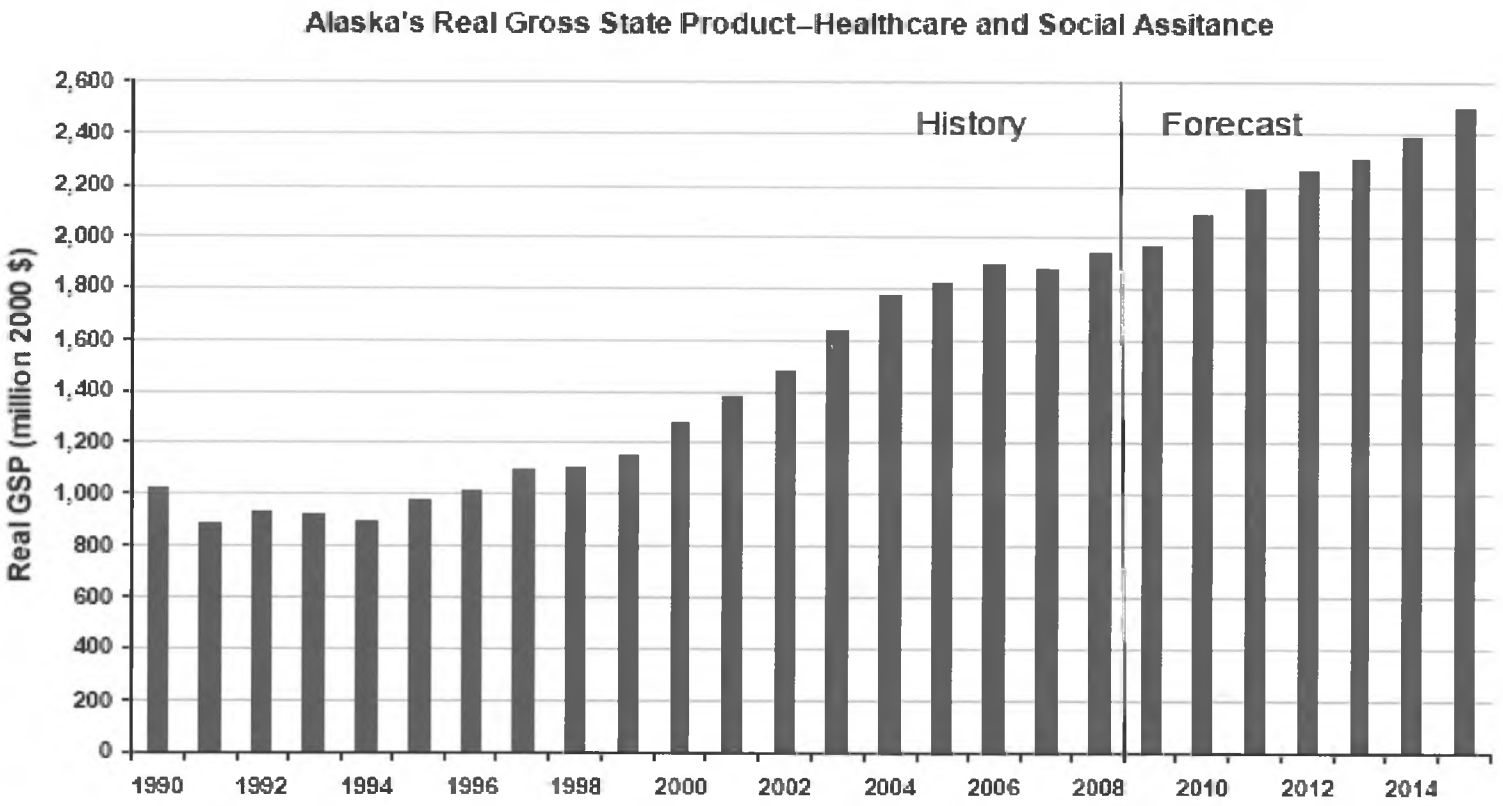
Health Care-The Number One Job Generator In The 2001-08 period



Source: Alaska Department of Labor and Workforce Development, Research and Analysis

Continued Growth is Expected

Healthcare Sector Expansion

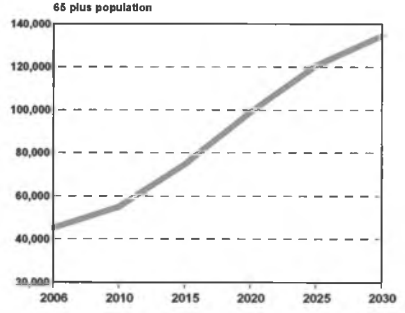


Source: Alaska Department of Labor and Workforce Development, Research and Analysis

Demographic Pressures

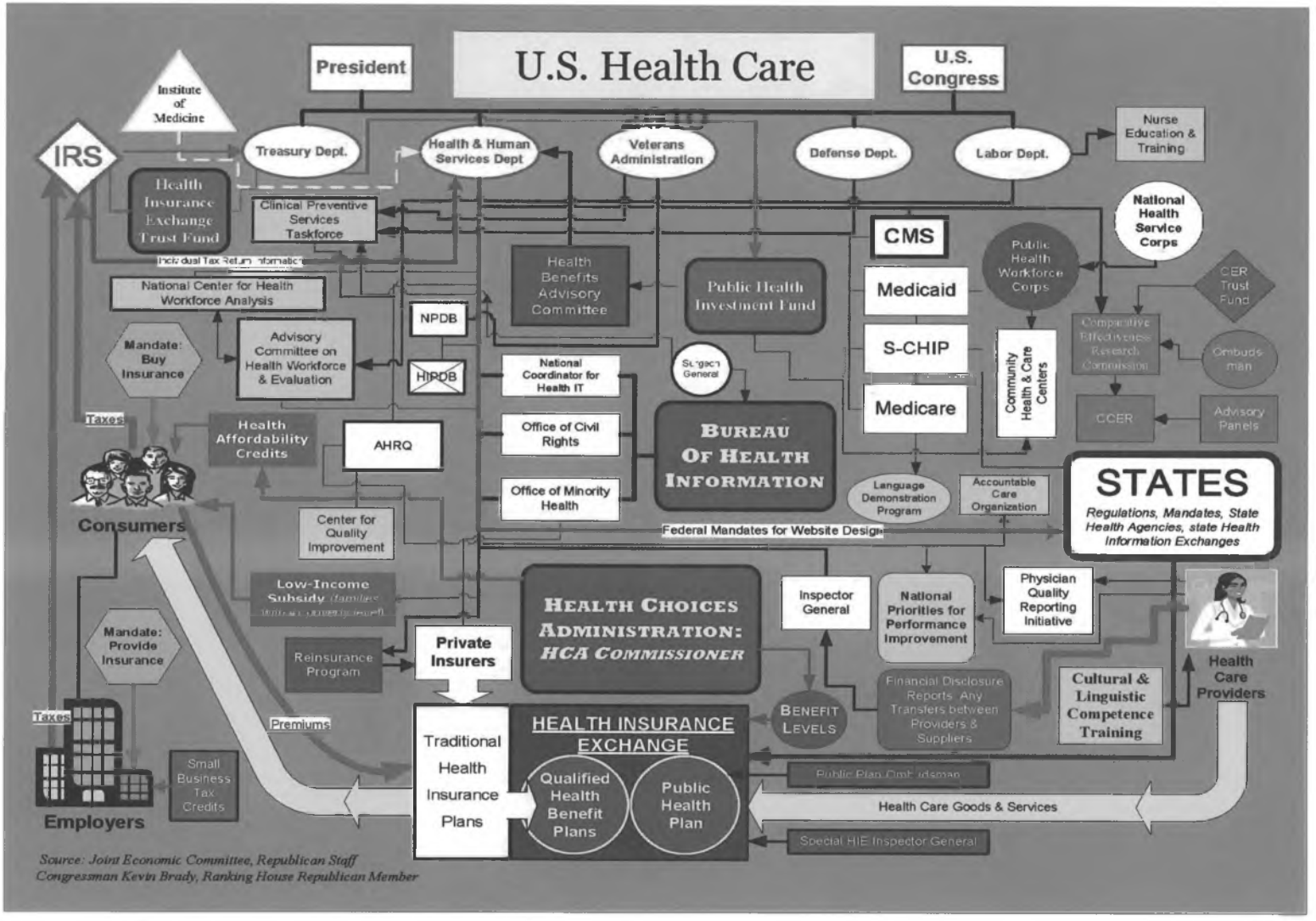
The Silver Tsunami

- **Fastest growing senior population in the nation** - will increase utilization of health services
  - Age 65+ will grow to ~20% of Alaska's population by 2025



- **Retirements** will accelerate health care staffing vacancies
- **Federal Health Reform** –potentially 64,000 Alaskans added to insurance rolls (50% Medicaid, 50% Exchange/Employer plans)
- **Result – growing critical workforce shortages in many occupations and professions**

Health Care is a Complex Industry



An Investment in Health Workforce Development is an Investment in Alaska

- Workforce shortages
  - Higher costs for health care
  - Limited access to care
  - Enormous recruitment/retention costs
    - ~$25 million in 2005 for 12 professions (> half for "travelers")
- Economic impact of industry/on other industries
- Educating Alaskans for Alaska legacy jobs

Critical Shortages/Distribution Issues

PRIMARY CARE
- Physicians
- Nurse Practitioners
- Physician Assistants
- Community Health Aides
- Pharmacists

HEALTH INFORMATICS

NURSING
- Nurse Specialists
- Nurse Educators
- Nurse Practitioners
- Direct Service Workers

BEHAVIORAL HEALTH
- Psychiatrists
- Licensed Clinicians
- Nurse Practitioners
- Counselors
- Behavioral Health Aides

ORAL HEALTH
- Dental Hygienists
- Dental Health Aide Therapists
- Dentists

THERAPIES
- Physical Therapists
- Therapy Assistants
- Occupational Therapists
- Speech-Language Therapists

Top 10 Positions/Vacancies/Vacancy Rates

Top Ten Health Occupations/Professions Based on Estimated Total Positions						
	Sample			Estimate		
Occupations	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Registered Nurse	2680.8	273.5	10.2%	**3176.0**	321.6	10.1%
Certified Nurse Assistant	1245.5	102.0	8.2%	**1444.9**	120.0	8.3%
Administrator/Director/CEO/Manager	837.0	25.0	3.0%	**1246.4**	33.5	2.7%
Human Services Worker HS	804.0	104.0	12.9%	**1198.9**	146.4	12.2%
Firefighter with Emergency Medical Service	903.0	26.0	2.9%	**1114.1**	32.1	2.9%
Billing Clerk/Technician	689.5	37.0	5.4%	**1096.1**	58.6	5.3%
Dental Assistant	574.0	34.0	5.9%	**968.3**	61.7	6.4%
Pharmacy Technician	774.5	23.0	3.0%	**819.9**	27.8	3.4%
Case Manager	620.5	33.0	5.3%	**810.2**	48.7	6.0%
Medical Assistant	357.0	13.5	3.8%	**706.7**	30.3	4.3%
Top Ten Health Shortage Occupations/Professions Based on Estimated Number of Vacancies						
	Sample			Estimate		
Occupations	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Registered Nurse	2680.8	273.5	10.2%	3176.0	**321.6**	10.1%
Human Services Worker HS	804.0	104.0	12.9%	1198.9	**146.4**	12.2%
Certified Nurse Assistant	1245.5	102.0	8.2%	1444.9	**120.0**	8.3%
Licensed Practical Nurse	393.0	44.5	11.3%	578.6	**68.2**	11.8%
Family Physician	315.8	43.0	13.6%	615.4	**67.1**	10.9%
Dental Assistant	574.0	34.0	5.9%	968.3	**61.7**	6.4%
Billing Clerk/Technician	689.5	37.0	5.4%	1096.1	**58.6**	5.3%
Family Nurse Practitioner	193.0	36.5	18.9%	337.3	**58.2**	17.2%
Case Manager	620.5	33.0	5.3%	810.2	**48.7**	6.0%
Chemical/Substance Counselor	225.0	37.0	16.4%	311.0	**48.0**	15.4%
Top Ten Health Shortage Occupations/Professions Based on Estimated Vacancy Rates						
	Sample			Estimate		
Occupations	Positions	Vacancies	Vacancy Rate	Positions	Vacancies	Vacancy Rate
Radiation Oncologist	5.0	3.0	60.0%	5.0	3.0	**60.0%**
Paramedic	9.0	4.0	44.4%	9.0	4.0	**44.4%**
Pediatric Nurse Practitioner	15.0	4.0	26.7%	27.8	10.4	**37.4%**
Physical Therapy Assistant	53.0	16.0	30.2%	62.3	17.8	**28.5%**
Nurse Midwife	25.0	4.0	16.0%	41.0	10.4	**25.4%**
Dietitian	36.5	9.0	24.7%	37.2	9.0	**24.2%**
Occupational Therapist	115.0	26.0	22.6%	128.5	29.3	**22.8%**
Women's Health Care Nurse Practitioner	23.0	5.0	21.7%	51.9	11.4	**22.0%**
Psychiatric Nurse Practitioner	25.0	6.0	24.0%	41.9	8.6	**20.5%**
Family Nurse Practitioner	193.0	36.5	18.9%	337.3	58.2	**17.2%**

2009 Vacancy Study, Alaska Center for Rural Health/Institute for Social and Economic Research

Activity Across the Workforce Continuum

- Engage – filling the pipeline; ensuring adequate preparation
- Train – supporting basic training and education, as well as continuing education; distributing across the state
- Recruit – improving Alaska's draw
- Retain – reducing turnover and its attendant costs

Alaska Health Workforce Plan

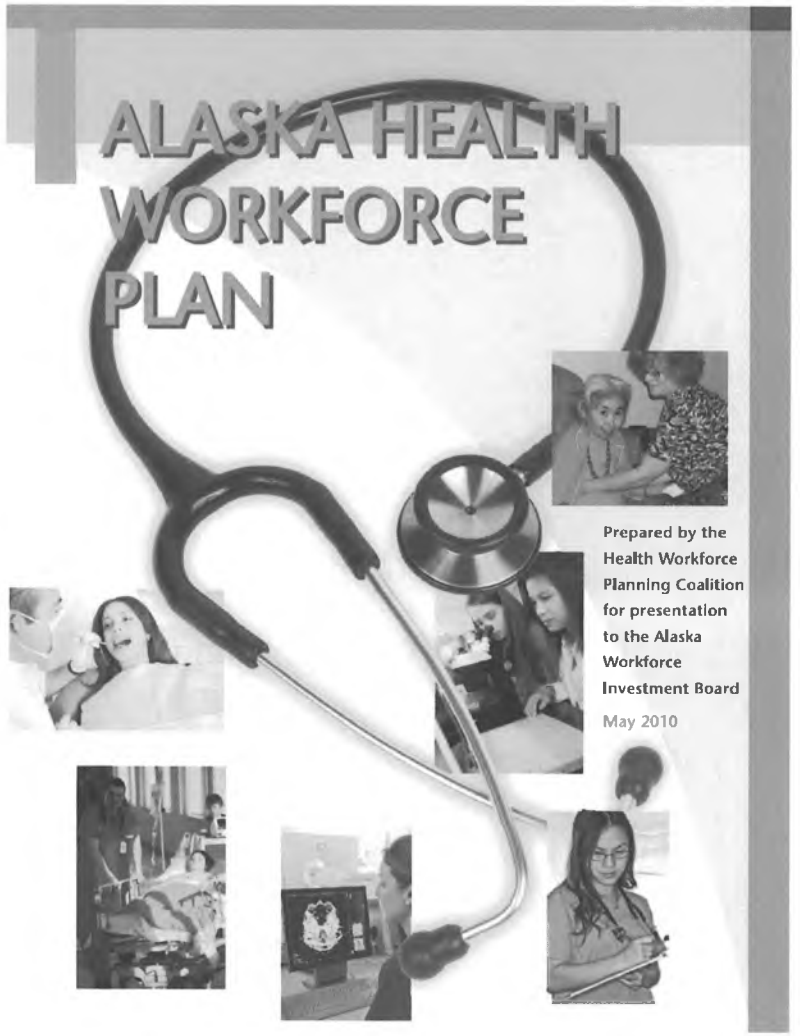
Alaska Healthcare Workforce Opportunities in 2011----and Beyond

Prepared by: Alaska Health Workforce Coalition

Who are we: An informal network of healthcare providers, educators and state agencies

Why is the plan needed:

Alaska continues to have a shortage of trained healthcare workers; state-wide strategies for workforce are critical to Alaska's success in providing services to its citizens



Plan Development

- Ad hoc group gathered in Summer 2009 to discuss health workforce development – became known as the Alaska Health Workforce Coalition
- Stakeholders were asked to provide input into a statewide health workforce plan – through forums, surveys and work groups - in Fall and Winter 2009-10
- AHW Plan was approved by the Alaska Workforce Investment Board in May 2010
- The AWIB received a small HRSA planning grant in September 2010 to continue refining Plan this year; Coalition members have also contributed funds to the effort

Health Care Workforce Plan Overview

ENGAGE	TRAIN	RECRUIT	RETAIN	SUSTAIN
▸ Engage Alaskans in health care workforce development · Create public awareness · Expand career awareness and counseling · Market high need professions · Attract Alaska job seekers into health careers	▸ Train Alaskans for health care employment · Strengthen secondary school offerings and programs · Provide health care occupational training and education programs · Deliver post-employment training opportunities · Develop needed faculty	▸ Recruit qualified candidates to fill health care positions · Promote health care employment opportunities in Alaska · Expand post-graduate opportunities · Improve coordination in recruitment among health care providers · Establish incentives to attract needed professionals · Create a positive environment for health care providers	▸ Retain a skilled health care workforce · Support and disseminate effective orientation programs for new employees · Provide opportunities for professional development and advancement · Promote positive work environments	▸ Develop formalized structure for ongoing activity and accountability · Ensure regular collection and assessment of workforce data · Align health status and workforce data · Develop effective funding sources to support strategies · Align granting agencies · Leverage existing resources · Monitor plan results · Ensure plan is reviewed and revised to changing health care environment · Develop policy environment that supports healthcare workforce

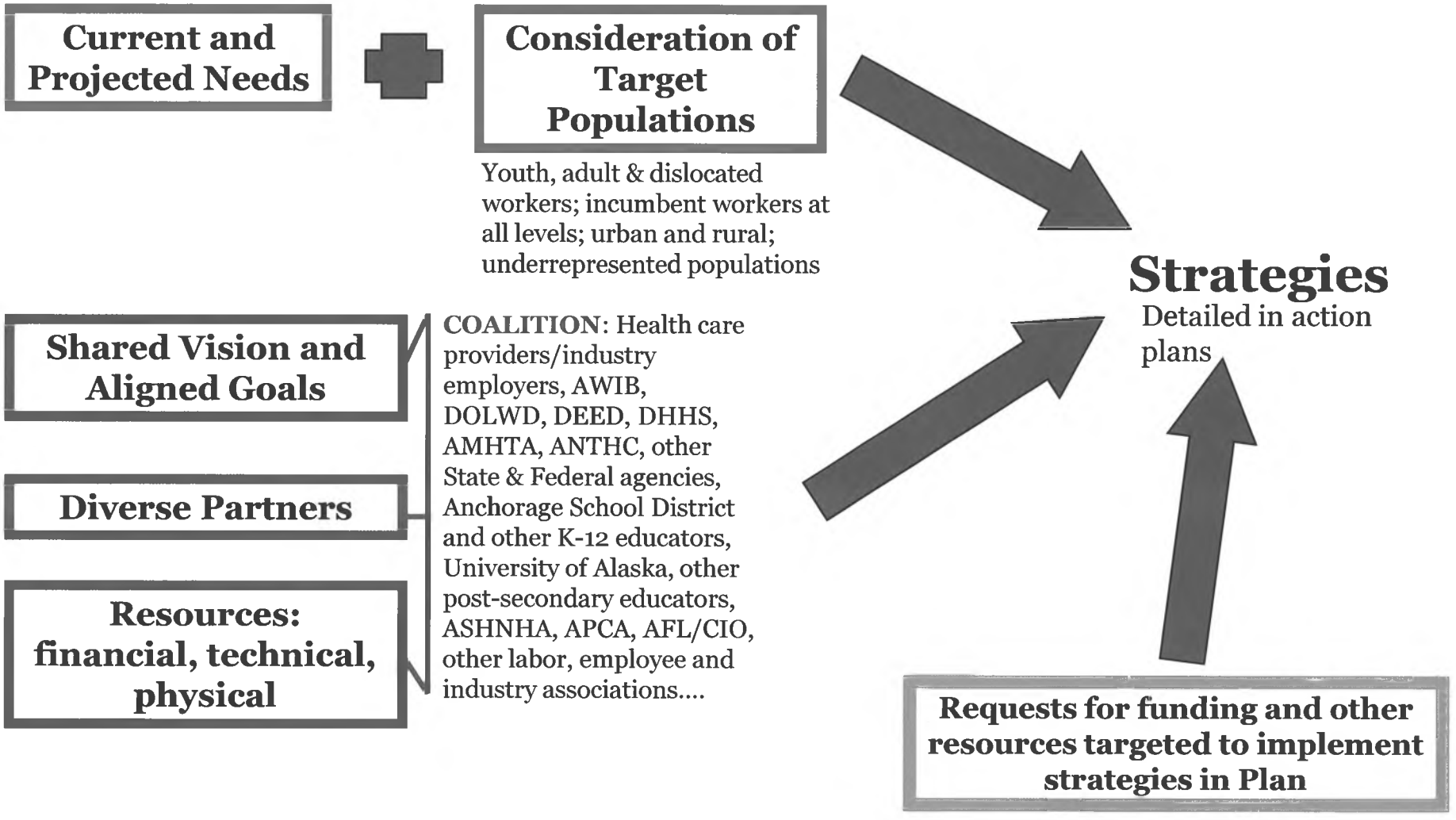
Initial Priority Occupations

- The 15 selected occupational groups include about 30 occupations and professions
  - Advanced Nurse Practitioner
  - Behavioral Health Aide/Village Counselor
  - Behavioral Health Clinician
  - Community Health Aide/Practitioner
  - Direct Care Worker
  - Health Informatics Staff
  - Human Services Worker
  - Nurse Educator
  - Oral Health Practitioner
  - Pharmacist
  - Primary Care Physician
  - Psychiatrist
  - Registered Nurse
  - Substance Abuse Counselor
  - Therapist and Therapist Assistant (Physical, Occupational, Speech-Language)

2011 Legislative Priorities

- Psychiatric Residency
- Loan Incentives and Repayment
- Alaska Health Education Centers (AHECs)

Alaska's Health Care Workforce Plan

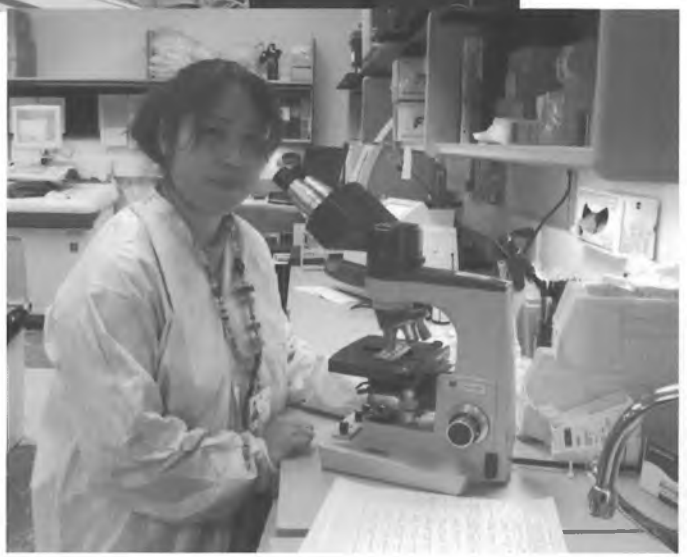


Investments Needed

What Will It Take to Resolve These Issues?

- Continued commitment of all stakeholders, including State government
- Support needed
  - **Strategic direction**
  - **Attention and advocacy**
    - **Loan Repayment/employment incentives** legislation
    - Support for **medical residency development – psychiatry**, pediatrics, others
    - **Implementation of plan** elements as they are ready – Alaska Health Workforce Plan and Career and Technical Education Plan
    - Funding of the **University of Alaska** budget
    - Funding for the **Area Health Education Center (AHEC)** workforce development system
  - **Participation**
  - **Other resources**

QUESTIONS?



OFFICE OF THE LONG TERM CARE OMBUDSMAN

Alaska State 27th Legislature,

February 2011

Authority

Federal Older Americans Act of 1965 (42 U.S.C. 3058g(j). Title VII).

AS 47.62.015. "The ombudsman shall investigate and resolve a complaint made by or on behalf of an older Alaskan who resides in a long term care facility… if the complaint relates to a decision, action or failure to act by a provider…or by a public agency or social services agency that may adversely affect the health, safety, welfare, or rights of the older Alaskan."

OLTCO Enforcement Authority

None, but can pursue legal or administrative remedies.

OLTCO does not take away licenses.

OLTCO does not remove vulnerable adults from homes.

OAA Mandate to OLTCO

- Investigate and resolve complaints.
- Monitor conditions in facilities.
- Advocate for vulnerable seniors.
- Raise public awareness.

Administration

Administratively housed in Alaska Mental Health Trust Authority.

Advised and represented by State Attorney General.

Funding: Federal OAA grant ($418,100), matching State GF ($265,400).

S Alaska 312 Locations

Staff and Volunteers

- 5 Staff cover approximately 312 facilities statewide. Responsible for investigations, "friendly visits," consultation with public, training for providers, managing volunteers.

- 12 volunteer ombudsmen in 23 facilities.

Complaints and Cases

	Average # of complaints/month	Average # of cases opened / month
FY 2009	32	14
FY 2010	38	18
FY 2011	66	30

Complaints
FY 2011

90% of complaints are about assisted living homes. 394 (out of total 465) verified.

Top 3 complaints:

- Poor medication management practices.
- Falls / improper handling of residents.
- Shortage of staff.

Resolution of Complaints
July 1, 2010 – January 31, 2011

465 complaints, 211 cases opened.

67% of complaints were resolved wholly or partially to satisfaction of resident or complainant.

23% were referred to another agency for resolution.

9% did not need action.

1% were not resolved to satisfaction of resident or complainant.

Improving the System of Care

Volunteer ombudsmen

- 20 hours of training, practicum, supervision.
- Assigned to 2-5 homes.
- Visit residents 1-2 times/month.
- Identify problems and resolve them BEFORE someone is hurt (or license is lost).

Problems solved by volunteers

Home too cold, medications not managed responsibly, meals not adequate, bedrooms locked from the outside, dirty bathrooms, cords/rugs creating hazard, staff treating seniors harshly.

Collaboration

- OLTCO reaching out to Filipino American ALH Provider Association for mutual communication and problem-solving.
- OLTCO provider education on dementia.
- OLTCO presents at DHSS Licensing orientation for new ALH administrators.
- DHSS interagency investigative protocol, mortality review team.

FY 2012 Budget

- Operating budget
  - Department of Revenue, OLTCO, $418.1 (IAA)
- Mental Health bill
  - Department of Revenue, OLTCO, $252.1 (GF)

Request to continue funding 1.0 FTE investigator (funded in FY 2010 with OTI, using an existing .5 FTE position).

check on this in Revenue

Contact Information

Diana Weber, MS
State of Alaska LTC Ombudsman
3745 Community Park Loop, Suite 200
Anchorage, AK 99507
(907) 334-4483
Diana.weber@alaska.gov

www.akoltco.com

Findings from the Older Alaskans Survey and Elder/Senior Community Forums

Senate Health and Social Services Committee
February 23, 2011

Alaska Commission on Aging

Presentation Overview

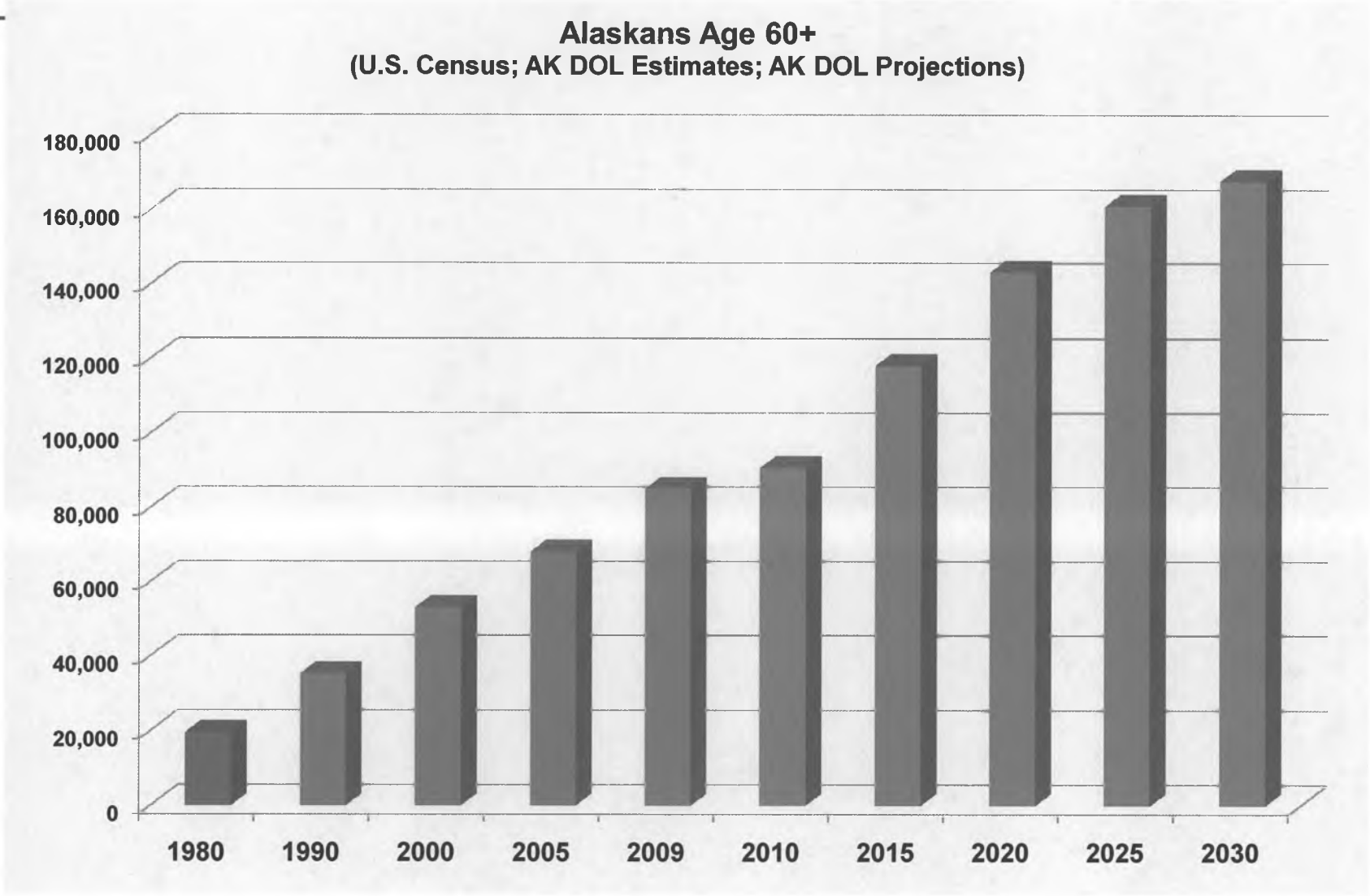
- Alaska senior demographics
- Purpose of needs assessment and methodology used
- Characteristics of survey respondents
- Findings of senior survey
- Elder/senior community forum results
- Priorities for seniors' future

Our Purpose

The mission of the Alaska Commission on Aging is to ensure the dignity and independence of all older Alaskans, and to assist them through planning, advocacy, education and inter-agency cooperation to lead useful and meaningful lives.

DEMOGRAPHICS

Growth of Alaska's Senior Population 1980-2030

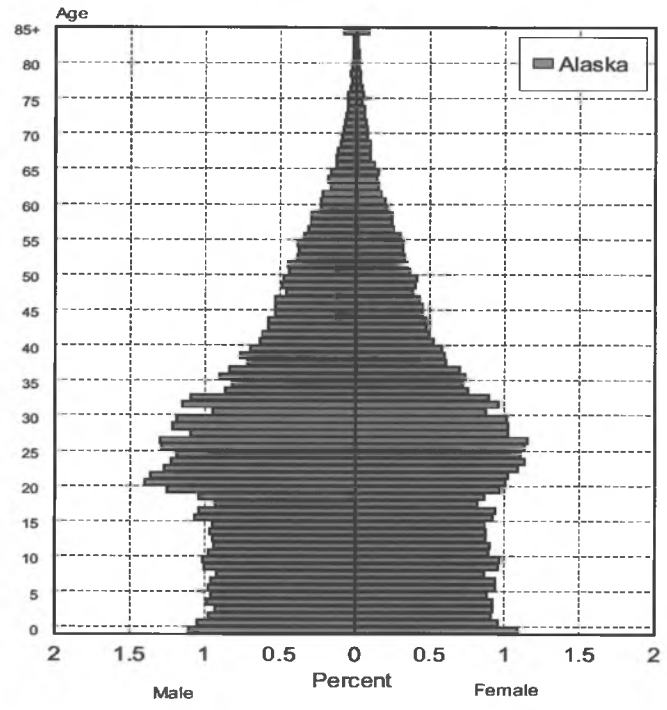


Comparison of Age Distribution 1977 and 2009

Alaska Department of Labor & Workforce Development, Research & Analysis Section

Alaska Population by Age and Sex, July 1, 1977

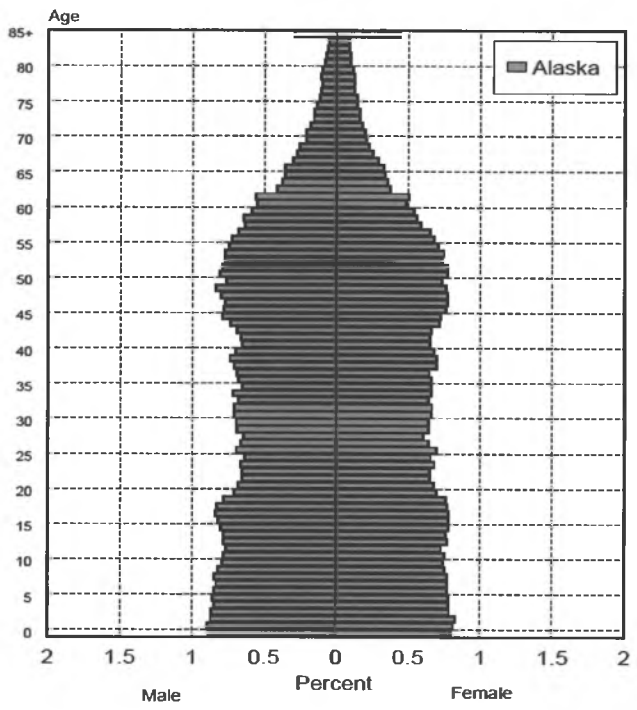
Percent Distribution



Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

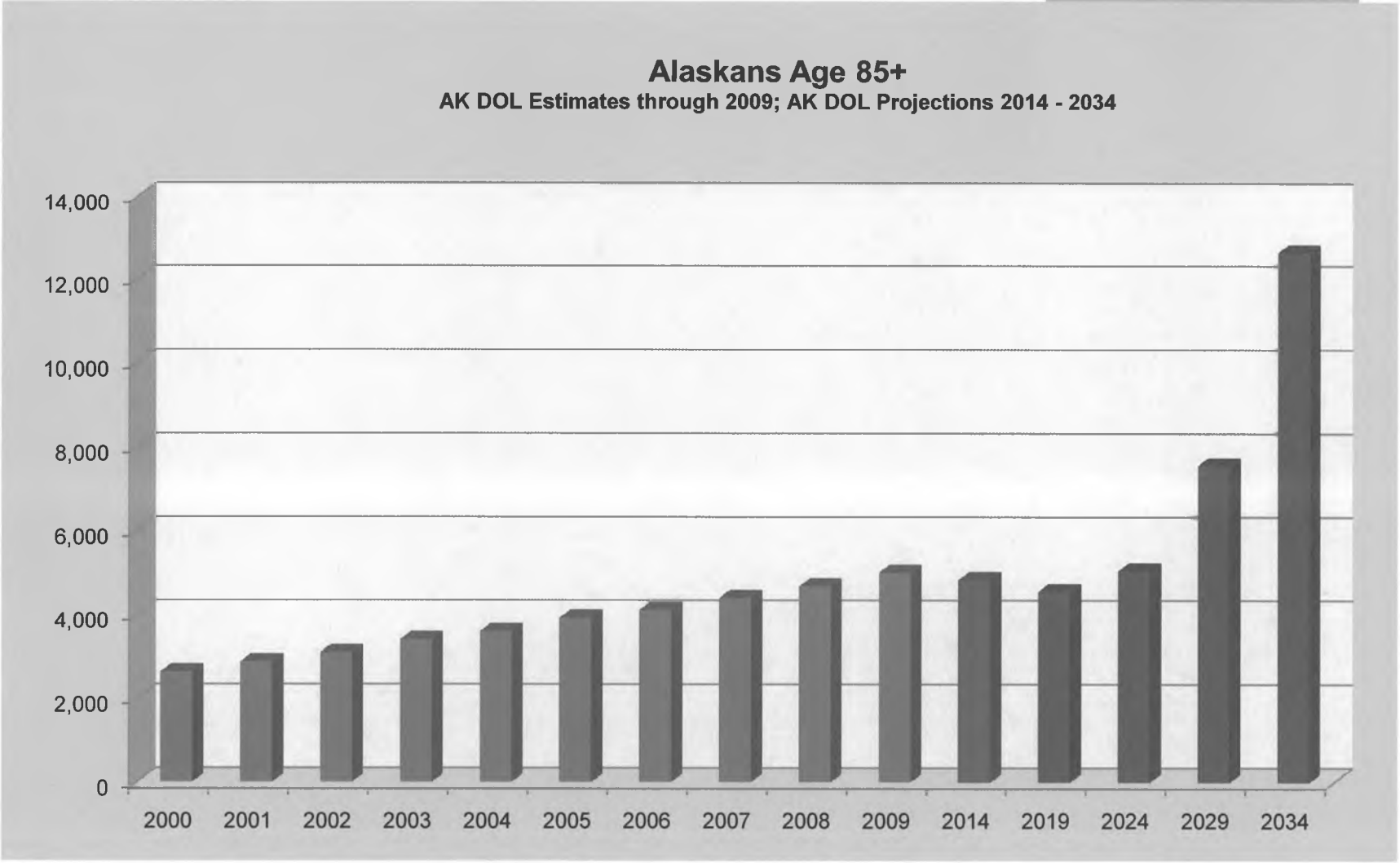
Alaska Population by Age and Sex, July 1, 2009

Percent Distribution

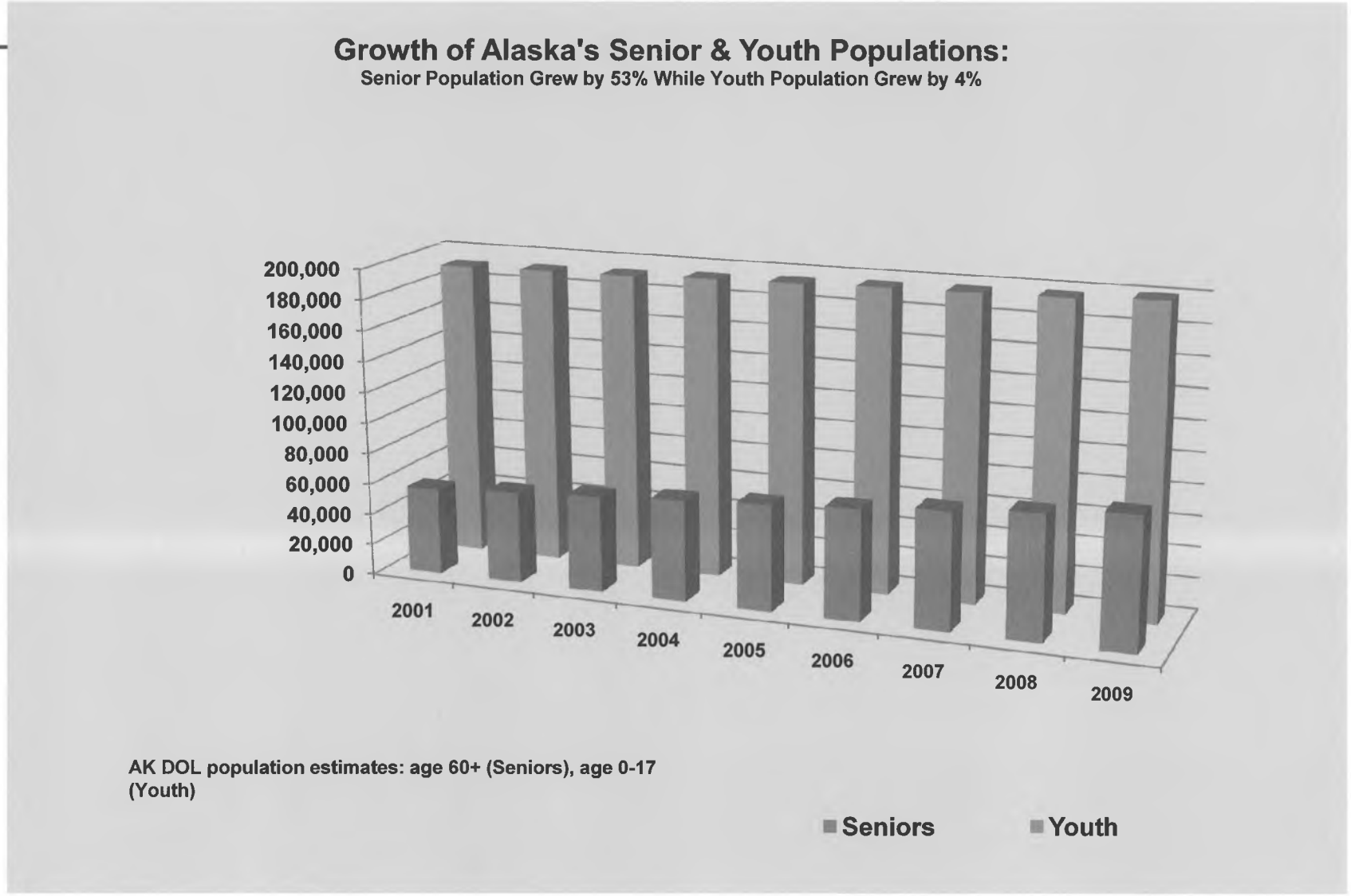


Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

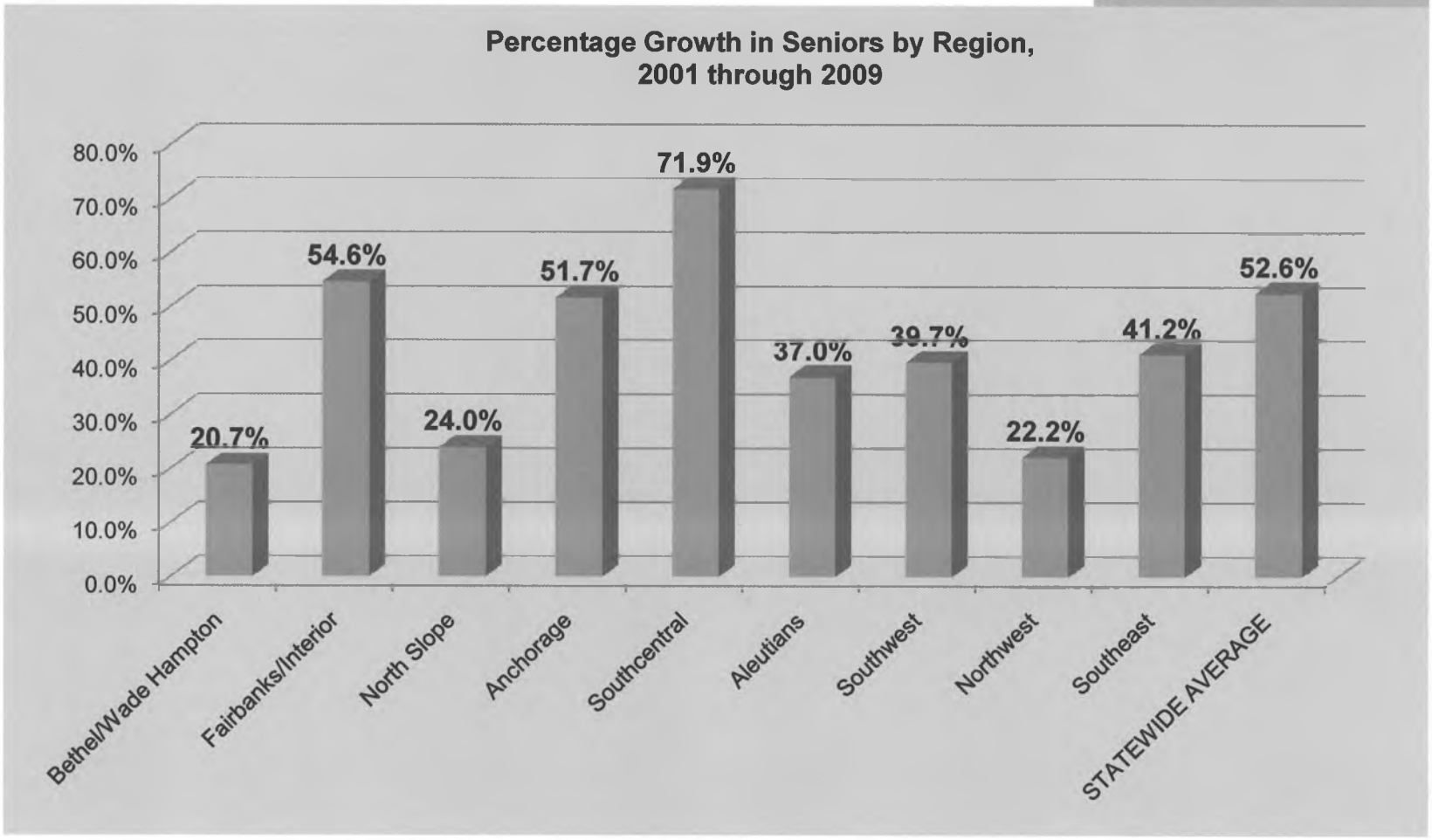
The population of Alaskans age 85+ will grow by nearly 500% from 2000 to 2034.



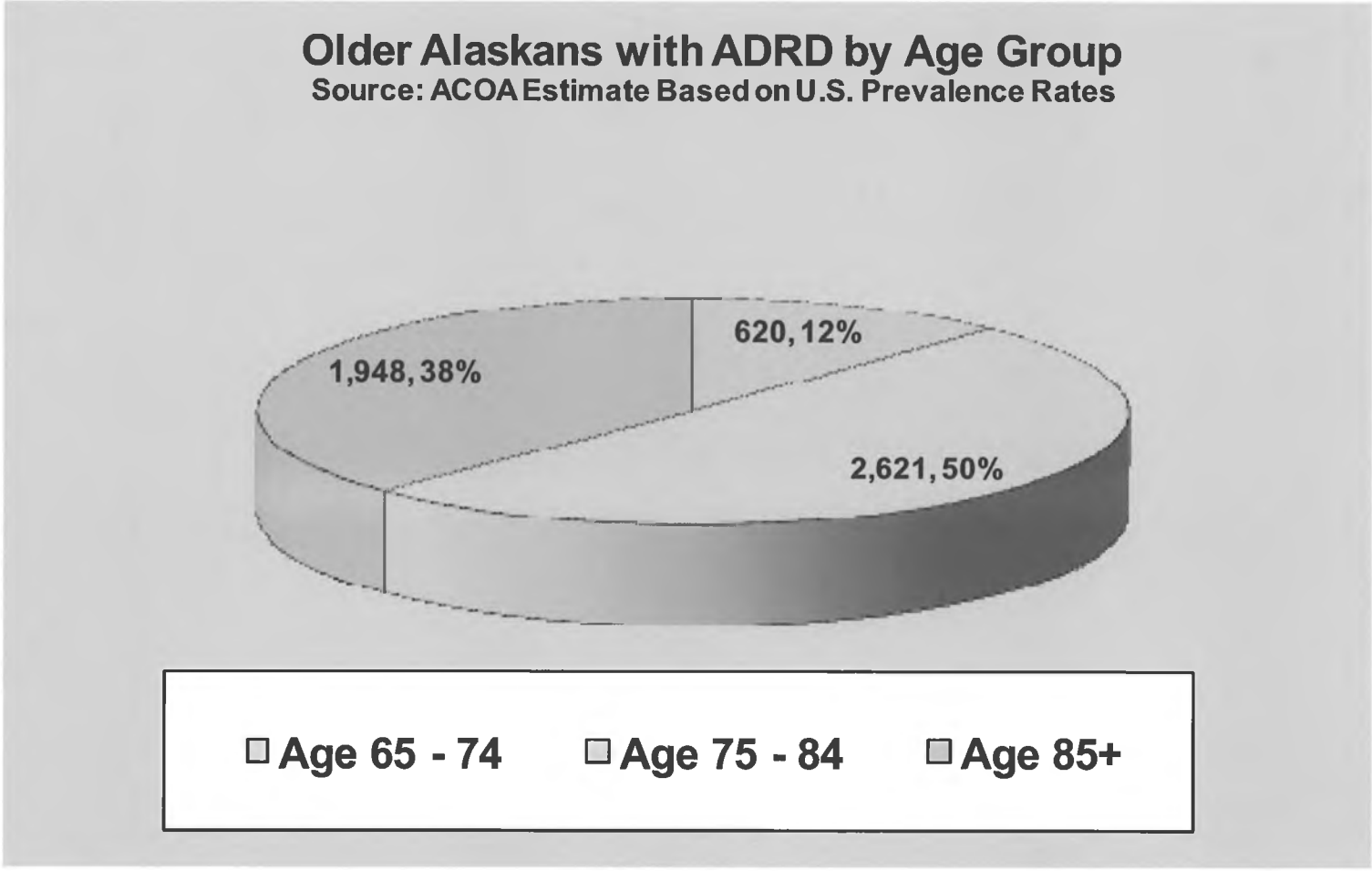
Growth of Alaska's Senior and Youth Populations



Senior Growth Rates Vary by Region



There are over 6,000 Alaskans with Alzheimer's disease and related dementias, based on national prevalence rates.



2010

NEEDS ASSESSMENT & METHODOLOGY

Needs Assessment Efforts for State Plan Development Process

- Six Elder/Senior Community Forums: Anchorage, Fairbanks, Juneau, Kotzebue, Bethel, Alaska Native Tribal Health Consortium
- Provider Survey: online questionnaire about current and projected senior needs and service usage; received 50 responses
- Senior Survey: 4-page survey for Alaskans age 50 and older; distributed through the Senior Voice, senior meal programs, and other methods; received 3,222 responses

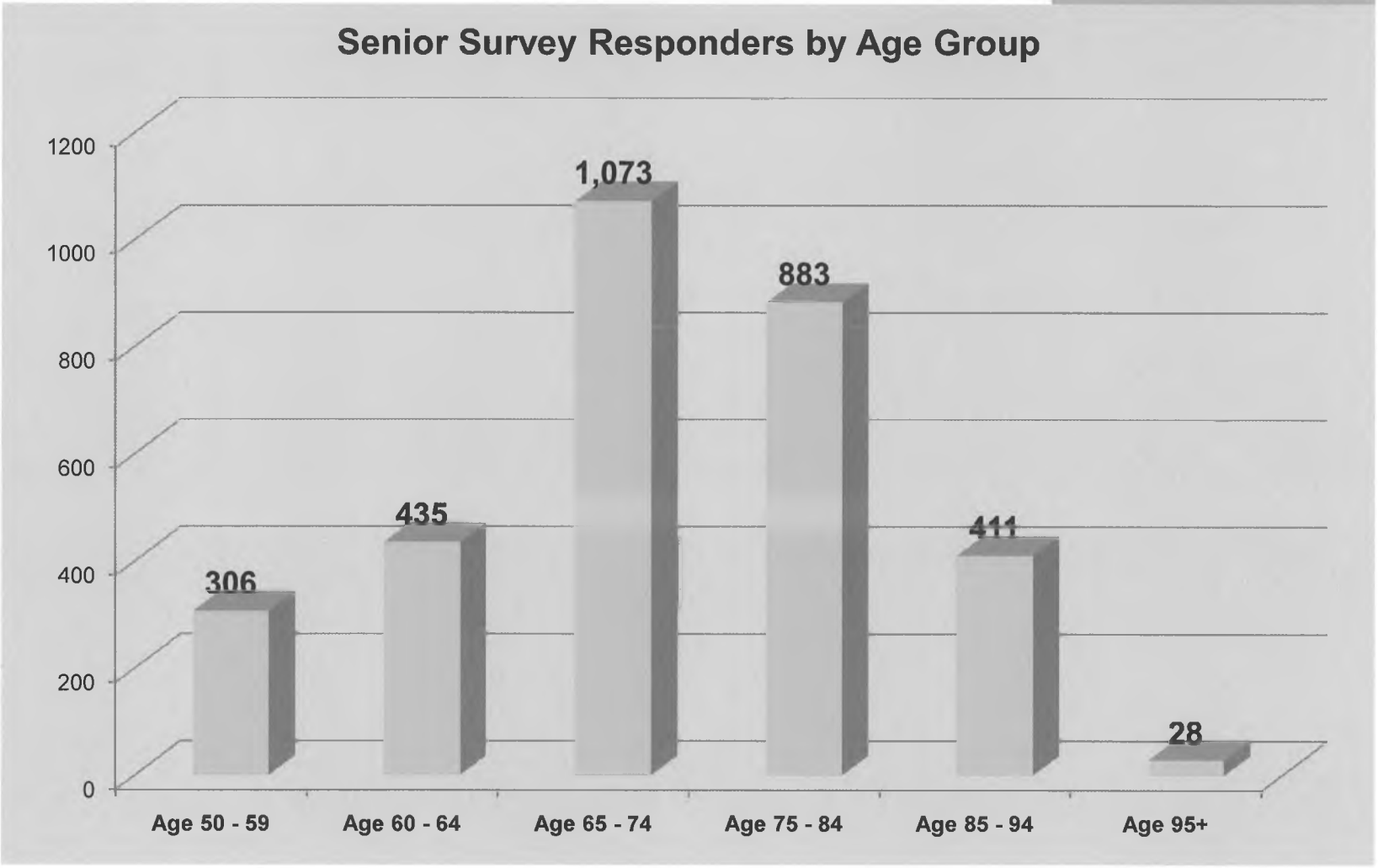
Intw356

Senior Survey Methodology

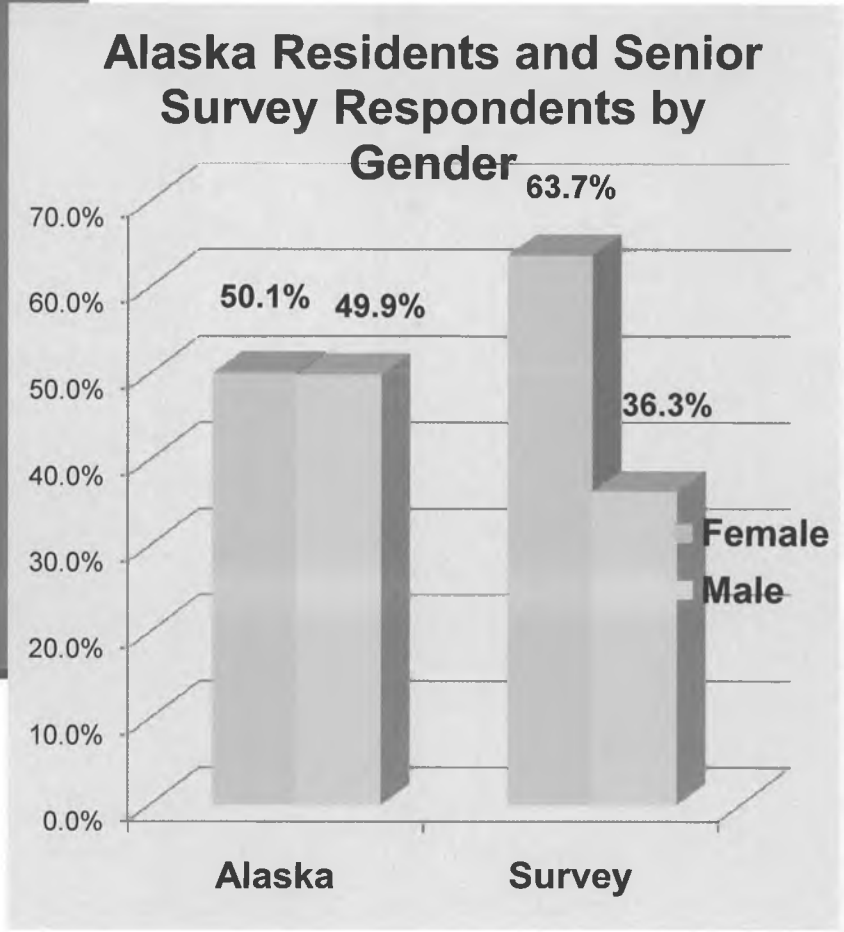
- Both paper copies (about 20,000) and links to an electronic version were widely distributed; postpaid reply envelopes were made available; Alaskans age 50 and older were invited to respond
- 3,222 responses were received (2,836 from seniors age 60 and older); roughly 600 were submitted online; the remainder were mailed back to us
- Paper responses were also entered into a Zoomerang online survey data base by ACOA staff
- ***This was NOT a random, statistically-valid sample of Alaska seniors; therefore, precise conclusions about the status of all older Alaskans cannot be drawn from it***
- However, the large number of responses and their representation of all regions, races, and age groups does offer us plenty of valuable information about the lifestyles and concerns of Alaska's seniors

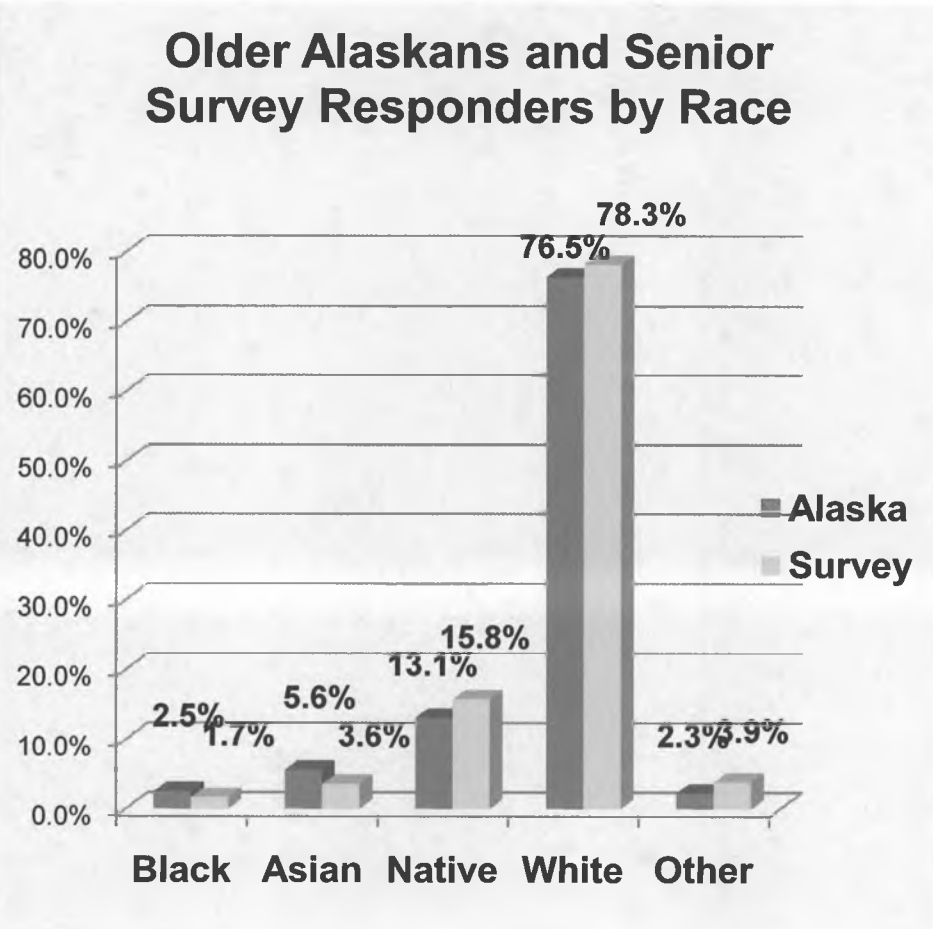
CHARACTERISTICS OF SURVEY RESPONDENTS

The great majority of survey responders were seniors (age 60+). We received responses from every senior age group. The oldest respondent was 107.

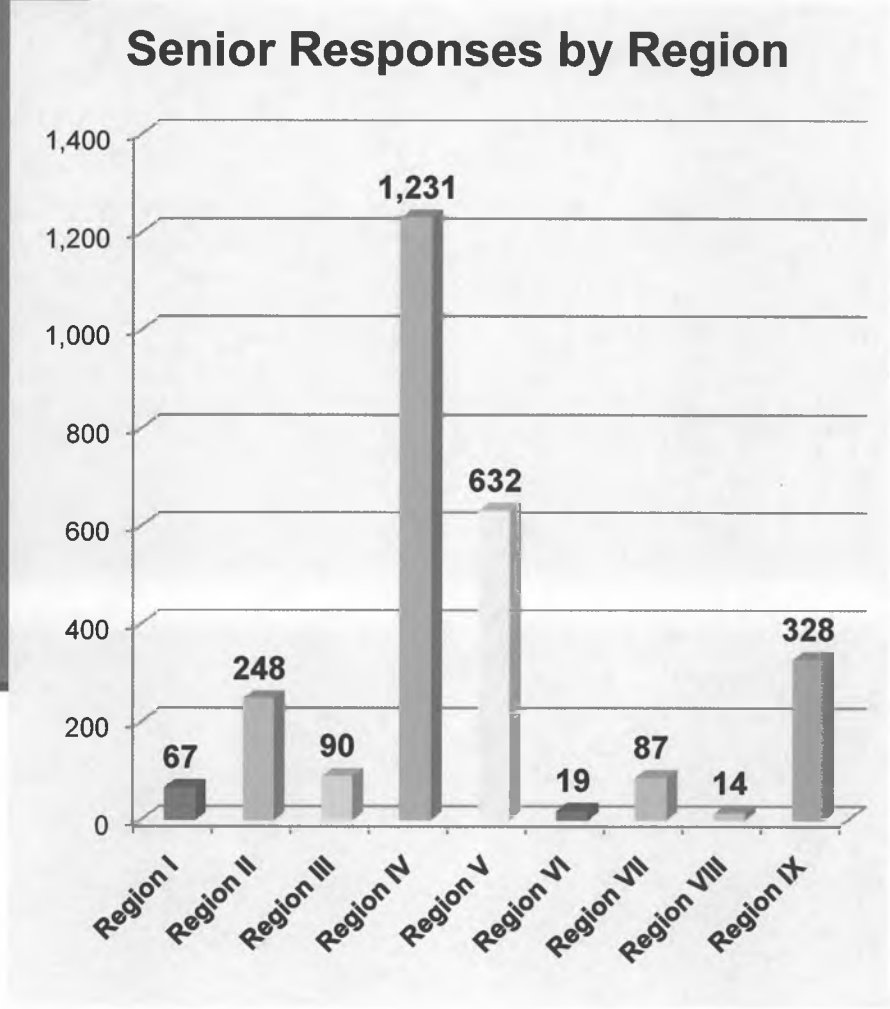


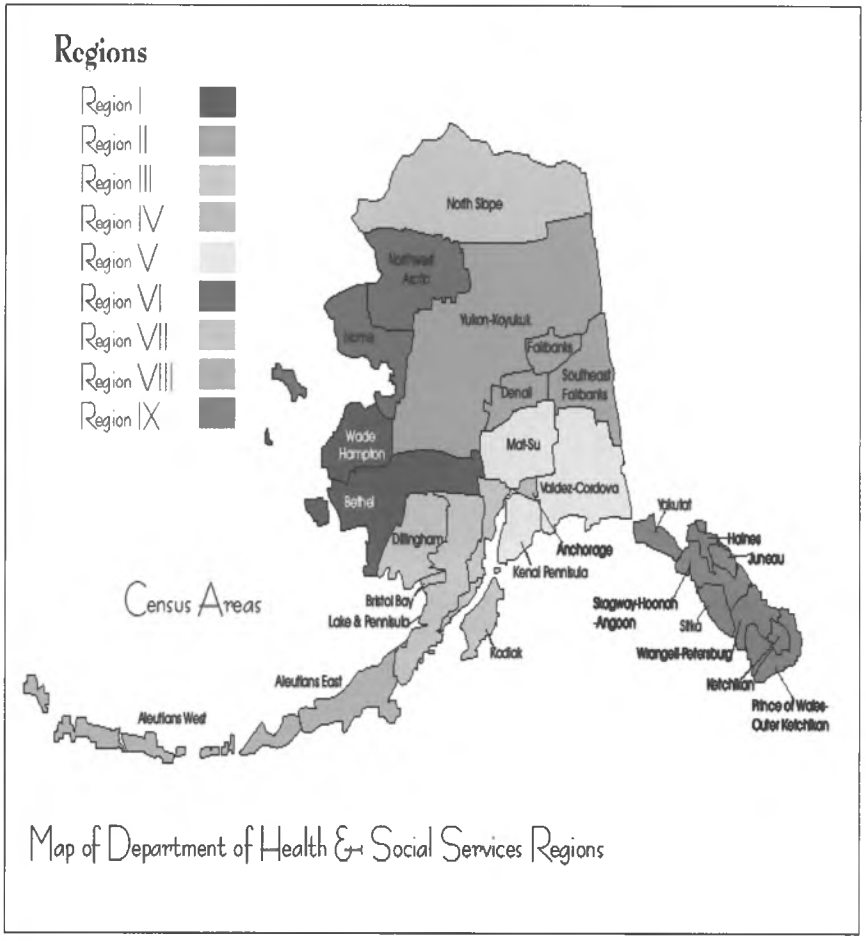
Survey responders were much more likely to be female and slightly more likely to be Native or White than the general population of Alaska seniors.



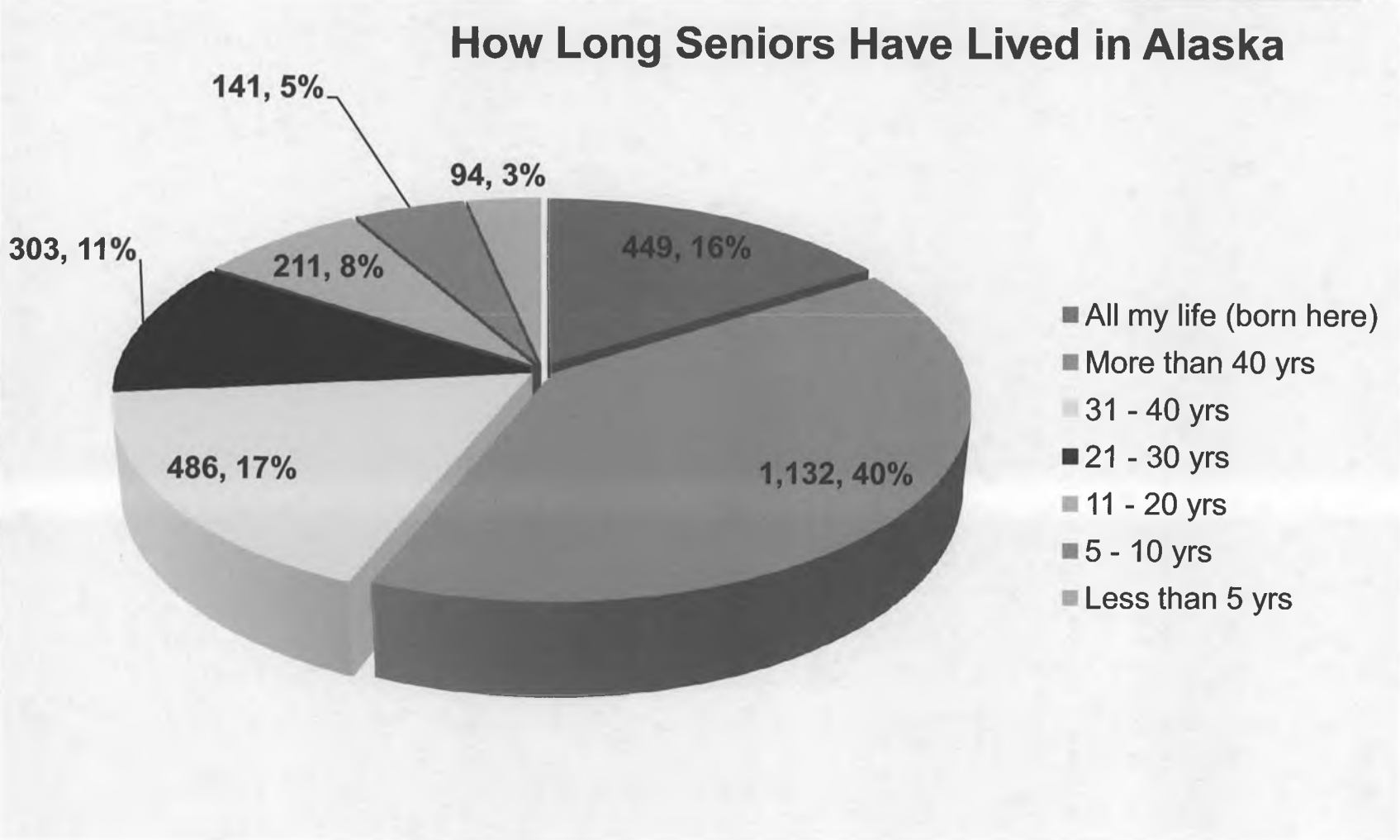


We received survey responses from every region of the state.



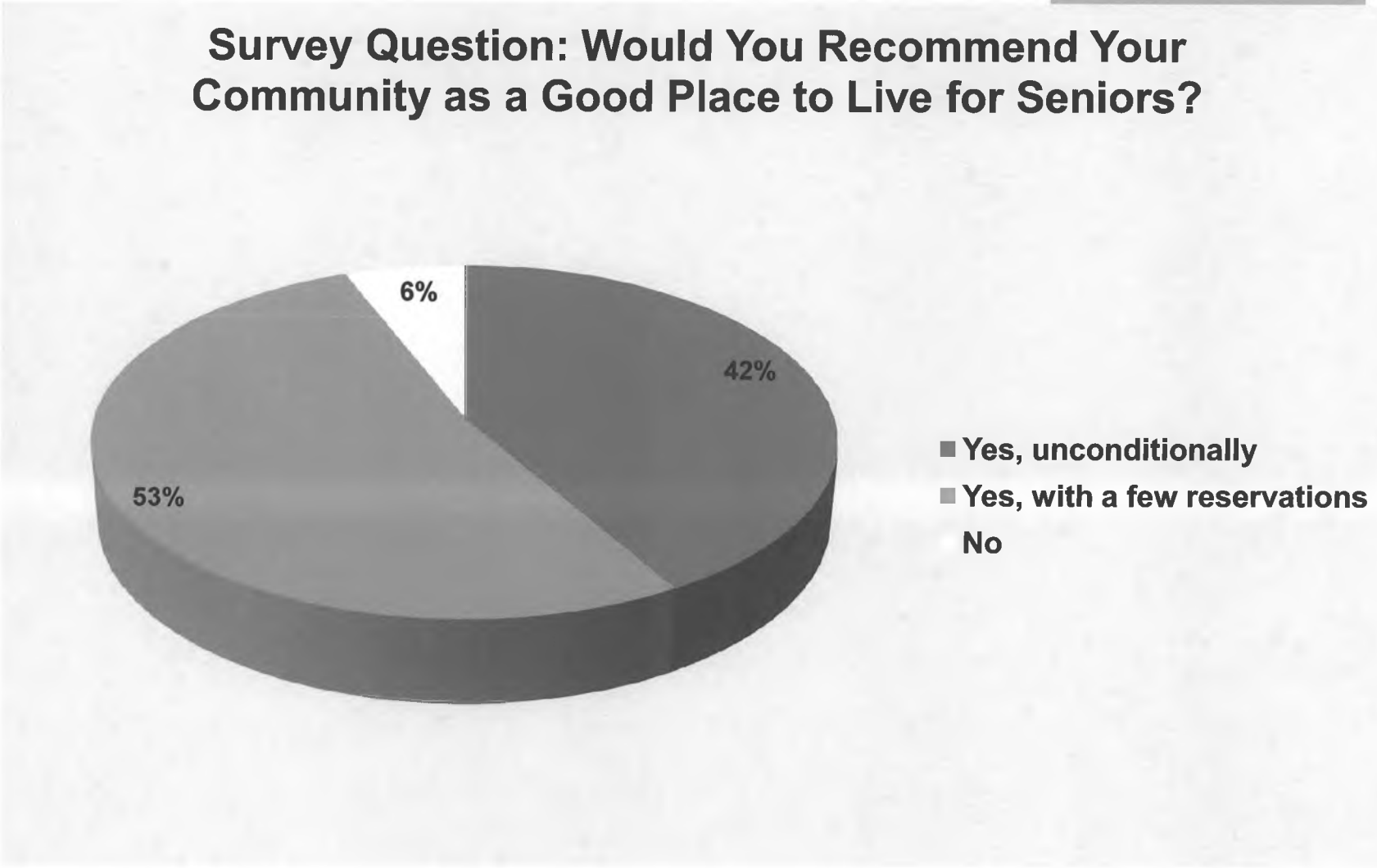


The majority of seniors who responded have lived in Alaska for 40 years or more.

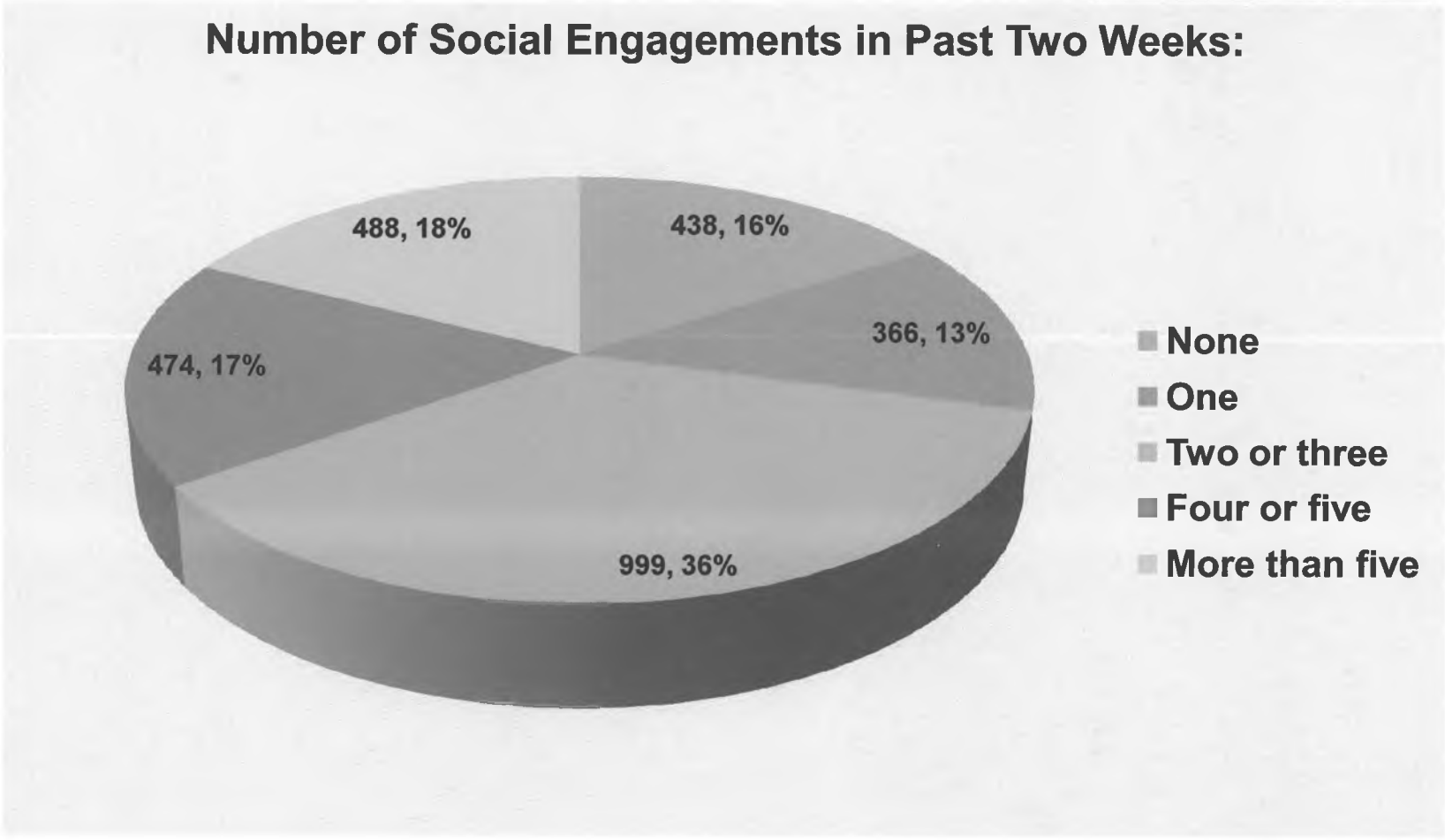


FINDINGS OF THE SENIOR SURVEY

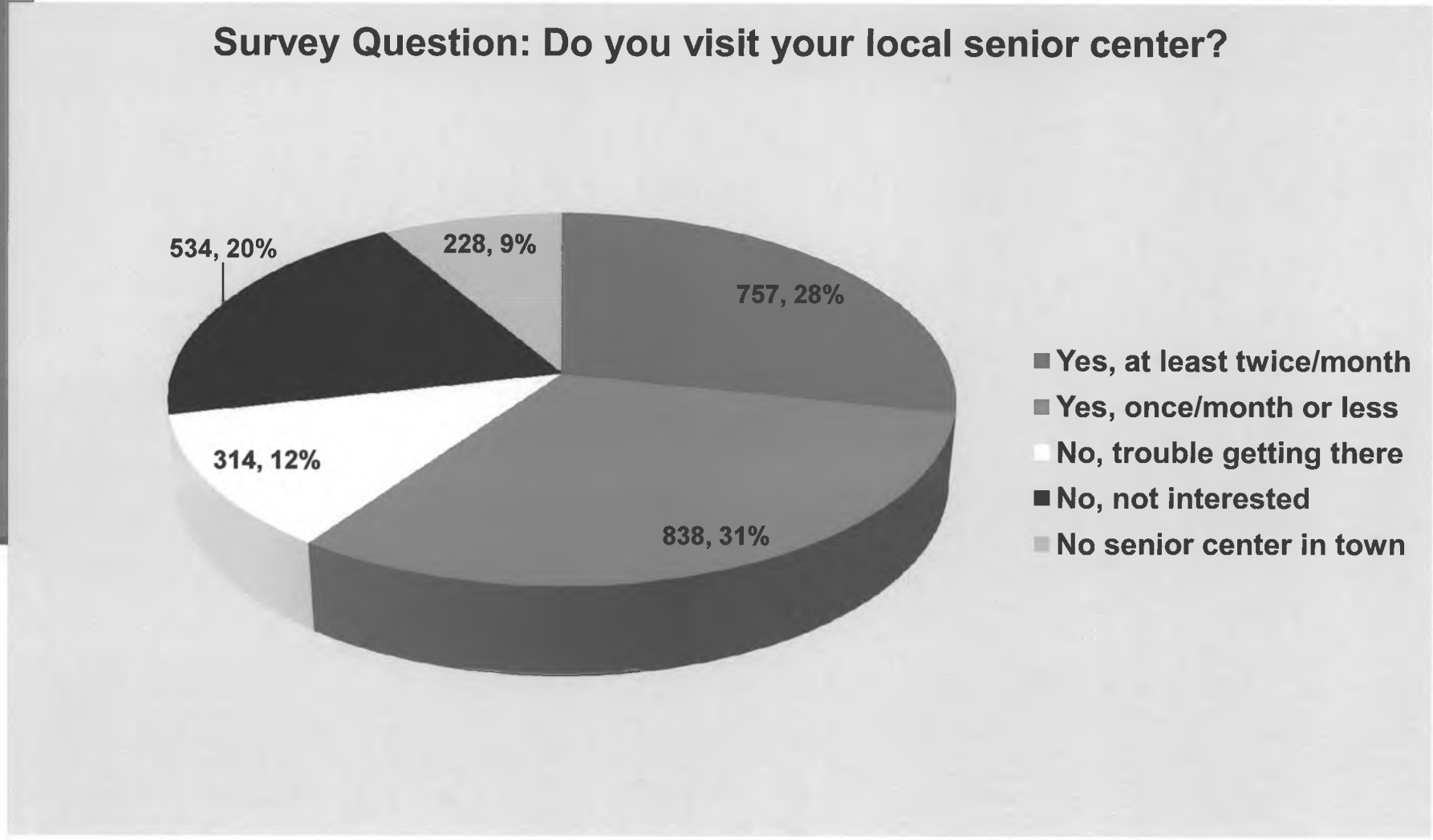
Alaskan seniors are very happy here. More than 9 out of 10 older Alaskans (94%) would recommend their community as a good place to live for seniors.



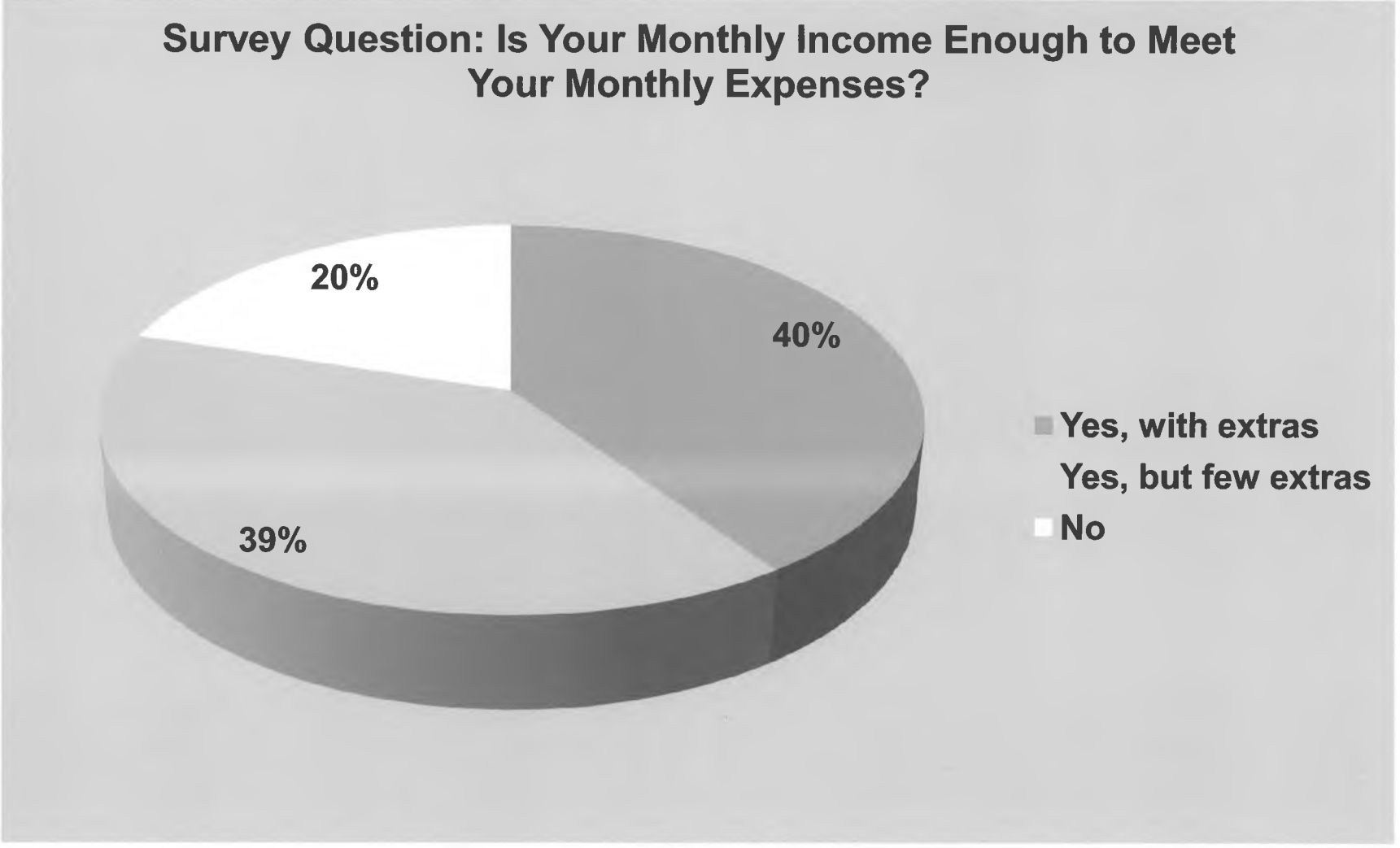
Research shows that social engagement is an important correlate of both mental and physical health for seniors.



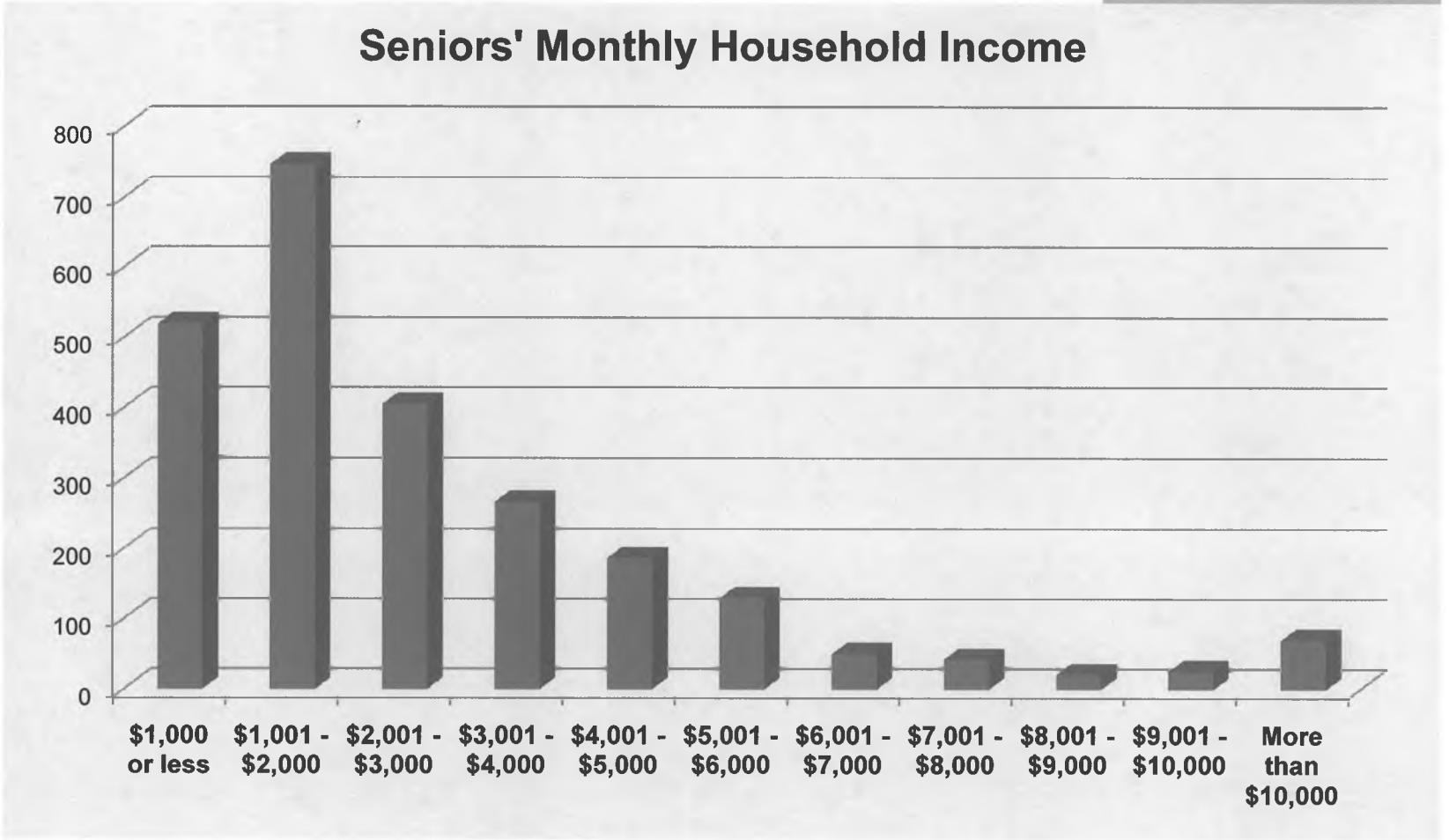
Senior centers are an important key to senior community involvement. Nearly six in ten seniors visit a local senior center at least occasionally.



Many older Alaskans are struggling financially. One in five cannot make ends meet, and another two in five are just getting by.



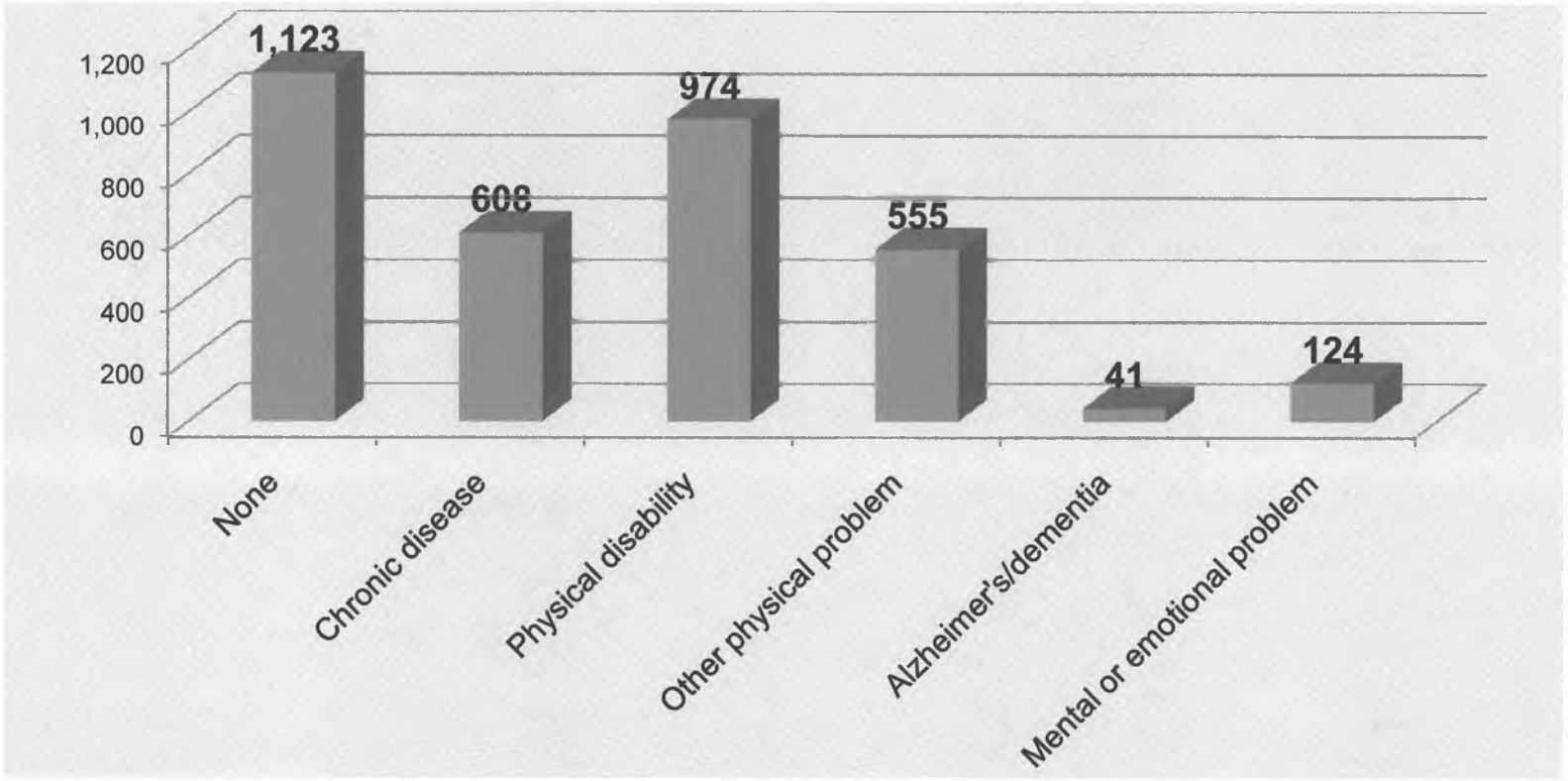
More than half of the older Alaskans who responded to the survey indicated that they live in a household with $2,000 or less of monthly income.



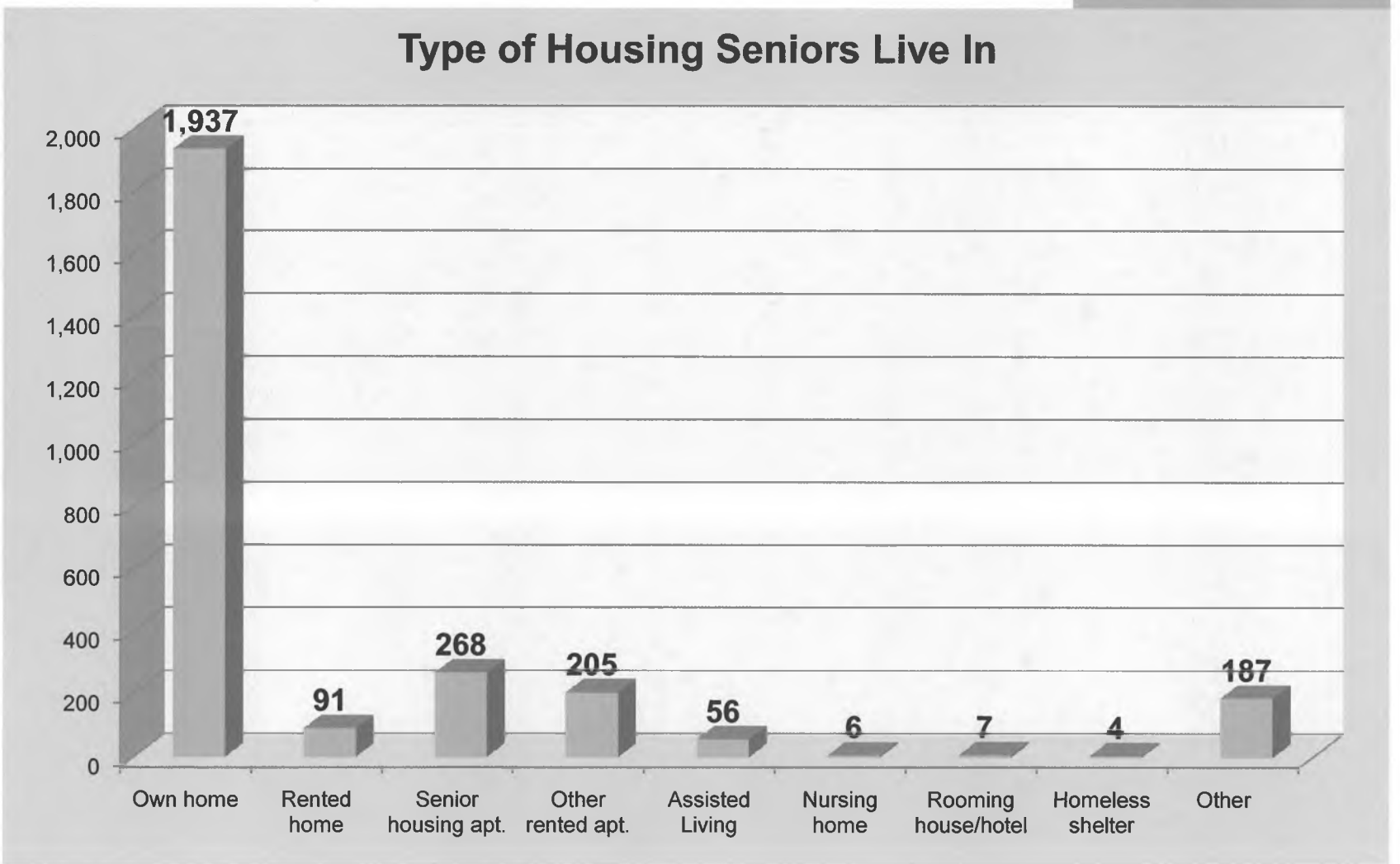
Three out of five older Alaskans surveyed have an illness or disability that limits the range of activities they can enjoy.

3 out of 5

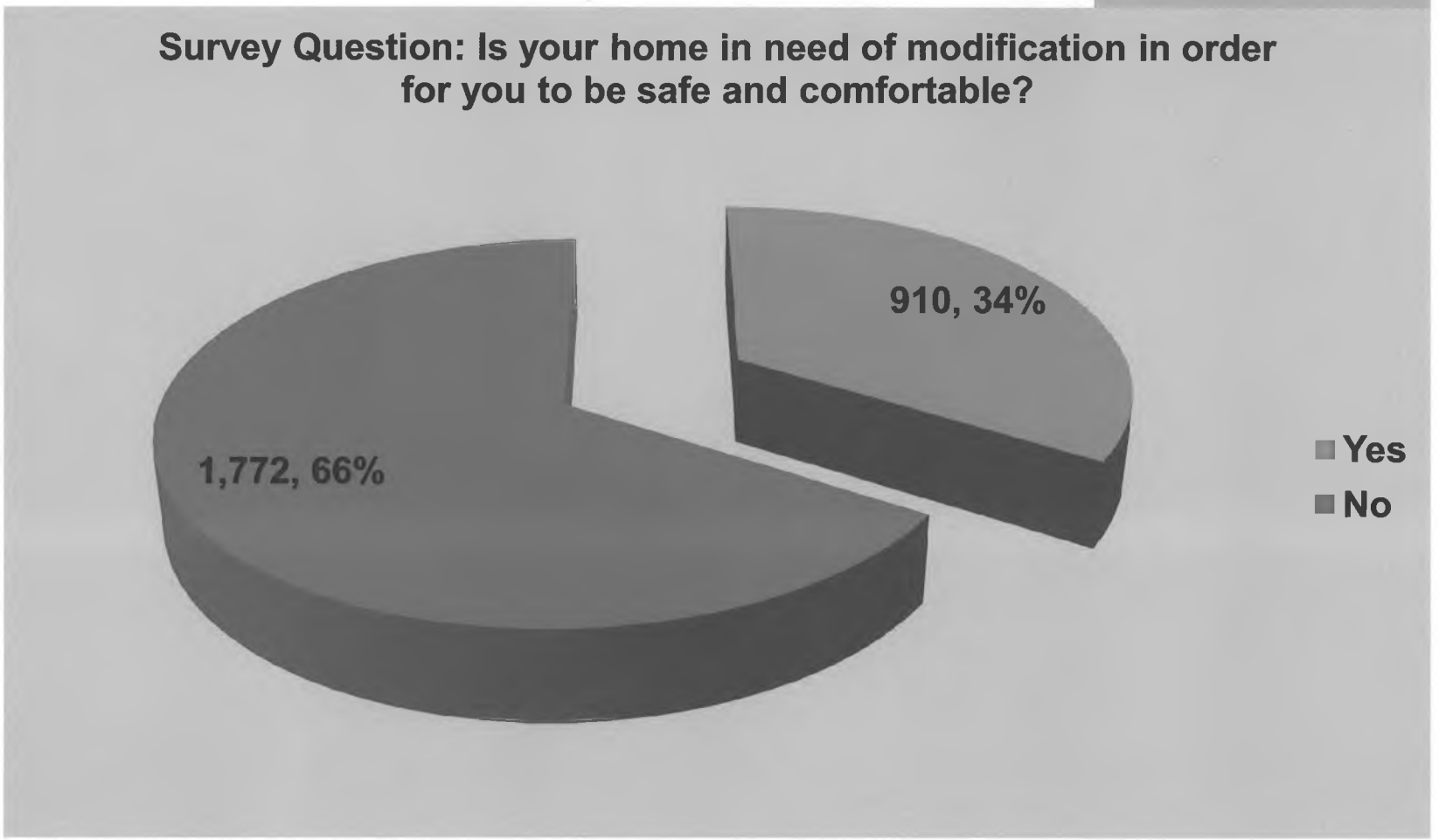
Survey Question: Do You Have an Illness or Disability?



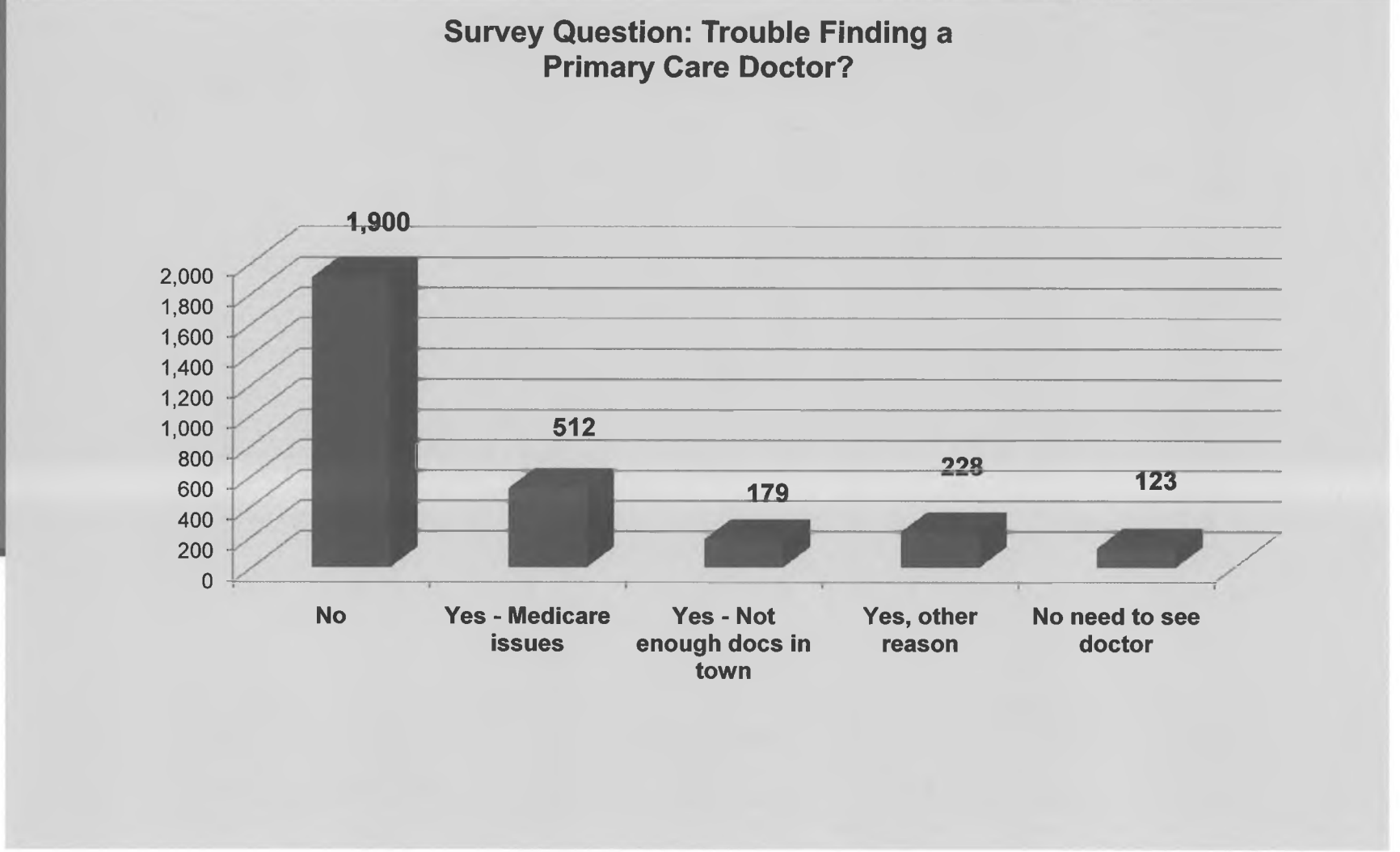
Seven out of ten responders live in a home they or a family member own. Two in ten live in a rented home or apartment.



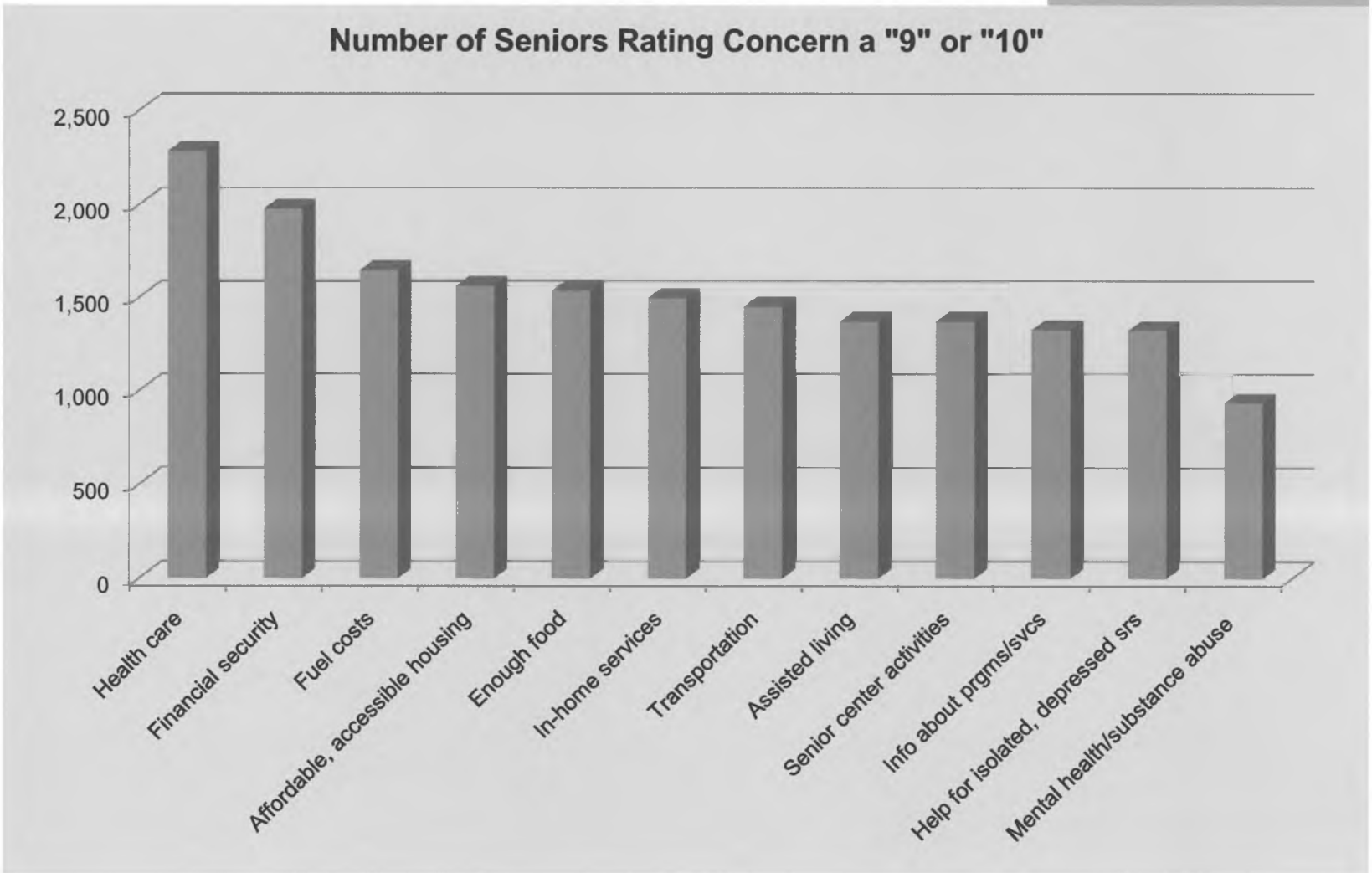
One in three seniors say their home needs some sort of modification – such as ramp installation, grab bars, or insulation – in order for them to be safe and comfortable.



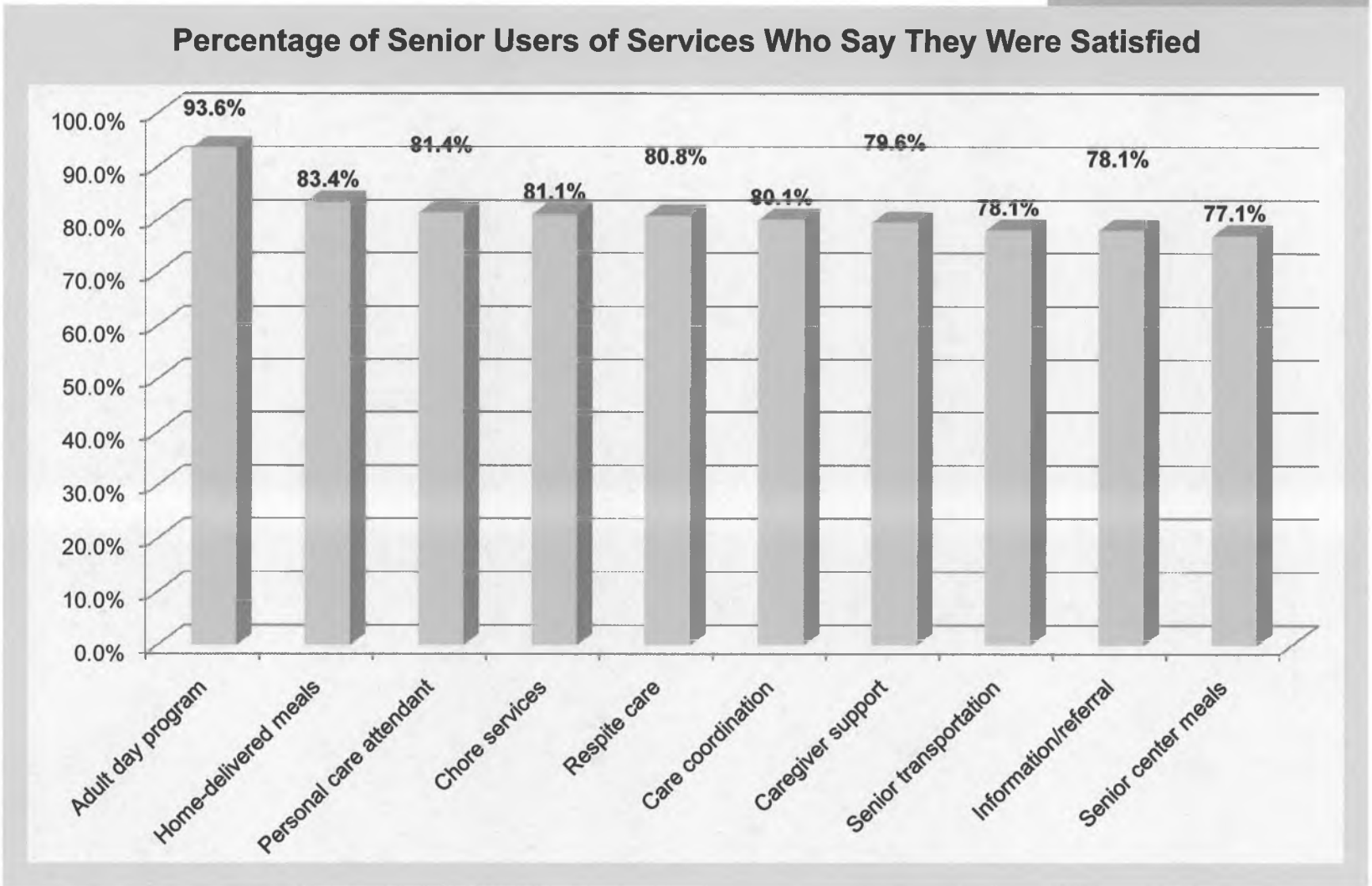
Most older Alaskans (69%) are not having trouble finding a primary care doctor. Of those who are, Medicare payment issues are the most often-cited reason.



More seniors rated "health care" and "financial security" as important issues than any other topic. These two issues were also the top concerns listed in our 2005 senior survey.



Most seniors have not used any of the available senior services. Of those who have, most are satisfied with the service they received.



Many seniors included open-ended comments on a wide range of topics.

- "Rental and fuel costs have been rising to the degree that people on fixed incomes are seriously impacted and could easily find themselves on the street. Affordable, safe housing central to businesses…is seriously needed."
- "Need assisted living in smaller communities and/or 24-hour personal care attendant services, to alleviate options of moving or nursing home."
- "They cut bus service in Chugiak. No senior transportation. If you don't drive, you stay home. Or find someone to drive you."
- "As a senior, one of the things I am most concerned about is snow and ice removal downtown and in midtown. I sometimes decide not to shop or attend an event because of treacherous conditions brought about by poor snow removal, lack of access to sidewalks, and dark conditions. Falling is terrifying; at my age, I don't bounce so good."
- "We desperately need to take care of our people. It is important that no one is left suffering, hungry, without good medical benefits. [Seniors should] have dignity without huge worries."

ELDER/SENIOR COMMUNITY FORUM RESULTS

Findings from the ACoA's elder/senior community forums held in Anchorage, Fairbanks, Juneau, Kotzebue, Bethel, and with the Alaska Native Tribal Health Consortium Elders Committee highlighted similar concerns:

- Access to primary care is limited due to Medicare and provider availability issues
- Long-term support services across the continuum of care need increased capacity, especially in rural areas that are culturally appropriate
- Expansion of the capacity, range and hours of senior transportation services
- Many communities need assisted living facilities to enable elders to remain close to home
- A centralized, one-stop-shop source of information and referral services which can direct seniors and family members to long-term care services, benefit programs, and other supports is desired

PRIORITIES FOR SENIORS' FUTURE

Future priorities for addressing senior needs and concerns include:

- Resolution of the primary care access for Medicare recipients
- Creation and implementation of a statewide long-term care plan
- Workforce development efforts to ensure that sufficient well-trained caregivers are available as the senior population expands
- Development of quality senior housing
- Expansion of community coordinated transportation
- Community prioritization of a senior-friendly environment
- Support for appropriate-scale assisted living facilities
- Adequate funding for information resources to guide seniors and their families to the services and programs available to help them
- Programs to address seniors with complex mental and behavioral health needs
- Financial assistance for seniors facing escalating costs for food, fuel, housing, and other basic life necessities.

Kotzebue Elders Community Forum
ACoA Rural Outreach Meeting, August 2009

Thank You

THE FOLLOWING DOCUMENT

HAS NOT BEEN FILMED BUT IS

AVAILABLE IN THE ORIGINAL FILE

15
Senior Property Tax Exemption

22
Health care reform 'slugfest'

NON-PROFIT
U.S. POSTAGE
PAID
ANCHORAGE, AK
PERMIT NO. 114
ISSN 0741-2894

SENIOR VOICE

Serving Older Alaskans and Their Families Since 1978

A publication of ***Older Persons Action Group, Inc.*** 325 E. Third Ave., Suite 300, Anchorage, Alaska 99501 Vol. 34 No. 2 February, 2011

Senior Benefits is a priority, legislators say

But extension of the program is not a given, advocates warn

By DAVID WASHBURN
Senior Voice

With the Alaska state legislature back in session, one issue is standing out as an immediate priority for senior advocacy groups: the state's Senior Benefits program, which provides monthly cash assistance to low-income Alaska seniors will end this summer unless legislators and the governor *agree to extend it. Bills have been introduced in* the state House and Senate to do just that.

The Senior Benefits program is the successor to the Longevity Bonus, which was halted by former Gov. Frank Murkowski and replaced with SeniorCare. That program was allowed to "sunset" in 2006 and was replaced when former Gov. Sarah Palin called a special legislative session to establish the Senior Benefits program as we know it now.

The program provides monthly cash assistance to Alaska seniors age 65 or older whose household income does not exceed 175 percent of the federal poverty guidelines. Payment amounts vary, depending on income:

- $250 per month for income of 75 percent of less of federal poverty level
- $175 per month for income between 75 and 100 percent of federal poverty level
- $125 per month for income between 100 and 175 percent of federal poverty level

More than 10,000 Alaskans currently receive payments, according to a sponsor statement by Rep. Mike Hawker, R-Anchorage, who introduced HB 16 to extend the program another four years. The bill has a host of co-sponsors, from both parties, and Hawker has said he would like it to be the first bill passed out of the House this session. Hawker authored the bill that created the Senior Benefits

page 18 please

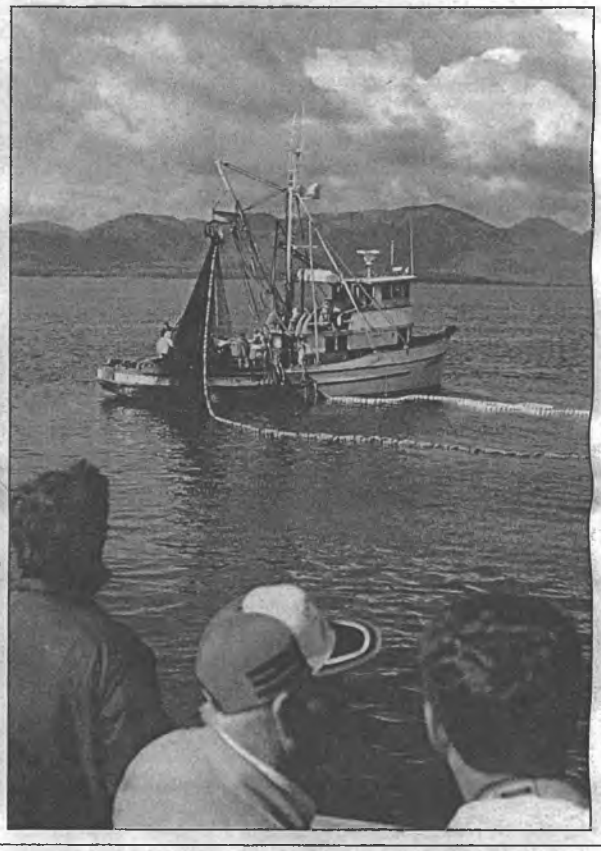
Inside

Editorials and Letters 3
Health and Medicine 5
Around the State 15
Calendar of Events 19
Tech Talk 27
Going Places 28

A good catch for nets and cameras

Fish on! In fact lots of fish on! If you would like to see and photograph the dynamic workings of Alaska salmon seiners (and other Alaska commercial fishing craft) you or visiting guests might consider booking this one-of-a-kind cruise offered by Dale Pihlman of Ketchikan. The cruise is called "Misty Fjords/ Commercial Fishing." You can do it next summer aboard his new expedition-class cruise vessel Misty Fjord. To learn about this and other innovative Pihlman cruises see Mike Miller's monthly travel column, "When Seniors Travel," on page 28.

Mike Miller photo



Survey produces wealth of information on older Alaskans

Note: The first in a series of three articles summarizing the results of a survey of older Alaskans conducted last summer and fall, this article will focus on the demographics, finances, and housing characteristics of the seniors who responded. Next month's article will explore health and service issues as reflected in the survey, and in March we'll look specifically at issues of concern for older Alaskans.

ALASKA COMMISSION ON AGING

More affordable, accessible housing and some help with living expenses would boost their quality of life, say many Alaskan seniors. In general, though, most are happy with the community in which they're living and productively engaged in volunteer work, family caregiving, and social get-togethers with family and friends.

Older Alaskans recently took the opportunity to share their candid opinions on issues ranging from health care and financial security to senior services and housing. Over 3,000 Alaskans age 50 and older completed the Alaska Commission on Aging's 2010 Survey of Older Alaskans, which was distributed in the August 2010 issue of the Senior Voice. Copies of the survey were also mailed in bulk to senior meal programs and other programs that receive federal or state grant funds. Of the total 3,222 survey responses received, 2,836 came from those aged 60 and over. That's more than twice as many responses as the Commission received to its 2005 survey, also distributed through the Senior Voice.

Why a survey?

The 2010 survey is part of an effort to gather information on senior needs as the commission

page 24 please

3/09/11 REPORT ON HOMELESSNESS: AK COALITION ON HOUSING AND HOMELESSNESS; AK HOUSING FIN CORP; NEIGHBOR WORKS ANC; RURAL CAP

<TARGET><BILL></BILL><SUBJECT>3-09-11 REPORT ON HOMELESSNESS ALASKA COALITION ON HOUSING AND HOMELESSNESS; ALASKA HOUSING FINANCE CORPORATION; NEIGHBOR WORKS ANCHORAGE; RURAL CAP</SUBJECT><COMM>SHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE

SESSION ADDRESS
Alaska State Capitol,
Room 30
Juneau, AK 99801
(907) 465-3822
Fax: (907) 465-3756

INTERIM ADDRESS
716 W. 4th Avenue,
Suite 400
Anchorage, AK 99501
(907) 269-0144
Fax: (907) 269-0148

Senator Bettye Davis
Press Release

For Immediate Release: February 28, 2011

Senator Davis Calls Meeting to Address Homelessness In Alaska

Lawmakers will take up current concerns as well as future solutions and possibilities

JUNEAU-Senator Bettye Davis, D-Anchorage, is calling on leaders and experts from around the state to come to Juneau so that Legislators can start tackling the problem of homelessness.

According to the 2009 Annual Homeless Assessment Report to Congress, Alaska has one of the top ten highest concentrations of homeless people in the nation, based on percentage of the state's total population.

From Alaska's largest urban communities to the state's smallest villages, the growing homelessness problem is something state leaders can't afford to ignore. The purpose of this meeting will be to hear concerns and statistics around homelessness and current solutions and possibilities for the future.

Some of the meeting's presenters will include representatives from the Alaska Coalition on Housing and Homelessness, the Alaska Council on the Homeless, the Alaska Housing Finance Corporation, NeighborWorks Anchorage, the Mental Health Trust, and the Rural Alaska Community Action Program (RurAL CAP).

Who: Senate Health and Social Services Committee
What: Meeting to address homelessness in Alaska
Where: Alaska State Capitol, Butrovich Room 205
When: 1:30 p.m. on Wednesday, March 9th

Anyone who can't attend the meeting in Juneau can join in by teleconference at any Legislative Information Office in their district.

For more information, please contact Celeste Hodge in Senator Davis' office at 907-465-3822.

###

Sen. Bettye Davis

From: Carolyn Kuckertz
Sent: Wednesday, March 09, 2011 12:51 PM
To: pressreleasedistribution
Subject: REMINDER: Senator Davis Calls Meeting to Address Homelessness In Alaska (1:30 this Afternoon)
Attachments: 030711_Homelessness_press_release.pdf

RECEIVED
MAR 09 2011

ALASKA STATE LEGISLATURE

Senator Bettye Davis
Press Release

For Immediate Release: March 7th, 2011

Senator Davis Calls Meeting to Address Homelessness In Alaska

Lawmakers will take up current concerns as well as future solutions and possibilities

JUNEAU-Senator Bettye Davis, D-Anchorage, is calling on leaders and experts from around the state to come to Juneau so that Legislators can start tackling the problem of homelessness.

According to the 2009 Annual Homeless Assessment Report to Congress, Alaska has one of the top ten highest concentrations of homeless people in the nation, based on percentage of the state's total population.

From Alaska's largest urban communities to the state's smallest villages, the growing homelessness problem is something state leaders can't afford to ignore. The purpose of this meeting will be to hear concerns and statistics around homelessness and current solutions and possibilities for the future.

Some of the meeting's presenters will include representatives from the Alaska Coalition on Housing and Homelessness, the Alaska Council on the Homeless, the Alaska Housing Finance Corporation, the Mental Health Trust, and the Rural Alaska Community Action Program (RurAL CAP).

Who: Senate Health and Social Services Committee
What: Meeting to address homelessness in Alaska
Where: Alaska State Capitol, Butrovich Room 205
When: 1:30 p.m. TODAY

Anyone who can't attend the meeting in Juneau can join in by teleconference (1-855-463-5009) or by attending at any Legislative Information Office in their district.

To watch this meeting live, go to http://www.aklegislature.tv

For more information, please contact Celeste Hodge in Senator Davis' office at 907-465-3822.

Celeste Hodge

From: Celeste Hodge
Sent: Monday, March 07, 2011 6:09 PM
To: Sen. Bettye Davis
Subject: Hearing on Homelessness

Senate Health and Social Services Committee Members,
Here's a rundown for Wednesday's Senate HSS committee meeting (March 9) – Homelessness presentations. Six agencies were invited to participate – see list below. The meeting will begin promptly at 1:30 PM. Thanks.

Presenters (In order of Presentation):

1. **Suzi Pearson, Alaska Coalition on Housing and Homelessness (on-line)**
2. **Dan Fauske – Chair of the Alaska Council on the Homeless (state appointed council) & CEO of AHFC and Jim Gurke of AHFC (both on-line)**
3. **Mark Romick, AHFC, and Stacy Schubert, AHFC (Voucher Program) (Juneau)**
4. **Deb Mahoney and Michael Courtney, Neighbor Works Anchorage - Affordable Housing (Juneau)**
5. **Kate Burkhart, Alaska Mental Health Board and the Advisory Board on Alcohol and Drug Abuse – (Juneau)**
6. **Kenny Scollan, Rural Cap – (Juneau)**

Focus areas for hearing on homelessness

- **Each agency will have no-more-than 15 minutes to present regardless to the number of presenters for that agency**
- **Each agency will describe what they do related to housing and homelessness**
- **Each agency will provide a description of the recipients utilizing their services (eligibility requirements, demographics, etc.)**
- **Each agency will describe the gaps or barriers to meeting the need for housing from their perspective**
- **Each agency will fully describe to the legislators specific types of support needed from the State to bridge these gaps and barriers and solve homelessness in Alaska**

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - April)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Memorandum

To: Senate Secretary

From: Senator Bettye Davis

Date: March 3, 2011

RE: Senate H&SS Committee Meetings, Week of March 7, 2011

Monday, March 7, 2011
Butrovich Room #205 1:30pm – 3:00pm

*+SB14 – PROTECT HEALTH CARE PROVIDER CONSCIENCE
*+SB5 –DENALI KIDCARE

Bills Previously Heard/Scheduled

Wednesday, March 9, 2011
Butrovich Room #205 1:30pm – 3:00pm

+Report on HOMELESSNESS

1. Suzi Pearson, Alaska Coalition on Housing and Homelessness (on-line)
2. Dan Fauske – Chair of the Alaska Council on the Homeless (state appointed council) and CEO of AHFC and Jim Gurke of AHFC (both on-line)
3. Mark Romick, AHFC, and Stacy Schubert, AHFC (Voucher Program) – Juneau
4. Deb Mahoney and Michael Courtney, Neighbor Works Anchorage - Affordable Housing (Juneau)
5. Kate Burkhart, Alaska Mental Health Board and the Advisory Board on Alcohol and Drug Abuse – (Juneau)
6. Kenny Scollan, Rural Cap – (Juneau)

Bills Previously Heard/Scheduled

Friday, March 11, 2011
Butrovich Room #205, 1:30pm – 3:00pm

NO MEETING SCHEDULED

*First Hearing
+Teleconferenced
Bills Previously Heard/Scheduled

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

AGENDA

WEDNESDAY, MARCH 9, 1:30 PM, Butrovich Room #205

1:30 PM – Call to Order

Today, we are calling on leaders and experts from around the state to provide critical information to us so we as legislators can help tackle the problem of homelessness. According to the 2009 Annual Homeless Assessment Report to Congress, Alaska has one of the top ten highest concentrations of homeless people in the nation, based on percentage of the state's total population. From Alaska's largest urban communities to the state's smallest villages, the growing homelessness problem is something we, as state leaders can't afford to ignore. The purpose of this meeting will be to hear concerns and statistics around homelessness and current solutions and possibilities for the future.

Presenters will include representatives from the Alaska Coalition on Housing and Homelessness, the Alaska Council on the Homeless, the Alaska Housing Finance Corporation, NeighborWorks Anchorage, the Mental Health Trust, and Rural Alaska Community Action Program (RurAL CAP). I'm asking members to hold all questions till the end to allow adequate time for all presenters.

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

Housing First Services for People Who Are Homeless With Co-Occurring Serious Mental Illness and Substance Abuse

Deborah K. Padgett
New York University School of Social Work

Leyla Gulcur
Sam Tsemberis
Pathways to Housing

The literature on homeless adults with severe mental illness is generally silent on a critical issue surrounding service delivery—the contrast between housing first and treatment first program philosophies. This study draws on data from a longitudinal experiment contrasting a housing first program (which offers immediate permanent housing without requiring treatment compliance or abstinence) and treatment first (standard care) programs for 225 adults who were homeless with mental illness in New York City. After 48 months, results showed no significant group differences in alcohol and drug use. Treatment first participants were significantly more likely to use treatment services. These findings, in combination with previous reports of much higher rates of housing stability in the housing first group, show that "dual diagnosed" adults can remain stably housed without increasing their substance use. Thus, housing first programs favoring immediate housing and consumer choice deserve consideration as a viable alternative to standard care.

Keywords: *homelessness; serious mental illness; dual diagnosis; psychiatric rehabilitation*

Homelessness in the United States, traceable to a famine in housing markets beginning in the early 1980s, afflicts thousands of persons who are psychiatrically disabled who lack adequate community-based care (Baumohl, 1996; Lovell & Cohn, 1998). Many are visible as they lead troubled lives on the streets; however, a growing number are likely to be incarcerated—the largest de facto psychiatric facility in the country is the Los Angeles County Jail (Butterfield, 2003). Regardless of whether the problem is viewed as one of individual pathology or systemic failure, the plight of people with mental illness and homeless remains one of the least understood and most contested service delivery problems in mental health today (Gonzalez & Rosenheck, 2002; McGray, 2004; Substance Abuse and Mental Health Services Administration [SAMHSA], 2003).

Social workers join other providers and advocates in lamenting the lack of service integration and the scarcity of resources available to meet the needs of adults who are homeless with mental illness who also abuse substances. However, the literature of social work and other professions is generally silent on a policy-relevant and practice-relevant debate surrounding service delivery for this population. The point of contention stems from fundamental differences in how people with mental illness who are homeless are viewed and in how consumer choice is defined and incorporated into a program's service delivery philosophy. Put another way, there are two contrasting paradigms in services for persons who are homeless with serious mental illness, one the traditional continuum of care approach favoring treatment first and the other a consumer-driven movement (housing first) that has gained momentum in recent years (Carling, 1990; Culhane, Metraux, & Hadley, 2001; Tsemberis, 1999).

Among a number of differences between them, a contrast of interest in this report lies in how they deal with substance abuse and whether abstinence is a precondition to independent housing and other services. Approximately 50% to 70% of persons who are homeless with mental illness abuse substances (Drake, Osher, & Wallach, 1991; SAMHSA, 2003), and these estimates are widely considered underreports because of denial, distrust, and fear of the consequences of divulging illegal behaviors (Drake, Yovetich, Bebout, Harris, & McHugo, 1997).

Housing first programs rank stable housing as the first and highest priority vis-à-vis abstinence from substance use and/or abuse, thus practicing a harm reduction approach (Inciardi & Harrison, 2000). Treatment first programs reverse this sequence and require detoxification and sobriety before giving access to services such as independent housing. For these programs, consumers'

Research on Social Work Practice, Vol. 16 No. 1, January 2006 74-83
DOI: 10.1177/1049731505282593
© 2006 Sage Publications

choice in adherence to mental health treatment and abstinence requirements must be relinquished for their own sake until they are deemed ready for independent living.

Our primary goals in this article are twofold: (a) to describe the historic development and core components of these two distinct service alternatives (treatment first and housing first) and (b) to provide findings related to substance and services use from the only randomized experiment designed to compare their effectiveness—the New York Housing Study.

BACKGROUND

The Treatment First Approach for People Who Are Homeless With Mental Illness

The era of deinstitutionalization opened the door to independent living for persons with diagnoses such as schizophrenia and bipolar disorder; however, these individuals still needed an array of support services as they made the transition from psychiatric hospital to community (Dixon, Krauss, Kernan, Lehman, & DeForge, 1995). Among these were medication management, psychological counseling, education, and job training. For a large subgroup, abuse of drugs and/or alcohol complicated matters considerably (Drake et al., 1997). Persons with mental illness who became homeless were disproportionately individuals who were "dual diagnosed" whose lives became a continual struggle to find shelter and avoid being victimized (Drake et al., 1991; Padgett & Struening, 1992).

The well-intentioned but underfunded system of public sector mental health services that evolved after the 1960s rarely interacted with drug and alcohol (D/A) treatment programs designed with clients without mental illness in mind. However, both service systems had one thing in common: They were predicated on assumptions of the need for structure and control. Different funding streams, staff expertise, and service philosophies, notwithstanding, the mental health, D/A, and homeless services systems share a "hurdle" approach in which gaining access to services requires relinquishing control and choice. In exchange for a bed and supportive services, consumers and/or clients submitted to rules requiring treatment compliance, abstinence, curfews, limited visitation, and a loss of privacy (Miller & Flaherty, 2000). From the perspective of a person who was dually diagnosed living on the street, this threshold for entry can seem daunting at best. It is also a high-stakes gamble because rule breaking usually leads to expulsion and a return to the streets.

Evaluations of treatment first programs have produced modest results in achieving housing stability (Lipton, Siegel, Hannigan, & Samuels, 2000); however, program attrition and a return to the "institutional circuit" (Hopper, Jost, Hay, Welber, & Haugland, 1997) remain a problem when trying to ascertain change over time. Recent innovations in programs designed specifically for persons with dual diagnoses have shown promising results for integrated treatment models (Drake et al., 1997; Bebout, Drake, Xie, McHugo, & Harris, 1997; Minkoff, 2001) and Double Trouble in Recovery 12-step groups (Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002). Indeed, the cumulative findings have made integrated treatment for persons who are dual diagnosed the "state of the art" in terms of effectiveness (Tsuang, Fong, & Ho, 2003).

When integrated treatment was linked to housing options in a randomized trial, positive outcomes were associated with supervised living and on-site clinical services (McHugo et al., 2004). However, no study of integrated treatment to date has tested its comparative effectiveness as part of the consumer choice model as is the focus of the current study.

Reversing the Continuum: The Pathways Model of Housing First for Adults Who Are Psychiatrically Disabled and Homeless

By the early 1990s, a consumer-centered approach surfaced that reversed the treatment first continuum. Its proponents argued for "supported housing," with tenets of consumer choice, ongoing support services, and community integration (normal housing, not "treatment" residences; Carling, 1990; Ridgeway & Zipple, 1990; Srebnik, Livingston, Gordon, & King, 1995). They described treatment first approaches as "supportive housing" with on-site (or proximal) staff and rules governing behavior ranging from curfews to visitation to abstinence. Most involve congregate living with other consumers who are homeless and function as transitional housing, that is, therapeutic environments designed to foster independent living skills enabling clients to graduate to living on their own. In contrast, housing first is a type of "supported housing" that separates treatment from housing, considering the former voluntary and the latter a fundamental need and human right. As such, it provides scatter-site housing without on-site staff supervision and generally promotes harm reduction rather than requiring abstinence.

Although confusion can arise regarding what are considered essential and defining program components in supported versus supportive housing (Fakhoury, Murray,

Shepherd, & Priebe, 2002), housing first shares a bottom-line commitment to consumer choice and to immediate and continuing access to scatter-site independent housing. To our knowledge, the agency model that is the subject of the current study—Pathways to Housing, Inc.—stands alone in embodying the following elements: (a) immediate independent permanent housing that is not contingent on treatment compliance and is retained regardless of the client's temporary departure because of inpatient treatment or incarceration; (b) choice and harm reduction with respect to mental health treatment and substance use; (c) integrated Assertive Community Treatment (ACT) services (Drake et al., 1998) that work in conjunction with housing staff and a nurse practitioner to address ongoing housing and health needs.

The New York Housing Study

With its funding of a national multisite study of housing alternatives for persons who are homeless with mental illness, the federal agency SAMHSA chose the Pathways to Housing (PTH) program as the experimental condition for the New York City site (Shern et al., 2000). The New York Housing Study (NYHS), which began in 1996, was a 4-year randomized trial comparing the PTH version of housing first with treatment first continuum of care programs in the New York City area.

Published findings from the NYHS have shown higher rates of housing stability (Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004) and cost savings (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003) for the PTH model. In addition to housing stability, the NYHS also assessed outcomes related to mental health symptoms, quality of life, drug and alcohol use, and utilization of substance abuse treatment. Analyses of the 24-month data showed no significant group differences in these outcomes with the exception of higher use of substance abuse treatment services by the control group (Tsemberis et al., 2004). The NYHS maintained a remarkable 87% retention rate of participation for 4 years (Stefancic, Shaefer-McDaniel, Davis, & Tsemberis, 2004).

In summary, the NYHS found that "a person's mental health diagnosis is not related to his or her ability to obtain or to maintain independent housing" (Tsemberis et al., 2004, p. 654). Moreover, housing such persons without requiring abstinence and sobriety did not increase their use of substances during a 2-year period despite comparatively lower levels of use of substance abuse treatment services. The control group's higher use of substance abuse services did not produce comparatively lower rates of drug or alcohol use, thus indicating that residence in "sober housing" did not produce the desired results in terms of abstinence.

In this report, we assessed substance-related and treatment-related outcomes from the full 48 months of data to determine if the previous findings are sustained or change during a much longer period of observation (4 years vs. 2 years). Thus, we address the following research questions:

Research Question 1: Are there group differences in alcohol and drug use at 48 months?

Research Question 2: Are there group differences in participation in substance abuse and mental health treatment at 48 months?

METHOD

Sampling and Recruitment

Individuals were eligible to participate in the NYHS if they signed an informed consent form (approved by federal and university Human Subjects Committees) and met three inclusion criteria. These were that the person (a) spent 15 of the last 30 days on the street or in other public places, (b) exhibited a history of homelessness during the past 6 months, and (c) had an Axis I diagnosis of severe mental illness. Although substance abuse was not a criterion for eligibility, 90% of the study participants had a diagnosis or history of alcohol or drug disorders according to clinical records. Psychiatric diagnoses were obtained from clinical records and interviews with referring providers.

Respondents were recruited from outreach teams, drop-in centers, state psychiatric facilities, psychiatric wards, and the streets. When it was determined that individuals met the inclusion criteria, they were asked if they would be interested in participating in a research study with compensation of U.S. $25 for each interview. It was further explained that based on a randomized lottery system, individuals would be referred to different housing programs in the city. Recruitment lasted from November 1997 to January 1999. The recruited sample was 225 people (99 in the experimental group and 126 in the control group) between ages 18 and 70 years.

Study Design and Description of Experimental and Control Conditions

The housing first model was developed by Pathways to Housing, Inc. (PTH) in 1992 as a consumer-driven approach to providing housing and support services to

adults who were homeless with mental illness. PTH gives immediate access to housing in independent scatter-site apartments and offers tenants an array of services through interdisciplinary Assertive Community Treatment (ACT) teams that include social workers, psychiatrists, vocational trainers, and substance abuse counselors. Two modifications of the ACT model initiated by PTH were the addition of a nurse practitioner to address health problems and a housing specialist to coordinate housing needs. As part of its vision of consumer choice, PTH does not make housing contingent on sobriety or treatment compliance. The single contingency in this model is a money management program for PTH clients who are unable to meet landlord requirements for leases (e.g., credit histories) or who are not ready to conserve resources necessary to make monthly rent payments. Because it does not refuse clients with histories of violence or incarceration, PTH has accepted and housed the most problematic among persons who are homeless with mental illness, that is, those other programs would not take or had ejected (Tsemberis, 1999).

PTH tenants who abuse drugs or alcohol are counseled by clinical services staff based on their readiness for change. Those with serious substance abuse problems are urged to accept referrals to residential treatment (and their apartments held for them or another one found when they are discharged). PTH also offers harm reduction support groups at its various branch offices. PTH clients whose substance use causes disruption face the usual consequences of a tenant in a similar situation with the exception that PTH staff will assist them in moving to another apartment if evicted.

Individuals randomly assigned to the control group were referred to usual care programs that offer abstinent-contingent housing and services based on a treatment first model. A typical program would be exemplified by a group home or a single-room occupancy residence in which clients are expected to attend day treatment, 12-step, and other therapeutic groups and follow medication regimens enforced by on-site staff. Sleeping, cooking, and bathing facilities are shared, and house rules strictly prohibit consumption of any substances and overnight guests.

During the research design phase, volunteer tenants at PTH reviewed the proposal and provided feedback. Tenants also served on the PTH Institutional Review Board (IRB) and had a voting role as to whether the project and the randomization process was fair and not harmful. Fidelity to the ACT model in the experimental condition was assessed using the Dartmouth fidelity model (Teague, Bond, & Drake, 1998) and was found to be satisfactory (Shinn, Tsemberis, & Moran, 2005).

Data Collection and Measures

A structured interview was administered at 6-month intervals for 48 months. To reduce attrition and maintain contacts, monthly 5-minute call-in interviews were conducted. Participants were paid $25 for in-person interviews (9 in all) and $5 for the monthly calls. These repeated contacts are one of the reasons for the study's high retention rate (Stefancic et al., 2004).

Because the NYHS was one of eight sites participating in a federally funded demonstration project, standardized cross-site measures were used to assess key variables.

Use of alcohol and illegal drugs. Use of alcohol and illegal drugs was assessed with the Six-Month Follow-Back Calendar (Sobell, Sobell, Leo, & Cancella, 1988). Participants reported the number of days drinks were consumed, and the number of days that certain illicit drugs were used during the 6-month period. Four summary variables were defined by the cross-site team: any use of alcohol, any use of illegal substances, heavy use of alcohol (more than 28 days in 6 months), and heavy use of drugs (more than 4 days in 6 months). Of these four variables, two (heavy use of alcohol and heavy use of drugs) were utilized in analyses for the current study.

It is possible that individuals in the treatment first programs underreport substance use differentially because these programs typically require abstinence or at least the promise of sobriety. Although such a bias would work against finding effects favoring the experimental condition, we considered this possibility of differential self-report in interpreting the findings.

Participation in substance abuse treatment. Participation in substance abuse treatment was collected through the use of a modified Treatment Services Review (McLellan, Alterman, Woody, & Metzer, 1992). Service use was computed as the average of a seven-item measure consisting of questions such as whether the participant had received treatment in a detox program or consulted with a counselor to talk about substance problems, and attended AA, NA, or any other substance abuse self-help group.

Participation in mental health treatment. Mental health service use was also collected through the modified Treatment Services Review (McLellan et al., 1992). Service use was computed as the average of a five-item measure consisting of questions such as whether the participant had received overnight treatment in a psychiatric hospital, attended a day hospital program or day

treatment center, and visited with a doctor or nurse to discuss medication or emotional problems.

For both utilization variables, the average proportion of services used is reported as the outcome of interest. A proportion of .20, for example, means that group members averaged one of a possible five "yes" answers to the mental health services measure.

Data Analyses

Checks on random assignment. A preliminary data analysis question checked on random assignment of the sample retained at each data collection point. One of the best guarantees of random assignment is a strong retention rate, which we successfully attained. We compared respondents who were and were not retained in the sample at several data collection points to see if they differed from baseline and found no differences in key demographic or other baseline variables. Because random assignment produced satisfactory equivalence of the groups, no demographic variables were used as covariates because they were not correlated with the outcomes. For this reason, we reported the demographic characteristics for the total sample rather than by group (see Table 1).

Analyses of research questions. Research Question 1 was analyzed graphically and with a growth curve model with group-by-time interactions to formally assess whether differences are changing over time, also known as hierarchical linear modeling (Bryk & Raudenbush, 1992). We created a Level-1 (repeated measures) model for the trajectory of each participant, and a Level-2 (person level) model to examine differences in experimental versus control trajectories for participants. At Level 1 (repeated measures), we estimated a regression equation for alcohol and drug use outcomes as a function of time. At Level 2 (person level), we estimated whether the intercept and growth parameters of the Level-1 models differed by group. Note that with nine points of data collection, we were able to include participants in this analysis even if they missed as many as one half of the assessments; this was an advantage of utilizing SAS Proc Mixed over repeated measures MANOVA.

Research Question 2 was tested using a sub-sample of participants who were in some type of service-related program, namely, experimental participants who were currently housed by the PTH/housing first program and control participants who reported living in one of the following places at time of the interview: supportive single-room-occupancy (SRO) hotels, drop-in centers, safe havens, detox facilities, crisis housing, intermediate care, boarding houses, transitional housing, group homes, alcohol and/or drug-free facilities, or treatment and/or recovery programs. The rationale for using this subsample for Research Question 2 was to "level the playing field" in terms of including only housed study participants—those in shelters, incarcerated, or on the streets were considered less able to avail themselves of such services. Because participants' residential status changed from one time point to the next, the subsamples also changed; we, therefore, had to conduct separate *t* tests for each time point instead of SAS Proc Mixed.

Perhaps it is not surprising to note, sample sizes varied considerably in this analysis across the nine points of data collection (every 6 months for 48 months). Thus, control group sample sizes ranged from a high of 126 at baseline to a low of 53 at 24 months. Similarly, experimental group sizes ranged from a high of 99 at baseline to a low of 35 at 12 months. In addition to the analysis decision to include only individuals who were housed at each specific time of

TABLE 1: ***Participant Characteristics***

Variable	*Number*	*Percentage*
Study group: Experimental	99	44
Control	126	56
Gender: Female	52	23.1
Male	173	76.9
Age: 18 to 30 years	43	19.1
31 to 40 years	62	27.6
41 to 50 years	68	30.2
51 to 60 years	41	18.2
61 to 70 years	11	4.9
Race: White	63	28
African American	90	40
Hispanic American[a]	33	14.7
Mixed and/or other[a]	39	17.3
Education: Some high school or less	94	42
High school diploma or GED Equivalent	55	24.6
Postsecondary education	75	33.5
Marital status: Married	8	3.6
Separated[b]	20	8.9
Divorced[b]	32	14.3
Widowed[b]	9	4
Never married[b]	155	69.2
Residence at baseline: Streets/subway/drop-in[v]	114	50.7
Shelter and/or safe haven[v]	14	6.2
Crisis housing with family and/or friends[d]	11	4.9
Psychiatric hospital	80	35.6
Hotel and/or motel[d]	5	2.2
Short-term transitional housing[d]	1	.4
Psychiatric Diagnosis: Psychosis	121	53.8
Bipolar Disorder	30	13.3
Major Depression	32	14.2
Other[e]	10	4.4
Missing[e]	32	14.2

NOTE: Some percentages do not add up to 100% due to rounding error. Categories with the same superscripts were combined for analysis of group differences.

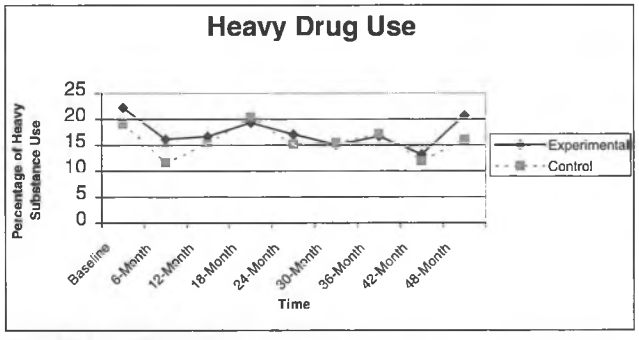


Figure 1: Heavy Drug Use, Baseline to 48 Months

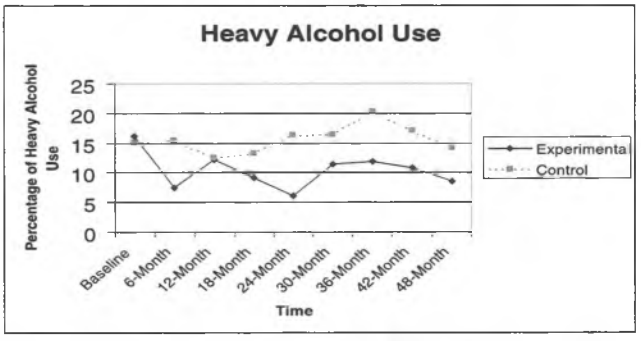


Figure 2: Heavy Alcohol Use, Baseline to 48 Months

data collection, samples were reduced because of study dropout, no-shows, incarceration, or other forms of institutionalization. PTH (experimental) participants were not considered "housed" if they were institutionalized even though they had access to housing on discharge. Because of these multiple group comparisons, a more conservative significance level was applied using a Bonferroni-corrected alpha of .006.

RESULTS

Description of the Study Sample

As can be seen in Table 1, the sample consisted of 173 men (76.9%) and 52 women (23.1%) with an average age of 41.5 years. Most of the participants (69.2%) had never been married. Sixty-three (28%) participants identified their race as White, and 90 (40%) identified their race as African American. Twenty-three (10.3%) participants did not go beyond eighth grade in their education. Among Axis I diagnoses, psychotic disorders were dominant (53.8%).

Thirty nine (17.6%) of the participants reported becoming homeless before age 18 yrs. The average age at which participants reported experiencing homelessness for the first time was 29.5 yrs (age range was 5 to 64 yrs). The longest period of time homeless was an average of 4.4 years with a median of 3 years. The majority (50.1%) of the participants lived on the streets or public place or in a drop-in shelter at time of the baseline interview, and 36% (n = 81) were living in a psychiatric hospital. According to their psychosocial histories, 90% had substance use disorders either in the past or currently. At the study's end at 48 months, housing first clients were stably housed 75% of the time during the previous 6 months compared to 50% of the time for treatment first clients (L. Gulcur, personal communication, July 25, 2005).

Group Differences in Alcohol and Drug Use

To answer Research Question 1, SAS Proc Mixed was utilized to test whether there were changes in reported drug and alcohol use over time. Because of low reported levels of drug and alcohol use, the "heavy use" variables were analyzed and predicted by time, group assignment, and the Time × Group Assignment interaction. As can be seen in Figures 1 and 2, none of the parameters were significant: Reports of drug use remained constant during the 48 months of the evaluation project, the groups did not differ from each other, nor were there differences in their rates of change over time. The same predictors were used to examine change in alcohol use over time, and again, none of the parameters were significant. However, there was a visual trend indicating that the PTH group used less alcohol than the control group.

Group Differences in Substance Treatment and Psychiatric Services Utilization

Substance treatment utilization showed notable differences at 6 months (p = .012), 18 months (p = .021), 24 months (p = .025), 36 months (p = .006) and 48 months (p = .014) with the control group members showing higher utilization (see Figure 3). With the Bonferroni correction, these differences were significant only at 36 months. Control groups members were somewhat higher utilizers of mental health treatment though the differences were statistically significant only at 48 months (p = .003; see Figure 4).

Discussion

The above results extend those cited earlier (Tsemberis et al., 2004) to an additional 2 years of data collection. We

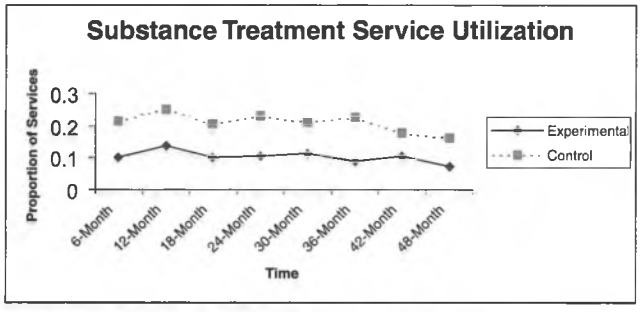


Figure 3: Substance Treatment Service Utilization, Baseline to 48 Months

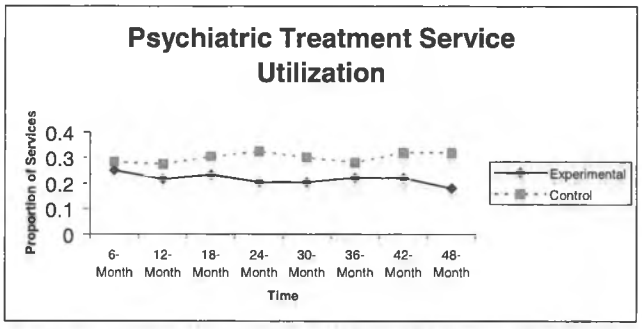


Figure 4: Psychiatric Treatment Service Utilization, Baseline to 48 Months

note the continued absence of group differences in alcohol and drug use, though with a nonsignificant trend toward lower alcohol use by the housing first group. The lack of compliance with sobriety requirements by a significant proportion of the treatment first group—now extending to 4 years' duration—is an indication that such strictures fall short in bringing about abstinence among consumers whose primary need is for housing (Watkins, Shaner, & Sullivan, 1999). Although substance use was almost certainly underreported by members of both groups, it is likely to be greater among those in treatment first because the adverse consequences of any admission of substance use are greater for them.

The treatment first group's higher use of substance abuse treatment services during the 48 months of the study must be considered in this context in which service use is linked to housing. It is not unusual to see clients continue to use drugs or drink surreptitiously even while attending treatment groups (Wolford et al., 1999). Our findings that treatment first clients did not reduce substance use and had comparably greater use of substance abuse and mental health services underscore this possibility.

Access to and availability of such services might influence these findings aside from program philosophies and requirements. However, it is useful to distinguish between services that are available versus those that are required. Housing first participants had an array of services available to them but were not required to use them. Control participants were required to use certain services (e.g., detox, 12-step groups, day treatment) to maintain their housing and presumably had access to them. Given the systemic factors influencing an individual's ability and willingness to seek help for mental health and substance abuse problems, our findings of "no significant difference" in substance use despite lower treatment service utilization and no program-specific restraints on substance use connotes clinical and programmatic significance favoring the housing first approach.

Limitations of the Study and Implications for Future Research

Despite a rigorous experimental design, low attrition rate and the use of standardized measures known for their reliability among persons who are homeless with mental illness, the current study is subject to concerns about accuracy in recall and social desirability bias. Such concerns are common to studies using self-report measures (Calsyn, Morse, & Klinkenberg, 1997) but are especially pertinent given the complex interplay of mental symptoms, drug effects (illicit and prescribed), and the severe deprivations of homelessness. If a man who is homeless is taken to a hospital emergency room disheveled, incoherent, and violent, he could be psychotic, high, or both. When it comes to substance abuse and psychiatric medication adherence, study participants may have a number of reasons for memory loss, misunderstanding Likert-type questions, or deliberately misleading researchers (Wolford et al., 1999).

In the current study, the thresholds selected as indices of a substance abuse problem do not necessarily square with providers' perceptions (Drake et al., 1991) nor should they be construed as clinically significant. In addition, the lower overall rates of substance use reported in this sample do not conform to estimates from previous sources. It is possible that this discrepancy is because of measurement bias or deliberate underreporting. As well, previous estimates may have been higher because of their reliance on persons who were dually diagnosed and homeless rather than those enrolled in services as in the current study. The absence of verification measures (e.g., urine toxicology tests) makes it impossible to draw definite conclusions about these reported rates.

Concerns about inaccuracies in detecting substance use are widespread in research dealing with problems of persons with severe mental illness. Yet Wolford et al. (1999) were surprised to find that self-report was superior to laboratory tests and clinical exams in a controlled evaluation of detection methods with this population. Although beyond the scope of this article, methodological problems related to accuracy in detecting and diagnosing substance abuse continue to challenge clinicians and researchers alike (Calsyn et al., 1997; Wolford et al., 1999). The current study's reliance on psychosocial histories and clinic records, rather than formal *DSM* diagnoses (Axis I or II) limits our capacity to analyze or compare findings based on *DSM* criteria. However, we are reasonably certain that the Axis I eligibility criteria were met.

Given the unquestionable negative effects of drug and alcohol abuse on rehabilitation of persons with mental illness, it is imperative that researchers pursue a number of avenues for understanding the beginning and ending of substance abuse among individuals in this population (Hohmann & Shear, 2002; Ridgway, 2001). To this end, the NYHS investigators and the first author have embarked on a longitudinal qualitative study designed to address this gap in knowledge by asking consumers about their histories of substance use and experiences in the service delivery system.

Beyond methodological improvements, future research is needed on supported housing in general (and housing first programs in particular) to compare outcomes across different settings and geographic areas (Mares, Kasprow, & Rosenheck, 2004). Currently, the PTH program is being replicated in a number of cities (Anderson, 2005), and plans for formal evaluations of the replicated model are under way.

Implications for Practice and Policy

The results of the current study show that individuals with severe mental illness and substance use problems do not have to undergo mandatory treatment to be able to live independently in the community. Moreover, consumer-driven programs that practice housing first and harm reduction are not linked to increased substance use despite the absence of restrictions. The current study has also revealed consistent (and probably underreported) use of illicit substances by individuals enrolled in treatment first programs despite abstinence requirements.

Our findings have distinct relevance for practitioners charged with engaging and retaining clients who are homeless with mental illness in care. Thus, the one-size-fits-all assumption that mental disorders and homelessness cannot be addressed until a client is clean and sober is no longer valid. Indeed, engagement and retention may be far more effective when clients who are dually diagnosed are able to actively participate in their own treatment decisions.

Yet long-held beliefs are difficult to change. Research has shown that consumers who are dually diagnosed and homeless prefer independent living while clinicians recommend supervised congregate housing (Schutt, Weinstein, & Penk, 2005; Watkins et al., 1999). Although the landscape of mental health and homeless policies is continually changing (McGray, 2004), there is a marked lag in implementation of empirical findings in policy and practice (Tsuang et al., 2003). Even individual components taken separately from housing first "packaging" (e.g., harm reduction and integrated treatment) remain far less common than treatment first and abstinence-oriented approaches. Organizational cultures, funding streams, and a conservative sociopolitical climate present obstacles to change and have the ultimate impact of restricting consumer choice (Tsuang et al., 2003).

As part of a federally funded national demonstration project, the NYHS was intended to inform housing and treatment policies for this deeply vulnerable population. Millions of public and private dollars are spent each year on treatment for persons with mental illness, and services for persons who are homeless have expanded exponentially (McGray, 2004). For example, the New York State Office of Mental Health has an annual budget of $5.6 billion, yet a small fraction (about $6.5 million) is dedicated to supported housing initiatives.

Further support for housing first approaches comes from comparative cost analyses. A groundbreaking study released in 2001 documented substantial cost savings from community-based care compared to shelters, jails, and hospital beds (Culhane et al., 2001). Because "community-based care" encompasses many noninstitutional approaches, future policy decisions to redirect public funds toward more effective alternatives will invariably also consider costs. Annual per capita costs of the PTH program are $22,500 compared with $40,000 to $50,000 for treatment first congregate housing programs, $85,000 for a jail bed, and $175,000 for a state psychiatric hospital bed (Anderson, 2005).

Social work practitioners, policy makers, and educators can benefit from these findings as some of the strongest support for "evidence-based practice" in housing and services for persons who homeless with mental illness. As the largest single group of mental health practitioners

and a significant part of the substance abuse treatment workforce, social workers play a critical role in implementing best practices for this vulnerable population.

Heartened by results showing that housing first leads to residential stability even for those considered least capable of benefiting, we end on a note of optimism that future research will shed additional light on the complex dynamic surrounding decisions of individuals who are homeless about substance use and the many other dimensions of successful recovery from mental illness. In this context, program philosophies favoring choice over restrictions and empowerment over compliance deserve consideration as not only effective but humane.

REFERENCES

Anderson, L. (2005, June 20). A reverse approach to homelessness [Electronic version]. *Baltimore Sun*, p. 1A.

Baumohl, J. (Ed.). (1996). *Homelessness in America*. Phoenix, AZ: Oryx.

Bebout, R. R., Drake, R. E., Xie, H., McHugo, G. J., & Harris, M. (1997). Housing status among formerly homeless dually diagnosed adults. *Psychiatric Services*, *48*(7), 936-942.

Bryk, A. S., & Raudenbush, S. W. (1992). *Hierarchical linear models: Applications and data analysis methods*. Newbury Park, CA: Sage.

Butterfield, F. (2003, October 22). Study finds hundreds of thousands of inmates mentally ill. *The New York Times*, p. A1, A7.

Calsyn, R. J., Morse, G. A., & Klinkenberg, W. D. (1997). Reliability and validity of self-report data of homeless mentally ill individuals. *Evaluation and Program Planning*, *20*, 47-54.

Carling, P. J. (1990). Major mental illness, housing, and supports: The promise of community integration. *American Psychologist*, *45*, 969-975.

Culhane, D. P., Metraux, S., & Hadley, T. (2001). The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections, and emergency shelter systems: The New York-New York Initiative. *Housing Policy Debate*, *5*, 107-140.

Dixon, L. B., Krauss, N., Kernan, E., Lehman, A. F. & DeForge, B. R. (1995). Modifying the PACT model to serve homeless persons with severe mental illness. *Psychiatric Services*, *46*, 684-688.

Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., et al. (1998). Assertive community treatment (ACT) for persons with co-occurring severe mental illness and substance use disorder. *American Journal of Orthopsychiatry*, *68*, 201-215.

Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist*, *36*, 1149-1158.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. (1997). Integrated treatment for dually diagnosed adults. *Journal of Nervous and Mental Disease*, *185*(5), 298-305.

Fakhoury, K. H., Murray, A., Shepherd, G., & Priebe, S. (2002). Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology*, *37*, 301-315.

Gonzalez, G., & Rosenheck, R. A. (2002). Outcomes and service use among homeless persons with serious mental illness and substance abuse. *Psychiatric Services*, *43*(4), 437-446.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. *Journal of Community and Applied Social Psychology*, *13*, 171-186.

Hohmann, A. H., & Shear, M. K. (2002). Community-based intervention research: Coping with the "noise" of real life in study design. *American Journal of Psychiatry*, *159*, 201-207.

Hopper, K., Jost, J., Hay, T., Welber, S., & Haugland, G. (1997). Homelessness, severe mental illness and the institutional circuit. *Psychiatric Services*, *48*, 659-665.

Inciardi, J. A., & Harrison, L. D. (2000). *Harm reduction: National and international perspectives*. Thousand Oaks, CA: Sage.

Lipton, F. R., Siegel, C., Hannigan, A., & Samuels, J. B. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services*, *51*, 479-486.

Lovell, A. M., & Cohn, S. (1998). The elaboration of "choice" in a program for homeless persons labeled psychiatrically disabled. *Human Organization*, *57*, 8-20.

Mares, A. S., Kasprow, W. J., & Rosenheck, R. A. (2004). Outcomes of supported housing for homeless veterans with psychiatric and substance abuse problems. *Mental Health Services Research*, *6*(4), 199-211.

McGray, D. (2004, June). The abolitionist: Bush's homelessness czar has some new ideas. *Atlantic Monthly*, *101*, 36–39.

McHugo, G. J., Bebout, R. R., Harris, M., Cleghorn, S., Herring, G., Xie, H., et al. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, *30*(4), 969-982.

McLellan, A. T., Alterman, A. L., Woody, G. E., & Metzer, D. (1992). *Treatment services review*. Philadelphia: University of Pennsylvania.

Miller, N. S., & Flaherty, J. A. (2000). Effectiveness of coerced addiction treatment (alternative consequences): A review of clinical research. *Journal of Substance Abuse Treatment*, *18*, 9-16.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, *52*, 597-599.

Padgett, D. K., & Struening, E. L. (1992). Victimization and traumatic injuries among the homeless: associations with alcohol, drug, and mental problems. *American Journal of Orthopsychiatry*, *62*, 525-534.

Ridgeway, P. (2001). Restorying disability: Learning from first-person narratives of recovery. *Psychiatric Rehabilitation*, *24*, 335-343.

Ridgeway, P., & Zipple, A. M. (1990). The paradigm shift in residential services: From the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal*, *13*, 11-31.

Schutt, R. K., Weinstein, B., & Penk, W. E. (2005). Housing preferences of homeless veterans with dual diagnoses. *Psychiatric Services*, *56*(3), 350-352.

Shern, D. L., Tsemberis, S., Anthony, W., Lovell, A. M., Richmond, L., Felton, C. J., et al. (2000). Serving street-dwelling individuals with psychiatric disabilities: Outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health*, *90*, 1873-1878.

Shinn, M., Tsemberis, S., & Moran, L. (2005). *Fidelity outcomes for a consumer preference living model of housing*. Manuscript in preparation.

Sobell, L. C., Sobell, M. B., Leo, G. L., & Cancella, A. (1988). Reliability of a timeline method: Assessing normal drinkers' reports of

recent drinking and a comparative evaluation across several populations. *British Journal of Addiction*, *83*, 393-402.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal*, *31*, 139-152.

Stefancic, A., Shaefer-McDaniel, N., Davis, A., & Tsemberis, S. (2004). Maximizing follow up of adults with histories of homelessness and disabilities. *Evaluation and Program Planning*, *27*, 433-442.

Substance Abuse and Mental Health Services Administration. (2003). *Report to Congress on the prevention and treatment of co-occurring substance use disorders and mental disorders*. Washington, DC: U.S. Department of Health and Human Services.

Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, *68*, 216-232.

Tsemberis, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology*, *27*, 225-241.

Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services*, *51*, 487-493.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, *94*, 651-656.

Tsuang, J. W., Fong, T. W., & Ho, A. P. (2003). Dual diagnosis and treatment compliance. *Psychiatric Services*, *54*(4), 576.

Watkins, K. E., Shaner, A., & Sullivan, G. (1999). The role of gender in engaging the dually diagnosed in treatment. *Community Mental Health Journal*, *35*(2), 115-125.

Wolford, G. L., Rosenberg, S. D., Drake, R. E., Mueser, K. T., Oxman, T. E., Hoffman, D., et al. (1999). Evaluation of methods for detecting substance use disorder in persons with severe mental illness. *Psychology of Addictive Behaviors*, *13*(4), 313-326.

CONTACTS :

Carol Vieira, Burness Communications, 401-714-0821

Prabhu Ponkshe, Substance Abuse Policy Research Program, 703-918-4860

Embargoed by JAMA: 4:00 p.m., Eastern, March 31, 2009

HOUSING FOR HOMELESS ALCOHOLICS CAN REDUCE COSTS TO TAXPAYERS

JAMA study finds drinking goes down even if residents are allowed to drink

Seattle, WA, March 31- Providing housing and support services for homeless alcoholics costs taxpayers less than leaving them on the street, where taxpayer money goes towards police and emergency health care. Stable housing also results in reduced drinking among homeless alcoholics, according to a Seattle-based study published today in the *Journal of the American Medical Association (JAMA)*.

The study found that the program saved taxpayers more than $4 million dollars over the first year of operation. During the first six months, even after considering the cost of administering housing for the 95 residents in a Housing First program in downtown Seattle, the study reported an average cost-savings of 53 percent -- nearly $2,500 per month per person in health and social services, compared to the costs of a wait-list control group of 39 homeless people.

"Our study suggests that homeless alcoholics who qualify to take part in Housing First can stay out of jails and emergency rooms, and cost the taxpayer a lot less money as a result," said Mary E. Larimer, PhD, professor of psychiatry and behavioral sciences and adjunct professor of psychology at the University of Washington and lead author of the study. "We also found that these benefits increase over time and that they are possible without requiring that participants stop drinking. And yet, the longer the participants stay in the housing program, the less they drink."

"The Housing First model was developed in response to the problem of long-term homelessness among those living with severe mental illnesses and substance abuse problems," said William G. Hobson, a co-author on the JAMA paper and executive director of Downtown Emergency Service Center in Seattle. "In most US cities, people with behavioral health disabilities die on the streets far more frequently than any other subset of the homeless population. Before they die, they use large amounts of taxpayer-funded services in our healthcare and criminal justice systems. The housing program, known in Seattle as the 1811 Eastlake project, was created to stabilize people and stop them from endlessly cycling through emergency rooms, prisons and other crisis institutions, reducing the amount of taxpayer money spent on them."

The Housing First approach offers stable housing to chronically homeless, alcohol-dependent individuals without requirements of abstinence or treatment. It is being implemented in major cities throughout the United States. Initiatives that have adopted the comprehensive model have been criticized for allowing enrollees -- virtually all with severe substance abuse problems -- to continue to consume alcohol in their new quarters. The 1811 Eastlake study, funded by the Substance Abuse Policy Research Program (SAPRP) of the Robert Wood Johnson Foundation,

[redacted]

represents the first US controlled assessment of the effectiveness of Housing First specifically targeting chronically homeless alcoholics.

Researchers began enrolling people for the study and the control group in November 2005 and finished in March 2007. A list of the most expensive homeless users of health and social services in the community provided the target population from which participants were drawn.

"These findings suggest that stable housing provided to people who are still drinking and addicted to alcohol can reduce their use of crisis services and ultimately their consumption of alcohol," Larimer said, noting that virtually every person invited to participate had agreed to enroll. The study also notes that restrictions on the consumption of alcohol in a housing environment may well prevent those most in need from accepting help.

The wait-list comparison study lasted six months, comparing usage of health and social services of participants in the program to those in the control group. But researchers also followed the enrollees for another six months, looking at the trend in alcohol consumption among residents and comparing their use of services to levels in the year before they enrolled in Housing First. After one year in the program, the 95 participants had reduced total costs relating to their care by more than $4 million compared to the year before.

"Each of them had cost state and local governments an average of $86,062 per year before being housed, compared to an average of $13,440 it costs per person per year to administer the housing program," Larimer said.

In assessing utilization and cost of services, the researchers collected data from jail bookings, days incarcerated, shelter and sobering center use, hospital-based medical services, publicly-funded alcohol and drug detoxification and treatment, emergency medical services, and Medicaid-funded services.

Because healthcare and criminal justice system costs for the participants continued to decrease over time, as did their alcohol use, Larimer says, she and her co-authors concluded that permanent housing may be necessary in order to take full advantage of the cost-savings identified in the study. The authors concluded that several factors were key to the success of the program, including the decision to limit rules and regulations on residents, and to provide them with supportive case managers, as well as easy access to providers of mental health and health care services within the housing program.

The authors started with a list of 388 of the most expensive users of hospitals, jails and sobering centers. The study enrolled every willing candidate until the downtown apartment building was filled up. Hobson said "we only had to offer housing to 79 people to get 75." The waiting list was comprised of others who also wanted the housing.

The Substance Abuse Policy Research Program (www.saprp.org) of the Robert Wood Johnson Foundation funds research into policies related to alcohol, tobacco and illegal drugs.

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For

more than 30 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves, helping Americans lead healthier lives and get the care they need. The Foundation expects to make a difference in our lifetime. For more information, visit www.rwjf.org .

About SAPRP | P: 336.286.4414 | F: 336.286.4550
SAPRP . One Leadership Place . Greensboro, NC 27410 . saprp@ccl.org

Additional Information on Homelessness Visit the Following Sites:

National Alliance on Ending Homelessness
http://www.endhomelessness.org/

Corporation for Supportive Housing
http://www.csh.org/index.cfm?nodeid=81

SAMHSA-Homeless Resource Center
http://homelessness.samhsa.gov/

Alaska Scorecard
http://www.hss.state.ak.us/dhcs/healthplanning/scorecard/assets/scorecard.pdf

Common Ground: Prioritizing housing using the Vulnerability Index,
http://www.commonground.org/?page_id=789

100,000 homes campaign
http://100khomes.org/

Innovative Services for Alaska's Homeless Persons with Mental Illness
Alaska Federation of Natives
Submitted to the Center for Substance Abuse Treatment
(Bernard Segal, PH.D., Center for Alcohol and Addiction Studies, UAA, 2003)
http://www.ahfc.state.ak.us/iceimages/homeless/homeless_progress_report.pdf

Alaska Prisoner Reentry Task Force Five-Year Prisoner Reentry Strategic Plan, 2011-2016
http://www.correct.state.ak.us/corrections/commish/docs/StrategicPlan.pdf

DESC-Seattle's Successful Housing First Model 1811 Eastlake
http://www.seattle.gov/housing/homeless/HousingFirst.htm

DESC- Vulnerability Assessment Tool

http://www.desc.org/vulnerability.html

Domestic Violence and Homelessness
http://www.aclu.org/FilesPDFs/housing%20paper.4.pdf
http://www.nlchp.org/content/pubs/Some%20Facts%20on%20Homeless%20and%20DV.pdf
http://www.endhomelessness.org/content/article/detail/1647

National Low Income Housing Coalition
http://www.nlihc.org/template/index.cfm

Alaska Coalition on Homelessness
http://akcoalition.com/index.html
Juneau Homeless Coalition
http://www.jedc.org/housing-coalition.shtml

Anchorage Coalition on Homelessness
http://www.anchoragehomeless.org/

Alaska Council on the Homeless
http://www.ahfc.state.ak.us/homeless/homeless.cfm

KTUU- Stones in the Backpack: The Burden of Teen Prostitution in Alaska
http://www.ktuu.com/news/stonesinabackpack/

Rural Alaska Community Action Program, Inc

Anchorage Services Division

MARCH, 2011

Homeward Bound

RurAL CAP's Anchorage Services Division provides services to chronic homeless alcoholics, many of whom have severe mental health and substance abuse problems. Homeward Bound is one of only a few programs in the United States with such comprehensive services as outreach, transitional housing in a 25-bed facility, intensive case management, employment assistance, and public education. In addition, the Anchorage Services Division provides Affordable Housing to low-income people in Anchorage and graduates of transitional housing programs, such as Homeward Bound. It does this by collaborating with a network of housing and alcohol treatment service providers and building and maintaining strong partnerships and linkages. The Anchorage Services Division also serves individuals and families experiencing income limitations by providing affordable housing.

AVERAGE HOMEWARD BOUND RESIDENT

- **78% Alaska Native Male**
- **10 or more years homeless**
- **29 years as an alcoholic**
- **15 or more pickups by Community Patrol in the last year**

Affordable Housing

The philosophy behind the Affordable Housing program is to provide high-quality, affordable housing to formerly homeless, special needs and low income people who "fall through the cracks" after leaving transitional housing and are at risk of becoming homeless again if they cannot obtain permanent housing. Our approach to property management emphasizes personal responsibility, assisting tenants in obtaining supportive services from third-party providers when needed and not judging tenants on past behaviors. We involve tenants in improving and maintaining the property and in reinforcing security and a sense of community.

Housing First

A Housing First approach rests on the belief that helping people access and sustain permanent, affordable housing should be the central goal of our work with people experiencing homelessness. By providing housing assistance, case management and supportive services responsive to individual needs after that individual is housed, communities can significantly reduce the time people experience homelessness and prevent further episodes of homelessness. A central tenet of the Housing First approach is that social services to enhance individual well-being can be more effective when people are in their own home.

For More Information

Melinda Freemon
Director

Ken Scollan
Division Manager

(907) 279-7535

Identifying & Filling The Need

1965

- *RurAL CAP Established*
- *Alaska's only CAP agency*

1997

- Homeward Bound implemented

1999

- Affordable Housing implemented
- 3 Affordable Housing Properties purchased

2001

- 2 Additional Affordable Housing properties purchased

2005-06

- 3 Affordable Housing properties purchased
- Properties grow to 40 units

Affordable Housing Properties: N. Bliss (far left), Tarwater (above and left), Bragaw St. (upper right) & (NSP) Huntsman Dr. (right)

2008

- Special Needs Housing Grant (SNHG) awarded
- First Affordable Housing (SNHG) property purchased
- First Residential Services Specialist

SNHG properties Peterkin Ave. (above), Davis St. (below), & N. Lane (right)

2009

- 2 Additional Affordable Housing (SNHG) properties purchased
- Neighborhood Stabilization (NSP) Grant Awarded
- First NSP construction property purchased

Recently constructed NSP 7-unit property on Medfra St. (right)

2010

- 1 NSP renovation property purchased
- Large capacity Housing First property purchased – Karluk Manor

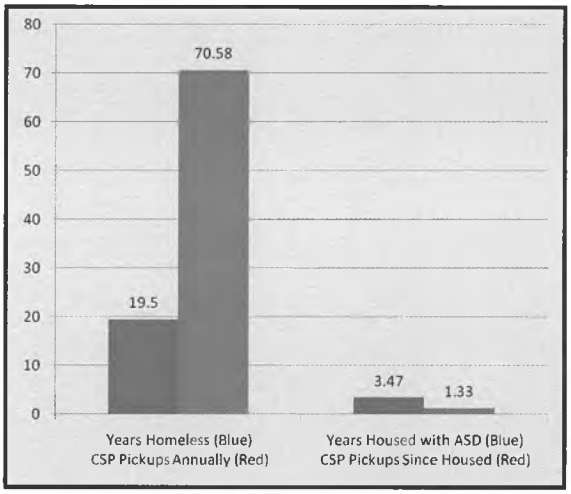
2011

- Karluk Manor renovation project

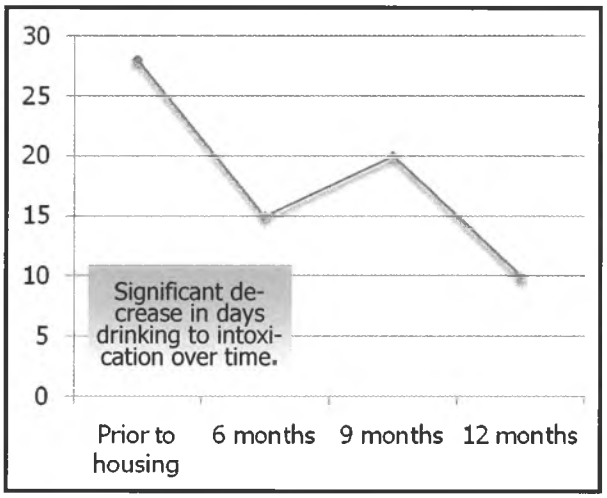
North (above) & South (below) wings of Karluk Manor

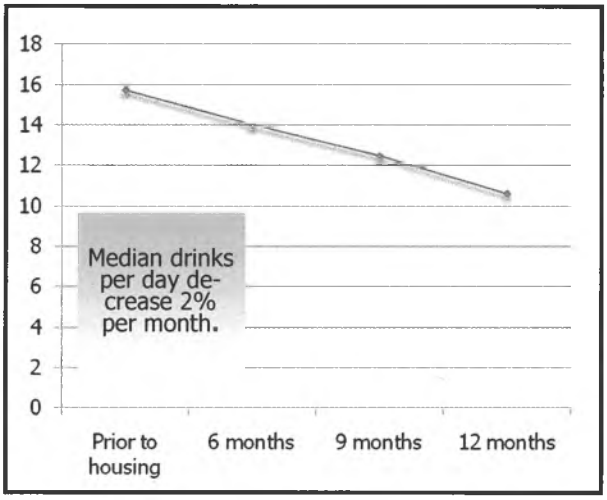
Staying Off The Streets

Tenant	Years Homeless	Average CSP calls (annual)	Years in ASD Housing	Average of CSP calls since Housed (annual)
T.A.	25	103	0.25	0
R.A.	15	41	0.5	5
S.M.	18	10	1	0
D.K.	7	18	1.5	0
F.E.	21	46	2	0
I.S.	11	72	2	0
L.O.	40	15	2.5	1
P.K.	19	284	2.5	10
E.L.	17	40	3.5	0
V.N.	6	109	4	0
M.E.	46	45	5	0
E.Q.	8	55	9	0
O.H.	12	81	10	0



Anchorage Services Division Housing Statistics (left and above)
1811 Eastlake-Housing First Statistics (below)





Success Stories

Elsie had been living on the streets, since she was 12 years old. Abusing drugs and alcohol, she found her way to Homeward Bound. After graduating from the program, Elsie moved into an affordable housing apartment in Mt. View where she continues to maintain her housing.

Paul, Homeward Bound's first graduate, has been sober for over 9 years. Due to his alcohol use, Paul began to have difficulty holding down jobs and maintaining a stable home. Today Paul has a steady income, a home, a vehicle and the pride of many accomplishments. Homeward Bound is proud to feature Paul in the statewide educational campaign entitled, "You Know Me."

RurAL CAP HB

Anchorage Services Division

120 North Hoyt Street
Anchorage, AK 99508
Phone: (907) 279-7535
Fax: (907) 279-9428
E-mail: mfreemon@ruralcap.com
www.ruralcap.com

"Healthy People, Sustainable Communities, Vibrant Cultures"

2005 SAMHSA Exemplary Program Award

John J. Gunther Blue Ribbon Best Practices Award, HUD

Drucker Foundation, Best Practices

Recognized as an Alaskan promising practice in 2006

Funded By:

Residential Services Specialists: The Heart of Special Needs Housing

The Anchorage Services Division receives funding through the Alaska Housing Finance Corporation for the Special Needs Housing Grant (SNHG). In conjunction with the Alaska Mental Health Trust Authority, this grant provides funding to develop housing for people who otherwise would be homeless.

2010 saw the increase of Anchorage Services Division Special Needs properties (3726 Peterkin St. and 100 Davis St.). This included the addition of two more onsite Residential Services Specialists (RSS). With the upcoming Karluk Manor project, this will increase the RSS staff to five.

Officially, the main task of the RSS is to: "*Promote a supportive and accepting environment for the residents, regularly monitor each resident to assure the residents' needs are met, and provide interventions as necessary, act as the focal point of communication between the residents and other social service agencies. Provide reports to program managers as needed.*"

As a key point of daily contact for most tenants, it takes a lot more than what can be outlined in a job description to accurately portray the role of the RSS's. In addition to training and experience, it requires compassion, patience, empathy, respect and creativity. The Anchorage Services Division is fortunate to have exemplary staff who go beyond the job description and really put their hearts into the care of each tenant.

Gloria Gomez-Villanueva, RSS at Peterkin, tells a story of a tenant, "John," who wanted to learn how to cook a meal. One evening, several months ago, Gloria helped "John" to prepare a full chicken dinner, with all the trimmings, in the kitchen that is in her office. Gloria described how proud and happy "John" was to share his first "home-cooked" meal with her. Today, they have cooking classes twice a week. Gloria also encourages her tenants to attend outings with her such as the movies or Karaoke.

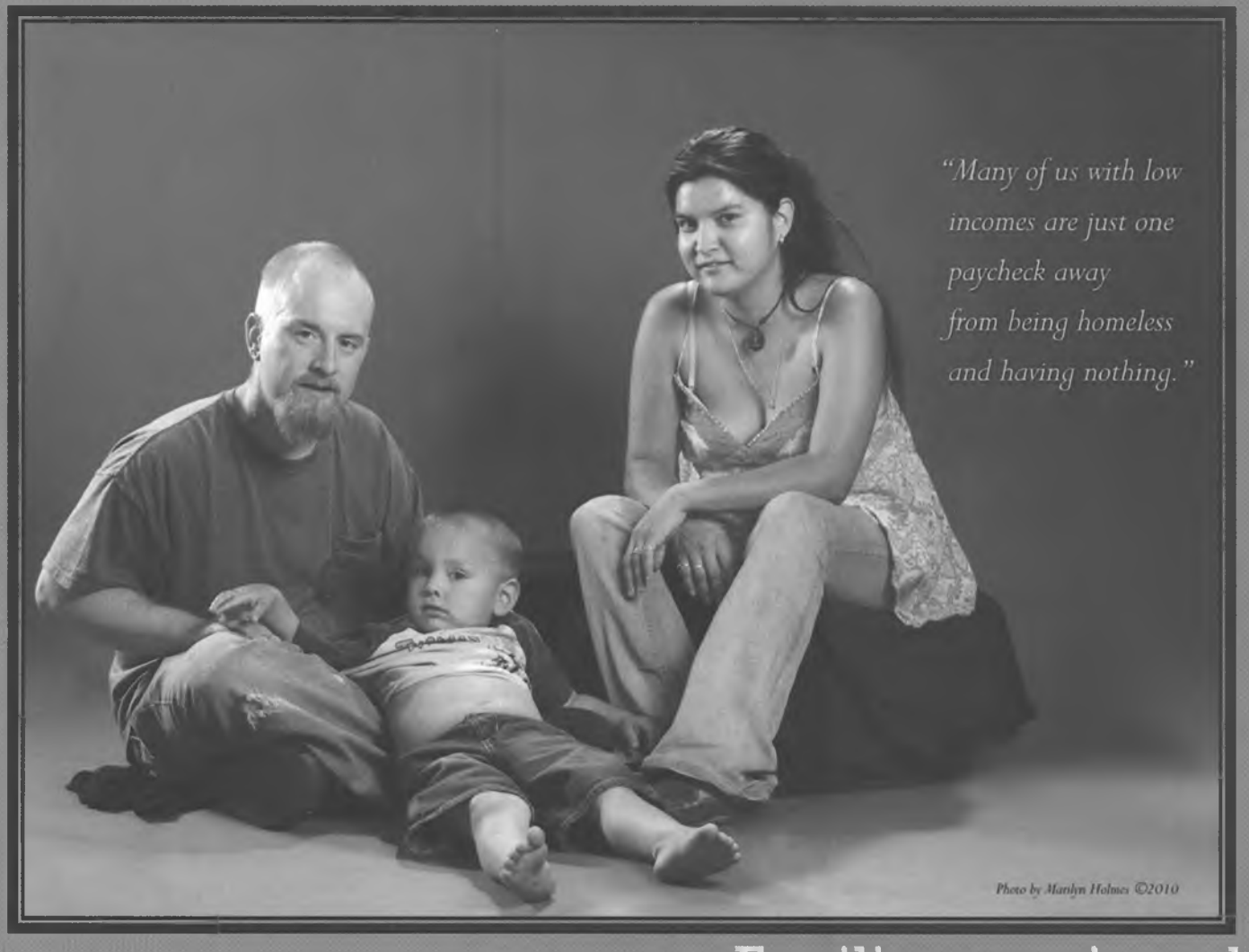
Linda Forrester, RSS at North Lane has several tenants who now join her on regular grocery shopping trips. When in the office, it is common to find tenants seated on the couch watching a movie with the smell of popcorn wafting in the air. More recently, Linda hosted an Autumn barbeque. Many tenants enjoyed the fresh air, sunshine and good food.

Henry Ferguson, RSS at Davis Street, is also well-known for his "world famous" barbeque talents. He also leads physical fitness classes. Equipped with fitness balls, mats and exercise machines, he helps to encourage and strengthen the choice for healthier lifestyles.

To teach people how to navigate day-to-day living takes a special kind of person—with every need being different. Gloria, Linda and Henry are on the front lines every day making the difference.

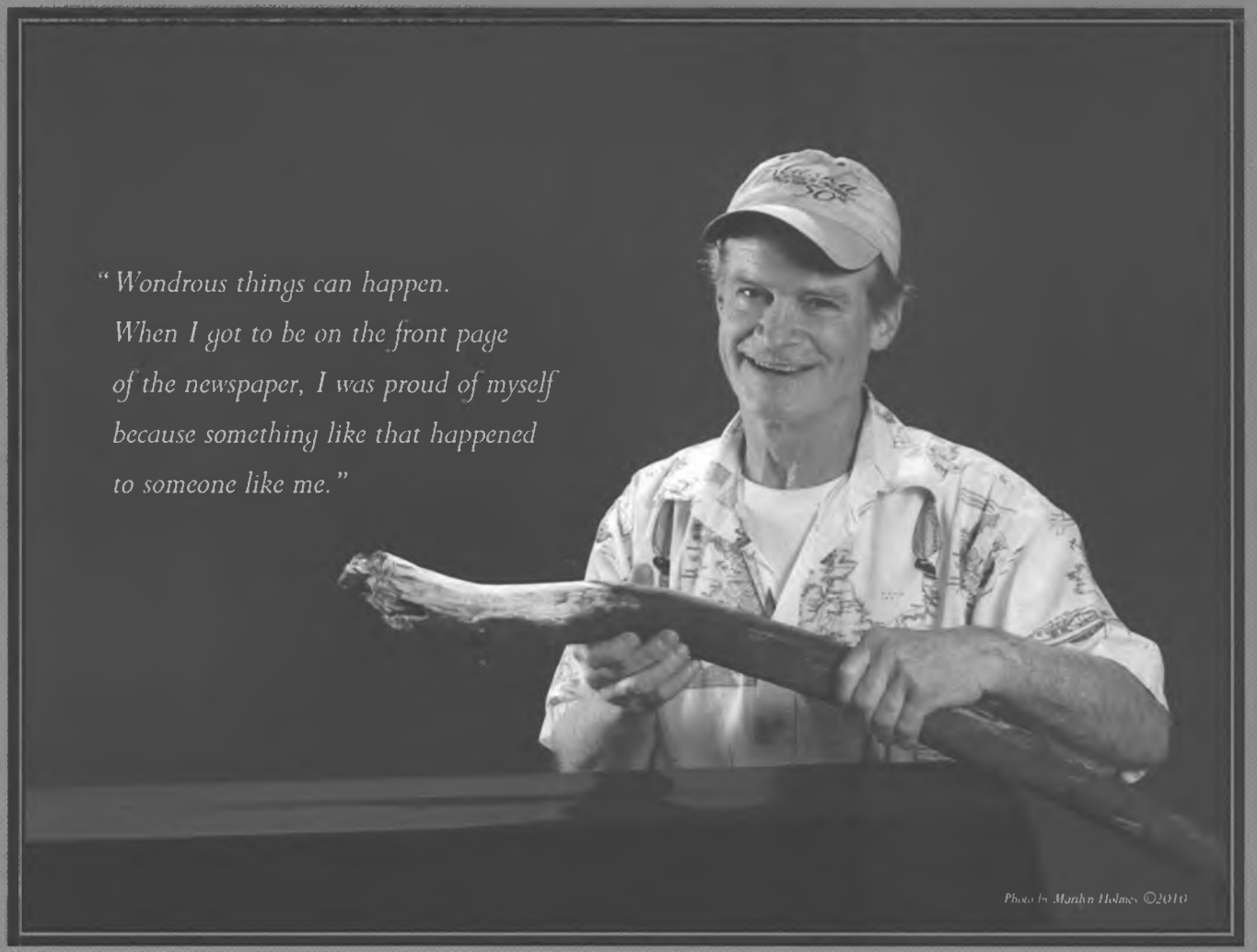
Alaska's Homeless

A Snapshot of Who In Alaska Experiences Homelessness



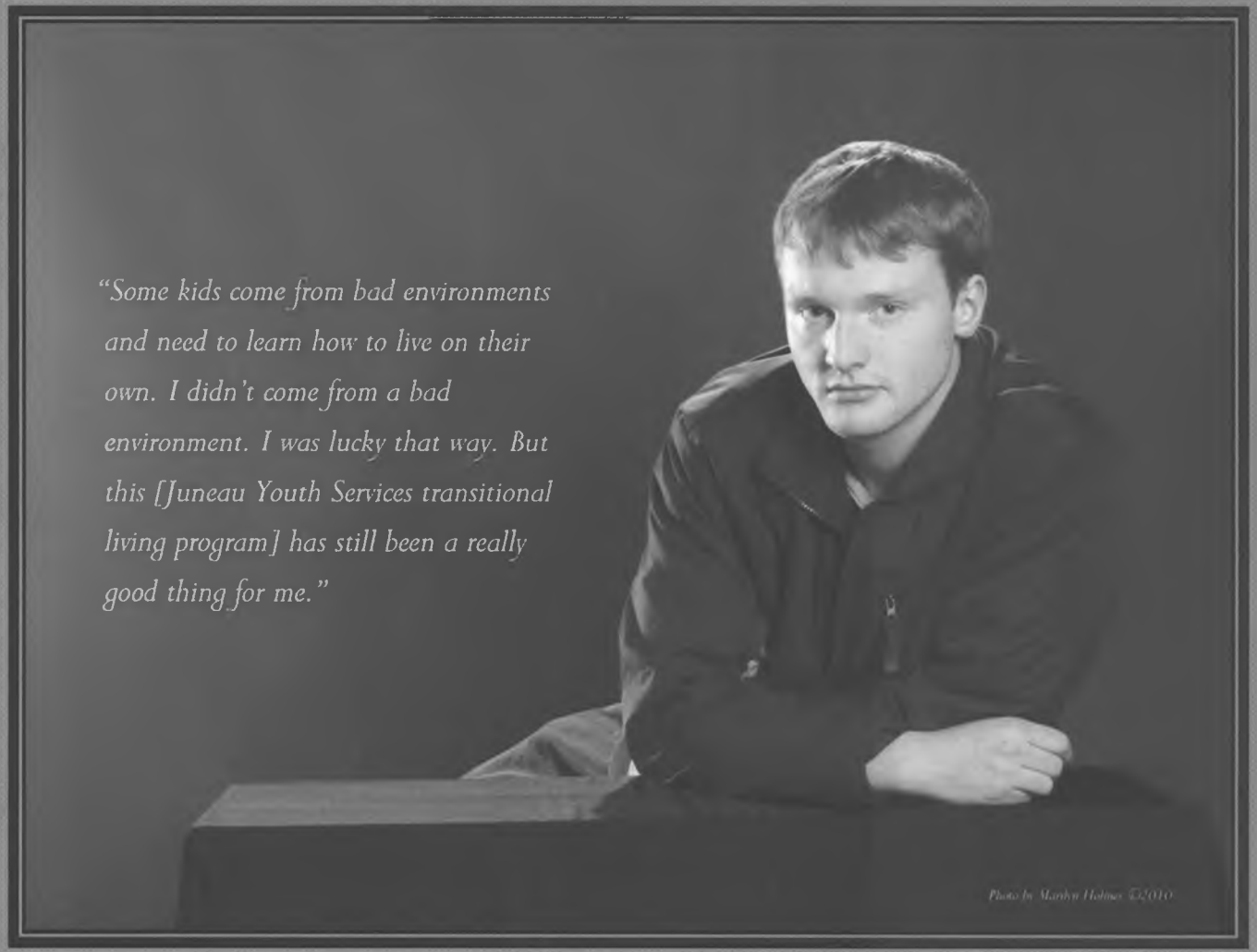
Families experience homelessness

29% of homeless households were families with children (January 2010)
National rate was 23-31% of all homeless households (2008)
4,218 children were identified as homeless during 2009-10 school year



Veterans experience homelessness

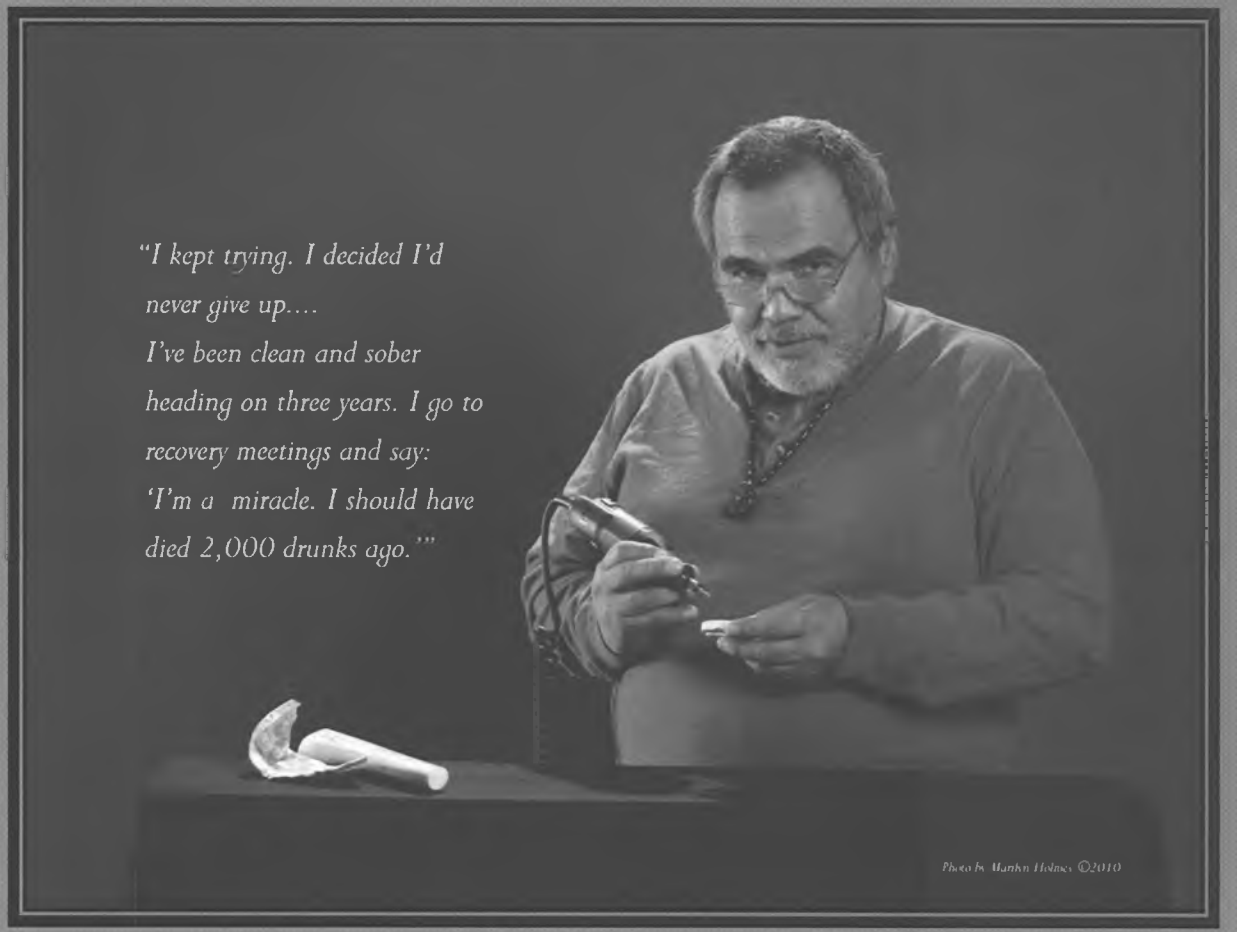
Veterans were 6% of all homeless Alaskans (January 2010)
National rate of homelessness for veterans was 13% (2009)
Nationally, homeless veterans are more likely to be single adult men



Youth experience homelessness

1,306 10th-12th graders were homeless during 2009-2010 school year

Homeless youth are more at risk for suicide, exploitation, mental health disorders, PTSD, and substance use disorders



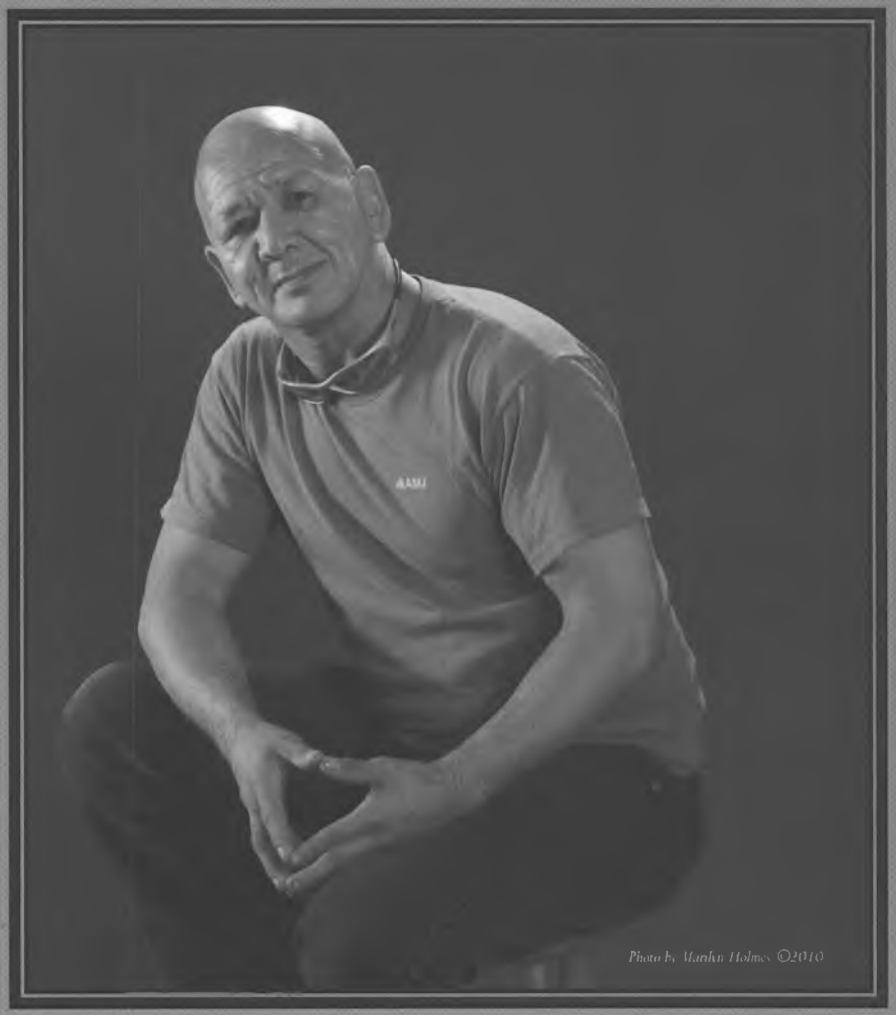
People with substance use disorders experience homelessness

16% of homeless individuals report chronic substance abuse (January 2010)
2.1% higher than reported chronic substance abuse in January 2009

N.B. Many Homeless Connect participants decline to answer, affecting data

Victims of domestic violence experience homelessness

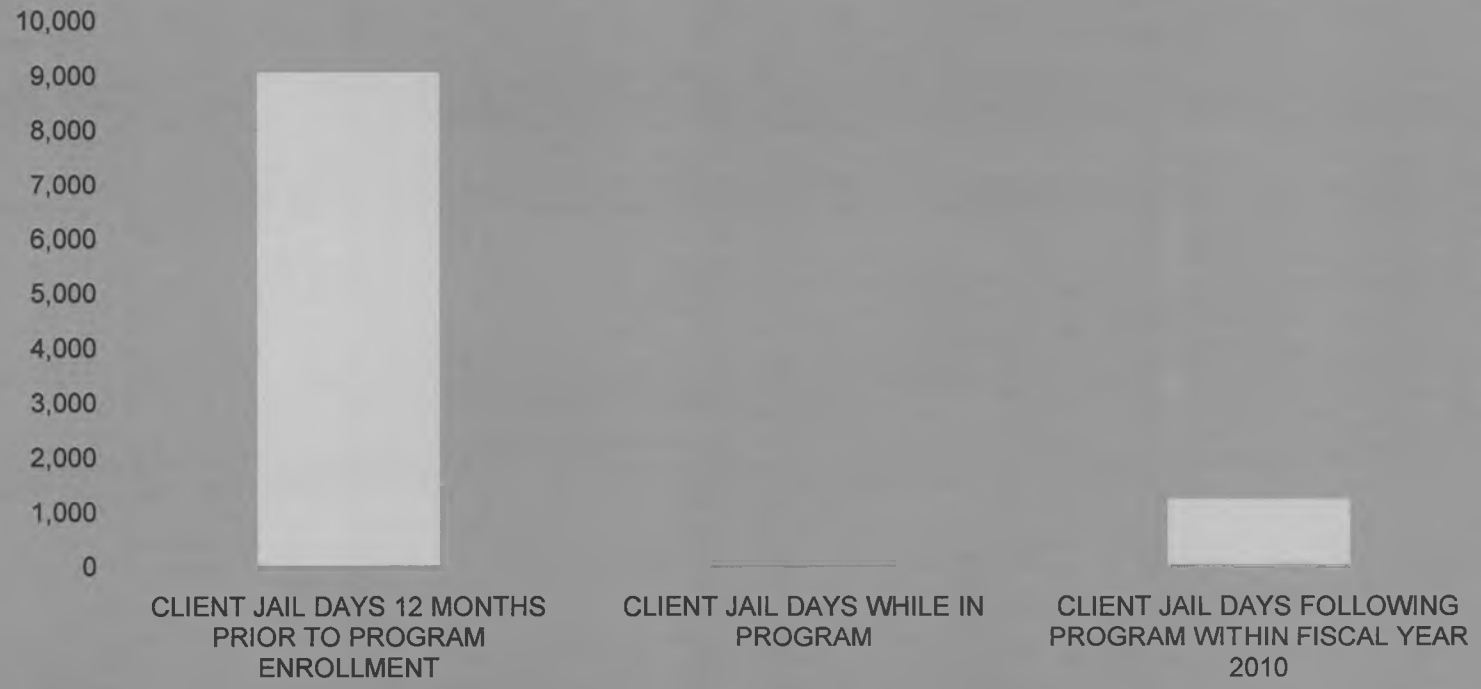
10.7% of homeless people reported past domestic violence (January 2010)
3.6% increase since January 2009
Nationally, 22-25% of homeless women report past domestic violence



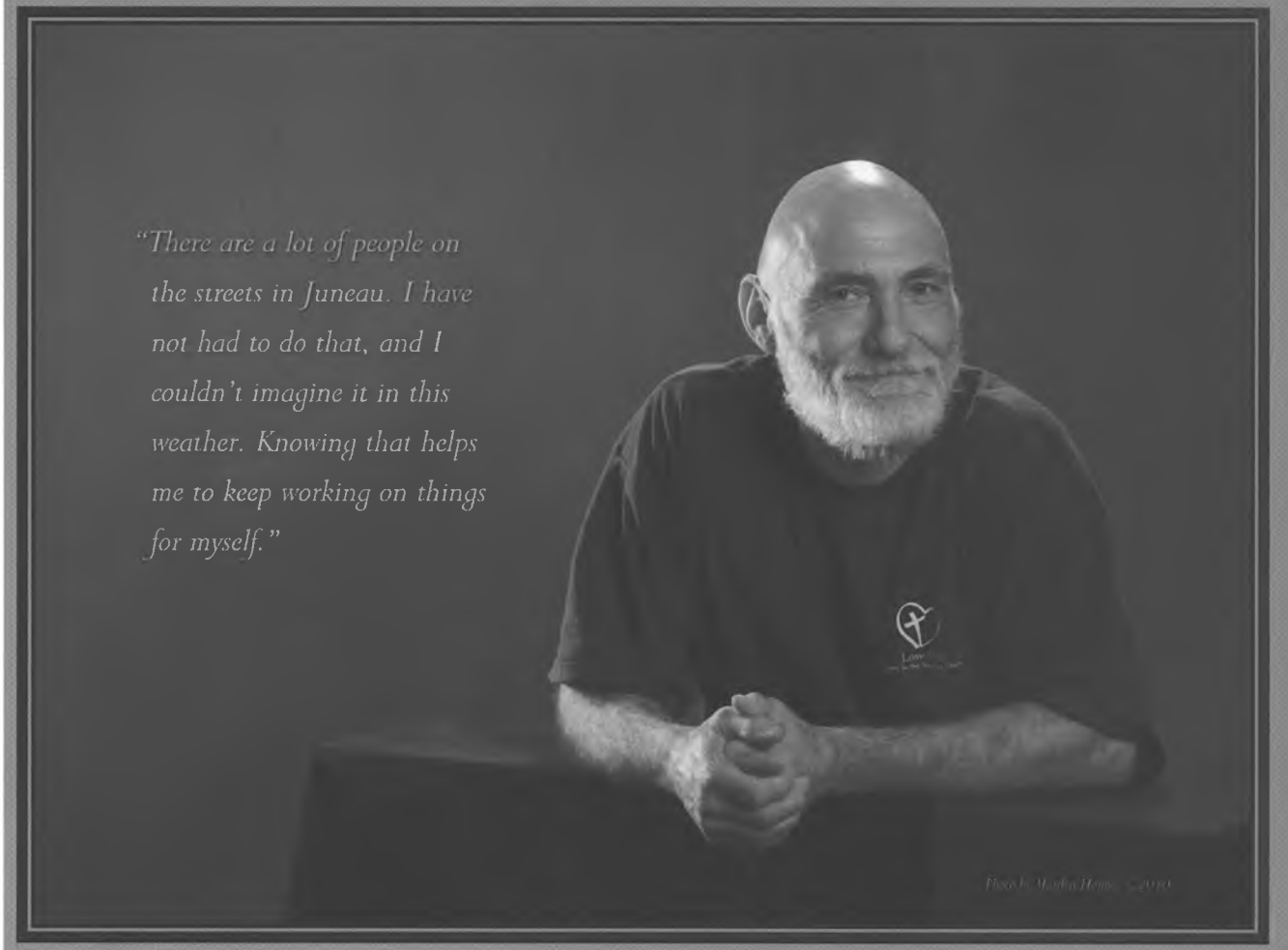
Prisoners experience homelessness before and after incarceration

Nationally, over 50% of homeless people report previous incarceration
20% of prisoners reporting mental illness were homeless before prison

DOC Discharge Incentive Grant Program



N = 43 clients served in Assisted Living Homes with augmented services and reimbursement because their needs were too high for standard assisted living

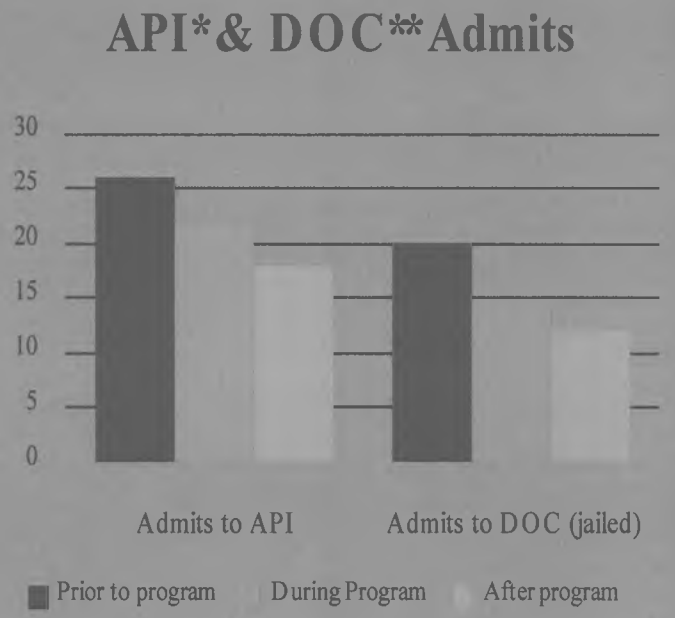


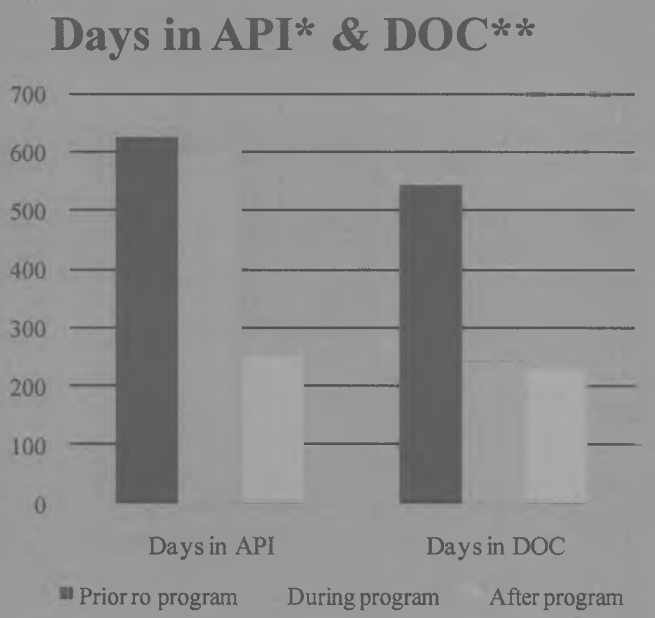
People with serious mental illness experience homelessness

18%of homeless people reported serious mental illness (January 2010)

(N.B. Many Homeless Connect participants decline to answer, affecting data)
Nationally, 26% of homeless people experience serious mental illness

Bridge Home Programs





Outcomes 1 year prior, 1 year during and 1 year after participation in Bridge Home program at Anchorage Community Mental Health Services

Effective Housing Models

- Transitional Housing
  - Covenant House, Anchorage –Juneau Youth Services, Juneau
- Prioritizing by Vulnerability
  - Common Ground, New York City
- Supportive Housing for People Experiencing Serious Mental Illness
  - Downtown Assisted Living, Fairbanks – Polaris House & JAMHI, Inc., Juneau - Evans House, Seattle
- Supportive Housing for Chronic Alcoholics
  - Jacob's Place, Sitka – Karluk Manor, Anchorage - 1811 East Lake, Seattle

A Mile From Home

5,281 Alaskans were homeless in 2010.

Agenda

Suzi Pearson, Alaska Coalition on Housing and Homelessness (on-line)

Dan Fauske – Chair of the Alaska Council on the Homeless (state appointed council) and CEO of AHFC and Jim Gurke of AHFC (both on-line)

Mark Romick, AHFC, and Stacy Schubert, AHFC (Voucher Program)

Debe Mahoney and Michael Courtney, Neighbor Works Anchorage (Affordable Housing)

Jeff Jesse or representative of the Mental Health Trust

Representative of Rural Cap

Celeste Hodge

From: Melinda Freemon [mfreemon@ruralcap.com]
Sent: Monday, February 28, 2011 3:49 PM
To: Celeste Hodge
Cc: Kenny Scollan
Subject: Focus areas for hearing on Solving Homelessness

Importance: High

Dear Celeste,
Here are my ideas for shaping the 1 ½ hour hearing on Solving Homelessness.

I hope this is helpful. I can be available at any time today through Wednesday as I fly out of state Wednesday night. After Wednesday, if you need further brainstorming, I would suggest contacting our Division Manager, Ken Scollan. He will be presenting in Juneau and has a great deal of experience in the areas of housing and homelessness and knows all of the presenters.
I have copied him on this email and his direct line is 865-7507.

Focus areas for hearing on homelessness

- **Each agency has a total of 18 minutes to present regardless of the number of presenters for that agency**
- **Each agency describes what they do related to housing and homelessness**
- **Provide a description of the recipients utilizing their services (eligibility requirements, demographics, etc.)**
- **Each agency needs to describe the gaps or barriers to meeting the need for housing from their perspective**
- **Fully describe to the legislators specific types of support needed from the State to bridge these gaps and barriers and solve homelessness in Alaska**

Let me know if this is what you had in mind. I can revise this if you need more information. I am here for several more hours, so just let me know how I can help.
Direct line 865-7507

Melinda Freemon, MS, LPC, CCS
Director, Anchorage Services Division
RurAL CAP
120 N. Hoyt St
Anchorage, AK 99508
907 279-7535

Celeste Hodge

From: David Hardenbergh [dhardenbergh@ruralcap.com]
Sent: Monday, February 28, 2011 8:47 PM
To: Celeste Hodge
Cc: Melinda Freemon; Kenny Scollan; Sarah Scanlan
Subject: RE: Focus areas for hearing on Solving Homelessness

Dear Celeste,

You've done a fabulous job putting this together!

Thank you for the hard work and dedication that you put into your job.

As I mentioned when Sarah Scanlan and I visited you last week, I will be in DC on March 9th, week, but will look forward to hearing from Kenny how it all went.

It looks like this hearing is in good hands!

Cheers,

- David

RurAL CAP
Healthy People, Sustainable Communities, Vibrant Cultures

David Hardenbergh
Executive Director
DHardenbergh@ruralcap.com
www.ruralcap.com

Rural Alaska Community Action Program, Inc.
P.O. Box 200908
Anchorage, AK 99520-0908
tel: 907-865-7364
fax: 907-278-2309

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Monday, February 28, 2011 8:41 PM
Cc: Kenny Scollan; Melinda Freemon; Debe Mahoney; Stacy Schubert; Michael Courtney; jeff.jessee@alaska.gov; Jessee, Jeffrey L (DOR); Burkhart, Kate (HSS); Busch, Rebecca E (HSS); Burke, Nancy (DOR); David Hardenbergh; suzi_p@awaic.org; mromick@ahfc.state.ak.us; jgurke@ahfc.state.ak.us; dfauske@ahfc.state.ak.us
Subject: Focus areas for hearing on Solving Homelessness

First, thank you for participating in the hearing next **Wednesday, March 9, 1:30 PM** in the Butrovich Room of the Capitol to discuss homelessness – a couple of you will be presenting on-line outside of Juneau. Unfortunately, because of limited time, each agency regardless to the number of presenters for that agency has no-more-than 15 minutes to present information. Please be mindful of the time allotted in order to ensure every presenting agency gets equal time.

Presenters (In order of Presentation):

1. Suzi Pearson, Alaska Coalition on Housing and Homelessness (on-line)
2. Dan Fauske – Chair of the Alaska Council on the Homeless (state appointed council) and CEO of AHFC and Jim Gurke of AHFC (both on-line)
3. Mark Romick, AHFC, and Stacy Schubert, AHFC (Voucher Program) – Juneau

4. Deb Mahoney and Michael Courtney, Neighbor Works Anchorage - Affordable Housing (Juneau)
5. Kate Burkhart, Alaska Mental Health Board and the Advisory Board on Alcohol and Drug Abuse – (Juneau)
6. Kenny Scollan, Rural Cap – (Juneau)

Focus areas for hearing on homelessness

- **Each agency has no-more-than 15 minutes to present regardless of the number of presenters for that agency**
- **Each agency describes what they do related to housing and homelessness**
- **Provide a description of the recipients utilizing their services (eligibility requirements, demographics, etc.)**
- **Each agency needs to describe the gaps or barriers to meeting the need for housing from their perspective**
- **Fully describe to the legislators specific types of support needed from the State to bridge these gaps and barriers and solve homelessness in Alaska**

We will have a computer and projector in case you need one. However, you will need to let me know if you plan on using it – and remember, please be mindful of your time. If you have handouts, please bring seven copies for the members. If you email your presentation to me by Wednesday of this week, I can make the copies for you. If you have questions, please let me know by 5 PM tomorrow. I will be out of the office tomorrow evening, returning on Monday, March 7. Thank you.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Burke, Nancy (DOR) [nancy.burke@alaska.gov]
Sent: Monday, February 28, 2011 1:55 PM
To: Celeste Hodge
Cc: Jessee, Jeffrey L (DOR); Burkhart, Kate (HSS); Busch, Rebecca E (HSS)
Subject: RE: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Hi Celeste,

I wanted to touch base with you on the presentation on homelessness. We are compiling some information on homelessness and Trust beneficiaries for the committee hearing to provide to you. I'm wondering if you have a final list of people who will be presenting? This will help us tailor our information on topics that are not covered by other partners.

One other update: Jeff was unable to cancel his trip out of state over this time, so we have asked our partner, Kate Burkhart at the Alaska Mental Health Board and the Advisory Board on Alcohol and Drug Abuse to present on this day. Kate and her staff have been very involved with our housing initiative and she will be knowledgeable of the area for the committee report.

I look forward to talking with you more about the hearing. However, I wanted to let you know that I am leaving town tomorrow evening, but I have copied our partners on the presentation here so you have someone to connect with in my absence.

Thank you again for your work in this area, Nancy

Nancy Burke
(907) 269-7961

-----Original Message-----
From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Sunday, February 20, 2011 3:14 PM
To: Burke, Nancy (DOR); Jessee, Jeffrey L (DOR)
Subject: RE: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Nancy,
Thanks for your prompt response and for forwarding the information to Jeff. I look forward to hearing from you on Tuesday.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

-----Original Message-----
From: Burke, Nancy (DOR) [mailto:nancy.burke@alaska.gov]
Sent: Sunday, February 20, 2011 3:09 PM
To: Celeste Hodge; Jeff Jessee
Subject: Re: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Celeste,
Thanks to you for organizing this session and to the Senator for the opportunity to present the work that the Trust is doing in this critical area.

I am out of town for the date identified, however, our team will be happy to meet and provide materials. I am copying our CEO who will also be a contact for the hearing and who may be able to present in my absence.
I will contact you on Tuesday to confirm and to seek additional information on the focus of the session.
Nancy

Celeste Hodge <Celeste_Hodge@legis.state.ak.us> wrote:

Nancy,
Hello. I'm Celeste Hodge, Committee Aide to the Senate Health & Social Services Committee (SHSS) chaired by Senator Davis. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. Suzi Pearson, chair of Alaska Coalition on Homelessness suggested I contact you to see if you could provide a brief presentation on the impact of homelessness in our communities. Please let me know of your availability. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the

intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

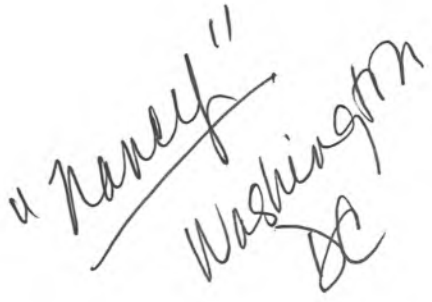
Celeste Hodge

To: Melinda Freemon; David Hardenbergh
Cc: Kenny Scollan; Sarah Scanlan
Subject: RE: Follow-up on March 9th Senate Committee Meeting on Homelessness

Melinda,
Great! I'll contact you this afternoon. THANKS!

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us



Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Melinda Freemon [mailto:mfreemon@ruralcap.com]
Sent: Friday, February 25, 2011 9:21 AM
To: Celeste Hodge; David Hardenbergh
Cc: Kenny Scollan; Sarah Scanlan
Subject: RE: Follow-up on March 9th Senate Committee Meeting on Homelessness

Greetings Celeste,
I would be happy to discuss possible presenters with you at any time.
Feel free to give me a call at your convenience or email me if you prefer. My direct line is 865-7507.

I am looking forward to assisting you with this very valuable opportunity to discuss homelessness and solutions to this community concern.

Melinda Freemon

Melinda Freemon, MS, LPC, CCS
Director, Anchorage Services Division
RurAL CAP
120 N. Hoyt St
Anchorage, AK 99508
907 279-7535

Celeste Hodge

From: Suzi Pearson [suzi_p@awaic.org]
Sent: Wednesday, February 16, 2011 4:12 PM
To: Celeste Hodge
Subject: RE: Alaska Coalition on Housing and Homelessness

Celeste,

I would certainly be available to participate but I would have to do it telephonically. I can't come to Juneau that week.

Regarding other agencies to involve, Alaska Housing Finance Corporation has many resources for homeless programs and their voucher program is a critical resource for housing. There are over 4,400 people on the waitlist for these vouchers in Anchorage alone and I think involving them in the conversation of homelessness and affordable housing is critical. Two contacts there are Mark Romick (mromick@ahfc.state.ak.us) and Jim Gurke (jgurke@ahfc.state.ak.us). The CEO of AHFC is Dan Fauske and he is also the Chair of the Alaska Council on the Homeless, a state appointed council.

I would also recommend contacting the CEO of Rural Cap, David Hardenbergh (dhardenbergh@ruralcap.com). They are a statewide organization and provide homeless services in Anchorage.

Another aspect that deeply affects the homeless population is substance abuse and mental health issues. I would recommend either John Sperbeck (jsperbeck@acmhs.org) from Anchorage Community Mental Health Services or Nancy Burke (nancy.burke@alaska.gov) from the Alaska Mental Health Trust to discuss the impact of these issues in our communities.

What specific issues around homelessness do you want to address? I would highly recommend a discussion of affordable housing in our communities and how the lack of it leads to homelessness. I would suggest that I go first with some of the concerns and statistics around homelessness and then the others can talk about current solutions and possibilities for the future.

I hope I'm not overstepping boundaries with my suggestions. It is such an important topic and I appreciate the Senator's interest in discussing it.

Please let me know how I can help. Thank you so much for the opportunity.

Best regards,

suzi

Report on Homelessness
→ Suzie-
→ affordable Housing - Dave Mahoney
→ Substance Abuse & mental Health Issues
Mental Trust
→ John Sperbeck Mental Health Trust

AWAIC
Abused Women's Aid in Crisis

100 W. 13th Ave
Anchorage, AK 99501

Suzi Pearson
Executive Director

907.743.5726 Office
907.279.7244 Fax
907.279.9581 AWAIC
907.272-0100 Crisis

suzi_p@awaic.org
www.awaic.org

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 16, 2011 8:32 AM
To: suzi_p@awaic.org
Subject: Alaska Coalition on Housing and Homelessness

Suzi,
Hi. I am Celeste Hodge, committee aide to the Senate Health and Social Services (SHSS) Committee that Senator Davis chairs. I understand you are the chair of the Alaska Coalition on Housing and Homelessness. I'm wondering if the coalition is available to provide an update at the March 9 (Wed.), 1:30 PM, Senate HSS meeting in the Butrovich Room. We have one other organization scheduled to present thus far (NeighborWorks Anchoarge). I would like the agenda for this particular meeting to surround Homelessness and will probably invite one or two other groups to present. If you could suggest a couple of other groups to present, that would be great. Please let me know if you have questions. Thank you.

Celeste Graham-Hodge
Committee Aide, SHSS
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Celeste Hodge
Sent: Tuesday, February 22, 2011 2:16 PM
To: Stacy Schubert
Cc: 'Dan Fauske'
Subject: PRESENTATION TO SENATE HSS ON MARCH 9, 2011

Stacy,
Thanks for contacting me to follow-up on the request for a representative to speak at the upcoming Senate Health and Social Services Committee on March 9, 1:30 PM in the Butrovich Room. Please let me know if you were able to locate someone to represent AHFC during the meeting either in person or via teleconference. Specifically, we would like to hear what AHFC is doing as it relates to homelessness and the voucher program. As it relates to the Alaska Council on the Homeless, the state appointed council chaired by Dan Fauske, the committee would like to hear an update of the council by a representative of the council. Please let me know if you have questions. Again, thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: David Hardenbergh [dhardenbergh@ruralcap.com]
Sent: Thursday, February 24, 2011 5:10 PM
To: Celeste Hodge
Cc: Kenny Scollan; Melinda Freemon; Sarah Scanlan
Subject: RE: Follow-up on March 9th Senate Committee Meeting on Homelessness

Hi Celeste,

It was a pleasure meeting with you yesterday!

By way of follow up, I would suggest that you speak with Melinda Freemon, RurAL CAP's Anchorage Services Division Director (wk: 865-7507 cell 529-7911) regarding contact information and areas of expertise for some of the leaders on homeless issues as well as for her input on key areas to discuss during this presentation. Melinda is very knowledgeable and very well-connected on homeless issues, but as I mentioned, she will be out-of-state on March 9th.

The person who Sarah and I suggested for the March 9th presentation is Kenny Scollan, RurAL CAP's Anchorage Services Division Manager (cell 529-2798). Kenny has been managing RurAL CAP's Affordable Housing (72 units) and Homeward Bound (25-bed facility in Mountain View for chronic homeless alcoholics) programs for more than a decade. He is planning to move his office into the Karluk Manor housing first facility when that 46-bed project opens later this year. Kenny is a strong public presenter and he also knows many of the leaders and issues around homelessness in Alaska. I will encourage Kenny to attend the committee meeting in person in Juneau on March 9th if he is able.

Please feel free to call or email both Melinda and Kenny if you don't hear from them first.

Thank you Celeste!

- David

RurAL CAP
Healthy People, Sustainable Communities, Vibrant Cultures

David Hardenbergh
Executive Director

DHardenbergh@ruralcap.com
www.ruralcap.com

Rural Alaska Community Action Program, Inc.
P.O. Box 200908
Anchorage, AK 99520-0908
tel: 907-865-7364
fax: 907-278-2309

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 24, 2011 10:46 AM
To: David Hardenbergh
Subject: Follow-up

Dave,
I would like to follow-up on our conversation yesterday regarding the homelessness presentation I'm attempting to organize for the upcoming Senate Health and Social Services committee meeting on Wednesday, March 9, 1:30 PM in

the Butrovich Room #205 of the Capitol. I really appreciated your thoughts yesterday and would like to firm up presenters for the meeting today. Can you provide the names and contact information of those you recommended yesterday, including their areas of expertise? I would also appreciate receiving your thoughts of key areas to discuss during this first presentation on homelessness. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 24, 2011 5:14 PM
To: David Hardenbergh
Cc: Kenny Scollan; Melinda Freemon; Sarah Scanlan
Subject: RE: Follow-up on March 9th Senate Committee Meeting on Homelessness

David,
Great! Thanks for the information.

Kenny,
I will follow-up with via phone to see if you're available to participate and contact Melinda for possible suggestions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: David Hardenbergh [mailto:dhardenbergh@ruralcap.com]
Sent: Thursday, February 24, 2011 5:10 PM
To: Celeste Hodge
Cc: Kenny Scollan; Melinda Freemon; Sarah Scanlan
Subject: RE: Follow-up on March 9th Senate Committee Meeting on Homelessness

Hi Celeste,

It was a pleasure meeting with you yesterday!

By way of follow up, I would suggest that you speak with Melinda Freemon, RurAL CAP's Anchorage Services Division Director (wk: 865-7507 cell 529-7911) regarding contact information and areas of expertise for some of the leaders on homeless issues as well as for her input on key areas to discuss during this presentation. Melinda is very knowledgeable and very well-connected on homeless issues, but as I mentioned, she will be out-of-state on March 9th.

The person who Sarah and I suggested for the March 9th presentation is Kenny Scollan, RurAL CAP's Anchorage Services Division Manager (cell 529-2798). Kenny has been managing RurAL CAP's Affordable Housing (72 units) and Homeward Bound (25-bed facility in Mountain View for chronic

homeless alcoholics) programs for more than a decade. He is planning to move his office into the Karluk Manor housing first facility when that 46-bed project opens later this year. Kenny is a strong public presenter and he also knows many of the leaders and issues around homelessness in Alaska. I will encourage Kenny to attend the committee meeting in person in Juneau on March 9th if he is able.

Please feel free to call or email both Melinda and Kenny if you don't hear from them first.

Thank you Celeste!

- David

RurAL CAP
Healthy People, Sustainable Communities, Vibrant Cultures

David Hardenbergh
Executive Director
DHardenbergh@ruralcap.com
www.ruralcap.com

Rural Alaska Community Action Program, Inc.
P.O. Box 200908
Anchorage, AK 99520-0908
tel: 907-865-7364
fax: 907-278-2309

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 24, 2011 10:46 AM
To: David Hardenbergh
Subject: Follow-up

Dave,
I would like to follow-up on our conversation yesterday regarding the homelessness presentation I'm attempting to organize for the upcoming Senate Health and Social Services committee meeting on Wednesday, March 9, 1:30 PM in the Butrovich Room #205 of the Capitol. I really appreciated your thoughts yesterday and would like to firm up presenters for the meeting today. Can you provide the names and contact information of those you recommended yesterday, including their areas of expertise? I would also appreciate receiving your thoughts of key areas to discuss during this first presentation on homelessness. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited.

Local Coalitions

Anchorage Coalition on Homelessness
The mission of the Anchorage Coalition on Homelessness is to be a network of businesses, non-profits and community members who provide a continuum of support to prevent homelessness and connect the homeless to safe, secure and affordable housing, visit the Anchorage Coalition on Homelessness website.

Alaska Council on the Homeless
The Alaska Council on the Homeless (The Council) is a state-wide council appointed by the Governor of Alaska. Read more about the Alaska Council on the Homeless. or visit their website, AHFC's Alaska Council on the Homeless.

Fairbanks Homeless Coalition
The Fairbanks Homeless Coalition meets on the 3rd Thursday of each month at noon at the Fairbanks Rescue mission. For more information, contact Rodney Gaskins, Chair, at (907) 452-5343, or interior2293@yahoo.com.

Juneau Homeless Coalition
The Juneau Homeless Coalition meets every third Thursday at the Tlingit Haida Regional Housing Authority from 11:30-1:00 p.m. For more information, contact Scott Ciambor at the United Way of Southeast Alaska at (907) 463-5530 or by e-mail, leadership@unitedwayseak.org

Mat-Su Housing Coalition
Meets bi-monthly at 1:30 PM in the conference room of the Century Plaza Building at 1075 Check Street in Wasilla, AK. For more information, please contact Katherine Foster-Dalmolin, Director, at (907) 357-0473.

Statewide

Working to increase affordable housing and eliminate homelessness in our great state.

Sen. Bettye Davis

From: Michael Courtney [mcourtney@nwanchorage.org]
Sent: Tuesday, February 22, 2011 10:09 AM
To: Celeste Hodge; Debe Mahoney
Cc: Shannon Rothermel; Sen. Bettye Davis
Subject: RE: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

RECEIVED
FEB 22 2011

Hi Celeste!

I'm sure Debe will be responding, but I know she doesn't get cell service where she's at in Arizona. We will be putting a power point together this week and will be sure to get it sent to you within the timeframe you need it. I will be working with Brian on the presentation and will be sure to address our efforts to reduce homelessness!

Have a wonderful morning!

Mike

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Sunday, February 20, 2011 1:22 PM
To: Debe Mahoney
Cc: Shannon Rothermel; Michael Courtney; Sen. Bettye Davis
Subject: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Debe,
Hello. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. As Executive Director of NeighborWorks Anchorage, I am inviting you to participate by presenting a ten minute overview of NeighborWorks Anchorage, to include information on NWA's affordable housing efforts. Also, at the appropriate time, you'll be invited to discuss possible solutions to the homeless situation. I also need to know if you will need to utilize a computer/projector. If you have a PowerPoint presentation, please email the presentation to me at least one week prior to the meeting. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Celeste Hodge

From: Stacy Schubert [sschubert@ahfc.state.ak.us]
Sent: Wednesday, February 23, 2011 11:04 AM
To: Celeste Hodge
Subject: RE: PRESENTATION TO SENATE HSS ON MARCH 9, 2011

Hi Celeste:

Our plan is to have Mark Romick and me in Juneau for this hearing. Dan Fauske and Jim Gurke are expected to be online for opening comments and to answer questions.

Thank you for the invitation.
-S

Stacy Schubert
Director, governmental relations & public affairs
Alaska Housing Finance Corporation
4300 Boniface Parkway
P.O.B. 101020
Anchorage, AK 99510-1020
http://www.ahfc.state.ak.us

D: (907) 330-8445
C: (907) 301-4556

"The mission of AHFC is to provide Alaskans access to safe, quality, and affordable housing."

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Tuesday, February 22, 2011 2:16 PM
To: Stacy Schubert
Cc: Dan Fauske
Subject: PRESENTATION TO SENATE HSS ON MARCH 9, 2011

Stacy,
Thanks for contacting me to follow-up on the request for a representative to speak at the upcoming Senate Health and Social Services Committee on March 9, 1:30 PM in the Butrovich Room. Please let me know if you were able to locate someone to represent AHFC during the meeting either in person or via teleconference. Specifically, we would like to hear what AHFC is doing as it relates to homelessness and the voucher program. As it relates to the Alaska Council on the Homeless, the state appointed council chaired by Dan Fauske, the committee would like to hear an update of the council by a representative of the council. Please let me know if you have questions. Again, thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol

Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

RECEIVED
FEB 22 2011

Sen. Bettye Davis

From: Sarah Scanlan [Sscanlan@ruralcap.com]
Sent: Tuesday, February 22, 2011 3:21 PM
To: Celeste Hodge
Cc: Sen. Bettye Davis; David Hardenbergh; Melinda Freemon
Subject: RE: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Hi Celeste, thank you for your invitation to RurAL CAP to participate in the SHSS Homelessness discussion. David Hardenbergh and I will be in Juneau tomorrow and Thursday, and we'll stop by the Senator's office to discuss this with you and to advise on who our representative will be. Is there a time that works best for you? Thank you, and look forward to seeing you in the next day or so.

Sarah Scanlan
Deputy Director
RurAL CAP
(907) 865-7365 Direct Line
(907) 279-2511 Main
www.ruralcap.com

From: Celeste Hodge [Celeste_Hodge@legis.state.ak.us]
Sent: Sunday, February 20, 2011 12:15 PM
To: David Hardenbergh
Cc: Sen. Bettye Davis
Subject: RE: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

David,
Hello. I'm Celeste Hodge, Committee Aide to the Senate Health & Social Services Committee (SHSS) chaired by Senator Davis. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. As CEO of Rural Cap, a statewide organization that provides homeless services in Anchorage, I am inviting you to participate by presenting a ten minute overview of Rural Cap and at the appropriate time, discuss solutions and possibilities for the future. Please let me know of your availability. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Celeste Hodge

From: DiSanto, Diane (Begich) [Diane_DiSanto@begich.senate.gov]
Sent: Thursday, February 10, 2011 2:37 PM
To: Celeste Hodge
Subject: RE: do you know of a state organization i can invite to present to the Senate HSS Committee on Homelessness? Hope all is well.

Sure but they only do Anchorage
RurAL Cap would be excellent

Diane DiSanto
Legislative Assistant
Office of Alaska Senator Mark Begich
202-224-9626
E-newsletter signup: begich.senate.gov

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 10, 2011 6:36 PM
To: DiSanto, Diane (Begich)
Subject: RE: do you know of a state organization i can invite to present to the Senate HSS Committee on Homelessness? Hope all is well.

Perfecto!!!! I want Anchorage Neighborhood Housing too – what do you think?

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: DiSanto, Diane (Begich) [mailto:Diane_DiSanto@begich.senate.gov]
Sent: Thursday, February 10, 2011 2:34 PM
To: Celeste Hodge

Subject: RE: do you know of a state organization i can invite to present to the Senate HSS Committee on Homelessness? Hope all is well.

Suzi Pearson AK Coalition on Homelessness chair of the AK Coalition
If in Juneau, the Juneau Coalition has some good folks, Scott (can't remember his last name)
Michelle Brown, United Way
Carma Reed, HUD
Don't forget ANFC, Kris Duncan

Does this help?
P.S. I would have a homeless person, focus on family homelessness

Diane DiSanto
Legislative Assistant
Office of Alaska Senator Mark Begich
202-224-9626
E-newsletter signup: begich.senate.gov

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 10, 2011 6:28 PM
To: DiSanto, Diane (Begich)
Subject: do you know of a state organization i can invite to present to the Senate HSS Committee on Homelessness? Hope all is well.

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: DiSanto, Diane (Begich) [Diane_DiSanto@begich.senate.gov]
Sent: Thursday, February 10, 2011 2:34 PM
To: Celeste Hodge
Subject: RE: do you know of a state organization i can invite to present to the Senate HSS Committee on Homelessness? Hope all is well.

Suzi Pearson AK Coalition on Homelessness chair of the AK Coalition
If in Juneau, the Juneau Coalition has some good folks, Scott (can't remember his last name)
Michelle Brown, United Way
Carma Reed, HUD
Don't forget ANFC, Kris Duncan

Does this help?
P.S. I would have a homeless person, focus on family homelessness

Diane DiSanto
Legislative Assistant
Office of Alaska Senator Mark Begich
202-224-9626
E-newsletter signup: begich.senate.gov

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 10, 2011 6:28 PM
To: DiSanto, Diane (Begich)
Subject: do you know of a state organization i can invite to present to the Senate HSS Committee on Homelessness? Hope all is well.

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

To: dfauske@ahfc.state.ak.us
Cc: Sen. Bettye Davis
Subject: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Dan,
Hello. I'm Celeste Hodge, Committee Aide to the Senate Health & Social Services Committee (SHSS) chaired by Senator Davis. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. As chair of the Alaska Council on the Homeless – the state appointed council, I am inviting you to participate by presenting a ten minute overview of the Alaska Council on the Homeless at the meeting. I also understand there are over 4,400 people on the waitlist for vouchers through Alaska Housing Finance. As CEO of AHFC, it would be great if you or a representative of the voucher program (Mark Romick or Jim Gurke) could address this topic. Please let me know of your availability. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Celeste Hodge
Sent: Sunday, February 20, 2011 1:22 PM
To: Debe Mahoney
Cc: 'Shannon Rothermel'; Michael Courtney; Sen. Bettye Davis
Subject: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Debe,
Hello. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. As Executive Director of NeighborWorks Anchorage, I am inviting you to participate by presenting a ten minute overview of NeighborWorks Anchorage, to include information on NWA's affordable housing efforts. Also, at the appropriate time, you'll be invited to discuss possible solutions to the homeless situation. I also need to know if you will need to utilize a computer/projector. If you have a PowerPoint presentation, please email the presentation to me at least one week prior to the meeting. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Celeste Hodge
Sent: Sunday, February 20, 2011 12:16 PM
To: 'dhardenbergh@ruralcap.com'
Cc: Sen. Bettye Davis
Subject: RE: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

David,
Hello. I'm Celeste Hodge, Committee Aide to the Senate Health & Social Services Committee (SHSS) chaired by Senator Davis. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. As CEO of Rural Cap, a statewide organization that provides homeless services in Anchorage, I am inviting you to participate by presenting a ten minute overview of Rural Cap and at the appropriate time, discuss solutions and possibilities for the future. Please let me know of your availability. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Monday, February 14, 2011 9:27 AM
To: Celeste Hodge
Subject: FW: Homeless Task Force

march 9

See comments below.

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

This e-mail, including attachments, is intended for the use of the person or entity to which it is addressed and may contain CONFIDENTIAL or privileged information that is protected by federal and state regulation. If the reader of this e-mail is not the intended recipient or his or her agent, the reader is notified that any dissemination, distribution or copying of this e-mail is prohibited. If you think you have received this e-mail in error, please advise the sender by reply e-mail and delete this e-mail immediately.

From: Horton, Tara J (HSS)
Sent: Monday, February 14, 2011 9:24 AM
To: Laughlin, Wilda J (HSS)
Cc: Streur, William J (HSS)
Subject: RE: Homeless Task Force

Yes, it's called the Alaska Coalition on Housing and Homelessness. I believe they meet every other month. The next meeting is tomorrow at the Trust.
Suzi Pearson with AWAIC is the coalition chair.
Suzi Pearson
907-743-5726
suzi_p@awaic.org
There are also regional Homeless Coalitions like Anchorage, Juneau, Fairbanks etc. Also Mayor Dan Sullivan appointed a Homeless Task Force just for the city of Anchorage in 2009 I believe.

From: Laughlin, Wilda J (HSS)
Sent: Saturday, February 12, 2011 4:26 PM
To: Horton, Tara J (HSS)
Cc: Streur, William J (HSS)
Subject: FW: RE:

Is there still a homelessness task force?

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

This e-mail, including attachments, is intended for the use of the person or entity to which it is addressed and may contain CONFIDENTIAL or privileged information that is protected by federal and state regulation. If the reader of this e-mail is not the intended recipient or his or her agent, the reader is notified that any dissemination, distribution or copying of

this e-mail is prohibited. If you think you have received this e-mail in error, please advise the sender by reply e-mail and delete this e-mail immediately.

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Saturday, February 12, 2011 4:24 PM
To: Laughlin, Wilda J (HSS)
Subject: RE: RE:

Yes. I would like to have them present at an upcoming HSS meeting. Thanks.

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Laughlin, Wilda J (HSS) [mailto:wilda.laughlin@alaska.gov]
Sent: Saturday, February 12, 2011 4:22 PM
To: Celeste Hodge
Subject: RE:

You have an answer to this, correct?

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

This e-mail, including attachments, is intended for the use of the person or entity to which it is addressed and may contain CONFIDENTIAL or privileged information that is protected by federal and state regulation. If the reader of this e-mail is not the intended recipient or his or her agent, the reader is notified that any dissemination, distribution or copying of this e-mail is prohibited. If you think you have received this e-mail in error, please advise the sender by reply e-mail and delete this e-mail immediately.

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 10, 2011 1:27 PM
To: Laughlin, Wilda J (HSS)
Subject:

Wilda,
Can you tell me if the state has a homelessness task force? I know there is one at the municipal level. Thanks.

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Celeste Hodge
Sent: Sunday, February 20, 2011 2:32 PM
To: 'nancy.burke@alaska.gov'
Subject: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Nancy,
Hello. I'm Celeste Hodge, Committee Aide to the Senate Health & Social Services Committee (SHSS) chaired by Senator Davis. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. Suzi Pearson, chair of Alaska Coalition on Homelessness suggested I contact you to see if you could provide a brief presentation on the impact of homelessness in our communities. Please let me know of your availability. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Debe Mahoney [dmahoney@nwanchorage.org]
Sent: Thursday, February 10, 2011 11:54 AM
To: Celeste Hodge
Cc: Michael Courtney; owenc@alaska.net
Subject: RE: I was thinking about NeigborWorks last night while sleeping and wondered if the organizatin ever presented before the legislators?

March 10th would work for us but that is a Thursday. Does it need to be Wednesday the 9th? The idea of affordable housing/homelessness agenda is good! Mike and Shannon could work on arrangements while I'm gone if you all think this would work out.

Debe

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Thursday, February 10, 2011 11:36 AM
To: Debe Mahoney
Cc: Michael Courtney; owenc@alaska.net
Subject: RE: I was thinking about NeigborWorks last night while sleeping and wondered if the organizatin ever presented before the legislators?

I was hoping it could be sooner since we will have limited time for presentations in March as Bills will generate much of our agenda as we move closer to the end of the session. With that being said, March is still doable. Let me know what you decide and if March 10th would work for you. Remember, our committee meets on Monday's, Wednesday's and Friday's at 1:30 PM. Currently, we are not scheduling meetings on Friday's. Also, I could set the entire agenda around Homelessness and Affordable Housing and have various agencies present information. Just thinking out loud and trying to get NeighborWorks some face time with legislators so that important information about the organization can be shared. Thanks.

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Debe Mahoney [mailto:dmahoney@nwanchorage.org]
Sent: Thursday, February 10, 2011 9:56 AM
To: Celeste Hodge

Cc: Michael Courtney; owenc@alaska.net
Subject: RE: I was thinking about NeigborWorks last night while sleeping and wondered if the organizatin ever presented before the legislators?

That is a great idea! I won't be back in town until March 7th. Would that be too late? I leave tomorrow morning. Mike and I could come down though in March. Perhaps Owen might want to go too.

Debe

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Wednesday, February 09, 2011 11:38 AM
To: Debe Mahoney; owenc@alaska.net
Subject: I was thinking about NeigborWorks last night while sleeping and wondered if the organizatin ever presented before the legislators?

I think it would be good to present information about the organization to the legislators. What are your thoughts? I could get you scheduled to present in front of the Senate Health and Social Services Committee (HSS) (Chair, Sen. Davis) and connect you to the House HSS committee to possibly schedule during that same time-frame. It's a good way to get the information out about the organization and become known to those that appropriate funds. Let me know. Thanks.

Celeste Graham-Hodge
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Click here to report this email as spam.

Celeste Hodge

From: Burke, Nancy (DOR) [nancy.burke@alaska.gov]
Sent: Sunday, February 20, 2011 3:09 PM
To: Celeste Hodge; Jeff Jessee
Subject: Re: HOMELESSNESS PRESENTATION BEFORE THE SENATE HEALTH & SOCIAL SERVICES COMMITTEE

Celeste,
Thanks to you for organizing this session and to the Senator for the opportunity to present the work that the Trust is doing in this critical area.

I am out of town for the date identified, however, our team will be happy to meet and provide materials. I am copying our CEO who will also be a contact for the hearing and who may be able to present in my absence.
I will contact you on Tuesday to confirm and to seek additional information on the focus of the session.
Nancy

Celeste Hodge <Celeste_Hodge@legis.state.ak.us> wrote:

Nancy,
Hello. I'm Celeste Hodge, Committee Aide to the Senate Health & Social Services Committee (SHSS) chaired by Senator Davis. As most in this state, Senator Davis is very concerned about the homeless situation in Alaska and asked me to organize a SHSS meeting to hear concerns and statistics around homelessness and current solutions and possibilities for the future. The meeting is set for Wednesday, March 9, 1:30 PM in the Butrovich Room of the Capitol. Suzi Pearson, chair of Alaska Coalition on Homelessness suggested I contact you to see if you could provide a brief presentation on the impact of homelessness in our communities. Please let me know of your availability. Once presenters are confirmed, details for the meeting will be emailed to participants. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Alaska Council on the Homeless

History

The Alaska Council on the Homeless (The Council) is a state-wide council appointed by the Governor of Alaska. It was first established on April 30, 2004 by Governor Frank H. Murkowski through Administrative Order 214. Governor Murkowski appointed a dozen members from state and federal agencies to the Council and charged them with preparing recommendations on how state resources may be directed towards ending homelessness. In his Administrative Order establishing the Council, Governor Murkowski identified the need to develop a statewide plan that would include short-term and long-term strategies to effectively address the problem of Alaska's homeless population. He said the development of the plan should serve to educate all Alaskans about the tragedy of homelessness and engage both governmental agencies and the private sector in finding solutions to this problem. The Council completed its mission in October 2005 by releasing the report "Keeping Alaskans Out of the Cold."

On May 1, 2007 Governor Palin re-authorized the Governor's Council through Administrative Order 236. She made it a more permanent council under the auspices of Alaska Housing Finance Corporation (AHFC). The Alaska Council on the Homeless membership includes representation from AHFC, the Alaska Mental Health Trust Authority, the Alaska State Departments of Education, Public Safety, Corrections and Health and Social Services and six public members from the homeless provider community, rural housing authorities, local government and the real estate industry. The Council's role continues as a public policy forum for recommendations on the use of state and federal resources to address homelessness within Alaska.

Current Activities

During 2008 and 2009, the Council is focusing on the development of a Ten Year Plan on Homelessness. For more information on this plan and its development, check AHFC's Alaska Council on the Homeless:

Alaska Council on the Homeless

Summary

On April 30, 2004, Gov. Frank H. Murkowski established the Alaska Council on the Homeless through Administrative order 214. He appointed a dozen members from state and federal agencies and charged them with preparing recommendations on how state resources could be directed towards ending homelessness. In his Administrative Order establishing the Council, Gov. Murkowski identified the need to develop a statewide plan that would include short-term and long-term strategies to effectively address the problem of Alaska's homeless population. He said the development of the plan should serve to educate all Alaskans about the tragedy of homelessness and engage both governmental agencies and the private sector in finding solutions to this problem. The Council completed its mission in October 2005 by releasing the report "Keeping Alaskans Out of the Cold."

On May 1, 2007 Governor Palin re-authorized the Governor's Council through Administrative Order 236. She made it a more permanent council under the auspices of AHFC. The current Council membership includes AHFC, the Alaska Mental Health Trust Authority, the Alaska State Departments of Education, Public Safety, Corrections and Health and Social Services and six public members from the homeless provider community, rural housing authorities, local government and the real estate industry. The role of the Governors Council continues as a public policy forum for recommendations on the use of state and federal resources to address homelessness within Alaska.

Alaska Council on the Homeless Report

"Keeping Alaskans Out of the Cold" - Alaska's Recommended Strategies to Address Homelessness
10 year Plan to Reduce Long Term Homelessness

Meeting Information

November 29, 2010
May 27, 2010
November 13, 2009
May 28, 2009
August 7, 2008

Reference Information

Governor Palin's Administrative Order 236 re-authorizing the Alaska Council on the Homeless
Alaska Mental Health Trust Authority Strategic Plan on Housing
Alaska Wage/Rent Disparity Chart
Consolidated Housing and Community Development Plan for the State of Alaska, 2005 - 2010
"Costs of Serving Homeless Individuals in Nine Cities," Corporation for Supportive Housing, November 2004
Fair Market Rent Chart
Faith-Based & Community Initiatives Task Force
Federal Legislative Agenda for Affordable Housing (AHFC)
Governor Murkowski's Administrative Order 214 forming the Alaska Council on the Homeless
Homeless Funding Matrix
Homeless Surveys
Innovative Services for Alaska's Homeless Persons with Mental Illness
Municipality of Anchorage Ten-Year Plan on Homelessness
Policy Academy for Improving Access to Mainstream Services for Families with Children Experiencing Homelessness Action Plan, 2005
U.S. Inter-Agency Council on Homelessness Strategic Plan to Prevent and End Homelessness

Keeping Alaskans Out of the Cold

STATE OF ALASKA
REPORT TO GOVERNOR FRANK MURKOWSKI
RECOMMENDED STRATEGIES TO ADDRESS HOMELESSNESS

OCTOBER 2005

Clare House provides temporary, emergency 24-hour shelter and case management for women and women with children.

The Office of
Governor Frank H. Murkowski

Homelessness is a wrenching problem that confronts an estimated 14,000 Alaskans a year, according to this report.

My goals in establishing the Interagency Council on Homeless were to find ways to address the problem, encourage public discussion, and increase Alaskans' understanding of the complexities surrounding homelessness.

The Interagency Council looked at the many causes of homelessness in Alaska. It is no surprise that the primary reason is a change in economic status and the inability to pay increased housing cost.

The council recognized that many government and nongovernment organizations, including community and faith-based groups, are involved in helping. Yet, with all this effort, the problem persists. As a result of their efforts, the council made a number of recommendations for action that can help move toward the elimination of homelessness in Alaska.

My belief is that the best way to help someone meet the basic necessities of life is to have opportunities for job training and hence permanent employment. That is why my priority is creating employment opportunities for Alaskans by stimulating private sector investment through development of Alaska's natural resources.

I am grateful to the Lieutenant Governor, the commissioners, and other executives who served on the panel and produced this report. I thank in particular all of the citizens who participated, presented testimony, and made recommendations to the council.

I encourage Alaskans to read this report to gain insight into the complex problems surrounding homelessness in Alaska and look forward to further work on the recommendations.

Sincerely yours,

Frank H. Murkowski
Governor

Alaska Housing
FINANCE CORPORATION

Headquarters
4300 Boniface Parkway
Anchorage, Alaska
907-338-6100

Mailing Address
PO Box 101020
Anchorage, AK 99510-1020

Internet Web Site
http://www.ahfc.state.ak.us

October 13, 2005

Governor Frank Murkowski
Office of the Governor
PO Box 110001
Juneau, Alaska 99811-0001

Dear Governor Murkowski

On behalf of the interagency Alaska Council on Homelessness, I am pleased to transmit to you this report and recommended strategies for addressing homelessness in Alaska. As you know, the members of the council include eight department commissioners, the executive director of the Alaska Mental Health Trust, and two ex-officio members, the Lieutenant Governor and the director of the Alaska HUD office. It was my honor to serve as the chair.

Over the past 17 months, we held a number of public meetings, discussions and hearings to develop this information. Council members were well qualified for the assignment. Each is knowledgeable about the complexities of the state's homeless problem, and each addressed it from a different perspective, based on his or her professional background.

We all agreed that homelessness is a costly and serious problem. It has the potential to become critical in times of a major economic downturn or, conversely, in times of another boom like the state experienced during the 1970s. Council members also agreed that the most cost effective strategy for the state is to prevent homelessness and thereby avoid dealing with its many consequences.

Although dozens of recommendations for a state strategy were discussed, council members agreed to pare the list to a realistic handful considered affordable and ones that could be acted upon relatively quickly. You will find in this report the following recommendations:

1. Support programs that assist low income families to preserve, maintain and weatherize homes and multi-family housing, so the families can continue living in their homes and not become homeless.

2. Expand renter education programs statewide so that new renters, including young people first leaving home and rural residents relocating to urban communities, have an understanding of their obligations as a renter and of the consequences of not paying rent on time or neglecting maintenance needs.

3. Create a working group of representatives from the departments of Health and Social Services, Public Safety and Corrections, the Alaska Mental Health Trust, and local community partners and stakeholders to identify policies and procedures that would provide individuals a well coordinated transition from institutionalization to independent living. Currently, about 5,000 Alaskans are released each year from a state hospital, a correctional facility or a foster care setting into homelessness status.

4. Increase the inventory of affordable housing and thereby ease the burden on community-funded shelter services by reducing homelessness. Accomplish this objective by bringing together a working group comprised of policy makers, local partners, and representatives of housing builders, financiers and providers, land use planners, Native corporations, and community and faith-based organizations to identify housing priorities and regions of the state most in need. The working group would be available to provide counsel and recommendations to the state executive and legislative branches of government.

5. Appoint a steering committee to assist the Governor and Legislature to establish an affordable housing trust that would help the state fund programs that increase the inventory of affordable housing and accomplish the recommendations to end homelessness, identified in this report.

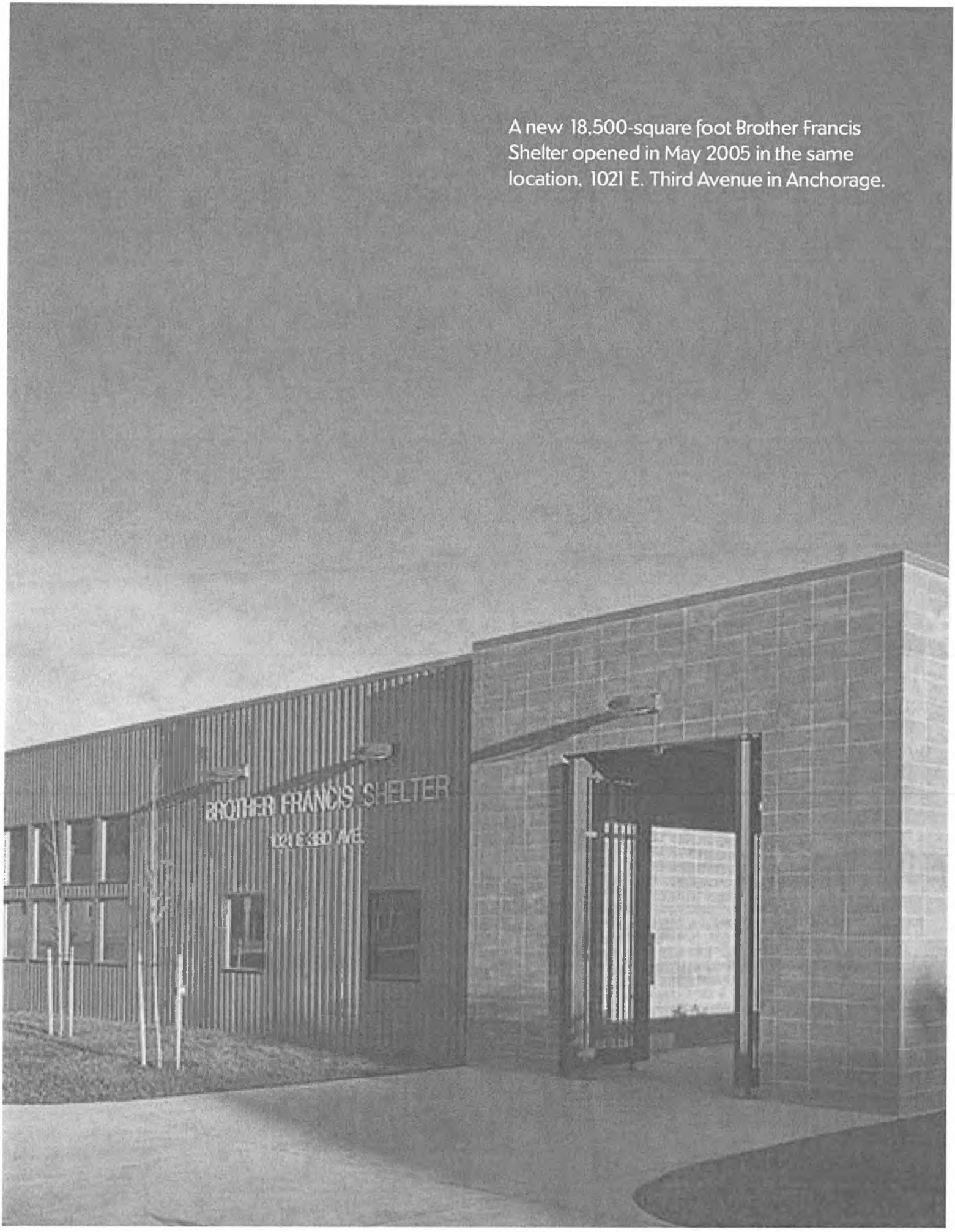
With delivery of this report, the Interagency Council on Homelessness considers its assignment completed, and unless otherwise directed, dissolves. As the administration evaluates these recommendations and contemplates implementation, those of us who served stand ready to provide counsel and assistance, and to serve on working groups that may be formed.

Thank you for the opportunity to serve on the council. It has been a rewarding and enlightening experience for all of us. We hope that the recommendations in the report are of help to you as your administration continues to address the complex problem of Alaska's homeless population.

Sincerely,

Daniel R. Fauske

Dan Fauske
Chair



A new 18,500-square foot Brother Francis Shelter opened in May 2005 in the same location, 1021 E. Third Avenue in Anchorage.

Introduction

It is estimated that 14,000 people experience homelessness in Alaska at some time each year. That's the equivalent of all the people in communities such as Ketchikan or Kodiak or the Bethel region living without housing. Homelessness is a complex problem surrounded by many issues in addition to housing. It is one of the most challenging domestic matters facing Alaska and the nation.

The costs of homelessness in Alaska are enormous – both in terms of human suffering and economic impact. Annually, more than $14 million are spent on homeless services in Alaska, and include assistance with housing, health, education, social services and public safety. A 2003 study of chronic homelessness in Fairbanks, conducted by the University of Alaska Center for Alcohol and Addiction Studies, revealed that more than $40,000 per person was spent in public intervention over a 20-month period.

Statewide strategies to address homelessness were first developed through the Alaska Coalition on Housing & Homelessness. Established in 1989, the Coalition is a partnership of faith-based and community organizations, public agencies and concerned citizens. Urban communities also have established similar networks of local partnerships, and mayoral task forces in several Alaskan communities have studied homelessness over the past 15 years. Despite these efforts, homelessness has continued to grow throughout Alaska.

Faith-based and community organizations over the years have fulfilled a critical role in providing assistance to Alaskans in need. In recognition of this, Gov. Murkowski in 2002 called upon Lt. Gov. Loren Leman to lead a task force that examined issues and ways in which the various organizations might be able to improve delivery of services and how the government might reduce hurdles that hinder this delivery. "This task force surveyed current needs in Alaska and determined that the concern voiced most often was the lack of adequate safe and affordable housing." (Alaska Faith Based and Community Initiatives Task Force Report, February 2004.)

In April 2004, Governor Murkowski furthered his commitment to address the needs of Alaskans by joining 44 other states in appointing an interagency council on homelessness. The Alaska Council on the Homeless is comprised of eight state commissioners (from the departments of Health and Social Services; Corrections; Public Safety; Transportation and Public Facilities; Education and Early Development; Labor and Workforce Development; Military and Veterans Affairs and Commerce, Community and Economic Development) and representatives from the Governor's office, Lt. Governor's office, the Alaska Mental Health Trust Authority (AMHTA) and the U.S. Dept. of Housing & Urban Development (HUD). The governor designated the CEO of the Alaska Housing Finance Corporation, Dan Fauske, to chair the Council and to provide the resources and staff time necessary for the Council to assess the problem and develop strategies.

A two-tiered strategy was adopted by the Council. First, the Council looked internally at the role state government should take. Following that, the Council explored ways to bring together other partners and stakeholders to identify actions that the state, federal, and local governments, along with non-profits, faith-based and private organizations, could take to end homelessness in Alaska.

The Council held a series of six meetings and formal public hearings to gather information and to formulate strategies. All meetings included the opportunity for public comment. Active participation

was also sought from a number of identified partners, including the U.S. Dept. of Veterans Affairs, the Social Security Administration, Alaska Coalition on Housing & Homelessness, Alaska Policy Academy team on Homeless Families and Youth, the Anchorage Mayor's Task Force on Homelessness and representatives of the faith and community-based providers. Meaningful insights were also shared by people who had personally experienced homelessness.

This report examines homelessness in Alaska and offers potential strategies for further consideration. The report, along with other state and local planning documents, will assist stakeholders and policy makers to create a comprehensive statewide action plan to end homelessness.

Covenant House staff and friends from Homeward Bound at a vigil for homeless youth.

Overview of Homelessness in Alaska

How does homelessness impact the state?

Homelessness is a costly problem that threads its way throughout state systems. While only a few discrete programs are specifically related to homelessness, the needs of homeless people, families and children intersect among numerous state services. For example, homeless children will often require financial, nutritional and medical support from the Department of Health and Social Services or from state-sponsored social service partners. Additionally, these children will intersect with the Department of Education and Early Development (DEED). Not only does homelessness affect school performance, but it may also cause a reduction or channeling of federal funds for purposes outside the classroom. For example, schools are penalized for poor academic performance, and additional costs are borne by school districts to provide specialized tutoring and to transport homeless children to their home schools, no matter where they currently live in the district. During the 2004/2005 school year, the DEED reported 3,023 children were homeless or residing in inadequate housing at some time during the school term.

More than 3,000 Alaska children were homeless or in inadequate housing during the school term.

State and state-supported agencies address other needs of homeless families, as well. Without adequate housing, family stability becomes precarious. Work, child care and transportation may become tenuous, due to the uncertainty of where the family will be living from one day to the next. State job reemployment services assist these families in rebuilding economic stability, while government supported shelters and case managers are often called upon for transitional support purposes. Homeless families are a priority for public and subsidized housing, and often seek help with securing permanent housing from AHFC or regional housing authorities.

A stay at Alaska Psychiatric Institute costs $732 per day; a trip to a detox center costs $270 per day; incarceration costs $111 per day. By contrast, a supportive housing program costs $70 per day.

The impact of chronic homelessness upon state services is also significant. The underlying issues that result in chronic homelessness lead to crisis and public safety interventions that are especially costly to the State. The cost for a stay at Alaska Psychiatric Institute (API) is $732 per day. A trip to detox is $270 per day and incarceration is $111 per day. Prevention of homelessness is cost-effective. By contrast, placement in a supportive housing program is estimated to be only $70 per day, and can provide early intervention to avoid these additional human and financial costs. Placements in supportive housing may also lead to reductions in the secondary costs of homelessness to the many state, federal and community-based resources.

An estimated 14,000 Alaskans experience homelessness at some point each year.

How is homelessness defined?

The definition of homelessness varies among different federal funding sources. The definition from the McKinney-Vento Act is the most inclusive, and is used in determining eligibility for various health and education programs. The U.S. Department of Housing & Urban Development (HUD) provides a different and more restrictive definition. HUD defines homeless as: "an individual or family who lacks a fixed, regular, and adequate nighttime residence and an individual who has a primary nighttime residence that is

(a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

(b) an institution where the person is within one week of discharge with no identified residence or resources to obtain a residence; or

(c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

The HUD definition is not a perfect fit because it does not address several specific issues surrounding homelessness, such as homeless students or overcrowding caused by shared housing. However, the best available data on homelessness according to HUD's definition of those who are homeless is gathered annually for HUD's Continuum of Care process. Consequently, unless otherwise noted, the data presented in this report utilizes HUD's definition and should be treated as a conservative estimate of number and characteristics of the population.

How many homeless are there?

At least 3,500 Alaskans are identified as homeless, based upon point-in-time surveys regularly conducted by AHFC twice each year. This total represents only those who happened to interact with a homeless enumerator on that particular survey day. In communities where shelters or other related services are unavailable, homeless persons are not likely to be counted. According to a study by the Urban Institute, (Martha R. Burt, Oct. 1, 2001) "during a year's time, four or five times as many people experience homelessness as are homeless on any particular day." Annual service reports from Alaska providers support this estimate, thus indicating that in the course of a year, approximately 14,000 Alaskans experience a period of homelessness.

What are their characteristics?

28 percent of Alaska's homeless are families with children.

32 percent of Alaska's homeless are "chronically homeless."

Homeless Alaska Natives and African-Americans are over-represented compared to their proportion of the population.

There are many subpopulations among those who experience homelessness. These subpopulations include single men and women of all ages, single mothers with children, single fathers with children, two-parent or "blended" families with children, disabled persons, runaway or abandoned youth, victims of domestic violence and veterans. Over the last two years, the AHFC Homeless Survey reveals that approximately 28 percent of the reported households were families with children. Homelessness for many of these families may be the result of a sudden economic downturn from causes such as illness, injury, divorce or job loss. According to the Summer 2004 AHFC Homeless Survey, 32 percent of the homeless were "Chronically Homeless." HUD defines the chronically homeless as "single individuals with a disabling condition who have been homeless for a year or more, or who have experienced at least four episodes of homelessness within three years." In at least 50 percent of the chronic homeless cases, the "disabling" condition was mental illness and/or substance abuse.

Homeward Bound's Mission is to provide the homeless chronic alcoholic with the tools needed to travel the journey home.

Alaska Natives are over-represented among Alaska's homeless. They represent 36 percent of the homeless counted over the last 10 years of the survey, but are only 19 percent of the state's population. African-Americans are also over-represented, accounting for 8 percent of the homeless reported compared to 3 percent for the overall population in Alaska.

According to shelter providers around the state, some of the most difficult people to house are those recently released from institutions with no resources or family support and essentially nowhere to go. In a survey of inmates conducted in January 2005 by the Alaska Department of Corrections, 373 (35 percent) of the 1,067 respondents stated they either had no place identified to reside upon release, or they were certain they would enter a homeless shelter and/or live on the streets. Reports from Alaska Psychiatric Institute also indicate a 5-10 percent discharge rate each month to homelessness.

What services are currently in place?

Alaska has 1,229 emergency shelter beds, 817 transitional housing beds, 450 targeted permanent supportive housing beds.

The fundamental components of a "continuum of care" for homelessness include prevention, outreach/assessment/intake, supportive services, emergency shelter, transitional housing and permanent housing. Alaska's current HUD-defined "Continuum of Care" inventory consists of 1,229 emergency shelter beds (including 376 secure beds for domestic violence victims), 817 transitional housing beds, and 450 permanent supportive housing beds that specifically target homeless persons.

A critical component for housing retention is the provision of supportive services that reinforce housing stability and break the cycle of homelessness for people with complex problems. Testimony from formerly homeless people overwhelmingly confirmed the value of case management, particularly during the early stages of a housing crisis when someone to help "navigate the system" is vital. Existing "housing first" programs report that private landlords are more willing to accept persons with clouded housing histories when a case manager is available to call should problems arise. The Council also recognized employment assistance, transportation, and child care as other essential elements for housing retention.

How are homeless services currently funded?

$14 million is spent on homeless services in Alaska annually.

A combination of private and public funds is used to assist Alaska's homeless. Annually, Alaska spends more than $14 million for services ranging from housing, health, education, social services and public safety, as tabulated from the 2004 Continuum of Care applications for Anchorage and the remainder of the state. Many of the emergency shelters and food pantries serving the general public were developed by faith-based organizations such as the Salvation Army, Catholic Social Services, Lutheran Social Services and St. Vincent de Paul. These agencies generally rely on private donations and government support to keep their doors open. Pitted against a community's need for public safety, education and transportation, these shelters struggle every year to keep a line in their local government budget.

Numerous federal programs also contribute funding for services to the homeless. HUD's Emergency Shelter Grant provided $83,573 for Anchorage and $119,198 for the remainder of the state for the federal fiscal year (FFY) 2004. Federal funding for domestic violence shelters, under the Victims of Crime Act, totaled $867,100 in FFY03.

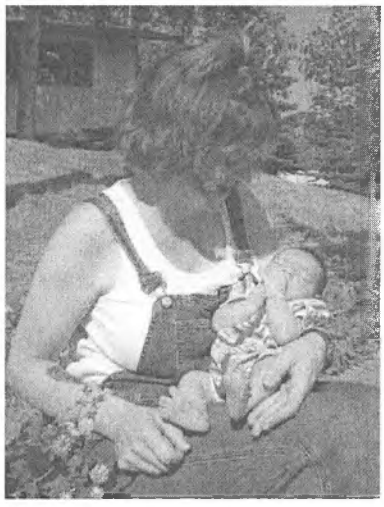
Federal funding plays a greater role in longer-term homeless assistance, most notably through the Stewart B. McKinney Act. Under this act, a combination of formula and competitive awards is made each year by the federal government to assist the homeless in Alaska. Formula awards include funds to the Alaska Department of Education and Early Development to provide continuity in the education of homeless children. In July 2004, 12 agencies throughout the state competed under HUD's Continuum of Care process to renew 17 projects that were

Clare House serves as a temporary haven through which homeless women and children are assisted on their paths toward independence and self-respect.

originally funded in the mid- to late 1990s. These projects ranged from transitional housing for victims of domestic violence to scattered-site housing for homeless persons with mental disabilities. The most recent FFY04 award totaled $3,574,089. To meet HUD's matching requirements, AHFC has annually awarded about $1 million to Continuum of Care grantees.

As the recipient of a number of federal formula funds, the State of Alaska is in a position to make a concerted effort to address homelessness. Federal funds awarded through block grants all come with provisions that allow states wide discretion to determine priority programs and beneficiaries, including homeless persons. The State can also play a key role in ensuring that federal grant funding which specifically targets homeless persons such as PATH (Projects for Assistance in Transition from Homelessness), Healthcare for the Homeless and Homeless Education are used in association with other State and local homeless programs to maximize benefits.

A growing concern among agencies in the homeless service sector is securing funding for operating and program expenses. Most of the private foundations operating in Alaska and many of the federal programs limit their awards to capital (building) projects or one-time program start-ups. The harsh reality of homelessness is that people in this situation are not in a position to pay for the services they need. Without a united effort from all sectors, Alaska cannot expect to break the cycle of homelessness.



Clare House served 452 clients in FFY04; 60 percent were children.

Strategies to End Homelessness

Major strategies emerged, including education, early crisis intervention, housing preservation and increase of affordable housing stock.

The Council conducted two fact-finding meetings and held a public hearing to examine the causes of homelessness. A list of 21 needs and issues was extracted from reports and plans generated by such groups as the Alaska Coalition on Housing & Homelessness, the Faith-Based & Community Initiatives Task Force, Continuum of Care applications and the Mental Health Trust Authority.

Throughout the planning process, Council discussions centered on the role the State of Alaska should or could play in ending homelessness. Council members were provided with strategies and recommendations contained in plans from other states and in local plans to assess best practices. In addition, the Council reviewed the draft plan created by the Alaska Policy Academy Team on Homeless Families and Youth, as well as the recently completed "Ten-Year Plan on Homelessness" for the Municipality of Anchorage. The Council also heard a presentation from the Chair of the Mayor's Task Force on Homelessness and the executive director of the Faith-Based and Community Initiatives, Alaska Department of Health and Social Services. Also, a public hearing was conducted on April 26, 2005, so people could respond to a draft report that proposed recommendations to address homelessness, and, in some cases, to offer additional recommendations.

After assessing all the information, the Council narrowed its focus to a few central themes. Three major areas emerged as change points to ending homelessness:

1. Sufficient affordable housing;
2. Well-coordinated transition from institutionalization to independent living and
3. Homeless prevention and housing retention.

Affordable Housing

16,000 new affordable housing units are needed.

National research has shown that the supply of affordable housing is directly related to the incidence of homelessness.

According to AHFC's 2005 Consolidated Housing and Community Development Plan and the 2005 Alaska Housing Needs Assessment, about 300 to 350 units of affordable housing are added annually in Alaska. But an estimated 16,000 new housing units are currently needed to meet population growth, relieve overcrowding and replace substandard housing. An annual average of 1,000 housing units are weatherized, repaired or modified for accessibility, but more than 20,000 units currently are in need of major repair. An estimated additional 25,000 units require weatherization improvements and/or accessibility modifications.

20,000 units are in need of major repair, and 25,000 units require weatherization improvements and/or accessibility modifications.

Alaska also faces challenges on the other side of the housing affordability equation – affordable rents. Alaska has relied upon a variety of federal and state programs to lower rental costs to make housing more affordable. Unfortunately, "affordable" rents are often more than the amount very low-income Alaskans can manage and various federal rental subsidy programs, as well as funds for public and Indian housing, are being significantly reduced.

Thirty-four states already have created housing trusts to supplement current funding for affordable housing development and rental subsidy programs. These states fund their trusts through unclaimed property funds, general fund appropriations and other methods. Nationwide, state housing trust funds commit $400 million annually to provide 50,000 units of affordable housing. On average, each housing trust fund dollar leverages eight additional dollars of housing funding.

Many state housing trust funds target specific purposes. Three states have homeless trust funds specifically addressing the needs of the homeless. These include the Georgia Trust Fund for the Homeless, Nebraska Homeless Assistance Trust Fund and Wisconsin's Interest Bearing Trust Account.

One successful multi-faceted housing trust fund is the Burlington (Vermont) Housing Trust Fund. During its ten-year history, this fund has supported the construction or rehabilitation of 750 units of low-income housing; the continuous operation, building maintenance and improvement of Way Station, a 36-bed shelter for the homeless; and the operation of Project HOME – a program that links people who have extra living space with those who are seeking affordable housing.

One important component of the Burlington Housing Trust Fund activities has been its funding support of the Burlington Community Land Trust projects providing low-income housing alternatives. Between 1984 and 2002, the Burlington Community Land Trust developed 259 affordable single-family homes and condominiums. All of these homes were sold to first-time homebuyers subject to durable controls over their occupancy and resale. These controls are designed to maintain availability and affordability for low-income households far into the future.

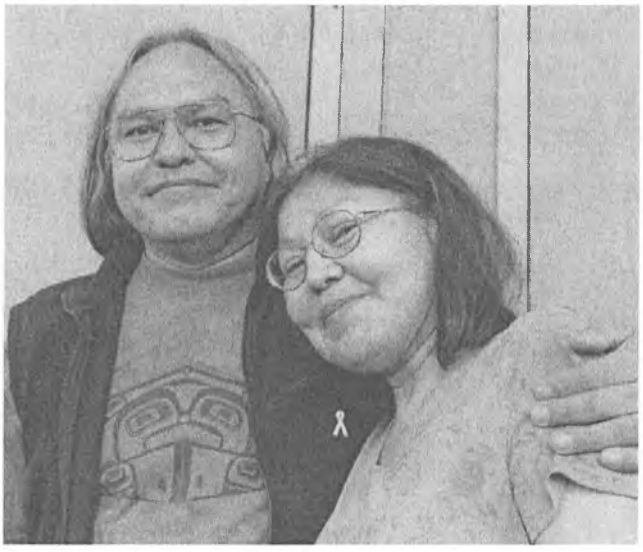
Over the past five years, AHFC has funded affordable rental housing development totaling more than 950 units at a total development cost of $170 million. During this same period, state funding of $15 million has leveraged $155 million in federal funds – a ten-fold leveraging. That leveraging came from low-income housing tax credits and mortgage financing and it made affordable housing projects feasible. Projects included 500 units set aside for households at or below 50 percent of median family income, with an additional 250 units set aside for households at or below 60 percent of median family income. The Council recognizes the importance of leveraging federal and other funds through commitment of state funds, and knows that such leveraging is critical to increasing affordable housing stock across the state.

AHFC has funded more than 950 units of affordable rental housing over the past five years.

AHFC has also proposed a federal legislative agenda involving modifications to the federal tax code that would increase funds for affordable housing. A number of housing authorities from other states support this initiative. The federal agenda can be accessed through the Reference Guide, which can be found at the end of the report.

Council Recommendation: Develop a State Affordable Housing Trust

The Council recommends the Governor and Legislature establish an affordable housing trust. A steering committee should be formed, representing public and private interests, to research options and develop a housing trust framework to present for the Governor's approval, which will maintain the affordability of housing. The steering committee should examine the various resources – statewide and nationwide – currently available to develop and operate affordable rental housing and ownership programs; develop a mission statement and performance measures for the housing trust; establish policies and procedures; determine the financing mechanism of the trust; and develop enabling legislation to be considered during the next legislative session.



Elsie entered the Homeward Bound program after spending most of her adult life on the streets of Anchorage. She graduated from the program this year and now enjoys her own apartment. She was recently reunited with her brother Ben, a counselor from Sitka, for the first time in 30 years.

Institutional Services Discharge

A growing body of research is showing significant cost savings when public funds are invested in a well-coordinated transition from institutionalization to independent living. Those leaving a state hospital, a correctional facility or a foster care setting are likely to have little or no income and lack significant social skills to make a positive transition into society. Without support from family or friends, these individuals may be vulnerable to homelessness. Often this risk is increased by lack of adequate support, or expectations to secure housing, employment, medical and mental health services and legal assistance. Some of these individuals require substantial and long-term support to achieve a successful and lasting transition. It is estimated that more than 4,700 Alaskans are released from institutional care into homelessness every year.

It is estimated that more than 4,700 Alaskans are released from institutional care into homelessness every year.

Council Recommendation: Institutional Services Discharge

The Council recommends the State of Alaska adopt policies to reduce the likelihood of homelessness upon discharge from institutions by creating a working group comprised of representatives from the departments of Health and Social Services, Public Safety and Corrections, the Alaska Mental Health Trust, and local community partners and stakeholders. This group would evaluate the barriers to effective discharge planning and make recommendations for modifications to policies that would reduce the risk of homelessness.

Homeless Prevention/ Housing Retention

Emergency shelters are expensive and problematic for local communities. The Council unanimously agreed that one of the best ways to reduce the need for shelters is to keep homelessness from happening. From the presentations and discussions on this topic, three major strategies emerged: education, early crisis intervention, housing preservation and increase of affordable housing stock. The Council also recognized the need for adequate supports in transportation, job opportunities and, in some cases, supportive services to assure housing stability.

Renter Education

According to testimony, young people first leaving home and rural residents relocating to urban centers often have a difficult time retaining housing. They are not fully prepared for, nor do they understand the consequences of not paying rent on time or neglecting the maintenance needs of their units. To mitigate this problem, several providers around the state, such as Catholic Social Services in Anchorage and St.Vincent de Paul in Juneau, have developed successful renter education programs that cover such topics as budgeting, housing search techniques, understanding and negotiating a lease, maintenance dos-and-don'ts and skills

Homeward Bound has served 212 program participants since April 1997. Participants have repaid $330,670 in debt previously considered unrecoverable.

for dealing with guests and roommates. AHFC currently provides free day-long seminars throughout the state to educate prospective home buyers about various aspects of buying and caring for a new home. This program could be modified easily to provide information pertinent to renters. Several other states such as Minnesota, Wisconsin, Virginia and Michigan provide renter education courses through their Cooperative Extension Service.

Council Recommendation: Expand Renter Education

The Council recommends the expansion of renter education opportunities in Alaska through existing delivery systems and educational programs, such as the Department of Education and Early Development, the University of Alaska Cooperative Extension Service, AHFC and community and faith-based groups.

Housing Preservation and Increasing Inventory of Affordable Housing

Other critical elements of homeless prevention are the preservation of existing housing stock and increasing the inventory of affordable housing. Programs that assist low-income homeowners make needed repairs or modifications, improve energy efficiency, or create additional affordable housing can ease the burden on community-funded shelter services by reducing homelessness. Additionally, support for maintenance and weatherization programs aids in reducing the rising costs of utilities and extend the life of existing homes.

Council Recommendation Long-Term: Appoint a Working Group to Continue the Discussion on Homelessness and its Solutions

The Council recommends the Governor bring together policy makers, partners from within our communities, and other stakeholders as a working group to address ongoing housing issues mentioned in this report, including the goal of expanding the affordable housing inventory and preserving existing housing stock. This working group should include housing builders, housing financiers, current housing providers, land use planners, Alaska Native corporations, and faith-based and community organizations.

The working group's primary charge should be to address community and statewide barriers and solutions to ending homelessness. It should work closely with the housing trust to encourage investments in affordable housing in areas most in need. Documents created from state and local planning efforts to address homelessness, community "best practices" and resources can be shared and used to craft an ongoing action plan that produces measurable results, and achieves the goal of ending homelessness in Alaska.

Alaska Council on the Homeless

Members

Dan Fauske, CEO/Executive Director, Chair
Alaska Housing Finance Corporation

Lt. Governor Loren Leman

Mark Antrim, Commissioner
Department of Corrections

Mike Barton, Commissioner
Eric Taylor, Manager of Statewide Plan & Transit
Department of Transportation & Public Facilities

Colleen Bickford, Anchorage Field Office Director
U.S. Department of Housing & Urban Development

Major General Craig Campbell,
Adjutant General/Commissioner
Jerry Beale, Deputy Director
Department of Military & Veterans Affairs

Dennis DeWitt, Special Assistant
Office of the Governor

Karleen Jackson, Commissioner
Department of Health & Social Services

Jeff Jessee, Executive Director
Alaska Mental Health Trust Authority

Greg O'Claray, Commissioner
Department of Labor & Workforce Development

Roger Sampson, Commissioner
Department of Education & Early Development

William Tandeske, Commissioner
Department of Public Safety

Alaska Council on the Homeless
(l to r) Eric Taylor, Mark Antrim, William Tandeske, Jeff Jesse, Karleen Jackson, Colleen Bickford, Dennis DeWitt, Loren Leman, Dan Fauske, Roger Sampson and Jerry Beale.

Reference Guide

Links to the following information can be found at www.ahfc.us/homeless/homeless.cfm#reference.

A. 2004 Gaps Analysis for the Continuum of Care, Balance of State

B. 2005 Policy Academy for Improving Access to Mainstream Services for Families with Children Experiencing Homelessness Action Plan

C. Alaska Mental Health Trust Authority Strategic Plan on Housing

D. Alaska Wage/Rent Disparity Chart

E. Consolidated Housing and Community Development Plan for the State of Alaska, 2005 - 2010

F. "Costs of Serving Homeless Individuals in Nine Cities," Corporation for Supportive Housing, November 2004.

G. Continuum of Care Housing Activity Charts

H. Continuum of Care Service Activity Chart

I. Fair Market Rent Chart

J. Faith-Based & Community Initiatives Task Force

K. Governor's Administrative Order No. 214 forming the Alaska Council on Homeless

L. Homeless Funding Matrix

M. AHFC Homeless Surveys

N. Alaska Council on the Homeless minutes and public hearing proceedings

O. Municipality of Anchorage Ten Year Plan on Homelessness

P. "Innovative Services for Alaska's Homeless Persons with Mental Illness," Bernard Segal, PH.D., Center for Alcohol and Addiction Studies, University of Alaska, 2003.

Q. AHFC federal legislative agenda for affordable housing

R. "Keeping Alaskans Out of the Cold," State of Alaska, Report to Governor Frank Murkowski, Recommended Strategies to Address Homelessness, October 2005.

10 YEAR PLAN TO END LONG TERM HOMELESSNESS IN ALASKA

"Opportunity begins with a Home"

Alaska Council on the Homeless

Adopted May 28, 2009

Executive Summary:

This Ten Year Plan to Address Long-term Homelessness in Alaska (Plan) is based on four years of work by state and local governments and the input of hundreds of people and homeless service providers. It is realistic and achievable. It will reduce the number of homeless individuals and families in total and decrease the duration of time spent in homelessness.

The Plan recommends:

1. 1,000 new units over the next 10 years
2. 500 new rental assistance vouchers
3. 160 new supportive service slots
4. $3 million annually to establish a coordinated pool of funds for prevention activities.

The plan establishes realistic goals and details specific actions steps to achieve them. It will take $10 million in additional resources to achieve a reduction of greater than 50% in the homeless population.

The state Homeless Assistance Program (HAP), the Housing for Persons with AIDS/HIV(HOPWA), and McKinney-Vento homeless programs, along with activities of the private sector through non-profits and faith based organizations are the reason for our current successes. They form the base line that is responsible for the current successes in addressing homelessness. This plan assumes that current efforts will be maintained and additional resources will help create future successes.

The amount of funding needed to take Alaska beyond its current status of "maintaining" rather than "reducing" homelessness is not astronomical. While some additional investment is necessary, much can be accomplished through redirection of existing resources and greater interagency cooperation. This plan focuses on three approaches that have been proven successful throughout the US in addressing homelessness. These three approaches are:

- the creation of supportive housing. It brings support services together with appropriate housing to allow the homeless with co-occurring disorders (mental health, substance abuse) to live independently or under supervision. This approach is far more cost effective than reliance on emergency room visits, or periodic stays in the Alaska Psychiatric Institute or prison to address homelessness;

- New rental assistance for families and individuals that need short term assistance to get back into the work force; and

- Prevention activities. The most expensive way to address homelessness is to wait until a family's situation becomes a crisis requiring reliance on emergency assistance. A small

amount of money (less than $2,000), made available at the right time can prevent a family or individual from becoming homeless.

With incremental additions to the housing inventory and the adequate living supports identified in this plan, Alaska can handily reduce its homeless numbers from thousands to hundreds by 2019.

Introduction

The face of homelessness in Alaska is a child playing in a shelter. It is a veteran struggling with post-traumatic stress, estranged from family and distrustful of "the system." It is a camp concealed in the trees until discovered, dismantled and all of the inhabitants' possessions are taken. It is a foster child who must now fend for themselves because a birthday suddenly turned them into a legal "adult." The face of homelessness is people of every age and ethnic group more often caught up in circumstances beyond their control who are looking for the path that will lead them home. Homelessness is not a character flaw.

This document is the product of a continuing effort in the state of Alaska to strategically reduce the tragedy of long-term homelessness in our state. For many years the Alaska Coalition on Housing & Homelessness, a grass-roots statewide organization had been collecting data and promoting policies that would more aggressively address this growing problem. In 2005, then Governor Frank Murkowski signed an executive order creating the Alaska Council on the Homeless, a cabinet-level interagency task force comprised of state commissioners and the Executive Directors of Alaska Housing Finance Corporation (AHFC) and the Alaska Mental Health Trust Authority. The Council was charged with developing a plan to combat homelessness in our state.

In October 2005, the Council released its report, "Keeping Alaskans Out of the Cold." The plan contained three key recommendations: 1) establishment of a state affordable housing trust; 2) formation of a task force to help reduce the incidence of discharges from state-funded institutions to homelessness; and 3) expansion of renter education opportunities. During the next two years progress was made on a number of the recommendations. A structure was developed for a housing trust and a plan produced and submitted to Governor Murkowski, a more coordinated effort was developed by state agencies to try and reduce discharges to homelessness, and existing renter education program models were identified and one was selected for implementation.

In May 2007, Governor Sarah Palin reactivated the Alaska Council on the Homeless, and expanded its membership to include representatives from local government, Native housing authorities, homeless advocates and members of the public-at-large. The Council was tasked with further developing the recommendation of a housing trust, establishing a statewide homeless action plan, monitoring progress during the implementation of the plan and issuing an annual report to the governor on the use of state resources to end homelessness.

In January 2008, legislation was introduced to create a coordinated fund source within the Alaska Housing Finance Corporation (AHFC). During the deliberation process, questions were raised about the long-term financial commitment attached to the legislation when there was not yet an action plan to review and react to. The end result was an increase in funding for an existing homeless program administered by AHFC and a directive to produce a 10-year action to address homelessness in Alaska.

After several meetings and a full-day work session, the Council, in consultation with the Alaska Coalition on Housing & Homelessness, produced this action plan which will serve as the guide for directing state resources toward reducing long-term homelessness in the coming years. The plan includes current baseline data and measurable goals to track progress, determine funding levels, and implement programmatic adjustments along the way. Recognizing that a "one-size-fits-all" approach to combating long-term homelessness is unrealistic, this plan contains a number of action steps that are grouped within specific focus areas.

How Alaska Measures Up

Although the absolute number of homeless in Alaska is less than 5,000 people at any given time:

- Alaska had double the national average of per capita homelessness in 2008.
- Alaska is in the top ten states in per capita homelessness.

To measure the extent of homelessness, communities throughout the country have embraced the "point-in-time" (PIT) approach for gathering statistical information. Since 1995, AHFC has coordinated statewide PIT counts. In conformance with guidelines issued by the U.S. Department of Housing & Urban Development (HUD), PIT counts are conducted during the last week in January each year. Recent (2008) PIT data tells us the following:

- The total count of homeless Alaskans was 3,305
- The number of homeless households with children was 494 (1,507 persons)
- 627 persons met the HUD definition of a "chronic" homeless person
- 161 beds existed in the homeless housing inventory to target chronic homeless persons.

In addition to PIT information, the Department of Corrections reports that approximately 8,000 persons are discharged from prison each year with no identified housing arrangement.

Nationally, overall chronic homelessness decreased between 2005 and 2007. This is the result of a re-targeting of HUD resources and the narrow definition HUD uses that includes a person sleeping in an 1) emergency homeless shelter; 2) a transitional housing facility that targets homeless persons or; 3) a place not suitable for human habitation like a sidewalk or their car.

Those who have been turned away because a shelter is full or those in a community that lacks a shelter and must turn to family or friends to avoid the streets are not included in HUD reports.

Alaska's PIT count distinguishes homeless populations that fit in HUD-prescribed charts from those that are homeless by displacement, by their lack of permanent housing, by those who are temporarily staying in a motel or with friends or relatives. The 3,305 homeless persons counted in 2008 represent the sum of all groups. AHFC has a statutory definition of "homelessness" that aligns with the McKinney-Vento definition as it applies to the Department of Education and Department of Health and Human Services and is inclusive of all groups.

Success is Achievable

In January 2009, in conjunction with the annual PIT count, the Anchorage Homeless Coalition organized a one-day, one-stop service fair called Project Homeless Connect (PHC). A comparison of PHC data shows that nearly the same number of homeless persons attended the January 2008 (519) and January 2009 (524) events. Of these participants, 77% were attending for the first time, and less than 15% had attended each of the last 3 PHC events. Nearly 34% stated they had been homeless for less than six months. These figures indicate there are a significant number of people who are newly experiencing homelessness. They also show that for many, prevention reduces the duration of a homeless episode.

The ever-increasing momentum of government, corporate and philanthropic investment in supportive housing has been bolstered by research documenting its effectiveness. Supportive housing is a term used to describe housing that combines a residential environment with support services that address each family or individual's particular service needs. Research shows that supportive housing costs far less than a stay in a correctional facility, a hospital or psychiatric institution, and decreases the cost of emergency services. The Corporation for Supportive Housing has spearheaded a national effort to document the costs and benefits of supportive housing. They report studies to indicate[1]:

Positive impacts on health. Decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services.

Positive impacts on employment. Increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing, and a significant decrease in dependence on entitlements - a $1,448 decrease per tenant each year.

Positive impacts on treating mental illness. At least a third of those people living in streets and shelters have a severe and persistent mental illness (20% in Alaska). Supportive housing

[1] Corporation for Supportive Housing, *Research Summaries*, www.csh.org . 2009

has proven to be a popular and effective approach for many mentally ill people, as it affords both independence and as-needed support.

A study of nearly 900 homeless people with mental illness provided with supportive housing found 83.5% of participants remained housed a year later, and that participants experienced a decrease in symptoms of schizophrenia and depression[2]. A study of almost 5,000 homeless individuals with mental illness placed in supportive housing through the NY/NY program confirmed that nearly 80% remained housed a year later, with 10% moving on to independent settings.

Positive impacts on reducing or ending substance use. Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to stay clean and sober. A one-year follow-up study of 201 graduates of the Eden Programs chemical dependency treatment programs in Minneapolis found that 56.6% of those living independently remained sober; 56.5% of those living in a halfway house remained sober; 57.1% of those living in an unsupported SRO remained sober; while 90% of those living in supportive housing remained sober.

The University of Alaska's Institute of Social and Economic Research (ISER)[3] just completed a study of the cost benefit of treatment and re-entry programs on the Alaskan prison population and the long term cost savings to the Corrections system from an investment in these programs. The results are conclusive: Investing in treatment and rehabilitation programs reduces the recidivism rate. The ISER report found that for an additional $4 million annual investment, through existing programs, the state could save $321 million over the next 20 years. That's equivalent to an average return of approximately $16 million or 400%.

The Alaska Mental Health Trust Authority (AMHTA) and its partners operate the Bridge Home program which helps beneficiaries obtain stable living environments through the provision of rental assistance and support services. A recent AMHTA report showed that Bridge Home participants had 38% less admissions to API and 48% less to Corrections. The number of days spent in both these systems dropped 32% for API and 68% for Corrections.

For many years, the Kodiak Brother Francis Shelter (KBFS) has used the prevention component of the Homeless Assistance Program (HAP) to nearly eliminate family homelessness and keep their shelter census at nearly 50% of capacity. As a "one-stop-shop," works closely with the local housing authorities and private landlords to either avert displacement or work to rapidly

---

[2] US Dept. of Health and Human Services. *Making a Difference: Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults.* 1994.

[3] ISER Research Summary January 2009, RS NO. 71

re-house the few that become homeless. As of January 2008, AHFC's public housing waitlist only showed one homeless family and one household fleeing domestic violence in Kodiak.

Plan Description

Based on the work of the Governor's Council and the public input over the last several years, this Plan encompasses several guiding principles:

1. **Preservation and Full Utilization of Existing Resources**

   The recent decreases in chronic homelessness are the result of the existing housing and service resources that are available in Alaska. Some of these resources can be re-directed in a manner to increase the impact on homeless populations. All of the resources in our current housing continuum (including shelters and transitional housing) are necessary to maintain the level of success we have today. A net loss of zero existing housing and supportive services is a main principle of this plan.

2. **Prevention and Intervention is Integral to addressing long-term homelessness**

   Experience shows that preventing a family or individual from becoming homeless is far easier and less costly than providing any type of housing or service assistance after the fact. Assistance must be directed further "upstream" to prevent people from falling into homelessness.

3. **Expansion of Supportive Services outside Medicaid Eligible Costs is Critical**

   As the nation has moved closer to a "Medicaid eligible only" model for providing supportive services to the disabled and low income families, necessary services for life skill training and periodic interventions to insure independent living have been reduced. Not all families and individuals need intensive medical services to remain independent.

4. **The provision of housing is an immediate fix to homelessness, but the long term solution is greater employment opportunities.**

   The majority of families and individuals who find themselves homeless at any given time are there as a result of economic circumstances. Job creation and economic development are important solutions to homelessness. The rise and fall of economic activity is a function of many different variables. Many of these variables are beyond the scope of any effort to reduce homelessness. This plan suggests program activities specifically in area of employment for people being discharged from institutions but focuses mainly on the immediate stabilization of housing for families and individuals.

This plan focuses on four major areas:

□ production of supportive housing;

□ additional rental assistance for homeless families;

□ supportive services to help homeless individuals and families transition to a permanent housing situation; and

□prevention activities.

These four categories were developed as a result of the many years of public input from social service providers, state agencies, the work of the Governor's Council, the Alaska Coalition on Housing and Homelessness and the local homeless planning efforts that are ongoing in communities like Anchorage, Barrow, Fairbanks, Juneau, the Mat-Su Borough and Kenai Peninsula. This plan provides the "three legs of the stool" to address the range of needs that affect the homeless population in Alaska; housing, operating and supportive housing. Not all homeless people need intensive support services to move out of homelessness, some just need a helping hand on a temporary basis.

The Plan calls for a central funding mechanism to minimize the number of "places to go" for resources to meet the outcomes of the plan. Better coordination in allocating state funding resources means greater efficiency in the distribution of funds and more direct impact on the problem.

Plan Format

The Alaska Ten Year Plan for Addressing Homelessness is based on a format by the State of Minnesota. It is organized into three components; 1) Goals, 2) Action Steps and 3) Outcomes on a one year, five year and ten year basis. The goals, action steps and outcomes anticipated are broad in scope, so that the local action plans of communities in Alaska can fit within them. The success of this ten year plan will be based on the participation of local governments, for-profits housing developers, non-profits and faith based organizations. An estimate of the sources and uses of the funds proposed for the effort and a financing plan make up the other parts of the plan.

The financing plan estimate forms the basis of the ten year plan. It identifies the different uses of the funds, how the costs were calculated and where the potential additional funding could come from. This plan attempts to be realistic in the type and sources of funds that may be available over time, with an understanding that the State of Alaska can't bear the burden alone. A significant proportion of the funding will come from re-directing existing resources to focus on this effort. A similar effort by HUD over the last five years has lead to substantial reductions in chronic homelessness in the US.

Measuring Our Success

Throughout the planning process, Council members and staff have acknowledged the need to attach measurable outcomes to every action taken or dollar invested. Each focus area has a baseline upon which progress will be evaluated. Not only will homeless counts and units added be measured, but also the degree of housing stability after a housing crisis is resolved. As more agencies link into the central Homeless Management Information System (HMIS), more will become known about migration patterns and characteristics of homeless subpopulations. The system can also be used as a tool to determine which programs and services are the most effective. All of these resources will be used to generate an annual progress report to the Council and Coalition.

Next Steps

This plan is under the purview of the Governor's Council on Homelessness. The Council will serve as the guiding force for the accomplishments of the Ten Year plan. It will monitor the success of the plan on an annual basis and advise on the allocation of state resources that are made available for the effort. As AHFC is the designated coordinator for addressing homelessness in Alaska, AHFC will provide the staff support necessary to collect information to measure the outcomes of the Ten Year Plan. This Plan is a living document and will be revised as appropriate when housing market and employment conditions change in Alaska.

The immediate first steps are to secure increased funding to finance this plan and re-align, where practical, existing programs to place greater emphasis on reducing homelessness.

GLOSSARY OF TERMS

AHFC – Alaska Housing Finance Corporation

AMHTA – Alaska Mental Health Trust Authority

Chronic Homeless – HUD term that refers to a subset of the homeless populations that experience repetitive instances of homelessness and suffer from disabilities or co-occurring disorders like substance abuse.

Continuum of Care - HUD planning process that coordinates the application of projects to HUDs McKinney-Vento Homeless programs, the Shelter Plus Care and Supportive Housing programs.

DHSS – Department of Health and Social Services – State of Alaska

ESG – Emergency Shelter Grant - HUD program for the support of emergency shelters.

FUP – Family Unification Program – HUD rental assistance program that encourages the reunification of families that have been separated from their children through incarceration or other similar life events.

HAP – Homeless Assistance Program – AHFC/AMHTA/DHSS funded program that reduces homelessness in Alaska through temporary housing, and prevention programs.

HERA Act of 2008 – enabling federal legislation creating the NSP and NHT programs.

HOPWA – Housing For Persons with HIV/AIDS – HUD program that provides housing assistance to individuals suffering from HIV or AIDS.

HOME – Home Investment Partnership Program – a HUD program that funds affordable housing options for families at 80% of the median and below.

"Homeless" as defined in AHFC Statutes – much broader definition of "homelessness" than federal definition, includes people in shelters and doubled up family or friends.

Housing Choice Voucher (Section 8) – HUD program operated by AHFC that provides rental assistance to low income families throughout Alaska. Families rent units from private landlords and pay a fixed 30% of their income towards the rent.

LIHTC – Low Income Housing Tax Credit Program – a federal tax incentive for private sector development of low-income rental housing for families below 60% of the median income.

McKinney-Vento – federal enabling legislation that authorizes the distribution of funds for homeless programs through the US, by HUD, the department of Education and other federal agencies.

NHT – National Housing Trust – program created under HERA Act of 2008 to create more affordable housing in the US. Funds come from a percentage of value from Fannie Mae and Freddie Mac. Funds won't become available until Federal Fiscal Year 2010. Seventy-five percent of funds will be targeted towards families below 30% of median income.

NSP – Neighborhood Stabilization Program – program created under HERA Act of 2008 to return foreclosed/abandoned and blighted property to residential occupancy. Alaska recieve an allocation of $19.6 million, 25% of which is targeted to families below 50% of median income.

Public Housing – rental units owned by AHFC and occupied by low-moderate income families and individuals. Rent is fixed at 30% of the families income. Rental assistance is provided through a contract from HUD.

SCHDF – Senior Citizens Housing Grant Program – AHFC funded program that develops housing for families meeting the federal definition of "senior".

Section 202 – HUD program that provides capital funds and rental assistance to low-income senior households.

Section 811 – HUD program that provides capital funds and rental assistance to low-income disabled households.

SNHG – Special Needs Grant Program – AHFC funded program that develops housing for special needs populations with special emphasis on the "hard to house" and mental helath trust beneficiaries.

Shelter Plus Care – a HUD program that is part of the Continuum of Care which provides rental assistance for chronic homeless disabled individuals. The program requires that a matching amount of services "care" is provided to each client.

Supportive Housing – term that refers to housing where the families and individuals participate in one or more service programs. These programs can support the participants in transitioning back into the mainstream after a period of homelessness or institutionalization.

Financing Estimates for Ten Year Plan

Activity	Average $/U	#need	$$ over 10 Years
1. New Construction*	$200,000	1000	$194,300,000
2. Operating Support/Rental Assistance**	$550	500	$33,000,000
3. Supportive Services***	$30,000	160	$48,000,000
4. Prevention Resources****	$600	500	$3,000,000
Ten year Total			**$278,300,000**
Annual Total			**$27,830,000**
Existing Long Term Resources to be used Annually:			
LIHTC/HOME/SCHDF Development programs			(8,000,000)
Special Needs Housing Grant Program (SNHG)			(1,750,000)
Partial Utilization of HUD 811/202 programs			(1,000,000)
National Housing Trust (not till 2010)			(2,700,000)
Other Federal/State/Private Sources			(4,380,000)
ADDITIONAL ANNUAL RESOURCES TO ADDRESS NEED			**$10,000,000**

*Average of new construction, acquisition and rehab costs per 2009 GOAL program apps. Assumes $5.7 million of Neighborhood Stabilization Program and other Economic Stimulus $ in 1st Year (30%).

**Based on average cost of rental assistance per family under Section 8 Housing Choice Vouchers

***Based on average per person supportive service cost per the 2009 SNHG program apps.

****Based on average cost of prevention costs per 2008 HAP Prevention Report

FINANCING PLAN ESTIMATE (2010-2020)

(millions)

SOURCES	USES
LIHTC /H0ME/SCHDF Coordinated Homeless Fund (HAP,SNHG, AMHTA, SOA/GF, AHFC Receipts, Foundations) AHFC LOAN FINANCING HUD Section 811 and 202 programs Total $194.3	1. New Housing through New construction/Acquisition and Rehab. (1,000 units over 10 years) $194.3
HOPWA McKinney-Vento/HEARTH HUD PUBLIC HOUSING/SECTION 8 HUD Section 811 HERA ACT 2008 HOME Coordinated Fund (HAP,SNHG, AMHTA, AHFC Receipts, Foundations) Total $33.0	3. Rental/Operating assistance (500 units over 10 years) $ 33.0
Coordinated Homeless Fund (HAP,SNHG, AMHTA, SOA/GF,AHFC Receipts, Foundations) McKinney-Vento /HEARTH Programs Total $ 48.0	4. Supportive Services $ 48.0 16 people per year over 10 years
Coordinated Homeless Fund (HAP,SNHG, AMHTA, SOA/GF, AHFC Receipts, Foundations) Emergency Shelter Grant (HUD) Total $ 3.0	5. Prevention Services $ 3.0
TOTALS $ 278.3	TOTALS $ 278.3

Alaska Council on the Homeless

Ten-Year Plan to Reduce Long Term Homelessness

F-1. Housing for Chronic & Special Needs Homeless		**Baseline:** 627 chronic homeless out of 3,311 total homeless (PIT) 161 Chronic Housing units out of 428 Permanent Supportive Housing inventory		
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
1.Expand housing options (construction/rehab/rental assistance) *Section 811 and 202 are HUD programs that provide capital funding and rental assistance for the elderly and disabled. Funds are distributed competitively annually. HOME refers to the HOME Investment Act Partnership Program	1.a Build capacity to maximize flexible use of resources (811/202; HOME*) 1b Develop prototype model for supportive housing 1.c Develop a coordinated homeless fund to house more high need homeless persons 1.d Develop intensive service-enriched housing for persons w/high needs exiting API & DOC	1.a List of 202/811 applicants developed for next 10 yrs 1.b Prototypes/ models identified 1.c Fund established 1.d Four agencies identified through RFQ process to develop prototype	1.a 25 new 202 units and 25 new 811 units 1.b, 10 new programs developed from model 1.c&d 300 additional households assisted	1.b 50 new 202 units 50 new 811 units 1.b,c,d 800 additional households assisted

F-1. Housing for Chronic & Special Needs Homeless Continued:				
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
2. Increase supplemental support for services not covered by Medicaid	2. a Identify unmet service needs and costs	2.a Funding sources identified for unmet service needs	2.a 30% of service needs addressed	2.a 70% of service needs addressed
	2.b Utilize housing finance resources to cover cost of room & board for persons served by Adult Protective Services (APS)	2.b Housing & service costs delineated	2.b 50% of APS clients receiving housing assistance	2.b 100% of APS clients receiving housing assistance
3. Increase pool of operating support to preserve existing housing stock	3.a Inventory existing projects for operating assistance needs 3.b Issue NOFA to award project-based assistance	3. 20 project-based rent assistance	3. 100 project-based rent assistance	3. 200 project-based rent assistance

F-2. Housing for Persons Discharged from State Custody		Baseline: 8,000/yr discharged from DOC w/no identified housing 33 existing beds for transitioning youth (ANC & JNU)		
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
1. Revise discharge policies to explicitly discourage discharge to homeless shelters.	1.a Review policies and identify text revisions 1.b Establish baseline on discharges to homelessness	1a. Policy revisions completed	1.b 50% reduction of discharge to shelter or streets	1.b 75% reduction of discharge to shelter or streets
2. Increase # of units available to transitioning youth	2.a Identify exact # of transitional beds needed (300 est.) 2b. Apply for Family Unification Program (FUP)vouchers from HUD	2.a Needs baseline established 2.b Vouchers awarded by HUD	2.a 50% of needed beds added to inventory 2.b 100% FUP voucher utilization	2.a 50% of need added to inventory 2.b 100% FUP voucher utilization

F-2. Housing for Persons Discharged from State Custody Continued				
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
3. Identify landlords and develop landlord incentives to rent to "hard to house" persons.	3.a. Identify incentives and outreach (e.g. damage fund, rent-up bonus, etc) 3.b Develop a coordinated homeless fund to house more high need homeless persons	3.a Incentive program developed 3.b Fund established	3.a&b 50% placement success	3.a&b 75% placement success
4. Increase employment/vocational opportunities for persons in transition.	4.a Identify models	4. a Model selected for implementation	Programs in every DOC & DJJ facility	100% job referral upon discharge

F-3. Permanent Housing for Households w/Children Transitioning from Homelessness		Baseline: 1,507 People (494 Families) out of 3,311 total homeless in PIT		
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
1.Expand housing options (construction/rehab/rental assistance) *HOME/TBRA is a tenant based rental assistance program funded from HUD's HOME Investment Partnership Act program	1.a Build capacity to maximize use of resources (HOME/TBRA*) 1.b Create incentives to utilize existing housing programs to address needs of low-income families 1.c Develop s coordinated homeless fund to assist more homeless families	1.a Agencies identified for intensive technical assistance 1.b GOAL policies/ priorities revised to target homeless families 1.c Fund established	1.b&c 150 Units w/20% f/large families	1.b&c 300 Units w/20% f/large families
2. Increase pool of operating support to preserve existing housing stock	2. Inventory existing projects for operating assistance needs	2. Inventory completed and needs identified	100 assisted units	200 assisted units

F-3. Permanent Housing for Households w/Children Transitioning from Homelessness Continued				
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
3. Provide rapid re-housing services for households w/children	3.a Create incentives for central intake & assessment of family homeless needs 3.b Develop coordinated homeless fund for move-in costs.	3.a Central clearinghouse identified in each AK community 3.b Fund established	3.a &b. 50% Households re-housed within 90 days	3.a&b. 85% Households re-housed within 90 days
4. Improve outreach & linkages to housing resources & services	4.a Build capacity among homeless school liaisons & rural school districts 4.b Expand outreach on use of AK Housing Locator 4.c Improve 211 to accurately reflect all local homeless services	4.a 25% increase in homeless school liaison participation in state housing coalition 4.b 50% increase in Locater listings 4.c 65% coverage	4.a 50% increase in homeless school liaison participation in state housing coalition 4.b 100% increase in Locator listings 4.c 80% coverage	4.a 100% increase in homeless school liaison participation in state housing coalition 4.b 200% increase in Locator listings 4.c 95% coverage

F-4. Short-Term Homeless Prevention / Crisis Intervention		2008 Baseline: 324 households served by HAP-funded prevention component in SFY08/ 67% housing retention rate		
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
1. Create local centralized pool of prevention resources to provide assistance with rent, mortgage & utility arrearages OR to cover housing costs for persons temporarily absent due to hospitalization, substance abuse treatment or short-term incarceration (less than 60 days).	1.a Coordinate existing resources (ESG, LIHEAP, EFSP, ATAP Diversion) 1.b Develop framework for central prevention pools 1.b Set aside min. 30% of funding authorization for prevention activities 1.c Develop a coordinated homeless fund to assist more households at-risk of homelessnes	1.b Framework developed 1.b Award funds w/priority to central pools 1.c Fund established	100% increase in # of households served 75% retention rate	200% increase in # of households served 85% retention rate
2. Apply a uniform assessment tool to identify barriers to housing stability	2.a Integrate assessment tool into existing Homeless Management Information System (HMIS)	2.a Updated version installed	60% assessments completed on prevention cases	100% assessments completed on prevention cases
3. Maintain and/or expand emergency lodging options as needed	3.a Identify shelter gaps in the homeless housing inventory by community and target population	3.a. Points added to HAP application for projects targeting unserved or underserved populations	No net loss to shelter inventory & 3 unserved communities add new beds	No unmet shelter needs

F-5. Data Collection				
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
1. Expand HMIS coverage to all federal and state-funded homeless programs.	1.a Continue ongoing training and access project to connect all providers of shelter & transitional housing in AK (except DV)	1.a 50% bed coverage in HMIS	75% bed coverage in HMIS	85% bed coverage in HMIS
2. Coordinate prevention report from all potential funding sources	2. Develop MOU w/fund sources to coordinate report	2. Fund administrators meet & forge agreement	2. Report reflects 50% coverage	2. Report reflects 90% coverage

F-6. Community Infrastructure – Local Planning Efforts to Coordinate Activities				
Strategy	**Action Steps**	**12-Month Outcome**	**By the Year 2014**	**By the Year 2019**
1. Ensure housing policy is addressed at the local level 2. Provide operational support to local housing planning organizations to coordinate services and reporting	1.a Educate Alaska Municipal League & local Continuum of Cares re: housing component in comprehensive plans 2.a Develop long-range organizational plan	1.a Comprehensive plan enabling legislation introduced 2.a. Statewide organization fully staffed	1.a Comprehensive plan enabling legislation enacted & 30% comp plans inc. housing element 2.a Local organizations established in 5 communities	1.a Comprehensive plan enabling legislation enacted & 70% comp plans inc. housing element 2.a Local organizations established. in 9 communities

Administrative Orders
FROM THE OFFICE OF THE GOVERNOR OF ALASKA

Sarah Palin
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

May 1st, 2007

ADMINISTRATIVE ORDER NO. 236

I, Sarah Palin, Governor of the State of Alaska, under the authority of art. III, secs. 1 and 24, of the Alaska Constitution, and in accordance with AS 44.19.145(c), establish the Alaska Council on the Homeless in the Alaska Housing Finance Corporation.

BACKGROUND AND PURPOSE

Homelessness is one of the most challenging domestic issues facing the United States. Alaska is no exception. Alaska's Faith-Based and Community Initiatives Task Force found housing to be the most commonly identified challenge facing those in need. The Alaska Council on the Homeless (council) was initially established by Administrative Order No. 214 in April 2004 to develop a statewide action plan addressing homelessness in Alaska.

The plan, *Keeping Alaskans Out of the Cold,* was completed and submitted in October 2005. Included in its recommendations was the appointment of a steering committee to assist the governor and the legislature to develop an affordable housing trust. The steering committee completed its work in 2006 and the current council has recommended that the Alaska Housing Trust Fund (fund) be created within the Alaska Housing Finance Corporation (AHFC) under AS 18.56. The purpose of this Administrative Order is to add additional members to the council and to expand the council's duties.

MEMBERSHIP

The council consists of members appointed by the governor to serve at the pleasure of the governor. Continuing members of the original council are: one representative each from the Alaska Housing Finance Corporation, Alaska Mental Health Trust Authority, Department of Health and Social Services, Department of Education and Early Development, Department of Public Safety, and Department of Corrections serving on the effective date of this Order. New members are: one representative of regional Native housing authorities, one representative of municipal government, and four additional members with experience and expertise in housing development or as consumers of affordable housing.

The council may invite to its meetings non-voting representatives from federal and local government agencies, the business community, providers of services to the homeless, philanthropic agencies, faith-based organizations, homeless advocacy organizations, homeless persons, and community leaders. The council may elect a chair and other officers as determined necessary.

DUTIES OF THE COUNCIL

The council's duties set out in Administrative Order No. 214 are amended by adding new duties as follows:

1. Assist with the development of the fund.

2. Upon establishment of the fund, annually evaluate housing needs and priorities to establish a statewide homeless action plan and recommend to the AHFC Board of Directors the allocation of money in the fund to implement the plan; other duties specific to the fund include monitoring implementation of the fund budget, recommending methods for evaluating and monitoring fund activities, recommending methodology for reporting to public and elected officials, coordinating the fund with other available financing sources, seeking additional money to support fund activities, and ensuring that projects supported by the fund are sustainable.

3. Monitor and review implementation of the statewide homeless action plan and annually report to the governor the council's findings and recommendations regarding implementation of the plan.

4. Annually report to the governor on how state resources, in addition to the fund, may be used to end homelessness.

ADMINISTRATIVE SUPPORT

The AHFC shall provide administrative support for the council. In accordance with law, the AHFC may enter into intergovernmental agreements necessary to accomplish the purposes of this Order.

GENERAL PROVISIONS

The following general provisions apply to the activities of the council:

1. Council members do not receive compensation as a member of the council. Per diem and travel expenses for state and federal members of the council are the responsibility of the state or federal agency the member represents.

2. To reduce costs, the council may use teleconferencing or other electronic means to the extent practicable in order to gain the widest public participation at minimum cost.

3. The council shall establish procedures for voting and meetings of the council.

4. Meetings of the council shall be conducted, and notice of the meetings provided, in accordance with AS 44.62.310 and 44.62.320 (Open Meetings of Governmental Bodies).

This Order takes effect immediately. This Order supplements Administrative Order No.

214 on this matter.

DATED at Juneau, Alaska, this 1st day of May, 2007.

/s/Sarah Palin
Governor

WWW.GOV.STATE.AK.US

Administrative Orders 201-present | Contact the Governor | Webmaster | State of Alaska

Frank H. Murkowski
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

April 30, 2004

ADMINISTRATIVE ORDER NO. 214

I, Frank H. Murkowski, Governor of the State of Alaska, under the authority of art. III, secs. 1 and 24, of the Alaska Constitution, and in accordance with AS 44.19.145(c), establish the Alaska Council on the Homeless in the Office of the Governor.

BACKGROUND AND PURPOSE

Homelessness is one of the most challenging domestic issues facing the United States as a nation. Alaska is no exception. Alaska's Faith-Based and Community Initiatives Task Force found housing to be the most commonly identified challenge facing those in need. The purpose of this Administrative Order is to establish the Alaska Council on the Homeless (council) and recognize the need to develop a statewide plan that would include short-term and long-term strategies to effectively address the problem of Alaska's homeless population. The development of the statewide plan by the council should serve to educate all Alaskans about the tragedy of homelessness and engage both governmental agencies and the private sector in finding solutions to this problem.

MEMBERSHIP

The council consists of members appointed by the governor to serve at the pleasure of the governor. Council members will be representatives of appropriate state agencies, with ex-officio representation by the lieutenant governor or the lieutenant governor's designee and by the director for the United States Department of Housing and Urban Development for Alaska or the director's designee. The council may invite to its meetings other non-voting representatives from federal and local government agencies, the business community, providers of services to the homeless, philanthropic agencies, faith-based organizations, homeless persons advocacy organizations, homeless persons, and community leaders. The executive director of the Alaska Housing Finance Corporation, or the executive director's designee, shall chair the council. The council may elect other officers as determined necessary.

DUTIES OF THE COUNCIL

The council shall prepare and submit to the governor a statewide homeless Alaskans

action plan by June 30, 2005. The action plan must include at least the following:

1. accurate fiscal and demographic information on the homeless in this state, to support policy development;

2. an inventory and analysis of all existing activities and programs in this state that assist homeless persons;

3. an inventory and assessment of existing statutory and regulatory provisions relating to the homeless and suggested changes to those provisions needed to implement the plan;

4. short-term and long-term statewide strategies designed to substantially lessen homelessness in this state within the next 10 years; these strategies should:

a. identify funding opportunities to assist homeless persons in this state;

b. involve non-traditional stakeholders, including business, philanthropic, faith-based, and other community organizations; and

c. promote systems integration, including interagency agreements, to reduce duplication among homeless assistance programs;

5. performance measures and accountability mechanisms to provide policymakers with tools to assess the success of the plan over time.

In addition, the council shall conduct a public hearing on the issue of homelessness.

The council shall monitor and review implementation of the action plan, and shall annually provide to the governor a report containing the council's findings and recommendations regarding implementation of the plan.

ADMINISTRATIVE SUPPORT

The Alaska Housing Finance Corporation shall provide administrative support for the council. In accordance with law, the Alaska Housing Finance Corporation may enter into intergovernmental agreements necessary to accomplish the purposes of this Order.

GENERAL PROVISIONS

The following general provisions apply to the activities of the council:

1. Council members do not receive compensation as a member of the council. Per diem and travel expenses for members of the council are the responsibility of the state or federal agency the member represents.

2. To reduce costs, the council may use teleconferencing or other electronic means to the extent practicable in order to gain the widest public participation at minimum

cost.

3. The council shall establish procedures for voting and meetings of the council.

4. Meetings of the council shall be conducted, and notice of the meetings provided, in accordance with AS 44.62.310 and 44.62.320 (Open Meetings of Governmental Bodies).

This Order takes effect immediately.

DATED at Juneau, Alaska, this 30th day of April, 2004.

/s/Frank H. Murkowski
Governor

Administrative Orders 201-present | Contact the Governor | Webmaster | State of Alaska

COSCDA
Council Of State Community Development Agencies

2011 Homeless Program Managers Training Conference Agenda

Monday, March 14

7:30 am –9:00 am	**Registration/Coffee and Tea Service**
8:00 am – 9:00 am	**Welcome and Washington Update** (Joint with Community Development and Housing Conference) **Location: Dupont Ballroom** U.S. Department of Housing and Urban Development (HUD) Assistant Secretary for Community Planning and Development (CPD) will provide an overview of CPD priorities in the coming year, including the increased focus on comprehensive planning. **Moderator:** Gordon Walker, COSCDA President and the Director of Housing and Community Development, Utah Department of Community and Culture **Speaker:** Assistant Secretary Mercedes Marquez Community Planning and Development U.S. Department of Housing and Urban Development
9:00 am – 10:30 am	**HEARTH Act Overview** **Location: Fox Hall B & C** Get the latest information and an overview of the HEARTH Act, which reauthorizes the McKinney-Vento Homelessness Programs, from the Director of the Office of Special Needs Assistance at HUD. Discuss state recommendations on regulations.

DRAFT

	Moderator: TBD **Speaker:** Ann Oliva, Director, Office of Special Needs Assistance, U.S. Department of Housing and Urban Development
10:30 am – 10:45 am	**Networking Break**
10:45 am – 12 noon	**HMIS Update** **Location: Fox Hall B & C** Get advice and guidance from HUD on your HMIS questions and concerns. **Moderator:** Scott Gary, Supportive Housing Manager, Ohio Department of Development **Speaker:** Julie Hovden, Program Analyst, Office of Special Needs Assistance Programs, U.S. Department of Housing and Urban Development
12 noon – 1:00 pm	**Joint Networking Lunch** **Location: Glover Park Ballroom**
1:00 pm – 2:15 pm	**Veterans' Homelessness** **Location: Fox Hall B & C** Hear the latest in federal and state initiatives regarding assistance to homeless veterans. **Moderator:** Gordon Walker, COSCDA President and the Director of Housing and Community Development, Utah Department of Community and Culture **Speakers:** John Kuhn, U.S. Veterans Administration Maureen Ryan, Bureau Administrator, New Hampshire Department of HHS-Bureau of Homeless and Housing Service Stephanie Nagy, Abt Associates

DRAFT

2:15 pm – 2:30 pm	**Networking Break (No refreshments)**
2:30 pm – 3:45 pm	**Innovations in Supportive Housing** **Location: Fox Hall B & C** The Corporation for Supportive Housing will highlight efforts to integrate affordable supportive housing into mixed income properties. **Moderator:** Jordan Press, Corporation for Supportive Housing **Speakers** Holly Denniston, Corporation for Supportive Housing
3:45 pm – 5:00 pm	**COSCDA Homeless Committee Meeting** **Location: Fox Hall B & C** Participate in developing COSCDA policy and positions related to the McKinney-Vento programs. All are welcome!
5:30 pm – 7:00 pm	**Networking Reception** **Location: Glover Park Ballroom** Meet and greet your colleagues attending the housing, community development, and homeless conferences.

Tuesday, March 15

8:00 am – 9:00 am	**Coffee and Tea Service**
8:00 am – 9:45 am	**Effective Strategies for Homeless Families** **Location: Fox Hall B & C** Get the latest information on serving this vulnerable homeless group from the National Alliance to End Homelessness and the Center on Family Homelessness. Hear the State of Utah's experience in serving this group. **Moderator:** Kris Duncan, Planner, Alaska Housing Finance Corporation

DRAFT

	Speakers: Norm Suchar, National Alliance to End Homelessness Natalie Thompson, Center on Family Homelessness Jayme Day, Planning Director, Utah Department of Community and Culture
9:45 am – 10:00 am	**Networking Break**
10:00 am – 11:00 am	**Coordination with Mainstream Programs** **Location: Fox Hall B & C** Review how McKinney-Vento programs can be coordinated with other funding sources, such as TANF, CSBG, other assisted housing and state and local income support programs. Hear tips on how states improve coordination with these programs, and how the State of Utah is coordinating its assistance and services. **Moderator:** Steve Berg, National Alliance to End Homelessness Jonathan Hardy, Director State Community Services Office, Utah Department of Community and Culture
11:00 am – noon	**Program Managers Roundtable** **Location: Fox Hall B & C** Discuss a variety of topics on homelessness with your state peers! **Moderator:** Kris Duncan, Planner, Alaska Housing Finance Corporation
12 noon -1:30 pm	**Lunch on your own**
1:30 pm – 3:00 pm	**Federal Efforts on Homelessness for 2011** **Location: Fox Hall B & C** Hear staff from the Interagency Council on the Homeless and the Congressional Caucus on Homelessness to discuss their visions for federal and state homeless policy for this year.

DRAFT

Moderator:
Jonathan Hardy, Director State Community Services Office, Utah Department of Community and Culture

Panelists:
Nicole Austin, staff, Congresswoman Judy Biggert, U.S. House of Representatives

Jennifer Ho, Interagency Council on the Homeless

James Ahn, Staff, Senator Jack Reed's Office

3:00 pm – 3:15 pm **Networking Break (No refreshments)**

3:15 pm – 5:00 pm **HUD Special Needs Assistance Office Staff**
Location: Fox Hall B & C

Program staff from the SNAPS Office will provide information on program guidance, regulations, and the funding outlook affecting HUD's Homeless prevention programs.

Moderator:
Edward Geiger, III, Director-Center for Community Financing, Pennsylvania Department of Community and Economic Development

Speaker
Ann Oliva, Director, Office of Special Needs Assistance Programs, U.S. Department of Housing and Urban Development

5:00 pm **Conference Adjourns**

DRAFT

COSCDA
Council Of State Community Development Agencies

2011 Housing Program Managers Training Conference Agenda

Monday, March 14

7:30 am –9:00 am	**Registration/Coffee and Tea Service**
8:00 am – 9:00 am	**Welcome and Washington Update** (Joint with Community Development and Homeless Conference) **Location: Dupont Ballroom** U.S. Department of Housing and Urban Development (HUD) Assistant Secretary for Community Planning and Development (CPD) will provide an overview of CPD priorities in the coming year, including the increased focus on comprehensive planning. **Moderator:** Gordon Walker, COSCDA President and the Director of Housing and Community Development, Utah Department of Community and Culture **Speaker:** Assistant Secretary Mercedes Marquez Community Planning and Development U.S. Department of Housing and Urban Development
9:00 am – 10:30 am	**Affirmatively Furthering Fair Housing** (Joint with Community Development Conference) **Location: Dupont Ballroom** This session will provide an overview of HUD's Affirmatively Furthering Fair Housing (AFFH) requirements as they relate to the CDBG and HOME Programs to assist COSCDA members in meeting their

DRAFT

AFFH responsibilities. Experts will provide practical advice on how states can enhance AFFH compliance

Moderator:
Chris Westlake, Deputy Director for Division of Financial Assistance, California Department of Housing and Community Development

Panelists:
John Trasviña, Assistant Secretary Fair Housing and Equal Opportunity, U.S. Department of Housing and Urban Development

Michael Allen (attorney for the Westchester County, New York case) Relman, Dane and Colfax, PLLC Washington DC

10:30 am – 10:45 am **Networking Break**

10:45 am - 12:00 noon **Affirmatively Furthering Fair Housing – (continued)**
Location: Dupont Ballroom

12 noon – 1:00 pm **Joint Networking Lunch**
Location: Glover Park Ballroom

1:00 pm – 2:15 pm **Section 3 Training/Listening Session** (Joint with Community Development Conference)
Location: Dupont Ballroom

Part three in a series COSCDA has sponsored on Section 3 Implementation for Community Development programs, this session will offer practical ways for States to comply with Section 3 requirements as well as providing an opportunity for HUD staff to hear your comments on what changes you would like to see as HUD develops the Final Rule.

Moderator:
Gail Hammond, Director, Office of Community Renewal, NYS Housing Trust Fund Corporation

Panelist:
Staci Gilliam Hampton, Director, Economic Opportunity Section 3 Division, U.S. Department of Housing and Urban Development

DRAFT

2:15 pm – 2:30 pm **Networking Break (No refreshments)**

2:30 pm – 3:45 pm **Realigning State Housing**
Location: Fox Hall A

The Obama Administration through the Domestic Policy Council is currently undertaking an effort called Rental Harmonization, to look at ways that the regulations for federal housing programs at HUD, and the Departments of Agriculture and Treasury can be realigned to eliminate duplicative processes. Hear how the State of Oregon initiated a partnership to reduce the costs of both public reporting and inspections for owners and administrators of affordable housing which has resulted in a collaborative initiative to streamline compliance procedures in Oregon.

Moderator:
TBD

Panelists:
Molly C. Rogers, Asset Management Director, Housing Development Center, Portland, OR

Diana Koppes, Administrator of Asset and Property Management for the Oregon Housing and Community Services, Portland, OR

3:45 pm – 5:00 pm **COSCDA Housing Committee Meeting**
Location: Fox Hall A

Participate in developing COSCDA policy and positions related to the Home Investment Partnership Program (HOME) and other housing related programs. All are welcome!

5:30 pm – 7:00 pm **Networking Reception**
Location: Glover Park Ballroom

Meet and greet your colleagues attending the housing, community development, and homeless conferences.

Tuesday, March 15

8:00 am – 10:00 am **HUD Compliance Monitoring Training** (Joint with Community Development)
Location: Dupont Ballroom

	Get an overview of the laws, regulations, and HUD guidance that will help you understand your obligations before HUD comes to monitor your project(s) for compliance. Panelists will address: NSP Environment (NEPA) Davis Bacon Uniform Relocation Act (URA) **Moderator: TBD** **Panelists:** John Laswick, NSP Team Leader, U.S. Department of Housing and Urban Development Joan Morgan, Director of Relocation and Real Estate Division, Office of Affordable Housing Programs, U.S. Department of Housing and Urban Development
10:00 am – 10:15 am	**Networking Break**
10:15 am – 12:00 noon	**HUD Compliance Monitoring Training (continued)** **Panelists:** Jade Banks, Senior Policy Advisor, Office of Labor Relations, U.S. Department of Housing and Urban Development Charles Bien, Acting Director for the Office of Environment and Energy, Environmental Review Division Director, U.S. Department of Housing and Urban Development
10:00 am – 10:15 am	**Networking Break**
12:00 noon – 1:30 pm	**Lunch on your own**
1:30 pm – 3:00 pm	**HOME TA Training** **Location: Fox Hall A**
3:00 pm – 3:15 pm	**Networking Break (No refreshments)**
3:15 pm – 5:00 pm	**HUD Officials** **Location: Fox Hall A**

DRAFT

Program staff from the Office of Community Planning and Development Office of Affordable Housing Programs will provide information on program guidance, regulations, and the funding outlook affecting the HOME program.

Moderator: TBD

Panelists:
Cliff Taffet, Acting General Assistant Secretary,
Office of Community Planning and Development,
U.S. Department of Housing and Urban Development

Virginia Sardone, Director (Acting) and Deputy Director,
Office of Affordable Housing Programs, U.S. Department of Housing and Urban Development

Marcia Sigal, Director, Program Policy Division, Office of Affordable Housing Programs, U.S. Department of Housing and Urban Development

5:00 pm **Conference Adjourns**

DRAFT

COSCDA
Council Of State Community Development Agencies

2011 Community Development Program Managers Training Conference Agenda

Monday, March 14

7:30 am –9:00 am	**Registration/Coffee and Tea Service**
8:00 am – 9:00 am	**Welcome and Washington Update** (Joint with Housing and Homeless Conference) **Location: Dupont Ballroom** U.S. Department of Housing and Urban Development (HUD) Assistant Secretary for Community Planning and Development (CPD) will provide an overview of CPD priorities in the coming year, including the increased focus on comprehensive planning. **Moderator:** Gordon Walker, COSCDA President and the Director of Housing and Community Development, Utah Department of Community and Culture **Speaker:** Assistant Secretary Mercedes Marquez Community Planning and Development U.S. Department of Housing and Urban Development
9:00 am – 10:30 am	**Affirmatively Furthering Fair Housing** (Joint with Housing Conference) **Location: Dupont Ballroom** This session will provide an overview of HUD's Affirmatively Furthering Fair Housing (AFFH) requirements as they relate to the CDBG and HOME Programs to assist COSCDA members in meeting their AFFH responsibilities. Experts will provide practical advice on how states can enhance AFFH compliance

DRAFT

	Moderator: Chris Westlake, Deputy Director for Division of Financial Assistance, California Department of Housing and Community Development **Panelists:** John Trasviña, Assistant Secretary Fair Housing and Equal Opportunity, U.S. Department of Housing and Urban Development Michael Allen (attorney for the Westchester County, New York case) Relman, Dane and Colfax, PLLC, Washington DC
10:30 am – 10:45 am	**Networking Break**
10:45 am - 12:00 noon	**Affirmatively Furthering Fair Housing – (continued)** **Location: Dupont Ballroom**
12 noon – 1:00 pm	**Joint Networking Lunch** **Location: Glover Park Ballroom**
1:00 pm – 2:15 pm	**Section 3 Training/Listening Session** (Joint with Housing Conference) **Location: Dupont Ballroom** Part three in a series COSCDA has sponsored on Section 3 Implementation for Community Development programs, this session will offer practical ways for States to comply with Section 3 requirements as well as providing an opportunity for HUD staff to hear your comments on what changes you would like to see as HUD develops the Final Rule. **Moderator:** Gail Hammond, Director, Office of Community Renewal, NYS Housing Trust Fund Corporation **Panelist:** Staci Gilliam Hampton, Director, Economic Opportunity Section 3 Division, U.S. Department of Housing and Urban Development
2:15 pm – 2:30 pm	**Networking Break (No refreshments)**
2:30 pm – 3:45 pm	**IDIS Training (PER)** **Location: Dupont Ballroom**

DRAFT

HUD's IDIS System need not have you looking like a "deer in the headlights." This panel will address the use of the system, helping to remove the mystery and the fear of using it. Specifics to be covered include:

IDIS Online and the State PER – entering funding by source year.

Timely distribution of State CDBG funds including reporting and findings for non-compliance.
Timely Expenditure reports.

Moderator:
Basil Julian, Grants Division Director, Arkansas Economic Development Commission

Speaker:
James McCann, CPD Specialist, Office of State and Small Cities, U.S. Department of Housing and Urban Development

3:45 pm – 5:00 pm

COSCDA Community Development Committee Meeting
Location: Dupont Ballroom

Participate in developing COSCDA policy and positions related to the Community Development Block Grant (CDBG) program, All are welcome!

5:30 pm – 7:00 pm

Networking Reception
Location: Glover Park Ballroom

Meet and greet your colleagues attending the housing, community development, and homeless conferences.

Tuesday, March 15

8:00 am – 10:00 am

HUD Compliance Monitoring Training (Joint with Housing)
Location: Dupont Ballroom

Get an overview of the laws, regulations, and HUD guidance that will help you understand your obligations before HUD comes to monitor your project(s) for compliance. Panelists will address:

DRAFT

NSP
Environment (NEPA)
Davis Bacon
Uniform Relocation Act (URA)

Moderator: TBD

Panelists:
John Laswick, NSP Team Leader, U.S. Department of Housing and Urban Development

Joan Morgan, Director of Relocation and Real Estate Division, Office of Affordable Housing Programs, U.S. Department of Housing and Urban Development

10:00 am – 10:15 am **Networking Break**

10:15 am – 12:00 noon **HUD Compliance Monitoring Training (continued)**

Panelists:
Jade Banks, Senior policy Advisor, Office of Labor Relations U.S. Department of Housing and Urban Development

Charles Bien, Acting Director for the Office of Environment and Energy, Environmental Review Division Director, U.S. Department of Housing and Urban Development

12:00 noon – 1:30 pm **Lunch on your own**

1:30 pm – 3:00 pm **Job Creation Through Community Development and CDBG**
Location: Dupont Ballroom

CDBG has a powerful economic development impact, creating jobs, something sorely needed as the country strives to overcome lingering low employment. This panel offers several speakers who will share their State's approach and their practices. We know States often combine their own resources with CDBG funding, as well as with private investment creating a layered process for maximizing use of CDBG

Moderator:
Brian Williamson, Assistant Commissioner, Georgia Department of Community Affairs

Panelists:
Jean Noble, Grants Manager, Arkansas Economic Development Commission

Patrick Howard, Small Cities Staff, Florida Department of Community Affairs

Joanie Perry, Director, Office of Economic Development, Georgia Department of Community Affairs

3:00 pm – 3:15 pm **Networking Break (No refreshments)**

3:15 pm – 5:00 pm **HUD Officials**
Location: Dupont Ballroom

Program staff from the Office of Community Planning and Development State and Small Cities Office will provide a program update on program guidance, regulations, and the funding outlook affecting the CDBG program.

Moderator: TBD

Speaker:
Stan Gimont, Director, Office of Block Grant Assistance, U.S. Department of Housing and Urban Development

Diane Lobasso, Director, Special Assistant to the Director, Office of Block Grant Assistance, U.S. Department of Housing and Urban Development

Steve Rhodeside, Acting Director, State and Small Cities Division, U.S. Department of Housing and Urban Development

5:00 pm **Conference Adjourns**

DRAFT

AHFC's Role in Addressing Homelessness

Senate HSS Hearing
March 9, 2010

4300 Boniface Parkway • Anchorage, Alaska 99504 P.O. Box 101020 • Anchorage, Alaska 99510

AHFC Homeless Impact Programs

- **Homeless Assistance Program Fund–** These funds are granted to local communities/agencies to help develop programs to prevent homelessness by providing assistance to families in imminent danger of becoming homeless or those who are currently homeless. Organizations qualified to apply include municipalities and public or private nonprofit corporations. Activities funded are consistent with the State of Alaska's strategic plan to address homelessness and focused on homeless prevention, intervention, temporary assistance and support services.

- **Beneficiary & Special Needs Housing –** Special Needs Housing Grant Program (referred to as "SNUG"). The program provides funds to Alaskan nonprofit service providers to increase housing opportunities for Mental Health Trust beneficiaries and other special needs populations throughout the state, including the homeless. The funds may be used for housing development and/or other housing related purposes. Organizations qualified to apply include municipalities and public or private nonprofit corporations.

- **Emergency Solutions Grant Program** – HUD program for emergency shelters for homeless in balance of state ($121,000) and Anchorage ($85,000).

AHFC Homeless Impact Programs

- **Housing for Persons with AIDS/HIV** – HUD program provides rental assistance and supports services to persons with HIV/AIDS to prevent homelessness. Grants go to non-profit organizations who administer services in Fairbanks, South Central and Southeast.

- **Shelter Plus Care** – provides rental assistance to disabled homeless persons. Grants go to non-profit organizations working in Anchorage, Mat-Su Borough, Bethel and Juneau.

- **Tenant Based Rental Assistance for Prisoner Re-Entry**

  As part of the Department of Corrections efforts to address prisoner re-entry issues and recidivism, AHFC is using federal funds to provide tenant based rental assistance to exiting prisoners allowing them to find housing upon release. A special set-aside is available for persons with disabilities and at-risk populations. TBRA is essential to meeting the unmet needs of special needs and at-risk populations by providing opportunities for those seeking individual living options in normal residential settings or in need of subsidized rental housing; TBRA will help narrow the gap in benefits and services received and help reduce recidivism.

AHFC Homeless Impact Programs

- **Continuum of Care Matching Grant Program** Nationwide, grants are made available annually by the federal government or private institutions or foundations that target the housing needs of low-income families, special needs groups, senior citizens, those with mental illness, physical disability or the homeless, and others. These program funds are used to match the grant funds received by local nonprofit organizations, municipalities and other organizations that deliver housing-related services. The average match ratio is 2:1 federal/state.

- **Housing Choice Voucher Program**

  The Housing Choice Voucher Program provides eligible low-income Alaskans (below 50 percent of median) with a method of obtaining affordable housing. It helps families lease privately-owned rental units from participating landlords. The household pays 30 percent of their income toward rent, the remainder is paid by AHFC. AHFC administers the voucher program in *11 communities throughout Alaska.* There are approximately 4,200 vouchers in Alaska.

- **Public Housing Properties**

  AHFC owns more than 1,600 safe, decent and affordable rental housing across Alaska where low-income families (below 80 percent of median) can access supportive services; however, AHFC is required to target 40 percent of all new admissions from families earning below 30 percent of median income. The household pays 30 percent of their income toward rent, the remainder is paid by AHFC. Public housing and Section 8 new housing developments are located in 14 communities across Alaska.

Public Housing Statistical Overview

If The Budget Cuts Proposed by Congress for the FY2012 Budget pass:

- AHFC will lose about $1.23 million for the repair and renovation of public housing stock.
- AHFC will lose about $782,000 from the statewide Housing Choice Voucher administrative fund.
- No new vouchers will be received.
- Veteran Affairs Supportive Housing (VASH) voucher program will be zeroed out. AHFC currently administer 95 VASH vouchers within Anchorage and Fairbanks and hoped to expand the program to Juneau.
- A $10 million cut to tenant protection vouchers. This program was the source of the 59 vouchers AHFC received in 2010 with the demolition of the Loussac Manor project.
- A $149 million cut to the Public Housing Operating Fund, a 3 percent reduction from current $4.775 billion funding level. Significantly, Congress may try to have public housing authorities pay a substantial portion of their operating expenses by drawing on reserves otherwise available for unanticipated capital repairs.

Public Housing Statistical Overview

- Of the 5,176 voucher holders ages 19 and older, 1,112 (21.5 percent) have full or part-time work

- Average duration on the program today = 8.9 years
- Average duration about 10 years ago = 3.6 years
- Percentage of families on program more than 10 years = 7.5 percent
- Percentage of families on program more than 5-10 years = 71.5 percent
- Percentage of families on program fewer than 5 years = 21 percent

Alaska Coalition on Housing & Homelessness
Housing Facts for Alaska
FFY 2010

Source: National Low Income Housing Coalition www.nlihc.org

Alaska Housing Finance Corporation

Rent-Wage Disparity					
Community	**Affordable Rent** for households at 30 percent AMI*	**Affordable Rent** for households receiving SSI/ and Adult Public Assistance	**2-BR FMR** Fair Market Rent	**Wage Needed to Afford 2-BR FMR** Per Hour	**Hrs pr wk @ Min Wage****
Anchorage	$627	$202/$109	$1,031	$19.83	109
Barrow	$637	$202/$109	$1,292	$24.85	137
Bethel	$362	$202/$109	$1,418	$27.27	150
Dillingham	$453	$202/$109	$1,174	$22.58	125
Fairbanks	$576	$202/$109	$1,004	$19.31	107
Juneau	$683	$202/$109	$1,281	$24.63	136
Kenai	$537	$202/$109	$855	$16.44	91
Ketchikan	$594	$202/$109	$1,124	$21.62	119
Kodiak	$587	$202/$109	$1,210	$23.27	128
Mat-Su	$567	$202/$109	$981	$18.87	104
Nome	$440	$202/$109	$1,205	$23.17	128
Sitka	$622	$202/$109	$1,073	$20.63	114
Unalaska	$722	$202/$109	$1,174	$22.58	125
Valdez	$603	$202/$109	$1,057	$20.33	112

*Affordable rent means monthly rent affordable to a household earning 30 percent of Annual Median Income, applying the generally accepted standard of spending not more than 30 percent of income on housing costs.

** Minimum wage of $7.15/hr, effective

FMR-Fair Market Rent as issued by HUD March 11, 2010

Cost Effectiveness of Supportive Housing

	Cost per day
Hospital	$1,600
API	$732
Nursing Home	$412
Detox	$270
Jail/Prison	$153
Supportive Housing[1]	$70

Sources: OMB, API, DHSS, DOC, Clitheroe Center, & AHFC

[1]Supportive Housing calculation includes rent subsidy of $600/mo-$20/day; care coordination at $20/day; social supports (bus tokens, meal services, etc.) at $20/day; and administrative overhead at $10/day.

Alaska Housing
FINANCE CORPORATION

Figure 1

AK Homeless Point-in-Time Count
Winter 2008 - Winter 2010

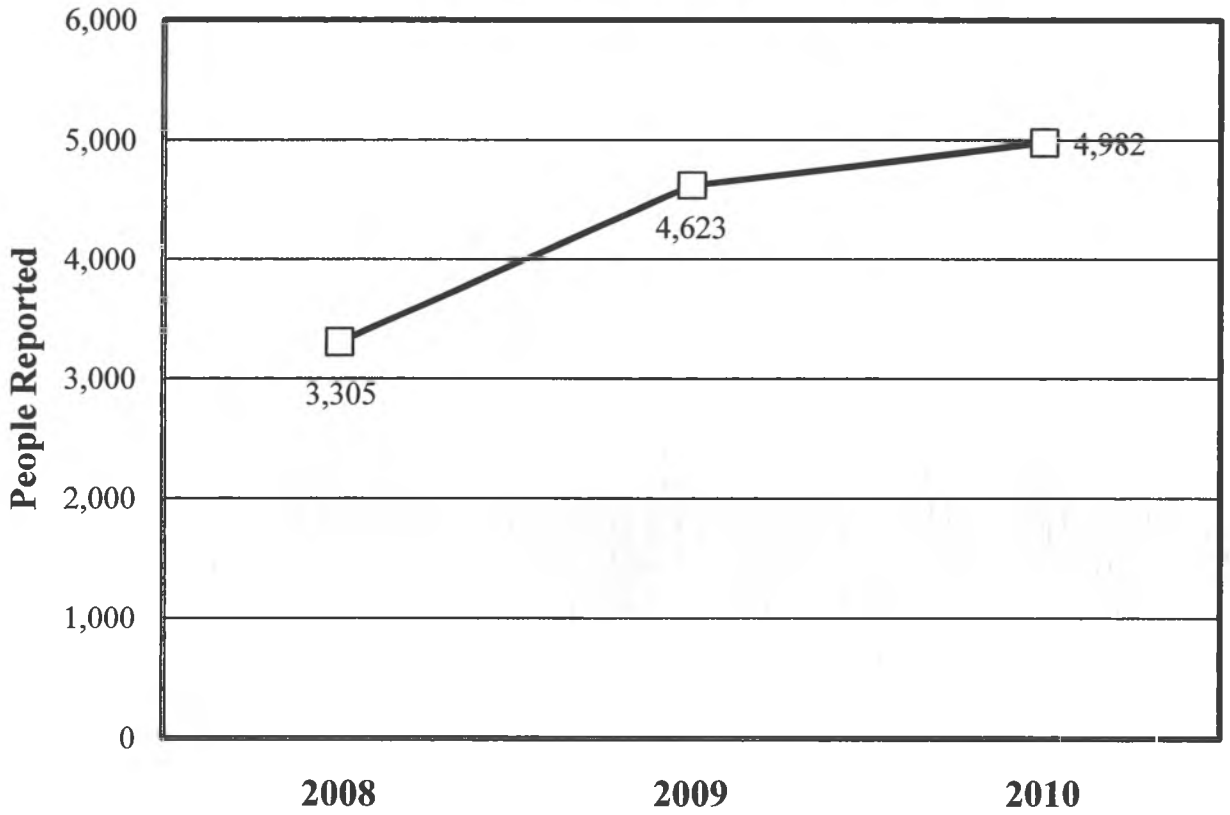
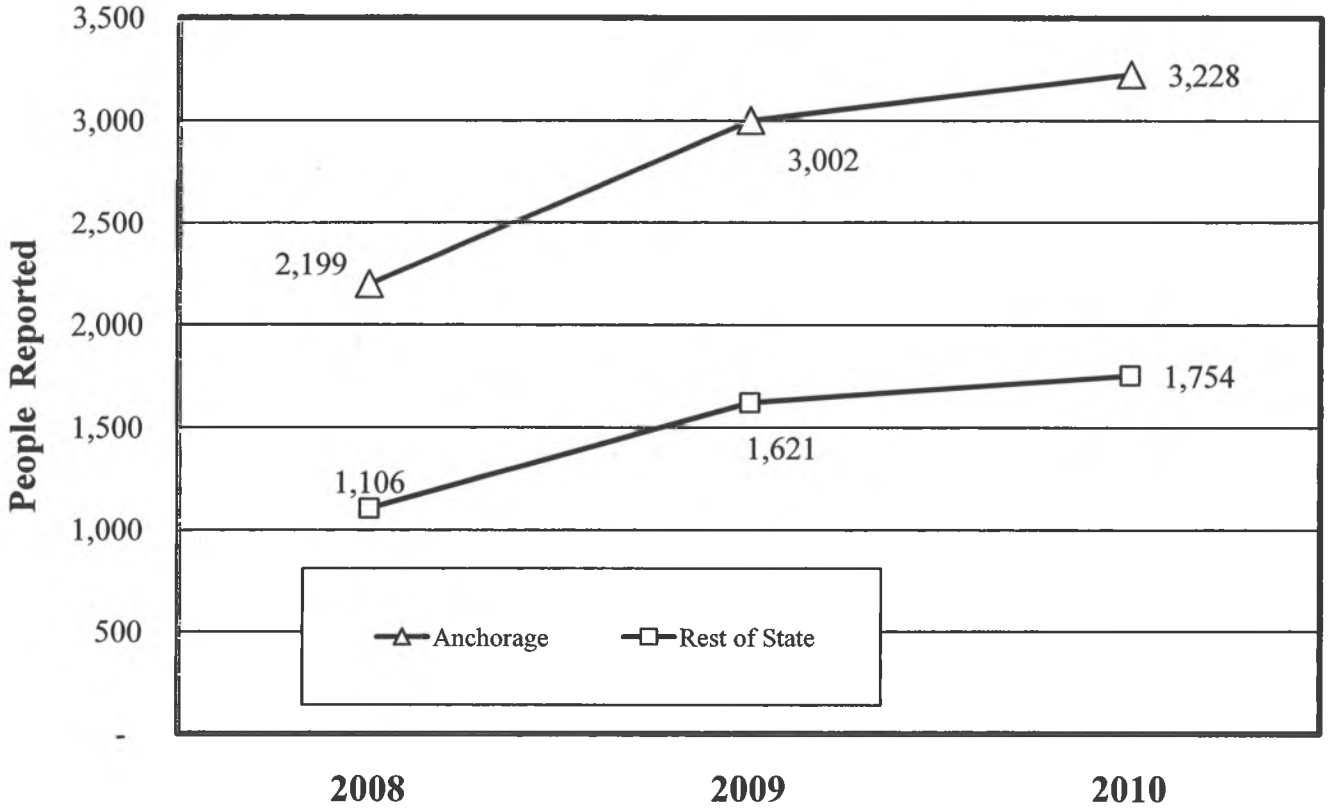


Figure 2
Regional Homeless Comparison
Winter 2008 - Winter 2010



THE "*REAL WORLD*" OF HOUSING NEEDS IN ALASKA

Alaska Housing FINANCE CORPORATION

Dave & Emily have two children ages 4 and 7. Dave works variable hours at a large home improvement store and Emily works at a small engine repair shop. They lost their apartment after their youngest child developed complications from the flu and Emily had to stay with the child at the hospital and later at home. Though Denali Kid Care covered the medical expenses, Emily's employer did not provide paid leave. Without her paycheck, the family got behind on their rent and utilities. They applied to the local Salvation Army and several churches for help with the arrearages but were repeatedly told that their timing was bad as funds were exhausted for the year. The family is #1348 on the Public Housing Voucher waitlist and is currently bouncing between motels and several friends' homes, never staying in one place for more than two weeks.

Solution: Provide adequate funding for short-term rent and utility arrearages
Increase federal & state funding for tenant based rental vouchers

Jeremy is a 24-year old former foster child. He was removed from the home where he was abused, neglected and sexually molested when he was nine. Considered "difficult to manage," he was placed in multiple foster homes. The longest period of stability Jeremy has known is the two years he spent at McLaughlin Youth Facility between 16-18 years. He has no stable adult mentors or relatives. Jeremy has worked at various fast-food restaurants but his volatile relationships with co-workers and managers often results in his losing or walking off the job. He tried shared apartment living but could not maintain relationships with his roommates. When the memories of his childhood or recent failures get overwhelming, Jeremy self-medicates with alcohol and/or drugs. He is too old for services from Covenant House but says he doesn't relate to the people who sleep at a Brother Francis-type shelter. Instead, he either camps or finds friends to take him in temporarily. Jeremy tried to apply for public housing but was turned down due to a history of disorderly conduct. He would like to enter a trade school but he can't afford the cost and is fearful of any entrance exam.

Solution: Link long-term care coordination and counseling for persons formerly in foster care with job service centers
Provide tax credits for businesses that develop workforce housing in industrial and commercial zones.

4300 Boniface Parkway • Anchorage, Alaska 99504 PO Box 101020 • Anchorage, Alaska 99510

THE "*REAL WORLD*" OF HOUSING NEEDS IN ALASKA

Grace is a 55-year old single mother with **Phillip,** a 30-year old developmentally disabled son. For many years, Grace ran a children's day care center out of her home. Last year, she had to close the business due to a deteriorating back condition. Currently the family is living off of Phillip's SSI check of $675 a month and food stamps. Grace has completed a course in tax preparation and hopes she can work through the tax season but her earnings will not be enough to stop foreclosure on her home. She has tried to sell her house but no one is interested in all the modifications that were made for her business.

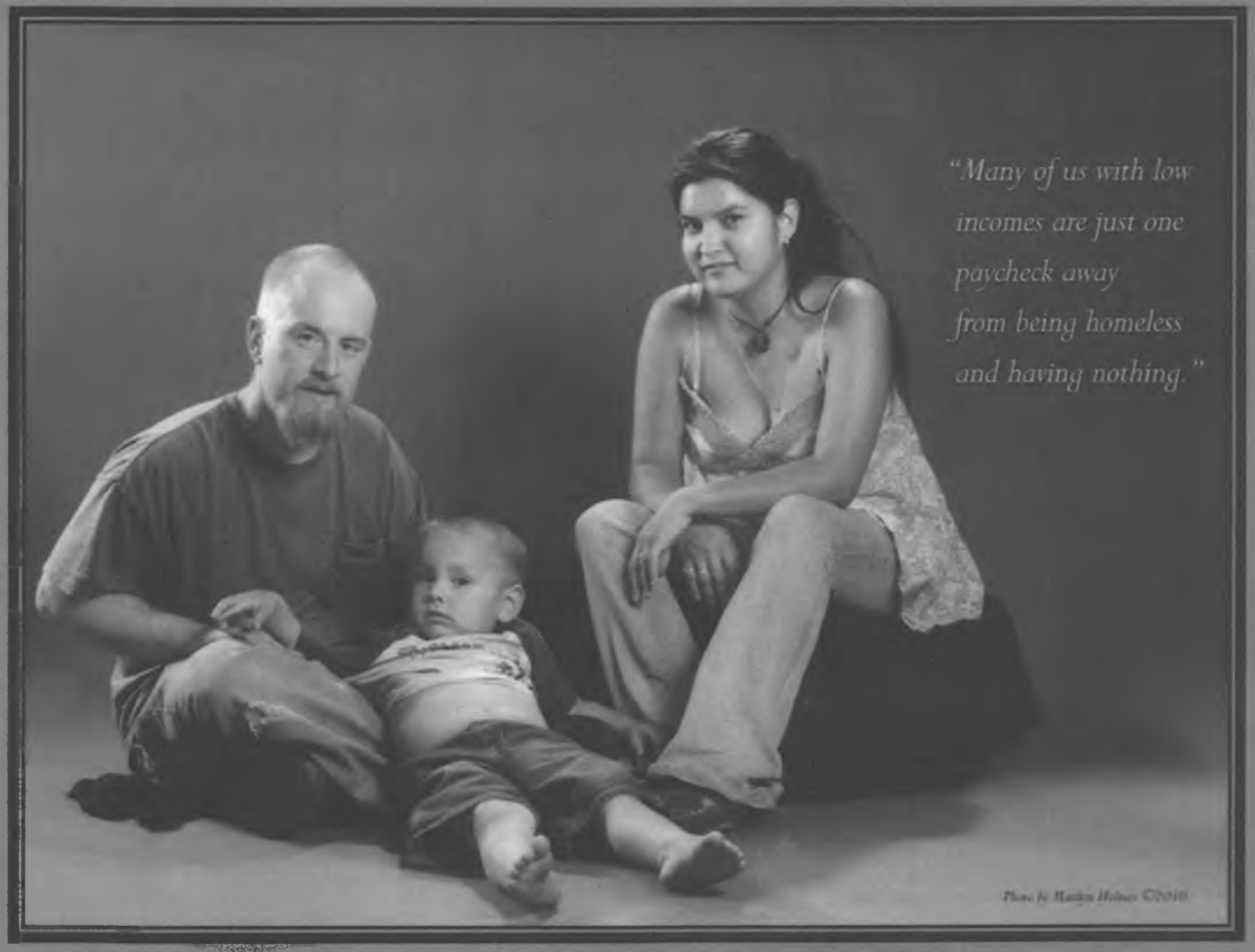
Grace has no idea where they will go next. Grace is #2113 on the Public Housing wait list but hopes Phillip's Medicaid waiver will qualify them for a special set-aside voucher for this population. She knows there are no suitable shelters that can accommodate her son's disability without her. Due to her son's disability, most of her friends and family keep their distance.

Solution: Increase federal & state funding for tenant based rental vouchers

4300 Boniface Parkway • Anchorage, Alaska 99504 P.O. Box 101020 • Anchorage, Alaska 99510

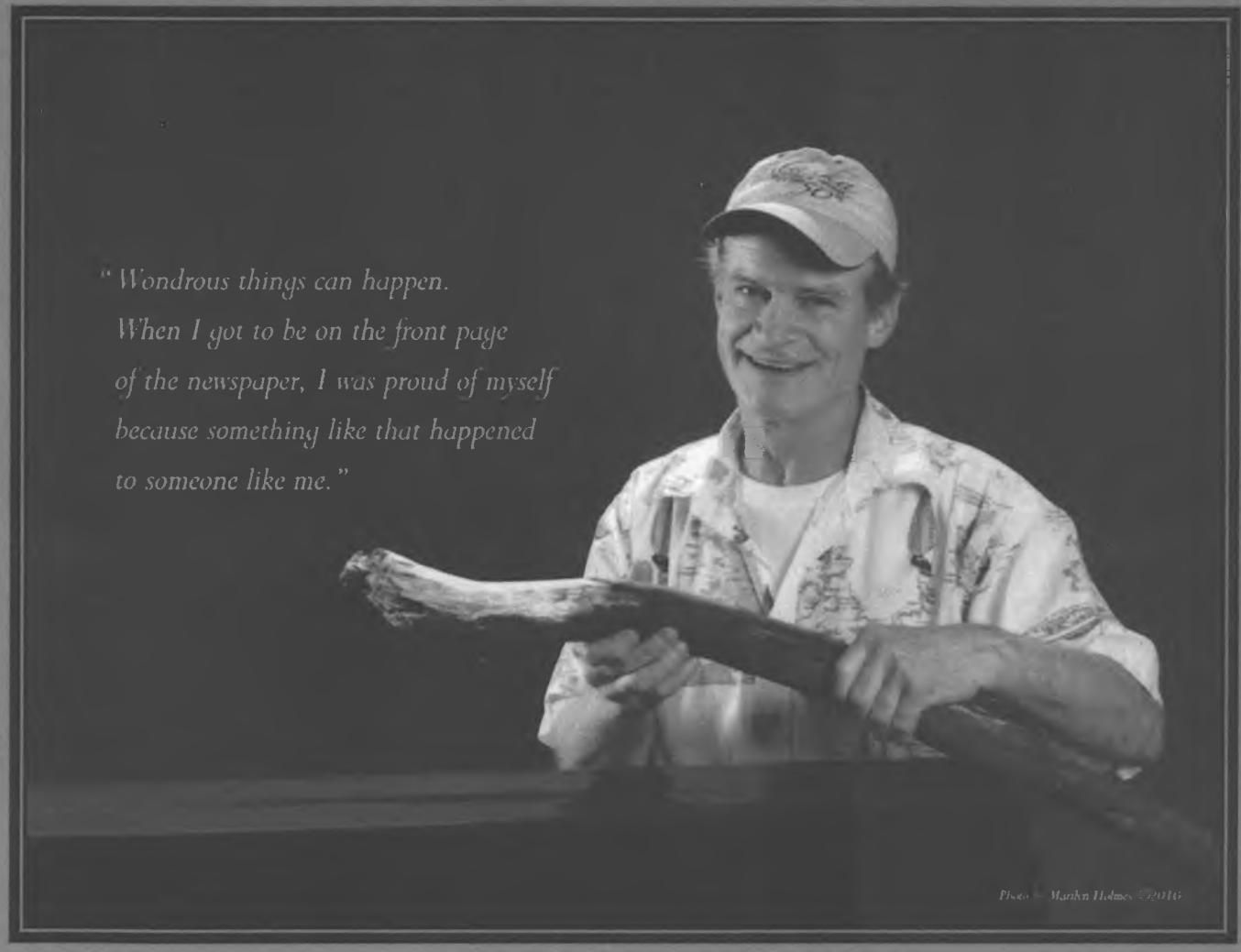
Alaska's Homeless

A Snapshot of Who In Alaska Experiences Homelessness



Families experience homelessness

29% of homeless households were families with children (January 2010)
National rate was 23-31% of all homeless households (2008)
4,218 children were identified as homeless during 2009-10 school year



Veterans experience homelessness

Veterans were 6% of all homeless Alaskans (January 2010)

National rate of homelessness for veterans was 13% (2009)

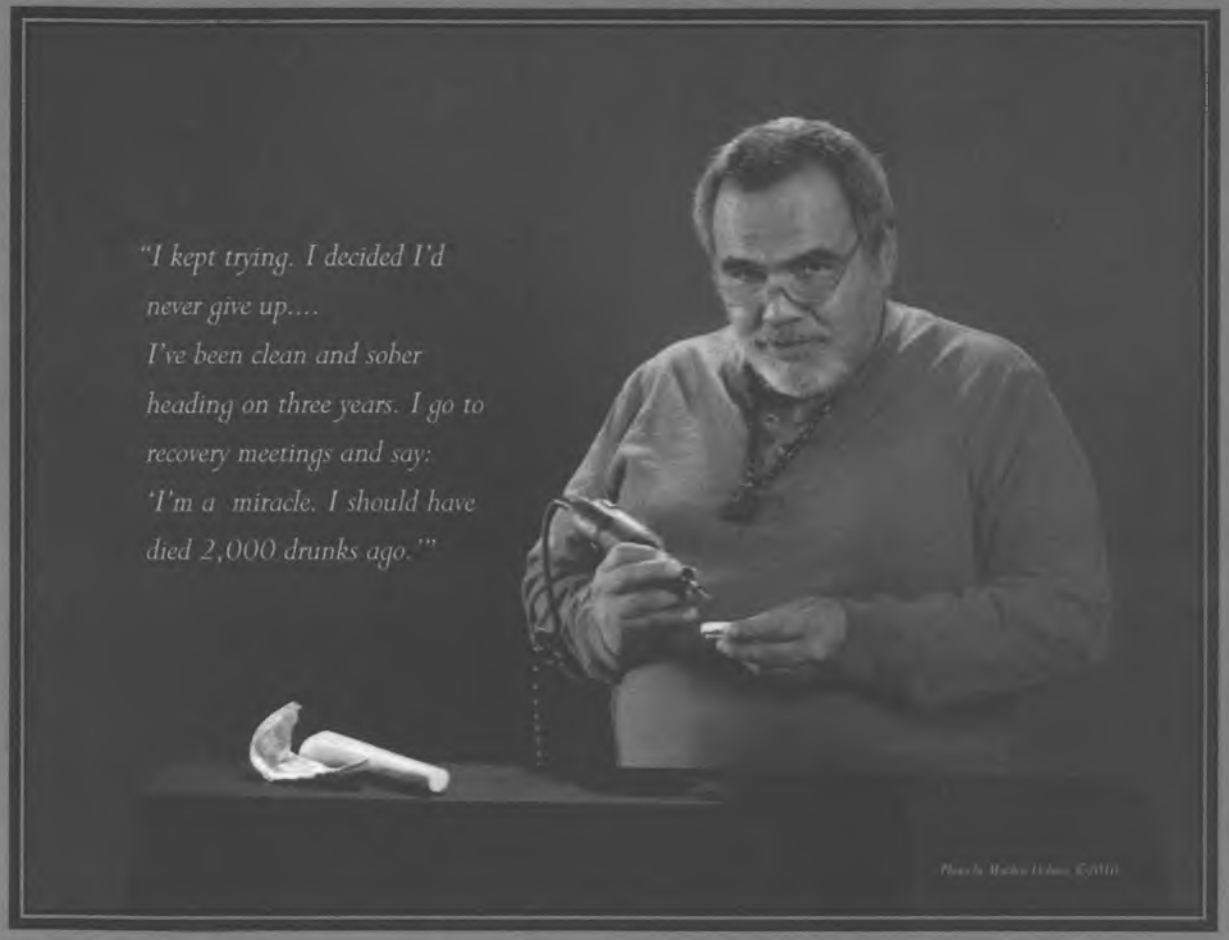
Nationally, homeless veterans are more likely to be single adult men

"Some kids come from bad environments and need to learn how to live on their own. I didn't come from a bad environment. I was lucky that way. But this [Juneau Youth Services transitional living program] has still been a really good thing for me."

Youth experience homelessness

1,306 10th-12th graders were homeless during 2009-2010 school year

Homeless youth are more at risk for suicide, exploitation, mental health disorders, PTSD, and substance use disorders



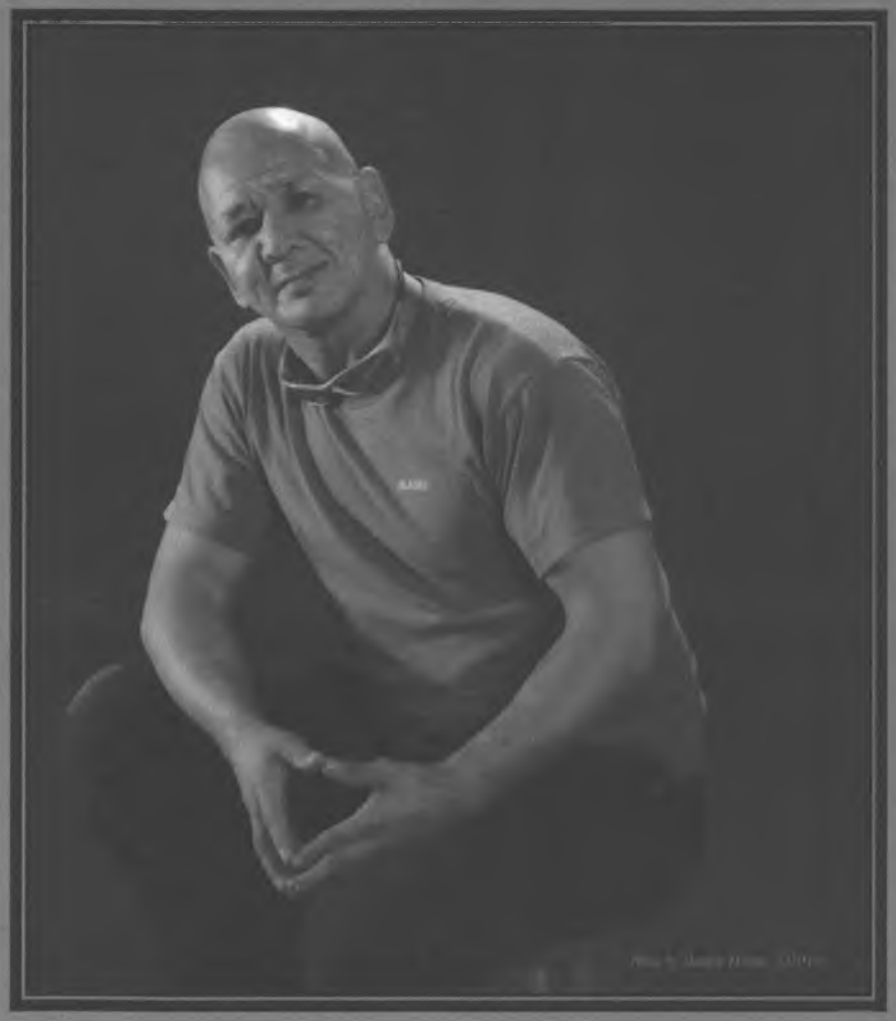
People with substance use disorders experience homelessness

16% of homeless individuals report chronic substance abuse (January 2010)
2.1% higher than reported chronic substance abuse in January 2009

N.B. Many Homeless Connect participants decline to answer, affecting data

Victims of domestic violence experience homelessness

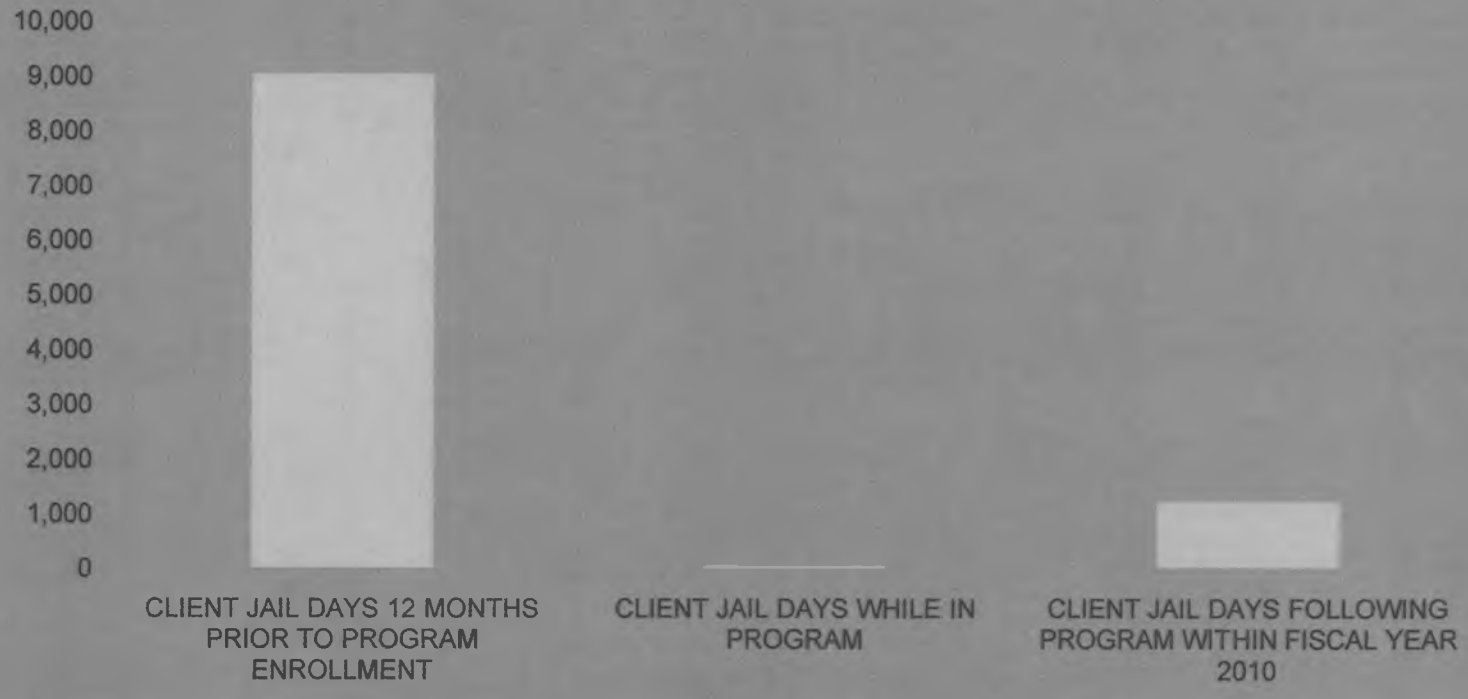
10.7% of homeless people reported past domestic violence (January 2010)
3.6% increase since January 2009
Nationally, 22-25% of homeless women report past domestic violence



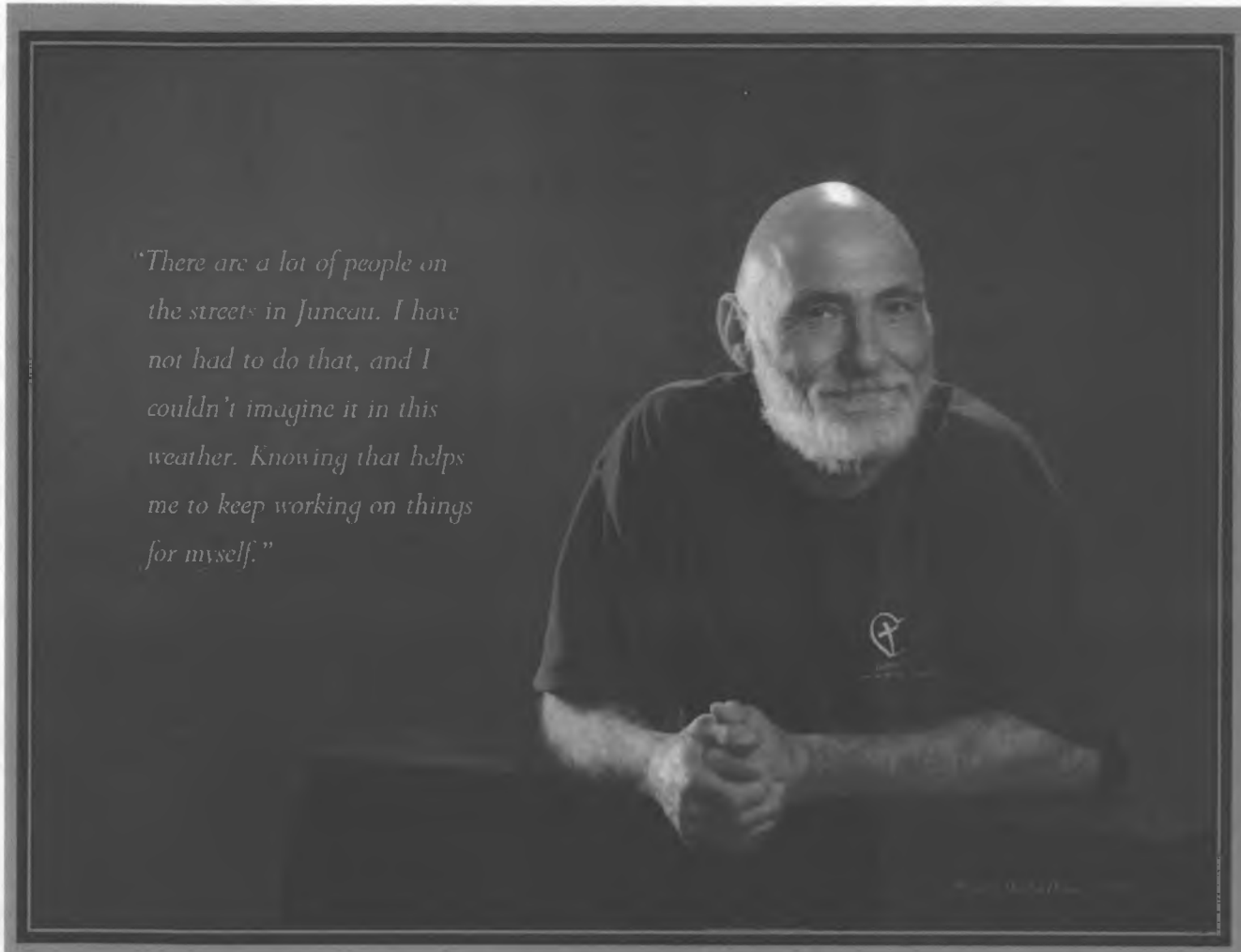
Prisoners experience homelessness before and after incarceration

Nationally, over 50% of homeless people report previous incarceration
20% of prisoners reporting mental illness were homeless before prison

DOC Discharge Incentive Grant Program



N = 43 clients served in Assisted Living Homes with augmented services and reimbursement because their needs were too high for standard assisted living

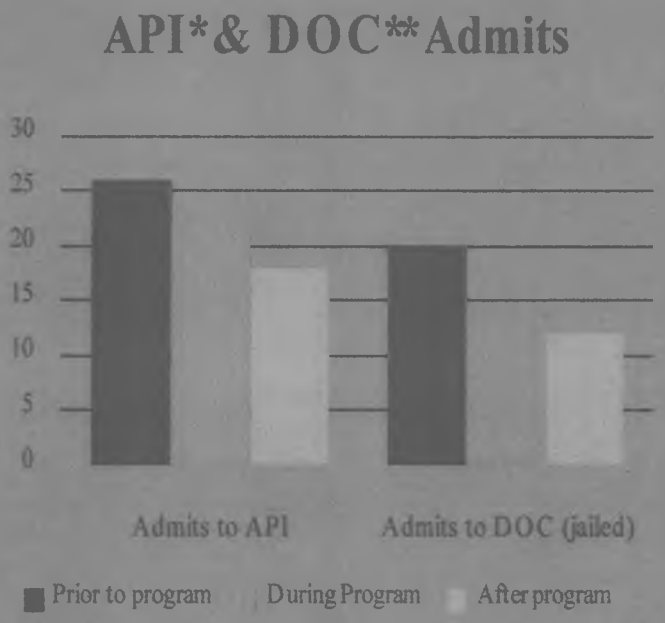


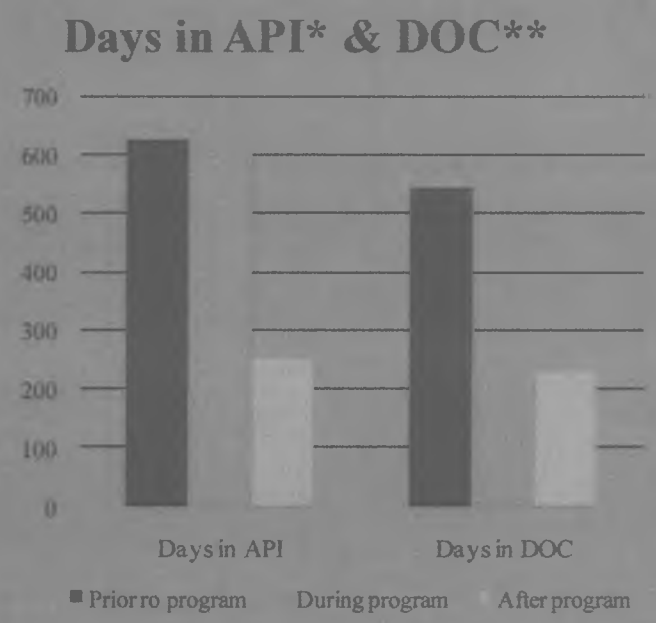
People with serious mental illness experience homelessness

18%of homeless people reported serious mental illness (January 2010)

(N.B. Many Homeless Connect participants decline to answer, affecting data)
Nationally, 26% of homeless people experience serious mental illness

Bridge Home Programs





Outcomes 1 year prior, 1 year during and 1 year after participation in Bridge Home program at Anchorage Community Mental Health Services

Effective Housing Models

Transitional Housing

- Covenant House, Anchorage –Juneau Youth Services, Juneau

Prioritizing by Vulnerability

- Common Ground, New York City

Supportive Housing for People Experiencing Serious Mental Illness

- Downtown Assisted Living, Fairbanks – Polaris House & JAMHI, Inc., Juneau - Evans House, Seattle

Supportive Housing for Chronic Alcoholics

- Jacob's Place, Sitka – Karluk Manor, Anchorage - 1811 East Lake, Seattle

A Mile From Home

5,281 Alaskans were homeless in 2010.

Additional Information on Homelessness Visit the Following Sites:

National Alliance on Ending Homelessness
http://www.endhomelessness.org/

Corporation for Supportive Housing
http://www.csh.org/index.cfm?nodeid=81

SAMHSA-Homeless Resource Center
http://homelessness.samhsa.gov/

Alaska Scorecard
http://www.hss.state.ak.us/dhcs/healthplanning/scorecard/assets/scorecard.pdf

Common Ground: Prioritizing housing using the Vulnerability Index,
http://www.commonground.org/?page_id=789

100,000 homes campaign
http://100khomes.org/

Innovative Services for Alaska's Homeless Persons with Mental Illness
Alaska Federation of Natives
Submitted to the Center for Substance Abuse Treatment
(Bernard Segal, PH.D., Center for Alcohol and Addiction Studies, UAA, 2003)
http://www.ahfc.state.ak.us/iceimages/homeless/homeless_progress_report.pdf

Alaska Prisoner Reentry Task Force Five-Year Prisoner Reentry Strategic Plan, 2011-2016
http://www.correct.state.ak.us/corrections/commish/docs/StrategicPlan.pdf

DESC-Seattle's Successful Housing First Model 1811 Eastlake
http://www.seattle.gov/housing/homeless/HousingFirst.htm

DESC- Vulnerability Assessment Tool

http://www.desc.org/vulnerability.html

Domestic Violence and Homelessness
http://www.aclu.org/FilesPDFs/housing%20paper.4.pdf
http://www.nlchp.org/content/pubs/Some%20Facts%20on%20Homeless%20and%20DV.pdf
http://www.endhomelessness.org/content/article/detail/1647

National Low Income Housing Coalition
http://www.nlihc.org/template/index.cfm

Alaska Coalition on Homelessness
http://akcoalition.com/index.html
Juneau Homeless Coalition
http://www.jedc.org/housing-coalition.shtml

Anchorage Coalition on Homelessness
http://www.anchoragehomeless.org/

Alaska Council on the Homeless
http://www.ahfc.state.ak.us/homeless/homeless.cfm

KTUU- Stones in the Backpack: The Burden of Teen Prostitution in Alaska
http://www.ktuu.com/news/stonesinabackpack/

Housing First Services for People Who Are Homeless With Co-Occurring Serious Mental Illness and Substance Abuse

Deborah K. Padgett
New York University School of Social Work

Leyla Gulcur
Sam Tsemberis
Pathways to Housing

The literature on homeless adults with severe mental illness is generally silent on a critical issue surrounding service delivery—the contrast between housing first and treatment first program philosophies. This study draws on data from a longitudinal experiment contrasting a housing first program (which offers immediate permanent housing without requiring treatment compliance or abstinence) and treatment first (standard care) programs for 225 adults who were homeless with mental illness in New York City. After 48 months, results showed no significant group differences in alcohol and drug use. Treatment first participants were significantly more likely to use treatment services. These findings, in combination with previous reports of much higher rates of housing stability in the housing first group, show that "dual diagnosed" adults can remain stably housed without increasing their substance use. Thus, housing first programs favoring immediate housing and consumer choice deserve consideration as a viable alternative to standard care.

Keywords: *homelessness; serious mental illness; dual diagnosis; psychiatric rehabilitation*

Homelessness in the United States, traceable to a famine in housing markets beginning in the early 1980s, afflicts thousands of persons who are psychiatrically disabled who lack adequate community-based care (Baumohl, 1996; Lovell & Cohn, 1998). Many are visible as they lead troubled lives on the streets; however, a growing number are likely to be incarcerated—the largest de facto psychiatric facility in the country is the Los Angeles County Jail (Butterfield, 2003). Regardless of whether the problem is viewed as one of individual pathology or systemic failure, the plight of people with mental illness and homeless remains one of the least understood and most contested service delivery problems in mental health today (Gonzalez & Rosenheck, 2002; McGray, 2004; Substance Abuse and Mental Health Services Administration [SAMHSA], 2003).

Social workers join other providers and advocates in lamenting the lack of service integration and the scarcity of resources available to meet the needs of adults who are homeless with mental illness who also abuse substances. However, the literature of social work and other professions is generally silent on a policy-relevant and practice-relevant debate surrounding service delivery for this population. The point of contention stems from fundamental differences in how people with mental illness who are homeless are viewed and in how consumer choice is defined and incorporated into a program's service delivery philosophy. Put another way, there are two contrasting paradigms in services for persons who are homeless with serious mental illness, one the traditional continuum of care approach favoring treatment first and the other a consumer-driven movement (housing first) that has gained momentum in recent years (Carling, 1990; Culhane, Metraux, & Hadley, 2001; Tsemberis, 1999).

Among a number of differences between them, a contrast of interest in this report lies in how they deal with substance abuse and whether abstinence is a precondition to independent housing and other services. Approximately 50% to 70% of persons who are homeless with mental illness abuse substances (Drake, Osher, & Wallach, 1991; SAMHSA, 2003), and these estimates are widely considered underreports because of denial, distrust, and fear of the consequences of divulging illegal behaviors (Drake, Yovetich, Bebout, Harris, & McHugo, 1997).

Housing first programs rank stable housing as the first and highest priority vis-à-vis abstinence from substance use and/or abuse, thus practicing a harm reduction approach (Inciardi & Harrison, 2000). Treatment first programs reverse this sequence and require detoxification and sobriety before giving access to services such as independent housing. For these programs, consumers'

Research on Social Work Practice, Vol. 16 No. 1, January 2006 74-83
DOI: 10.1177/1049731505282593
© 2006 Sage Publications

choice in adherence to mental health treatment and abstinence requirements must be relinquished for their own sake until they are deemed ready for independent living.

Our primary goals in this article are twofold: (a) to describe the historic development and core components of these two distinct service alternatives (treatment first and housing first) and (b) to provide findings related to substance and services use from the only randomized experiment designed to compare their effectiveness—the New York Housing Study.

BACKGROUND

The Treatment First Approach for People Who Are Homeless With Mental Illness

The era of deinstitutionalization opened the door to independent living for persons with diagnoses such as schizophrenia and bipolar disorder; however, these individuals still needed an array of support services as they made the transition from psychiatric hospital to community (Dixon, Krauss, Kernan, Lehman, & DeForge, 1995). Among these were medication management, psychological counseling, education, and job training. For a large subgroup, abuse of drugs and/or alcohol complicated matters considerably (Drake et al., 1997). Persons with mental illness who became homeless were disproportionately individuals who were "dual diagnosed" whose lives became a continual struggle to find shelter and avoid being victimized (Drake et al., 1991; Padgett & Struening, 1992).

The well-intentioned but underfunded system of public sector mental health services that evolved after the 1960s rarely interacted with drug and alcohol (D/A) treatment programs designed with clients without mental illness in mind. However, both service systems had one thing in common: They were predicated on assumptions of the need for structure and control. Different funding streams, staff expertise, and service philosophies, notwithstanding, the mental health, D/A, and homeless services systems share a "hurdle" approach in which gaining access to services requires relinquishing control and choice. In exchange for a bed and supportive services, consumers and/or clients submitted to rules requiring treatment compliance, abstinence, curfews, limited visitation, and a loss of privacy (Miller & Flaherty, 2000). From the perspective of a person who was dually diagnosed living on the street, this threshold for entry can seem daunting at best. It is also a high-stakes gamble because rule breaking usually leads to expulsion and a return to the streets.

Evaluations of treatment first programs have produced modest results in achieving housing stability (Lipton, Siegel, Hannigan, & Samuels, 2000); however, program attrition and a return to the "institutional circuit" (Hopper, Jost, Hay, Welber, & Haugland, 1997) remain a problem when trying to ascertain change over time. Recent innovations in programs designed specifically for persons with dual diagnoses have shown promising results for integrated treatment models (Drake et al., 1997; Bebout, Drake, Xie, McHugo, & Harris, 1997; Minkoff, 2001) and Double Trouble in Recovery 12-step groups (Magura, Laudet, Mahmood, Rosenblum, & Knight, 2002). Indeed, the cumulative findings have made integrated treatment for persons who are dual diagnosed the "state of the art" in terms of effectiveness (Tsuang, Fong, & Ho, 2003).

When integrated treatment was linked to housing options in a randomized trial, positive outcomes were associated with supervised living and on-site clinical services (McHugo et al., 2004). However, no study of integrated treatment to date has tested its comparative effectiveness as part of the consumer choice model as is the focus of the current study.

Reversing the Continuum: The Pathways Model of Housing First for Adults Who Are Psychiatrically Disabled and Homeless

By the early 1990s, a consumer-centered approach surfaced that reversed the treatment first continuum. Its proponents argued for "supported housing," with tenets of consumer choice, ongoing support services, and community integration (normal housing, not "treatment" residences; Carling, 1990; Ridgeway & Zipple, 1990; Srebnik, Livingston, Gordon, & King, 1995). They described treatment first approaches as "supportive housing" with on-site (or proximal) staff and rules governing behavior ranging from curfews to visitation to abstinence. Most involve congregate living with other consumers who are homeless and function as transitional housing, that is, therapeutic environments designed to foster independent living skills enabling clients to graduate to living on their own. In contrast, housing first is a type of "supported housing" that separates treatment from housing, considering the former voluntary and the latter a fundamental need and human right. As such, it provides scatter-site housing without on-site staff supervision and generally promotes harm reduction rather than requiring abstinence.

Although confusion can arise regarding what are considered essential and defining program components in supported versus supportive housing (Fakhoury, Murray,

Shepherd, & Priebe, 2002), housing first shares a bottom-line commitment to consumer choice and to immediate and continuing access to scatter-site independent housing. To our knowledge, the agency model that is the subject of the current study—Pathways to Housing, Inc.—stands alone in embodying the following elements: (a) immediate independent permanent housing that is not contingent on treatment compliance and is retained regardless of the client's temporary departure because of inpatient treatment or incarceration; (b) choice and harm reduction with respect to mental health treatment and substance use; (c) integrated Assertive Community Treatment (ACT) services (Drake et al., 1998) that work in conjunction with housing staff and a nurse practitioner to address ongoing housing and health needs.

The New York Housing Study

With its funding of a national multisite study of housing alternatives for persons who are homeless with mental illness, the federal agency SAMHSA chose the Pathways to Housing (PTH) program as the experimental condition for the New York City site (Shern et al., 2000). The New York Housing Study (NYHS), which began in 1996, was a 4-year randomized trial comparing the PTH version of housing first with treatment first continuum of care programs in the New York City area.

Published findings from the NYHS have shown higher rates of housing stability (Tsemberis & Eisenberg, 2000; Tsemberis, Gulcur, & Nakae, 2004) and cost savings (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003) for the PTH model. In addition to housing stability, the NYHS also assessed outcomes related to mental health symptoms, quality of life, drug and alcohol use, and utilization of substance abuse treatment. Analyses of the 24-month data showed no significant group differences in these outcomes with the exception of higher use of substance abuse treatment services by the control group (Tsemberis et al., 2004). The NYHS maintained a remarkable 87% retention rate of participation for 4 years (Stefancic, Shaefer-McDaniel, Davis, & Tsemberis, 2004).

In summary, the NYHS found that "a person's mental health diagnosis is not related to his or her ability to obtain or to maintain independent housing" (Tsemberis et al., 2004, p. 654). Moreover, housing such persons without requiring abstinence and sobriety did not increase their use of substances during a 2-year period despite comparatively lower levels of use of substance abuse treatment services. The control group's higher use of substance abuse services did not produce comparatively lower rates of drug or alcohol use, thus indicating that residence in "sober housing" did not produce the desired results in terms of abstinence.

In this report, we assessed substance-related and treatment-related outcomes from the full 48 months of data to determine if the previous findings are sustained or change during a much longer period of observation (4 years vs. 2 years). Thus, we address the following research questions:

Research Question 1: Are there group differences in alcohol and drug use at 48 months?

Research Question 2: Are there group differences in participation in substance abuse and mental health treatment at 48 months?

METHOD

Sampling and Recruitment

Individuals were eligible to participate in the NYHS if they signed an informed consent form (approved by federal and university Human Subjects Committees) and met three inclusion criteria. These were that the person (a) spent 15 of the last 30 days on the street or in other public places, (b) exhibited a history of homelessness during the past 6 months, and (c) had an Axis I diagnosis of severe mental illness. Although substance abuse was not a criterion for eligibility, 90% of the study participants had a diagnosis or history of alcohol or drug disorders according to clinical records. Psychiatric diagnoses were obtained from clinical records and interviews with referring providers.

Respondents were recruited from outreach teams, drop-in centers, state psychiatric facilities, psychiatric wards, and the streets. When it was determined that individuals met the inclusion criteria, they were asked if they would be interested in participating in a research study with compensation of U.S. $25 for each interview. It was further explained that based on a randomized lottery system, individuals would be referred to different housing programs in the city. Recruitment lasted from November 1997 to January 1999. The recruited sample was 225 people (99 in the experimental group and 126 in the control group) between ages 18 and 70 years.

Study Design and Description of Experimental and Control Conditions

The housing first model was developed by Pathways to Housing, Inc. (PTH) in 1992 as a consumer-driven approach to providing housing and support services to

adults who were homeless with mental illness. PTH gives immediate access to housing in independent scatter-site apartments and offers tenants an array of services through interdisciplinary Assertive Community Treatment (ACT) teams that include social workers, psychiatrists, vocational trainers, and substance abuse counselors. Two modifications of the ACT model initiated by PTH were the addition of a nurse practitioner to address health problems and a housing specialist to coordinate housing needs. As part of its vision of consumer choice, PTH does not make housing contingent on sobriety or treatment compliance. The single contingency in this model is a money management program for PTH clients who are unable to meet landlord requirements for leases (e.g., credit histories) or who are not ready to conserve resources necessary to make monthly rent payments. Because it does not refuse clients with histories of violence or incarceration, PTH has accepted and housed the most problematic among persons who are homeless with mental illness, that is, those other programs would not take or had ejected (Tsemberis, 1999).

PTH tenants who abuse drugs or alcohol are counseled by clinical services staff based on their readiness for change. Those with serious substance abuse problems are urged to accept referrals to residential treatment (and their apartments held for them or another one found when they are discharged). PTH also offers harm reduction support groups at its various branch offices. PTH clients whose substance use causes disruption face the usual consequences of a tenant in a similar situation with the exception that PTH staff will assist them in moving to another apartment if evicted.

Individuals randomly assigned to the control group were referred to usual care programs that offer abstinent-contingent housing and services based on a treatment first model. A typical program would be exemplified by a group home or a single-room occupancy residence in which clients are expected to attend day treatment, 12-step, and other therapeutic groups and follow medication regimens enforced by on-site staff. Sleeping, cooking, and bathing facilities are shared, and house rules strictly prohibit consumption of any substances and overnight guests.

During the research design phase, volunteer tenants at PTH reviewed the proposal and provided feedback. Tenants also served on the PTH Institutional Review Board (IRB) and had a voting role as to whether the project and the randomization process was fair and not harmful. Fidelity to the ACT model in the experimental condition was assessed using the Dartmouth fidelity model (Teague, Bond, & Drake, 1998) and was found to be satisfactory (Shinn, Tsemberis, & Moran, 2005).

Data Collection and Measures

A structured interview was administered at 6-month intervals for 48 months. To reduce attrition and maintain contacts, monthly 5-minute call-in interviews were conducted. Participants were paid $25 for in-person interviews (9 in all) and $5 for the monthly calls. These repeated contacts are one of the reasons for the study's high retention rate (Stefancic et al., 2004).

Because the NYHS was one of eight sites participating in a federally funded demonstration project, standardized cross-site measures were used to assess key variables.

Use of alcohol and illegal drugs. Use of alcohol and illegal drugs was assessed with the Six-Month Follow-Back Calendar (Sobell, Sobell, Leo, & Cancella, 1988). Participants reported the number of days drinks were consumed, and the number of days that certain illicit drugs were used during the 6-month period. Four summary variables were defined by the cross-site team: any use of alcohol, any use of illegal substances, heavy use of alcohol (more than 28 days in 6 months), and heavy use of drugs (more than 4 days in 6 months). Of these four variables, two (heavy use of alcohol and heavy use of drugs) were utilized in analyses for the current study.

It is possible that individuals in the treatment first programs underreport substance use differentially because these programs typically require abstinence or at least the promise of sobriety. Although such a bias would work against finding effects favoring the experimental condition, we considered this possibility of differential self-report in interpreting the findings.

Participation in substance abuse treatment. Participation in substance abuse treatment was collected through the use of a modified Treatment Services Review (McLellan, Alterman, Woody, & Metzer, 1992). Service use was computed as the average of a seven-item measure consisting of questions such as whether the participant had received treatment in a detox program or consulted with a counselor to talk about substance problems, and attended AA, NA, or any other substance abuse self-help group.

Participation in mental health treatment. Mental health service use was also collected through the modified Treatment Services Review (McLellan et al., 1992). Service use was computed as the average of a five-item measure consisting of questions such as whether the participant had received overnight treatment in a psychiatric hospital, attended a day hospital program or day

treatment center, and visited with a doctor or nurse to discuss medication or emotional problems.

For both utilization variables, the average proportion of services used is reported as the outcome of interest. A proportion of .20, for example, means that group members averaged one of a possible five "yes" answers to the mental health services measure.

Data Analyses

Checks on random assignment. A preliminary data analysis question checked on random assignment of the sample retained at each data collection point. One of the best guarantees of random assignment is a strong retention rate, which we successfully attained. We compared respondents who were and were not retained in the sample at several data collection points to see if they differed from baseline and found no differences in key demographic or other baseline variables. Because random assignment produced satisfactory equivalence of the groups, no demographic variables were used as covariates because they were not correlated with the outcomes. For this reason, we reported the demographic characteristics for the total sample rather than by group (see Table 1).

Analyses of research questions. Research Question 1 was analyzed graphically and with a growth curve model with group-by-time interactions to formally assess whether differences are changing over time, also known as hierarchical linear modeling (Bryk & Raudenbush, 1992). We created a Level-1 (repeated measures) model for the trajectory of each participant, and a Level-2 (person level) model to examine differences in experimental versus control trajectories for participants. At Level 1 (repeated measures), we estimated a regression equation for alcohol and drug use outcomes as a function of time. At Level 2 (person level), we estimated whether the intercept and growth parameters of the Level-1 models differed by group. Note that with nine points of data collection, we were able to include participants in this analysis even if they missed as many as one half of the assessments; this was an advantage of utilizing SAS Proc Mixed over repeated measures MANOVA.

Research Question 2 was tested using a sub-sample of participants who were in some type of service-related program, namely, experimental participants who were currently housed by the PTH/housing first program and control participants who reported living in one of the following places at time of the interview: supportive single-room-occupancy (SRO) hotels, drop-in centers, safe havens, detox facilities, crisis housing, intermediate care, boarding houses, transitional housing, group homes, alcohol and/or drug-free facilities, or treatment and/or recovery programs. The rationale for using this subsample for Research Question 2 was to "level the playing field" in terms of including only housed study participants—those in shelters, incarcerated, or on the streets were considered less able to avail themselves of such services. Because participants' residential status changed from one time point to the next, the subsamples also changed; we, therefore, had to conduct separate *t* tests for each time point instead of SAS Proc Mixed.

Perhaps it is not surprising to note, sample sizes varied considerably in this analysis across the nine points of data collection (every 6 months for 48 months). Thus, control group sample sizes ranged from a high of 126 at baseline to a low of 53 at 24 months. Similarly, experimental group sizes ranged from a high of 99 at baseline to a low of 35 at 12 months. In addition to the analysis decision to include only individuals who were housed at each specific time of

TABLE 1: ***Participant Characteristics***

Variable	*Number*	*Percentage*
Study group: Experimental	99	44
Control	126	56
Gender: Female	52	23.1
Male	173	76.9
Age: 18 to 30 years	43	19.1
31 to 40 years	62	27.6
41 to 50 years	68	30.2
51 to 60 years	41	18.2
61 to 70 years	11	4.9
Race: White	63	28
African American	90	40
Hispanic American[a]	33	14.7
Mixed and/or other[a]	39	17.3
Education: Some high school or less	94	42
High school diploma or GED Equivalent	55	24.6
Postsecondary education	75	33.5
Marital status: Married	8	3.6
Separated[b]	20	8.9
Divorced[b]	32	14.3
Widowed[b]	9	4
Never married[b]	155	69.2
Residence at baseline: Streets/subway/drop-in[v]	114	50.7
Shelter and/or safe haven[v]	14	6.2
Crisis housing with family and/or friends[d]	11	4.9
Psychiatric hospital	80	35.6
Hotel and/or motel[d]	5	2.2
Short-term transitional housing[d]	1	.4
Psychiatric Diagnosis: Psychosis	121	53.8
Bipolar Disorder	30	13.3
Major Depression	32	14.2
Other[e]	10	4.4
Missing[e]	32	14.2

NOTE: Some percentages do not add up to 100% due to rounding error. Categories with the same superscripts were combined for analysis of group differences.

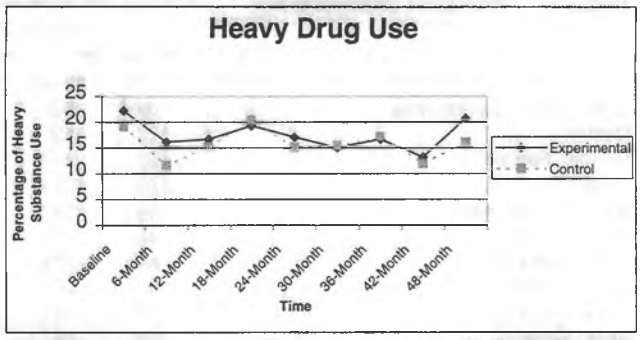


Figure 1: Heavy Drug Use, Baseline to 48 Months

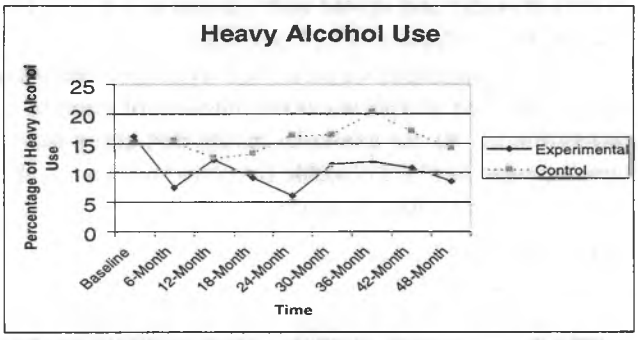


Figure 2: Heavy Alcohol Use, Baseline to 48 Months

data collection, samples were reduced because of study dropout, no-shows, incarceration, or other forms of institutionalization. PTH (experimental) participants were not considered "housed" if they were institutionalized even though they had access to housing on discharge. Because of these multiple group comparisons, a more conservative significance level was applied using a Bonferroni-corrected alpha of .006.

RESULTS

Description of the Study Sample

As can be seen in Table 1, the sample consisted of 173 men (76.9%) and 52 women (23.1%) with an average age of 41.5 years. Most of the participants (69.2%) had never been married. Sixty-three (28%) participants identified their race as White, and 90 (40%) identified their race as African American. Twenty-three (10.3%) participants did not go beyond eighth grade in their education. Among Axis I diagnoses, psychotic disorders were dominant (53.8%).

Thirty nine (17.6%) of the participants reported becoming homeless before age 18 yrs. The average age at which participants reported experiencing homelessness for the first time was 29.5 yrs (age range was 5 to 64 yrs). The longest period of time homeless was an average of 4.4 years with a median of 3 years. The majority (50.1%) of the participants lived on the streets or public place or in a drop-in shelter at time of the baseline interview, and 36% (n = 81) were living in a psychiatric hospital. According to their psychosocial histories, 90% had substance use disorders either in the past or currently. At the study's end at 48 months, housing first clients were stably housed 75% of the time during the previous 6 months compared to 50% of the time for treatment first clients (L. Gulcur, personal communication, July 25, 2005).

Group Differences in Alcohol and Drug Use

To answer Research Question 1, SAS Proc Mixed was utilized to test whether there were changes in reported drug and alcohol use over time. Because of low reported levels of drug and alcohol use, the "heavy use" variables were analyzed and predicted by time, group assignment, and the Time × Group Assignment interaction. As can be seen in Figures 1 and 2, none of the parameters were significant: Reports of drug use remained constant during the 48 months of the evaluation project, the groups did not differ from each other, nor were there differences in their rates of change over time. The same predictors were used to examine change in alcohol use over time, and again, none of the parameters were significant. However, there was a visual trend indicating that the PTH group used less alcohol than the control group.

Group Differences in Substance Treatment and Psychiatric Services Utilization

Substance treatment utilization showed notable differences at 6 months (p = .012), 18 months (p = .021), 24 months (p = .025), 36 months (p = .006) and 48 months (p = .014) with the control group members showing higher utilization (see Figure 3). With the Bonferroni correction, these differences were significant only at 36 months. Control groups members were somewhat higher utilizers of mental health treatment though the differences were statistically significant only at 48 months (p = .003; see Figure 4).

Discussion

The above results extend those cited earlier (Tsemberis et al., 2004) to an additional 2 years of data collection. We

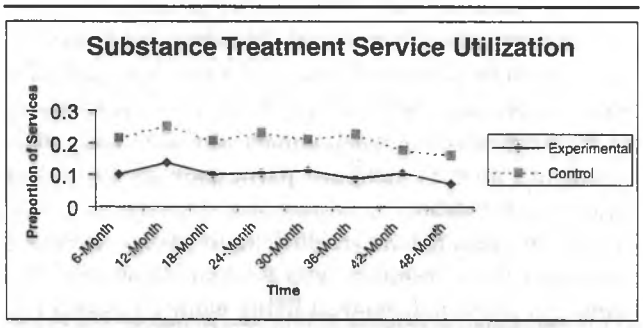


Figure 3: Substance Treatment Service Utilization, Baseline to 48 Months

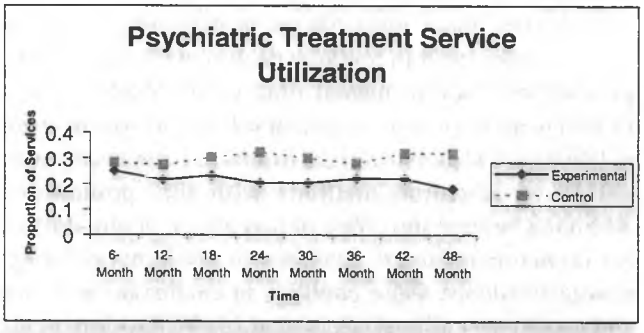


Figure 4: Psychiatric Treatment Service Utilization, Baseline to 48 Months

note the continued absence of group differences in alcohol and drug use, though with a nonsignificant trend toward lower alcohol use by the housing first group. The lack of compliance with sobriety requirements by a significant proportion of the treatment first group—now extending to 4 years' duration—is an indication that such strictures fall short in bringing about abstinence among consumers whose primary need is for housing (Watkins, Shaner, & Sullivan, 1999). Although substance use was almost certainly underreported by members of both groups, it is likely to be greater among those in treatment first because the adverse consequences of any admission of substance use are greater for them.

The treatment first group's higher use of substance abuse treatment services during the 48 months of the study must be considered in this context in which service use is linked to housing. It is not unusual to see clients continue to use drugs or drink surreptitiously even while attending treatment groups (Wolford et al., 1999). Our findings that treatment first clients did not reduce substance use and had comparably greater use of substance abuse and mental health services underscore this possibility.

Access to and availability of such services might influence these findings aside from program philosophies and requirements. However, it is useful to distinguish between services that are available versus those that are required. Housing first participants had an array of services available to them but were not required to use them. Control participants were required to use certain services (e.g., detox, 12-step groups, day treatment) to maintain their housing and presumably had access to them. Given the systemic factors influencing an individual's ability and willingness to seek help for mental health and substance abuse problems, our findings of "no significant difference" in substance use despite lower treatment service utilization and no program-specific restraints on substance use connotes clinical and programmatic significance favoring the housing first approach.

Limitations of the Study and Implications for Future Research

Despite a rigorous experimental design, low attrition rate and the use of standardized measures known for their reliability among persons who are homeless with mental illness, the current study is subject to concerns about accuracy in recall and social desirability bias. Such concerns are common to studies using self-report measures (Calsyn, Morse, & Klinkenberg, 1997) but are especially pertinent given the complex interplay of mental symptoms, drug effects (illicit and prescribed), and the severe deprivations of homelessness. If a man who is homeless is taken to a hospital emergency room disheveled, incoherent, and violent, he could be psychotic, high, or both. When it comes to substance abuse and psychiatric medication adherence, study participants may have a number of reasons for memory loss, misunderstanding Likert-type questions, or deliberately misleading researchers (Wolford et al., 1999).

In the current study, the thresholds selected as indices of a substance abuse problem do not necessarily square with providers' perceptions (Drake et al., 1991) nor should they be construed as clinically significant. In addition, the lower overall rates of substance use reported in this sample do not conform to estimates from previous sources. It is possible that this discrepancy is because of measurement bias or deliberate underreporting. As well, previous estimates may have been higher because of their reliance on persons who were dually diagnosed and homeless rather than those enrolled in services as in the current study. The absence of verification measures (e.g., urine toxicology tests) makes it impossible to draw definite conclusions about these reported rates.

Concerns about inaccuracies in detecting substance use are widespread in research dealing with problems of persons with severe mental illness. Yet Wolford et al. (1999) were surprised to find that self-report was superior to laboratory tests and clinical exams in a controlled evaluation of detection methods with this population. Although beyond the scope of this article, methodological problems related to accuracy in detecting and diagnosing substance abuse continue to challenge clinicians and researchers alike (Calsyn et al., 1997; Wolford et al., 1999). The current study's reliance on psychosocial histories and clinic records, rather than formal *DSM* diagnoses (Axis I or II) limits our capacity to analyze or compare findings based on *DSM* criteria. However, we are reasonably certain that the Axis I eligibility criteria were met.

Given the unquestionable negative effects of drug and alcohol abuse on rehabilitation of persons with mental illness, it is imperative that researchers pursue a number of avenues for understanding the beginning and ending of substance abuse among individuals in this population (Hohmann & Shear, 2002; Ridgway, 2001). To this end, the NYHS investigators and the first author have embarked on a longitudinal qualitative study designed to address this gap in knowledge by asking consumers about their histories of substance use and experiences in the service delivery system.

Beyond methodological improvements, future research is needed on supported housing in general (and housing first programs in particular) to compare outcomes across different settings and geographic areas (Mares, Kasprow, & Rosenheck, 2004). Currently, the PTH program is being replicated in a number of cities (Anderson, 2005), and plans for formal evaluations of the replicated model are under way.

Implications for Practice and Policy

The results of the current study show that individuals with severe mental illness and substance use problems do not have to undergo mandatory treatment to be able to live independently in the community. Moreover, consumer-driven programs that practice housing first and harm reduction are not linked to increased substance use despite the absence of restrictions. The current study has also revealed consistent (and probably underreported) use of illicit substances by individuals enrolled in treatment first programs despite abstinence requirements.

Our findings have distinct relevance for practitioners charged with engaging and retaining clients who are homeless with mental illness in care. Thus, the one-size-fits-all assumption that mental disorders and homelessness cannot be addressed until a client is clean and sober is no longer valid. Indeed, engagement and retention may be far more effective when clients who are dually diagnosed are able to actively participate in their own treatment decisions.

Yet long-held beliefs are difficult to change. Research has shown that consumers who are dually diagnosed and homeless prefer independent living while clinicians recommend supervised congregate housing (Schutt, Weinstein, & Penk, 2005; Watkins et al., 1999). Although the landscape of mental health and homeless policies is continually changing (McGray, 2004), there is a marked lag in implementation of empirical findings in policy and practice (Tsuang et al., 2003). Even individual components taken separately from housing first "packaging" (e.g., harm reduction and integrated treatment) remain far less common than treatment first and abstinence-oriented approaches. Organizational cultures, funding streams, and a conservative sociopolitical climate present obstacles to change and have the ultimate impact of restricting consumer choice (Tsuang et al., 2003).

As part of a federally funded national demonstration project, the NYHS was intended to inform housing and treatment policies for this deeply vulnerable population. Millions of public and private dollars are spent each year on treatment for persons with mental illness, and services for persons who are homeless have expanded exponentially (McGray, 2004). For example, the New York State Office of Mental Health has an annual budget of $5.6 billion, yet a small fraction (about $6.5 million) is dedicated to supported housing initiatives.

Further support for housing first approaches comes from comparative cost analyses. A groundbreaking study released in 2001 documented substantial cost savings from community-based care compared to shelters, jails, and hospital beds (Culhane et al., 2001). Because "community-based care" encompasses many noninstitutional approaches, future policy decisions to redirect public funds toward more effective alternatives will invariably also consider costs. Annual per capita costs of the PTH program are $22,500 compared with $40,000 to $50,000 for treatment first congregate housing programs, $85,000 for a jail bed, and $175,000 for a state psychiatric hospital bed (Anderson, 2005).

Social work practitioners, policy makers, and educators can benefit from these findings as some of the strongest support for "evidence-based practice" in housing and services for persons who homeless with mental illness. As the largest single group of mental health practitioners

and a significant part of the substance abuse treatment workforce, social workers play a critical role in implementing best practices for this vulnerable population.

Heartened by results showing that housing first leads to residential stability even for those considered least capable of benefiting, we end on a note of optimism that future research will shed additional light on the complex dynamic surrounding decisions of individuals who are homeless about substance use and the many other dimensions of successful recovery from mental illness. In this context, program philosophies favoring choice over restrictions and empowerment over compliance deserve consideration as not only effective but humane.

REFERENCES

Anderson, L. (2005, June 20). A reverse approach to homelessness [Electronic version]. *Baltimore Sun*, p. 1A.

Baumohl, J. (Ed.). (1996). *Homelessness in America*. Phoenix, AZ: Oryx.

Bebout, R. R., Drake, R. E., Xie, H., McHugo, G. J., & Harris, M. (1997). Housing status among formerly homeless dually diagnosed adults. *Psychiatric Services*, *48*(7), 936-942.

Bryk, A. S., & Raudenbush, S. W. (1992). *Hierarchical linear models: Applications and data analysis methods*. Newbury Park, CA: Sage.

Butterfield, F. (2003, October 22). Study finds hundreds of thousands of inmates mentally ill. *The New York Times*, p. A1, A7.

Calsyn, R. J., Morse, G. A., & Klinkenberg, W. D. (1997). Reliability and validity of self-report data of homeless mentally ill individuals. *Evaluation and Program Planning*, *20*, 47-54.

Carling, P. J. (1990). Major mental illness, housing, and supports: The promise of community integration. *American Psychologist*, *45*, 969-975.

Culhane, D. P., Metraux, S., & Hadley, T. (2001). The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections, and emergency shelter systems: The New York-New York Initiative. *Housing Policy Debate*, *5*, 107-140.

Dixon, L. B., Krauss, N., Kernan, E., Lehman, A. F. & DeForge, B. R. (1995). Modifying the PACT model to serve homeless persons with severe mental illness. *Psychiatric Services*, *46*, 684-688.

Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., et al. (1998). Assertive community treatment (ACT) for persons with co-occurring severe mental illness and substance use disorder. *American Journal of Orthopsychiatry*, *68*, 201-215.

Drake, R. E., Osher, F. C., & Wallach, M. A. (1991). Homelessness and dual diagnosis. *American Psychologist*, *36*, 1149-1158.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. (1997). Integrated treatment for dually diagnosed adults. *Journal of Nervous and Mental Disease*, *185*(5), 298-305.

Fakhoury, K. H., Murray, A., Shepherd, G., & Priebe, S. (2002). Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology*, *37*, 301-315.

Gonzalez, G., & Rosenheck, R. A. (2002). Outcomes and service use among homeless persons with serious mental illness and substance abuse. *Psychiatric Services*, *43*(4), 437-446.

Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fischer, S. (2003). Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes. *Journal of Community and Applied Social Psychology*, *13*, 171-186.

Hohmann, A. H., & Shear, M. K. (2002). Community-based intervention research: Coping with the "noise" of real life in study design. *American Journal of Psychiatry*, *159*, 201-207.

Hopper, K., Jost, J., Hay, T., Welber, S., & Haugland, G. (1997). Homelessness, severe mental illness and the institutional circuit. *Psychiatric Services*, *48*, 659-665.

Inciardi, J. A., & Harrison, L. D. (2000). *Harm reduction: National and international perspectives*. Thousand Oaks, CA: Sage.

Lipton, F. R., Siegel, C., Hannigan, A., & Samuels, J. B. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *Psychiatric Services*, *51*, 479-486.

Lovell, A. M., & Cohn, S. (1998). The elaboration of "choice" in a program for homeless persons labeled psychiatrically disabled. *Human Organization*, *57*, 8-20.

Mares, A. S., Kasprow, W. J., & Rosenheck, R. A. (2004). Outcomes of supported housing for homeless veterans with psychiatric and substance abuse problems. *Mental Health Services Research*, *6*(4), 199-211.

McGray, D. (2004, June). The abolitionist: Bush's homelessness czar has some new ideas. *Atlantic Monthly*, *101*, 36–39.

McHugo, G. J., Bebout, R. R., Harris, M., Cleghorn, S., Herring, G., Xie, H., et al. (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, *30*(4), 969-982.

McLellan, A. T., Alterman, A. L., Woody, G. E., & Metzer, D. (1992). *Treatment services review*. Philadelphia: University of Pennsylvania.

Miller, N. S., & Flaherty, J. A. (2000). Effectiveness of coerced addiction treatment (alternative consequences): A review of clinical research. *Journal of Substance Abuse Treatment*, *18*, 9-16.

Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, *52*, 597-599.

Padgett, D. K., & Struening, E. L. (1992). Victimization and traumatic injuries among the homeless: associations with alcohol, drug, and mental problems. *American Journal of Orthopsychiatry*, *62*, 525-534.

Ridgeway, P. (2001). Restorying disability: Learning from first-person narratives of recovery. *Psychiatric Rehabilitation*, *24*, 335-343.

Ridgeway, P., & Zipple, A. M. (1990). The paradigm shift in residential services: From the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal*, *13*, 11-31.

Schutt, R. K., Weinstein, B., & Penk, W. E. (2005). Housing preferences of homeless veterans with dual diagnoses. *Psychiatric Services*, *56*(3), 350-352.

Shern, D. L., Tsemberis, S., Anthony, W., Lovell, A. M., Richmond, L., Felton, C. J., et al. (2000). Serving street-dwelling individuals with psychiatric disabilities: Outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health*, *90*, 1873-1878.

Shinn, M., Tsemberis, S., & Moran, L. (2005). *Fidelity outcomes for a consumer preference living model of housing*. Manuscript in preparation.

Sobell, L. C., Sobell, M. B., Leo, G. L., & Cancella, A. (1988). Reliability of a timeline method: Assessing normal drinkers' reports of

recent drinking and a comparative evaluation across several populations. *British Journal of Addiction, 83*, 393-402.

Srebnik, D., Livingston, J., Gordon, L., & King, D. (1995). Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal, 31*, 139-152.

Stefancic, A., Shaefer-McDaniel, N., Davis, A., & Tsemberis, S. (2004). Maximizing follow up of adults with histories of homelessness and disabilities. *Evaluation and Program Planning, 27*, 433-442.

Substance Abuse and Mental Health Services Administration. (2003). *Report to Congress on the prevention and treatment of co-occurring substance use disorders and mental disorders*. Washington, DC: U.S. Department of Health and Human Services.

Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry, 68*, 216-232.

Tsemberis, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*, 225-241.

Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services, 51*, 487-493.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*, 651-656.

Tsuang, J. W., Fong, T. W., & Ho, A. P. (2003). Dual diagnosis and treatment compliance. *Psychiatric Services, 54*(4), 576.

Watkins, K. E., Shaner, A., & Sullivan, G. (1999). The role of gender in engaging the dually diagnosed in treatment. *Community Mental Health Journal, 35*(2), 115-125.

Wolford, G. L., Rosenberg, S. D., Drake, R. E., Mueser, K. T., Oxman, T. E., Hoffman, D., et al. (1999). Evaluation of methods for detecting substance use disorder in persons with severe mental illness. *Psychology of Addictive Behaviors, 13*(4), 313-326.

Alaska 10-Year Plan to End Homelessness

Progress Briefs (3/1/2011)

▲ = Good News

▼ = Bad News

PROGRAM PLANNING & COORDINATION

▲Homeless Coordinator grants awarded to Anchorage, Fairbanks & Mat-Su
▲Five -Year Prisoner Reentry Strategic Plan Released by DOC
▲ Number of communities working on a homeless strategy increased to 9
▲ *Number of Project Homeless Connect events increased from 3 to 5* in 2011

1. Housing for Chronic & Special Needs Homeless

▲33 new units developed under HUD 811 or 202 opened their doors in 2010
▲Count of chronic homeless continued to drop in AK to 240 from 453 in 2009
▲Number of VASH housing vouchers for homeless veterans rose from 35 to 95
▼10 TH units & 8 PSH units for homeless disabled persons eliminated in Mat-Su
▼Deaths among unsheltered homeless in ANC continued to rise

2. Housing for Persons Discharged from State Custody

▲Re-entry rental assistance program fully operational outside of ANC
▼AHFC application for Family Unification Program vouchers unsuccessful

3. Housing for Families w/Children

▼Number of homeless households with dependent children rose by nearly 10%
▼Average subsidy per household reduced est. # of vouchers from 4,275 to 3,982

4. Homelessness Prevention /Crisis Intervention

▲ Family Hope Center in Kenai increased # of transitional beds
▲# of HH receiving HAP-funded Prevention rose to 844 compared to 556 in '09
▼Housing retention rate dropped from 95% in '09 to 83% in '10

5. Data & Reporting

▲ Participation in HMIS increased

State of Alaska Homeless Count – January 2010

(all areas including Anchorage)

Part 1: Homeless Population	Sheltered		Unsheltered	Total
	Emergency	Transitional		
1. Number of Households **with** Dependent Children	118	121	10	**249**
1a. Number of Persons in these Households (adults & children)	392	389	36	**817**
2. Number of Adult Households **without** dependent children	656	310	186	**1,152**
2a. Total Number of Persons in these Households	662	313	188	**1,163**
3. Number of Single, Unaccompanied Youth Households	21	3	3	**27**
Total Persons (lines 1a +2a+3)	**1,075**	**705**	**227**	**2,007**
Part 2: Homeless Subpopulations	**Emergency**	**Transitional**	**Unsheltered**	**Total**
a. Chronically Homeless	79		52	**131**
b. Severely Mentally Ill	158	148	57	**363**
c. Chronic Substance Abuse	316	173	90	**579**
d. Veterans	125	87	35	**247**
e. Persons with HIV/AIDS	14	2	3	**19**
f. Victims of Domestic Violence	150	54	11	**215**

Part 1: Homeless Population	Not Recognized by HUD		Total
	With Family/Friends	Motel (Temporary)	
1. Number of Households **with** Dependent Children	516	57	**573**
1a. Number of Persons in these Households (adults & children)	1,789	230	**2,019**
2. Number of Adult Households **without** dependent children	749	98	**847**
2a. Total Number of Persons in these Adult Households	780	103	**883**
3. Number of Single, Unaccompanied Youth Households	72	1	**73**
Total Persons (lines 1a +2a+3)	**2,641**	**334**	**2,975**
Part 2: Homeless Subpopulations	**With Family/Friends**	**Motel (Temporary)**	**Total**
a. Chronically Homeless	76	33	**109**
b. Severely Mentally Ill	133	38	**171**
c. Chronic Substance Abuse	170	38	**208**
d. Veterans	65	19	**84**
e. Persons with HIV/AIDS	26	0	**26**
f. Victims of Domestic Violence	100	3	**103**

State of Alaska Homeless Count – January 2010

(all areas including Anchorage))

TOTALS

Part 4: Homeless Population	HUD	Non-HUD	Total
1. Number of Households **with** Dependent Children	249	573	**822**
1a. Number of Persons in these Households (adults & children)	817	2,019	**2,836**
2. Number of Adult Households **without** dependent children	1,152	847	**1,999**
2a. Total Number of Persons in these Households	1,163	883	**2,046**
Total Number of Households both **with and without** Dependent Children	1,401	1,420	**2,821**
3. Number of Single, Unaccompanied Youth Households	27	73	**100**
4. *Number of homeless students reported by school district in unspecified households*			*299*
Total Number of Homeless Persons	**2,007**	**2,975**	**4,982** + *299 = 5,281*
Part 3a: Homeless Subpopulations	**HUD**	**Non-HUD**	**Total**
a. Chronically Homeless	131	109	**240**
b. Severely Mentally Ill	363	171	**534**
c. Chronic Substance Abuse	579	208	**787**
d. Veterans	247	84	**331**
e. Persons with HIV/AIDS	19	26	**45**
f. Victims of Domestic Violence	215	103	**318**

Alaska Total Homeless Count - January 2009

(all areas *<u>including</u>* Anchorage*)*

Part 1: Homeless Population	**Sheltered**		**Unsheltered**	**Total**
	Emergency	**Transitional**		
1. Number of Households **<u>with</u>** Dependent Children	118	92	27	237
1a. Number of Persons in these Households (adults & children)	383	293	77	753
2. Number of Households **<u>without</u>** dependent children	596	348	249	1,193
2a. Total Number of Persons in these Households	596	348	250	1,194
Total Persons (lines 1a +2a)	**979**	**641**	**327**	**1,907**
Part 2: Homeless Subpopulations	**Sheltered**		**Unsheltered**	**Total**
a. Chronically Homeless	245		78	323
b. Severely Mentally Ill	350		51	401
c. Chronic Substance Abuse	438		84	522
d. Veterans	201		37	238
e. Persons with HIV/AIDS	12		4	16
f. Victims of Domestic Violence	234		15	249
g. Unaccompanied Youth (under 18 years)	45		6	51

Part 3: Homeless Population	**<u>Not</u> Recognized by HUD**		**Total**
	With Family/Friends	**Motel (Temporary)**	
1. Number of Households **<u>with</u>** Dependent Children	460	51	511
1a. Number of Persons in these Households (adults & children)	1,582	190	1,772
2. Number of Households **<u>without</u>** dependent children	818	76	894
2a. Total Number of Persons in these Households	826	78	904
Total Persons (lines 1a +2a)	**2,408**	**268**	**2,676**
Part 3a: Homeless Subpopulations	**With Family/Friends**	**Motel (Temporary)**	**Total**
a. Chronically Homeless	110	20	130
b. Severely Mentally Ill	112	19	131
c. Chronic Substance Abuse	128	21	149
d. Veterans	79	17	96
e. Persons with HIV/AIDS	9	5	14
f. Victims of Domestic Violence	67	11	78
g. Unaccompanied Youth (under 18 years)	66	4	70

Alaska Total Homeless Count - January 2009

(all areas *<u>including</u>* Anchorage*)*

Part 4: Homeless Population	**HUD**	**Non-HUD**	**Total**
1. Number of Households **<u>with</u>** Dependent Children	237	511	748
1a. Number of Persons in these Households (adults & children)	753	1,772	2,525
2. Number of Households **<u>without</u>** dependent children	1,193	894	2,087
2a. Total Number of Persons in these Households	1,194	904	2,098
Total Number of Households both **<u>with and without</u>** Dependent Children	1,390	1,405	2,835
Total Number of Persons in Households both **<u>with and without</u>** Dependent Children	**1,907**	**2,676**	**4,623**
Part 3a: Homeless Subpopulations	**HUD**	**Non-HUD**	**Total**
a. Chronically Homeless	323	130	453
b. Severely Mentally Ill	401	131	532
c. Chronic Substance Abuse	522	149	671
d. Veterans	238	96	334
e. Persons with HIV/AIDS	16	14	30
f. Victims of Domestic Violence	249	78	327
g. Unaccompanied Youth (under 18 years)	51	70	121

Alaska CoC Homeless Count - January 2008

Part 1: Homeless Population	Sheltered		Unsheltered	Total
	Emergency	Transitional		
1. Number of Households **with** Dependent Children	41	34	13	88
1a. Number of Persons in these Households (adults & children)	112	103	36	251
2. Number of Households **without** dependent children	206	116	56	378
2a. Total Number of Persons in these Households	206	116	56	378
Total Persons (lines 1a +2a)	**319**	**219**	**92**	**629**

Part 2: Homeless Subpopulations	Sheltered	Unsheltered	Total
a. Chronically Homeless	116	23	139
b. Severely Mentally Ill	86	22	108
c. Chronic Substance Abuse	141	28	169
d. Veterans	45	11	56
e. Persons with HIV/AIDS	2	0	2
f. Victims of Domestic Violence	123	5	128
g. Unaccompanied Youth (under 18 years)	9	1	10

Part 1: Homeless Population	Not Recognized by HUD		Total
	With Family/Friends	Motel (Temporary)	
1. Number of Households **with** Dependent Children	85	8	93
1a. Number of Persons in these Households (adults & children)	226	22	248
2. Number of Households **without** dependent children	220	14	234
2a. Total Number of Persons in these Households	220	15	235
Total Persons (lines 1a +2a)	**446**	**37**	**483**

Part 2: Homeless Subpopulations	With Family/Friends	Motel (Temporary)	Total
a. Chronically Homeless	31	6	37
b. Severely Mentally Ill	40	6	46
c. Chronic Substance Abuse	48	5	53
d. Veterans	24	3	27
e. Persons with HIV/AIDS	0	0	0
f. Victims of Domestic Violence	44	5	49
g. Unaccompanied Youth (under 18 years)	17	1	18

Anchorage Homeless Count - January 2008

Part 1: Homeless Population	Sheltered		Unsheltered	Total
	Emergency	Transitional		
1. Number of Households **with** Dependent Children	42	41	1	84
1a. Number of Persons in these Households (adults & children)	178	147	3	328
2. Number of Households **without** dependent children	353	236	99	688
2a. Total Number of Persons in these Households	357	239	99	695
Total Persons (lines 1a +2a)	**535**	**386**	**102**	**1,023**
Part 2: Homeless Subpopulations	**Sheltered**		**Unsheltered**	**Total**
a. Chronically Homeless	145	94	61	300
b. Severely Mentally Ill	57	97	15	169
c. Chronic Substance Abuse	136	125	34	295
d. Veterans	58	86	18	162
e. Persons with HIV/AIDS	2	3	2	7
f. Victims of Domestic Violence	99	45	18	162
g. Unaccompanied Youth (under 18 years)	5	0	0	5

Part 3: Homeless Population	Not Recognized by HUD		Total
	With Family/Friends	Motel (Temporary)	
1. Number of Households **with** Dependent Children	202	27	229
1a. Number of Persons in these Households (adults & children)	649	94	743
2. Number of Households **without** dependent children	349	83	432
2a. Total Number of Persons in these Households	349	84	433
Total Persons (lines 1a +2a)	**998**	**178**	**1,176**
Part 3a: Homeless Subpopulations	**With Family/Friends**	**Motel (Temporary)**	**Total**
a. Chronically Homeless	105	46	151
b. Severely Mentally Ill	29	16	45
c. Chronic Substance Abuse	47	18	65
d. Veterans	57	16	73
e. Persons with HIV/AIDS	4	1	5
f. Victims of Domestic Violence	71	15	86
g. Unaccompanied Youth (under 18 years)	41	1	42

A Look at Homelessness in Alaska

Homelessness, and its impact on individuals, families, and society, is an issue of growing concern both nationally and in Alaska. In the U.S., about 1,594,000 individuals used an emergency shelter or transitional housing, or both, between October 1, 2007 and September 30, 2008. On a single night in January 2008, the U.S. homeless population was estimated at 664,000 according to this annual Point-In-Time (PIT) count. These figures are part of the Department of Housing and Urban Development's (HUD) "2008 Annual Homeless Assessment Report to Congress" released in July 2009. HUD also reports that although the overall homeless rate was down one percent in 2008 from the prior year, the number of people in families using homeless shelters increased by 9 percent, a possible reflection of the effects of the current recession.

"Homelessness" is defined in the United States Code, Chapter 119, Subchapter I, §11302, "General definition of homeless individual":

> ... the term "homeless" or "homeless individual or homeless person" includes—
>
> 1. an individual who lacks a fixed, regular, and adequate nighttime residence; and
> 2. an individual who has a primary nighttime residence that is —
>
> A. a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
>
> B. an institution that provides a temporary residence for individuals intended to be institutionalized; or
>
> C. a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

In 2008, Alaska ranked tenth among the 50 states in concentration of homeless people, with 0.24 percent of the total state estimated to be homeles (Table 1). Oregon was number one with 0.54 percent, Nevada number two at 0.48 percent, Hawaii was number three at 0.47 percent, and California was fourth ranked with 0.43 percent. Homelessness in the U.S. is concentrated in urban areas. But from September 2007 to September 2008, the number of homeless nationally in suburban and rural areas rose from 23 percent of the homeless population to 32 percent.

It is important to note that most homeless counts rely on homeless agency participation—which varies year to year. Any counts of homelessness are estimates. Each count is a snapshot of a given moment and reflects data collected for individuals at a particular time.

Table 1. States with Highest Concentrations of Homeless People, 2008

Estimates of homeless persons as a percentage of state's total population.

Rank*	State	Homeless population N	Homeless population % of total population
1	Oregon	20,653	0.54 %
2	Nevada	12,610	0.48
3	Hawaii	6,061	0.47
4	California	157,277	0.43
5	Washington	21,954	0.34
6	New York	61,125	0.31
7	Colorado	14,747	0.30
8	Michigan	28,248	0.28
9	Florida	50,158	0.27
10	Alaska	1,646	0.24

* Rank is based on the number of homeless persons as a percentage of the state's total population.

Source of data: *2009 Annual Homeless Assessment Report to Congress, U.S. Department of Housing and Urban Development, Office of Community Planning and Development*

Who are the homeless in the U.S.?

Of the 1,594,000 homeless who used emergency shelter or transitional housing between October 1, 2007 and September 30, 2008:

- 32% were homeless persons in families.
- 68% were homeless individuals.
- 64% of homeless adults were male.
- 62% of the homeless were a minority.
- 43% had a disability.
- 40% of all these individuals were between 31 and 50 years old.

Table 2. Subpopulations of Homeless Persons, by Type, Anchorage and Alaska, January 2009

	Anchorage						Alaska (includes Anchorage)					
	Sheltered[1]		Unsheltered[2]		Total		Sheltered[1]		Unsheltered[2]		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Chronically homeless	207	7.4 %	46	29.3 %	**253**	**8.5 %**	312	7.3 %	78	23.9 %	**390**	**8.5 %**
Chronic substance abuse[3]	347	12.4	52	33.1	**399**	**13.5**	554	13.0	84	25.7	**638**	**13.9**
Victims of domestic violence	140	5.0	7	4.5	**147**	**5.0**	312	7.3	15	4.6	**327**	**7.1**
Veterans	190	6.8	25	15.9	**215**	**7.3**	257	6.0	37	11.3	**294**	**6.4**
Severely mentally ill	243	8.7	22	14.0	**265**	**8.9**	453	10.6	51	15.6	**504**	**11.0**
Unaccompanied youth (under 18 years)	45	1.6	0	0.0	**45**	**1.5**	115	2.7	6	1.8	**121**	**2.6**
Persons with HIV/AIDS	17	0.6	4	2.5	**21**	**0.7**	26	0.6	4	1.2	**30**	**0.7**
Total number of homeless	**2,805**		**157**		**2,962**		**4,256**		**327**		**4,583**	

Note: Percentages are calculated by averaging all available data points. This approach, a moving average, provides a clearer picture of the long-term trends in the homeless population. Veteran's Affairs homeless count was not included in this count, but generally adds 10 to 20 individuals to the count. Some homeless individuals are members of more than one subpopulation. Not all individuals were members of a subpopulation.

1. *Sheltered homeless* includes individuals living in emergency shelters, transitional shelters, living with extended family and/or friends, or temporarily living in motels.
2. *Unsheltered homeless* includes individuals living in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street.
3. *Chronic homeless* is defined by the federal government as either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years. A *disabling condition* is a diagnosable substance abuse disorder, a serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. An *episode of homelessness* is a separate, distinct, and sustained stay on the streets and/or in a homeless emergency shelter.

Source of data: *"Anchorage Homeless Count—January 2009: Preliminary Count w/o Data from VA" and "Alaska Total Homeless Count—January 2009," Alaska Housing Finance Corporation*

Estimates of subpopulations of the homeless based on the nationwide single-night January 2008 PIT count show:

- About 15% were veterans.
- Almost 13% were recent victims of domestic violence.
- Nearly 26% were persons with severe mental illness.
- 37% were persons with chronic substance abuse issues.
- 2% were unaccompanied youth under age 18.
- 4% were persons with HIV/AIDS.

The chronically homeless are another subpopulation. The federal definition of chronically homeless used by HUD states that a chronically homeless person is:

> ...either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied inividual with a disabling condition who has had at least four episodes of homelessness in the past three years.

To be considered chronically homeless, a person must have been on the streets or in emergency shelter (i.e., not in transitional or permanent housing) during these stays.

The nationwide 2008 PIT count estimated that:

- About 19% of the *total homeless population* (individuals and families) are chronically homeless.
- About 30% of homeless *individuals* are chronically homeless.

The number of chronically homeless remained about the same from 2007 to 2008 nationally.

Who are the homeless in Alaska?

Based on the January 2009 single-night count, Alaska's homeless number 4,583 persons. (The total state population in July 2008 was estimated at 679,200.) This figure includes individuals who meet HUD's definition of homeless, as well persons temporarily housed in a motel or with family/friends:

- 93% (4,256 persons) were "sheltered," which includes living in emergency shelters, transitional shelters, with extended family and/or friends, or temporarily in motels.
- 7% (327 persons) were "unsheltered," which includes living in a place not meant for human habitation such as cars, parks, sidewalks, abandoned buildings, or on the street.
- Among the sheltered, 57.5% were households with children.
- Among the unsheltered, 23.5% were households with children.

This 2009 count (including sheltered and unsheltered persons) showed the following figures for homeless subpopulations (Table 2):

- Almost 9% are chronically homeless.
- Nearly 14% have chronic substance abuse issues.
- Over 7% are victims of domestic violence.
- About 6% are veterans.
- Approximately 11% are severely mentally ill.
- Nearly 3% are unaccompanied youth under the age of 18.
- Less than 1% have HIV/AIDS.

Table 3. Alaska Homeless Counts 2007–2009

Area	2007	2008	2009
Anchorage	1,653	2,199	2,962
Fairbanks	171	280	428
Kenai Peninsula Borough	191	153	166
Mat –Su Borough	127	95	472
City of Juneau	232	203	403
Homer	62		
Bethel	28		
Rest of state	190	381	152
Total homeless count	**2,654**	**3,311**	**4,583**
Anchorage population	282,375	284,994	—
Alaska population	674,510	679,200	—

Source of data: *Alaska Homeless Counts, 2007, 2008, 2009, compiled and reported by Alaska Homeless Management Information System, Alaska Housing Finance Corporation; Population estimates from Alaska Department of Labor and Workforce Development, http://laborstats.alaska.gov/*

Where are the homeless in Alaska?

In 2009, the January single-night homeless count across the state showed the highest number of homeless was in Anchorage, with 2,962 homeless persons—nearly 65 percent of the state's total homeless population. The next highest number was in the Matanuska-Susitna Borough with 472 persons, followed by Fairbanks North Star Borough with 428 homeless, the City of Juneau with 403 homeless individuals, and the Kenai Peninsula Borough with 166 homeless. The number of homeless persons increased from 2007 to 2009 in all the above areas, with the exception of the Kenai Peninsula Borough. (See Table 3.)

Who are the homeless in Anchorage?

According to the January 2009 count, Anchorage, the state's most populous city, had 2,805 persons who were sheltered

Please see ***Homelessness****, page 4*

Table 4. Homeless Persons, by Family Status, Anchorage and Alaska, January 2009

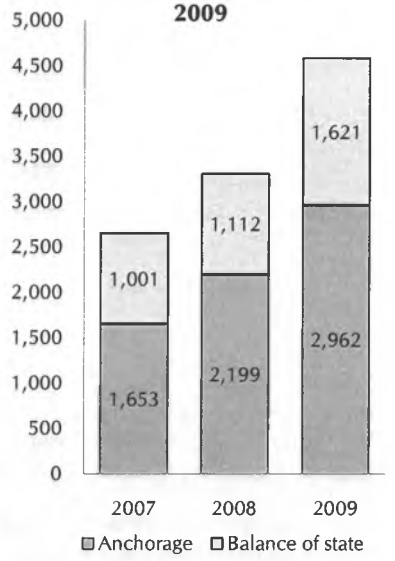
	Anchorage						Alaska (includes Anchorage)					
	Sheltered[1]		Unsheltered[2]		Total		Sheltered[1]		Unsheltered[2]		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Persons in households without children	1,167	41.6 %	132	84.1 %	**1,299**	**43.9 %**	1,808	42.5 %	250	76.5 %	**2,058**	**44.9 %**
Persons in households with children (adults & children)	1,638	58.4	25	15.9	**1,663**	**56.1**	2,448	57.5	77	23.5	**2,525**	**55.1**
Total number of homeless	**2,805**		**157**		**2,962**		**4,256**		**327**		**4,583**	

Note: Percentages are calculated by averaging all available data points. This approach, a moving average, provides a clearer picture of the long-term trends in the homeless population. Veteran's Affairs homeless count was not included in this count, but generally adds 10 to 20 individuals to the count. Some homeless individuals are members of more than one subpopulation. Not all individuals were members of a subpopulation.

1. *Sheltered homeless* includes individuals living in emergency shelters, transitional shelters, living with extended family and/or friends, or temporarily living in motels.
2. *Unsheltered homeless* includes individuals living in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street.

Source of data: *"Anchorage Homeless Count—January 2009: Preliminary Count w/o Data from VA" and "Alaska Total Homeless Count—January 2009," Alaska Housing Finance Corporation*

Figure 1. Homeless Persons in Alaska by Year, 2007–2009



Homelessness

(continued from page 3)

homeless, and 157 who were unsheltered. (Anchorage's total population in July 2008 was estimated to be 284,994.) The count included households with and without dependent children:

- Over 25% of all homeless households in Anchorage had dependent children.
- There was a 49% increase in households with dependent children from 2008 to 2009.

A survey for HUD of Anchorage homeless persons over the period October 1, 2007 to September 30, 2008 showed that of *sheltered persons in families*:

- 73% were female.
- 55% were under the age of 12.
- 29 % were American Indian or Alaska Native.
- 20% were White.
- 18% were Black or African American.
- 21% were between the ages of 18 and 30 years.
- 16% were between the ages of 31 and 50 years.
- 34% stayed in shelters or transitional housing for 1 to 3 months.

Data for *individuals in shelters* show:

- 80% were male.
- 42% were American Indian or Alaska Native.
- 39% were White.
- 13% were Black.
- Over half (55%) were between the ages of 31 and 50 years.
- 27% were between the ages of 51 and 61 years.
- 68% stayed in shelters or transitional housing for a week or less.

Anchorage's homeless subpopulations include sheltered and unsheltered persons. (See Table 4.) According to the January 2009 count of Anchorage's homeless population:

- Nearly 9% are chronically homeless.
- Over 13% have chronic substance abuse issues.
- Approximately 5% are victims of domestic violence.
- Close to 7% are veterans.
- About 9% are severely mentally ill.
- Close to 2% are unaccompanied youth under the age of 18.
- Less than 1% have HIV/AIDS.

Table 5. Homeless Students Enrolled in Anchorage School District, 2004–2009

Year	Total student population	Homeless students N	Homeless students % of total student population
2004–05	49,454	1,052	2.1 %
2005–06	49,589	1,767	3.6
2006–07	49,068	1,637	3.3
2007–08	48,457	1,752	3.6
2008–09	48,440	2,010	4.1

Note: Anchorage School District defines *homeless* according to the McKinney-Vento Homeless Education Assistance Improvements Assistance Act of 2001. ASD has improved its identification process since the 2004–2005 school year, resulting in a significant percentage increase in 2005–2006.

Source of data: *Anchorage School District, 2009*

Single-night homeless counts from 2007, 2008, and 2009, both statewide and in Anchorage, show a definite rise in the overall number of homeless. (See Figure 1.) In 2008, more than 20 percent of sheltered and unsheltered individuals in Anchorage, and nearly 19 percent of persons statewide met the definition of chronically homeless. However, the 2009 January count showed a drop in chronic homelessness to about 9 percent both in Anchorage and statewide.

Members of the Alaska Coalition on Housing and Homelessness have looked at this decrease in the percentage of the chronically homeless. Coalition members have suggested that factors for the difference in the rates for 2008 and 2009 may include: 1) temporary closure of some supportive housing resources in 2008 which contributed to a rise in numbers for that year, and 2) in 2009, the increasing number of chronically homeless mentally ill persons who are in the judicial and correctional systems, rather than in the community at large. Homeless service providers also suggest that earlier intervention with the homeless may be having an effect and that because episodes of homelessness may be fewer or farther apart in time, fewer number of homeless meet the definition of "chronically homeless" (see page 2 for the federal definition).

The Anchorage School District (ASD) tracks the number of homeless students in grades Kindergarten through 12, and uses the definition of homeless children and youth found in the 1987 McKinney-Vento Homeless Assistance Act which was reauthorized in January 2002 through the No Child Left Behind Act. The term "homeless children and youths" is defined in Title VII, Subtitle B of the McKinney-Vento Act:

> [Homeless children and youths include] ...individuals who lack a fixed, regular, and adequate nighttime residence...and includes (i) children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement....(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children....

The percentage of homeless students in Anchorage has risen steadily from 3.3 percent in the school year 2006-2007 to 3.6 percent in 2007-2008, to 4.1 percent for 2008-2009. This translates to a total of 2,010 homeless students in 2008-2009. (See Table 5.)

Most recently, statistics on the homeless in Anchorage were collected at the July 31, 2009 Project Homeless Connect coordinated by the Anchorage Coalition on Homelessness. Project Homeless Connect is a "one-day, one-stop event to provide housing, services, and hospitality in a convenient one-stop model directly to people experiencing homelessness in Anchorage"(www.anchoragehomeless.org/project-homeless-connect). The day-long event provided services to 646 individuals:

- 62% were male.
- 53% were Alaska Native as identified by Alaska Native Regional Corporation.
- 25% were White.
- 7% were Black or African American.

Table 6. Homeless Persons by Year, Anchorage and Alaska, 2007–2009

	2007			2008			2009		
	Sheltered[1]	Unsheltered[2]	Total	Sheltered[1]	Unsheltered[2]	Total	Sheltered[1]	Unsheltered[2]	Total
Anchorage	1,521	132	**1,653**	2,097	102	**2,199**	2,805	157	**2,962**
Balance of state (excluding Anchorage)	942	59	**1,001**	1,020	92	**1,112**	1,451	170	**1,621**
Alaska total	**2,463**	**191**	**2,654**	**3,117**	**194**	**3,311**	**4,256**	**327**	**4,583**

Note: Percentages are calculated by averaging all available data points. This approach, a moving average, provides a clearer picture of the long-term trends in the homeless population. Veteran's Affairs homeless count was not included in this count, but generally adds 10 to 20 individuals to the count.

1. *Sheltered homeless* includes individuals living in emergency shelters, transitional shelters, living with extended family and/or friends, or temporarily living in motels.
2. *Unsheltered homeless* includes individuals living in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street.

Source of data: *"Anchorage Homeless Count—January 2009: Preliminary Count w/o Data from VA" and "Alaska Total Homeless Count—January 2009," Alaska Housing Finance Corporation*

- 22% reported being homeless more than one month and up to six months.
- 24% reported having slept the previous night in "a place not meant for human habitation."
- 21% reported a chronic substance abuse issue.
- 17% reported a mental illness.
- 26% had a physical disability.
- 23% of the females stated they had been victims of domestic violence.

The Alaska Council on the Homeless, the Alaska Coalition on Housing and Homelessness (there are regional coalitions across the state), the Municipality of Anchorage, Alaska Housing Finance Corporation, HUD, and the Anchorage Coalition on Homelessness are among the agencies looking at ways to prevent homelessness and provide assistance to homeless individuals and families. The Alaska Council on the Homeless, a state entity established in 2004, adopted a "10 Year Plan to End Long Term Homelessness in Alaska" in May of this year. To assist regional areas of the state, Alaska Housing Finance Corporation is working with local coalitions to develop their own "10 Year Plans" that will interface with the State Council's "Plan."

As part of the State Council's "10 Year Plan," a program is in development through Alaska Housing Finance Corporation to provide rental assistance to another group that has been identified as being at risk for homelessness: persons with disabilities who are being discharged from correctional facilities. In addition, the Alaska Council on Homelessness reports data from the Department of Corrections indicating that overall about 8,000 persons are released from state correctional facilities each year with "no identified housing arrangement."

The Municipality of Anchorage Department of Health and Human Services published an "Overview of Homelessness in Anchorage, Alaska" in July 2009 which includes statistics from specific shelters in Anchorage. In examining shelter numbers from January through June 2009, the report found that AWAIC (Abused Women's Aid in Crisis) and Clare House were operating over capacity, but other Anchorage shelters were not. The Municipality has also issued a 2008 redraft of Anchorage's "Ten-Year Plan on Homelessness," and Anchorage Mayor Dan Sullivan recently released a "Mayor's Strategic Action Plan" on chronic public inebriates and related issues of homelessness.

National, state, and local agencies continue to collect data on the homeless, the causes and prevention of homelessness, and explore ways to assist those individuals and families experiencing homelessness.

Faculty News

Dr. Sharon Chamard has been promoted to the rank of Associate Professor and awarded tenure in the Justice Center in the UAA College of Health and Social Welfare. Dr. Chamard holds a Ph.D. in Criminal Justice from Rutgers-Newark and has been a Justice Center faculty member since 2003.

Justice Center Research Overview

The Justice Center has launched a new monthly publication, *Justice Center Research Overview*. These brief papers cover a specific justice-related topic and provide a snapshot of the most recent information. Recent *Overviews* include:

- Batterer Intervention Programs (BIPs)
- Violent and Property Offenses in Anchorage, 2003–2007
- Victim-Suspect Relationship in Sexual Assault Cases Reported to Law Enforcement: Alaska and National Data
- Sex Offender Registries and Notification Programs
- Violent and Property Offenses in Anchorage, 2003–2008

The *Research Overviews* are available online at http://justice.uaa.alaska.edu/overview/index.html. If you would like to receive an electronic copy monthly by e-mail, please send an e-mail to justiceresearch@uaa.alaska.edu.

UAA **Alaska Justice Forum**

Editor: Barbara Armstrong
Editorial Board: Allan Barnes, Sharon Chamard, Ron Everett, Pamela Kelley, Alan McKelvie, Brad Myrstol, Deborah Periman, Marny Rivera, André Rosay
Typesetting and Layout: Melissa Green

Justice Center, André Rosay, Director

Published quarterly by the

Justice Center
University of Alaska Anchorage
3211 Providence Drive
Anchorage, AK 99508
(907) 786-1810
(907) 786-7777 fax
ayjust@uaa.alaska.edu
http://www.uaa.alaska.edu/just/

© 2009 Justice Center,
University of Alaska Anchorage
ISSN 0893-8903

The opinions expressed are those of individual authors and may not be those of the Justice Center.

The University of Alaska provides equal education and employment opportunities for all, regardless of race, color, religion, national origin, sex, age, disability, or status as a Vietnam-era or disabled veteran.

Keeping Kids Off the Street: Snapshot of Covenant House Alaska

By Stephanie Martin and Alejandra Villalobos Meléndez

March 2010
Institute of Social and Economic Research • University of Alaska Anchorage

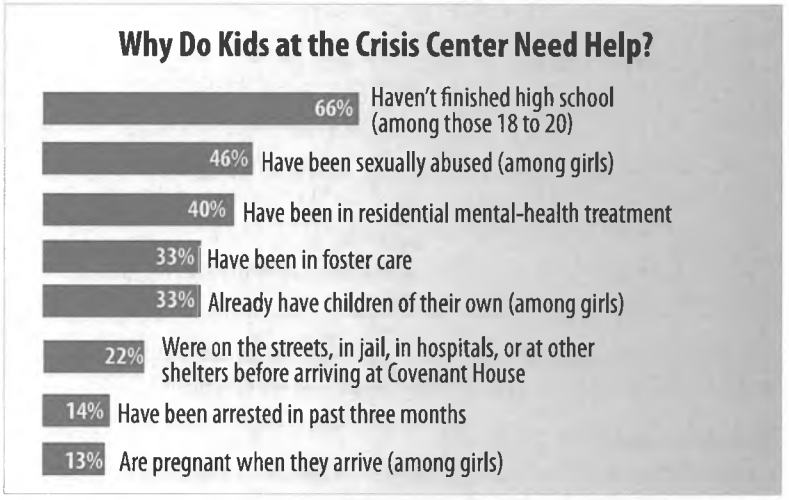
In 1988, Covenant House Alaska became the first shelter for homeless teenagers in Anchorage—and it is still the only such shelter in the city and in the entire state of Alaska .

More than 18,000 young people (ages 13 to 20) have walked into Covenant House's Crisis Center so far. Some come just for a bed for the night, but many also receive medical care, help getting back into school, counseling with their families, or other services.

About 1,300 young people stayed at Covenant House for at least one night in 2008, and 600 stayed longer and received more help getting back on their feet or reuniting with their families.

But many Alaskans know little about Covenant House, which today operates not only the crisis center but three other facilities for young people (see box on back page). This is a broad profile of what Covenant House's Crisis Center does, who it helps, and why so many need help.

Stephanie Martin and Alejandra Villalobos Meldendez of the Institute of Social and Economic Research (ISER) prepared this profile for Covenant House Alaska. Nationwide, Covenant House is trying to form collaborative relationships with academic partners in all the cities where it has sites, to help Americans better understand the characteristics and needs of homeless young people and provide better information for its program development.



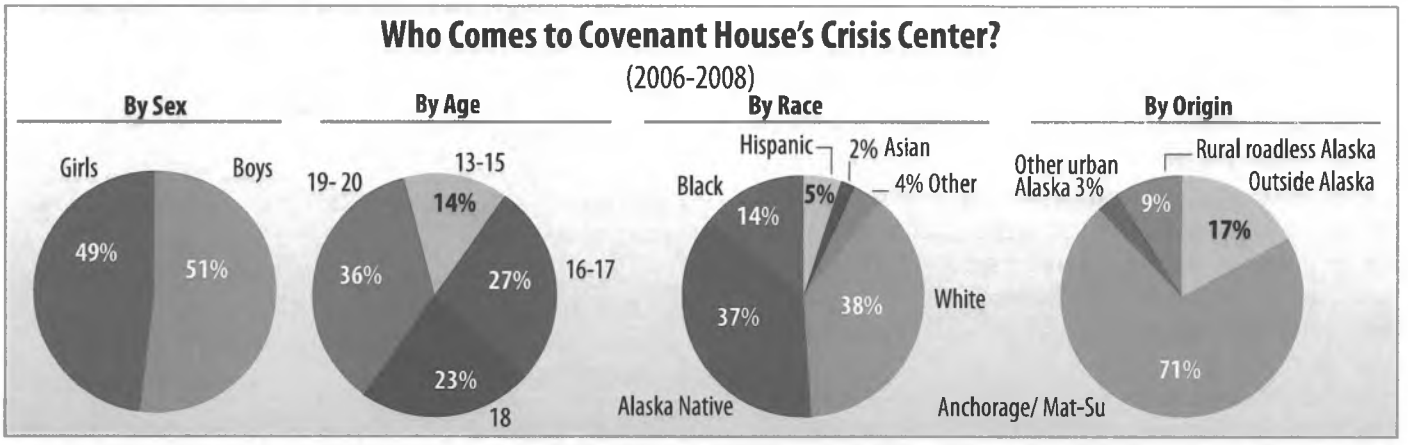
Who Comes to the Crisis Center?

The figure below shows characteristics of young people who came to the Crisis Center in recent years. They were:

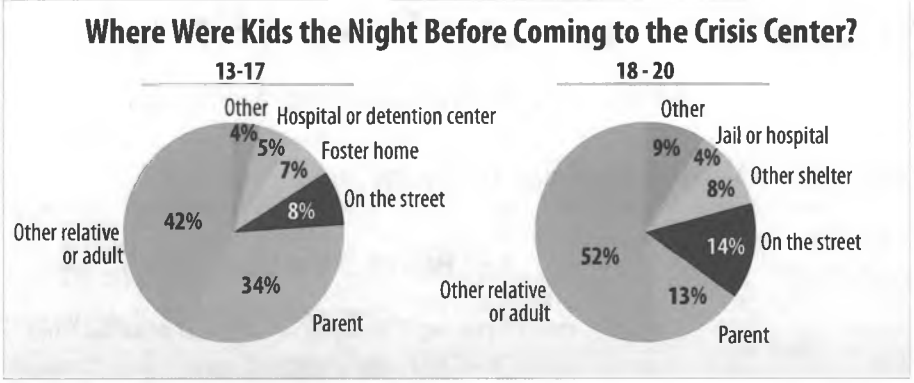
- Almost evenly divided between boys and girls
- Mostly older teenagers
- Primarily White and Alaska Native
- Mostly from Anchorage, but with significant numbers from remote rural areas of Alaska and from outside the state.

Why Do They Need Help?

Teenagers who come to Covenant House typically have very serious problems, as the figure above shows. Those include living on the streets before arriving at Covenant House; having been treated for mental health problems; having been sexually assaulted; failing to graduate from high school; and being pregnant or already having children.



ISER is part of the University of Alaska Anchorage and is Alaska's oldest public policy research institution. To learn more about ISER, visit:
www.iser.uaa.alaska.edu



Where Were Kids Before?

Kids who turn to Covenant House's Crisis Center come from various living situations, as the figure above shows. There are also differences in living situations of the younger and the older teenagers.

- *Only about a third of the younger teenagers and 13% of the older ones live with their parents* before coming to Covenant House.
- *Close to half of the younger and the older teenagers live with some other relative* or an unrelated adult before arriving at Covenant House.
- *Nearly one in ten of the younger teenagers and about one in seven of the older ones come from the streets.* Some also come directly from juvenile detention centers, jails, or hospitals.
- *Some of the younger teenagers leave foster homes for Covenant House*, and some of the older ones come from shelters that are for adults.

What's Changed Over the Years?

Covenant House Alaska began as essentially a place where homeless teenagers could find shelter. Today it offers a range of services to help them reunite with their families or become self-sufficient.

The profile of teenagers coming to Covenant House's Crisis Center has also changed in recent years, as the adjacent figure shows.

- The average time teenagers spend at the Crisis Center increased from ***10 days in 2001 to 13 days in 2008***. Those longer average stays put more stress on the center's capacity.
- Substantially more boys than girls came to the Crisis Center as recently as 2003, ***but in 2008 girls actually outnumbered boys***. That change also has implications for Covenant House's capacity, because girls require a different mix of services than boys.
- Ten years ago, almost all those coming to the Crisis Center were from Anchorage and the adjacent Mat-Su Borough. ***But in 2008 nearly a third came from other areas***, with 17% from outside Alaska and 8% from remote rural places.

Covenant House reports that about 25% of the teenagers from outside the state had originally been from Alaska and are returning after receiving mental-health treatment in other states—and then finding themselves homeless. Most of those from places off the road system are Alaska Native, which reflects a broader trend that's been documented in Alaska recently: thousands of Alaska Natives are moving from rural to urban Alaska. We also know, from recent ISER research, that some of the Alaska Native teenagers moving to Anchorage are coming without their parents and plan to live with other relatives.*

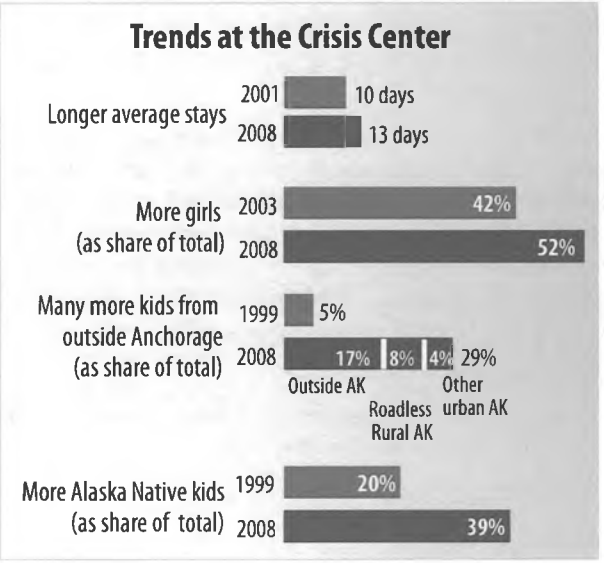
**New Students in the Anchorage School District: Where Are they Coming From?* By Marie Lowe. Available at: www.iser.uaa.alaska.edu/Publications/LoweMigrationReportFinal.pdf

- Alaska Native teenagers make up a growing share of those coming to Covenant House, ***up from about 20% in 1999 to 39% in 2008.*** That probably reflects the growing number of Alaska Native residents of Anchorage, as well as the increasing numbers arriving from rural Alaska.

Where Is Covenant House Headed?

Covenant House foresees growing needs at its Crisis Center, as Anchorage grows and as the center increasingly helps teenagers from many places besides Anchorage. It also provides different services and accommodations not only for boys and a growing number of girls, but also for young people of different ages—from those who are barely into their teens to those on the verge of being adults.

Because the young people turning to the Crisis Center need such a broad range of help, Covenant House reports that it has reached its functional capacity—and in early 2010 it is trying to raise money to pay for construction of a new, larger facility.



Covenant House Alaska
Opening Doors for Homeless Youth

www.covenanthouseak.org

Covenant House Alaska is one of 21 sites of Covenant House International in North America and Central America. This summary describes just Covenant House Alaska's Crisis Center, which provides short-term shelter and other services for homeless teenagers. Covenant House also operates several other facilities in Anchorage:

- *Community Services Center* provides young people (13 to 20) with tutoring, health care, referrals for treatment of substance abuse, help getting jobs, and other services.
- *Rights of Passage* is a residential care program to help homeless young people (18 to 20) become self-sufficient and get ready to live on their own.
- *Passage House* is a residential program for girls 17 to 20 who are pregnant or have children.

The authors thank Deirdre Cronin, Daniel Lemaire, Alison Kear, and Carlette Mack of Covenant House Alaska and Miranda Yates of the Covenant House Institute for providing data and other help.

Editor: Linda Leask • Graphics: Clemencia Merrill

McKinney-Vento Homeless Data Summary 2009-2010

D-ID	District Name	Students Enrolled														Primary Nighttime Residence				
		PK	K	1	2	3	4	5	6	7	8	9	10	11	12	Total	1 - S	2- D	3-U	4-HM	Total
State Totals		109	326	321	296	287	289	268	226	256	263	271	327	481	498	4218	1125	2226	547	320	4218
McK-V Subgrant Districts																					
5	Anchorage	71	201	192	171	189	166	171	144	154	145	152	160	175	239	2330	586	1268	282	194	2330
22	Juneau	4	13	19	15	11	9	16	5	11	11	8	10	39	23	194	90	74	12	18	194
24	Kenai	8	25	21	19	14	21	7	7	14	15	18	30	33	44	276	28	186	31	31	276
33	Mat-Su	12	38	35	39	33	44	36	39	49	51	52	73	167	117	785	128	427	189	41	785
McK-V Totals		95	277	267	244	247	240	230	195	228	222	230	273	414	423	3585	832	1955	514	284	3585
NON-McK-V Subgrant Districts																					
3	Alaska Gateway															0					0
4	Aleutian Region															0					0
56	Aleutians East															0					0
6	Annette Island															0					0
7	Bering Strait	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	0	0	1
8	Bristol Bay	0	0	0	0	0	0	0	1	0	0	0	1	0	1	3	1	2	0	0	3
9	Chatham															0					0
10	Chugach	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	0	1
11	Copper River															0					0
12	Cordova	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	0	1
13	Craig															0					0
14	Delta-Greely	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	0	1
2	Denali															0					0
15	Dillingham	0	1	0	2	2	0	1	2	2	1	2	3	3	6	25	19	6	0	0	25
16	Fairbanks	8	34	41	34	27	33	30	24	20	32	34	41	58	43	459	200	191	32	36	459
17	Galena	0	1	1	0	0	0	0	0	0	1	0	0	0	1	4	3	1	0	0	4
18	Haines	0	0	0	0	0	0	0	0	0	0	0	0	1	4	5	0	5	0	0	5
19	Hoonah	0	2	2	0	0	4	1	1	1	3	2	3	0	2	21	0	21	0	0	21
20	Hydaburg															0					0
21	Iditarod															0					0
23	Kake															0					0
55	Kashunamiut															0					0
25	Ketchikan	0	2	1	3	0	2	1	1	0	0	0	0	0	0	10	0	10	0	0	10
27	Klawock	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	0	1
28	Kodiak	0	2	1	0	0	0	0	0	0	2	0	0	0	1	6	6	0	0	0	6
29	Kuspuk															0					0
30	Lake & Peninsula															0					0
31	Lower Kuskokwim	0	4	2	2	3	4	1	0	0	0	0	0	0	0	16	16	0	0	0	16
32	Lower Yukon															0					0
98	Mt Edgecumbe															0					0
34	Nenana															0					0
35	Nome	0	1	2	4	4	4	0	1	0	0	0	0	0	0	16	16	0	0	0	16
36	North Slope	6	2	3	3	1	2	2	0	1	1	1	1	0	0	23	23	0	0	0	23
37	Northwest Arctic															0					0
38	Pelican															0					0
39	Petersburg															0					0
40	Pribilof															0					0
46	Saint Mary's															0					0
42	Sitka	0	0	1	0	2	0	2	0	3	0	1	4	4	6	23	8	14	1	0	23
43	Skagway															0					0
44	Southeast Island															0					0
45	Southwest Region	0	0	0	2	0	0	0	0	0	1	0	1	0	0	4	1	3	0	0	4
53	Tanana															0					0
47	Unalaska															0					0
48	Valdez	0	0	0	2	1	0	0	1	0	0	1	0	0	3	8	0	8	0	0	8
49	Wrangell	0	0	0	0	0	0	0	0	0	0	0	0	1	2	3	0	3	0	0	3
50	Yakutat	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	2	0	0	2
51	Yukon Flats															0					0
52	Yukon-Koyukuk															0					0
54	Yupiit															0					0
Other district totals		14	49	54	52	40	49	38	31	28	41	41	54	67	75	633	293	271	33	36	633

Primary Nighttime Residence Key

1 - S = Sheltered 2- D = Doubled Up 3-U = Unsheltered 4-HM = Hotel/Motel

WEDNESDAY
JANUARY 26, 2011

PROJECT HOMELESS CONNECT ANCHORAGE

FREE SERVICES AVAILABLE ON-SITE

Birth Certificates
Childcare Services
Credit Report
DMV ID Cards
Emergency Shelter
Employment Services
Family Services
Foot Care
Groceries
Long Distance Calling
Hair Cuts
Heath Care Services
HIV Testing
Housing Information
Legal Services
Lunch
Mental Health Services
Needle Exchange
Payee Services
Public Benefits (SSI/APA)
Substance Abuse Counseling
Teen & Youth Services
Veteran Services
Vision

Some services are limited/First come First serve

EGAN CENTER
555 - 5th Ave
10am - 3pm

Alaska Housing Finance Corporation
Anchorage Coalition on Homelessness
Cook Inlet Housing Authority
United Way of Anchorage
First National Bank Alaska
The Trust — The Alaska Mental Health Trust Authority
ConocoPhillips Alaska
TESORO
Royal Business Systems

Municipal Department of Health Human Services
Human Services Division - Safety Links Program
8th Anchorage Project Homeless Connect - January 26, 2011

		Count	Percent
Attendee Count		**847**	—
Gender	Female	308	36.4%
	Male	535	63.2%
	Transgendered Female to Male	1	0.1%
	No Response	3	0.4%
Age Groups	Less than 18	3	0.4%
	18 - 21	48	5.7%
	22 - 30	122	14.4%
	31 - 40	140	16.5%
	41 - 50	247	29.2%
	51 - 61	220	26.0%
	62 and over	55	6.5%
	No Response	12	1.4%
Household Type	Single Adult Household	567	66.9%
	Household with 2+ Adults	150	17.7%
	Family with Children Under the Age of 18	113	13.3%
	Unaccompanied Minor (Under 18)	1	0.1%
	No Response	16	1.9%
Household Member Information	# of Adults in Household	1,129	—
	# of Adults with Disability	99	9.1%
	# of Children Under 18 in Household	262	—
	# of Children with Disability	9	3.4%
	# of Attendees plus Household Members	**1,391**	—
	Average Children per Household	2.32	—
Where Did You Sleep Last Night	Domestic Violence Shelter (i.e. AWAIC)	9	1.1%
	Emergency Shelter (i.e. Brother Francis / Rescue Mission)	238	28.1%
	Foster Care / Group Home	2	0.2%
	Hospital (including Emergency Room)	4	0.5%
	Hotel / Motel (Due to Displacement)	86	10.2%
	Jail, Prison or Juvenile Facility	8	0.9%
	Own House	17	2.0%
	Permanent Housing for Formerly Homeless	1	0.1%
	Place Not Meant for Habitation (i.e. Tent / Car)	79	9.3%
	Rent Apartment / House	83	9.8%
	Stayed With Family	92	10.9%
	Stayed With Friends	150	17.7%
	Subsidized Housing (i.e. Public Housing)	5	0.6%
	Substance Abuse Treatment Center	1	0.1%
	Transitional Housing for Homeless	45	5.3%
	Does Not Know or Remember	1	0.1%
	Refused	1	0.1%
	No Reponse	25	3.0%
	Homeless - Based on HUD Criteria	**371**	**43.8%**
	Homeless - Additional Alaska Criteria	**328**	**38.7%**
	Homeless - Based on HUD + Alaska Criteria	**699**	**82.5%**
	Housed - Based on HUD + Alaska Criteria	**121**	**14.3%**

Municipal Department of Health Human Services
Human Services Division - Safety Links Program
8th Anchorage Project Homeless Connect - January 26, 2011

		Count	Percent
Duration of Homelessness	**Not Homeless**	**22**	**2.6%**
	1 Month or Less	64	7.6%
	More than 1 Month to 6 Months	172	20.3%
	More than 6 Month to 1 Year	114	13.5%
	More than 1 Year to 2 Years	124	14.6%
	More than 2 Years to 3 Years	75	8.9%
	More than 3 Years to 4 Years	33	3.9%
	More than 4 Years to 5 Years	33	3.9%
	More than 5 Years to 6 Years	24	2.8%
	More than 6 Years to 7 Years	9	1.1%
	More than 7 Years to 8 Years	4	0.5%
	More than 8 Years to 9 Years	3	0.4%
	More than 9 Years to 10 Years	23	2.7%
	More than 10 Years to 15 Years	19	2.2%
	More than 15 Years to 20 Years	16	1.9%
	More than 20 Years to 25 Years	7	0.8%
	More than 25 Years to 30 Years	3	0.4%
	More than 30 Years to 40 Years	6	0.7%
	More than 40 Years	2	0.2%
	Homeless Based on Duration of Homelessness	**731**	**86.3%**
	No Response	94	11.1%
Times Homeless in Last 3 Years	0 times	12	1.4%
	1 to 3 times	456	53.8%
	4+ times	180	21.3%
	Homeless in the Last 3 Years	**636**	**75.1%**
	No Response	199	23.5%
Primary Reason for Becoming Homeless	Domestic Violence	47	5.5%
	Hours of Work Cut	11	1.3%
	Illness / Injury	52	6.1%
	Loss of Job	211	24.9%
	Loss of Partner / Roommate	46	5.4%
	Moved Here from Another Community	73	8.6%
	Release from Jail or Prison	67	7.9%
	Release from Mental Health Facility	5	0.6%
	Rent / Utility Rate Hike after Move-in	30	3.5%
	Substance Abuse / Mental Health Incident	110	13.0%
	Other	139	16.4%
	No Response	56	6.6%
Employed	Yes	65	7.7%
	No	782	92.3%

Municipal Department of Health Human Services
Human Services Division - Safety Links Program
8th Anchorage Project Homeless Connect - January 26, 2011

		Count	Percent
Primary Sources of Support in Last 30 Days	Adult Public Assistance	134	15.8%
	ATAP / TANF	49	5.8%
	Child Support	7	0.8%
	Family / Friend Gifts	63	7.4%
	Native Dividends	108	12.8%
	Panhandling	35	4.1%
	Social Security (SSI / SSDI / SSA)	192	22.7%
	Unemployment	83	9.8%
	Wages	76	9.0%
	Other Sources	174	20.5%
	No Income	44	5.2%
Has Health Care (e.g. Indian Health Care, Denali Kid Care, etc.)	Yes	617	72.8%
	No	230	27.2%
U.S. Military Veteran	Yes	127	15.0%
	No	719	84.9%
	Does Not Know	1	0.1%
Received Eviction Notice this Month	Yes	39	4.6%
	No	808	95.4%
Conditions Affecting Ability to Retain Housing			
• **Chronic Substance Abuse**	Yes	165	19.5%
	No	682	80.5%
• **Domestic Violence**	Yes (Women)	76	9.0%
	Yes (Men)	31	3.7%
	Yes (Total)	107	12.6%
	No (Total)	740	87.4%
• **HIV / AIDS**	Yes	9	1.1%
	No	838	98.9%
• **Mental Illness**	Yes	123	14.5%
	No	724	85.5%
• **Physical Disability**	Yes	185	21.8%
	No	662	78.2%

Municipal Department of Health Human Services
Human Services Division - Safety Links Program
8th Anchorage Project Homeless Connect - January 26, 2011

		Count	Percent
Primary Race	Alaska Native or American Indian	444	52.4%
	Asian	11	1.3%
	Black or African American	57	6.7%
	Native Hawaiian or Other Pacific Islander	9	1.1%
	White	262	30.9%
	Don't Know	1	0.1%
	Refused	2	0.2%
	Other	54	6.4%
	No Response	7	0.8%
Alaska Native Regional Corporation	Ahtna Corp.	10	2.3%
	Aleut Corp.	14	3.2%
	Arctic Slope Regional Corp.	17	3.8%
	Bering Straits Native Corp.	51	11.5%
	Bristol Bay Native Corp.	32	7.2%
	Calista Corp.	95	21.4%
	Chugach Alaska Corp.	6	1.4%
	Cook Inlet Regional Corp.	45	10.1%
	Doyon Limited Corp.	38	8.6%
	Koniag Incorp.	3	0.7%
	NANA Regional Corp.	43	9.7%
	Sealaska	41	9.2%
	13th Regional Corp.	3	0.7%
	No Response	64	14.4%
Number of PHC Events Attended Prior to this Event	0	342	40.4%
	1	249	29.4%
	2	110	13.0%
	3	42	5.0%
	4	15	1.8%
	5	5	0.6%
	6	1	0.1%
	7	3	0.4%
	No Response	80	9.4%

Municipal Department of Health Human Services
Human Services Division
Safety Links Program
(907) 343-6589
6th Project Homeless Connect
Janaury 2010

		Count	Percent
Client Count		769	-
Household Count		755	-
Gender	Female	282	37%
	Male	480	62%
	Transgender Male to Female	2	0.3%
	Null (No Response)	5	1%
Age Groups of Clients	Less than 18 years	2	0.3%
	18 - 21	27	4%
	22 - 30	92	12%
	31 - 40	134	17%
	41 - 50	292	38%
	51- 61	165	21%
	62 and over	44	6%
	Null (No Response)	13	2%
Household Type	Adult Individual(s) without Children under the age of 18	617	82%
	Household with Children under the age of 18 *	111	15%
	Unaccompanied Minor	2	0.3%
	Null (No Response)	25	3%
Household with Children under the age of 18	Households	104	13.8%
	Children	200	-
	Average Children per Household	1.9	-
Where Did You Sleep Last Night	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	255	33%
	Foster care home or foster care group home	1	0.1%
	Hospital (non-psychiatric)	4	1%
	Hotel or motel paid for without emergency shelter voucher	46	6%
	Jail, prison or juvenile detention facility	2	0.3%
	Owned by client, no housing subsidy	21	3%
	Owned by client, with housing subsidy	1	0.1%
	Permanent housing for formerly homeless persons(such as SHP, S+C, or SRO Mod Rehab)	3	0.4%
	Place not meant for habitation inclusive of 'non-housing service site(outreach programs only)	61	8%
	Psychiatric hospital or other psychiatric facility	2	0.3%
	Rental by client, no housing subsidy	73	9%
	Rental by client, with VASH housing subsidy	1	0.1%
	Rental by client, with other (non-VASH) housing subsidy	2	0.3%
	Safe Haven	1	0.1%
	Staying or living in a family member's room, apartment or house	79	10%
	Staying or living in a friend's room, apartment or house	147	19%
	Subsidized Housing	6	1%
	Substance abuse treatment facility or detox center	0	0%
	Transitional housing for homeless persons (including homeless youth)	28	4%
	Don't Know	0	0%
	Refused	0	0%
	Other	28	4%
	Null (No Response)	8	1%

Municipal Department of Health Human Services
Human Services Division
Safety Links Program
(907) 343-6589
6th Project Homeless Connect
Janaury 2010

		Count	Percent
	Homeless Based on HUD Criteria	**345**	**45%**
	Additional Alaska Homeless Criteria	**272**	**35%**
	Homeless Based on HUD + Alaska Criteria	**617**	**80%**
	Housed Based on HUD + Alaska Criteria	**152**	**20%**
Duration of Homelessness (How long have you been homeless?)	1 Month or Less	54	7%
	More than 1 Month to 6 Months	156	20%
	More than 6 Month to 1 Year	102	13%
	More than 1 Year to 2 Years	101	13%
	More than 2 Years to 3 Years	50	7%
	More than 3 Years to 4 Years	34	4%
	More than 4 Years to 5 Years	30	4%
	More than 5 Years to 6 Years	11	1%
	More than 6 Years to 7 Years	12	2%
	More than 7 Years to 8 Years	10	1%
	More than 8 Years to 9 Years	3	0.4%
	More than 9 Years to 10 Years	28	4%
	More than 10 Years to 15 Years	24	3%
	More than 15 Years to 20 Years	20	3%
	More than 20 Years to 25 Years	3	0.4%
	More than 25 Years to 30 Years	5	1%
	More than 30 Years to 40 Years	3	0.4%
	More than 40 Years to 45 Years	1	0.1%
	Null (No Response)	122	16%
	Homeless Based on Duration of Homelessness	**647**	**84%**
Times Homeless in Last 3 Years	0 - 3 times	337	44%
	4 + times	187	24%
	Null (No Response)	245	32%
Received Eviction Notice this Month (Housed, Not Homeless)	Yes	46	6%
	No	554	72%
	Null (No Response)	169	22%
Health Benefits (Such as Medicaid, Denali KidCare, Indian Health Services, Medicare)	Yes	518	67%
	Null (No Response)	0	0%
Chronic Substance Abuse	Yes	205	27%
	No	92	12%
	Null (No Response)	472	61%
Mental Illness	Yes	165	21%
	No	109	14%
	Null (No Response)	495	64%
Physical Disability	Yes	227	30%
	No	97	13%
	Null (No Response)	445	58%
HIV/AIDS	Yes	58	8%
	No	597	78%
	Null (No Response)	114	15%
Victim of Domestic Violence - Women	Yes 29% of Women	81	11%
Victim of Domestic Violence - Men	Yes 4% of Men	18	2%
Victim of Domestic Violence - Total	Yes 13% of both Women and Men	99	13%
	No	129	17%

Municipal Department of Health Human Services
Human Services Division
Safety Links Program
(907) 343-6589
6th Project Homeless Connect
Janaury 2010

		Count	Percent
	Null (No Response)	541	70%
U.S. Military Veteran	Yes	102	13%
	No	613	80%
	Null (No Response)	54	7%
Primary Race	Alaska Native	377	49%
	American Indian	48	6%
	Asian	8	1%
	Black or African American	69	9%
	Native Hawaiian or Other Pacific Islander	14	2%
	White	205	27%
	Other	2	0.3%
	Other Multi-Racial	30	4%
	Don't Know (HUD)	1	0.1%
	Refused (HUD)	6	1%
	Null (No Response)	9	1%
Primary Alaska Native Regional Corporation	Ahtna Corp.	4	1%
	Aleut Corp.	6	2%
	Arctic Slope Regional Corp.	21	6%
	Bering Straits Native Corp.	54	14%
	Bristol Bay Native Corp.	45	12%
	Calista Corp.	102	27%
	Chugach Alaska Corp.	7	2%
	Cook Inlet Regional Corp.	31	8%
	Doyon Limited Corp.	40	11%
	Koniag Incorp.	2	1%
	NANA Regional Corp.	35	9%
	Sealaska	29	8%
	13th Regional Corp.	1	0.3%
	Total Alaska Natives Identified by Alaska Native Regional Corporation	377	100%

Received at Project Exit	**Count**	**Percent**
Giveaways	260	48%
Groceries	285	52%

Number of PHC Events Attended	**1**	**2**	**3**	**4**	**5**	**Null**	**Total**
Count	361	138	31	9	5	225	544
Percentage	66%	25%	6%	2%	1%	41%	100%

This event has been helpful.	**Strongly Agree**	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**	**Null** (No Response)	**Total**
Count	358	100	50	18	14	229	540
Percentage	66%	19%	9%	3%	3%	42%	100%

Homeless?

Couch Surfing?

Worrying about where you might sleep tonight?

Is there a service you need?

Attend Project Homeless Connect
When: Monday, January 24, 2011
10 a.m. – 3 p.m.
Centennial Hall

Participate in the annual homeless count and receive services

Each year hundreds of people of all ages face homelessness in Juneau.
Why is a count important? In order to know the amount of services needed, the community needs to know how many people need them.
All Information collected is kept confidential.
Help us bring awareness to the fact that homelessness happens in Juneau and help us have better information to bring more resources to assist you.

Food * Haircuts * Housing Services * Medical Care * Rental Assistance * Employment Services * Transportation to the DMV * Legal services * Foot Care * Public Assistance * Clothing * Toiletries * Entertainment * And Much More……

JUNEAU
HOMELESS
COALITION

Juneau Project Homeless Connect - Second Event - January 24, 2011
Organized in Partnership by the Juneau Homeless Coalition
Participant Profile Report

		Count	Percent
Attendee Count		**167**	—
Gender	Female	69	41.3%
	Male	97	58.1%
	Transgender	0	0.0%
	No Response	1	0.6%
Age Groups	Less than 18	0	0.0%
	18 - 21	7	4.2%
	22 - 30	22	13.2%
	31 - 40	25	15.0%
	41 - 50	47	28.1%
	51 - 61	40	24.0%
	62 and over	7	4.2%
	No Response	19	11.4%
Household Type	Single Adult Household	94	56.3%
	Household with 2+ Adults	32	19.2%
	Family with Children Under the Age of 18	38	22.8%
	Unaccompanied Minor (Under 18)	0	0.0%
	No Response	3	1.8%
Household Member Information	# of Adults in Household	243	—
	# of Adults with Disability	58	23.9%
	# of Children Under 18 in Household	83	—
	# of Children with Disability	11	13.3%
	# of Attendees plus Household Members	**326**	—
	Average Children per Household	2.18	—
Where Did You Sleep Last Night	Emergency Shelter (i.e. Glory Hole / Aware)	12	7.2%
	Foster Care / Group Home	0	0.0%
	Hospital (including Emergency Room)	0	0.0%
	Hotel / Motel (Due to Displacement)	20	12.0%
	Jail, Prison or Juvenile Facility	0	0.0%
	Own House	0	0.0%
	Permanent Housing for Formerly Homeless	0	0.0%
	Place Not Meant for Habitation (i.e. Tent / Car)	30	18.0%
	Rent Apartment / House	29	17.4%
	Stayed With Family	35	21.0%
	Stayed With Friends	22	13.2%
	Subsidized Housing (i.e. Public Housing)	6	3.6%
	Substance Abuse Treatment Center	1	0.6%
	Transitional Housing for Homeless	11	6.6%
	Does Not Know or Remember	0	0.0%
	Refused	0	0.0%
	No Reponse	1	0.6%
	Homeless - Based on HUD Criteria	**53**	**31.7%**
	Homeless - Additional Alaska Criteria	**77**	**46.1%**
	Homeless - Based on HUD + Alaska Criteria	**130**	**77.8%**
	Housed - Based on HUD + Alaska Criteria	**36**	**21.6%**

Juneau Project Homeless Connect - Second Event - January 24, 2011
Organized in Partnership by the Juneau Homeless Coalition
Participant Profile Report

		Count	Percent
Duration of Homelessness	**Not Homeless**	**10**	**6.0%**
	1 Month or Less	8	4.8%
	More than 1 Month to 6 Months	26	15.6%
	More than 6 Month to 1 Year	27	16.2%
	More than 1 Year to 2 Years	18	10.8%
	More than 2 Years to 3 Years	19	11.4%
	More than 3 Years to 4 Years	10	6.0%
	More than 4 Years to 5 Years	4	2.4%
	More than 5 Years to 6 Years	6	3.6%
	More than 6 Years to 7 Years	3	1.8%
	More than 7 Years to 8 Years	2	1.2%
	More than 8 Years to 9 Years	0	0.0%
	More than 9 Years to 10 Years	1	0.6%
	More than 10 Years to 15 Years	8	4.8%
	More than 15 Years to 20 Years	1	0.6%
	More than 20 Years to 25 Years	1	0.6%
	More than 25 Years to 30 Years	0	0.0%
	More than 30 Years to 40 Years	0	0.0%
	More than 40 Years	0	0.0%
	Homeless Based on Duration of Homelessness	**134**	**80.2%**
	No Response	23	13.8%
Times Homeless in Last 3 Years	0 times	16	9.6%
	1 to 3 times	99	59.3%
	4+ times	46	27.5%
	Homeless in the Last 3 Years	**145**	**86.8%**
	No Response	6	3.6%
Primary Reason for Becoming Homeless	Domestic Violence	11	6.6%
	Hours of Work Cut	6	3.6%
	Illness / Injury	8	4.8%
	Lacking Financial Resources	4	2.4%
	Loss of Job	43	25.7%
	Loss of Partner / Roommate	16	9.6%
	Medical Condition	1	0.6%
	Moved Here from Another Community	10	6.0%
	Release from Jail or Prison	3	1.8%
	Release from Mental Health Facility	1	0.6%
	Rent / Utility Rate Hike after Move-in	20	12.0%
	Substance Abuse / Mental Health Incident	19	11.4%
	Other	12	7.2%
	No Response	13	7.8%
Employed	Yes	23	13.8%
	No	144	86.2%

Juneau Project Homeless Connect - Second Event - January 24, 2011
Organized in Partnership by the Juneau Homeless Coalition
Participant Profile Report

		Count	Percent
Primary Sources of Support in Last 30 Days	Adult Public Assistance	57	34.1%
	ATAP / TANF	14	8.4%
	Child Support	5	3.0%
	Family / Friend Gifts	12	7.2%
	Native Dividends	42	25.1%
	Panhandling	3	1.8%
	Social Security (SSI / SSDI / SSA)	48	28.7%
	Unemployment	18	10.8%
	Wages	29	17.4%
	Other Sources	23	13.8%
	No Income	16	9.6%
Has Health Care (e.g. Indian Health Care, Denali Kid Care, etc.)	Yes	130	77.8%
	No	37	22.2%
U.S. Military Veteran	Yes	24	14.4%
	No	143	85.6%
	Does Not Know	0	0.0%
Received Eviction Notice this Month	Yes	25	15.0%
	No	142	85.0%
Conditions Affecting Ability to Retain Housing			
• Chronic Substance Abuse	Yes	33	19.8%
	No	134	80.2%
• Domestic Violence	Yes (Women)	16	9.6%
	Yes (Men)	6	3.6%
	Yes (Total)	22	13.2%
	No (Total)	145	86.8%
• HIV / AIDS	Yes	0	0.0%
	No	167	100.0%
• Mental Illness	Yes	30	18.0%
	No	137	82.0%
• Physical Disability	Yes	53	31.7%
	No	114	68.3%

Juneau Project Homeless Connect - Second Event - January 24, 2011
Organized in Partnership by the Juneau Homeless Coalition
Participant Profile Report

		Count	Percent
Primary Race	Alaska Native or American Indian	115	68.9%
	Asian	0	0.0%
	Black or African American	3	1.8%
	Native Hawaiian or Other Pacific Islander	1	0.6%
	White	44	26.3%
	Don't Know	0	0.0%
	Refused	0	0.0%
	Other	3	1.8%
	No Response	1	0.6%
Alaska Native Regional Corporation	Ahtna Corp.	0	0.0%
	Aleut Corp.	0	0.0%
	Arctic Slope Regional Corp.	1	0.9%
	Bering Straits Native Corp.	3	2.6%
	Bristol Bay Native Corp.	0	0.0%
	Calista Corp.	1	0.9%
	Chugach Alaska Corp.	0	0.0%
	Cook Inlet Regional Corp.	0	0.0%
	Doyon Limited Corp.	2	1.7%
	Koniag Incorp.	0	0.0%
	NANA Regional Corp.	1	0.9%
	Sealaska	106	92.2%
	13th Regional Corp.	0	0.0%
	No Response	1	0.9%
Number of PHC Events Attended Prior to this Event	0	127	76.0%
	1	37	22.2%
	No Response	3	1.8%

Juneau Project Homeless Connect – First Event – January 25, 2010
Participant Profile Report

		Count	Percent
Client Count		167	-
Gender	Female	59	35%
	Male	108	65%
	Null (No Response)	0	0%
Age Groups of Clients	Less than 18	0	0%
	18 - 21	8	5%
	22 - 30	22	13%
	31 - 40	23	14%
	41 - 50	57	34%
	51- 61	45	27%
	62 and over	10	6%
	Null (No Response)	2	1%
Household Type	Adult Individual(s) without Children under the age of 18	140	84%
	Household with Children under the age of 18 *	18	11%
	Unaccompanied Minor	2	1%
	Null (No Response)	7	4%
Household with Children under the age of 18	Households	18	-
	Children	28	-
	Average Children per Household	1.6	-
Where Did You Sleep Last Night	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	25	15%
	Foster care home or foster care group home	0	0%
	Hospital (non-psychiatric)	0	0%
	Hotel or motel paid for without emergency shelter voucher	14	8%
	Jail, prison or juvenile detention facility	0	0%
	Owned by client, no housing subsidy	3	2%
	Owned by client, with housing subsidy	0	0%
	Permanent housing for formerly homeless persons(such as SHP, S+C, or SRO Mod Rehab)	1	1%
	Place not meant for habitation inclusive of 'non-housing service site(outreach programs only)	27	16%
	Psychiatric hospital or other psychiatric facility	0	0%
	Rental by client, no housing subsidy	13	8%
	Rental by client, with VASH housing subsidy	0	0%
	Rental by client, with other (non-VASH) housing subsidy	0	0%
	Safe Haven	0	0%
	Staying or living in a family member's room, apartment or house	26	16%
	Staying or living in a friend's room, apartment or house	34	20%
	Subsidized Housing	2	1%
	Substance abuse treatment facility or detox center	3	2%
	Transitional housing for homeless persons (including homeless youth)	8	5%
	Refused	2	1%
	Other	7	4%
	Null (No Response)	2	1%
	Homeless Based on HUD Criteria	**60**	**36%**
	Additional Alaska Homeless Criteria	**74**	**44%**
	Homeless Based on HUD + Alaska Criteria	**134**	**80%**
	Housed Based on HUD + Alaska Criteria	**33**	**20%**

Juneau Project Homeless Connect – First Event – January 25, 2010
Participant Profile Report

		Count	Percent
Duration of Homelessness (How long have you been homeless?)	1 Month or Less	12	7%
	More than 1 Month to 6 Months	28	17%
	More than 6 Month to 1 Year	22	13%
	More than 1 Year to 2 Years	20	12%
	More than 2 Years to 3 Years	16	10%
	More than 3 Years to 4 Years	8	5%
	More than 4 Years to 5 Years	5	3%
	More than 5 Years to 6 Years	6	4%
	More than 6 Years to 7 Years	2	1%
	More than 7 Years to 8 Years	5	3%
	More than 8 Years to 9 Years	0	0%
	More than 9 Years to 10 Years	4	2%
	More than 10 Years to 15 Years	6	4%
	More than 15 Years to 20 Years	5	3%
	More than 20 Years to 25 Years	2	1%
	More than 25 Years to 30 Years	1	1%
	Null (No Response)	25	15%
	Homeless Based on Duration of Homelessness	**142**	**85%**
Times Homeless in Last 3 Years	0 - 3 times	69	41%
	4 + times	43	26%
	Null (No Response)	55	33%
What Was the Primary Reason for Becoming Homeless	Loss of Job	29	17%
	Lacking Financial Resources	42	25%
	Release from Jail or Prison	9	5%
	Release from a Mental Health Facility	2	1%
	Substance Abuse	4	2%
	Mental Health Disability	10	6%
	Physical Disability	7	4%
	Domestic Violence	7	4%
	Medical Condition	8	5%
	Divorce or Separation	9	5%
	Other	26	16%
	Null	14	8%
Employed	Yes	16	10%
	No	149	89%
	Null (No Response)	2	1%
Sources of Income In Last Month	Employment	22	13%
	General Assistance	30	18%
	TANF	10	6%
	Contributions from Other People	9	5%
	Child Support	4	2%
	SSI / SSDI	33	20%
	No Income	56	34%
	Unemployment Insurance	12	7%
	Other Sources	30	18%
Has Health Insurance or Health Benefits	Yes	112	67%
	No	32	19%
	Null (No Response)	23	14%
Physical Disability	Yes	55	33%
	No	1	1%
	Null (No Response)	111	66%

Juneau Project Homeless Connect – First Event – January 25, 2010
Participant Profile Report

		Count	Percent
Chronic Substance Abuse	Yes	23	14%
	No	1	1%
	Null (No Response)	143	86%
Mental Illness	Yes	34	20%
	No	1	1%
	Null (No Response)	132	79%
HIV/AIDS	Yes	0	0%
	No	1	1%
	Null (No Response)	166	99%
Developmental Disability	Yes	13	8%
	No	1	1%
	Null (No Response)	153	92%
Victim of Domestic Violence - Women	Yes 20% of Women	12	7%
Victim of Domestic Violence - Men	Yes 7% of Men	8	5%
Victim of Domestic Violence - Total	Yes 12% of both Women and Men	20	12%
	No	1	1%
	Null (No Response)	146	87%
Received Eviction Notice this Month	Yes	16	10%
	No	118	71%
	Null (No Response)	33	20%
U.S. Military Veteran	Yes	30	18%
	No	122	73%
	Null (No Response)	15	9%
Primary Race	Alaska Native	84	50%
	American Indian	8	5%
	Asian	1	1%
	Black or African American	1	1%
	Native Hawaiian or Other Pacific Islander	1	1%
	White	63	38%
	Other	0	0%
	Other Multi-Racial	4	2%
	Don't Know (HUD)	0	0%
	Refused (HUD)	0	0%
	Null (No Response)	5	3%
Primary Alaska Native Regional Corporation	Ahtna Corp.	0	0%
	Aleut Corp.	0	0%
	Arctic Slope Regional Corp.	0	0%
	Bering Straits Native Corp.	1	1%
	Bristol Bay Native Corp.	0	0%
	Calista Corp.	1	1%
	Chugach Alaska Corp.	0	0%
	Cook Inlet Regional Corp.	2	2%
	Doyon Limited Corp.	1	1%
	Koniag Incorp.	0	0%
	NANA Regional Corp.	0	0%
	Sealaska	79	94%
	13th Regional Corp.	0	0%
	Total Alaska Natives Identified by Alaska Native Regional Corporation	84	100%

Juneau Project Homeless Connect – First Event – January 25, 2010
Participant Needs Report - Sorted on Need

Need	Count	Percent of Need Forms Returned
DMV IDs	25	15%
Education Services	25	15%
Employment Services	43	26%
Family Services	12	7%
Food Stamps	25	15%
Foot Care	21	13%
H1N1 / DPT / HEPB Shots	20	12%
Haircut	39	23%
Health Care Services	29	17%
HIV & TB Test	12	7%
Housing Assistance	59	35%
Legal Services	18	11%
Lunch	57	34%
Mental Health Services	8	5%
Payee Services	3	2%
Pre-Natal Care	2	1%
Public Assistance	22	13%
Senior Services	7	4%
Shelter Beds	10	6%
SSA / SSI Assistances	19	11%
Substance Abuse Services	5	3%
Veteran Services	6	4%
Vision Care - Unavailable	34	20%
Wheelchair / Medical Equipment	4	2%
Youth Services	0	0%
Other Services	17	10%
Giveaways	35	21%
Groceries	33	20%

Number of PHC Events Attended	1	2	3	4	5	Null	Total
Count	80	1	0	0	1	85	167
Percentage	48%	1%	0%	0%	1%	51%	100%

Overall, I was satisfied with how I was treated	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Null (No Response)	Total
Count	61	17	5	0	0	84	167
Percentage	37%	10%	3%	0%	0%	50%	100%

Juneau Project Homeless Connect – First Event – January 25, 2010
Participant Needs Report - Sorted on Count

Need	Count	Percent of Need Forms Returned
Housing Assistance	59	35%
Lunch	57	34%
Employment Services	43	26%
Haircut	39	23%
Giveaways	35	21%
Vision Care - Unavailable	34	20%
Groceries	33	20%
Health Care Services	29	17%
DMV IDs	25	15%
Education Services	25	15%
Food Stamps	25	15%
Public Assistance	22	13%
Foot Care	21	13%
H1N1 / DPT / HEPB Shots	20	12%
SSA / SSI Assistances	19	11%
Legal Services	18	11%
Other Services	17	10%
Family Services	12	7%
HIV & TB Test	12	7%
Shelter Beds	10	6%
Mental Health Services	8	5%
Senior Services	7	4%
Veteran Services	6	4%
Substance Abuse Services	5	3%
Wheelchair / Medical Equipment	4	2%
Payee Services	3	2%
Pre-Natal Care	2	1%
Youth Services	0	0%

Number of PHC Events Attended	**1**	**2**	**3**	**4**	**5**	**Null**	**Total**
Count	80	1	0	0	1	85	167
Percentage	48%	1%	0%	0%	1%	51%	100%

Overall, I was satisfied with how I was treated	**Strongly Agree**	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**	**Null** (No Response)	**Total**
Count	61	17	5	0	0	84	167
Percentage	37%	10%	3%	0%	0%	50%	100%

Other Services Requested

Count	Other Service Requested
1	bus tokens
4	clothing
	clothing
	clothing and boots
	clothing jackets
4	dental
	dental
	dental
	dental
1	gas vouchers
2	hearing services
	hearing services, need hearing aide
1	home care
1	medicaid application/medicare
2	message
	message
1	THRHA

In your opinion, what would improve this event
bath towels, toilet paper
bus passes
Bus passes, (3 months), travel to anchorage
camp supplies (stove)
Can you make this on the weekend, so that kids can take haircuts and other services.
Closed too early, I came here at 3:30 and couldn't receive my shot.
Despite the urging of the russian judge to the contrary i award your routine a 5, as you had what i needed ~good job!
Didn't get the hlep he needed, still homeless with two littl girls and a disabled wife.
DMV
DMV
Doing a good job, we need it.
education no show.
espresso
Everything was taken care of, thank you.
Glad we are doing something!
great
great
Haircutting open longer.
It's very organized! Thank You!
more emergency kits please.
more hats and gloves
more helpful
more organized
more people helping with check in
more publicity, more blankets, backpacks
More things for kids
more things for kids
physical address issues
put it on the radio
some peeps who know what they are doing.
three type event during the year
toilet paper to give out
towels, blankets, sleeping bags
very helpful
very thankful to everyone for helping with our needs, thank you
Vision left early, would appreciate it if they'd stay until the end.

Alaska Coalition on Housing & Homelessness
Housing Facts for Alaska
FFY 2009

Rent-Wage Disparity					
Community	**Affordable Rent***	**SSI/APA Affordable Rent**	**2-BR FMR**	**Wage Needed to Afford 2-BR FMR**	**Hrs pr wk @ Min Wage****
			Fair Market Rent	Per Hour	
Anchorage	$606	$202/$109	$990	$19.04	107
Barrow	$620	$202/$109	$1,232	$23.69	133
Bethel	$352	$202/$109	$1,352	$26.00	145
Dillingham	$440	$202/$109	$1,120	$21.54	120
Fairbanks	$560	$202/$109	$957	$18.40	103
Juneau	$686	$202/$109	$1,222	$23.50	131
Kenai	$527	$202/$109	$815	$15.67	88
Ketchikan	$578	$202/$109	$1,072	$20.62	115
Kodiak	$570	$202/$109	$1,154	$22.19	124
Mat-Su	$547	$202/$109	$935	$17.98	101
Nome	$428	$202/$109	$1,149	$22.10	124
Sitka	$605	$202/$109	$1,024	$19.69	110
Unalaska	$703	$202/$109	$1,120	$21.54	120
Valdez	$587	$202/$109	$1,008	$19.38	108

Source: National Low Income Housing Coalition www.nlihc.org

*Affordable rent means monthly rent affordable to a household earning 30% of Annual Median Income, applying the generally accepted standard of spending not more than 30% of income on housing costs.

** Minimum wage of $7.15/hr, effective 1/1/03

FMR-Fair Market Rent as issued by HUD 10/1/2008 (Federal fiscal year 09 began Oct. 1, 2008)

Cost Effectiveness of Supportive Housing	
	Cost per day
Hospital	$1,600
API	$732
Nursing Home	$412
Detox	$270
Jail/Prison	$114
Supportive Housing[1]	$70

Sources: OMB, API, DHSS, DOC, Clitheroe Ctr, & AHFC

[1] Supportive Housing calculation includes rent subsidy of $600/mo-$20/day; care coordination at $20/day; social supports (bus tokens, meal svcs, etc.) at $20/day; and administrative overhead at $10/day.

CONTACTS :
Carol Vieira, Burness Communications, 401-714-0821
Prabhu Ponkshe, Substance Abuse Policy Research Program, 703-918-4860

Embargoed by JAMA: 4:00 p.m., Eastern, March 31, 2009

HOUSING FOR HOMELESS ALCOHOLICS CAN REDUCE COSTS TO TAXPAYERS

JAMA study finds drinking goes down even if residents are allowed to drink

Seattle, WA, March 31- Providing housing and support services for homeless alcoholics costs taxpayers less than leaving them on the street, where taxpayer money goes towards police and emergency health care. Stable housing also results in reduced drinking among homeless alcoholics, according to a Seattle-based study published today in the *Journal of the American Medical Association (JAMA).*

The study found that the program saved taxpayers more than $4 million dollars over the first year of operation. During the first six months, even after considering the cost of administering housing for the 95 residents in a Housing First program in downtown Seattle, the study reported an average cost-savings of 53 percent -- nearly $2,500 per month per person in health and social services, compared to the costs of a wait-list control group of 39 homeless people.

"Our study suggests that homeless alcoholics who qualify to take part in Housing First can stay out of jails and emergency rooms, and cost the taxpayer a lot less money as a result," said Mary E. Larimer, PhD, professor of psychiatry and behavioral sciences and adjunct professor of psychology at the University of Washington and lead author of the study. "We also found that these benefits increase over time and that they are possible without requiring that participants stop drinking. And yet, the longer the participants stay in the housing program, the less they drink."

"The Housing First model was developed in response to the problem of long-term homelessness among those living with severe mental illnesses and substance abuse problems," said William G. Hobson, a co-author on the JAMA paper and executive director of Downtown Emergency Service Center in Seattle. "In most US cities, people with behavioral health disabilities die on the streets far more frequently than any other subset of the homeless population. Before they die, they use large amounts of taxpayer-funded services in our healthcare and criminal justice systems. The housing program, known in Seattle as the 1811 Eastlake project, was created to stabilize people and stop them from endlessly cycling through emergency rooms, prisons and other crisis institutions, reducing the amount of taxpayer money spent on them."

The Housing First approach offers stable housing to chronically homeless, alcohol-dependent individuals without requirements of abstinence or treatment. It is being implemented in major cities throughout the United States. Initiatives that have adopted the comprehensive model have been criticized for allowing enrollees -- virtually all with severe substance abuse problems -- to continue to consume alcohol in their new quarters. The 1811 Eastlake study, funded by the Substance Abuse Policy Research Program (SAPRP) of the Robert Wood Johnson Foundation,

[redacted]

represents the first US controlled assessment of the effectiveness of Housing First specifically targeting chronically homeless alcoholics.

Researchers began enrolling people for the study and the control group in November 2005 and finished in March 2007. A list of the most expensive homeless users of health and social services in the community provided the target population from which participants were drawn.

"These findings suggest that stable housing provided to people who are still drinking and addicted to alcohol can reduce their use of crisis services and ultimately their consumption of alcohol," Larimer said, noting that virtually every person invited to participate had agreed to enroll. The study also notes that restrictions on the consumption of alcohol in a housing environment may well prevent those most in need from accepting help.

The wait-list comparison study lasted six months, comparing usage of health and social services of participants in the program to those in the control group. But researchers also followed the enrollees for another six months, looking at the trend in alcohol consumption among residents and comparing their use of services to levels in the year before they enrolled in Housing First. After one year in the program, the 95 participants had reduced total costs relating to their care by more than $4 million compared to the year before.

"Each of them had cost state and local governments an average of $86,062 per year before being housed, compared to an average of $13,440 it costs per person per year to administer the housing program," Larimer said.

In assessing utilization and cost of services, the researchers collected data from jail bookings, days incarcerated, shelter and sobering center use, hospital-based medical services, publicly-funded alcohol and drug detoxification and treatment, emergency medical services, and Medicaid-funded services.

Because healthcare and criminal justice system costs for the participants continued to decrease over time, as did their alcohol use, Larimer says, she and her co-authors concluded that permanent housing may be necessary in order to take full advantage of the cost-savings identified in the study. The authors concluded that several factors were key to the success of the program, including the decision to limit rules and regulations on residents, and to provide them with supportive case managers, as well as easy access to providers of mental health and health care services within the housing program.

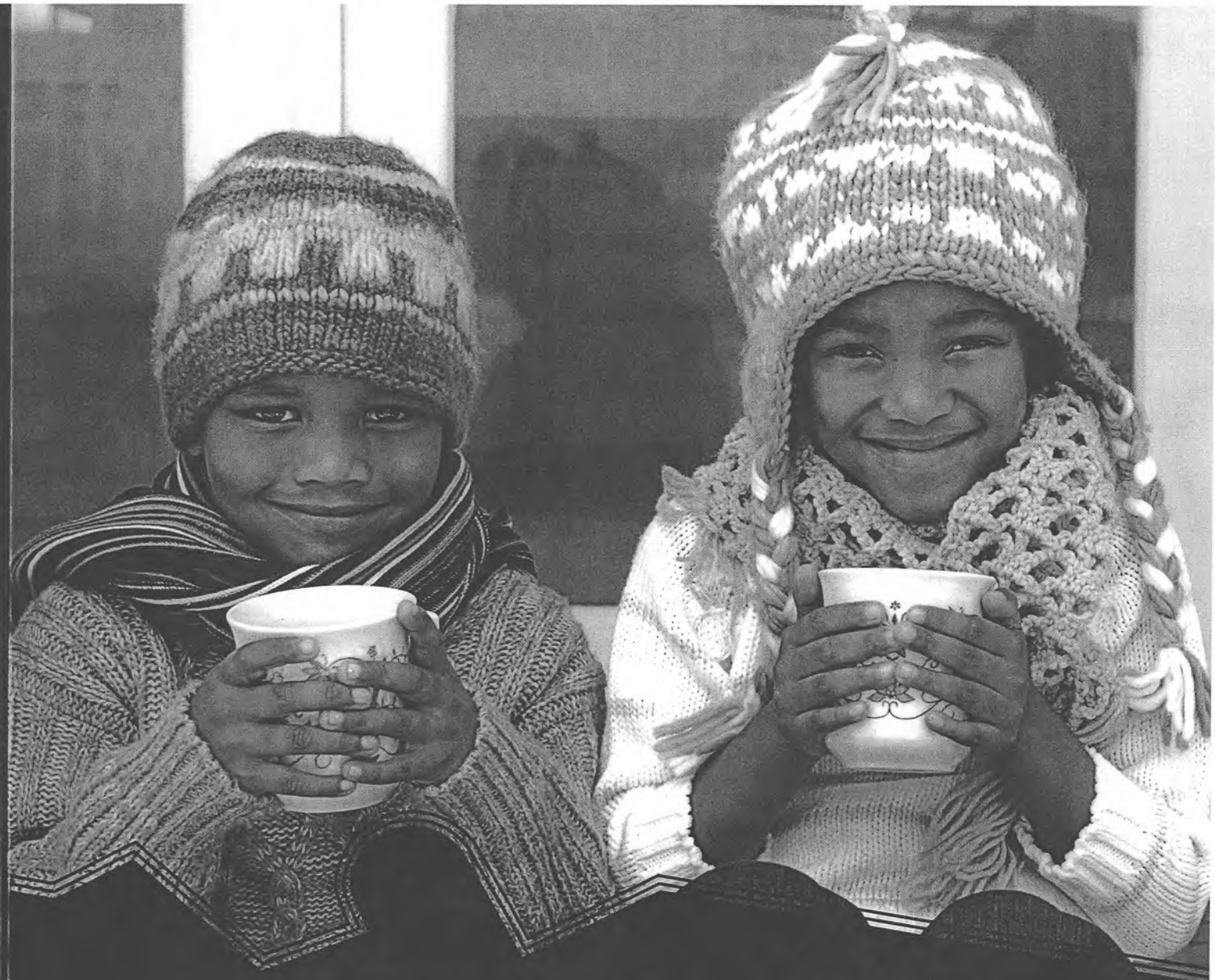
The authors started with a list of 388 of the most expensive users of hospitals, jails and sobering centers. The study enrolled every willing candidate until the downtown apartment building was filled up. Hobson said "we only had to offer housing to 79 people to get 75." The waiting list was comprised of others who also wanted the housing.

The Substance Abuse Policy Research Program (www.saprp.org) of the Robert Wood Johnson Foundation funds research into policies related to alcohol, tobacco and illegal drugs.

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful and timely change. For

more than 30 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves, helping Americans lead healthier lives and get the care they need. The Foundation expects to make a difference in our lifetime. For more information, visit www.rwjf.org .

About SAPRP | P: 336.286.4414 | F: 336.286.4550
SAPRP . One Leadership Place . Greensboro, NC 27410 . saprp@ccl.org



NeighborWorks®

ANCHORAGE

Building Community Through Neighborhoods

COMMUNITY COLLABORATION

NeighborWorks®
ANCHORAGE

Community Collaboration

NeighborWorks® Anchorage ardently believes that collaboration is the most powerful way to achieve our goal to build community through neighborhoods. By working together, sharing skills and knowledge, and pooling our resources, we can meet the needs of our community. We share a common vision with many partners of a strong, vibrant and sustainable community where everyone has a place to call home.

We are dedicated to a philosophy of teamwork, sharing ideas, and are focused on the people we serve. Our teamwork is part and parcel of everything we do, and our staff work collaboratively with one another and with our partners. Working together as a team, we can accomplish great things.

NeighborWorks® Anchorage works to develop, sustain, and further our community partnerships and collaborations. We cultivate strong bonds with the public, private and non-profit sectors to make a positive and lasting impact on the communities we serve.

Our community partners and supporters are wide and varied, ranging from service providers such as the ARC of Anchorage, Anchorage Community Mental Health Services, Catholic Social Services, other housing providers like Cook Inlet Housing Authority, Habitat for Humanity and Anchorage Housing Initiatives, to public agencies including Alaska Housing Finance Corporation, HUD, and Department of Neighborhoods at the Municipality of Anchorage.

Our work is made possible through the support of the private sector where we count many lenders, businesses and suppliers as our friends and colleagues.

NeighborWorks® Anchorage is COMPASSIONATE.

Please contact our office if you would like further information. We can be reached at 907-677-8490.

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

COMMUNITY BUILDING

NeighborWorks® ANCHORAGE

Community Building

NeighborWorks® Anchorage believes that all residents should have opportunities for civic engagement, leadership development and connections to the wider community. We empower people to make a positive difference in our neighborhoods and our city. We bring people together and focus on what makes a community a positive place to live. We teach people how to work with a diversity of opinions and backgrounds, and build strong, vibrant, and sustainable neighborhoods.

We offer unique opportunities for community building and engagement:

LEADERSHIP DEVELOPMENT

We are a member of NeighborWorks® America's Community Leadership Institute program, and our training workshops teach skills needed for successful community based leaders and advocates. Skills learned are then applied to a neighborhood project. Members are empowered to address issues by finding positive solutions that build and strengthen their neighborhoods.

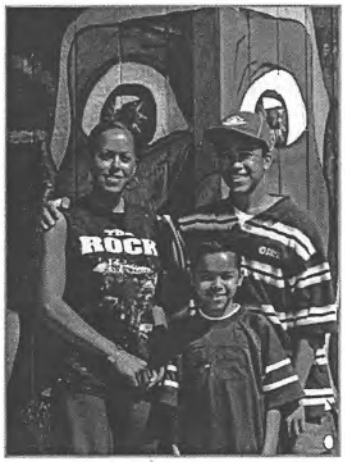
RESIDENT SERVICES AND CONNECTIONS

We work to develop relationships through resident councils, social activities and community events. These services are available to all residents at any NeighborWorks® Anchorage apartment community.

We can also facilitate access to vital services that enhance quality of life.

COMMUNITY OUTREACH

We collaborate with businesses, schools, community groups, and partner agencies to provide volunteer opportunities, workshops, and seminars to all members of the community. We support activities that encourage and foster a brighter future for everyone.



NeighborWorks® Anchorage is EMPOWERING.

We invite you and/or you organization to get involved in our community building activities. Please contact our office if you would like further information about our programs. We can be reached at 907-677-8490.

NeighborWorks® CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

HOME REHAB

NeighborWorks® ANCHORAGE

Home Rehab and Accessibility

Even the best built home will, at some point, need to undergo repairs or major replacements. Often the cost of replacing a roof or heating system will be a major expense. NeighborWorks® Anchorage can support current homeowners by maintaining the health, safety, and value of their homes through our repair and rehabilitation programs.

NeighborWorks® Anchorage manages grant programs on behalf of the U.S. Department of Housing and Urban Development, the Municipality of Anchorage, and the Alaska Housing Finance Corporation. Our knowledgeable and caring staff are experienced in guiding our customers through this often complicated process of outlining the work, hiring the contractor, and managing the project.

GRANTS

• **Minor Repair Program:** This program assists income eligible families who own and occupy a single family residence or mobile home in need of minor repair. Typical repairs may include roof repair/replacement, replacement of heating systems, or other health and safety improvements. Accessibility repairs can also be performed with Minor Repair Program funds.

• **Senior Access Program:** This program provides home accessibility modifications for qualified seniors, which allow them to continue to live independently in their own homes. Available to persons over 55 years of age, this grant can provide for accessibility improvements such as bathroom modifications, ramps, handrails, or stair lifts. Small assisted living homes of five bedrooms or less may be eligible for smaller grants to make improvements for eligible senior residents.

HOME IMPROVEMENT LOANS

NeighborWorks® Anchorage may be able to finance home improvement projects. These loans are made on a case-by-case basis. We welcome your questions, so please feel free to call our staff if you are interested in a home improvement loan.

NeighborWorks® Anchorage provides a SANCTUARY.

PAINT THE TOWN

Originally introduced in 1988, NeighborWorks® Anchorage re-launched Paint the Town in 2007 as part of the NeighborWorks® America nationwide NeighborWorks® Week. In the last two years we have assisted nearly 30 families with their exterior painting. Each year we hope to grow the program in order to help more families maintain the curb appeal of their homes. We invite you and/or your organization to get involved in this great community project.

Please contact our office if you would like further information about any of our home improvement programs. We can be reached at 907-677-8490.

NeighborWorks® CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

HOMEOWNERSHIP

NeighborWorks®
ANCHORAGE

Counseling * Education * Lending

Home ownership remains at the heart of most Americans and that dream is alive and well in Anchorage. NeighborWorks® Anchorage offers homebuyer education and an array of affordable loan programs designed to assist home buyers with purchasing a home. Experienced staff assist potential new homeowners with the lending process and help determine how our loan products may best fit their needs. We offer down payment and closing cost assistance loans, first mortgages, and partner with a number of local lenders. All loan programs are subject to income limits and other borrower eligibility requirements.

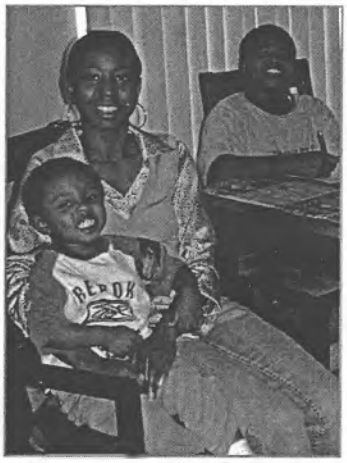
COUNSELING AND EDUCATION

- **Pre-and Post-Purchase Counseling and Education:** Staff are HUD certified counselors and well versed in working with individuals and families in preparing them for homeownership. Pre-purchase counseling helps prospective homebuyers determine affordability based on their individual financial situation. Post-purchase classes help integrate new homeowners into their community and make them stronger, more self-reliant and more comfortable in their roles as new homeowners.
- **Foreclosure Prevention:** NeighborWorks® Anchorage has joined the Homeownership Preservation Foundation in a national campaign to help homeowners who are facing foreclosure. Borrowers can call: 1-888-995-HOPE or visit www.995hope.org/.
- **Financial Literacy:** The ABCs of Money program, designed for both adults and children, offers an opportunity to learn the basics of saving and money management, credit building, and lending practices.
- **Predatory Lending Prevention:** NeighborWorks® Anchorage is a key member of the statewide Don't Borrow Trouble® Alaska campaign.

Victims of predatory lending or loan scams can call the hotline at 1-800-478-6501 or visit www.muni.org/dontborrowtroublealaska.

LENDING PROGRAMS

- **AnCHOR (Anchorage Communities Home Ownership Resource) Loan:** Through our partnership with the Municipality of Anchorage, the program provides a second or third mortgage to low- to moderate-income homebuyers to help pay for down payment and/or closing costs.
- **Revolving Loan Fund:** The "gap" loan fund provides the difference between a homebuyer's first mortgage and the sales price. This results in a lower monthly payment and increases the homebuyer's purchasing power.
- **NeighborHomes Loan:** In concert with Alaska Housing Finance Corporation, we provide down payment assistance loans to make homeownership available to households that may otherwise not be able to afford a conventional loan.
- **First Mortgage Loans:** First mortgage loans are offered on a case by case basis. These loans provide funding for borrowers who might not meet traditional lending requirements.



NeighborWorks® Anchorage is a STEPPING STONE.

Please contact our office if you would like further information about any of our home ownership programs. We can be reached at 907-677-8490.

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

NeighborWorks® ANCHORAGE

Affordable Rental Housing

HOME SWEET HOME

NeighborWorks® Anchorage is dedicated to providing quality, safe, and clean affordable apartment homes in convenient locations all over Anchorage. From well appointed three-bedroom units to practical efficiencies, we have an apartment that is ideal for any lifestyle. All our apartment communities are professionally managed and are located near schools, bus lines, and shopping. Many of our properties are also located close to major employment centers, including the downtown, midtown, and southeast business districts. Our Single Room Occupancy communities offer a less expensive alternative to the traditional studio apartment, allowing residents more freedom to pursue other interests without devoting most of their income to housing. We offer housing opportunities to people of all income levels, and some of our units feature rental assistance to qualified applicants.

Each of our employees embodies our values of integrity, professionalism, and customer first service. Our hard-working staff is focused on delivering the highest level of service and treating each resident first and foremost as a valued customer. Maintenance is available 24 hours a day to ensure the utmost comfort for our residents. We believe that everyone deserves a place to call home.

YOUR HOME IS OUR PASSION

At NeighborWorks® Anchorage, we value our partnership with those who serve in the armed forces. We participate in the Military Rental Partnership Program with both Elmendorf Air Force Base and Fort Richardson Army Post. Garden Villa, Boniface Plaza, and Stephens Park Apartments are properties approved for this program, and we encourage our military personnel to apply.

We believe a home is more than just a roof over your head. Residents can join programs and activities at many of our properties and become part of their greater community. Community building is a resident driven process in which people from all walks of life work effectively and collaboratively to create more livable and inclusive communities. Resident councils and leadership development activities are just two examples of volunteer opportunities available to our residents. Our goal is to create an environment that enhances every resident's quality of life in a safe, positive, family setting.

NeighborWorks® Anchorage is QUALITY.

LIVE ✶ WORK ✶ PLAY

Our mission is to provide clean, affordable and inclusive rental communities where our residents can enjoy a great quality of life, children can play safely, and families can enjoy their homes in peaceful settings. We are building community through neighborhoods!

Please contact our office if you would like further information on our apartment communities or our affordable rental housing programs. We can be reached at 907-677-8490. Our knowledgeable staff will be happy to answer your questions.

NeighborWorks® CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

NeighborWorks® Anchorage

Building Community Through Neighborhoods

NeighborWorks® Anchorage
Who We Are:

- Non-Profit community development organization founded in 1981 by Faye Connolly for neighborhood advocacy
- Originally called Anchorage Neighborhood Housing Services, Inc.
- Have operated as NeighborWorks® Anchorage since 2008
- Charter member of the national NeighborWorks® America family of community development and affordable housing organizations

NeighborWorks® Anchorage What We Do:

- Community Engagement and Resident Services
- Affordable Rental Housing & Real Estate Development – 9 rental communities with 950 units
- Homeownership and Home Rehabilitation Services

Beyond Bricks and Mortar:
Community Engagement and Resident Services

- Our experience teaches us that creating opportunities for residents provides more than just a place to call home. When people face overwhelming challenges, our programs and partnerships assists them in becoming self – sufficient, independent, and empowered.

- Our ultimate goal is to increase the likelihood of individuals and families retaining stable, permanent housing. We believe this is a foundation to a better quality of life.

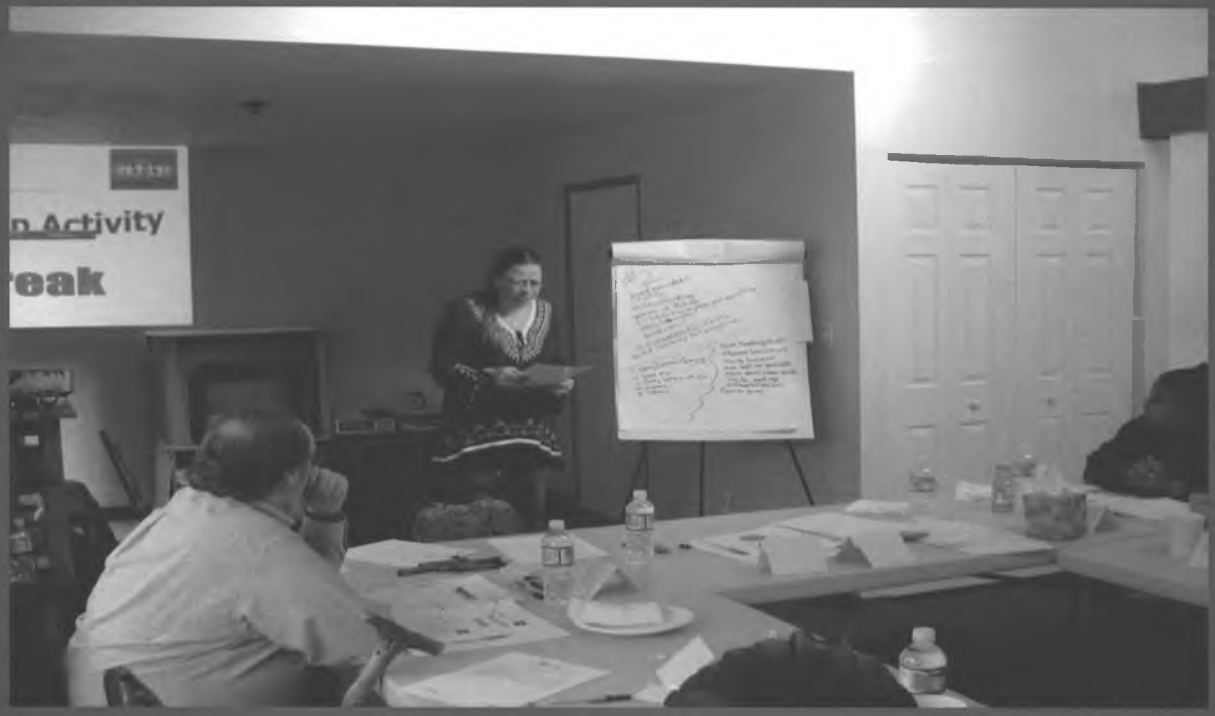
Community Partnerships

- We partner with over 30 community organizations to provide safe, affordable housing to homeless and hard to house families and individuals
- Member of the Alaska Coalition on Housing and Homelessness, the Anchorage Coalition on Homelessness and the Beyond Shelter group, all working together to reduce homelessness

Community Engagement

Residents and staff volunteer with over 55 community agencies and 300 volunteers at Project Homeless Connect. Not only do we provide housing opportunities at the event, but our residents, who were formerly homeless, are empowered to give back to the greater community, by volunteering at the event.

Leadership Training



Community and resident leadership workshops are presented quarterly by NeighborWorks® staff. The workshops facilitate individual leadership and advocacy skill development. In 2010, 27 individuals participated in these classes, and many continue as community leaders.

Community Engagement

Since 2007, resident volunteers helped to distribute nearly 200,000 lbs. of food to over 9,000 families and individuals in the Anchorage community. These resident volunteers were honored as Heart of Anchorage Award nominees in 2010, recognizing their contribution to the community.

Stepping Stones:
(One-on-One Mentoring)

Our work with at risk adults facing overwhelming challenges teaches us that one-on-one mentoring can transform lives long term. NeighborWorks® Anchorage's Stepping Stones program will provide the training and tools to support individuals as they work toward achieving their goals.

The Adelaide

Breaking the Cycle of Homelessness

- A 73 unit property exclusively for homeless individuals
- In 2010, 27 people were transitioned from homeless-ness into a place of their own
- Includes project rental assistance for each resident
- Active Resident Council

Loussac Sogn

Transition to Independent Living

- Historic building in the heart of downtown Anchorage with 52 units
- Affordable rents serving very low income individuals
- Active Resident Council
- Housed 6 new previously homeless individuals in 2010

Under Development

Serving Anchorage's Vulnerable Citizens

- The Roosevelt (HUD 811 funding) – 10 units of rental housing for low income people experiencing disabilities (includes rental assistance for residents)

Under Development

Serving Anchorage's Vulnerable Citizens

- Connolly Square (HUD 202 funding) – 20 units of rental housing for low income seniors over the age of 62 (includes rental assistance for residents)

2010 Community Impact

- 33 homeless individuals were transitioned to affordable apartments
- Working with partners we provided 10 hard to house families with a place to call home
- 30 additional units of affordable rental housing are being developed for those at high risk of homelessness

NeighborWorks® Anchorage
Takeaways

- We reduce homelessness through community engagement and affordable housing opportunities.
- Addressing housing and homelessness issues is a community wide problem, requiring the collaboration of the entire community. Partnerships are crucial in making greater impact possible.

Questions?

We would love to hear from you!

Deputy Director: Mike Courtney

Find us on Facebook

480 West Tudor Road
Anchorage, AK 99503
907-677-8490

NeighborWorks® Anchorage

Building Community Through Neighborhoods

NeighborWorks® Anchorage
HomeOwnership Center
Services

- Lending Programs
- Counseling and Education
- Home rehabilitation grants for people of modest means
- Accessibility grants for elderly / disabled individuals and families
- We assist the underserved to fulfill their dream of homeownership

Housing Continuum

- We offer opportunities at all stages of the housing continuum. Homeless, affordable rental, home ownership and preservation.
- The NeighborWorks® approach to home ownership is built upon the triad of preparing, investing, and retention.
- Stable families, stable neighborhoods and stable communities are built on home ownership.
- The American dream of home ownership is still possible!

Barriers to Home Ownership

- High cost of housing in Anchorage
- Aging and limited affordable housing stock
- Complicated buying process/steps to buying a home
- Underserved are vulnerable to mortgage scams and predatory lending
- Limited loan products

Preparing and Investing
Education and Lending

- Buying a home starts with financial capability and an understanding of the responsibilities of home ownership.
- One-on-one counseling and education programs build home buyer capacity.
- Our lending programs are tailored primarily to the first time and underserved home buyers.

Home Ownership
Retention and Preservation

- Retaining and preserving home ownership requires smart money management and continual upkeep of a home.

- Our post purchase education and home maintenance programs support successful long term home ownership.

2010 Community Impact

- We loaned $908,000, which leveraged $5,223,168 in first mortgages
- We provided pre-purchase and post-purchase counseling to 134 individuals
- 114 homes were rehabilitated through the Minor Repair, Senior Access and Home Modification programs

NeighborWorks® HomeOwnership Center

HomeOwnership Center Overview

A NeighborWorks® HomeOwnership Center provides services and education that customers need to successfully:

- shop for a home
- buy a home
- rehabilitate a home
- insure a home
- maintain a home

All in one physical location

Benefits of a NeighborWorks® HomeOwnership Center

- "One Stop Shop" in a convenient location
- Highly trained and licensed staff
- Advisory council of community partners
- Quality customer service and tracking systems
- Certified Full-Cycle Lending Services®
- One of 100 NeighborWorks® HomeOwnership Centers nationwide

NeighborWorks® Full-Cycle Lending Approach

The NeighborWorks® HomeOwnership Center Approach

- Works with potential home buyers that traditional mortgage companies ignore (the underserved).
- Reduces predatory lending, mortgage scams, and "trendy" mortgage products.
- Pre- and Post- Purchase counseling and education supporting stronger home buyers.

Home buyers attending pre and post purchase classes are better prepared for the responsibilities of owning a home.

NeighborWorks® HomeOwnership Center Outcomes

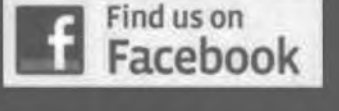
- A simplified home buying process for 1st time and /or underserved buyers.
- Sustainable homeownership through responsible underwriting and lending practices.
- Hands on home repair and skill building classes.
- Financially capable home buyers.

Questions?

We would love to hear from you!

Director of Lending and

Home Ownership: Barb Worley



480 West Tudor Road

Anchorage, AK 99503

907-677-8490

NeighborWorks®
ANCHORAGE

Merrill Crossing

1275 East 9th Avenue • 888-818-3459

Clean & conveniently located near downtown, shopping & bus routes. On-site laundry. Garages available for an add'l monthly cost. Sorry, No Pets!

Floor Plans
Eff's Starting at $635 | 1 BR's Starting at $735 | 2 BR's Starting at $835
Security Deposit $400-450. Income limits on some units
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Stephen's Park

3200 LaTouche Street • 907-279-1224

Extra large units w/balconies. Some with Fireplaces. Covered parking. Beautifully landscaped lawns, playground, and clubhouse. All utilities included. Sorry, No Pets!

Floor Plans
1 BR's Starting at $810 | 2 BR's Starting at $985 | 3 BR's Starting at $1300
Security Deposit $500-600. Income Restrictions, ask for Details.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

The Mallary

660 West 34th Avenue • 907-563-3574

Clean, conveniently located in Midtown. Playground & picnic area, BBQ grills. Laundry Facilities. On-site Management. Small Pets on Approval.

Floor Plans
1 BR's Starting at $775+E | 2 BR's Starting at $875+E
Security Deposit $450-500 Income limits on some units.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Spruce View

10605 Spruce View Loop • 907-349-5055

Spacious townhouse style units. 2-car heated garage. Storage. Washer/Dryer hook-ups. Beautiful landscaping, including a playground and clubhouse. Sorry, No Pets!

Floor Plans
2 BR's Starting at $915 | 3 BR's Starting at $1045 | Plus Utilities
Security Deposit $500. Income Limits Apply.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

NeighborWorks®
ANCHORAGE

Our Apartments

Building Community through Neighborhoods

DOWNTOWN/GOV'T HILL

Merrill Crossing
Efficiency, 1 & 2 Bedrooms
1275 E. 9th Avenue **279-8957**

Panoramic View
Efficiency, 1, 2 & 3 Bedrooms
787 Elm Street **272-2536**

The Adelaide SRO
Efficiency Units
201 E. 9th Avenue **258-9017**

Loussac Sogn SRO
Efficiency Units
429 D Street **272-4446**

SOUTHSIDE

Spruce View
2 & 3 Bedrooms
10605 Spruce View Loop **349-5055**

MIDTOWN

Hampstead Heath
2 & 3 Bedrooms
6641 Hampstead Drive **349-3323**

The Mallary
1 & 2 Bedrooms
660 W. 34th Avenue **563-3574**

Stephen's Park
1, 2 & 3 Bedrooms
3200 LaTouche Street **279-1224**

EASTSIDE

Boniface Plaza
2 Bedrooms
5301 E. 26th Avenue **337-7434**

Garden Villa
1 & 2 Bedrooms
5340 E. 26th Avenue **337-7434**

Formerly Known As
Anchorage Neighborhood Housing Services, Inc.
www.nwanchorage.org

NeighborWorks®
ANCHORAGE

NeighborWorks® ANCHORAGE

Hampstead Heath

6641 Hampstead Drive • 907-349-3323

Beautiful Landscaping

Quiet, Community Living. Spacious 2 & 3 Bedrooms in South Anchorage spread over 19 acres of land. We have a clubhouse with a F/P, playground and basketball court. On-site management. One Small Pet on Approval.

Floor Plans
2 BR's (800 sq. ft.) Starting at $ 925+E
3 BR's (1012 sq. ft.) Starting at $1140+E
Security Deposit $550.
Income Limits Apply.
Call Manager for Details.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Features/Amenities
- Garage Space (for 1-Car)
- W/D Hook-ups
- Private Storage
- Heat Included
- Cable Available at a Reduced Rate

Think you don't make enough to live the good life? Think again.

If your yearly income is less than the following maximum incomes you may qualify to live at Hampstead Heath.

- 1 Person $33,060
- 2 People $37,800
- 3 People $42,480
- 4 People $47,220
- 5 People $51,000
- 6 People $54,780

Boniface Plaza

5301 East 26th Avenue • 907-337-7434

Balconies. 1-car garage. Wood burning F/P's, W/D hookups. Upper floor units have cathedral-style ceilings. Large, well maintained, landscaped yard. Close to bases. Preferred cable offered at a reduced rate. Sorry, No Pets!

Floor Plans
2 BR's – Lower Units $1025+E | 2 BR's – Upper Units $1075+E
Security Deposit $550
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Garden Villa

5430 East 26th Avenue • 907-337-7434

Extra large, clean & conveniently located close to military bases, bus routes and shopping. Some units have fireplaces & balconies. Laundry facilities on-site. Small Pets on Approval.

Floor Plans
1 BR's starting at $750+E | 2 BR's starting at $950+E.
Security Deposit $450
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

NeighborWorks® ANCHORAGE

Panoramic View

787 Elm Street • 907-272-2536

Next door to Elmendorf Air Force Base

Our community on Government Hill offers quality, affordable rental housing. Many units feature spectacular views of Anchorage and the surrounding Chugach Mountains. We are two minutes from Anchorage's most popular salmon fishing stream, Ship Creek. Sorry, No Pets!

Floor Plans
Eff's Starting at $600+E
1 BR's Starting at $695+E
2 BR's Starting at $800+E
3 BR's Starting at $925+E
Security Deposit $350-500
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Features/Amenities
- Keyed Access
- Garages Available
- Playground

Directions
Take "A" Street north through downtown, cross over the Ship Creek Bridge, drive up the hill (E. Loop Rd.) and turn right at the stop light on Hollywood Dr. Our leasing office is on the corner of Hollywood & Elm. Welcome Home to Panoramic View!

Loussac Sogn SRO

429 "D" Street • 907-272-4446

Rooms for Rent, Standard, Single or Deluxe

Furnished unit w/kitchenette in a historic 3 story building with keyed entrance, elevator, community kitchen facilities, lounge areas with cable TV, computer lab and washer/dryer on each floor. On-Site Management. Sorry, No Pets!

Floor Plans
Standard Single Rm $425 | Deluxe Single Rm $485 | Heat and Electric included. Security Deposit $150. Units are restricted to persons whose annual income does not exceed $17,632 (standard) or $20,387 (deluxe)
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

The Adelaide

201 E. 9th Avenue • 907-258-9017

Single Room Occupancy

Furnished unit with small kitchenette in a keyed access building with an elevator, community kitchen facilities, lounge areas w/cable TV, computer lab and W/D on each floor. Resident council. On-site management. Sorry, No Pets!

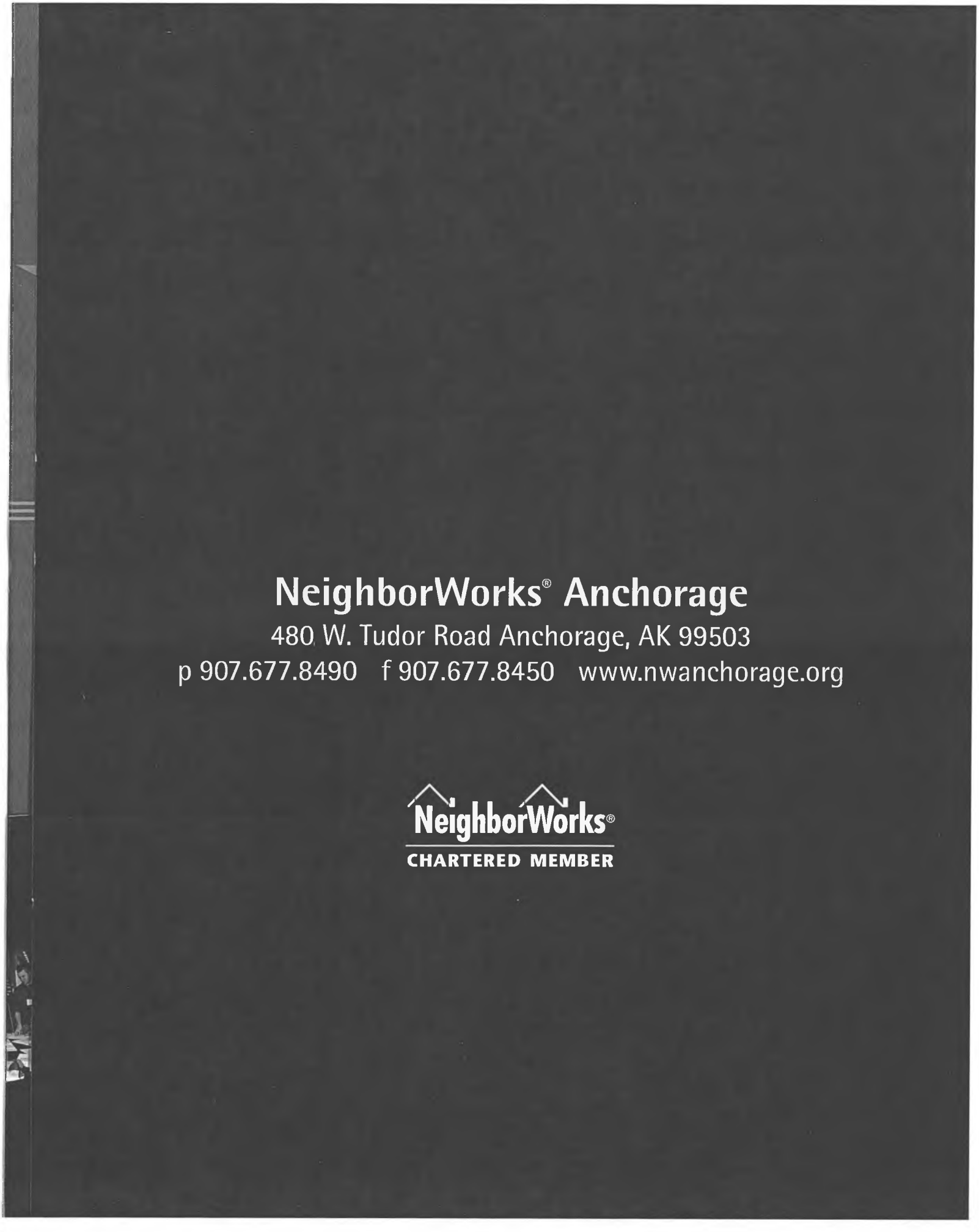
Floor Plans
Single Room $603. Heat & electric included. Security Deposit Required. Section 8 Based Assistance: rent = to 30% of resident's gross monthly income ($50 Min.) To qualify, applicant must be homeless.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Mike Courtney
Deputy Director

mcourtney@nwanchorage.org
480 West Tudor Road, Anchorage, AK 99503
p 907.677.8424 f 907.677.8451

NeighborWorks®
CHARTERED MEMBER



NeighborWorks® Anchorage

480 W. Tudor Road Anchorage, AK 99503

p 907.677.8490 f 907.677.8450 www.nwanchorage.org

NeighborWorks®

CHARTERED MEMBER

1/31/12 PRESENTATION: ALZHEIMER'S RESOURCE OF ALASKA

<TARGET><BILL></BILL><SUBJECT>1-31-12 PRESENTATION ALZHEIMER'S RESOURCE OF ALASKA</SUBJECT><COMM>SHSS27</COMM></TARGET>

Contact Information: Patrick M Cunningham, DSW
Associate Professor, School of Social Work
College of Health, University of Alaska Anchorage
3211 Providence Drive, Anchorage, Alaska 99508
907-786-6902 afpmc@uaa.alaska.edu

TESTIMONY
Joint Session House and Senate HSS Committees
January 31, 2012

My name is Patrick Cunningham and I am a member of the Board of Directors of Alzheimer's Resource of Alaska. I am also an Associate Professor of Social Work in the College of Health, University of Alaska Anchorage.

Thank you for the opportunity of meeting with you to present information regarding Alzheimer's Disease and Related Dementia. Related to this, I wish to thank Senator Bettye Davis for introducing Senate Bill 179 creating missing vulnerable adult prompt response and notification plans. This is similar to the Amber Alert for missing children, but targets adults. Victims of Alzheimer 's disease and related dementia have a tendency to wander as one of the manifestations of the condition and are at risk. Just last month in Fairbanks, a 63 year old woman suffering from Alzheimer's Disease froze to death after she became disoriented while driving, ran out of gas, and tried walking several miles to seek help.

A number of University of Alaska Anchorage Bachelor and Master of Social Work graduates are employed by Alzheimer's Resource of Alaska and provide education and support services as well as care coordination. Last July, I attended the Alzheimer's Association International Conference on Alzheimer's disease, in Paris , France.

Attending this Conference were over 5,000 scientists from all over the world who are engaged in a variety of research ventures seeking the causes of the disease and developing treatment interventions. I had the opportunity of reporting on challenges of care coordination in Alaska listing 20 challenges and proposing 20 solutions. Among the solutions was an emphasis on proactive early detection and engagement in services. I learned at the Conference that it is possible to identify individuals who are at risk for the Disease ten years prior to onset with 80% accuracy. The identification of biomarkers that may be measured with brain scans, spinal fluid analysis, blood, and cognitive markers consisting of tests for mild cognitive impairment are methods that are being used. At the Conference, the results of The World Alzheimer Report 2011 provided evidence that early dementia diagnosis, coupled with early intervention, is cost-effective, as the costs of an earlier diagnosis are more than offset by savings from the use of antidementia drugs and delayed institutionalization. Other key findings were

- when people with dementia are well prepared and supported, their initial feelings of shock, anger, and grief often give way to a sense of reassurance and empowerment;
- earlier diagnosis allows patients to plan ahead while they can still make important decisions about their future care and allows them and their families to access timely practical advice and support, as well as to access available therapies that may improve their cognition and enhance their quality of life; and
- most people with early-stage dementia would want to be told of their diagnosis.

The Alaska Division of Public Health conducts the Behavioral Risk Factor Surveillance System (BRFSS). Data are collected on risk and preventive behaviors and chronic disease prevalence that are especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs. Although Alzheimer 's disease is listed as the 8th leading cause of death in Alaska and predicted to increase, it is not referenced in the section dealing with chronic disease. The Center for Disease Control Healthy Aging Program has developed an Impact of Cognitive Impairment Module to assess and monitor the public's beliefs about the impact of cognitive impairment. So far, 20 states have added it to the Behavioral Risk Factor Surveillance System. It consists of 10 questions. The CDC has also developed a Caregiver Module to examine various aspects of caregiving. It also contains 10 questions. If the Division of Public Health were to include these modules in the survey, this would provide service providers like Alzheimer's Resource of Alaska with essential information to assist them in health promotion and disease prevention programs.

To date, treatment interventions for Alzheimer 's disease and Related Dementia consists of pharmacological and non-pharmacological approaches. Some medication has been found to delay the progression of the disease, if identified early, but not cure it. Among the non-pharmacological approaches are prevention of risk factors, psychological, diet, exercise, and cognitively stimulating activities. Some experts are advocating for a paradigm shift away from the current approach of treating symptoms as they emerge to targeting the disease in its very earliest, preclinical stage. These are individuals with mild cognitive impairment who have not progressed to Alzheimer 's

disease. This offers the best opportunity, to date, to prevent or substantially delay the Disease.

A study reported at the Conference that I attended stated that up to 50% of Alzheimer's Disease cases are potentially attributable to 7 preventable risk factors. These include smoking, physical inactivity, midlife obesity, midlife hypertension, depression, diabetes, and cognitive inactivity. This is where interventions to increase education and physical activity and reduce smoking rates and depression could potentially have a dramatic impact on Alzheimer's prevalence over time. At the national level, government action on AD does not reflect the expanding human, social, and economic burden of the disease for American families. Today there are 5.4 million Americans with Alzheimer 's disease and by 2050, as many as 16 million Americans will have Alzheimer's and the cost of care will surpass $1 trillion annually. There is currently no cure for AD and no disease-modifying treatment, so the current best hope lies in identifying prevention strategies.

Psychological interventions target behavioral and psychological symptoms of dementia. The most obvious are agitation, aggression, mood disorders and psychosis. Some examples of interventions are art, music, activity, and validation therapy.

In terms of diet, a study of relatively healthy elderly adults found that those with diets rich in several vitamins B,C,D,E, or omega-3 fatty acids had better cognitive function and less brain atrophy associated with Alzheimer's disease than their peers with diets less abundant in these nutrients. Those who ate a diet rich in red meat and full-fat dairy foods were more likely to get Alzheimer's disease compared to those who ate a diet

consisting mostly of nuts, poultry, fish, fruits, and vegetables. A chemistry professor at UAA has been recently rewarded a grant to study the effect of bog blueberries on dementia. Circumin derived from the spice turmeric reduces amyloidal accumulation and synaptic marker loss associated with Alzheimer 's disease. There is currently a clinical trial underway to determine the effect of the herb sage as a potential treatment for the disease. Sage has been demonstrated to enhance memory and mental function.

Mounting evidence suggests that physical activity may have benefits beyond a healthy heart and body weight. Through the past several years, population studies have suggested that exercise which raises your heart rate for at least 30 minutes several times a week can lower your risk of Alzheimer's. A number of clinical trials are examining the effect of aerobic fitness training on human cognition, brain structure, and brain functioning in older adults. The use of a Nintendo gaming console called WII Fit is being tested for aerobics, strength training and balance improvement with individuals with a diagnosis of mild dementia. A nurse at the University Of Washington School Of Nursing is evaluating an exercise and health promotion program for older adults with mild memory loss. And lastly, an even more promising program included exercise and mental activity. The participants rode recumbent bikes for an average of 3 rides per week, plus they had a virtual reality display that allowed them to ride in a 3-dimensional landscape and race against a ghost rider based on their own last best performance.

In a group of healthy elderly individuals, researchers found that greater participation throughout life in cognitively stimulating activities such as reading, writing, and playing

challenging games ~~was~~ were associated with less beta-amyloid deposition in the brain, a hallmark of AD. Other cognitive activities for AD patients is to engage them in activities of recollection which are not only general in nature, but also can focus on memory skills that can be directly helpful to them in activities of daily living, such as where they left a purse or wallet, or what is their living address. These memory exercises are also beneficial to their caregivers, who often get frustrated with the memory deficits of their family member.

One of the functions of the agency's Education and Support Program is to provide education to the health care provider. Since it is the primary health care provider who bears the responsibility for managing most of the AD patients, there clearly is a need to assist these clinicians with best practices guidelines. When best prepared, the provider will be able to make the appropriate diagnosis and, in a timely manner, inform the patient so that crises can be avoided, therapeutic and rehabilitative support can be initiated, and the patient can be adequately informed so that choices can be made for the future while decision-making capability remains. The patient and family face many short-term and long-term decisions that are best made based on knowledge of the disease process, the range of symptom progression, and the ultimate prognosis. This would include making decisions about advance directives to physicians, appointing a durable medical power of attorney, discussing end of life decisions with whoever will be designated as the surrogate decision maker, and future living arrangements. This is where a referral to the agency education and support services is warranted.

In terms of an economy of scale, when you consider the services provided by this program it becomes very cost effective when it may prevent the development of Alzheimer's Disease or delay it resulting in the individual remaining in their home and community for as long as possible, extending their quality of life and remaining out of an assisted living facility or nursing home. If the services the program provides delays for one year a nursing home admission for two clients, it results in a savings of well over $200,000. When you consider this, the request for $223,000 additional funding for the grant is a very modest one. Even more funding would enable an even greater outreach program.

Alzheimer's Disease & Related Disorders (ADRD) - Education and Support Program
Request for Funding Increment – FY 13

Budget Component: Senior Community Based Grants (2787)
RDU: Senior and Disabilities Services (487)

The ***ADRD Education and Support Program*** of the Alzheimer's Disease Resource Agency of Alaska provides support and education services ***statewide*** for people with Alzheimer's disease and related dementias as well as healthcare professionals, service provider agencies and the general public. The program provides outreach, information & referrals, consultations, memory screenings, support groups, and education for professionals and the general public. Through this program's activities the Alzheimer's Resource of Alaska raises public awareness of ADRD (signs and symptoms, diagnosis, healthy behaviors, etc.) which helps reduce the stigma associated with the disease. This program is a portal into the continuum of care and has a tremendous reach considering its very few resources. The Alzheimer's Resource of Alaska has provided these services on-going for 27 years. Overtime, we designed new programs and expanded service offerings to keep up with the population growth and the demand for services.

The senior population in Alaska is growing at a staggering rate and the number of people affected by Alzheimer's disease is growing proportionately. In 1990 an estimated 2,200 people had Alzheimer's disease while today that number is over 6,000 (172% increase).

SDS currently provides a $127,118 grant for this program. The original grant in 1984 was $28,838. From FY 92 through FY 08 the grant remained flat at $115,443. In FY09 the grant was increased approximately 10% to the current $127,118. In 20 years (FY92-FY2012), the grant was increased once by 10%.

The expectations for the organization for the use of these funds are significant:

- ⇨ Statewide Services
- ⇨ Demonstrated knowledge and expertise in providing education, training and support to caregivers, individuals, service providers and the community about ADRD
- ⇨ Statewide outreach with particular attention to rural and underserved communities
- ⇨ Information, referral and assistance via a statewide toll-free line
- ⇨ Individual and family consultations
- ⇨ Group education and training
- ⇨ Education of professionals and provision of technical assistance to those who are serving ADRD clients
- ⇨ Support groups
- ⇨ Conduct public awareness activities
- ⇨ Maintain staffed offices in Anchorage, Fairbanks, Juneau and the Mat-Su
- ⇨ Maintain a lending library

The Alzheimer's Resource of Alaska supplements this grant with private funds from foundations, corporations and individuals. This amount varies but on an annual basis it can range $20,000-$40,000.

In FY 11, the ADRD Education & Support Program served an **unduplicated** 430 individuals and 253 service providers. In addition, the program provided education services to 5,147 individuals statewide (may include some, but minimal, duplication). The following is a sample of the growth in the program in the last 10 years:

Service Levels	FY 2001	FY 2011	Increase in Service Levels
Information & Referral Contacts	6218	28,409	357%
Individual/Family Consultations	270	367	36%
Support Groups	72	153	113%
Consultations for Providers	121	268	121%
Education Activities	62	124	100%
Public Awareness Activities	84	353	320%
Communities Served	61	102	67%

Looking at a longer time span, the increase is even more dramatic. For example, from FY97 to FY11 the number of Information & Referral contacts increased almost 1600%. Given the demographics that we are familiar with, this is not much of a surprise. The demand for services is great now and increasing. The disparity is that in 20 years the State's investment has been minimal with only one increase of 10% in 2009.

The services provided through the *ADRD Education & Support Program* are preventive in nature and give individuals with ADRD and their families tools to preserve independence and maintain persons living at home for as long as it is feasible. Research shows that providing education, counseling and support to caregivers can keep people with ADRD out of nursing homes for an extra 1 ½ years. If this program can keep just ten people out of nursing homes each year, it will save the state more than $2 million each year. Given the high number of individuals this program serves, it is an extremely cost-effective approach. This program also supports professionals and thus raises the overall quality of care. How many individuals are admitted to API or the ER due to dementia related issues? Are all the staff at these facilities familiar with ADRD behaviors and knowledgeable of how to respond? How many care coordinators are writing care plans for those with ADRD with no understanding of the special needs of these individuals? How many clients with dementia are refused admission back to their assisted living home after a hospitalization or evicted due to behaviors? Training in this very specialized area is an investment in much needed workforce development.

The Alzheimer's Resource of Alaska has done well with the limited resources, however a great deal more work is needed to adequately respond to the demand in services: increased outreach/travel to rural areas, translation of materials to disseminate information to various communities, increased technical assistance and staff training for assisted living facilities and other service providers statewide, increased availability of qualified, professional staff to provide consultations and support to individuals concerned with memory loss and their families, just to name a few of the areas that require attention. With the expected continued growth in this population, additional resources for these basic services need to be allocated to this program. To meet the current program expectations and address the population growth with a reasonable level of effectiveness the **Alzheimer's Resource of Alaska respectfully requests an increase of $223,000 for the statewide *ADRD Education & Support Program* for a total grant amount of $350,000.**

Celeste Hodge

From: Hollie Hendrikson <hollie.hendrikson@ncsl.org>
Sent: Friday, February 10, 2012 1:23 PM
To: Celeste Hodge
Subject: RE: Suicide Presentation

Hi Celeste,
Okay, first for your question on funding. I don't track funding of this issue very closely, but the Suicide Prevention Resource Center seems to have relatively updated info on funding opportunities within states. I have pasted their information about legislation that involves funding and recent federal funding streams. I hope this helps.

As for the press release, I will be speaking on suicide rates (both Alaskan and US) and I will provide some detail about rates among specific demographic groups. I will also discuss state laws and 2012 legislation that aim to prevent suicide.

A short bio from me:
Hollie Hendrikson, MSc. Ms. Hendrikson has been a policy analyst at the National Conference of State Legislatures since April 2010 and is responsible for tracking state legislation related to injury and violence prevention including trauma systems. She contributes to multiple publications for state legislators related to policies that aim to reduce injury and violence rates, and address health care access.
I bio will probably not be needed for Laura since she will be accompanying me as my supervisor and trainer and will not be presenting.

And, I do plan on having a power point presentation and I will bring copies of my presentation to disseminate. Please let me know how many I should bring.

I hope this answers all your questions. Please let me know if I have forgotten anything. Thanks!

-Hollie

Hollie Hendrikson, MSc.
NCSL, Health Program
303-856-1525
7700 East First Place
Denver, CO 80230
Hollie.Hendrikson@ncsl.org

From the Suicide Prevention Resource Center

Legislation/Resolutions:

- **2009** – House Bill 123: Extends the statewide Suicide Prevention Council another four years, through June 30, 2013. It also expands the membership of the Council to include a public member as well as representatives from the Department of Health and Human Services and the Department of Education and Early Development.
- **2009** – House Bill 83: Makes appropriations for the operating and capital expenses of the state's integrated comprehensive mental health program. Specifically, the act appropriates $2,135,700 for rural services and suicide prevention for FY2010.
- **2007** – $2,241,243 is appropriated for suicide prevention and the rural human services system.

Tips on being a friend
PAGE 5

Alzheimer's research in Alaska
PAGE 10

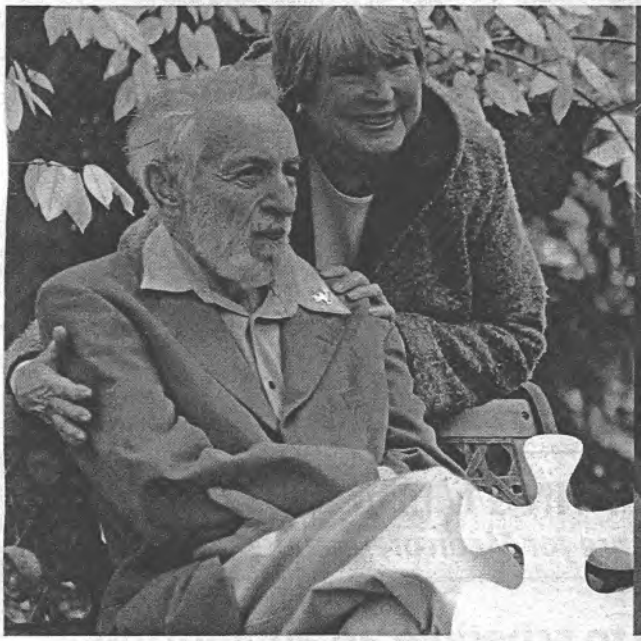
What's it like to have Alzheimer's?
PAGE 5

Alzheimer's Resource of Alaska

PRESS

Alzheimer's Resource of Alaska

until a cure is found...



Self-care tips for caregivers
PAGE 8

Local programs and services
PAGE 9

One woman making a difference
PAGE 16

Dear Readers,

Today, in Alaska more than 6,000 people have Alzheimer's.

Alaska has the fastest growth rate of aging population in the nation. From 1990 to 2010, the number of people over age 65 grew 146%. Since the incidence of Alzheimer's disease and related dementias (ADRD) increases with age, the number of people affected is increasing proportionately. When the Alzheimer's Resource of Alaska started in the early 80's as a grassroots effort less than 2,000 Alaskans were affected; since then the number as more than tripled.

To address these demographics, the Alzheimer's Resource of Alaska has expanded the depth of its services to educate, support and care for the individuals affected, their families and communities. The organization serves the entire state of Alaska with offices in Anchorage, Fairbanks, Juneau and Palmer, and we hire workers in local communities to provide home care in rural areas. With the number of people with ADRD expected to double in the next 10 years, we are preparing to address the challenges in the years ahead.

Alzheimer's is a disease that affects the entire family. More than three-quarters of people with ADRD live at home where they are cared for by family and friends. Although most families who care for their aging relatives in the home view care giving as a positive experience, providing 24-hour care is a demanding and draining task. The person with Alzheimer's disease can experience confusion or disorientation, loss of communication skills, agitation or hostility and in the later stages, a need for total care. The caregiver is responsible for all aspects of care and safety for their loved one. Over the course of the disease, watching a loved one's abilities decline from Alzheimer's disease is comparable to a sustained grieving process - a continual loss of the person they once knew.

At the Alzheimer's Resource of Alaska we provide the information that individuals concerned with memory loss are seeking. We help them navigate the health care system and provide the reassuring support and comfort that lets them know they are not alone. We provide hands-on care in the home to help individuals preserve their independence for as long as it is possible. And, we give family members the knowledge and tools necessary to become skilled caregivers and preserve their own emotional, physical and mental well-being.

Alzheimer's Resource of Alaska

While caring for those affected by ADRD, the Alzheimer's Resource of Alaska does not underestimate the importance of research as perhaps the most important factor in solving the Alzheimer's puzzle. Although there are some medications available that may temporarily improve symptoms, there is still no cure for Alzheimer's. A great deal of promising research is underway worldwide as many countries are concerned with the financial and social impact this devastating disease will have on society. Right here in Alaska, at the UAF Alaska Basic Neuroscience Program, research is in progress exploring causes and potential therapies for Alzheimer's. Our organization is fully committed to investing in research efforts and this year we established the "Alzheimer's Resource of Alaska Research Fund" with the University of Alaska Foundation to support the excellent work of our research partners here in Alaska.

At the Alzheimer's Resource of Alaska we will continue working hard to ensure respect, dignity and comfort in the lives of those we serve until a cure is found. We hope the next few pages will provide you with some answers about Alzheimer's disease and other dementias and insight into the experiences of those affected. We all know someone who has been touched by this disease and we must begin talking about it not as a myth but as a reality.

Dulce Nobre
Executive Director

Contents

3 What is the difference between Alzheimer's and dementia?

4 Mind Matters

5 What is it like to have Alzheimer's?

6 Living with Alzheimer's in Nunapitchuk

7 One caregiver's story: Jim Clark

8 Self-care for caregivers

9 Programs and services

10 *Alzheimer's research* in Alaska

12 Dementia training for pros

13 Dear Lisa

14 Mental fitness

15 It's more than a helping-hand

16 One woman making a difference

Alaska Medicare Clinic

NOW ACCEPTING MEDICARE PATIENTS!

Primary care for Medicare-eligible patients.

Call today to schedule an appointment.

(907)-433-5100

O'Malley Square Building
11260 Old Seward Highway
www.alaskamedicareclinic.org

What is the difference between dementia and Alzheimer's disease?

ONE OF THE MOST FREQUENTLY asked questions is: "What is the difference between dementia and Alzheimer's disease?" Dementia is not a disease itself. It is a term used to describe a number of symptoms that can be caused by various conditions and diseases that affect the brain. Dementia symptoms include a decline and loss of cognitive functions and memory, confusion, behavioral and personality changes in the affected person. Alzheimer's is just one disease that causes dementia.

There are a number of conditions that have similar cognitive effects as Alzheimer's disease. Vascular dementia, Parkinson's disease and Lewy Body dementia are just a few that exhibit many of the same symptoms and are often referred to as "related dementias".

The confusion between dementia and Alzheimer's is because the terms are often used interchangeably even though dementia can have a number of other causes. It is even possible for a person to have more than one form of dementia at the same time. One of the most common combinations of dementias is referred to as Mixed dementia, which is the combination of Alzheimer's disease and Vascular dementia.

Alzheimer's disease (AD) is the most common cause of dementia. It affects approximately 6,000 Alaskans and 5.4 million people nationwide. It attacks the brain and over time causes serious mental *and physical decline, eventually leading to death.* The disease is typically associated with memory loss but symptoms also include a loss of language and thinking abilities as well as changes in personality and behavior. These changes happen over time and symptoms come on gradually.

In Alzheimer's a buildup of Amyloid plaques and tau-containing neurofibrillary tangles keep the brain from making connections. With AD these buildups typically start in the region of the brain that concerns memory. As the disease progresses, more blockages are formed and connections are continuously inhibited. Simultaneously, there is a decline of Acetylcholine, a chemical responsible for transmitting messages from one brain cell to the next. Eventually nerve and brain cells begin to die causing the brain itself to shrink.

Causes of Alzheimer's are still unknown for the majority of cases. It is thought that a combination of genetic, environmental and life-style factors may lead to the disease but there is no definite answer. There is one exception, families who have a history of early-onset AD (AD before the age of 65), can pass a genetically transferrable gene mutation to their children. Mutations found in the APP, PSEN 1 or PSEN 2 genes, if inherited will cause Early-Onset Familial Alzheimer's (EOFA). However this genetic link is extremely rare and only found in a small portion of all Alzheimer's cases.

There is still much to learn about Alzheimer's disease and other forms of dementia. Medications have been developed to temporarily slow symptoms in those with progressive mental impairments, but eventually these disorders catch up. Until a cure is found, Alzheimer's Resource of Alaska is dedicated to providing education, support and services to all individuals affected by Alzheimer's disease or a related dementia.

RELATED FORMS OF DEMENTIA include:

- Vascular dementia
- Parkinson's disease
- Lewy Body dementia
- Frontotemporal dementia
- Creutzfeldt-Jakob disease
- Normal pressure hydrocephalus

HEALTHY HABITS

Recent research suggests that leading an overall healthy lifestyle may lower the risk of developing Alzheimer's disease and related dementias. Healthy habits include:

- Exercise
- Engaging in mentally stimulating activities
- Eating well
- Staying socially active

Ten Warning Signs

Alzheimer's disease is not normal aging. Alzheimer's disease is an illness which leads to a loss of cognitive abilities (i.e. memory, judgment, reasoning, language, perception, etc.). Symptoms usually occur in adults 65 years and older, although people in their 30s, 40s, and 50s may also be affected. Alzheimer's disease is the most common form of dementia. However, it is not the only cause of dementia.

Check for these 10 warning signs. If you find yourself answering yes to a number of these questions contact a doctor or the Alzheimer's Resource of Alaska.

Do You Or A Loved One Have...

1. Recent memory loss that affects daily living skills?
2. Difficulty performing familiar tasks?
3. Problems with language?
4. Disorientation of time, place?
5. Poor or decreased judgment?
6. Problems with abstract thinking?
7. A problem frequently misplacing things?
8. Sudden changes in mood or behavior?
9. Dramatic changes in personality?
10. Significant loss of initiative?

Mind Matters

A program for those with early memory loss

"I LIKE TO BE AROUND PEOPLE who believe in me," John announced. The focus of the morning's discussion among group members of Mind Matters, an early memory loss support program, was whether or not to tell others about a medical condition affecting their brain. Many confessed to remaining silent on such disclosure, fearing that friends and neighbors might begin treating them differently. Others like Tim say they have had to because it is now obvious that something is wrong.

This group meets once a week. The men and women sitting around the room are living with various degrees of memory loss. Some have been diagnosed with Mild Cognitive Impairment (MCI), others with Alzheimer's, Tim has Parkinson's. They come together week after week to connect with others experiencing similar challenges and engage in activities that connect them to the community.

Mind Matters is an education and support program for individuals with early memory loss facilitated by the Alzheimer's Resource of Alaska. The program offers a forum for people like Tim and John with early memory loss to share information, understanding, camaraderie, humor and hope with each other through discussions and activities.

Today is a discussion day and the group continues to talk about how there are friends and neighbors who find it difficult to remain in touch with a person living with memory loss and other cognitive changes. Probably because they don't know how to react or have fears that they won't be able to communicate. Discussions for the group typically revolve around topics like these as well as understanding diagnosis and the impact of the disease, managing lifestyle and relationship changes and preparing for the future.

According to Marilyn McKay, program facilitator and education specialist at the Alzheimer's Resource of Alaska, "This is definitely a time of challenge in the lives of group members and those closest to them. It's a time to sort through feelings of fear, anger and frustration. By group members sharing with family, friends and the community they feel less alone. The program is a process of learning and sharing among accepting and understanding peers. It's also a reminder that life continues with all of its ups and downs."

For Tim, "[The program] is about learning what other people are doing and how they deal with it. People are airing their inner most feelings and pieces of information here and there to help."

Program participants engage in a variety of activities including writing poetry, volunteering to bag food for the Children's Lunchbox Program, listening to guest speakers and on one chilly spring morning even bird watching at Westchester Lagoon.

"Having a variety of activities provides opportunities to continue to be creative, help others, learn something new and relax in the company of friends" says McKay.

These kinds of early memory loss programs were pioneered by Robyn Yale, LCSW, of San Francisco in 1986, and are now being replicated throughout the world. Her model combined education and support to better serve individuals living with early memory loss and their families.

Research has shown that groups like Mind Matters play an important role in reducing the isolation experienced by those living with early memory loss. Sharing personal experiences, helping others living through similar experiences, learning about memory loss, ways of coping and caring for self, along with the encouragement received from others eases individual distress and loneliness.

But research doesn't capture the reason these participants come back week after week. Jim comes for a shared feeling of learning and hopefulness. "I've heard there is no way out of this. I can't accept that. There has to be something. I come to learn from others." And he will as he shows up weekly to the new discussions and activities of Mind Matters.

I AM

I am Long Island, Seattle, Los Angeles and Boston,
North Dakota, Alabama, Kansas and Missouri,
I am Rocky River, Ohio.

I am father and son, husband and grandpa.
I am mother, daughter and wife.
I am family.

I am a gardener
bird watcher
reader of books
cross-country skier
I am one who likes to patschke.

I am honesty and integrity,
caring and compassion.
I am love.

—Members of Mind Matters
An Early Memory Loss Program of
the Alzheimer's Resource of Alaska
September 6, 2011

What Is It Like to Have Alzheimer's Disease?

ABOUT THE AUTHOR:
Dr. Richard Taylor, a retired professor and psychologist, was diagnosed with dementia of the Alzheimer's type a decade ago. Since his diagnosis, he has been thinking, speaking and writing about his condition as well as advocating for those with early-stage and early-onset Alzheimer's disease.

FEBRUARY 24TH DR. TAYLOR WILL BE SPEAKING at Alzheimer's *Resource of Alaska's Winter* Workshop. The workshop will be held at the BP energy center and those that attend will have an opportunity to talk to Dr. Taylor and Eden Mentor, Dr. Allen Power.

This is an excerpt from Dr. Richard Taylor's book: Alzheimer's From the Inside Out a collection of essays he has written since his Alzheimer's diagnosis in 2001.

WHAT IS IT LIKE to drive your car from Houston to Anchorage? The answer depends on many things: the type of car you will drive, the age of the car, how well you maintained it, where you are in your trip, if others are helping you with the drive, if you have enough gas or access to a gas credit card, if you have accepted the fact you must drive to Anchorage, whether or not you are afraid of arriving in Anchorage.

What is it like to have Alzheimer's? This, too, depends on many things: Do you have an existing group of individuals who are committed to your well-being? Are you a proactive or a reactive person when it comes to dealing with doctors, our health insurance company, and yourself? Where do you live: Houston, Texas, or Houston, Nigeria? Do you have insurance? Especially long- term care insurance? Does your culture and economic class encourage and promote younger generations taking responsibility and care of their family's older generations? There are dozens of important factors outside of yourself that will directly and significantly influence you and your inner experiences with the disease.

After meeting, speaking, and corresponding with hundreds of people who have Alzheimer's, I am convinced there is no universal answer to the question, "What is it like to have Alzheimer's?"

Since the disease process unpredictably and seemingly randomly destroys various cognitive processes and undermines the basis of most all understanding and memory, each person has a unique and personal way of dealing with the rate, the degree, and the various components of the syndromes we attribute to Alzheimer's disease. Neurologists who tell us they understand the disease because they see 4 or 40, or 400, individuals with Alzheimer's does not mean they understand me or you. Just as there really is no single "average" person, there is no meaningful "average" Alzheimer's disease experience.

I was diagnosed with dementia of the Alzheimer's type two years before I wrote this piece. I imagined, maybe hoped, that some day I would wake up and a heavy velvet curtain would have fallen during the night. I would wake up to a world where I could see shapes but not enough details to know what or who they were, sort of like Plato's flickering shadows on the wall produced by the fire on the cave floor.

Instead, right now, I feel as if I am sitting in my grandmother's living room, looking at the world through her lace curtains. From time to time, a gentle wind blows the curtains and changes the patterns through which I see the world. There are large knots in the curtains and I cannot see through them. There is a web of lace connecting the knots to each other, around which I can sometimes see. However, this entire filter keeps shifting unpredictably in the wind. Sometimes I am clear in my vision and my memory, sometimes I am disconnected but aware of memories, and other times I am completely unaware of what lies on the other side of the knots. As the wind blows, it is increasingly frustrating to understand all that is going on around me, because access to the pieces and remembering what they mean keeps flickering on and off, on and off.

Thanks in large part to my family caregivers, I am still functioning in the non-Alzheimer's world. I drive, I learn (although I seem to forget much of what I learn), I teach, I love, I mostly understand—but not all the time, and not always the way others do. It is a constant effort to look around the lacy webs and to have to put effort into understanding and doing things that came naturally but a few months ago (cooking, reading, driving to a new store, remembering the recent past). Some activities hide beyond the knots and rarely have clarity (arithmetic, reading a watch, remembering what I just read). It is not a lot of fun, but I can still do it!

Does the disease increasingly dominate my life, or has the disease insidiously and largely unconsciously become a part of my life?

Does the chicken come first, who I am?

Does the egg come first, Alzheimer's disease?

Today, but not yesterday, I firmly believe: Individuals have a cold, have cancer, have the measles. Alzheimer's has the individual. Ask me again tomorrow! I am trying to be rational and realistic, using tools that are rusting and increasingly out of sync with each other. In my writings you will feel me leaning one way in one paragraph (I am in a war with this disease and I will go down fighting. This is an opportunity for me to grow in ways few people have an opportunity to experience), or another way (I'm mad, I'm sad, and I feel sorry for myself. Why won't others join my self-pity party?).

My writings don't offer answers, just my own observations from my own increasingly unsure perspective.

Tips on being a friend

Talk to me
Please don't direct all your conversation only to the person who is with me.

Listen to me
I may have difficulty finding the words I need, but I have things to say. Please be patient with me as I share my thoughts with you.

Treat me as you always have
I'm not invisible. I'm not contagious.

Let me help
I have advice, strength, time and a desire to give to others. Please invite me to help you.

Include me
Help me to feel comfortable in small groups by including me in the conversation or activities.

Respect my feelings
At times I can be very emotional. Please stay with me if I want you to, or offer me a quiet space.

Encourage me
Recognize that I'm doing the best I can. Celebrate accomplishment with me.

Do things with me
Please don't assume you have to do everything for me.

Tell me what you would like me to do
Choices can be hard for me. It is much easier for me to say "yes" or "no."

Be positive
I'm going to make mistakes and I'm going to feel bad about that. Accept me for who I am right now and with your positive comments let me know that that is enough.

Tips are adapted from the words of Robert Simpson in Through the Wilderness of Alzheimer's *(1999)*

Living with Alzheimer's in Nunapitchuk

One family's story

CARING FOR SOMEONE with Alzheimer's is not an easy task but doing so in rural Alaska presents a unique set of challenges. Elsie and Ivan Jacobs live in Nunapitchuk a small Yup'ik village in western Alaska set on the Johnson River about 30 miles west of Bethel.

Elsie and Ivan are life long companions, and Elsie cares for her husband who has been diagnosed with Alzheimer's disease. She is responsible for feeding, clothing and bathing both Ivan and herself with the limited resources available. If it is raining, Elsie will make sure to collect the rain so she can use that water to give her husband a bath later in the evening. Running water is not piped into the homes in Nunapitchuk due to freezing problems. They have a small supply of potable water delivered to the house when needed, so she tries to be conservative.

Preserving water, she only washes clothes on the weekends and starts by soaking them the day before. This loosens dirt so she can finish scrubbing them by hand the following day. Winters can make this chore particularly difficult.

These tasks are a part of daily life for many rural Alaskans without being thought of as an added inconvenience. But when compounded with caring for someone with Alzheimer's disease or related dementia (ADRD) managing what were once routine activities can become nearly impossible.

Elsie was referred to Alzheimer's Resource of Alaska for respite services in August 2010 to help her care for her husband with suspected dementia. Soon after, Alzheimer's Resource of Alaska hired workers to provide Elsie and Ivan with services in the home and started sending the couple incontinent supplies from its loan closet to help with their growing needs.

In December of 2010 Ivan had a stroke and needed more help than was available in the village. Just hearing Elsie talk about it best describes how difficult it can be to get advanced medical care in a village with no roads.

"The nearest doctor is two hours by boat and I don't know how many hours by snow machine" she says.

That is how long it takes her to get to Bethel where the nearest hospital is located. She can take the Kuskokwim River or drive by four-wheeler or snow machine. But in an emergency such as when Ivan suffered a stroke, rural Alaskans need to be medevac'd to a hospital where they have access to more care.

It was during this time Elsie made the decision to keep Ivan at home in the village rather than send him to an Anchorage facility. Aside from the added expenses it would take to relocate Ivan, people with Alzheimer's always do much better surrounded by family, friends and the things they are used to. And as Elsie said, with a few extra hands around the house it has become possible to care for him at home.

Today, two Alzheimer's Resource of Alaska workers provide approximately 17 hours of services per week. These workers help Elsie care for her husband's personal needs and do chores such as heavy lifting, washing and housekeeping. Elsie uses some of this time for her own respite to go to appointments and get some time to herself.

"I need help mostly in the mornings. That is when it is hardest" she says. "They really really help me... I thank god for them."

Elsie will repeat this over and over again. She has no lack of appreciation for the in-home workers that come to her house weekly.

After a diagnosis of Alzheimer's was received in January, Alzheimer's Resource of Alaska awarded Elsie a mini-grant funded by the Mental Health Trust Authority to periodically send care packages to their home. The packages typically include items she can't get or are astronomically expensive in the village. For example, a package of Depends costs almost $40 in Nunapitchuk as compared to the $19.99 it costs in Anchorage. As a retired teacher's aid those are prices Elsie can't afford. Other items include food supplements (ensure, food thickeners, etc.) and rubber gloves. Elsie loves the rubber gloves and will mention them often if asked about what helps her the most (other than her in-home workers).

"I'm doing my best to help my husband" she says.

And she is. Elsie had the courage to reach out for help when she needed it most and, as a result, she and Ivan can continue their life together in the unique yet familiar surroundings of Nunapitchuk.

Lose Fat. Get Healthy. **Feel Better!** *That's my Promise to You!*
Bonnie Murphy, Owner
bonnie@bfitandwell.com

Call me Right Now to Get Your
FREE Week of Fitness Classes
(907) 229-7652

203 W. 15th Ave, Suite 101 • 99501

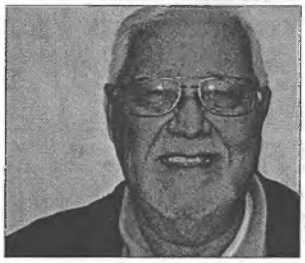
Look at these Results!

Dana lost 25 Pounds of Fat!

Marilyn Lost 4 Dress Sizes in 90 Days!

For more testimonials: www.bfitandwell.com

bfit &well
www.bfitandwell.com



Jim Clark

One caregiver's story

EVERY FRIDAY, LIKE CLOCKWORK Jim and Ginny Clark show up at the Alzheimer's Resource of Alaska for Art Links. Jim parks Ginny at the table in front of a white piece of paper on a blue sheet next to a set of water colors and brushes. Ginny is usually the first one in the room as others trickle in to join her for the painting session. She can't really paint anymore but Jim still brings her so she can get out of the house and be around people.

Once Ginny is settled Jim takes a moment to "make the rounds". He pops his head into each office at Alzheimer's Resource of Alaska with opening lines like, "I got a joke for ya..." and "did I tell you the one about..." He knows just about everyone in the building and is sure to collect as many hugs as possible. "I'm a bull-shitter," He says with a big grin, "nowadays they call it a people person."

It has been a long road for Jim and Ginny. In early 2006 the couple found out that Ginny had Alzheimer's. The first time Jim noticed something was wrong was in 2005. He was returning his son's truck they borrowed and Ginny was following him. Her driving was erratic, but at the time Jim didn't know why.

The progression of the disease was slow at first. Ginny continued working for another six months after the diagnosis. But eventually she needed to stop.

"To me it was a real shock about how our life was going to change" said Jim.

They had known a bit about the disease because Ginny's mother, sister and one aunt all were diagnosed. In fact, her mother developed signs in the early 60's and was committed to a mental institution at the time. Jim thinks that this history of the disease in her family is why, after being diagnosed, Ginny was always compliant when he was caring for her. "She knew I was trying to help her" he explains "she was always very receptive".

For Jim, after finding out Ginny had Alzheimer's the hardest part was figuring out what to do and how to go about it. Through this process was how he first made contact with Alzheimer's Resource of Alaska.

"I went to the library at the organization, and talked to a young man who worked there at the time, Tony. Smartest move I've ever done in my life" says Jim.

He went on to take classes and join support groups at the Alzheimer's Resource of Alaska. He even had the organization help him talk to his entire family about Ginny's condition and the care she was receiving.

He did this all for his wife. "I owed it to Ginny, I wanted to. I love that woman, I really do... I just need to take care of her."

For Jim, there was never any question who would be taking care of Ginny through this difficult time. Years ago when Jim got back from the Korean War she stood by him and helped him through some difficult times. Now it was his turn to do the same for her.

And he has in spite of all the challenges. Jim has learned to take blood pressure, comb her hair and coordinate with doctors and pharmacists. He made sure she ate well, regulated her meds (including the ones she hid in her cheek) and learned to work a roaming monitor. For years he slept with "one ear open".

Later in the progression of the disease, when Ginny got mad at the old lady in the mirror Jim put butcher paper up so she wouldn't be bothered anymore. "You've got to conquer what comes at the time" Jim explains "I don't think people really know what goes on, because it is a 24 hour, 7 day a week job".

But doing these things was not what made the disease difficult for him. Instead it was his constant guilt and concern for doing the right thing. If Ginny got sick his first thought was that it was because he didn't clean her well enough or he had exposed her to it somehow. "Sometimes you feel like you're going under" he says. "The most stressful part is wondering whether or not you are doing the right thing... if there's something else you should be doing. People can tell you that you are, but it doesn't always alleviate the questions you have."

For five years Jim didn't do anything major for himself. His life revolved around caring for Ginny and he had to learn a few coping techniques. While Ginny was still living at home he read a lot. He read for escape. He would get Ginny to bed, then go turn on a light, close the curtain to "read and nibble". According to Jim, finding a way to relax and get your mind clear for 15-20 minutes a day is essential. "You can't do it while they are there."

At times the stress got so bad that Jim says he just blocked it out. Most of the time, he didn't even realize how much stress he was under. At least not until he got in situations that would remind him, one time he recalls spending 15 minutes tearing the house apart looking for his cell phone. His son-in-law called to get a phone number Jim had stored on the phone. Eventually he realized it was in his hand, against his ear, his son-in-law was waiting on the other end.

Now Jim finds humor in these stories and others. "Ginny was always a very affectionate lady" he recalls. And this showed even as her disease progressed. At times they would be in the supermarket and Ginny would walk up to a complete stranger, arms open and say "Hello, I haven't seen you in a long time." She would hug them tight. All the while, Jim was dancing in the background pointing to Ginny and noiselessly mouthing the word "Alzheimer's". "And usually" Jim says "people would hug her back".

Jim encountered a lot of this kindness from strangers over the years. He is still amazed by how generous some people were no matter her condition. Staff at the Golden Coral and the Village Inn would go out of their way to take care of them and make them feel comfortable.

"Those are the little things that make it all worthwhile" says Jim.

Jim cared for Ginny in the home for five years. Now she is living at an assisted living facility where she can get round the clock care. Jim can visit and take her out whenever he likes as he does every Friday when he takes her to get her hair done and to Art Links just as she liked to do regularly before the Alzheimer's progressed.

"We've had a good life" he says. And before he leaves he asks "Did I tell you the joke about..."

Caregiver Facts

In Alaska, last year over 30,000 family caregivers provided over $420 worth of unpaid care to a loved with Alzheimer's or dementia.

34 million adults (16% of population) provide care to adults 50+ years.

8.9 million caregivers (20% of adult caregivers) care for someone 50+ years who have dementia.

5.8 million people (family, friends and neighbors) provide care to persons 65+ who need assistance with everyday activities.

Unpaid family caregivers will likely continue to be the largest source of long-term care services in the U.S. and are estimated to reach 37 million caregivers by 2050, an increase of 85% from 2000.

Trust Training Cooperative
Building Our Workforce Together

The Trust Training Cooperative (TTC) is a resource that promotes career development opportunities for direct service workers* and their supervisors engaged with Alaska Mental Health Trust Authority beneficiaries, by ensuring that technical assistance and training is accessible.

**Direct service worker is a position that requires a bachelor's degree or less and works at least 75% directly with consumers.*

Visit the TTC website at www.trusttrainingcoop.org

The TTC Learning Management System (LMS) provides training opportunities for Alaskan providers who serve Alaska Mental Health Trust Authority beneficiaries.

Visit the TTC LMS catalog of trainings at www.ttclms.org

TTC Sponsored Trainings: Frontline Leadership Institute, Mental Health First Aid, Hearing Voices that are Distressing, Full Lives Conference for Direct Service Professionals, We Are All Elders in Training Summit, Prevention of Abuse and Neglect of Vulnerable Adults, Learning Networks, and Acquired and Traumatic Brain Injury Case Management Series

Contact the Trust Training Cooperative at 907-272-8270

Grant funded by the Alaska Mental Health Trust Authority ID# 1384 and University of Alaska Anchorage Center for Human Development. UAA is an AA/EO employer and educational institution.

Caregiving

Do self-care in order to be a healthy caregiver

WHEN TALKING ABOUT ALZHEIMER'S the conversation often focuses on the individual who has been diagnosed. However, it is just as important to recognize the impact this disease has on family caregivers.

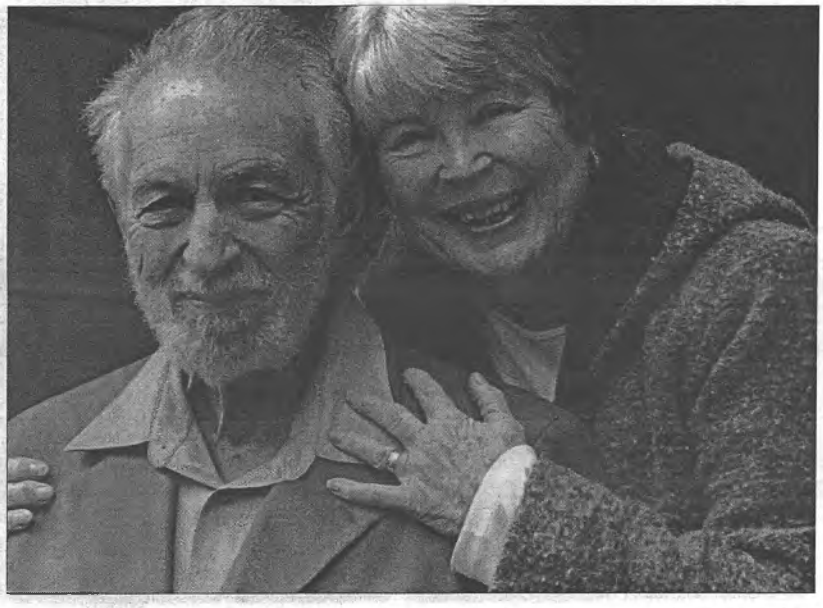
Caregiving is a physically, emotionally and mentally draining job and often, the last person to notice the toll it takes is the caregiver himself. The stresses of caregiving build up over time and for many, the job ends up consuming a person to the point where it becomes their sole role in life. They no longer have time to do things for themselves and they are constantly caring for someone else.

Caregivers, more often than not, are family members of a loved one who has been diagnosed. One of the most difficult aspects of caring for a loved one is that it forces people to change roles in ways they never imagined, especially in cases of Alzheimer's. A daughter helps her mother get out of bed, dress, eat and go to the bathroom as her mother once did for her. A husband does the same for his wife, as they once did together for their children.

This role reversal, on top of the financial, physical and logistical responsibilities of caring for someone contributes to caregiver stress and compassion fatigue. Compassion fatigue is a term used to describe someone who cares so deeply for another person that it becomes how they identify themselves. Everything in their lives revolves around the act of caregiving.

According to Lisa Wawrzonek, statewide Education Director at the Alzheimer's Resource of Alaska, this is dangerous because eventually the caregiver starts losing sight of some of their individual qualities. "You are committed to the point that eventually you become blinded to everything else, you are just in the mode of caregiver."

Becoming consumed by the role of caregiving is especially common in people who are considered part of the "sandwich generation". This is a term used to describe people who are caring for their children as well as their parents. They are caught in the middle and their role as a caregiver is pronounced by caring for two other generations simultaneously.



"It's important to be able to personally identify yourself away from these roles," says Wawrzonek. "You need to pay yourself first. And sometimes to do that, you need to find ways in which you can do self-care in order to be a healthy caregiver."

Doctors agree that to do something solely for oneself can provide an individual with a certain amount of self-care. They recommend taking time away from caregiving each day, even if it only adds up to 30 minutes a week. This allows a person to cope with the stress they are under and recharge for a moment.

"What it all comes down to," says Wawrzonek, "if you are not a happy, healthy caregiver you are not an effective caregiver."

Self-Care Tips *for the caregiver provided by Alzheimer's Resource of Alaska*

Support Groups: It always helps to know that you are not alone. It helps to hear that feelings of guilt, anxiety, anger, frustration and depression are normal. And you can discuss issues you are having with your loved one and get tips from others on how they have dealt with difficult situations.

"You" time: Find something separate from the role of caregiver, something that is just yours. And try to do this activity for at least 15 minutes a day. Read a book after everyone's in bed, take a bath, close the door and tell everyone not to disturb you.

Find yourself again: Ask yourself the question "Who am I?" and find something you can do to reinforce that. This is often a question that can be answered through identifying activities that you once enjoyed doing. For example, gardening, take a moment if you can and garden; at one time, you were not a caregiver, you were a gardener. Go back to that even if it is only for a short time.

Modify: Though you may not be able to take the time to garden anymore, you may be able to take 15 minutes and walk through the park, or visit a nursery. You will still be doing an activity that connects you to things you love, but it will be a modified, more obtainable version of that activity.

Set goals: Give yourself something to look forward to. Maybe it is taking an hour to get your hair done, getting easily through a meal with your loved one, or getting to a class once a month. Whatever you choose, make sure your goals are obtainable and have realistic expectations. Don't set yourself up for failure. Give yourself little successes in life and if you don't make it, it's alright.

Find a happy moment: Find a moment that made you really happy in life. A moment, day or event, that when you think about it, it makes you smile. And hold on to it for a few minutes during the day.

Shut off: Spend some time during the day to clear your mind. Try not to think about all the things you should be doing or will need to do. When something creeps in try pushing it out. Play some music and try it for the duration of the song.

Breathe: Breathe with purpose. Take deep breaths in through the nose and out through the mouth, expanding your stomach. Allow yourself to make noises as you exhale. Flush your system. Release some of those stresses.

Exercise: Research has proven that doing some exercise each day promotes better sleep, reduces tension, increases energy and decreases depression. This can be as simple as going for a walk or doing household chores. The key is to stay physically active.

A glass of wine: If it is something you enjoy, give yourself permission to have that glass of wine at night. Just one glass, any more can disrupt sleep, which is desperately needed for caregivers. But allow yourself to unwind at the end of the day.

Alzheimer's Resource of Alaska Programs and Services

MEMORY SCREENINGS
Free confidential memory screenings are available by appointment and administered at any of our office locations. Memory screenings must be done in person. Call to schedule an appointment at your local office.

CONSULTATIONS
Free confidential consultations are available for individuals, families and professionals to offer guidance in planning for the course of progressive dementia and other medical conditions. Consultations can be held in-person or by phone.

CARE COORDINATION
A service for individuals with physical or cognitive impairments who need assistance locating and accessing community resources for themselves or a loved one. Care Coordination enhances a person's independence, safety and comfort by coordinating the services he or she needs. Available only in the Municipality of Anchorage.

IN-HOME SERVICES
When physical or cognitive limitations make it difficult to remain safely at home, in home services offers a number of resources for clients and their families. Each service is uniquely designed to work with the health and financial considerations of the individual. Services include personal care assistance, chores and respite for family caregivers.

SUPPORT GROUPS
An opportunity for family members and friends to meet regularly for mutual support. Support groups are offered throughout the state of Alaska and we can help connect you with the group nearest you.

ADRD MINI GRANTS
Specifically for those diagnosed with Alzheimer's disease or related dementias, this grant program can assist in obtaining items or services when other funding sources are not available. Confirmation of diagnosis and estimates are required. Applications can be found on the web at www.AlzAlaska.org or www.mhtrust.org.

LENDING LIBRARY
As part of the University of Alaska's Consortium Library, we offer an extensive listing of materials on the topics of dementia, dementia care and diagnosis. Current titles on topics of interest to family and professional caregivers are available at all our locations and a number of resources can be found online at www.AlzAlaska.org.

MIND MATTERS
An educational and support program for those with early memory loss. Participants learn strategies to adapt with confidence and are encouraged to continue an active lifestyle. *(See page 4 for a closer look at the program)*

ART LINKS
Art Links is a weekly art program that provides a vehicle for self-expression for the memory impaired person. Family and friends are invited to participate. Classes are held in Anchorage and Palmer every Friday.

Education for Family and Friends:
ABC'S OF CAREGIVING
Two-hour workshops are offered every month for people caring for a frail elder or a person with Alzheimer's disease or a related dementia. The "ABC's of Caregiving" classes are free and held regularly in Anchorage, Palmer, Fairbanks, Juneau and the Copper River Basin. Topics include communication techniques, caregiving fundamentals, legal issues and Medicaid/Medicare concerns.

SAVVY CAREGIVER
A family caregiver education program that takes place over the course of 6 weeks, two hours each week. The program focuses on improving the practice of caregiving for both the individual living with dementia as well as the caregiver. Classes offered in Anchorage, Palmer, Fairbanks and Juneau.

Education for Professionals
SAVVY PROFESSIONAL
A one-day workshop that shares essential knowledge, practical skills and visionary outlook in dementia care. For those whose roles require dementia capable leadership, advocacy and mentoring.

DEMENTIA CARE ESSENTIALS
A training program for direct service workers wanting to improve their skills when caring for individuals with dementia. It offers an overview of Alzheimer's disease, understanding the dementia experience, communication skill development and enhancing activities of daily living. Past participants have included: respite workers, personal care attendants, care coordinators, home health workers, adult day, assisted living home, and long-term care staff. Currently offered in Anchorage, Fairbanks, Juneau and Palmer. Classes are also available via video conferencing.

DEMENTIA CARE WORKSHOP
A four hour workshop designed for long term care facilities and large organizations that need the fundamentals of dementia care. Facilities across the state can organize a workshop by calling the education department in Anchorage.

Education for Anyone:
RESEARCH FORUMS
Latest research and discussions on Alzheimer's disease and related disorders are offered with experts from around the nation. The forums are free events open to the public. This November Dr. Joshua Gatson will be speaking about Traumatic Brain Injury and its link to Alzheimer's disease. And in February Dr.'s Allen Power and Richard Taylor will be advocating on behalf of those with ADRD.

MENTAL FITNESS
A social and mentally stimulating program to help improve or maintain mental activity. Classes are held throughout the state at Alzheimer's Resource of Alaska offices and local senior centers.

AWARENESS PRESENTATIONS
For anyone interested in learning more about Alzheimer's disease and related dementias. Alzheimer's Resource of Alaska presents at civic groups, churches, and organizations. Call to schedule a presentation.

FOR MORE INFORMATION
on any of our programs or services contact Alzheimer's Resource of Alaska at one of our statewide offices or call toll free 1-800-478-1080.

ANCHORAGE
1750 Abbott Road
Anchorage, AK 99507
(907) 561-3313

FAIRBANKS
565 University Avenue, Suite 2
Fairbanks, AK 99707-2791
(907) 452-2277

JUNEAU
3100 Channel Drive, Suite 19
Juneau, AK 99801
(907) 586-6044

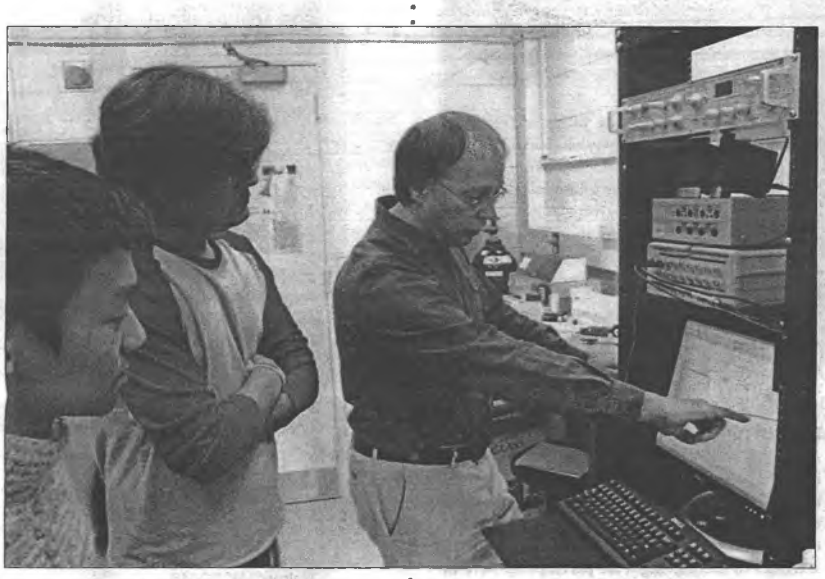
MATANUSKA-SUSITNA VALLEY
Trinity Barn Plaza
Mile 2.2 Palmer-Wasilla Hwy
Palmer, AK 99645
(907) 746-3413

You can also visit our website **www.AlzAlaska.org** for information, program schedules and information.

Many of these programs are made possible with funding by these major grantors: State of Alaska Senior & Disability Services, Alaska Mental Health Trust Authority, Mat-Su Health Foundation, Mat-Su Borough, Fairbanks North Star Borough.

Supporting Alzheimer's Research in Alaska

ALZHEIMER'S RESOURCE OF ALASKA established a fund this year with the University of Alaska Foundation to support promising Alzheimer's research being conducted here in Alaska. This year, the Alzheimer's Resource of Alaska's contribution was designated to Dr. Marvin Schulte's laboratory within the Alaska Basic Neuroscience Program at the University of Alaska Fairbanks (UAF). The lab has made significant progress developing a drug to treat the cognitive effects of Alzheimer's disease.



The Schulte lab has also received funding from the National Institute of Health (NIH) and American Recovery and Reinvestment Act (stimulus funding in 2009) to continue research and development on their lead compound desformylflustrabromine (dFBr). dFBr is a natural product that has been found to increase the activity of an important neurotransmitter that declines in Alzheimer's brains. This compound has the potential to improve cognitive abilities responsible for recalling, retaining and forming memories. Further research may lead to the development of new therapies for Alzheimer's disease.

In 2005 the lab started collaborating with Dr. Richard Glennon, Chair of Medicinal Chemistry at Virginia Commonwealth University to make synthetic variations of the compound. These synthetic variations change the structure of the compound allowing researchers in Schulte's laboratory to determine which properties of the base molecule are important for its therapeutic effects. These variations may enhance the drugs positive characteristics and reduce potential side effects.

According to Dr. Schulte the excitement surrounding this new drug has been undeniable. "The NIH funded the project on the first submission, which seldom happens." Dr. Glennon started working on changing the compound structure the day after speaking with Dr. Schulte. "We have received a lot of attention at scientific meetings from drug companies and other laboratories interested in this compound," says Schulte.

In order for cells to communicate with one another, a neuron will send a chemical messenger which will result in an electrical signal being discharged on the receiving cell. A person with Alzheimer's begins losing brain function because, for reasons that are not entirely clear, cells in the brain known as neurons start to lose the ability to send and receive signals to one another and ultimately die. Current medications for Alzheimer's act to increase the amount of the neurotransmitter chemicals available but they do not modulate the signal in the unique way the dFBr does.

"This is a very unique drug," says Schulte. "It doesn't activate or inhibit the receptors involved in Alzheimer's disease but instead modulates the signal that is produced".

In laymen's terms, what this means is that the drug dFBr, does nothing unless it is present along with the natural chemical signaling compound in the brain. When put together, the two produce a larger response then then would have been produced without the drug. In other words, dFBr enhances the signal or "turns up the volume" without significantly altering the brains normal control. This is a substantially different way of working then the current Alzheimer's drugs available to patients.

"There is great potential for this drug to help patients in the future" says Schulte. Dulce Nobre, Executive Director of Alzheimer's Resource of Alaska agrees. "Research is the essential piece that will help us solve the Alzheimer's puzzle and someday lead

FULLER DIAGNOSTICS, LLC

Kristi H. Fuller, Ph.D., ABPP | Richard D. Fuller, Ph.D.
Krista A. Pemberton, LCSW | Maureen Young, LCSW
2600 Denali Street, Suite 450, Anchorage, AK 99503
(907) 561-0552 | www.fulleralaska.com

A NEW SUPPORT GROUP FOR OLDER ADULTS

Krista Pemberton, LCSW and Maureen Young, LCSW introduce a new support group for older adults struggling with life cycle transitions. Our goal is to provide exceptional behavioral health care across the lifespan with special consideration of the challenges facing older Alaskans.

ft to right: Shane Rideout, Yeganeh Ataian (PhD student), Yanzhou Huang (PhD student), Marvin K. Schulte (primary investigator), ailesh Khatri (PhD student), Jordan Ross (undergraduate researcher)

to a cure. The research being done in our very own state is providing valuable knowledge to the entire Alzheimer's research community. And while caring for those affected today, the Alzheimer's Resource of Alaska believes in, and is committed to supporting and investing in promising research efforts."

THE FUND

The Alzheimer's Resource of Alaska Research Fund was set up with the University of Alaska Foundation to support the excellent work of our research partners' right here in Alaska. This fund will provide financial support to the Alaska Basic Neuroscience Program to further explore causes and potential therapies for Alzheimer's disease and related dementia (ADRD). The fund is open to anyone interested in contributing to ADRD research.

This year, the fund will allow one graduate student to work fulltime in the Marvin Schulte Laboratory. According to Dr. Schulte, "The ability to have one student concentrate 100 percent of their time in the lab, without distraction, is the most productive way to stimulate research".

Shane Rideout, a third year graduate student at the University of Alaska Fairbanks (UAF) was granted this funding. Rideout received his undergraduate degree in Biochemistry from UAF and went on to pursue a doctorate. He has been working in the lab since 2010 but until recently, has been splitting his time teaching, writing papers, giving presentations and mentoring.

According to Rideout the opportunity to work fulltime in the lab, doesn't just benefit him, "I am incredibly grateful on a personal level for this, but it affects so much more... When we can devote [all] of our time to research, it is a huge benefit to our productivity."

Over the next year Rideout will be characterizing the interactions of this promising compound, dFBr, as well as developing a new platform to permit more rapid testing of drugs produced by Dr. Glennon. This "high-throughput" type of testing will accelerate the pace of discovery and will potentially benefit other laboratories as well.

THE PROGRAM

The Alaska Basic Neuroscience Program (ABNP) began in 2000 when the University of Alaska Fairbanks (UAF) received one of 12 Specialized Neuroscience Research Program (SNRP) awards. This award from the National Institutes of Health initiated the development and coordination of neuroscience research and education in Alaska. Their goal is to facilitate high-quality neuroscience research and education opportunities addressing identified state and national needs in partnership with local communities, state and federal governments. The ABNP program has received over $10M in research funding that directly supports neuroscience research in Alaska. In addition to money received from the SNRP program, Neuroscience faculty members are highly productive and receive significant additional support from both NIH and NSF to conduct neuroscience research of relevance to AK. In addition to Alzheimer's research, this includes research into new models of disease and the treatment of stroke, SIDS, Autism, depression and neuroinflammation.

Facts and Figures

Alzheimer's is the **SIXTH-LEADING** cause of death in the country.

Alzheimer's disease is the **MOST COMMON** form of dementia, although there are a number of others with similar symptoms that is why we often refer to Alzheimer's disease and related disorders (ADRD).

Alzheimer's disease is the only cause of death among the top 10 in the United States that **CANNOT BE PREVENTED OR CURED.**

Geneva Tryck Mortimer, age 93, and daughter Sabra Tryck (right) with Helene Wood who helps care for Geneva. Helene is a Certified Nursing Assistant and volunteer for the Office of the Long Term Care Ombudsman.

We All Have The Power To Protect
you know me

At this stage of my life, I'm lucky to have people who look after me. We all need a support system, especially older Alaskans and people with severe disabilities. Harm comes in many forms: abandonment, abuse, financial exploitation, neglect and self-neglect.

If you know someone who needs help, call Adult Protective Services at (907) 269-3666 or (800) 478-9996 or visit www.hss.state.ak.us/dsds/aps.htm

The Alaska Commission on Aging
www.alaskaaging.org

The TRUST
The Alaska Mental Health Trust Authority
www.mhtrust.org

Dementia Care Training for Professionals and Paraprofessionals

ALZHEIMER'S RESOURCE OF ALASKA has launched three new specialized programs this year to train professionals and paraprofessionals in the field of dementia care.

The rapidly growing number of people with Alzheimer's disease or related dementia (ADRD) in Alaska has created great demand for a dementia-capable workforce in all areas from home-based services to institutional care. The number of people with ADRD is expected to almost double in the next 10 years, and the shortage of trained personnel will be at a breaking point.

Specialized dementia training is needed because caring for an individual with ADRD requires a unique set of skills for which not all medical professionals or direct care workers are trained. Alzheimer's Resource of Alaska is providing trainings to meet the growing need, accommodating individual workers and organizations by offering three new programs in different locations and venues throughout Alaska.

According to Lisa Wawrzonek, statewide education director of Alzheimer's Resource of Alaska, "These programs are incredibly important because the more professionals trained, the more we promote effective dementia care all-around. People that work with someone who has ADRD need to provide a special type of care, and when they use best care practices in dementia care it makes the experience better for themselves and the individual they're caring for."

The first program launched this year was Dementia Care Essentials (DCE). It was created specifically for direct care workers such as certified nursing assistants, workers in assisted living homes, personal care attendants, in-home workers and care coordinators. The course teaches the fundamentals of dementia, as well as practical skills such as communication techniques, activities planning and best practices in de-escalating difficult behaviors. DCE is a 10 hour class that takes place over the course of 5 weeks, two hours each week. This format allows participants to study and practice the skills learned each week and bring insights to the following class for further discussion.

The Dementia Care Workshop offers many of the same fundamentals as DCE but in a condensed four hour time frame. This format is typically used by larger facilities wanting to train a number of employees at once about the fundamentals of dementia and basic tools for working with individuals with ADRD. Nursing homes, assisted living facilities, adult day centers and hospitals have been scheduling this workshop in various locations throughout the state.

The third program, Savvy Professional, is an interactive workshop designed for those in leadership roles. The training equips administrators, supervisors, nurses, social workers and attorneys to provide leadership, advocacy and mentoring to others who work with individuals and families affected by ADRD.

So far this year over 200 people have participated in these programs and the response has been extremely positive. The training programs offer continuing education (C.E.) hours to nurses, C.N.A.'s, social workers and attorneys. They are available in Anchorage, Palmer, Fairbanks and Juneau and as of this fall, Education Specialists have began scheduling Dementia Care Essentials and Savvy Professional in other areas of the state.

In October, DCE will be offered via video conference for the first time. The new video conferencing is a result of collaboration between Alzheimer's Resource of Alaska and the Trust Training Cooperative. The first session will be open to professionals in Bethel and Nome.

WINE TASTING FUNDRAISER
NOVEMBER 5
TO BENEFIT ALZHEIMER'S RESOURCE OF ALASKA
The wine tasting will also feature
BLACKJACK, ROULETTE, POKER TABLES
and a SILENT AUCTION
November 5th at the Alaska Native Heritage Center.
Tickets are available for $45, $55, and $1,000 for VIP seating for eight.
Must be 21 to attend.
WineStyles®
TICKETS ARE AVAILABLE AT WINESTYLES
11109 OLD SEWARD
FOR ADDITIONAL DETAILS CONTACT
WINESTYLES AT 907-337-9463

Dear Lisa

Questions and answers

Dear Lisa,

I recently turned 50 and Alzheimer's has been on my mind more and more lately. Both my mom and my dad developed Alzheimer's later in life and now I am afraid that I might get it. I have heard a lot about Alzheimer's and genetics lately. Is there some sort of blood test I should get done to find out if I am going to end up with Alzheimer's too?

—Genetic Worrier

Good question GW, the short answer is no. What causes Alzheimer's in 99 percent of all cases is still unknown, but age and family history are the two main risk factors. You have probably been hearing about gene mutations in three genes which have been linked to an increased risk of developing Alzheimer's later in life. But it is not a definitive indicator that you will develop the disease. So even if you are tested for these mutations it doesn't mean much. Current research suggests that a combination of genetic and environmental factors cause Alzheimer's and in this case, scientists believe that an overall healthy lifestyle is the best way to prevent the disease.

That being said, Early-Onset Alzheimer's (EOA), which is developed before the age of 65, does not always fall into this category. Only 5 percent of all cases of Alzheimer's are classified as EOA and in only 1 percent of those cases there is a clear genetic link running in families with a long history of EOA. But again, this is very rare and if your parents developed the disease later in life there is no reason for you to be tested.

Dear Lisa,

My mother has been living with us for about seven years and we've been able to take care of her. We feel it is time to ask for help but have really no idea where even to start. Can you point us in the right direction? We'd like to keep her at home if we can.

—Helpless at Home

Dear Helpless,

First, congratulations on caring for your mother successfully at home for so many years. There is a place to start and I would recommend a consultation with a care coordinator at Alzheimer's Resource of Alaska. A care coordinator is an expert at community resources, services and funding sources. They can help with both short and long term plans and providing options for care for you and your family to choose from. You may feel after getting the information, you can arrange the necessary services but it is also nice to have a care coordinator ongoing to provide an extra set of eyes as well as someone who gets to know you and your loved one. This is helpful in the event of a significant change or decline. Knowing the situation can allow the care coordinator to jump right in with assistance rather than trying to learn from the ground up when you really need action.

Care coordinators know of the resources such as in-home services, adult day centers and companionship services that can provide your family a break, interaction with your loved one and peace of mind all around.

Dear Lisa,

My husband was recently diagnosed with Alzheimer's and lately, he's been asking me about things we did years ago or talking about places where we lived as though we are still there. I try to tell him that we're in Alaska, not Oregon anymore or remind him when these things happened but he gets really angry. How do I keep him calm? And why is he getting so angry at me?

—Unsure what to do

Dear Unsure,

This is a very common scenario so I'm glad you asked this question. Alzheimer's disease is affecting two areas of cognition that cause him to think of past experiences as if they are happening in the present. One is memory and the other is reasoning. Memory and reasoning are two of our cognitive thinking abilities that can be affected or impaired by Alzheimer's disease or related dementia. First, short term memory is affected so new learning will be impaired but individuals hold on to long term memories for a while. The individual begins to regress through his long term memory and those memories come back to him as if they are present reality. This becomes his reality. It then becomes difficult to reorient the person to our reality or truth because he loses the ability to reason.

Telling a person with Alzheimer's the truth becomes like telling him that he is wrong. Many will react confused, frustrated or even angry because they don't understand. The best thing to do when he starts telling you stories of things that happened years ago is to go with the flow. Validate his stories and maybe try to re-direct him to the task at hand. Use those stories as tools if he becomes agitated. You can say, "tell me about" and bring up one of the stories he can still remember. One positive spin is that these are experiences this disease has not taken away from him yet. And if you need to, don't hesitate to call for a consultation at the Alzheimer's Resource of Alaska. Someone there can help you find other ways of coping to meet your needs as well as your husband's.

Dear Lisa,

I have been taking care of my mother who was diagnosed with Alzheimer's for about a year now and things have been going fine, but recently her wondering has gotten worse. I find her in the kitchen trying to cook, creating dangerous situations like putting tinfoil in the microwave. And sometimes at night she gets up and tries to leave the house for "work". It has been getting more difficult to keep track of her. When I told my friend about this she mentioned something about a monitoring system with video cameras. This sounds strange to me. Does anybody use video cameras to monitor their loved one with Alzheimer's?

—Hall Monitor

Thank you for your question HM. Some family members do put up security cameras or motion detectors to monitor loved ones when they are still living alone or when wandering becomes an issue. It seems to work best when family is living very close by or is trying to get additional information about their loved one's activity. And it often helps the family better care for that individual. However, it certainly poses a question of privacy and I would recommend that there be a legal representative (like a Power of Attorney or guardian) involved in this type of decision. I would also recommend a consultation with someone at the Alzheimer's Resource of Alaska to provide more in-depth information.

Facts and Figures

In 2010 Alaskans provided **$213 MILLION** in unpaid care for by caring for a family member or friend with dementia.

Last year, Alzheimer's Resource of Alaska facilitated **153 SUPPORT GROUPS** across the state.

In 2010 almost 31,000 Alaskans provided over **25 MILLION HOURS** of unpaid care to an individual living with Alzheimer's disease or related dementia.

Mental Fitness

Facts and Figures

Alzheimer's Resource of Alaska served **102 COMMUNITIES** last year.

Alzheimer's disease usually begins after age 60 and **RISK INCREASES WITH AGE.** Younger people in their 30s, 40s and 50s may get Alzheimer's disease, but it is rare.

While there is no cure for Alzheimer's disease, there is **QUALITY CARE AVAILABLE.**

KEEPING OUR BRAINS HEALTHY and active is good advice at any age. Like any other part of our body the mind needs to be exercised. However, rarely do we do an activity with the deliberate intention of "working out" our minds. Some may think it is unnecessary since cognitively stimulating activities can be as simple as reading, doing crossword puzzles or learning a new word. But as we age, it becomes more and more important to seek out these activities.

When we are young, we go to school every day. We are constantly learning, reading and problem solving in various areas of study. But later in life we tend to lose some of these activities. This can be simply because we don't have the time to dedicate towards them, or maybe our job makes us utilize one area of the brain more than others. But like any other muscle, if an area of the brain is neglected it becomes weak.

Participating in structured mental fitness programs, no matter what age, can help challenge and exercise different areas of the brain in ways we may not do on our own. In these programs, various activities are created to stimulate creative, logical and problem solving functions in an entertaining way.

Though it is still unknown what causes one person to develop Alzheimer's and not another, studies have shown lower rates of Alzheimer's disease in people who maintain an overall healthy lifestyle. That includes physical exercise, maintaining a healthy diet, reducing stress, not smoking and engaging in social and cognitively stimulating activities. So let's get started by doing a few fun "workouts."

STIMULATING CREATIVITY:

Figure out what these re-written proverbs are:

The previously arriving feathered, winged biped captures the invertebrate crawler.

It's vastly preferable to remain unscathed than to be forced into repentance.

If you refrain from interrogating me, I'll articulate to you no prevarications.

When the terrain becomes arduous, the resolute becomes vigorous.

Heedful prudence is the preferred component of intrepidly.

Now re-write your own variations.

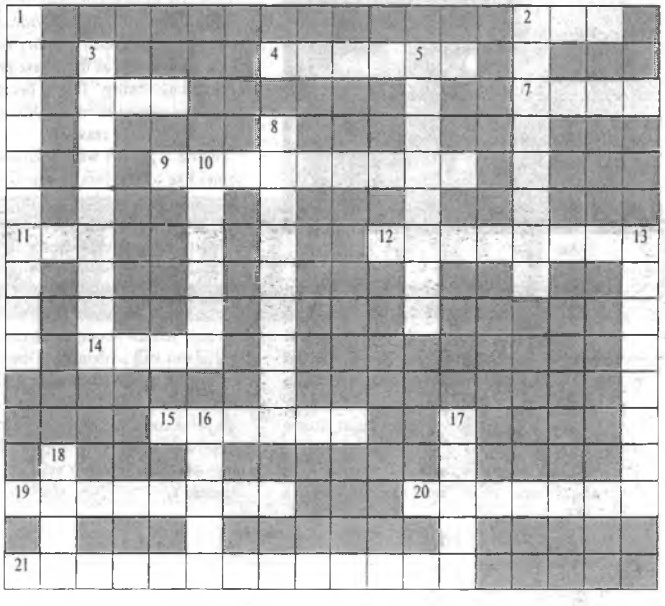
This activity is courtesy of Robert Winningham Ph. D., Geriatric Wellness Center at Northwest Rehabilitation Associates.

ACROSS

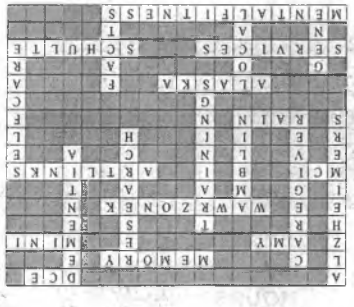
2. Prgm. for direct care workers (abr.)
4. _____ Screenings
6. Volunteer Extraordinar
7. Grant for individuals with Alzheimer's or related dementia
9. Education Director of Alzheimer's Resource of Alaska
11. Term for early memory loss abr.
12. Self-expression program for a memory impaired person
14. Elsie collects this
15. Has the fastest growing aging population in the nation
19. Care Coordination, respite, chore
20. UAF research lab
21. Stimulates the mind

DOWN

1. The sixth leading cause of death in the country
2. Term to describe a number of symptoms affecting cognitive function
3. Jim Clark
5. Important to someday finding a cure
8. Savvy Professional, Savvy Caregiver, DCE
10. Annual walk to benefit Alzheimer's Resource of Alaska
13. Important for caregivers
16. 1750 Abbott Rd. is Anchorage's _____ Alzheimer's Resource of Alaska Office
17. One in eight people over the age of 65 and one in two over 85 will develop Alzheimer's AND 6000 Alaskan's currently live with ADRD
18. APP, PSEN 1 or PSEN 2



Puzzle Answers



The early bird catches the worm.
Better safe than sorry.
Ask me no questions, I'll tell you no lies.
When the going gets tough, the tough get going
Discretion is the better part of valor.

It's more than a helping hand...

LOIS REPNOW AND HER HUSBAND KELLY have six children, ages 7 and under. It has been over a year since Kelly's father TeRoy Repnow, who was diagnosed with Alzheimer's disease, came to live with them. The Repnow's fit the "sandwich generation" description where they are caring for an elderly parent while still raising their own children. Due to several circumstances in the family, the choice became that either TeRoy came to live with the family or he went to an Alzheimer's care facility. At the time, Lois was pregnant with their sixth child. So the family was growing by two. In February, TeRoy's granddaughter was born and this was a time which Lois remembers vividly, "I will never forget the tenderness with which TeRoy held his newest granddaughter."

The Repnow's have been happy to have this time with TeRoy. "I have been very blessed to watch my children get to interact with their grandpa and love on him. Children are without guile and lavish love freely no matter one's physical or mental condition." Says Lois.

But caring for grandpa TeRoy has not always been easy on the family. His Alzheimer's is fairly advanced and he has become almost like another "chicky in the nest" according to Lois. However, he is an adult, and that carries its own challenges. TeRoy's needs have grown even in the short time he has been staying with the Repnows. The family's laundry load increased when TeRoy moved in. There were a few more spills around the house and his bedding needed to be washed frequently. This put a strain on the family's septic system and their basement in danger of flooding.

When the family contacted the Palmer Senior Center to find out what resources were available they learned of the Mini-Grant program administered by the Alzheimer's Resource of Alaska and funded by the Alaska Mental Health Trust Authority. They applied for the grant and were awarded a small amount to purchase resources that would help the family care for TeRoy.

With these funds the family purchased vitamins, a monitoring system, towels and a large capacity, resource efficient washer and dryer. The monitoring system allows Lois to go up and down the stairs to do all her daily tasks without having to worry about taking TeRoy with her to each room of the house. And the washer and dryer may have helped the most, "I can easily load 15-20 towels in one load, wash Dad's sheets and bedding in one load... I can do all of my laundry without having to worry about overtaxing the septic system and flooding our home!"

Lois and her family are extremely grateful for the mini-grant. They can now spend less time doing chores and spend more time enjoying grandpa TeRoy while he is in their home.

TeRoy has since moved to North Dakota to be closer to his wife in an assisted living facility where he can see her every day. It has been a joyful reunion for a couple that has been married 59 years. And should the need arise; he is welcome back in the Repnow home at any time.

Mini-Grants are awarded by the Alzheimer's Resource of Alaska and funded by the Alaska Mental Health Trust Authority. Applicants can apply for up to $2500 for items or services that improve the quality of life for a loved one diagnosed with Alzheimer's or related dementia.

Upcoming events

November is Alzheimer's Awareness Month www.AlzAlaska.org

Research Forum: Dr. Joshua Gatson regarding research in traumatic brain injuries and the link to Alzheimer's Disease.
October 31st from 6-8 pm at Providence Hospital East/West Auditorium, Anchorage
November 1st from 6-8 pm at Public Library, Fairbanks
November 2nd from 6-8 pm at the University Campus, Soldotna
November 3rd from 6-8pm at Centennial Hall, Juneau

When does Forgetting Become a Disease?
November 3rd from 10-12 noon at the Anchorage Senior Activity Center

WineStyles wine tasting & silent auction
November 5th from 7-10 pm at the Alaska Native Heritage Center

ABC's of Caregiving: What about the Kids? Alzheimer's through the eyes of a child
November 7th from 10-12 noon or 5:30-7 at Alzheimer's Resource of Alaska, Anchorage office

ABC's of Caregiving: When does Forgetting Become a Disease?
November 8th from 6-7:30 Alzheimer's Resource of Alaska, Palmer office

Momentum in Science: A film exploring scientific efforts to uncover the causes of Alzheimer's
November 10th from 10-12 noon at the Anchorage Senior Activity Center

National Memory Screening Day
November 15th Call your local office for events and appointments

ABC's of Caregiving: Holidays and traveling with those who have dementia
November 16th from 10-12 noon or 5:30-7 at Alzheimer's Resource of Alaska, Anchorage office

Being a Friend: Staying Connected with Individuals with Alzheimer's Disease or Related Dementia
November 17th 10- 12 noon at the Anchorage Senior Activity Center

Open House: Join classes, listen to presentations, meet staff and learn about the support and services of Alzheimer's Resource of ' Alaska.
November 18th from 1-5 at Alzheimer's Resource of Alaska's offices in Anchorage and Palmer

Alzheimer's Disease: Unraveling the Mystery
November 28th from 10-12 noon or 5:30-7 at Alzheimer's Resource of Alaska Anchorage office

Art Links:
Every Friday in Anchorage from 11-12 noon
Every Friday in Palmer from 1-2 p.m.

ASSISTED LIVING ASSOCIATION of ALASKA

ALAA

VISIT OUR WEBSITE FOR MORE INFORMATION: WWW.ALAA-ALASKA.ORG
OR EMAIL US AT ALAA-ALASKA.ORG

One Woman Making a Difference

OVER THE PAST FOUR YEARS Amy DeWitt has dedicated an extraordinary amount of time and effort to Alzheimer's Resource of Alaska. She has volunteered for numerous events as well as raised over $16,000 fundraising for Amblin' for Alzheimer's. Unbelievably, she has done all of this while raising six children and holding a full time job.

Amy got involved with Alzheimer's Resource of Alaska when she started serving Jackie Brunton and her mother Dorothy at the Bradley House seven years ago. The two would come in to eat about three to four times a week and Amy would go out of her way to make sure Dorothy was comfortable. Dorothy had Alzheimer's disease, and Jackie was caring for her at the time.

"It was about the only place I could take her. It is small, quaint and not overwhelming" Jackie explains. "And Amy took such good care of my mom."

Amy always had hugs and kisses for Dorothy when they came in. And when Dorothy stopped eating most foods, the kitchen started making her favorite dish, chicken fingers (which can now be found on the Bradley House menu). Amy even had the chicken fingers cut up so that Jackie wouldn't have to do it at the table and could enjoy a meal with her mother.

In 2008 Dorothy passed away, and around the same time Amy found out her grandfather Fredolin was diagnosed with Alzheimer's as well. The following year Amy decided to participate in Alzheimer's Resource of Alaska's fundraising walk, Amblin' for Alzheimer's. That first year, she and her youngest son Haden raised $1,621 for the organization.

This amount won her the top fundraising prize for all of Alaska in 2009. Amy was in shock when she learned she won. She wasn't even trying to compete with anyone. She found out when Jackie, who was then Board President of Alzheimer's Resource of Alaska, surprised Amy at work and presented her with two round-trip tickets courtesy of Alaska Airlines to anywhere she wanted to go. Amy knew right away it was Hawaii.

To top it off, when another set of her regulars at Bradley House found out she won the tickets they gave her their timeshare in Hawaii to use. Amy still can't believe they did that for her, but Jackie doesn't seem surprised.

"You know it really says a lot about Amy. She's so genuine, I don't know how else to describe her."

In 2010 and 2011 Amy kept up the momentum by raising more money for Amblin' than any individual in the state. However, since that first trip she took to Hawaii, all of the prizes she has won over the years she has given away.

When she won both of the following years she gave the airline tickets to her parents, and sent them off to Hawaii.

"They absolutely deserved it." she said. "They have never taken a vacation."

Over the years, ensuring that individuals with Alzheimer's have the services they need has become a cause that is deeply important to Amy. When she visited her grandfather on his birthday for the last time in 2010 Amy gained a clearer understanding of what takes place with the disease how it affects everyone who comes in contact with it.

She watched as family members expectations were let down as they visited and interacted with Fredolin. They wanted him to remember who they were and would say things like, "Hey grandpa, it's me! Don't you remember me?" And though their intentions were good, this would leave both people feeling disappointed. Her grandfather was frustrated because he had no idea who was talking to him but felt like he should, and the other person left the exchange sad and feeling forgotten.

It wasn't until seeing her Aunt Carol talk to Fredolin that Amy understood how simple changes of speech can alter an interaction completely. She watched as her grandfather lit-up when her aunt went to him and said "Hey, it's your birthday! Happy birthday!" she smiled, gave him a kiss and nothing more.

"Aunt Carol didn't need anything from him" Amy says. "She was just there to celebrate the day with him."

It was at that moment that Amy says it became apparent, "it is not about what we need from them, it is about what we can give to them."

Everyday she continues to give in a number of ways whether it is at the Bradley House or the Alzheimer's Resource of Alaska. For 2012 Amy has a slightly different plan from what she has done in the past. When Amblin' comes around next year, Amy may do some fundraising but will not be trying to break any more records.

"It's time for someone else" she says.

Not to say that she will be slowing down. Amy will just be committing her time to the organization in other ways. This year she is organizing donations and coming up with ideas for the silent auction benefit in November hosted by WineStyles. And she is already planning to donate her time as a server for Date Night in February.

"She just gives back" Jackie says, "and she does so much for so many... I couldn't love her anymore if she were [my] blood."

But Amy doesn't do it for the praise. Her dedication to Alzheimer's Resource of Alaska and the work they do, can be seen in her teary eyes as she says, "I just hope somebody was able to treat my grandfather like we do here."

Facts and Figures

ONE IN EIGHT people over the age of 65 will develop Alzheimer's disease, and nearly one in two over the age of 85.

Alaska has the **FASTEST GROWING** aging populations in the nation.

Approximately **6,000 ALASKANS** are currently living with Alzheimer's disease and related dementia and as many as 5.4 million Americans nationwide.

Tours Available Mon-Fri by Appointment

We Offer You Peace Of Mind While Providing Your Loved Ones With...

✓ Privacy
✓ Individuality
✓ Dignity
✓ Security in Daily Living

MARLOW MANOR
established 1999
ASSISTED LIVING

Come and Experience the FUTURE of elder care TODAY, at Marlow Manor Assisted Living. Marlow Manor is founded on the philosophy that by creating a warm, nurturing environment with personally developed service plans, our residents enjoy their daily living free from worries. Marlow Manor provides you the opportunity for an active partnership in helping to meet the needs of your loved one.

2030 Muldoon Road, Anchorage, AK 99504
(907) 338-8708 • Fax (907) 338-8627 • www.marlowmanor.com

2/01/12 PRESENTATIONS: ALASKA HEALTH CARE COMMISSION REPORT AND DEPARTMENT OF HEALTH & SOCIAL SERVICES OVERVIEW 2012

<TARGET><BILL></BILL><SUBJECT>2-01-12 PRESENTATIONS ALASKA HEALTH CARE COMMISSION REPORT AND DEPARTMENT OF HEALTH and SOCIAL SERVICES OVERVIEW 2012</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska's Approach to Increasing Value in Health Care:

Improve Quality, Lower Costs, Focus on Health

Presentation at the Joint Senate and House Health & Social Services Committee Hearing

Dr. Ward Hurlburt and Deborah Erickson
Alaska Health Care Commission

February 1, 2012

1

Presentation Overview

- Background on Commission
- Process & Strategy
- Findings to Date
- Recommendations to Date
- Next Steps
- A Note about Federal Reform

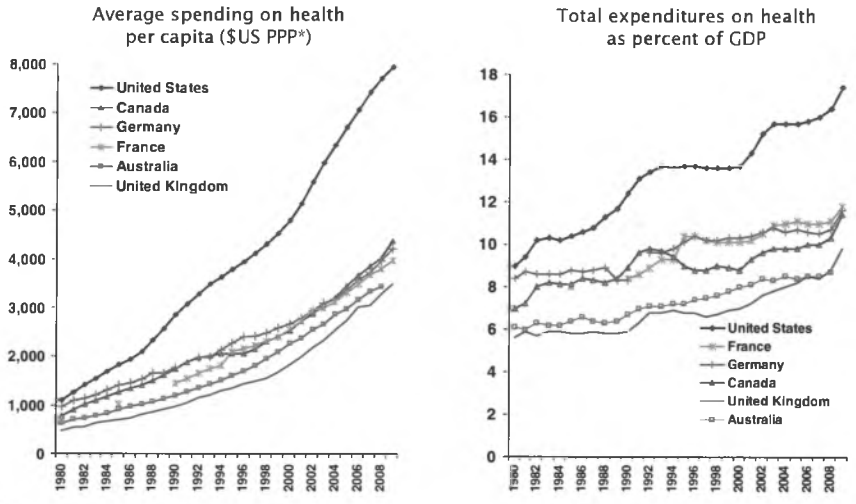
2

Commission Background

- " The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state." AS 18.09.010
  - Temporary body 2009; Statute enacted 2010
  - Advisory in nature
  - 14 members, appointed by Governor except for 2 leg.s
  - Policy recommendations due annually to Governor and Legislature

3

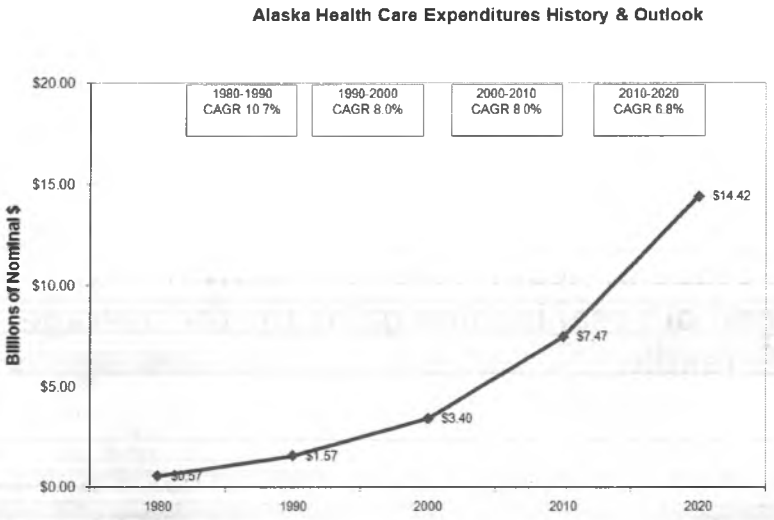
International Comparison of Spending on Health, 1980–2009



* PPP=Purchasing Power Parity.
Data: OECD Health Data 2011 (database), version 6/2011.

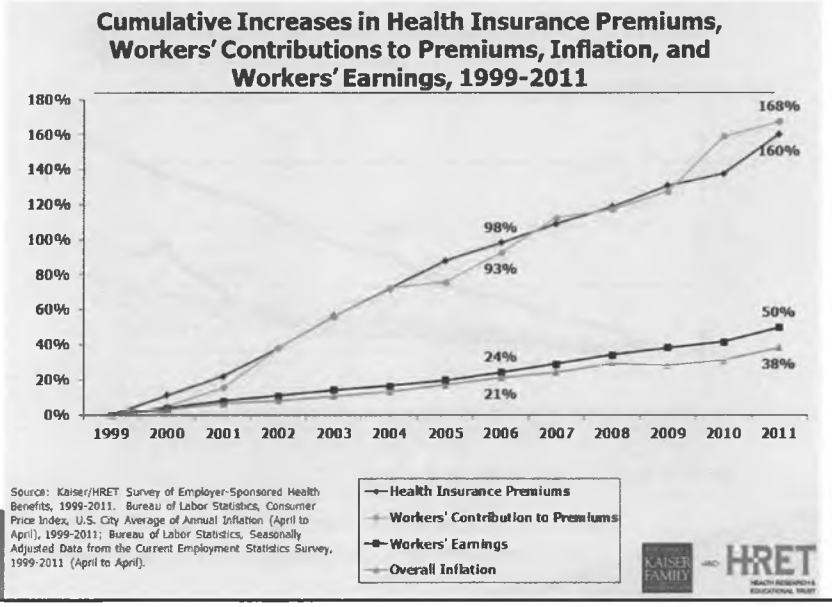
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Cost of Health Care in Alaska (MAFA/ISER)
Next Ten Years – Baseline Projection



5

Affordability – Cost vs. Inflation, Earnings



6

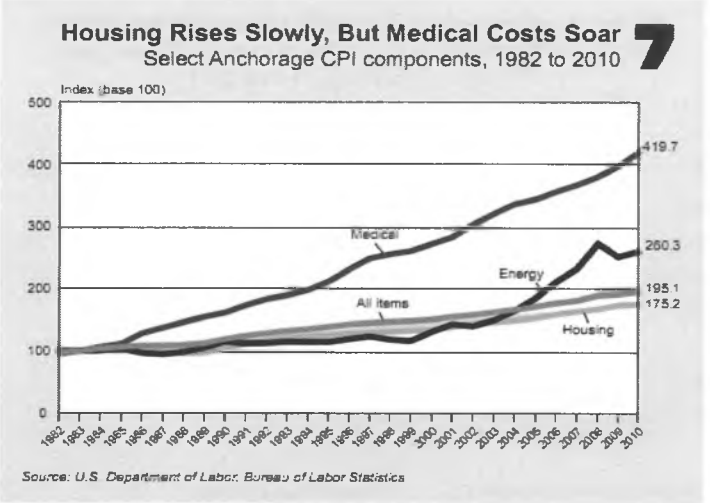
Affordability – U.S. Families

- Median income increased by $23,000 between 1999 and 2009
- Out of pocket costs for health care increased by nearly the same amount
- A decade of health care cost growth has wiped out real income gains for the average U.S. family

Source - Health Affairs, September 2011 30:9

7

Affordability – Alaskan Families



Over the past decade, medical costs in Anchorage increased by 46% compared to 27% nationwide

8

Affordability – Alaskan Employers

- Fewer Alaskan employers offer employee health benefits in 2010 than in 2003
  - Large employers dropped from 95% to 93% (96% US)
  - Small employers dropped from 35% to 30% (39% US)
- Commercial premiums in Alaska are roughly 30% higher relative to comparison states
  - $11,926/employee health benefits cost highest in the nation
  - Share employee pays increased from 17% to 22% for family coverage between 2003 and 2010

9

Value in Alaska's Health System

- **Coverage**: 14% – 19% uninsured[1]
- **Costs**: 2nd highest per capita expenditures[2]
- **Quality**: Ranked 38th for health care quality[3]
- **Outcomes**: 35th healthiest state in the nation[4]

1. Varies dependent on whether IHS beneficiaries without 3rd party coverage are included in the uninsured count or not
2. CMS Personal Health Expenditure Data
3. 2010 US DHHS Agency for Healthcare Research & Quality State Dashboard on Health Care Quality
4. 2011 United Health Foundation America's Health Rankings

10

What System?

Our health care system is perfectly designed to deliver the results we get.

So…

How can we redesign (transform) the system to deliver the best possible health and health care at the lowest possible cost?

11

The Conundrum (at least one of them)

- "If we don't cut costs, we'll have to cut care."
  Don Berwick
- "Cutting costs does not cut costs."
  Joe Flower

12

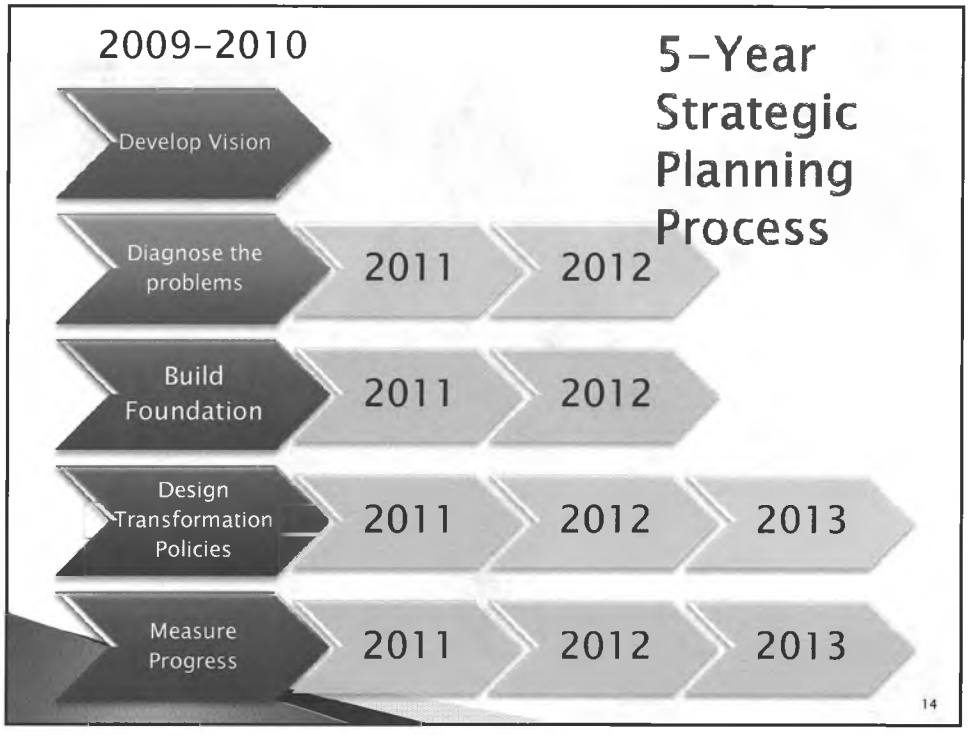
The Answer

- "The way to make health care less expensive is to make it better."

Don Berwick

So now how do we do that?

13



14

The Future

VISION

Goals

I. Improved Access

II. Affordable Costs

III. High Quality Care

IV. Increased Prevention

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

15

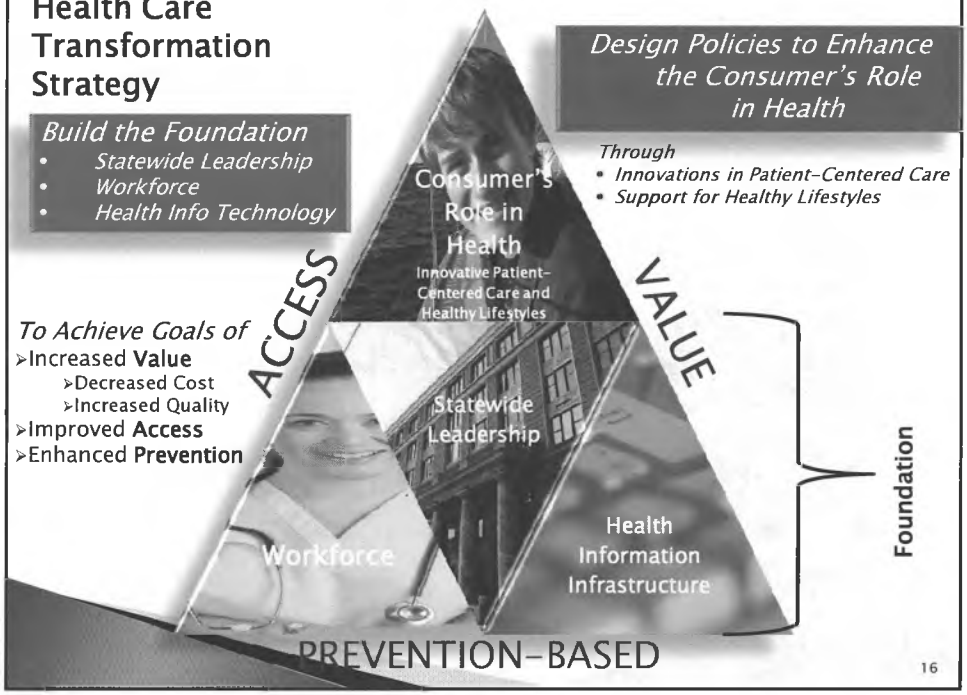
Health Care Transformation Strategy

Build the Foundation
- *Statewide Leadership*
- *Workforce*
- *Health Info Technology*

Design Policies to Enhance the Consumer's Role in Health

Through
- *Innovations in Patient-Centered Care*
- *Support for Healthy Lifestyles*

To Achieve Goals of
- Increased **Value**
  - Decreased Cost
  - Increased Quality
- Improved **Access**
- Enhanced **Prevention**



16

Diagnosing the Problem

- Description of Alaska's health care system (2009)
- Discussion of current challenges (2009)
  - Unsustainable costs
  - Inadequate insurance coverage
  - Logistical challenges
  - Fragmentation and duplication
  - Shortages and maldistribution in workforce
  - Health status, health risk behaviors and changing demographics
  - Use of health information technology
  - Urban Medicare access problem
- Overview of Affordable Care Act & Impact on Alaska (2010)

17

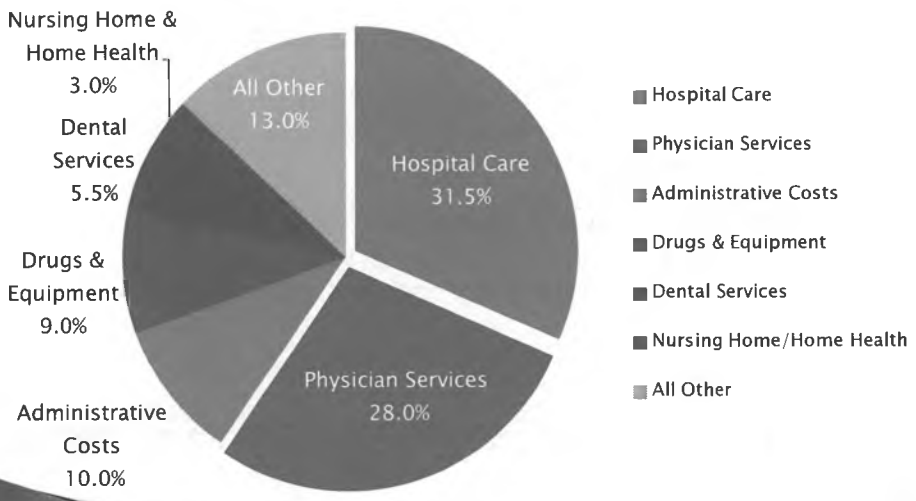
Diagnosing the Problem

- Understand health care cost drivers: Two complimentary analyses conducted in 2011

1. Economic Analysis: Health Care Spending and Cost Drivers in Alaska
   - ISER/MAFA
   - Update of 2005 and 1992 analyses
   - Big picture: Total spending – by who, for what
2. Actuarial Analysis: Health Care Prices and Cost Drivers in Alaska
   - Milliman, Inc.
   - Billed and allowed charges

18

What do Alaska's Health Care Dollars Buy?



19

Premiums

State	Health insurance PPO premiums					
	Single employee coverage		Family coverage		Per member	
	Monthly amount	Relative to comparison state average	Monthly amount	Relative to comparison state average	Monthly amount	Relative to comparison state average
Idaho	$486	91%	$1,358	98%	$451	95%
Washington	552	103%	1,413	102%	482	102%
Oregon	571	106%	1,406	101%	486	103%
Alaska	**684**	**128%**	**1,817**	**130%**	**613**	**130%**
Comparison State Average	$536	100%	$1,392	100%	$473	100%
Nationwide Average	$508		$1,390		$465	

- Premiums in Alaska are 30% higher per member than comparison state average

20

Cost Drivers: Utilization (Kaiser FF)

Relative to National Average, Alaska had (in 2009)

- 29% fewer hospital admissions
  - Alaska: 82/1,000 pop
  - U.S.: 116/1,000 pop
- 23% fewer inpatient bed days
  - Alaska: 485/1,000 pop
  - U.S.: 628/1,000 pop
- 2% more emergency room visits
  - Alaska: 425/1,000 pop
  - U.S.: 415/1,000 pop
- 21% more hospital outpatient visits
  - Alaska: 2,530/1,000 pop
  - U.S.: 2,091/1,000 pop

21

Utilization – Milliman's Conclusion

- "Alaska's utilization rates do not appear to be a major driver behind high premium rates."
- "Alaska's utilization is roughly in line with the comparison states, and significantly lower than the nationwide average."
- *Caveat from the Commission: This is the answer to one specific question (why are premiums higher in Alaska than other states), but is not meant to imply that reducing utilization and making it more effective and efficient is not an important strategy – it is actually an essential strategy.*

22

Alaska prices* are significantly higher than comparison states'

- Physician Services
  - 69% higher for commercial payers
  - 60% higher for all payers combined
  - Price differences between Alaska and the comparisons states vary significantly by specialty, e.g.,
    - Pediatrics: 43% higher for all payers; 39% higher for commercial
    - Cardiology: 83% higher for all payers; 101% higher for commercial
- Facility Services
  - 37% higher for commercial payers
  - 36% higher for Medicare
  - Price differences within Alaska vary significantly by payer, e.g., commercial reimbursement is 113% higher than Medicare

* "Price" means paid claims (i.e., allowed, not billed, charges), including patient co-pay

23

Sample comparisons: Mean commercial allowed charges non-facility-based professional svcs

Description/ Code	AK	ID	ND	OR	WA	WY
Office/outpatient visit (99214)	194.83	133.62	140.11	164.90	140.23	117.70
Obstetrical care (59400)	4704.80	2457.25	2500.69	3183.41	2601.20	3061.87
Tissue exam by pathgst (88305)	226.49	72.40	65.94	77.08	64.43	127.60
Ultrasound therapy (97035)	43.54	14.27	17.48	18.59	13.73	27.93
Routine venip-uncture (36415)	18.08	9.10	6.81	6.34	5.69	14.42
Insert intracoro-nary stent 92980	4486.68	1391.33	1524.52	1555.88	1331.22	2496.38

24

Sample comparisons: Mean commercial allowed charges non-facility-based professional svcs

Description/ Code	AK	ID	ND	OR	WA	WY
Total knee arthroplasty (27447)	7264.91	2566.63	2269.14	2461.07	2288.07	5406.51
Total hip arthroplasty (27130)	10557.38	2266.18	2175.36	2390.15	2263.44	3343.42
Frag. Kidney stone (50590)	4714.96	1227.63	1058.97	1344.22	1127.18	3548.51
Diagnostic colonoscopy 45378	1199.45	618.32	399.59	587.87	448.27	772.43
Lap cholecystectomy (47562)	4012.25	1433.64	1057.07	1253.79	1186.86	2588.80
Left heart cath (93510)	2203.48	389.01	416.15	453.32	389.54	605.25

25

Sample comparisons: within Alaska, by Payer

Description/ Code	Commercial	Medicare	TRICARE	VA	Medicaid	Work Comp
Office/outpatient visit (99214)	194.83	130.96	182.64	150.83	163.18	216.25
Obstetrical care (59400)	4704.80	2354.90	3181.81	4231.13	2821.81	5274.96
Tissue exam by pathgst (88305)	226.49	49.95	72.48	111.69	64.94	259.83
Ultrasound therapy (97035)	43.54	15.75	22.79	31.84	20.26	58.27
Routine venipuncture (36415)	18.08	3.00	3.00	11.76	3.00	29.03
Insert intracoronary stent 92980	4486.68	1110.09	1626.42	3639.24	1398.93	5295.65

26

Sample comparisons: within Alaska, by Payer

Description/ Code	Commercial	Medicare	TRICARE	VA	Medicaid	Work Comp
Total knee arthroplasty (27447)	7264.91	1934.46	2713.06	3832.63	2410.07	9278.23
Total hip arthroplasty (27130)	10557.38	1810.11	2537.88	3560.16	2254.09	12671.59
Frag. Kidney stone (50590)	4714.96	1087.25	1650.32	2000.26	1468.81	5015.77
Diagnostic colonoscopy 45378	1199.45	474.49	651.17	978.47	579.70	1494.59
Lap cholecystectomy (47562)	4012.25	924.42	1297.66	1663.71	1152.54	5566.71
Left heart cath (93510)	2203.48	n/a	471.79	603.85	n/a	5657.83

27

Cost (Price) Drivers – Operating Costs

- Medical salaries in Alaska are 2% to 10% higher than comparison states (does not include benefit costs, and excludes non-salaried physician income)
- Cost of living in Alaska is 15% to 20% higher
- Hospital operating costs are 38% higher in Alaska than the comparison states on average
  - But rural hospital operating costs in Alaska are 86% higher on average than the average of all hospitals in the comparison states

28

Cost (Price) Drivers – Provider Discounts

State	Provider Discounts			
	Inpatient Hospital	Outpatient Hospital	Professional	Overall
Alaska	**32%**	**35%**	**20%**	**28%**
Idaho	27%	20%	29%	25%
Oregon	36%	35%	32%	34%
Washington	46%	49%	35%	42%
Wyoming	19%	16%	26%	21%

29

Private Hospital Sector Average Operating Margins

Region/State	2008	2009	2010
Hawaii	-1.3%	-2.7%	3.4%
Idaho	5.8%	6.8%	6.1%
North Dakota	-0.6%	2.1%	4.0%
Oregon	2.9%	3.7%	6.1%
Washington	4.2%	4.9%	5.8%
Wyoming	6.5%	2.6%	9.4%
COMP STATE AVG.	**3.3%**	**3.9%**	**5.7%**
NATIONWIDE AVG.	**1.5%**	**3.8%**	**5.3%**
Urban Alaska (Anch/Fbx/Mat-Su)	11.5%	13.4%	16.2%
Rural Alaska (non-MSA)	5.4%	5.2%	6.1%
ALASKA	**9.8%**	**11.2%**	**13.4%**
AK relative to comp states	297.4%	289.0%	232.8%

30

Milliman's Cost (Price) Driver Conclusions

- Private Hospital Sector
  - Prices in Alaska are high relative to comparison states
    - Operating costs are driving higher prices in rural Alaska
      - Average of rural Alaskan hospitals' operating costs is 86% higher than average of all private comparison state hospitals
    - Operating margins are driving higher prices in urban Alaska
      - Average of private urban Alaskan hospitals' operating margins is 186% higher than the average of all private comparison state hospitals
- Physician Services (non-facility-based)
  - Prices for commercial payers are very high relative to comparison states
    - Low discounts indicative of high physician pricing power, likely due to relative scarcity particularly of specialists.
- Low Medicare rates create upward pressure on prices for other payers.

31

Solutions focused on Value and Health

32

5% of the U.S. population required 50% of health care spending in 2009*

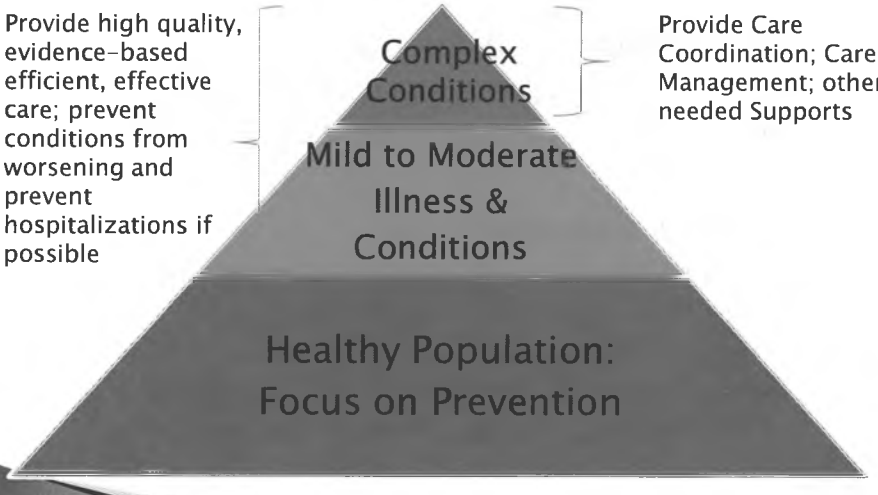
50% of the population required 3% of health care spending in that same year

* U.S. Agency for Healthcare Research & Quality/DHHS, January 2012

33

Focus on Health & Value

Provide high quality, evidence-based efficient, effective care; prevent conditions from worsening and prevent hospitalizations if possible



Provide Care Coordination; Care Management; other needed Supports

34

Ensure the best available evidence is used for making decisions

Solution #1

35

The need for application of high grade evidence

- Waste in the health care system due to misused medical resources is estimated to represent 30% of health care spending
- Just a few examples
  - Drugs pulled from the market due to dangerous side-effects: Vioxx, Avandia, Meridia
  - Therapies found to be harmful: Hormone therapy
  - Expensive invasive treatments no more effective than those less costly/invasive: arterial stents

36

Quality/Appropriateness of Care

- Evidence-based medicine aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of treatments (including lack of treatment).
- Isn't that what we've always done?
  - Not exactly
  - Requires understanding and interpretation of grades of evidence

Commission Recommendations

Foster the Use of Evidence-Based Medicine

- Encourage and support State health care programs to
  - engage in application of high grade evidence-based medicine (EBM) in benefit design and provider payment methods
- Require/Direct State health care programs to
  - Coordinate development and application of EBM policies
  - involve health care providers and consumers in decision-making related to application of EBM to public policy
  - Incorporate data on patient compliance in developing provider payment methods and benefit design
- Implement a web-based data system for public health information

Enhance quality and efficiency of care on the front end

Solution #2

39

Commission Recommendations

- Patient-Centered Primary Care
  - Recognize value through appropriate reimbursement
  - Promote patient-clinician relationship
  - Incorporate strategies proven to be successful
    - Vision focused on improving patient care
    - Phased approach to implementation
    - Tiered approach to managing patient populations
    - Local (practice-level) flexibility
    - Strong medical leadership and management
  - Include attributes of successful initiatives
    - Resources
    - Tools
    - Shared learning environment
    - Timely data
    - Infrastructure support
    - System of review
  - Support a State government led Patient-Centered Medical Home Initiative

40

Commission Recommendations

- Trauma System
  - Support all the components of a strong trauma system
  - Support continued implementation of 2008 ACS recommendations

41

Increase price and quality transparency

Solution #3

42

Commission Recommendations

- Preliminary Steps Toward Transparency
  - Encourage full participation in Hospital Discharge Database
  - Study feasibility of an All-Payers Claims Database

43

Statewide Hospital Discharge Database - Inpatient

Legislative mandate

*ND has a mandate-no collection since 2009

No collection

Voluntary collection

Alaska's Hospital Discharge Database

- Started in 2001
- Voluntary participation
- Utilization inconsistent due to:
  - Incomplete data
    - 11 of 27 hospital facilities (representing approximately 75% of discharges) participated in 2010
  - Unstable financial support
  - Lack of knowledge about potential uses and benefits

45

All-Payer Claims Databases (APCDs)

- Databases created by state mandate that include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers:
  - Insurance carriers (medical, dental, 3rd-party administrators, pharmacy benefit managers)
  - Public payers (Medicaid, Medicare)
- Augment (do not replace) hospital discharge, Medicaid, Medicare, registries, and other datasets

46

APCDs support transparency and answer questions to help improve health and health care

For Example:

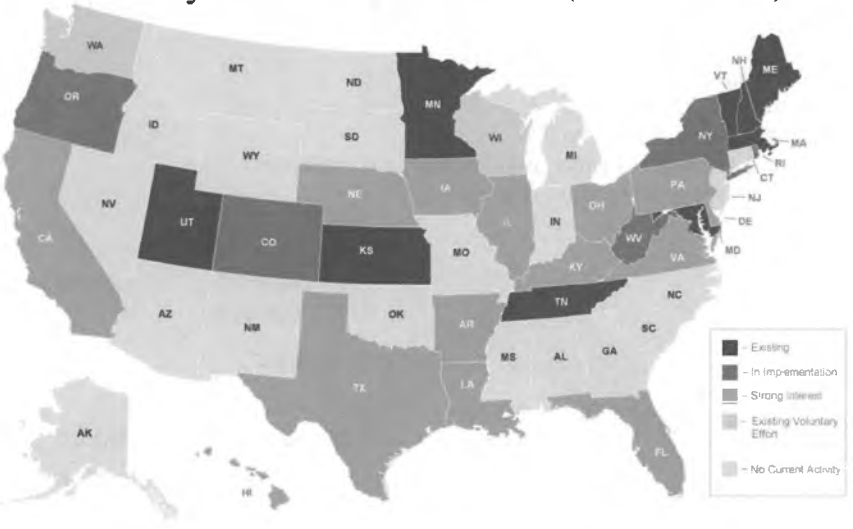
- What does a MRI cost by provider and by payer?
- In what communities is public health improving?
- If emergency room usage in Medicaid is higher than the commercial population, what are the drivers?
- How far do people travel for services? Which services?

All-Payer Claims Data Sources

Users of All-Payer Claims Data

- Consumers
- Employers
- Health Plans/Payers
- Health Care Providers
- Government (policy makers, Medicaid, public health, insurance department, etc.)
- Researchers (public policy, academic, etc.)

All-Payer Claims Databases (as of June 2011)



50

Pay for Value

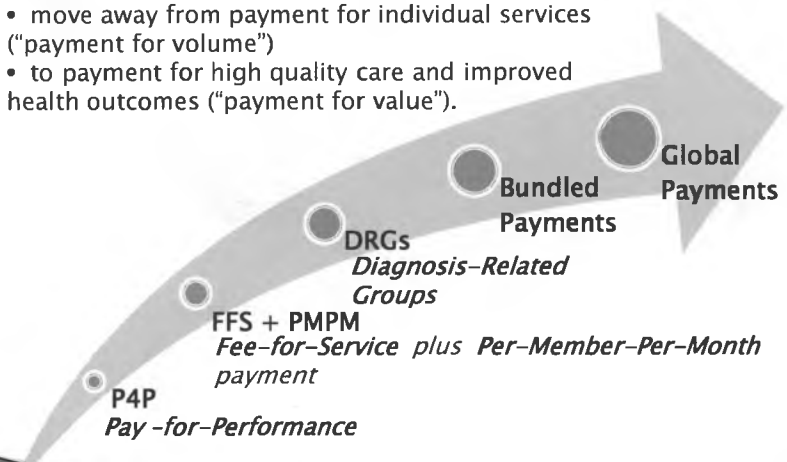
Solution #4

51

"Continuum" of Payment Reform

Restructuring how we pay for health care to:

- move away from payment for individual services ("payment for volume")
- to payment for high quality care and improved health outcomes ("payment for value").



52

Payment Reform System Requirements

Risk Management

Population Health Management

Organizational Alignment

Payment Policy Alignment

53

System Requirements for Supporting Payment Reform

- Capability to manage financial risk (both payers and providers)
  - Data and analytics for monitoring utilization and quality
  - Actuarial expertise for financial risk analyses
- Capability to manage health (patients, providers, payers)
  - Methods for targeting high risk patients
  - Capability to track, coordinate and follow-up on patient care
  - Patient education and self-management support
- Alignment of organizational structures (providers, facilitator?)
  - Trust relationships between physicians and hospitals
- Alignment of payment policies (payers)
  - Multi-payer approaches to avoid further fragmentation of payment systems

54

Alaska at the back of the pack?

- Alaska is one of only three states that reimburses Medicaid strictly on a FFS basis (along with NH & WY)
- Lowest HMO Penetration in the U.S. at 0.1% (July 2010)
- FFS + PMPM --- Preliminary plans :
  - Alaskan FQHC applicant(s) for Medicare Demo (but unsuccessful...)
  - Medicaid Task Force: Patient-Centered Medical Homes
    - AK DHSS Pilot Program expected to begin Jan 2013
- Payment Bundling for Diagnoses or Episodes of Care
  - Alaska VA RFP for in-state cancer care includes option for service and payment bundling

55

Commission Recommendations

- Utilize payment policies for improving value
- Take a phased approach - start with primary care
- Develop data collection and analysis capacity as a tool for quality improvement and payment reform
- Support efforts by State government officials collaborating on health care purchasing strategies
- Take a multi-payer approach to minimize burden on providers

56

Build the foundation of a strong health care system

Solution #5

57

Health Workforce

- 2009 Commission Recommendations
  - Make workforce development a priority and support coordinated planning
  - Strengthen the pipeline
  - Support workforce innovation and adaption as care models evolve
  - Increase the supply of primary care providers
    - Support educational loan repayment and financial incentives
    - Expand WWAMI
    - Support primary care residency development
- Currently tracking the impressive work of the Alaska Health Workforce Coalition

58

Health Information Infrastructure

- 2009 Commission Recommendations
  - Support HIT (electronic health records, health information exchange, and telemedicine) adoption and utilization
  - Ensure HIT is utilized for public health purposes
  - Ensure data available through the health information exchange is used to improve health care
  - Ensure privacy and security of health information
  - Facilitate broadband telecommunication service access
  - Improve reimbursement for telemedicine-delivered services

59

Focus on Prevention

Solution #6

60

Support healthy lifestyles: Obesity Prevention

- Findings
  - The most significant public health challenge facing Alaskans today
  - Related medical spending in Alaska estimated at $477 million
  - As many as 40% of Alaska's children are overweight or obese.
  - A child born today has a 34%–38% chance of developing diabetes in his or her lifetime
- **Recommendation**
  - Implement evidence-based programs.

61

Support healthy lifestyles: Immunizations

- Alaska ranked 49th in 2009 for rate of immunization completion for children aged 19–35 months
- **Recommendation**
  - Ensure adequate funding and support for program.

62

Support healthy lifestyles: Behavioral Health

- Almost one-quarter of all adult stays in U.S. community hospitals involve mental health or substance use disorders.
- Alaskans experience high rates of violence, with 47.6% of adult women reporting having experienced intimate partner violence in their families.
- Binge alcohol use in Alaska is among the highest in the nation.
- The 2009 age-adjusted suicide rate for all Alaskans was 20.2/100,000 - 140 lives lost.
- **Recommendations**
  - Integrate behavioral health and primary care services; support with new payment methodologies
  - Screen using evidence-based tools:
    - History of adverse childhood events
    - Substance abuse
    - Depression

63

Next Steps

64

Commission's 2012 Agenda

- Continue learning about current health care system challenges
  - Pharmaceutical Costs
  - Behavioral Health System
  - Impact of 2005 Malpractice Reform
  - Track Federal Health Care Reform
- Consider additional strategies for future recommendation
  - Reduce government regulations that hamper innovation and increase costs
  - Enhance the employer's role in health and health care
  - Improve patient choice in end-of-life care decisions
  - Use technology to facilitate access to care.

65

Update on Affordable Care Act

Included as Appendix C in the Commission's 2011 Annual Report

66

Thank You

For more information, visit the Commission's web site at:
http://hss.state.ak.us/healthcommission

For periodic updates, join the Commission's listserve by:

1. Visiting the Commission's home page, and
2. Clicking on: " Subscribe to our listserve"

67

Transforming Health Care in Alaska
2011 Annual Report Highlights

Alaska Faces Unique Health Care Challenges

The Commission's 2011 study of current health care challenges focused on understanding health care spending and cost drivers. Other challenges are described in prior year reports.

Health care cost increases in Alaska continue to outpace inflation.

- Health care spending in Alaska reached $7.5 billion in 2010, a 40% increase over 2005. State government's portion of this bill was close to $2 billion.
- At current trends health care spending is expected to double to more than $14 billion by 2020. By comparison the wellhead value of oil produced in Alaska in 2010 was $16.4 billion and is projected to be $18.6 billion in 2020.
- Since 1982 the Anchorage Consumer Price Index increased 95%, while prices for medical care in Anchorage over that time period increased 320%.

Health care is increasingly unaffordable for our employers, families.

- At $11,926 per employee, Alaska has the highest average annual cost for employee health benefits in the nation - twice what employers in the lowest cost state pay.
- Fewer Alaskan employers are offering employee health benefits, dropping from 35% to 30% of small employers between 2003 and 2010.
- The average cost of health care premiums in Alaska increased 51% for single coverage and 35% for family coverage between 2003 and 2010. The average annual commercial health insurance premium for family coverage in 2010 was $14,230.
- Despite the fact that Alaskans utilize roughly the same amount of care, health insurance premiums are about 30% higher here than in comparison states.

Health care prices paid in Alaska are much higher than in comparison states*.

- Different payers (Medicare, Medicaid, Workers' Compensation, commercial health insurers, TRICARE, and the Veterans Health Administration) pay different prices for the same service.
- The average reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers combined – 69% higher for commercial health insurers.
- The difference in reimbursement for physician services varies depending on specialty. For example, Alaskan pediatricians are paid 43% more, while cardiologists are paid 83% more.
- Commercial health insurance reimbursement for private sector hospital services is 37% higher than in comparison states; Medicare pays our private sector hospitals 36% more.
- Alaska's higher medical prices are due in part to higher operating costs for providers resulting from a higher cost of living, more costly employee benefits, transportation and shipping costs, fuel prices, and workforce shortages.
- Higher prices are also due to high physician pricing power compared to other states, and a high average operating profit margin for the private hospital sector.
- Low Medicare payment rates create upward pressure on prices for other payers.

Recommended Solutions – *built on the above and prior year findings*

Focus on value – increase the quality, effectiveness and efficiency of care for each dollar spent, from the patient's and consumer's perspective.

Ensure the best available evidence is used for making decisions. Support clinicians and patients to make clinical decisions based on high grade medical evidence regarding effectiveness and efficiency of testing and treatment options. Apply evidence-based principles in the design of health insurance plans and benefits.

Alaskan Solutions for Better Health and Health Care

The Alaska Health Care Commission was established by the Legislature in 2010 to advise the State on policies for improving health and health care for all Alaskans. Commission members are appointed by the Governor.

The Commission is implementing the following strategy for building a plan to transform Alaska's health care system.

TRANSFORMATION STRATEGY

I. Develop a vision of the ideal health care system

II. Study current health care challenges to inform policy recommendations

III. Build the foundation of a strong health care system
- Statewide leadership
- Health workforce
- Health information

IV. Design policies that enhance the consumer's role in health and health care through:
a) Innovations in patient-centered health care, and
b) Support for healthy lifestyles

V. Measure progress

* Washington, Oregon, Idaho, Wyoming, North Dakota, (and also Hawaii for hospital comparisons only).

Recommended Solutions *(continued)*

Enhance quality and efficiency of care on the front-end. Strengthen the role of primary care providers, and give patients and their clinicians better tools for making health care decisions. Improve coordination of care for patients with multiple providers, and care management for patients with chronic health conditions. Improve Alaska's trauma system.

Increase price and quality transparency. Provide Alaskans with information on how much their health care costs and how outcomes compare so they can become informed consumers and make informed choices. Provide clinicians, payers and policy makers with information needed to make informed health care decisions.

Pay for value. Design new payment structures that incentivize quality, efficiency and effectiveness. Support multi-payer payment reform initiatives to improve purchasing power for the consumer and minimize the burden on health care providers.

Build the foundation of a strong health care system. Ensure there is an appropriate supply and distribution of health care workers. Create the information infrastructure required for maintaining and sharing electronic health information and for conducting health care analytics to support improved clinical decisions, personal health choices, and public health.

Focus on prevention. Create the conditions that support Alaskans to exercise personal responsibility for living healthy lifestyles. High priorities include reducing obesity rates, increasing immunization rates, and improving behavioral health status.

The Commission's Vision for the Future, Goals and Guiding Values

VISION

Healthy Alaskans
*
High Value Health Care
*
Sustainable Health Care System
*
Satisfied Health Care Consumers and Providers
*

GOALS

I. Improved Access
II. Affordable Costs
III. Safe, High Quality Care
IV. Increased Prevention

GUIDING VALUES

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

Next Steps *– during 2012 the Commission will...*

Continue learning about current health care system challenges.

- **Pharmaceutical costs:** Compare prices for pharmaceuticals in Alaska across payer types to the comparison states and identify drivers of cost differentials.
- **Behavioral health:** Learn about the behavioral health care system in Alaska.
- **Malpractice reform:** Investigate the impact of the Alaska Medical Injury Compensation Reform Act of 2005 on medical professional liability insurance rates.
- **Federal health care reform:** Track implementation of the Affordable Care Act.

Consider additional strategies for future recommendations.

- **Reduce government regulations that hamper innovation and increase costs.** Identify state laws and regulations that create legal barriers to delivery and finance of the highest quality most affordable health care. Study alternative approaches to facilitate provider innovation while ensuring appropriate consumer and patient protections.
- **Enhance the employer's role in health and health care.** Identify the roles Alaska's employers can play in supporting the health of their employees and in their employees' access to health care. Study innovative approaches employers across the country are using to promote employee safety and health and to design health plans that improve care and contain costs.
- **Improve patient choice in end-of-life health care decisions.** Learn how improving quality of services and patient choice in health care decisions at the end of life can improve the patient's experience and contain costs.
- **Use technology to facilitate access to care.** Identify impediments to the use of telecommunications technology for improving access to health care, including barriers created by reimbursement, liability, licensure, and availability of tools. Design strategies to overcome barriers.

Please see the Commission's 2011 Annual Report for detailed findings and recommendations. For a copy of the 2011 and prior year reports and accompanying studies and reference materials, visit the web site at http://hss.state.ak.us/healthcommission.

Transforming Health Care in Alaska

2011

2011 Annual Report of the Alaska Health Care Commission

2010 – 2014
Strategic Plan
Update

Transforming Health Care in Alaska

2011 Report/2010-2014 Strategic Plan Update

Alaska Health Care Commission

Ward Hurlburt, MD, MPH, Chair
Patrick Branco
C. Keith Campbell
Valerie Davidson
Jeffrey Davis
Emily Ennis
Paul Friedrichs, MD
Allen Hippler
T. Noah Laufer, MD
David Morgan
Lawrence Stinson, MD
Ex Officio Members:
Linda Hall
Senator Donny Olson, MD
Representative Wes Keller

Deborah Erickson, Executive Director

Sean Parnell
Governor
State of Alaska

William J. Streur
Commissioner
Department of Health & Social Services

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA HEALTH CARE COMMISSION

SEAN PARNELL, GOVERNOR

3601 C Street, Suite 902
Anchorage, Alaska 99503
PHONE: (907) 269-7800

January 15, 2012

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present the 2011 Annual Report of the Alaska Health Care Commission in accordance with AS 18.09.070. During this past year the Commission continued to identify solutions for improving health and health care while working to better understand current challenges. This report includes findings from new studies regarding the cost of health care in Alaska, and policy recommendations intended to guide state government down a path that supports transformation of our health care system so that it better meets the needs of patients, providers, and employers.

Alaska's health care delivery system is headed towards a financial cliff. If medical costs continue to grow at current trends the results will be catastrophic. At risk is financial access to care for individual Alaskans, affordability of health benefits for employers, sustainability of public programs that pay for health care and support vulnerable Alaskans, and the long term economic viability of our health care providers. The Commission's recommended approach to containing cost growth is to improve care, not cut it, by focusing on value – increasing the quality of care for each dollar spent – and also by increasing efforts to prevent avoidable health problems.

The Commission's 2011 recommendations include strategies for enhancing care at the front end by strengthening the role of primary care and arming clinicians with tools for coordinating care and managing chronic disease. They call for increased price and quality transparency to better inform consumers and clinicians. Also suggested is an approach to design of new payment structures that incentivize quality and positive health outcomes. A continued focus on prevention emphasizes the need to control obesity, increase immunization rates, and improve behavioral health status. These recommendations build on those presented in 2010 regarding the importance of evidence-based medicine in improving quality and controlling costs.

Thank you for this opportunity to present solutions for transforming Alaska's health care system so that it is sustainable and provides value, meets the needs of patients and providers, and focuses on health.

Sincerely,

Ward B. Hurlburt, MD, MPH
Chair, Alaska Health Care Commission
Chief Medical Officer & Public Health Director
Department of Health & Social Services

Deborah Erickson
Executive Director
Alaska Health Care Commission

Table of Contents

Acknowledgements i

Executive Summary iii

Part I: Introduction 1

A. Purpose of this Report 1

B. Background on the Commission 2

C. Summary of 2011 Activities 3

D. 2010–2014 Strategic Plan Framework 4

E. Vision for Transformation of Alaska's Health Care System 5

F. Core Transformation Strategy 7

G. Definitions of Health & Health Care 8

Part II: Understanding Alaska's Health Care System Challenges 10

A. Summary of Prior Year Findings 10

B. 2011 Study: Cost of Health Care in Alaska 10

C. 2011 Study: Long Term Care in Alaska 15

D. Issues Prioritized for Study in 2012 16

Part III: Alaska Health Care System Transformation Strategies 17

A. Health Care System Foundation 17

B. 2011 Commission Recommendations 19

1. Patient-Centric Primary Care 19
2. Price & Quality Transparency 23
3. Payment Reform – Paying for Value, Rather than Volume 24
4. Alaska's Trauma System 26
5. Obesity in Alaska 28
6. Immunization against Vaccine-Preventable Disease 29
7. Population-Based Prevention & Behavioral Health 31

C. Strategies under Consideration for Study in 2012 32

APPENDICES *Available on the Commission's Web Site* at: *http://hss.state.ak.us/healthcommission/*

Appendix A: "Alaska's Health-Care Bill: $7.5 Billion and Climbing," Institute for Social & Economic Research with Mark A. Foster & Associates (under AHCC contract), August 2011

Appendix B: Hospital and Physician Services Payment Studies by Milliman, Inc., November 2011.

Appendix C: Overview & Update of Federal Health Reform in Alaska, PowerPoint Presentation, December 2011

Appendix D: Voting Records and Summary of Public Comments

Acknowledgements

The Commission benefited from the knowledge and experience of numerous experts from across the country as well as within Alaska who made presentations and participated on panels to help educate us on the various issues and potential solutions we studied this year. The Commission would like to acknowledge the gracious contributions of the following individuals and thank them for sharing their time and expertise.

Health Care Costs and Sustainability

- Becky Hultberg, Commissioner, Alaska Department of Administration
- William Streur, Commissioner, Alaska Department of Health & Social Services (DHSS)
- Mark Foster, MAFA and Associates
- Scott Goldsmith, Institute for Social & Economic Research
- Edward Jhu, Milliman, Inc.
- John Pickering, Milliman, Inc.

Patient-Centric Primary Care

- Harold Johnston, MD, Director, Alaska Family Medicine Residency Program
- Doug Eby, MD, MPH, Vice President of Medical Services, Southcentral Foundation
- James Shill, CEO, Tanana Valley Clinic
- Kevin Munson, CEO, Mat-Su Health Services, Inc.
- Robert Onders, MD, Kodiak Area Native Association
- T. Noah Laufer, MD, Medical Park Family Care
- Marilyn Kasmar, Executive Director, Alaska Primary Care Association
- Kim Poppe-Smart, Deputy Commissioner & State Medicaid Director, Alaska DHSS
- L. Allen Dobson, Jr., MD, President, Cabarrus Family Medicine, N. Carolina
- Margaret Mason, Manager, Clinical Programs Development, Blue Cross Blue Shield of Michigan
- Jean Malouin, MD, MPH, Associate Chair, Clinical Programs in Family Medicine, University of Michigan
- David Ford, President & CEO, CareOregon
- David Labby, MD, PhD, Medical Director, CareOregon

Payment Reform

- Harold Miller, Executive Director, Center for Healthcare Quality & Payment Reform; President & CEO, Network for Regional Healthcare Improvement; National Quality Forum; Carnegie Mellon University.
- Bruce Lamoureux, Senior Vice President/CEO, Providence Health & Services Alaska; Board Chair, Alaska State Hospital & Nursing Home Association
- Ryan Smith, CEO, Central Peninsula General Hospital
- Michael Banks, Acting CFO, Alaska Native Tribal Health Consortium
- Jeff Davis, President, Premera Blue Cross Blue Shield of Alaska
- T. Noah Laufer, MD, Medical Park Family Care

Alaska's Top Population Health Challenges

- Ward Hurlburt, MD, MPH, DHSS Chief Medical Officer and Public Health Director
- Melissa Stone, Director, DHSS Division of Behavioral Health

Trauma System

- Frank Sacco, MD, Alaska Trauma System Review Committee
- Dan Johnson, Director, Interior Region EMS Council
- Julie Rabeau, Alaska Trauma Program Manager, Division of Public Health, Alaska DHSS

Long Term Care

- Duane Mayes, DHSS Senior & Disabilities Services Director
- Millie Duncan, Administrator, Wildflower Court
- Dave Cote, Director, Division of Pioneer Homes, DHSS
- Denise Daniello, Executive Director, Alaska Commission on Aging
- Kay Branch, Elder/Rural Health Program Coordinator, Alaska Native Tribal Health Consortium
- Nancy Burke, Program Officer, Alaska Mental Health Trust Authority
- Sandra Heffern, Chair, Community Care Coalition
- Thea Agnew Bemben, Principal & Founding Partner, Agnew::Beck Consulting

Health Information Infrastructure

- Paul Cartland, State Health Information Technology Coordinator, DHSS
- Andrea Fenaughty, PhD, Deputy Chief, Section of Chronic Disease Prevention & Health Promotion, Division of Public Health, DHSS
- Joe McLaughlin, MD, State Epidemiologist & Chief of the Section of Epidemiology, Division of Public Health, DHSS.
- Jeannie Monk, Small & Rural Hospital Program Officer, Alaska State Hospital & Nursing Home Association.
- Denise Love, Executive Director, National Association of Health Data Organizations

Health Workforce Development

- Jan Harris, Vice Provost for Health Programs, University of Alaska
- Karen Perdue, President/CEO, Alaska State Hospital & Nursing Home Association
- Delisa Culpepper, Chief Operating Officer, Alaska Mental Health Trust Authority

Affordable Care Act

- William Streur, Commissioner, DHSS
- Linda Hall, Director, Division of Insurance, Alaska Department of Commerce, Community & Economic Development

Also, to the many Alaskans who took the time to testify before the Commission during public hearings, comment on the Commission's draft findings and recommendations, and attend Commission meetings, the Commission is grateful for your interest in improving the health of Alaskans and Alaska's health care system.

Executive Summary

Introduction

The Alaska Health Care Commission was established by the Legislature in 2010 to advise the state on policies for improving health and health care for all Alaskans. Members are appointed by the Governor, and represent stakeholder groups specified in statute. The Commission originally convened during 2009 under Governor's Administrative Order #246.

The Commission's approach to improving Alaska's health care system began with identification of a vision of the ideal health care system for Alaska, plus goals and guiding values for the planning process. We are now in an ongoing cycle of learning about current challenges to better understand why the system is not attaining the vision, designing policies that will transform the system into one that embodies the vision, and evaluating progress. Information, findings and recommendations presented in each annual report build on prior year reports, which should be referenced together for a full picture of the Commission's learning and recommendations to date.

The ideal health care system envisioned for Alaska places individuals and their family at the center of their care experience and focuses on creating health, not simply treating illness and injury. The best system will also provide value for Alaskans' health care dollar – delivering safe high quality care as efficiently as possible at an affordable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And the final but essential element of this picture is that Alaska's health care system will be sustainable over time.

The Commission's core strategy for attaining the goals of improved access, affordable costs, high quality care, and increased prevention, is to strengthen the consumer's role in health and health care through innovations in patient-centered care and through support for healthy lifestyles. This core strategy rests on the foundation of a sound health care system - a sustainable workforce, a complete health information infrastructure, and statewide leadership. Values the Commission adopted to guide recommendations emphasize the importance of sustainability, the need to increase efficiency and effectiveness of care, and the significance of individual choice and personal engagement.

Understanding Alaska's Health Care Challenges

To better understand why Alaska's health care system is not achieving the vision, the Commission began in 2009 by describing how health care in Alaska is delivered and funded today (see Appendix A of the 2009 report). Challenges described in the 2009 report identified the extent to which:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers experience logistical challenges in the delivery of care, and patients face similar challenges in accessing services;
- Fragmentation and duplication in Alaska's health care system create inefficiencies;
- Alaska suffers from shortages and maldistribution of certain health care workers;
- Health status, health risk behaviors and changing demographics influence utilization of health care services;
- Use of modern health information technology is taking hold in Alaska; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care.

In 2010 the Commission added to learning about Alaska's health care system challenges by compiling information on the newly passed federal health care reform law - reviewing and providing summaries of the law's provisions, and contracting with the Institute for Social & Economic Research for an analysis of the potential impact of the law in Alaska.

In 2011 the Commission focused on studying health care spending trends, pricing and cost drivers. The Commission also learned about Alaska's long term care system and the status of statewide planning to meet long term care needs, Alaska's trauma system and implementation of a plan to improve it, and the status of the Affordable Care Act. Highlights from this year's cost and pricing studies include:

- **Health care cost increases in Alaska continue to outpace inflation.**
  - Health care spending in Alaska reached $7.5 billion in 2010, a 40% increase over 2005. State government's portion of this bill was close to $2 billion.
  - At current trends health care spending is expected to double to more than $14 billion by 2020. By comparison the wellhead value of oil produced in Alaska in 2010 was $16.4 billion and is projected to be $18.6 billion in 2020.
  - Since 1982 the Anchorage Consumer Price Index increased 95%, while prices for medical care in Anchorage over that time period increased 320%.

- **Health care is increasingly unaffordable for our employers, families.**
  - At $11,926 per employee, Alaska has the highest average annual cost for employee health benefits in the nation - twice what employers in the lowest cost state pay.
  - Fewer Alaskan employers are offering employee health benefits, dropping from 35% to 30% of small employers between 2003 and 2010.
  - The average cost of health care premiums in Alaska increased 51% for single coverage and 35% for family coverage between 2003 and 2010. The average annual commercial health insurance premium for family coverage in 2010 was $14,230.
  - Despite the fact that Alaskans utilize roughly the same amount of care, health insurance premiums are about 30% higher here than in comparison states.

- **Health care prices paid in Alaska are much higher than in comparison states** (Washington, Oregon, Idaho, Wyoming, North Dakota, (and also Hawaii for hospital comparisons only)).
  - Different payers (Medicare, Medicaid, Workers' Compensation, commercial health insurers, TRICARE, and the Veterans Health Administration) pay different prices for the same service.
  - The average reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers – 69% higher for commercial health insurers.
  - The difference in reimbursement for physician services varies depending on specialty, for example Alaskan pediatricians are paid 43% more, while cardiologists are paid 83% more.
  - Commercial health insurance reimbursement for private sector hospital services is 37% higher than in comparison states; Medicare pays our private sector hospitals 36% more.
  - Alaska's higher medical prices are due in part to higher operating costs for providers resulting from a higher cost of living, more costly employee benefits, transportation and shipping costs, fuel prices, and workforce shortages.
  - Higher prices are also due to high physician pricing power compared to other states, and a high average operating profit margin for the private hospital sector.
  - Low Medicare payment rates create upward pressure on prices for other payers.

During 2012 the Commission plans to learn about pricing for pharmaceuticals, the behavioral health care system, and the impact of Alaska's malpractice reform law passed in 2005.

Alaska Health Care System Transformation Strategies

During 2009 the Commission developed general recommendations regarding the importance of patient-centric primary care and support for healthy lifestyles, and more detailed recommendations for promoting the use of health information technology, providing statewide health leadership, strengthening the health workforce, and improving access to primary care for Medicare enrollees. During 2010 the Commission added to these strategies with recommendations for employing evidence-based medicine to improve the quality of health care and contain cost growth.

This year the Commission identified findings and developed recommendations regarding:

- Patient-Centric Primary Care: Compiling lessons learned from a variety of patient-centered medical home programs from other states that are demonstrating success at improving patient care and outcomes and controlling costs, the Commission recommends the State of Alaska support a patient-centered medical home program and include the attributes they identified as common to successful programs.
- Price & Quality Transparency: Identifying the importance of price and quality transparency for empowering consumers and providers with information required for improving value in the health care system, the Commission provides recommended first steps toward improving and developing needed data systems to support this strategy.
- Payment Reform: Finding that changes in the way we pay for health care can improve quality and decrease costs without imposing price controls or rationing care, the Commission recommends the State of Alaska align state programs that purchase health care and utilize payment policies for improving value.
- Alaska's Trauma System: The Commission recommends the State of Alaska support a strong trauma system, defining the necessary elements for the system and emphasizing the need to continue implementation of a 2008 improvement plan.
- Population-based Prevention Priorities: The Commission identifies obesity, low immunization rates, and significant behavioral health challenges as the top health concerns in Alaska's population, and recommends the State of Alaska support efforts to address these problems.

Following is a general summary of the Commission's recommended solutions for improving health and health care in Alaska to-date:

Ensure the best available evidence is used for decision-making. Support clinicians and patients to make clinical decisions based on high grade medical evidence regarding effectiveness and efficiency of testing and treatment options. Apply evidence-based principles in the design of health insurance plans.

Enhance the quality and efficiency of care on the front-end. Strengthen the role of primary care providers, and give patients and their clinicians better tools for making health care decisions. Improve coordination of care for patients with multiple providers, and care management for patients with chronic health conditions. Improve Alaska's trauma system.

Increase price and quality transparency. Provide Alaskans with information on how much their health care costs and how outcomes compare so they can become informed consumers and make informed choices. Provide clinicians, payers and policy makers with information needed to make informed health care decisions.

Pay for value. Design new payment structures that incentivize quality, efficiency and effectiveness. Support multi-payer payment reform initiatives to improve purchasing power for the consumer and minimize the burden on health care providers.

Build the foundation of a strong health care system. Ensure there is an appropriate and sustainable supply and distribution of health care workers. Create the information infrastructure required for maintaining and sharing electronic health information and for conducting health care analytics to support improved clinical decisions, personal health choices, and public health.

Focus on prevention. Create the conditions that support Alaskans to exercise personal responsibility for living healthy lifestyles. High priorities include reducing obesity rates, increasing immunization rates, and improving behavioral health status.

Additional strategies the Commission will study and consider for future recommendations during 2012 include:

- Reduction in government regulations that hamper innovation and increase costs.
- Enhancement of the employer's role in improving quality and controlling cost of health care through the design of employee health benefits, and in improving the health of their employees through worksite wellness programs.
- Improvement of patient choice in end-of-life health care decision making.
- The use of technology and telecommunications to facilitate access to health care services.

Part I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the 2011 findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Alaska Statute 18.09.070. This report builds on the work of the original Alaska Health Care Commission (created by Governor Palin under Administrative Order #246) which in their 2009 Report presented a 5-year strategic planning framework as a "roadmap" for strengthening Alaska's health care delivery system. The 2009 report was described as a "living" plan meant to evolve each year as problems regarding health care quality, cost and access are studied, potential solutions are analyzed, and implemented strategies are evaluated. This latest report documents the continuation of that process.

Findings and recommendations by the Commission included in past reports are still current, but are not repeated in this report. Please see the Commission's 2009 Annual Report for the:

- Overview of current challenges in Alaska's health care system
- Findings & Recommendations on:
    - Patient-Centric Primary Care
    - Healthy Lifestyles
    - Statewide Leadership
    - Workforce
    - Health Information Technology
    - Medicare Access
- Detailed description of Alaska's health care system (separate report included as Appendix A)

Please see the Commission's 2010 Annual Report for the:

- Findings & Recommendations on Evidence-based Medicine
- Affordable Care Act Overview and Projected Impact in Alaska

Included in this Annual Report for 2011, are:

- Part I: An introduction including background on the Commission; a summary of the Commission's 2011 activities; a description of the Commission's strategic planning framework; the Commission's vision, goals, guiding values, and core strategy; and key definitions.
- Part II: Information on certain aspects of the current health care system, particularly challenges related to the rising cost of health care, and an overview of the long term care system in Alaska. 2012 plans for continued study of health care system challenges are also included.
- Part III: The Commission's 2011 recommendations for transformation of Alaska's health care system, and strategies that will be considered in 2012;
- Appendices: Copies of studies conducted for the Commission this year on health care spending and cost trends (by the Institute for Social & Economic Research), and on payment levels and cost drivers for hospital and physician services (by Milliman, Inc.); an overview and update on the implementation of the Affordable Care Act in Alaska (in chart pack format); and additional information by and about the Commission.

B. Background on the Commission

The Alaska Health Care Commission was first established by Governor Palin on December 4, 2008 under Administrative Order #246. Original Commission members were appointed on January 27, 2009 and the Commission met throughout 2009, producing a report on their findings and recommendations in January 2010. The Commission created under A.O. #246 terminated with the production of that report.

The current Alaska Health Care Commission was established in state statute (AS 18.09.010) during 2010 with the passage of Senate Bill (SB) 172 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. SB 172 was passed by the Alaska Legislature on April 17, 2010 and signed into law by Governor Parnell on June 21, 2010. Members were appointed in September and the new body convened for the first time in October, 2010.

Duties of the Commission prescribed by AS 18.09.070:

I. Serve as the state health planning and coordinating body;
II. Provide recommendations for and foster the development of a:
    1. Comprehensive statewide health care policy;
    2. Strategy for improving the health of Alaskans that
        i. Encourages personal responsibility for disease prevention, healthy living and acquisition of health insurance;
        ii. Reduces health care costs;
        iii. Eliminates known health risks, including unsafe water and wastewater systems;
        iv. Develops a sustainable health care workforce;
        v. Improves access to quality health care; and,
        vi. Increases the number of insurance options for health care services.
III. Submit a report to the Governor and the Legislature by January 15 of each year regarding the Commission's recommendations and activities.

Commission members are appointed by the Governor, with the exception of the two legislative representatives who are appointed by their respective bodies. Short biographies for each of the Commission members are provided on the Commission's web site. The members of the Commission are:

- **Ward Hurlburt, MD, MPH:** Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.
- **Patrick Branco:** Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of Ketchikan General Hospital; Ketchikan.
- **Keith Campbell:** Representing consumers; retired hospital administrator and former AARP Chair; Seward.
- **Valerie Davidson:** Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.
- **Jeffrey Davis:** Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.
- **Emily Ennis:** Representing the Alaska Mental Health Trust Authority; Executive Director of Fairbanks Resource Agency; Fairbanks.
- **Col. Paul Friedrichs, MD:** Representing the U.S. Department of Veterans Affairs health care system; Commander of the Air Force/Veterans' Affairs Joint Venture Hospital at Elmendorf; Anchorage.

- **T. Noah Laufer, MD:** Representing primary care physicians; family medicine physician and president of Medical Park Family Care; Anchorage.
- **David Morgan:** Representing community health centers; Reimbursement Director for the Southcentral Foundation; Anchorage.
- **Allen Hippier:** Representing the Alaska State Chamber of Commerce; Chief Financial Officer for Faulkner Walsh Constructors; Anchorage.
- **Lawrence Stinson, MD:** Representing Alaska health care providers; anesthesiologist and co-owner of Advanced Pain Centers of Alaska; Anchorage.

Ex-Officio (non-voting members)

- **Linda Hall:** Representing the Governor's Office; Director, Division of Insurance; Anchorage.
- **Representative Wes Keller:** Representing the Alaska House of Representatives; Wasilla.
- **Senator Donny Olson:** Representing the Alaska Senate; Golovin.

C. Summary of 2011 Activities

Meetings and public hearings: During 2011 the Commission held six face-to-face meetings, all but one in Anchorage: January 7 (the last meeting of the 2010 Commission to incorporate changes based on public comment, finalize and approve the 2010 report); March 31-April 1 (Juneau); June 23-24; August 25-26; October 11-12; and December 9. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend but interested in listening or providing testimony. The general format of each of the four quarterly two-day meetings included presentations by experts on the various topics studied, followed by a panel of Alaskan providers offering their perspective. Public hearings were also held during each of the four quarterly meetings. The Commission's voting record from these meetings and a summary of public comments received are included in Appendix D.

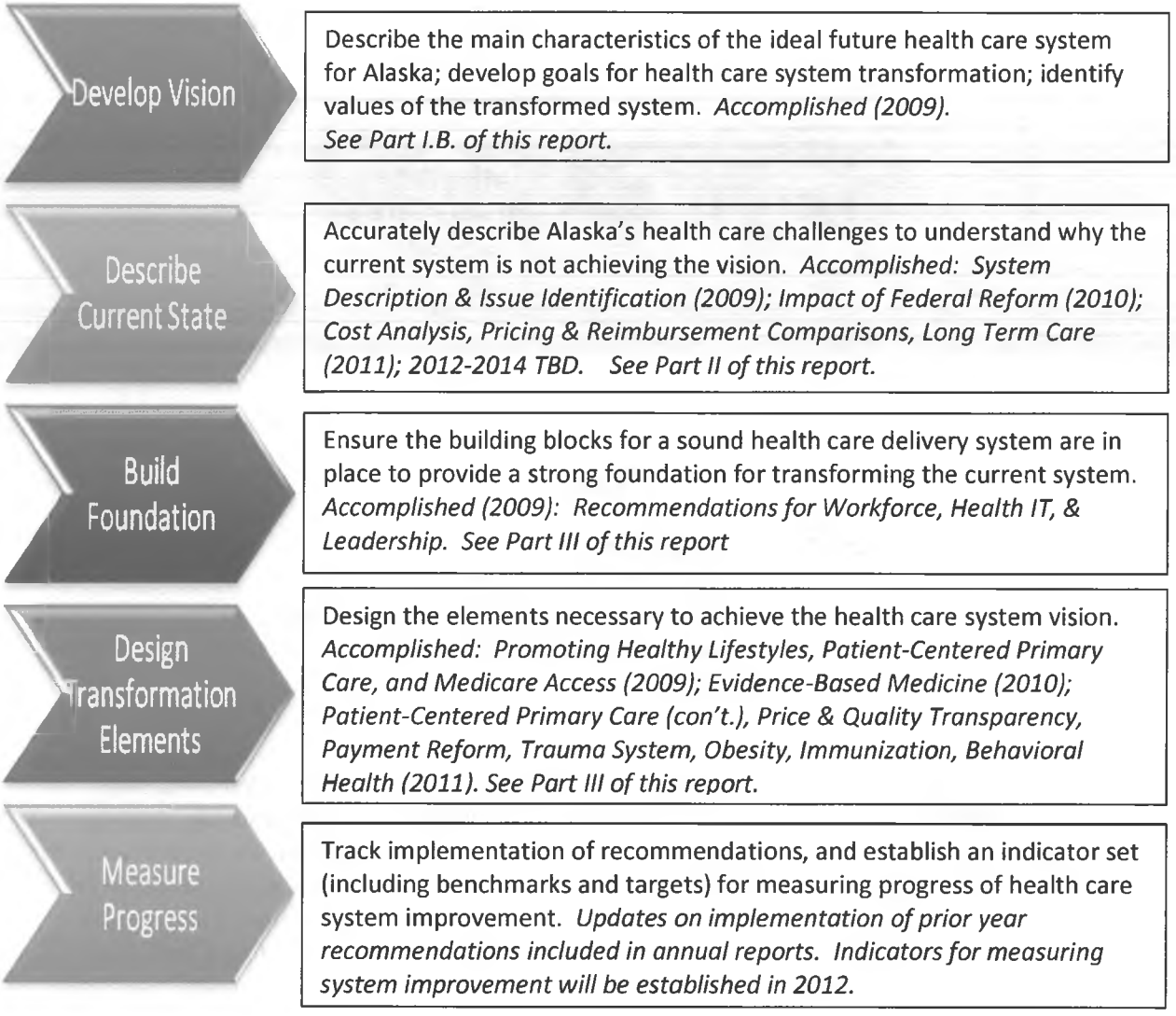
Administration: The Commission developed with guidance from the State's ethics attorney a Financial Disclosure form as required under AS 18.09.060. A copy of the Commission's meeting rules, by-laws, SFY 2012 budget, and ethics handbook are available on the Commission's website (see website address below). Copies of Commission members' 2011 Financial Disclosure forms are available from the Commission office on request.

Communication and coordination: The Commission updated and maintained a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (http://hss.state.ak.us/healthcommission/). The listserv established to maintain communication with system stakeholders and members of the public interested in receiving periodic updates was also enhanced, and by the end of 2011 there were over 600 subscribers. The Commission also maintained an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (also available on the website).

2011 Products: The Commission's primary product for this year is this annual report. In addition, the Commission contracted with consultants to conduct two studies during 2011. The Institute for Social & Economic Research and Mark Foster and Associates conducted an economic analysis of health care spending in Alaska for the Commission; and Milliman, Inc, an international health care actuarial firm, compared payment levels for hospital and physician services in Alaska to a number of other states. The Commission also held a three-part webinar series on successful patient-centered medical home programs in other states, and also a webinar on payment reform. The four reports resulting from the two consultant studies and recordings of the webinars are available on the Commission's website.

D. 2010–2014 Strategic Plan Framework

The following graphic depicts the framework the commission is using to guide the process for improvement of Alaska's health care system, and includes updates on the status of each step in the process.



E. Vision for Transformation of Alaska's Health Care System

Vision

Alaska's Health Care System:

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at an affordable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system is one that is sustainable over time.

Health Care Goals

I. Improved Access
II. Contained Cost
III. Safe, High Quality Care
IV. Prevention-Based

The Commission is crafting strategies focused on attainment of the following four goals for a transformed health care system:

I. **Access:** Improve access to affordable health care coverage and to a viable and vital health care delivery system.

II. **Cost:** Control the cost of health care so that the medical inflation rate in Alaska is below the national rate.

III. **Quality:** Health care services provided in Alaska meet the highest quality and safety standards.

IV. **Prevention:** Focus on preventive services, both clinical preventive services for individuals and community-based prevention policies, to support improved health status and control costs by reducing the burden of preventable disease and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission applies the following values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.

Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.

Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.

Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.

Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care. Individual investment is a vital part of a robust health care system.

F. Core Transformation Strategy

The figure below depicts in graphic form the core strategies identified by the Commission for transforming Alaska's health care system to achieve their vision, and the relationship of those strategies to one another and to the planning process.

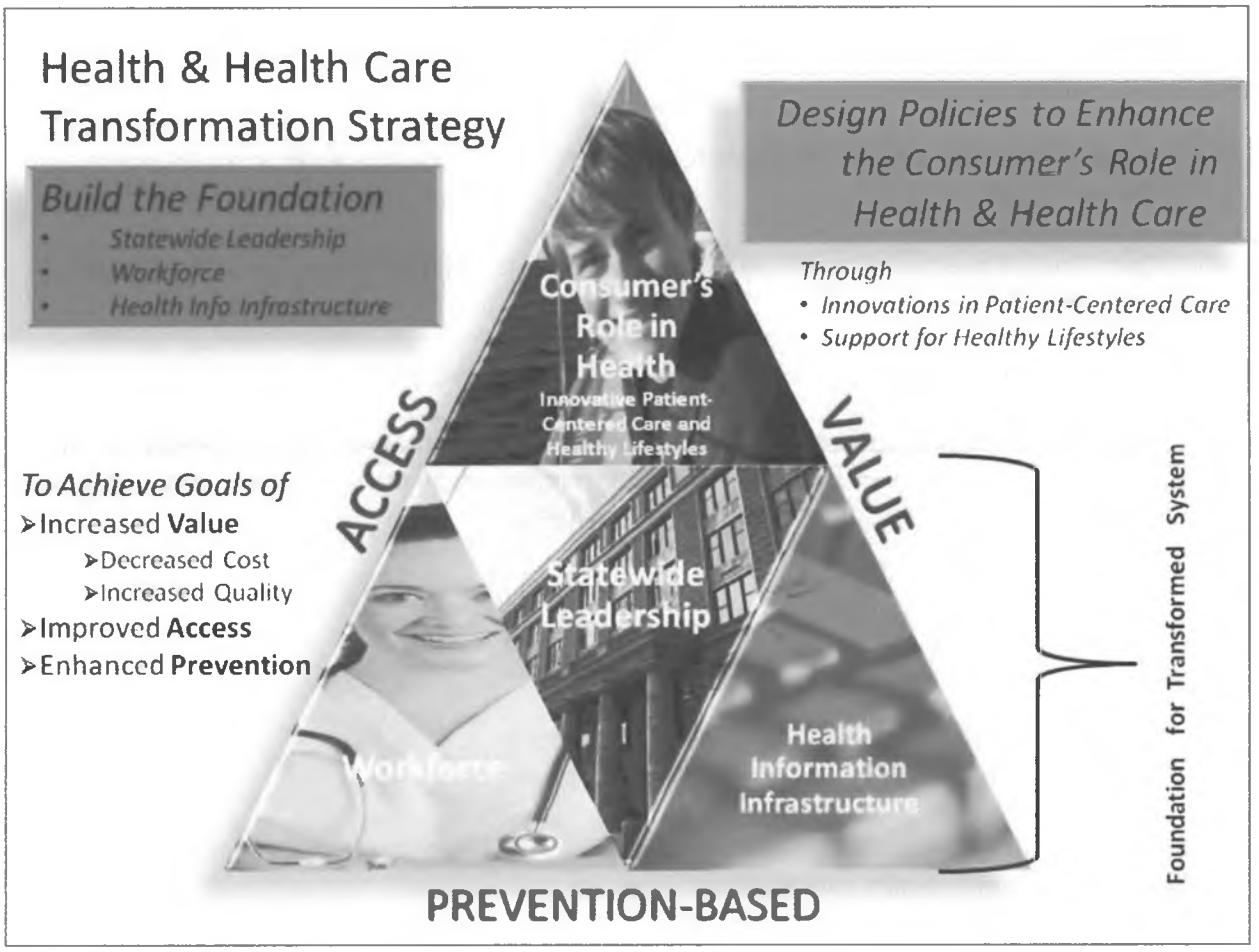


Figure 1: Alaska Health Care Commission's Core Strategy for Health Care System Transformation

Understanding and supporting the consumer's role in health care is the central focus of Commission's strategic approach to transformation of Alaska's health care system. Two aspects of the consumer's role are critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and an innovative patient-centered system depend. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. Ongoing study, planning, and policy development is necessary to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

G. Definitions of Health & Health Care

The commission adopted the following definitions as a tool for providing a common understanding for group discussion and for guiding planning efforts. These definitions are not meant to imply certain roles for government or health care providers.

Health & Healing

- Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health.

Physical	Fitness. Nutrition. Medical self-care. Control of substance abuse.
Emotional	Care for emotional crisis. Stress Management
Social	Communities. Families. Friends
Intellectual	Educational. Achievement. Career development
Spiritual	Love. Hope. Charity.

- An individual's health status is largely self-defined, encompassing a broader state of well-being beyond physical health and lack of disease or infirmity.

- Healing is restoration of wholeness and unity of body, mind and spirit. It involves curing when possible, but embraces more than cure. When illness is limited to disease and health care is limited to cure, the deeper dimensions of healing are missed.

Health Care

- Health Care means any care, treatment, service, or procedure to prevent disease, injury and other physical and mental impairment; and to maintain, diagnose, or otherwise affect an individual's physical or mental condition.

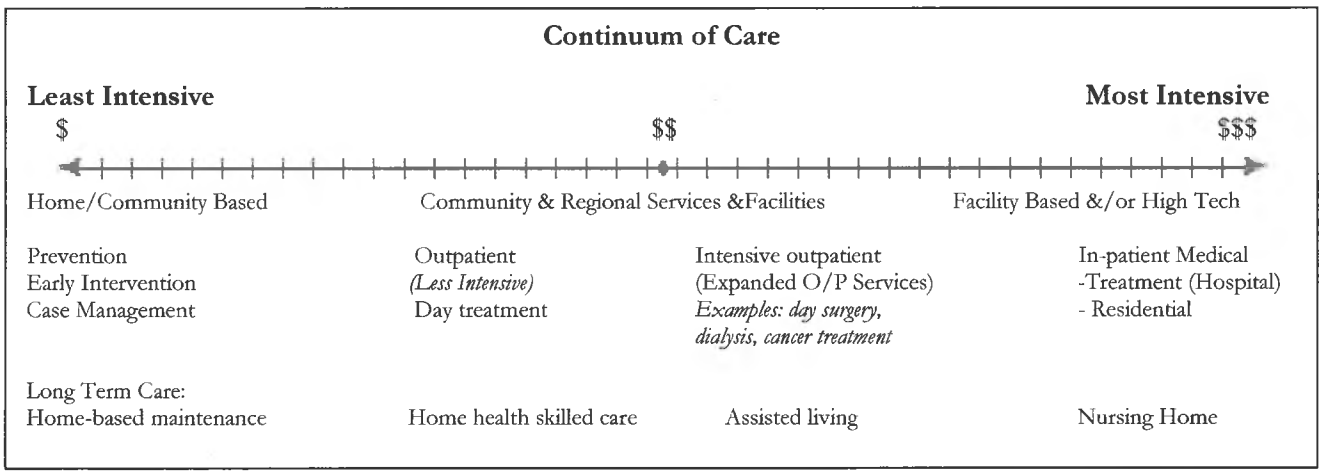
Health Care System

- A health care system is a collection of organizations, practitioners and allied workers, facilities and technologies, financing mechanisms, policies, and information that provide and support the provision of health care for a population.

- People in Alaska obtain health care through three different systems: the private sector, the military/VA, and the Alaska Tribal Health System.

Health Care Continuum

- The health care continuum is the full array of physical and behavioral health services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health of a population.



Public Health

- Public health is what society does collectively to assure the conditions for people to be healthy. The two main characteristics of public health are 1) it is concerned with prevention rather than cure, and 2) it is concerned with population-level rather than individual-level health concerns.

- Public health protects and improves communities by preventing epidemics and the spread of disease; promoting healthy lifestyles for children and families; protecting against hazards in homes, worksites, communities and the environment; and preparing for and responding to emergencies.

Part II: Understanding Alaska's Health Care System Challenges

A. Summary of Prior Year Findings

Concerns regarding the current condition of Alaska's health care system described in detail in past years' reports include the following. Please see the Commission's 2009 and 2010 reports for more detailed findings and discussion.

- The high and rising cost of health care in Alaska is unsustainable.
- Health insurance coverage in Alaska is inadequate.
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services.
- Fragmentation and duplication in Alaska's health care system creates inefficiencies.
- Alaska suffers from shortages and maldistribution of certain health care workers.
- Health status, health risk behaviors and changing demographics influence utilization of health care services.
- Use of modern health information technology is taking hold in Alaska, but much remains to be done.
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care.

B. 2011 Study: Cost of Health Care in Alaska

The Commission contracted for two studies this year to learn more about the cost of health care in Alaska. One was an economic analysis conducted by the Institute for Social & Economic Research (ISER)/MAFA on spending for health care services in Alaska, including estimates of total spending levels by payer and types of services. The other was a financial analysis conducted by Milliman, Inc., an international health care actuarial consulting firm, on health care pricing for hospital and physician services.

The purpose of these studies was to provide information regarding health care cost drivers in Alaska to inform future policy recommendations aimed at improving affordability and access to care. Hospital and physician services were the first two areas selected for study because they represent the highest proportion of spending for health care in Alaska at 31.5% and 28% (respectively), compared to 9% for prescriptions and equipment, 3% for nursing home and home health care services, 5.5% for dental services, 10% for administrative costs, and 13% for all other services. The Commission plans to study pricing for prescription medication during the coming year.

The economic analysis conducted by ISER/MAFA identified trends in levels of spending, who is paying the bills and how cost shifting occurs between payers, the services Alaskans are buying, the numbers of Alaskans with health insurance, and the proportion of employers offering health care coverage to their employees. This study, published in August, is included as Appendix A of this report and is available on the Commission's website at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm.

The financial analysis of physician payment rates conducted by Milliman, Inc. compares health care prices for the top 25 utilized procedure codes for each of 17 physician specialties in Alaska with five other states: Washington, Oregon, Idaho, Wyoming, and North Dakota. This analysis includes a comparison of billed and allowed charges for commercial payers, and fees for Medicare, Medicaid,

Workers' Compensation, the Veteran's Health Administration, and TRICARE. The report on physician payment rates also includes a comparison of the average reimbursement level for durable medical equipment (DME) overall and by payer.

The hospital payment rate analysis compares payment levels in Alaska's non-federal facilities with non-federal facilities in the same five comparison states plus Hawaii. Hawaii was added at the request of the state hospital association because it has logistical challenges somewhat similar to Alaska's, such as those associated with transportation costs, and because of the similarly high cost-of-living. This analysis was restricted to non-federal hospital facilities due to data limitations, and because federal facilities serve a defined beneficiary population, have unique federal funding streams, and operate under differing rules than non-federal facilities. Additionally, the commission's recommendations are primarily targeted at state government policy leaders and will have more limited influence on federal and tribal policies.

The hospital analysis includes 100% of the non-federal acute care facilities and 74% of licensed acute care beds in Alaska (federal tribal and military hospitals support 19% and 7% respectively of total licensed beds). The commission may choose to conduct a separate analysis of reimbursement levels and cost drivers for federal tribal and military hospital services at some point in the future if analysis of potential strategies related to affordability, cost of care and sustainability of the health care system require this additional information.

The analyses of hospital and physician payment rates and cost drivers are presented in three reports from Milliman, Inc. and are included in Appendix B of this report (available on the commission's website at: http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm). Note that these reports are systems-level analyses and are not intended to be utilized as an evaluation of individual facilities or physician practices. Statistics for individual facilities vary widely within the systems-level averages presented, and conclusions should not be drawn about specific facilities from these data without review of each individual facility's financial and cost reports.

Findings

- **Health care spending in Alaska continues to increase faster than the rate of inflation.**
  - Total spending for health care in Alaska reached $7.5 billion in 2010, a 40% increase from 2005. At current trends it is projected to double to more than $14 billion by 2020.
  - By comparison, the wellhead value of oil produced in Alaska was $16.4 billion in 2010, and is projected to be $18.6 billion in 2020.
  - Also by comparison, total wages earned by Alaskan employees was $15.4 billion in 2010.

- **Health care is becoming increasingly unaffordable for U.S. and Alaskan employers and families.**
  - The cost of health insurance premiums in the U.S. increased by 160% between 1999 and 2011, compared to an overall rate of inflation of 38% during that same period.
  - American workers' contributions to health insurance premiums increased 168% between 1999 and 2011, compared to a 50% increase in workers' earnings during that same period.
  - Since 1982 the Anchorage Consumer Price Index increased 95%, while the CPI for medical care in Anchorage over that time period increased 320%.
  - Alaska is number one in the nation for the cost of employee health benefits based on a newly released survey by United Benefits Advisors, which found that Alaska employers are paying an average of $11,926 per employee each year for health insurance – nearly twice as much as the least expensive state.

- Fewer Alaskan employers are offering employee health benefits in 2010 than in 2003.
  - The percentage of large employers in Alaska (those with more than 50 employees) offering coverage dropped from 95% in 2003 to 93% in 2010.
  - The percentage of small employers offering coverage dropped from 35% to 30% during that same period.
- Alaskan employees' share in the cost of their insurance premiums increased from 11% to 14% for single coverage and from 17% to 22% for family coverage between 2003 and 2010.
- The average cost of a health care premium increased 51% for single coverage and 35% for family coverage between 2003 and 2010.
- The average annual premium cost for family coverage in Alaska was $14,230 in 2010.

- **Cost shifting occurs between commercial and public payers.** Cost per unit of service is significantly higher for commercial payers relative to provider operating costs and compared to the two largest public payers, Medicaid and Medicare. For example, commercial reimbursement rates are 110% higher than Medicare reimbursement for hospital services in Alaska. Also, as spending has increased over time for all payers in Alaska, it increased at a higher rate for individuals and private employers compared to government employers and public programs.
  - Because of the cost shifting that occurs through rate disparities, rate reductions by public payers may result in higher rates charged to commercial insurers and translate into higher premiums for individuals who purchase private insurance and for employers who provide employee health benefits.
  - While the major public payers appear to under-reimburse providers compared to private payers, they provide additional financial support for health care through other mechanisms. For example, Medicare subsidizes physician residency training, Medicare and Medicaid provide Disproportionate Share Hospital (DSH) payments to hospitals that see a high proportion of Medicare and Medicaid patients, and the federal government through the Indian Health Service and Alaska Tribal Health System has funded much of the development of the rural health infrastructure in Alaska.
  - The existence of public insurance programs helps spread health care system fixed costs among more payers and beneficiaries.

- **Commercial insurance premiums in Alaska are roughly 30% higher relative to five comparison states, which are higher than the national average. Commercial insurance premiums are primarily a factor of utilization and price for health care services.**

- **Alaska's health care utilization rates do not appear to be a major driver behind higher premium rates relative to comparison states based on financial analysis of the private health care system. Utilization of health care services in Alaska is roughly in line with comparison states, and is lower than the nationwide average.**
  - Alaska uses 13% fewer services than the nationwide average to treat a similar Medicare patient.
  - Alaskan Medicare enrollees have fewer hip replacement surgeries and roughly the same number knee and shoulder replacement surgeries (rate per 1,000 enrollees).
  - For the commercially covered population, inpatient bed days are higher overall in Alaska, but lower in urban Alaska than the comparison states. Emergency room visits are higher, outpatient visits are about the same, and medication prescriptions are lower.

- **Health care prices paid in Alaska are significantly higher than in comparison states.**
  - Reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers based on a weighted average; and 69% higher for commercial (private insurance) payers.
  - The difference in reimbursement for physician services varies significantly depending on the specialty. For example, pediatricians in Alaska are reimbursed at rates 43% higher on average than pediatricians in the comparison states, and cardiologists in Alaska are reimbursed at rates 83% higher than cardiologists in the comparison states.
  - Commercial reimbursement for private sector hospital services is 37% higher in Alaska than in the comparison states. Medicare fees paid for private sector hospital services are 36% higher in Alaska than in the comparison states.

- **Medical prices are driven by two components: 1) operating costs associated with delivering medical services, and 2) operating margins. Following are attributes of medical prices in Alaska's private health care sector:**
  - Operating costs for health care providers are higher in Alaska relative to the comparison states. There is insufficient data available to fully analyze and compare physician practice operating costs, but analysis of publicly available hospital cost reports found Alaska private sector hospital operating costs are 38% higher overall and 86% higher for Alaska's private sector rural hospitals. Higher operating costs in Alaska for hospitals and physician practices are driven by:
    - The cost of living, which is 20-30% higher in Alaska than in comparison states (overall, not accounting for rural/urban differences).
    - Medical salaries for health care workers, which are 0% - 10% higher in Alaska (excluding self-employed physicians).
    - Health benefit costs for hospital and physician practice employees, which in Alaska are higher than any other state in the nation.
    - 11% - 15% utilization of "travelling" temporary staff, who typically are paid at a higher rate and whose employment results in other inefficiencies in delivery of health care services;
    - Administrative burdens associated with government regulation and compliance with payer requirements, including documentation requirements, fraud and abuse audits, licensing and certification requirements, and employee background checks.
    - Drivers of higher operating costs in Alaska specific to the private sector hospital system include:
      - RN staffing ratios, which average 29% higher than comparison states.
      - Occupancy rates, which on average are lower at 49.9% in Alaska relative to 58.1% in comparison states.
  - In 2010 the average all-payer operating margin for Alaska's private sector hospital system was 13.4% compared with the average of comparison states' hospital systems of 5.7%. Operating margins for individual Alaska facilities vary widely within these averages, ranging from -9.2% to 29.4%. For Medicare patients, the operating margin is 2.6 percentage points less than the comparison state average, at -11.5% in Alaska compared to -8.9% in the comparison states, causing upward pressure on commercial premiums in order to offset hospital losses.
  - Physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power relative to pricing.

- **Utilization for health care services in Alaska, while similar to the comparison states and low relative to the U.S. and other industrialized nations, is still a critically important factor to consider in containing cost growth and improving quality of care and health outcomes.** Utilization of health care resources is highly inefficient. The estimated level of wasted health care spending in the U.S. is between 30% and 50%, leaving significant room for improvement in the effectiveness and efficiency of health care delivery.

- **Market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska.** There are state laws and regulations in place that influence the market in such a way as to drive prices higher for the consumer.
    - Lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.
    - Relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges.
    - A separate state law requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.

- **The average payment for durable medical equipment (DME) in Alaska is 21% higher for all payers relative to the average comparison state payment level.** DME consists of non-pharmaceutical items ordered by a provider for a patient. By payer, the average reimbursement for DME is:
    - 23% higher for commercial payers in Alaska relative to the average across commercial payers in the comparison states
    - The same in Alaska for Medicare and TRICARE as the comparison states' Medicare and TRICARE average
    - 180% higher for the VA in Alaska relative to the average VA payment across the comparison states
    - 55% higher for the Alaska Medicaid program relative to the average Medicaid program payment across the comparison states (excluding N. Dakota)
    - 98% higher for the Alaska Workers' Compensation program relative to the average of N. Dakota and Washington states' Workers' Comp payment level (Idaho, Oregon and Wyoming not available)

C. 2011 Study: Long Term Care in Alaska

Long term care encompasses a broad range of medical and support services for individuals requiring assistance over time with meeting skilled acute care needs and custodial support with activities of daily life. These services can be provided in the home, community settings such as senior centers, assisted living facilities, and nursing homes. Alaskans with long term care needs span all ages and include children with intellectual and developmental disabilities, people with spinal cord and traumatic brain injury, people with persistent and severe behavioral health conditions, and seniors suffering decreased mobility or cognitive functioning due to aging or those with severely disabling chronic disease.

Medicaid is the primary payer for long term care services and supports in the U.S. and in Alaska. To become eligible for Medicaid coverage long term care recipients must spend down most of their personal resources. Medicare pays for time limited nursing home stays that are transitional and rehabilitative in nature, and will also pay for limited home health services if there is registered nurse oversight and the services are therapeutic. Other sources of funding include out-of-pocket spending (which accounts for 18% of long term care spending nationally), and long term care insurance (though only 7.2% of Americans have or use private insurance to pay for long term care). Unpaid family members and friends provide the majority of long term care services.

Nearly 50,000 Alaskans benefit from state-administered long term care services in Alaska, with a total expenditure of $422 million annually. 78% of state-supported long term care spending provides for home and community-based care. 97% of state-supported recipients receive long term care services and supports in a non-institutional setting. Currently in Alaska only 38% of senior and disability service recipients in Medicaid programs are seniors over 65 years of age.

Alaska policy makers have worked for years to move away from institutional care to a more balanced system emphasizing home and community-based care. Alaska is one of very few states that do not maintain a state facility for the developmentally disabled, and the only state to have no intermediate care facility for individuals with mental retardation. There are currently 15 nursing facilities with 662 licensed nursing home beds. While the senior population has tripled over the last 20 years, the number of nursing home beds has decreased as programs have moved away from institution-based care.

The move away from institutional care led to a substantial increase in Medicaid spending for home and community-based services, which more than quadrupled over the past decade from approximately $58 million in 2000 to nearly $280 million in 2010. Alaska Department of Health & Social Services officials cite the growing cost of providing long term care services as one of the most critical issues facing the state's Medicaid program. The department projects Medicaid spending for all long term care services will increase by 240% over the next decade to $922 million in 2020.

The State of Alaska conducted numerous studies over the past decade to develop recommendations for the future of long term care in Alaska, but a strategic plan focused on finding the most appropriate, cost effective, affordable, sustainable approach to meeting the long term care needs of Alaskans does not exist. A new coalition of long term care stakeholders was formed during 2011 to help facilitate that planning. In the short time since this coalition convened they have reviewed and compiled recommendations from the most recent studies, gathered existing data on the current system, and also gathered future cost and demographic projections. The commission benefited from presentations by the coalition this year, commends them on their rapid progress, and looks forward to additional information and future recommendations from the coalition.

D. Issues Prioritized for Study in 2012

The commission intends to focus on the following areas to continue learning about the current condition of Alaska's health care system during 2012:

- **State legal and regulatory barriers:** Identify barriers to innovation in health care delivery, financing and reimbursement in Alaska that are specifically created by Alaska laws and regulations. Consult with Alaska health care providers, payers, purchasers and patients to gather their ideas.
- **Cost of Pharmaceuticals in Alaska:** Compare pricing and reimbursement levels across payer types for pharmaceuticals to the comparison states, and identify drivers of cost differentials.
- **Behavioral Health Care:** Learn about the behavioral health care system in Alaska.
- **Malpractice Reform:** Tort reform legislation was passed in Alaska in 2005. Identify whether the new law had an impact on malpractice insurance rates for providers.
- **Federal Reform:** Continue to track Affordable Care Act implementation activities in Alaska.

Tabled for Study in Future Years

- **Genetic advancements in medicine**: This is sure to have an effect and result in issues related to cost, access and quality, but there is not much the commission can do to address it right now.
- **Malpractice Reform**: Tort reform legislation was passed in Alaska in 2005. Future work could address how standards of care are defined in case law, and study models for alternatives to litigation.
- **Fraud & Abuse**: Numerous new programs to prevent and control fraud and abuse are being implemented under federal reform and the state is trying to align state fraud and abuse efforts with the new federal programs and requirements as much as possible to minimize disruption for providers. The commission will wait and see how these programs develop.
- **Alaska's Public Health System:** The Alaska State Constitution vests the legislature with the duty to "provide for the promotion and protection of public health" (Article 7, Section 4). The commission may devote future study to learn about the system in place to fulfill this duty, and identification of strengths and weaknesses of the current system.
- **"Hyperconsumerism":** System incentives caused by third-party payment systems lead patients to seek more care and not seek value: This issue has been addressed in part in the 2011 payment reform and transparency discussions, and will be addressed further during 2012 discussions on employee health benefit and plan design.
- **Alaska's Worker's Compensation Program:** It is not the commission's role to develop operational recommendations for specific state programs such as Workers' Comp and Medicaid; however, issues related to state programs and general policy recommendations affecting them emerge in the course of the commission's work. Issues related to this program were identified in part in the 2011 cost studies, and will be further identified and addressed during 2012 through the work on the Employer's role in health and health care.
- **Demographic changes:** Specifically, the effects of the Baby Boom generation population bubble on the health care system following its "pop" – how will our kids and grandkids support (or dismantle) the huge infrastructure that will be created to care for us?

Part III: Alaska Health Care System Transformation Strategies

A. Health Care System Foundation

Health Workforce

The workers who provide patient care and support all other aspects of health and health care delivery are a foundational resource for the health system. Shortages of workers in certain health occupations can increase health care costs and limit access to care. The commission initially made a series of recommendations related to the health workforce during 2009. Since that time the commission has tracked the work of the Alaska Health Workforce Coalition, a public-private partnership of leading health industry, government, academic and training organizations formed in 2010 to address Alaska's health workforce needs.

In the short time since their formation the Alaska Health Workforce Coalition has made significant progress, leveraged through an impressive partnering effort and pooling of resources rarely seen between public and private sectors. The coalition identified a series of goals and strategies for strengthening the workforce and published the Alaska Health Workforce Plan in 2010, and during 2011 developed an "Action Agenda" to focus efforts on specific high-priority occupational and system improvement issues. The commission applauds the efforts of the coalition, and will continue tracking their work over the coming year. Of particular importance to the commission are the coalition's systemic change initiatives focused on improving workforce data to support needs-based planning and resource allocation, and on government policy barriers to and supports for workforce development.

Summary of current health workforce recommendations made by the commission in prior years:

- Make health workforce development a priority, and support coordinated planning
- Strengthen the pipeline of future health care workers
- Support workforce innovation and adaptation as care models evolve
- Increase the supply of primary care physicians
    - Support educational loan repayment and financial incentives for recruitment
    - Expand WWAMI Alaska medical school seats as resources allow
    - Support primary care residency program development & operation
        - Continue support for family medicine residency
        - Support development of pediatric and psychiatric residencies
        - Support planning for primary care internal medicine residency

Health Information Infrastructure

The health information infrastructure is the combination of all the people, data, policies and procedures, financial resources, facilities and technology which supports the creation, use, storage, protection and transmission of health information. Health information is required to support:

- Public health surveillance and epidemiologic studies
- Coordination and management of patient care by clinicians
- Performance management and quality improvement efforts of providers
- Decision-making by commercial payers, government policy makers, and community leaders
- Fraud and abuse prevention and control
- Consumer/patient decision-making regarding
    - Lifestyle choices
    - Purchase of health care services
    - Medical testing and treatment
    - Self-management of health conditions

Summary of current health information infrastructure recommendations made by the commission in prior years:

- Support health information technology (electronic health records, health information exchange, and telemedicine) adoption and utilization
- Ensure health information technology is utilized to protect the public's health
- Ensure data available through the health information exchange is used to improve health care
- Ensure privacy and security of health information
- Facilitate broadband telecommunications service access
- Improve reimbursement for telemedicine-delivered services

B. 2011 Commission Recommendations

1. Patient-Centric Primary Care

Findings

- Strong primary care systems are foundational to a high performing health care system. Improving access to primary care that is patient-centric and enhancing the role of primary care providers in the coordination and management of care improves health and lowers the per capita cost of health care.

- Improved evidenced-based care management, especially of patients with complex health conditions experiencing high needs and high costs, can reduce health care costs while improving patient care and outcomes.

- A renewed emphasis on the value of primary care and new models of primary care practice are borne out of a convergence in the progression of medicine and changes in patient needs.
  - The vast increase in medical knowledge over the past several decades has led to more complexity in the management of medical information and also increased specialization of medical practitioners.
  - Improvements in the prevention and control of infectious disease and injury have been accompanied by a higher prevalence of chronic disease in the population, which has led to a shift in patient care needs from acute episodic care to chronic care management.

- Changes in medicine and patient needs necessitate a stronger role for primary care providers in supporting patients with the navigation of medical information, coordination of care between specialists, and management of chronic health conditions. Primary care practitioners who have fully assumed these expanded responsibilities have demonstrated cost savings for the overall health care system and improved health status of their patients; however, traditional fee-for-service payment models do not adequately recognize the new functions and do not adequately compensate primary care providers for the additional work involved.

- Patient-centered primary care requires:
  - a continuous healing relationship between the clinical team and the patient; ensuring patients and their families have the information, skills and tools necessary to maintain and manage their health, and that they are treated in a way that is respectful, engaging and empowering.

  - a holistic approach to patient care that views the patient as a whole person, acknowledging and understanding behavioral as well as physical health needs, and integrating primary care for behavioral and physical conditions in a common clinical setting.

  - an active partnership between the primary care provider, community health and social service providers, and governmental public health agencies to effectively coordinate and manage the care of patients with complex health conditions and to support primary prevention for healthy patients.

- Innovative approaches to strengthening primary care and making it more patient-centric have been implemented and are being tested in many other states, by the Veteran's Administration and the Department of Defense, and here at home within the Alaska Tribal Health System. A number of these innovative programs are demonstrating that it is possible to improve care for patients, improve health outcomes for the patient population, and reduce health care costs for the payers. Some are beginning to move forward with multi-payer initiatives to drive further transformation of their health care systems. The design of pilot programs under development in Alaska can be informed by lessons learned from the experience of these early innovators, such as:
    - Community Care of North Carolina (CCNC), whose demonstrated cost savings and improvement in patient outcomes include:
        - Annual growth in Medicaid expenditures fell from a high of 11.5% in 2002 to 2.5% in 2010;
        - Total Medicaid savings of $1.5 billion between 2006 and 2010;
        - Scores in the top 10% in the nation on key quality measures related to care for diabetes, asthma, and heart disease.
        - Comparison of Medicaid Aged, Blind and Disabled members enrolled in CCNC to members not enrolled in the program demonstrated between 2007 and 2010:
            - Better access to care - 95.9% of enrollees use health care system compared to 86.5% of unenrolled population.
            - Average spending for inpatient hospital services decreased 6%, compared to a 25% increase for the unenrolled population.
            - Potentially preventable inpatient admissions declined by 12.5%, while increasing by 25.9% for the unenrolled.
    - Blue Cross Blue Shield of Michigan, which administers the largest patient-centered medical home (PCMH) program in the country with 2,500 physicians in 700 PCMH-designated practices, demonstrated in 2010 that PCMH practices had a
        - 7% lower rate of pediatric emergency room visits;
        - 25.5% lower rate of adult inpatient admissions among patients with manageable chronic conditions; and
        - 7.4% lower rate of adult high-tech radiology usage.
    - CareOregon, a non-profit Medicaid managed care plan in Oregon which piloted their Primary Care Renewal (PCR) program in 2007 and has been expanding it since. Results from the pilot test include a:
        - 7.6% increase in proportion of diabetic patients with blood sugar under control, and of hypertensive patients with blood pressure under control
        - Threefold increase in proportion of patients screened for depression
        - 9% decrease in average cost for dual eligible members (plan members enrolled in both Medicaid and Medicare) treated at a PCR site, compared to a 1.2% increase for those treated in non-PCR sites.
    - The Veterans Health Administration launched a three year plan in April 2010 to transition more than 900 primary care clinics across the country to patient-centered medical homes, investing more than $227 million to hire additional clinical staff, institute a nationwide training program, and develop regional learning collaboratives. In one year a sample clinic increased access to same-day appointments for veterans who previously had to wait as long as 3 months, reduced inappropriate emergency department visits from 52% to 12%, and improved blood sugar scores in 33% of patients with poorly controlled diabetes.

- Within the Department of Defense all three service branches are moving towards a medical home model of care in their military treatment facilities and is collaborating with TRICARE Management and the VA. The DOD and VA are working together on development of guidelines for evidence-based practices critical to the functioning of a medical home, and also on design of quality metrics and process evaluations.

- There is currently active interest and engagement in the development of patient-centered primary care models in Alaska on the part of health care payers and primary care providers.
  - The Alaska Medicaid Task Force, convened Sept 2010 – April 2011 to identify cost containment strategies, recommended that the state's Medicaid program pilot test patient-centered medical home. DHSS plans to contract with a consultant during SFY 2012 to assist with the design of the pilot program.
  - The Alaska Primary Care Association received a $400,000 capital grant from the state legislature this year to assist community health centers with transition to a medical home model.
  - The Alaska Native Tribal Health Consortium is supporting a collaborative of clinicians throughout the tribal health system in an Improving Patient Care initiative that includes testing and learning from patient-centered medical home projects.
  - Two primary care clinics in Alaska currently hold NCQA (National Committee for Quality Assurance) recognition as Patient Centered Medical Homes – the Southcentral Foundation (SCF) Primary Care Center (Level 3), and the Providence Family Medicine Center/Alaska Family Medicine Residency Program (Level 1).
  - Numerous private sector primary care clinics are actively working on implementing various aspects of the PCMH model, such as opening up schedules for same-day appointments, establishing or upgrading electronic medical records systems, and creating web-based patient information portals. The commission specifically learned about the efforts of the Tanana Valley Clinic in Fairbanks and Medical Park Family Care in Anchorage.
  - The state Department of Health & Social Services is participating in a multi-state collaborative ("TCHIC") funded by CMS to test quality measurement and health information technology applications to improve care for children in Medicaid. DHSS created a medical home pilot program under this initiative this year and awarded pilot-site grants to Central Peninsula Community Health Center (Kenai/Soldotna), Iliuliuk Family & Health Services (Unalaska), and SCF (Anchorage).
  - A number of clinics are working to integrate primary care and behavioral health services. Two organizations, Alaska Island Community Services (Wrangell) and SCF (Anchorage) received federal demonstration grants this year to introduce primary care services within behavioral health clinic settings.

Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska recognize the value of a strong patient-centered primary care system by supporting appropriate reimbursement for primary care services.

2. The Alaska Health Care Commission recommends the State of Alaska support state policies that promote the central tenet of patient-centered primary care – that it is a model of care based on a continuous healing relationship between the clinical team and the patient.

3. The Alaska Health Care Commission recommends the State of Alaska and other entities planning a patient-centered primary care transformation initiative incorporate the following strategies the Commission found to be common to start-up of successful programs studied as models. These successful models started with:
   a) Financial investment by the initiating payer organization (whether public or private).
   b) Strong medical leadership and management involved in planning and development.
   c) A collaborative partnership between the payers and clinical providers.
   d) A vision concerned with improving patient care, followed by identification of principles, definitions, criteria for participation, and tools and measures.
   e) A focus on local (i.e., practice-level) flexibility and empowerment.
   f) A phased approach to implementation.
   g) A tiered approach to managing patient populations.

4. The Alaska Health Care Commission recommends the State of Alaska and other entities implementing a patient-centered primary care transformation initiative include the following attributes the Commission found to be common to successful programs studied as models:
   a) **Resources** provided to primary care practices to support improved access and care coordination capabilities.
   b) **New tools and skill development opportunities** provided to primary care practices to support culture and practice transformation.
   c) **Shared learning environments** for clinical teams to support development of emergent knowledge through practice and dissemination of new knowledge.
   d) **Timely data** provided to primary care practices to support patient population management and clinical quality improvement, including centralized analytical and reporting capability and capacity.
   e) **Infrastructure support** for medical guidance, including a medical director for clinical management and improvement, case managers, pharmacists, and behavioral health clinicians.
   f) **A system of review** that includes both implementation monitoring by initiative partners and evaluation of initiative outcomes by an independent third-party.

5. The Alaska Health Care Commission recommends the State of Alaska support a patient-centered medical home (PCMH) initiative, recognizing:
   a) Front-end investment will be required for implementation, and it may take two to three years before a return on investment will be realized;
   b) Collaboration between State programs that pay for health care, other health care payers and the primary care clinicians who will be responsible for implementing this model is essential to success; and,
   c) Patient-centered primary care development is not the magic bullet for health care reform, but is an essential element in transforming Alaska's health care system so that it better serves patients, better supports providers, and delivers better value.

2. Price & Quality Transparency

Findings

- There currently is insufficient data and information to support consumerism in Alaska's health care market. Empowering consumers and health care providers with access to information on the cost and quality of care is an important strategy for improving value in Alaska's health care system.

- Some patients lack incentives to seek value in their health care decisions. Normal supply-and-demand price mechanisms do not always work when consumers are insulated from the cost of a good or service, which is one effect of the third-party payer health insurance system. Consumers who share directly in the out-of-pocket cost of their health care purchases are more likely to make decisions based on value (price and quality).

- State government and other payers require high quality health data sources and health analytics capacity to provide the information needed to guide payment reform and health care delivery improvement policies.

- Alaska's Hospital Discharge Database is an important source of health care data, and is a good example of collaboration between a health care provider group and the State to make health care data more transparent. However, this data set is currently incomplete due to lack of full participation by all of Alaska's hospitals. It is also insufficient for supporting full cost and quality transparency in that it represents care provided only by acute care hospitals.

- A number of states have implemented or are in the process of planning for All-Payers Claims Databases (APCDs) to complement data from their Hospital Discharge Data and Medicaid Management Information Systems. APCDs are large-scale databases that systematically collect and aggregate medical, dental and pharmacy claims data from public and private payers, and are valuable sources of information about outpatient services and health care payments for those states that have implemented them. They also minimize the burden on health care providers as the aggregated data from payers is an efficient alternative to collecting data directly from individual providers.

Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska encourage full participation in the Hospital Discharge Database by Alaska's hospitals.

2. The Alaska Health Care Commission recommends the State of Alaska study the need for and feasibility of an All-Payers Claims Database.

3. Payment Reform – Paying for Value, Rather than Volume

Findings

- Current fee-for-service and third-party payment structures reward delivery of high numbers of costly services; compel health care to be technology driven, volume-driven, fragmented, and expensive; and are a disincentive to innovations that improve health outcomes and the efficiency and effectiveness of health care services.

- There are options to health care cost containment strategies that do not rely on across-the-board rate reductions, price controls and rationing. These alternative approaches attempt to maximize value by moving away from payment for individual services to payment structures that reimburse providers for high quality care and improved health outcomes.

- Improving value in health care requires the following four mutually supportive components:
  1. **Consumer Empowerment**
     a. Educational materials and tools
     b. Engagement strategies that recognize the consumer as a partner/owner in their care
  2. **Price and Quality Reporting & Measurement**
     a. Measurement and analytics system design
     b. Reporting on quality, cost and experience of care
  3. **Value-Driven Health Care Delivery**, which empowers the patient and focuses first on keeping the patient healthy, minimizing the need for hospital care when health is compromised, and ensuring efficient successful outcomes when care is required.
     a. Design and delivery of care grounded in evidence-based medicine principles
     b. Technical assistance to providers
     c. Provider organization coordination
  4. **Value-Driven Payment Systems and Benefit Designs**.
     a. Payment system design
     b. Benefit design grounded in evidenced-based medicine principles
     c. Engagement of Purchasers
     d. Alignment of multiple payers

- Successful payment reform initiatives require systems that can support:
  - Capabilities to **manage financial risk** for payers and providers
    - Data and analytics for monitoring utilization and quality
    - Actuarial expertise for financial risk analyses
  - Capabilities to **manage health** for patients, providers, payers
    - Methods for targeting high risk patients
    - Capability to track, coordinate and follow-up on patient care
    - Patient education and self-management support
  - **Alignment of organizational structures** among providers
    - Trust relationships between physicians and hospitals
    - Significant regulatory barriers exist
    - Neutral, trusted facilitator may be required
  - **Alignment of payment policies** among payers
    - Multi-payer approaches to avoid further fragmentation of payment systems

- 26 cents of every health care dollar spent in Alaska are public funds administered either directly or indirectly by the State of Alaska, including state and federal Medicaid funds and spending for state employee and retiree health benefit s, correctional system inmates' care, workers' compensation, and other state health care programs. State government holds significant purchasing power that could be utilized to leverage improvement in Alaska's health care system.

Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska utilize payment policies for improving the value of health care spending – for driving improved quality, efficiency and outcomes for each health care dollar spent in Alaska – recognizing that:
    a. Local payment reform solutions are required for Alaska's health care markets
    b. Payment reform may not result in immediate cost savings, but efforts must begin immediately
    c. Payment reform is not the magic bullet for health care reform, but is one essential element in transforming Alaska's health care system so that it better serves patients, and delivers better value for payers and purchasers.

2. The Alaska Health Care Commission recommends the State of Alaska take a phased approach to payment reform, revising payment structures to support primary care transformation as a first step in utilizing payment policies for improving value in Alaska's health care system.

3. The Alaska Health Care Commission recommends the State of Alaska develop health data collection and analysis capacity as a tool for quality improvement and payment reform. Data collection, analysis and use decisions should involve clinicians, payers, and patients.

4. The Alaska Health Care Commission recommends the State of Alaska support efforts by state officials responsible for purchasing health care services with public funds to collaborate on the development of common purchasing policies. These collaborative efforts should include key stakeholders, and should be used as leverage to drive improved quality, effectiveness, efficiency and cost of care in Alaska's health care system. These efforts should endeavor to engage commercial payers and federal health care programs in alignment of payment policies in a multi-payer approach to minimize the burden on health care providers.

4. Alaska's Trauma System

Findings

- Injury is the leading cause of death for Alaskans who are one to 44 years of age. Roughly 400 to 500 Alaskans die each year as the result of an injury. Approximately 5,000 Alaskans are admitted to a hospital each year due to an injury, over 1,000 of who are left with a permanent disability.

- A trauma system that provides rapid, effective, and efficient response and treatment is critical to reducing death and disability due to injury. An improved trauma system improves overall care for any health condition that is time critical, such as heart attack and stroke, not just trauma.

- The Alaska Department of Health & Social Services made trauma system improvement a priority three years ago with the commission of a study by the American College of Surgeons Committee on Trauma. Subsequently the Division of Public Health began implementing the ACS recommendations for strengthening Alaska's trauma system by establishing a Trauma System Coordinator position to support development of a trauma system strategic plan, and reorganizing to consolidate the Emergency Medical Services Program with the Emergency and Disaster Preparedness Program. More recently the Division has invested in improving the Alaska Trauma Registry to ensure sound data is available for informing prevention and system improvement efforts.

- The Alaska Legislature made a commitment to strengthening Alaska's trauma system, passing a bill during the 2010 legislative session establishing the Uncompensated Trauma Care Fund to incentivize hospitals to meet trauma center standards.

- Alaska's health care community has made commitments to strengthening Alaska's trauma system. The Alaska Native Medical Center has demonstrated leadership in trauma care in Alaska for many years and is currently the only Level II designated trauma center in the state, the highest level any hospital in Alaska can attain. Four of Alaska's rural hospitals are designated Level IV trauma centers. An additional nine hospitals are actively working towards attainment of trauma center designation. However, Alaska remains the only state in the nation without a Level II or higher designated trauma center serving the general population.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska support a strong trauma system for Alaska that:
    - Is comprehensive and coordinated, including:
        - Public health system capacity for
            - studying the burden of injury in the local population
            - designing and implementing injury prevention programs
            - supporting the development and exercise of local and statewide emergency preparedness and response plans

        - Emergency medical service capacity for effective pre-hospital care for triage, stabilization and coordination of safe transportation of critically injured patients
        - Trauma center care for treatment of critically injured patients
        - Rehabilitation services for optimizing recovery from injuries
        - Disability services to support life management for individuals left with a permanent disability due to an injury
    - Is integrated, aligning existing resources to efficiently and effectively achieve improved patient outcomes.
    - Is designed to meet the unique requirements of the population served.
    - Provides evidence-based medical care to achieve the best possible outcomes for the patient.
    - Provides seamless transition for the patient between the different phases of care.

- The Alaska Health Care Commission recommends the State of Alaska support continued implementation of the recommendations contained in the 2008 consultation report by the American College of Surgeons Committee on Trauma, including achievement and maintenance of certification of trauma center status of Alaskan hospitals.

5. Obesity in Alaska

Findings

- The growing prevalence of overweight and obese Alaskans is the most significant public health challenge facing Alaska today. This largely avoidable condition affects Alaskans of all ages, from all regions, across all levels of education and income, and of all racial and ethnic backgrounds. The dramatic increase in overweight and obesity prevalence that occurred over the past 18 years will have lasting financial and health impacts on Alaskan families, communities, businesses, and the health care system for decades to come.

- Overweight and obesity cause 365,000 premature deaths a year in the U.S.

- Medical spending in the U.S. directly related to overweight and obesity was estimated at $147 billion annually in 2008, and $477 million in Alaska.

- As many as 40% of Alaska's children are overweight or obese.

- The generation of Americans born in the last decade may be the first generation of Americans who do not live as long as their parents, since our country began, due to the medical complications of overweight and obesity. A child born today has a 34-38% chance of developing diabetes in his or her lifetime.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska implement evidence-based programs to address the growing rate of Alaskans who are overweight or obese. First efforts should focus on nutrition and physical activity for children and young people and raise public awareness of the health risks associated with being overweight and obese.

6. Immunization against Vaccine-Preventable Disease

Findings

- Until the mid-20th century infectious diseases were a leading cause of illness, disability and death in Alaska. Few effective treatment and preventive measures existed. Since that time there has been a dramatic decline in the burden of infectious disease in the population due to significant achievements in control measures, especially for those diseases for which vaccines have been developed.

- During the 20th century the success of biomedical science in development of vaccines combined with the success of the public health system in immunizing the population led to the eradication of smallpox from the worldwide population and the elimination of polio from the U.S. population. Furthermore, immunizations have resulted in substantial declines in other diseases that had previously been a common cause of serious illness and death among children, such as measles, mumps, rubella, diphtheria, tetanus, pertussis, and bacterial meningitis.

- Despite remarkable progress in vaccine development and use, there are a number of challenges in maintaining sufficient immunization levels to protect the population.
    - Vaccination schedules have become increasingly complex. U.S. children require 19 doses of vaccine by age 35 months to be protected against 11 childhood diseases.
    - The success of immunization policies in controlling once-dreaded diseases has led to complacency among some subsets of the population toward vaccines.
    - Insufficient and erroneous information about vaccine safety and effectiveness creates confusion among parents, who must recognize immunizations as an important tool in protecting their children's health and actively seek them.
    - Health care providers must be kept informed of the latest developments and recommendations.
    - Vaccine supplies and financing must be made more secure.
    - Researchers must address increasingly more complex questions about safety, efficacy, indications, contraindications, and delivery.
    - Information technology must be used to support timely vaccination.
    - Adolescents and adults must be targeted for vaccine-preventable diseases that affect their age groups, such as influenza and pneumonia.

- Alaska's childhood immunization rate has declined in recent years to nearly the lowest in the nation. Alaska's rate of immunization completion for children ages 19 months to 35 months was just 56.6% in 2009, compared to the national average of 70.5%, ranking Alaska 49th among the 50 states and leaving Alaska's children vulnerable to preventable diseases that can result in serious complications, preventable hospitalizations, and in some cases death.

- The Alaska Division of Public Health, Department of Health & Social Services, maintained a "universal vaccine program" (providing all recommended childhood and adult vaccines to public and private health care providers in the state) for over three decades. The vaccine program was supported almost entirely with federal funding from two different sources, one of which is reducing its annual allocation to Alaska by $3.6 million in a phased 3-year reduction starting in FFY 11.

- As a result of the loss of funding the state discontinued provision of all adult vaccine and of human papillomavirus and meningococcal vaccines for children in FFY 11, and will no longer provide the following childhood vaccines for children who are not eligible for the Vaccines for Children Program ("VFC"; a program for children who are American Indian/Alaska Native, on Medicaid, or uninsured) beginning in FFY 12: influenza, pneumococcal conjugate, and rotavirus.
- Elimination of the universal vaccine program is expected to have the following consequences:
    - Reduction in the number of small private medical practices that provide vaccine to their patients due to the complexities of maintaining separate vaccine supplies (per VFC administrative requirements), and the cost of up-front purchase of expensive vaccine;
    - Reduced immunization coverage leading to increased risk of vaccine-preventable diseases such as measles, mumps, pertussis, chicken pox and hepatitis A; and,
    - Inability to maintain a stockpile of vaccine to support timely response to outbreaks of vaccine-preventable disease.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska ensure the state's immunization program is adequately funded and supported, and that health care providers give priority to improving immunization rates in order to protect Alaskans from serious preventable diseases and their complications.

7. Population-Based Prevention & Behavioral Health

Findings

- Behavioral health is essential to whole health. Almost one-quarter of all adult stays in U.S. community hospitals involve mental or substance use disorders. 83% of people diagnosed with serious mental illness are overweight or obese. The life span of a person with SMI is 27 years shorter than the average life span.

- Alaskans experience high rates of violence. According to the 2010 Alaska Victimization Study, 47.6% of adult women in Alaska experienced intimate partner violence in their lifetime. 37% experienced sexual violence, and 27% experienced alcohol or drug involved sexual assault.

- Adverse childhood experiences, such as recurrent and severe physical or emotional abuse, sexual abuse, or growing up in a household with an alcoholic or drug user, a member in prison, a mentally ill member, a mother treated violently, or both biological parents absent, are a significant determinant of health and well-being well into adulthood, correlating to poor health indicators such as obesity and depression.

- Binge alcohol use in Alaska is among the highest in the nation. 8% of all adults in Alaska, 20% of adults ages 18-25, and 25% of students in grades 10, 11, and 12 use marijuana.

- Alcohol use is suspected or proven in nearly 25% of all hospitalizations for injury.

- In 2009 the age-adjusted suicide rate for all Alaskans was 20.2/100,000 (140 lives lost). The suicide rate among Alaska Native people is two times that of non-Native.

- Routine screening for substance abuse, depression, and a history of adverse childhood events using evidence-based tools is an important strategy for reducing the prevalence of health conditions related to these problems.

- Integration of primary care for both behavioral and physical conditions in a common clinical setting is an essential feature of patient-centered primary care.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska support efforts to foster development of patient centered primary care models in Alaska that:
  - Integrate behavioral health services with primary physical health care services in common settings appropriate to the patient population.
  - Assure coordination between primary care and higher level behavioral health services.
  - Include screening for the patient population using evidence-based tools to screen for
    - A history of adverse childhood events
    - Substance abuse
    - Depression

- The Alaska Health Care Commission recommends the State of Alaska develop with input from health care providers new payment methodologies for state-supported behavioral health services to facilitate integration of primary physical health care services with behavioral health care services.

C. Strategies under Consideration for Study in 2012

- **Design policies to enhance the consumer's role in health and health care - A) Innovate to improve quality, affordability and access to care:**
  - **Legal barriers and cost drivers:** Identify policies to address cost drivers and state legal barriers identified through 2011 cost and pricing studies and 2012 legal barriers analysis.
  - **Employer's Role in Health & Health Care – Employee Health Benefit and Plan Design:** Identify the roles Alaska's employers play in their employees' health and access to health care, and study innovative approaches employers in Alaska and across the country are utilizing to improve the quality, affordability and access to health care for their employees.
  - **End-of-Life Care:** Learn how improving quality of services and patient choice in health care decisions at the end of life can improve the patient's and patient's family's experience and contain costs.
  - **Use of Technology to Facilitate Access to Care:** Determine the characteristics of a legitimate electronic patient visit, and identify impediments to use of telecommunications technology to improve access, including reimbursement, liability, licensure (including cross-state licensure), technological, etc. Study the Veteran's Health Administration experience with telemedicine.
  - **Transparency - All-Payers Claims Database:** Conduct a needs assessment and feasibility study for establishment of an All-Payers Claims Database for Alaska
  - **Track Developments in Alaska Related to Previous Recommendations:**
    - Value-Based Purchasing (Payment Reform and Price & Quality Transparency)
    - Patient-Centered Primary Care
    - Evidence-Based Medicine

- **Design policies to enhance the consumer's role in health and health care - B) Support Healthy Lifestyles**
  - **Employer's Role in Health & Health Care – Worksite Wellness:**
    Identify the roles Alaska's employers play in their employees' health and access to health care, and study innovative approaches employers in Alaska and across the country are utilizing to create cultures of wellness and promote the health and safety of their employees.
  - **Track Developments in Alaska Related to Previous Recommendations:**
    - Obesity
    - Immunizations
    - Behavioral Health

- **Build the foundation of a strong, stable health system**
  - **Statewide Leadership:**
    - Identify indicators for measuring statewide health care delivery system improvement
  - **Health Workforce Development**
    - Track developments in Alaska related to previous recommendations
  - **Health Information Infrastructure**
    - Track developments in Alaska related to previous recommendations

<u>Strategies Tabled for Future Years' Agendas</u>

- **Strategies to support innovations in patient-centric care**
  - **Health Benefit & Plan Designs that support patient engagement in seeking value:** This strategy will be addressed in large part during 2012 work on the employer's role in health and health care.
  - **Care coordination and management for patients with multiple chronic conditions:** Will track new Medicaid program initiatives in this area for now.
  - **Patient-Provider shared decision-making support tools:** Work during 2012 on employer efforts to craft innovative health plans focused in part on improving and supporting employee health and engagement in health care will inform future direction for this strategy.
  - **Process/Quality Improvement:** The commission may elect to study provider efforts to improve quality and design more efficient processes sometime in the future.

- **Strategies to support healthy lifestyles**
  - **Rural sanitation:** A very important community health issue, but the commission might not be able to add value to the current efforts underway in Alaska.
  - **Fluoridation:** Local decisions regarding this important public health issue should be based on high quality research and evidence. The commission may chose to investigate the status of this strategy and changes in community policies at some point in the future.

- **Health Workforce Development**
  - **Workforce issues related to supporting the Patient-Centered Medical Home::**
    - Sufficient supply of the appropriate workers needed to support the care team
    - Appropriate training and other workforce issues to support the roles of the care team members

Appendix A

"Alaska's Health-Care Bill: $7.5 Billion and Climbing,"

Institute for Social & Economic Research, University of Alaska
with Mark A. Foster & Associates
August 2011

Study Conducted under Contract for the Commission during 2011

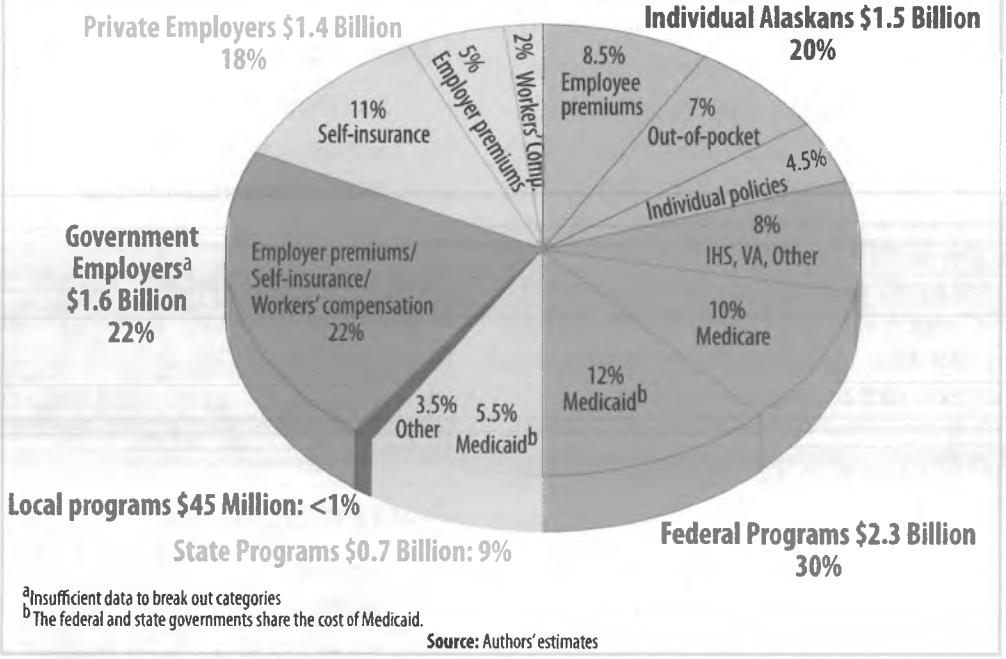
Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

Alaska's Health-Care Bill: $7.5 Billion and Climbing

By Mark A. Foster and Scott Goldsmith

UA Research Summary No. 18 • August 2011
Institute of Social and Economic Research • University of Alaska Anchorage

Figure 1. Who Pays for Health Care in Alaska?
(2010 Spending: $7.5 Billion)



[a] Insufficient data to break out categories
[b] The federal and state governments share the cost of Medicaid.

Source: Authors' estimates

Health-care spending for Alaskans reached about $7.5 billion in 2010. For comparison, that's close to half the wellhead value of all the oil produced in Alaska that year. It's also roughly equal to half the wages Alaskans collected in 2010.

The state's health-care spending has been rising fast, tripling since 1990 and jumping 40% just between 2005 and 2010—and at current trends it could double by 2020, reaching more than $14 billion.

Here we report on who's paying the bills, what we're buying, what's contributing to the growth, and other aspects of health-care spending. We conclude with a discussion of how Alaska could get better value for its health-care dollars.

- ***Who pays the bills?*** Individual Alaskans directly pay about 20%, state and federal programs around 40%, and private and government employers another 40% (Figure 1 and page 2).
- ***What's the biggest cost?*** Medicaid is the largest single expense, making up nearly 18% of all Alaska health-care spending. But that's down from 20% of total spending in 2005. Why? Because spending for Medicaid didn't grow as fast as other kinds of spending (page 3).
- ***Are costs shifting?*** Every category of spending increased since 2005—but because spending by individuals and private employers increased faster, their shares of total spending increased (page 4).
- ***What are we buying?*** Hospitals and doctors account for nearly 60% of total spending—but the next largest cost is the 10% that goes for administering private and government health insurance (page 4).
- ***What's driving spending*** Over the past 50 years, technology, income growth, medical-price inflation, changing insurance coverage, and a growing, aging population have driven health-care spending (page 5).
- ***How many Alaskans are uninsured?*** The answer varies depending on how "uninsured" is measured and when. But recent estimates say about 18% of adults and 9% of children are uninsured. Based on 2010 census figures, that would be about 17,000 children and 94,000 adults (page 6).
- ***How many Alaska businesses offer health insurance?*** More than 90% of large firms offer insurance, compared with just 30% of small businesses—and that's down from 35% in 2003 (page 7).
- ***Are prices higher in Alaska?*** Yes. But Alaska's isolation, small markets, and other factors contribute to those higher prices—a day in the hospital costs on average 50% more than in the U.S. as a whole, and costs for common procedures are roughly 35% higher (page 8).
- ***How is spending distributed?*** Just 10% of Americans are responsible for two-thirds of all health-care spending in an average year (page 9).
- ***What about the future?*** Expanded insurance coverage; an aging population; and continued growth in technology, incomes, and medical prices will keep driving growth in health-care spending in the coming years. Controlling that growth will be an ongoing challenge (page 11).

Who Pays the Bills?

Individuals, private employers, and governments share the direct costs of health care in Alaska (Figure 1 and Table 1).

Individual Alaskans spent about $1.5 billion for health care in 2010—20% of total spending.

- *Alaskans with employer-based insurance—both private and government—paid about $640 million* for premiums, and those with individual policies spent $350 million.
- *Out-of-pocket costs for Alaskans totaled about $545 million* in 2010. That includes deductibles and co-pays—the part of medical bills insurance doesn't pay. It also includes costs for services not covered by insurance, and money that uninsured Alaskans spent for medical bills.

Private employers spent about $1.4 billion—18% of total spending.

- *Alaska businesses spent around $835 million to self-insure* in 2010. They set aside money to pay medical bills themselves, rather than pay insurance premiums. They're betting that the medical bills will be less than the premiums they would have paid—and that their reserves will be enough to cover annual variation in claims. Many self-insured firms carry "stop loss" insurance, to protect them against very large claims. At first only large firms self-insured, but as insurance costs climbed, smaller businesses have also begun self-insuring.
- *Businesses spent about $400 million for insurance premiums* in 2010. That's only about half what businesses spent to self-insure, showing how widespread the practice of self-insuring is.
- *Medical bills of employees injured at work cost businesses about $150 million* in 2010. State law requires employers to pay for such injuries.

Government employers spent $1.6 billion for health benefits in 2010.

- *Local government employers—including school districts—spent about $630 million*, the federal government nearly $590 million, and the state $410 million.
- *Like businesses, many public employers self-insure, rather than pay insurance premiums*—but we don't have enough data to separate out those costs. The federal government also pays medical costs for active-duty and retired military personnel and veterans.

Governments spent nearly $3 billion for health programs in 2010.

- *Medicaid spending was nearly $1.3 billion in 2010*—$871 million in federal money and $409 million in state money. Medicaid is a federal program, but the state administers it and shares the costs (see page 3).
- *Medicare spending was $733 million in 2010*, accounting for nearly 10% of all health-care spending. Medicare is a federal program for people 65 and older and those with certain disabilities. Medicare spending is expected to grow rapidly in the next decade, as older Alaskans make up an ever-growing share of the population (see page 5).
- *The federal government spent close to $650 million for other health programs* in 2010, including the Indian Health Service, which provides medical care for Alaska Natives, and the Veterans Administration, which provides care for military veterans. Spending for these programs depends somewhat on enrollment, but it's also constrained by Congressional appropriations.
- *Besides its share of Medicaid, the state government spent about $260 million* for a variety of other programs in 2010, including grants to local governments, the state-operated Pioneer Homes for older Alaskans, and the Alaska Psychiatric Institute.

Table 1. Health-Care Spending in Alaska, 2010
(Total Spending: $7.5 Billion)

Individuals	**$1,529 million**
Employee premiums	$637
Out-of-pocket costs	$544
Individual policies	$348
Private Employers*	**$1,384 million**
Insurance premiums	$395
Self-insurance costs	$836
Workers' compensation medical	$153
Government Employers*	**$1,625 million**
Federal	$586
State	$408
Local	$631
Federal Health Programs	**$2,250 million**
Medicare	$733
Medicaid	$871
IHS, VA, Community Health Centers, public health, K-12 health	$646
State Health Programs	**$670 million**
Medicaid	$409
Local grants, API, Pioneer Homes, K-12 health, WAMI, Department of Corrections	$261
Local Health Programs	**$45 million**
Hospital and health program support	$40
Other local	$5

*Includes coverage for current and retired employees.
Source: Authors' estimates. See page 12 for a description of what's included in health-care costs.

- *Local health programs are much smaller*, at around $45 million in 2010, largely support for hospitals and health programs.

And finally, keep in mind that even though governments and businesses pays most of the *direct* costs of health care, individual Alaskans and other Americans *indirectly* pay all the costs of health care—because they buy goods and services, own businesses, and pay taxes.

Is There Also Spending Outside Alaska?

Our estimates are for health-care spending *in* Alaska. The health-care industry has been one of the state's fastest-growing sectors for decades, and it provides a broad range of care. But long-time Alaskans can remember when getting anything other than basic care required leaving Alaska. So some people wonder how much Alaskans spend for health care outside Alaska these days.

We know Alaskans still travel for some care—like very advanced cancer treatments available only in a few locations in the Lower 48. Also, some Alaskans go to other states—or even other countries—where medical prices are lower.

We don't have enough data to estimate overall health-care spending outside Alaska. In 2004, the federal Centers for Medicare and Medicaid Services estimated that the difference between spending *in Alaska* and spending *for Alaska residents* was roughly 2%.[1]

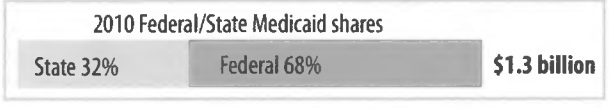
And Premera-Alaska, which has about 57% of the Alaska health-insurance market,[2] recently analyzed claims paid under one of its large group plans. Premera estimates that in a recent two-year period, a third of payments under that group plan went to providers outside Alaska. And of that third, one-third was paid to providers in Washington state and two-thirds to providers in other states (Figure 2).

Figure 2. Estimated Shares of Premera-Alaska's Payments For Care, Inside and Outside Alaska

Source: Jeff Davis, Premera-Alaska, based on analysis of recent claims of one of its large groups.

We can't generalize to other payers—like the Veterans Administration or the Indian Health Service or even other private insurers—that might have quite different spending patterns. Still, the Premera estimate offers interesting evidence that for at least some segments of the market, significant spending outside Alaska continues.

Largest Single Cost: Medicaid



The federal and state governments spent nearly $1.3 billion for Medicaid in 2010, making it by far the largest single health-care expense in 2010. So just what is Medicaid, and how many Alaskans benefit from it?

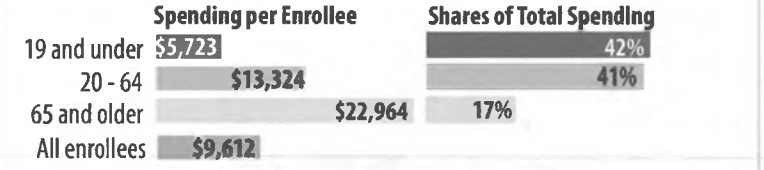
Medicaid is a joint federal-state health insurance program, administered by the state. The cost split has varied somewhat over the years, but it's typically closer to 50-50 than it was in 2010, when the American Recovery and Reinvestment Act (now expired) boosted the federal share.

Medicaid is for low-income families; adults with certain disabilities; and increasingly, long-term care in nursing homes for people who have spent down all their own assets and home-based services for those who meet specific disability criteria.[3]

Figure 3. Share of Alaskans in Medicaid, 2010

Sources: Alaska Department of Health and Social Services; 2010 U.S. census

Figure 4. Alaska Medicaid Spending by Age of Enrollee, 2010



Source: Alaska Department of Health and Social Services, Medicaid Budget Group, January 2011

There's also an expansion of Medicaid, called Denali KidCare, which covers children and pregnant women from families with incomes somewhat too high to qualify them for traditional Medicaid. Spending for both standard Medicaid and Denali KidCare are included in the $1.3 billion.

More than 135,000 of Alaska's 710,000 residents were enrolled in Medicaid and Denali KidCare in 2010—close to 20% of all Alaskans. Most of those—about 88,000—are children and teenagers. That means more than four in ten of all Alaskans 19 or younger are enrolled (Figure 3). About 38,500, or 9%, of working-age Alaskans are enrolled, as are nearly 9,000—or 16%—of Alaskans 65 or older.[4]

As Figure 4 shows, Medicaid spending is much different for younger and older enrollees. The average spending per child was under $6,000 in 2010—but because they make up so much of the enrollment, 42% of total spending was for them.

By contrast, average spending per enrollee 65 or older was close to $23,000. But because there aren't nearly as many older enrollees, they accounted for only 17% of total Medicaid spending. Some of those older Alaskans are in nursing homes, where care is expensive.

Enrollment in Alaska's Medicaid program increased about 23% over the past decade—but, as Figure 5 shows, Medicaid spending did not grow as fast as total health-care spending from 2005 to 2010. Medicaid spending was up about 32%, compared with 42% for total spending. The state held down cost increases in various ways in recent years—for example, by directing providers to prescribe generic rather than brand-name drugs whenever possible.

Still, spending for Medicaid and all other health-care expenses grew fast in recent years, and health-care spending is projected to continue growing fast in the coming years. In a later section we look at the factors contributing to that growth.

Figure 5. Increases in Medicaid and Total Health-Care Spending, 2005-2010

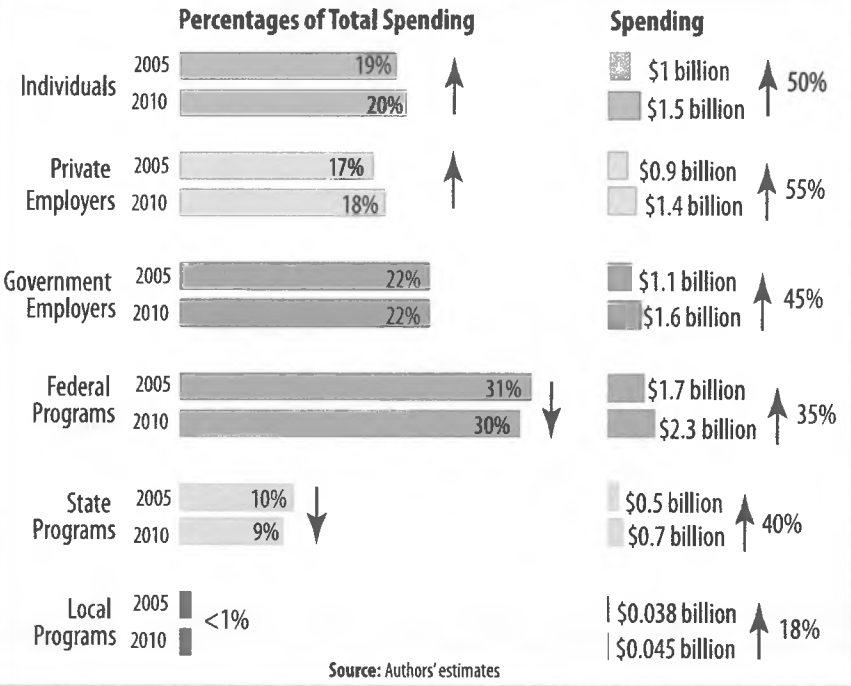
Sources: Alaska Department of Health and Social Services and authors' estimates

How Have Patterns of Spending Changed?

Every category of health-care spending increased between 2005 and 2010, but the shares of spending shifted slightly among the various payers. We don't have enough information to say exactly what caused this shift—but several things likely contributed, as we describe below.

- *Individuals paid 20% of Alaska's health-care bills in 2010, up from 19% in 2005.* As costs of health-care benefits increased rapidly, employers shifted more of those costs to employees (see page 7). Also, prices for policies individuals buy directly increased significantly.
- *Private employers' share of spending increased from 17% to 18%.* That increase was in part because private industry added nearly four times more jobs than governments did since 2005—and at least some of that bigger base of employees had health-care coverage.
- *Government employers' share of spending was about the same, at 22%.*
- *Government health programs accounted for a somewhat smaller share of spending, down from about 41% to 39%.* The federal and state governments have attempted to hold down growth in costs of health programs—but federal programs alone continue to make up nearly a third of all Alaska's health-care spending. Local government spending for health programs remains small, relative to that of the state and federal governments, and the increase in local spending was smaller as well.

Figure 6. Changes in Who Pays for Alaska Health-Care, 2005-2010



Source: Authors' estimates

How About Health-Care Jobs?

This summary looks at health care from the perspective of spending for care—but it's important to remember that the spending also supports jobs for Alaskans. As the Alaska Department of Labor and Workforce Development reports in its August 2011 *Alaska Economic Trends*:

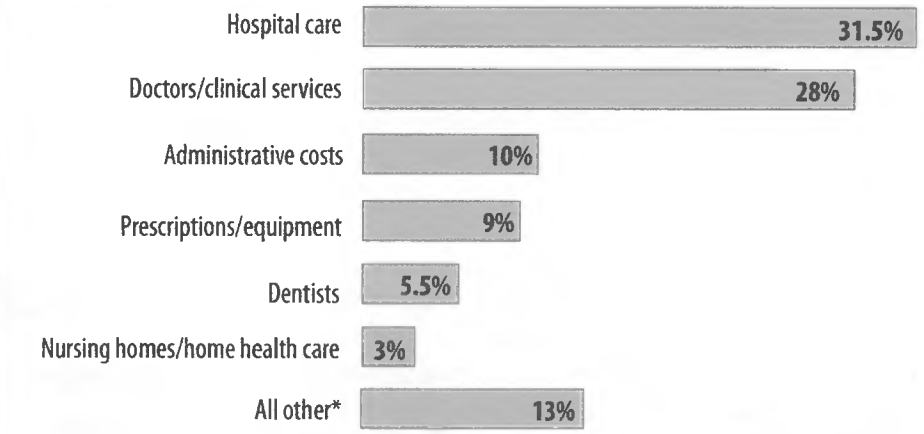
- Health-care spending directly supports 31,800 jobs in Alaska. That's one in ten of all wage and salary jobs—in hospitals, offices of doctors and other providers, nursing homes, and many other places.
- Many additional jobs related to health care—in government agencies, and among the self-employed—aren't included in that total.
- Alaska employment in health care has been increasing at an annual rate of 4.3% for the past decade.

What Do Health-Care Dollars Buy?

Alaska's $7.5 billion health-care bill includes everything from visits to doctors and dentists to prescriptions and nursing-home care.[5] Figure 7 summarizes what Alaska's health-care dollars bought in 2010.

- *Hospital care was the largest expense,* followed closely by payments for doctors and related clinical services—together they accounted for about 60% of Alaska health-care spending in 2010.
- *Administering private and public insurance plans cost one of every ten dollars* spent for Alaska health care in 2010. That's more than spending for prescriptions and medical equipment, and nearly twice the spending for dentists.
- *Spending for nursing homes and home-health care made up only about 3%* of total spending, even though spending for home health care has increased rapidly in the past decade. Much of this care is paid for under Medicaid.

Figure 7. What Do Alaska's Health-Care Dollars Buy?
(2010 Spending: $7.5 Billion)



*Other personal and professional care and public health activities.

Source: Mark A. Foster and Associates estimates, based on Centers for Medicare and Medicaid Services, National Health Expenditure accounts

What's Been Driving Growth in Health-Care Spending?

Health-care costs in Alaska are higher than U.S. averages partly because of small markets and other conditions specific to Alaska (see page 8). But the factors that have been driving *growth* in spending are common to Alaska and the rest of the country. Some of these are general factors—that is, factors that add to spending not only for health care but for everything. Others are specific to health-care spending.

General Growth Factors

Some factors have contributed to growth in spending for all sorts of things, including health care:

• *More people and more older people.* Alaska's population was up 13% in the past decade, and it's projected to increase nearly 10% in the next (Figure 8). And the percentage of Alaskans 65 and older is rising—up from 6% to 8% since 2000 and projected to reach 12% by 2020 (Figure 9). Older people have more health problems and so higher medical costs.

• *General inflation.* The Anchorage consumer price index recorded an increase of nearly 14% from 2005 to 2010 (Figure 10).

• *Growing incomes.* As the economy grew, Alaskans and other Americans spent more not only for health care but for most goods and services.

Factors Specific to Health-Care

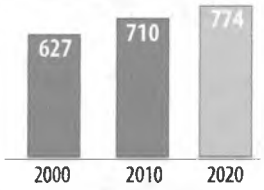
Other factors that have been driving up spending are specific to health care:

• *Faster inflation in health-care costs.* The health-care industry has been growing fast, in Alaska and nationwide, putting upward pressure on prices of many things that make up overall health-care costs. That partly explains why costs of medical care as reported in the Consumer Price Index (CPI) have been rising faster than general inflation (Figure 10). But the CPI also reflects some of the costs of new health-care technologies. It's impossible to sort out how much each factor contributes to growth in the CPI for medical-care—but it's important to recognize that the CPI is measuring not only changes in prices but changes in what is being priced.

• *New technologies and drugs.* Health care is not a fixed commodity but rather is continually changing as new technologies and drugs are developed. Some of these certainly make care more effective, while others may not—but adopting them adds to the price of health care.[6]

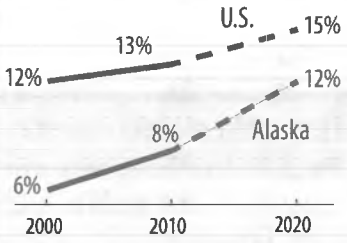
• *More use of medical services.* Alaskans and other Americans are making more visits and having more procedures, partly because they have new options but also because more are older. The changing prevalence of disease—some illnesses are more common and some less so—may also be increasing use of services. And a broad increase in insurance coverage in the past several decades may also have added to use.

Figure 8. Historical and Projected Alaska Population
(In Thousands)



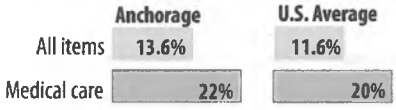
Sources: U.S. Bureau of the Census; Alaska Department of Labor and Workforce Development

Figure 9. Percentage of Population 65 or Older



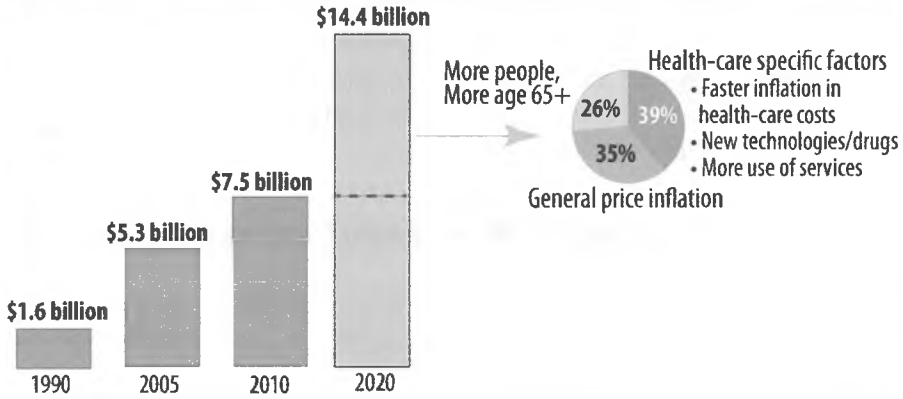
Sources: U.S. Census Bureau, 2010 population projections; Alaska Department of Labor, 2010 population projections

Figure 10. Increase in Consumer Price Index, Anchorage and U.S. Average, 2005 to 2010



Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers

Figure 11. Alaska Health-Care Spending Could Double by 2020, At Current Trends: What's Driving Growth?



Source: Mark A. Foster and Associates estimates, based on Centers for Medicare and Medicaid Services, National Health Expenditure accounts

What's Ahead?

Looking forward, Alaska's health-care spending could double in the next decade. Why? As Figure 11 shows:

• *General factors will likely account for about 61%* of growth between 2010 and 2020—with general price inflation accounting for 35% and a growing and aging population 26%.

• *The remaining 39% of projected growth can be traced to health-care specific factors.* But sorting out how much of that 39% can be traced to any specific factor—like more use of services—is impossible.

What Health-Coverage Do Alaskans Have?

Here we look at how individual Alaskans cover health-care costs. Many Alaskans have more than one type of coverage. The figures here are from two sources, which ask slightly different questions and use different definitions.

Figure 12 shows coverage for children for the period 2006 to 2008. It's from the American Academy of Pediatrics, based on the Current Population Survey (CPS), but with an important adjustment for Alaska.

Alaska Native children are eligible for care through the Indian Health Service, at IHS-supported clinics and hospitals; many also have coverage through Medicaid or private insurance. For some reason we don't understand, the CPS classifies children with *only* IHS coverage as "uninsured."

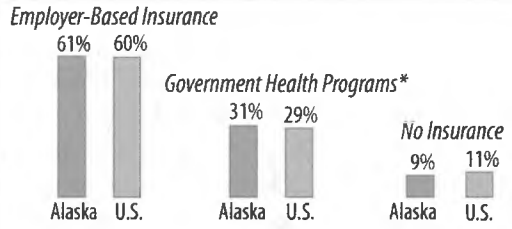
But the Academy of Pediatrics takes these IHS-only children out of the uninsured category, because they in fact have medical coverage. Classifying them as "uninsured" substantially increases the share of Alaska children shown as having no coverage. So keep in mind that the unadjusted CPS figures—which are often cited and used for comparisons across states—show a larger share of Alaska children as uninsured.[7]

Figure 12 shows 9% of Alaska children were uninsured in recent years. Based on 2010 census figures, that would be roughly 17,000 children. Children are less likely than adults to be uninsured. Denali KidCare—the Medicaid expansion for children and pregnant women—provides coverage for many children. The estimated share of uninsured children is smaller in Alaska than nationwide—9% versus 11%—in part because of IHS coverage.

Figures 13 and 14 show coverage for adult Alaskans, reported in a joint federal-state survey. That survey asks respondents to name only the coverage that pays *most* of their bills—but again, many Alaskans have more than one type of coverage.

- *Nearly one in five adults reported being uninsured in 2008*— based on 2010 census figures, that would be about 85,000 adults. Lack of insurance is most common among young adults, especially men.
- *Alaska's large number of military personnel and veterans is reflected in the 11%* of adults—mostly men—who report having coverage through either the military or the Veterans Administration.
- *About 9% of adults rely on Medicare.* But in Anchorage and other large Alaska communities, most primary-care doctors don't accept new Medicare patients.[8] So older Alaskans who have other options are using them—as the figure below shows.
- *Only 3% of adults in Alaska report relying on Medicaid,* while state figures show a substantially larger percentage (page 3). That discrepancy could be due to several things. Many Medicaid enrollees self-report themselves as uninsured. Also, some of those eligible for care through the Indian Health Service but also enrolled in Medicaid may have cited IHS as their principal source of coverage.

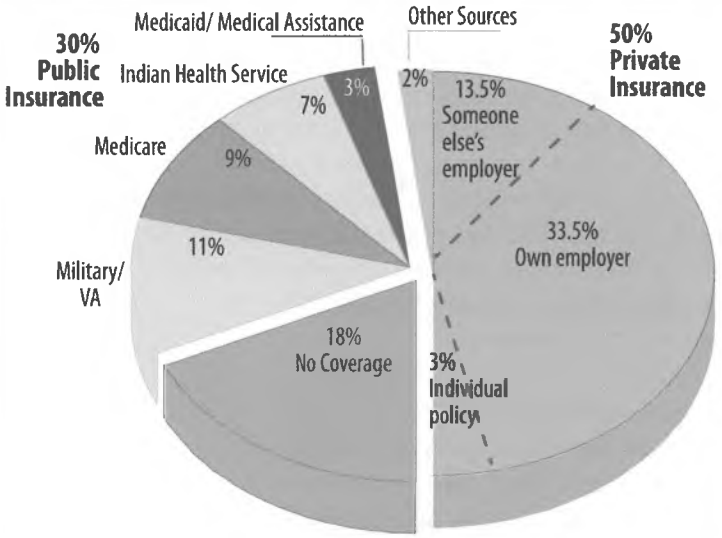
Figure 12. Health-Care Coverage for Children (18 and Under), Alaska and U.S.
(Average 2006-2008)



*Includes children enrolled in Medicaid and children eligible for care through the Indian Health Service and not covered by private insurance or Medicaid.

Source: American Academy of Pediatrics, based on Current Population Survey

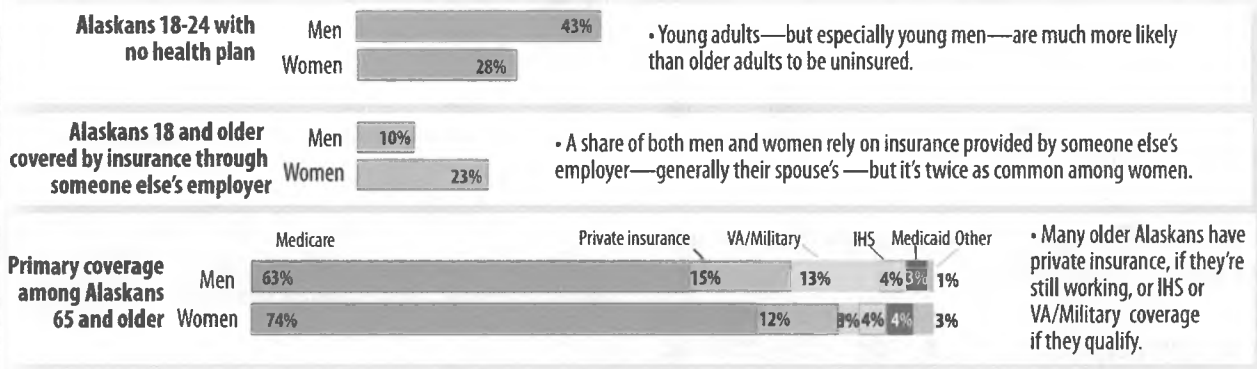
Figure 13. Health-Care Coverage by Type Among Alaskans 18 and Older, 2008*



*Type of coverage that pays most medical bills. Some Alaskans have more than one type of coverage; the survey asks respondents to list only the coverage that pays most of the bills.

Source: Behavioral Risk Factor Surveillance System survey, 2008

Figure 14. Differences in Coverage among Adult Alaskans, by Age and Sex



Source: Behavioral Risk Factor Surveillance System survey, 2008

Finally, uninsured Alaskans do have access to some care. Government-funded community health centers provide care and charge according to income, and federal law requires hospital emergency rooms to see all patients who come in. Also, annual insurance status is measured at a specific time; some people gain or lose coverage during the year.

How Many Alaska Businesses Offer Health-Insurance?

About 50% of adults in Alaska report using private insurance as their primary coverage (Figure 13). Here we report how many Alaska businesses offer insurance and how much it costs, based on a federal survey.

Figures 15 and 16 show that in the face of fast-rising premiums in recent years, businesses in Alaska and nationwide have been shifting more of the costs of insurance to their employees—and many small businesses have been dropping coverage altogether.

Premiums remain higher in Alaska, especially for single-person coverage. On the other hand, Alaska employees still pay a smaller share of premiums than the average U.S. employee.

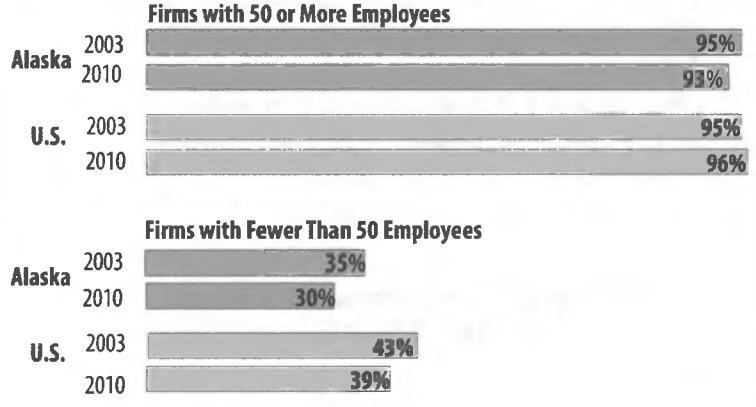
But keep in mind that premiums are only part of employee health-care costs. Employees pay not only their share of premiums, but also deductibles and co-pays. It's likely that many employers have also raised deductibles—the amount employees have to pay before insurance kicks in—as costs increased. Deductibles can be thousands of dollars.

Patterns of increase in premiums were not consistent between Alaska and the U.S. as a whole in recent years—and in Alaska, premiums for single-person coverage increased much faster than premiums for family coverage. We don't have enough data to explain what caused those differences.

Also, comparisons over time are complicated by changes in who's paying and what's being covered. So while the figures here are useful for showing patterns, remember that many things can affect premiums.

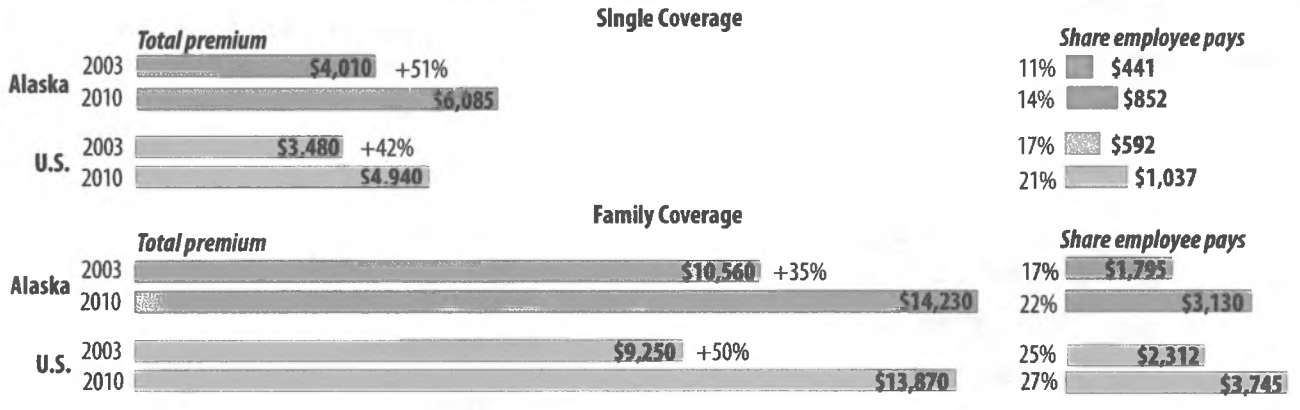
- *Almost all large businesses in Alaska offer employee health insurance*—but that share dropped from 95% in 2003 to 93% by 2010. Nationwide, the share of large businesses offering insurance actually blipped up, from 95% to 96%.
- *Relatively few small Alaska businesses offered employee insurance in 2003*, and that share got even smaller by 2010, dropping from 35% to 30%. The share of small businesses nationwide offering insurance also dropped, but at 39% it's still higher than in Alaska.
- *Premiums for single-person coverage in Alaska went up more than 50%* from 2003 to 2010, compared with a 40% increase around the country. Premiums were already higher in Alaska in 2003, and the gap widened in recent years. Single-person premiums in Alaska were 15% higher than the U.S. average in 2003, but 23% higher by 2010.
- *Family coverage in Alaska cost 35% more in 2010 than in 2003.* But around the U.S., premiums for family coverage jumped 50%. And because of that faster growth nationwide, by 2010 premiums for family coverage in Alaska were only about 3% higher than the U.S. average.
- *Private employees in Alaska paid about 14% of premium costs* for single coverage in 2010, up from 11% in 2003. In the U.S. as a whole, the employee share for single coverage went from 17% to 21%.
- *The employee share for family coverage in Alaska was 22% in 2010*, up from 17% in 2003. Around the country, the employee share for family coverage was 27% in 2010, up from 25%. Still, even though Alaskans saw a bigger percentage increase, their payments for family coverage in 2010 remained below the U.S. average—$3,130, compared with $3,745.

Figure 15. Percentage of Private Firms Offering Health Insurance, Alaska and U.S. Average, 2003 and 2010



Source: Medical Expenditure Panel Survey, 2003, 2010

Figure 16. Health Insurance Premiums at Private Firms, U.S. and Alaska, 2003 and 2010



Note: Figures are not adjusted for possible differences in coverage provided.

Source: Medical Expenditure Panel Survey, 2003, 2010

How is Alaska Different?

Health-care spending of $7.5 billion is a lot for a population of around 710,000. We can't entirely explain why that health-care bill is so high, but we know that special characteristics of Alaska contribute.

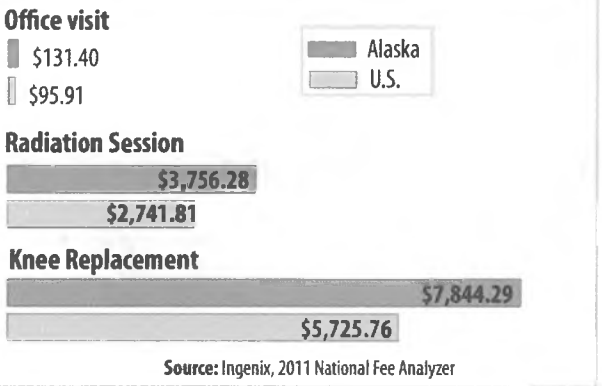
- Costs of most things remain higher than the U.S. average, because of Alaska's distance from the Lower 48, its many small, remote communities, and other factors. Improved transportation and growing urban markets have sharply reduced but not eliminated that historical difference in living costs.
- Alaskans have higher incomes than the U.S. average, and more work for government. People with more income tend to spend more for health care. Also, about one-quarter of Alaska jobs are in federal, state, or local government. Government jobs usually have good health insurance.
- Alaska's health-care system also faces conditions that tend to keep prices for care higher, relative to other U.S. places. Those include:

Alaska has to compete for doctors and other health-care professionals —and Alaska continues to be at a competitive disadvantage with other states. It's isolated; it has long, harsh winters; and many of its communities aren't even on the road system. To attract health-care workers, Alaska often has to offer them the opportunity to earn more or have other benefits.

Small, isolated Alaska hospitals tend to have higher staffing levels per patient than facilities in other states. Alaska hospitals outside urban areas are small and more isolated than small hospitals in other states. The number of patients in small Alaska hospitals can move up and down quickly—but they need to maintain enough capacity to meet times of high demand.

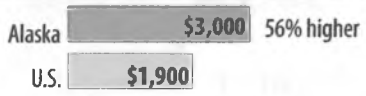
Small markets. Roughly half of all Alaskans live in Anchorage and nearby areas, but Alaska has hundreds of small communities—and the small markets in those places mean providers can't take advantage of economies of scale and have limited competition.

Figure 17. Private Insurance Payments to Doctors, Alaska and U.S., 2011



Source: Ingenix, 2011 National Fee Analyzer

Figure 18. Hospital Costs per Inpatient Day, 2009



Sources: Ingenix Almanac of Hospital Financial Operating Indicators; Medicare Cost Reports, Median Values

Those factors don't entirely explain Alaska's high health-care spending, but they help put it in context. Figures 17-19 show examples of price differences for medical care in Alaska and the U.S. as a whole.

- *Doctor's fees are in the range of 35% higher* for common procedures in Alaska, as Figure 17 shows. For example, private insurance might pay on average $3,700 for a radiation session in Alaska, compared with about $2,700 nationwide.
- *Average hospital costs per day are 56% higher in Alaska* (Figure 18).
- *Prescriptions on average cost 50% more in Alaska* in 2009, up from 26% in 2003 (Figure 19). At least part of that growing difference in price may be that generic drugs—which cost considerably less than brand-names—are not used as much in Alaska. There is also some evidence that Alaska's medical practitioners tend to quickly adopt new drugs, which are typically expensive.

Figure 19. Average Price of Prescriptions, Alaska and U.S., 2003 and 2009

Source: Kaiser Family Foundation, State Health Facts, Special Report

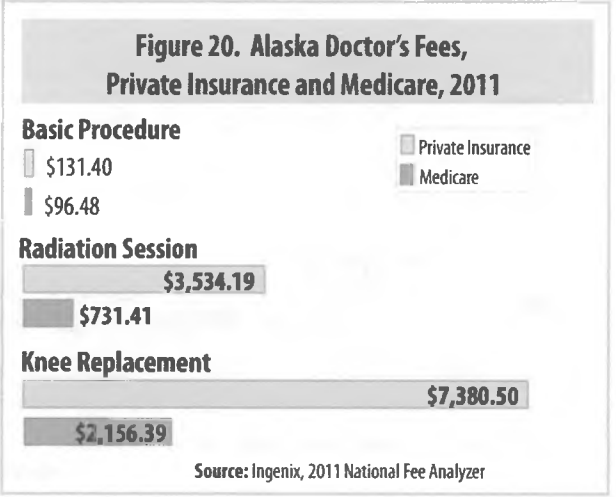
Gap in Medicare and Private Insurance Payments

Another health-care issue that's gotten a lot of attention in the past few years—especially in Alaska but also in the country as a whole—is the shortfall between what Medicare pays doctors and what private insurance pays them. Figure 20 provides examples of procedures, with Medicare paying only 30% to 77% of what private insurance pays.

And Medicare payments to doctors are scheduled to be reduced, as the federal government tries to hold down spending for the huge Medicare program.[9]

It's far outside the scope of this paper to discuss the possible future path for Medicare. Here we just want to note that if Medicare pays providers less than their actual costs, providers will attempt to recoup some of those costs by charging higher prices for those with private insurance. But we don't have data on providers' actual costs.

Figure 20. Alaska Doctor's Fees, Private Insurance and Medicare, 2011



Source: Ingenix, 2011 National Fee Analyzer

How is Spending Distributed?

Health-care needs differ across Alaskans and other Americans: some of us are born with genetic predispositions to certain illnesses; some of us take better care of ourselves; some of us are older and have costly, chronic ailments; some of us are just lucky.

We don't have figures specifically for Alaskans, but patterns of spending for Alaskans are not likely to be much different from those for all Americans. Here we look at average spending in the U.S. by type of ailment; by shares of the population; and by age.

Keep in mind that we're looking at how much the health-care system as a whole spends for certain groups—not how much individual Americans spend directly.

• *Patients with major acute ailments—like heart attacks or strokes—make up only about 8% of all patients treated across the U.S. but account for more than 22% of the cost.* Similarly, patients with major chronic ailments—like heart disease or diabetes—make up only about 5% of patients in the U.S. but account for 34% of costs (Figure 21).

• *By contrast, those with minor acute ailments make up 28% of all patients but are responsible for only 8%* of the costs. Those with minor chronic ailments—which don't require as intense care—make up 41% of patients but account for just 35% of costs.

• *Just 10% of Americans are responsible for 65% of all health-care spending in a typical year*—and the 1% of most expensive patients alone account for 20% of all spending (Figure 22).

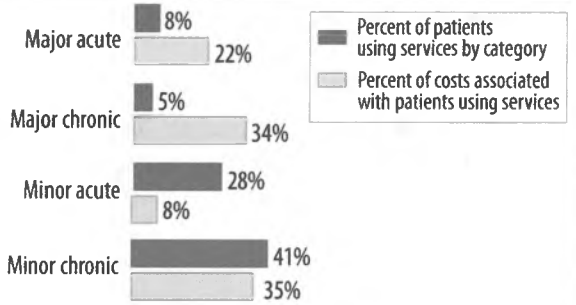
• *At the other extreme, half the population is responsible for only 3%* of health-care expenses—and 15% of Americans have no expenditures at all.

• *Americans with the highest expenses are disproportionately older, women, and White.* The uninsured make up only a tiny share (2%) of the patients with the highest medical bills—but those costs are covered either by government support or through higher prices for those with insurance.

• *Americans with very small health-care costs are mostly young* and one-quarter are uninsured—and many are Black or Hispanic men.

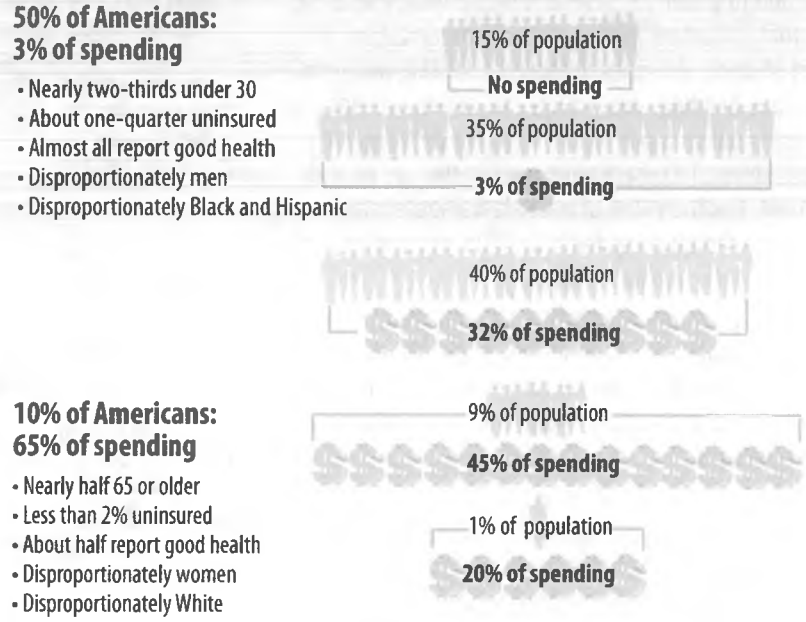
• *Health-care spending routinely increases with age—although among infants it's driven up* by the high costs of care for premature babies. Spending is at its lowest among children, increases somewhat through the 20s and 30s, and then begins a steep climb so that spending among those 85 years old averages nearly 10 times as much as among children (Figure 23).

Figure 21. Use and Costs Among Patients with Acute and Chronic Ailments in U.S.



Source: Adapted from Harold S. Luft, *Total Cure*, Harvard University Press, 2008

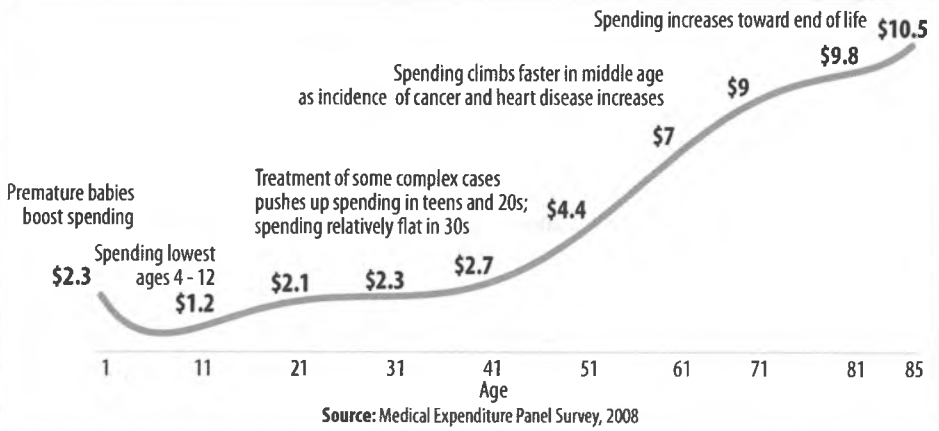
Figure 22. Distribution of Health-Care Spending per Person, U.S., 2008



Note: health-care spending here is defined as payments to hospitals, doctors, dentists, other health-care providers, and pharmacies by individuals or by private or government health insurance.

Source: MEPS Statistical Brief 309, *The Concentration and Persistence in the Level of Health Expenditures Over Time*, Agency for Healthcare Research and Quality, December 2010

Figure 23. Average Health Care Expenditures Among Americans, by Age, 2008
(In Thousands of Dollars)



Source: Medical Expenditure Panel Survey, 2008

Are Alaskans Healthier?

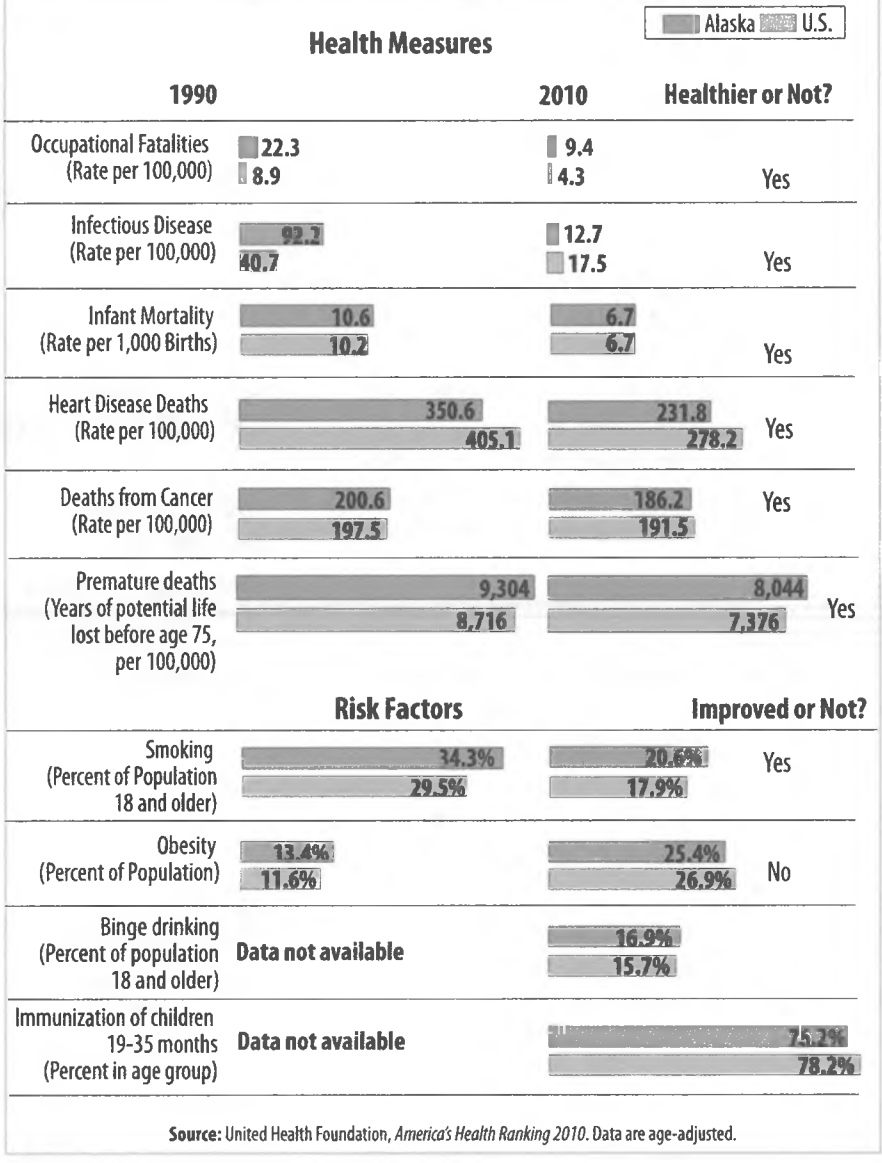
On a number of broad measures, Alaskans are healthier now than they were 20 years ago—and in some cases healthier than other Americans, as Figure 24 shows.

- *Deaths on the job are less than half as common* in Alaska now as in 1990, dropping from 22 per 100,000 to about 9 per 100,000—reflecting improved safety measures in many occupations, as well as the fact that a bigger share of Alaskans now work in generally safer jobs, like in retail stores. But many Alaskans still work in dangerous jobs—commercial fishing, for instance—so Alaska's rate of occupational fatalities remains twice that of the U.S. as a whole.
- *The rate of infectious disease in Alaska is now a small fraction* of what it was in 1990—down from 92 per 100,000 to under 13. Several things probably account for that, including higher rates of immunization. But a lot of credit also goes to federal and state programs that are building safe water and sewer systems in remote rural communities. The Alaska Department of Environmental Conservation reports that as recently as 1994, less than 40% of rural Alaska households had adequate sanitation systems. By 2005, nearly 80% had running water and flush toilets.[10]

And it's worth noting that the hundreds of millions of dollars the federal and state governments have spent for these sanitation systems is *not* defined as health-care spending—and so it's not included in our estimates.

- *Infant mortality has dropped sharply in both Alaska and the U.S. since 1990*, down from more than 10 infant deaths per 1,000 births to under 7. Experts say that infant survival is tied not only to the health of the mother but also to social and economic conditions in the communities where they're born, public health practices, and the availability of health care.[11]
- *Rates of death from heart disease and cancer—but especially heart disease—are down from 1990s levels* in both Alaska and the country as a whole. Treatments for those conditions have improved, and fewer Americans are smoking—which is a big risk factor for heart disease and cancer. Death rates for both heart disease and cancer are lower in Alaska than nationwide, even when adjusted for Alaska's younger population.
- *Alaskans are less likely to die prematurely now than they were in 1990,* but still more likely than other Americans to lose years off their lives—partly due to higher rates of occupational and other injury deaths.
- *The percentage of adult Alaskans who smoke has dropped from 34% in 1990 to about 21%*—but that remains above the national average, and means that one in five of all adult Alaskans still smokes.
- *Obesity is almost twice as common in Alaska now as in 1990.* Analysts link obesity to higher rates of diabetes, heart disease, and other illnesses.
- *Nearly 17% of adults in Alaska report binge drinking*—somewhat higher than the 16% among all Americans.

Figure 24. Changes in Health Measures and Risk Factors, 1990 -2010



Source: United Health Foundation, *America's Health Ranking 2010.* Data are age-adjusted.

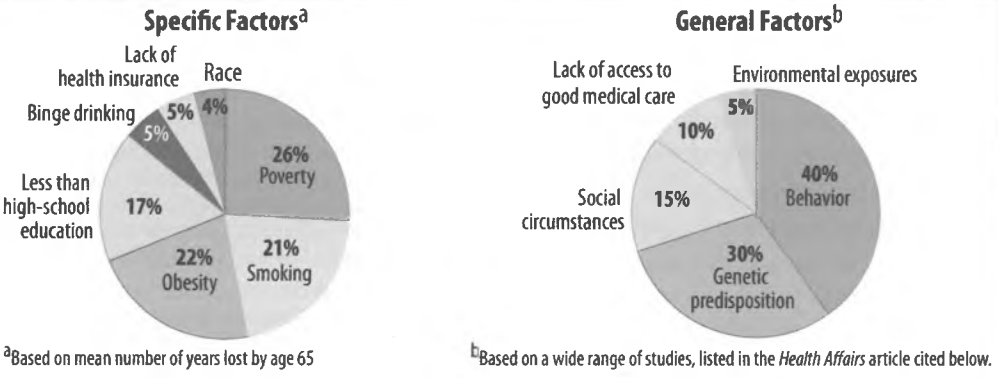
- *About one-quarter of Alaska children don't have all the recommended immunizations* before age three. The U.S. rate is only slightly better.

It's beyond the scope of this study to provide a detailed comparison of the quality of health care in Alaska with that in the rest of the U.S. or other countries. Measuring the quality of health care has many dimensions, and comparisons are influenced by many factors.

Still, even though comparisons across countries are fraught with complexity, it's worth pointing out that data collected by the World Health Organization currently rank the U.S. number 31 in "healthy life expectancy"—the number of years that a person can expect to live in "good" health. With an expectancy of 70 years, the U.S. is 6 years behind the perennial leader, Japan, where healthy life expectancy is 76 years.

Some of the difference is due to a higher U.S. infant mortality rate, compared with that of other developed countries—but the higher mortality rate among Americans persists throughout the adult years. Some of the difference can also be traced to the high homicide rate in the U.S.—double that of most European countries.

Figure 25. What Contributes to Early Deaths of Americans?



[a]Based on mean number of years lost by age 65

Source: *American Journal of Public Health*, Vol. 100, No. 9, " The Relative Health Burden of Selected Social and Behavioral Risk Factors in the U.S.," September 2010

[b]Based on a wide range of studies, listed in the *Health Affairs* article cited below.

Source: *Health Affairs*, Volume 21, Number 2, "The Case for More Active Policy Attention to Health Promotion," March/April 2002

What Contributes to Longevity?

Analysts are continuing to explore how important various factors are in making Americans live longer, healthier lives. They have looked at the issue in different ways, with different emphases. Figure 25 shows results from two assessments of what subtracts years from our lives. One assigns weight to specific factors—like smoking or lack of education—and the second generalizes to broader categories, like behavior and social circumstances.

The two ways of looking at the question aren't parallel, but they also aren't mutually exclusive. For instance, obesity—cited in the left-hand pie as one of the big contributors to early death—can be influenced by several factors in the right-hand pie: behavior (what people eat, as well as how much they eat); genetic predisposition; and social circumstances—for example, people without much money may eat more starchy, high-sugar foods that are cheaper but unhealthier.

What both sets of analysts do agree on is that lack of health insurance, or lack of access to good medical care, play relatively small roles in the overall longevity of Americans. That's not to say medical care isn't important: it saves thousands of lives daily.

But in the big picture, there are also many other individual, community, and social factors that affect health.

What About Health-Care Reform?

An obvious question, as we close this discussion of Alaska's current health-care spending and likely future growth, is how the 2010 federal health-care reform law might affect spending and coverage in Alaska.

We're not going to discuss that very complex question in this paper. The health-care reform law—formally, the Patient Protection and Affordable Care Act—runs to hundreds of pages and calls for substantial changes in health insurance and health-care sectors over the next decade. There is still uncertainty about how all the provisions will play out, or how they might be affected by any future changes in the law.

One of the authors of this paper has taken a preliminary look, in a separate paper, at the broad possible economic effects of the law in Alaska over the next decade. That paper finds that by 2019 overall health-care spending in Alaska is likely to be somewhat higher than it would otherwise have been—perhaps in the range of 3% to 4% higher—mostly because the new law will expand health-care coverage.[12]

Getting Good Value for Health-Care Spending

Analysts generally agree that the hundreds of billions of dollars Americans spend for health care are not giving us as much value as we should expect. Among the problems commonly cited are unnecessary care, fraud, system inefficiencies, failure to coordinate care, and care that could have been avoided, through preventive measures.[13] Spending per capita on health care is higher in the U.S. than in other developed countries, and yet by some measures the quality of care is lower.

Some researchers even believe we may be at a point where increased health-care spending is not translating into significant reductions in rates of illness and death. And clearly, fast growth in the nation's health-care bill limits our ability to pay for other important needs.

A growing, aging population and general inflation will continue to drive up the health-care bill in Alaska and across the country, as they have in the past. Rising incomes among Americans, and adoption of new technologies, will also add to future spending.

No one is suggesting that the U.S. try to curb health-care spending by reducing the development and implementation of new technologies that might provide real advances in health care. But we do need to think about how to rein in the growth in spending and get the best value from our health-care dollars.

What can we do? Many people inside and outside the health-care system agree on some general guidelines for change.

- *Consumer activism and improved transparency.* Patients should become more careful consumers of health care, and doctors and other providers should provide better information on alternate treatments and their comparative effectiveness.
- *System improvements and care coordination.* Hospitals, doctors, and other health-care providers should promote integrated delivery systems that put the patient at the center of the process. Building shared electronic medical record systems will be an important part of that.
- *Medical homes and culture of health.* Providers and patients should think of themselves as in a partnership, with the patients and the caregivers each taking an active part. Patients should take more responsibility for managing their own health—by paying attention to their own behavior, taking steps to try to prevent disease, and getting appropriate care for chronic diseases.

• *Patient safety and quality improvement.* The health-care industry should support initiatives to improve the quality of care and encourage a culture that continually strives to improve care.

• *Simplify reimbursement and reduce opportunities for fraud.* Providers, administrators, and patients should join together to help find ways of making the billing process easier and eliminating fraud, as well as recognizing those who demonstrate integrity in both billing and paying.

With those general guidelines in mind, many analysts suggest there are two areas of systemic reform that could help make the health-care system more efficient and cost-effective, and also moderate the rate of growth in future health-care spending. Those reforms are: changing how we pay for care, and changing how care is provided.

The current payment system is dominated by "fee-for service," which means payments to health-care providers are directly related to the volume of services they provide. So there's little incentive to reduce unnecessary care. By contrast, under a "bundled payment" approach, multiple providers are paid a single sum for all the services related to one episode of care—for example, a hospitalization plus a period of post-acute care. Some providers are adopting that payment system.

The current system for providing health care doesn't have mechanisms to screen treatments for either their medical effectiveness or their cost effectiveness. Many people agree that a reasonable step would be closer analysis of what treatments and technologies are worth the cost.

The challenge, of course, is that while many people believe the health-care system needs to be reformed, they disagree about how to make the changes. Also, the hurdles in reforming a system with very powerful vested interests will be formidable. But the savings from making the kinds of changes we just discussed could be in the range of 3% to 10% over 10 years.[14]

Given this national context, what about Alaska? Alaska's health-care system will always face challenges created by its special circumstances—remoteness and small, widely disbursed population—that will add to the cost of health care here, compared with other states.

Reducing that cost differential will require special programs—for example, investing in a "home-grown" supply of health-care workers. But Alaska has also already put into effect a number of initiatives to improve the value we get for our health-care spending.

One example is the Southcentral Foundation (serving Alaska Natives) which operates a patient-centered primary care system—NUKA—that the foundation reports has reduced per patient costs.[15] Another example is the recent training of dental technologist to do certain kinds of dental work in rural areas, to reduce the need to either fly dentists into remote villages of fly dental patients out. The state government also reduced the rate of growth in Medicaid spending in recent years, and the legislature recently expanded the state's authority to review increases in health-insurance rates.

Alaska's total health-care bill will continue to go up in the coming years, given that much of the bill is driven by population and general inflation. But potential systemic reforms—along with more initiatives like those we've just discussed—can make inroads in that growth, and give Alaskans more confidence that we're getting better value for our health-care dollars.

Endnotes

1. Centers for Medicare and Medicaid Services, *Health-Care Expenditures by State of Provider; Health Expenditures by State of Residence*, 2004.

2. Reported by Alaska Division of Insurance, FY 2010 Annual Report, Statistical and Financial Data, Accident and Health Market Share, Total Market, Direct Percent of Market, page 78.

3. See Family Medicaid Eligibility Manual, Alaska Department of Health and Social Services, Division of Public Assistance: http://dpaweb.hss.state.ak.us/manuals/fam-med/fmem.htm.

4. Here we use enrollment estimates of the Alaska Department of Health and Social Services, Medicaid Budget Group. Those estimates are not directly comparable to figures commonly found on the Kaiser State Health Facts website, which are from the Centers for Medicare and Medicaid Services and are based on enrollment counts for federal fiscal years. Reconciling the differences, typically less than 10%, was beyond the scope of this analysis.

5. We define health-care costs based on what's included in the National Health Expenditure accounts of the Centers for Medicare and Medicaid Services. These accounts include: hospital care; physician and clinical services; other professional services; dental services; other personal health care; home health care; nursing care facilities and continuing care retirement facilities; prescription drugs; durable medical equipment; non-durable medical products; government administration and net cost of private health insurance; government public health activity; and research structures and equipment.

6. Analysts often disagree about the effectiveness of new treatments. See, for example A. Rosen, et al., "The Value of Heart-Disease Care for the Elderly," *Health Affairs*, Vol. 26, No. 1, 2007; and M. Rothberg et. al., "Little Evidence of Correlation Between Growth in Health-Care Spending and Reduced Mortality," *Health Affairs* , Vol. 29, No. 8, August 2010.

7. The CPS also shows a smaller share of Alaska children—around 30%—relying on Medicaid in the 2006-2008 period than 2010 state figures show—about 40%. This may be because the figures are from different periods, or because the CPS is an underestimate.

8. Mark A. Foster and Rosyland Frazier, "How Hard Is It for Medicare Patients to Find Family Doctors," *Understanding Alaska* Research Summary No. 14, Institute of Social and Economic Research, University of Alaska Anchorage, March 2009.

9. Mark A. Foster and Associates, Medicare section, *Estimated Economic Effects of the Patient Protection and Affordable Care Act, As Amended, in Alaska*. May 2011. Also, the recent Congressional agreement to raise the U.S. debt limit includes requirements for future budget cuts that could also affect Medicare reimbursement levels.

10. Alaska Department of Environmental Conservation, Village Safe Water program. See www.dec.state.ak.us/water/vsw/index.htm

11. B. Hamilton, J. Martin, S. Ventura, "Births: Preliminary Data for 2007," National Vital Statistics Reports, Volume 57, National Center for Health Statistics, 2009.

12. See note 9.

13. See, for example, B. Kelley and R. Fabius, *A Path To Eliminating $3.6 Trillion in Wasteful Health-Care Spending*, White Paper, Thomson Reuters, June 2010, at factsforhealthcare.com.

14. See, for example, Hussey, et al., "Controlling U.S. Health-Care Spending—Separating Promising from Unpromising Approaches," *New England Journal of Medicine* 2009, 361: 2109-2111, November 26, 2009; and B. Kelley and R. Fabius, cited in note 13.

15. See http://southcentralfoundation.com/files/nuka.pdf

About ISER

The Institute of Social and Economic Research at UAA is Alaska's oldest and largest public policy research organization—celebrating its 50th anniversary in 2011. It's in Anchorage at 907-786-7710. For more information go to:

www.iser.uaa.alaska.edu

About the Authors

Scott Goldsmith is a professor of economics at ISER who has studied the Alaska economy and public policy issues for 35 years.

Mark A. Foster is a consultant to ISER, with many years of experience in analyzing health-care issues in Alaska.

Editor: Linda Leask • Graphics: Clemencia Merrill

Appendix B

Hospital & Physician Payment Studies by Milliman, Inc.

Studies Conducted under Contract for the Commission during 2011

1. **Physician Payment Rates in Alaska and Comparison States, November 29, 2011**

2. **Facility Payment Rates in Alaska and Comparison States, November 21, 2011**

3. **Drivers of Health Care Costs in Alaska and Comparison States, November 29, 2011**

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

Milliman

Physician Payment Rates in Alaska and Comparison States

Prepared for:
Alaska Health Care Commission

Prepared by:
Milliman, Inc.
1301 Fifth Ave.
Seattle, WA 98101-2605

John Pickering, FSA, MAAA
john.pickering@milliman.com
206 504 5884

Edward Jhu, FSA, MAAA
edward.jhu@milliman.com
206 504 5828

November 29, 2011

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY 1

2. RESULTS 2

3. METHODOLOGY AND DETAILED RESULTS 9

4. LIMITATIONS AND CONSIDERATIONS 14

APPENDIX A 15

APPENDIX A-1 SUMMARY OF RELATIVE REIMBURSEMENT

APPENDIX A-2 ALL SPECIALTIES

APPENDIX A-3 CARDIOLOGY

APPENDIX A-4 CARDIOTHORACIC SURGERY

APPENDIX A-5 CHIROPRACTIC

APPENDIX A-6 DME

APPENDIX A-7 ENT

APPENDIX A-8 FAMILY PRACTICE/GENERAL PRACTICE

APPENDIX A-9 GASTROENTEROLOGY

APPENDIX A-10 GENERAL SURGERY

APPENDIX A-11 INTERNAL MEDICINE

APPENDIX A-12 INTERNAL CARDIOLOGY

APPENDIX A-13 LABORATORY

APPENDIX A-14 NEUROLOGY

APPENDIX A-15 OBSTETRICS/GYNECOLOGY

APPENDIX A-16 OPHTHALMOLOGY

APPENDIX A-17 ORTHOPEDICS

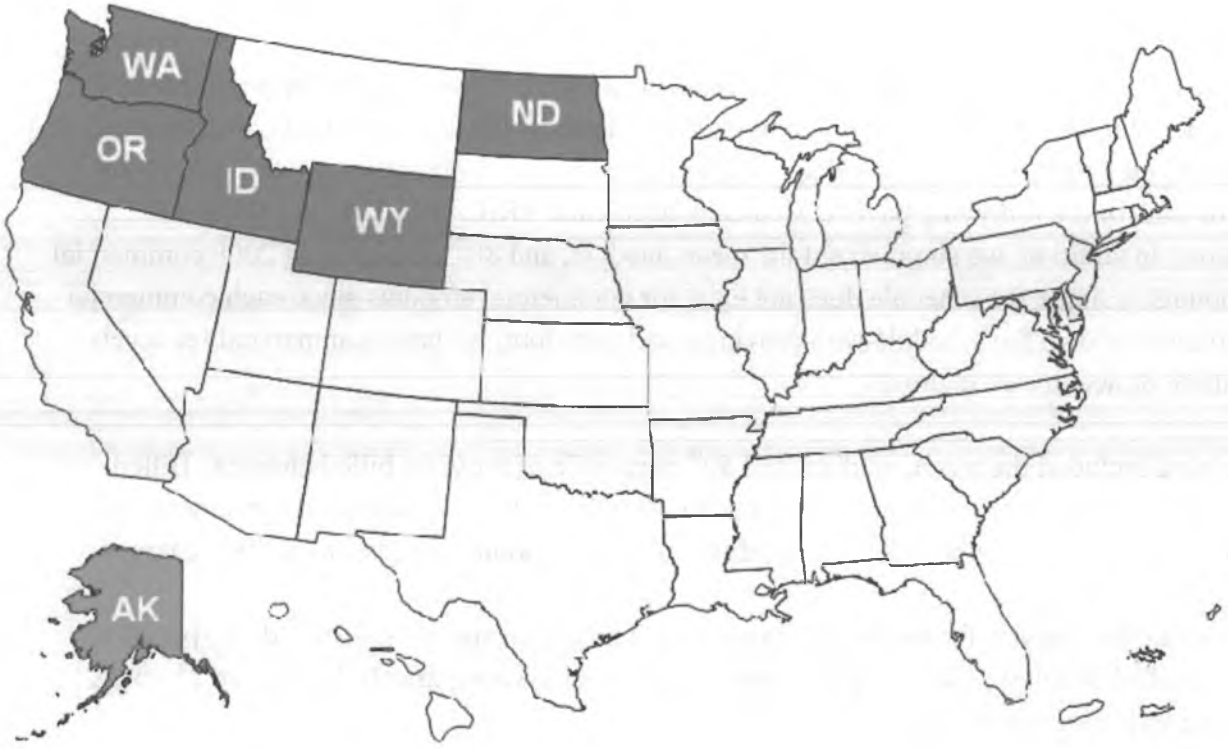
APPENDIX A-18 PEDIATRICS

APPENDIX A-19 RADIOLOGY

APPENDIX A-20 UROLOGY

1. Executive Summary

The Alaska Health Care Commission ("AHCC") engaged Milliman to compare Alaska's health care payment rates and underlying drivers to those in certain other states. The comparison states are Washington, Oregon, Idaho, Wyoming, and North Dakota.



This report is the first of three reports. This report is focused on how Alaska's physician payment rates compare to other states. The second report will analyze facility payment rates. The final report will identify the key drivers of the cost differences across states.

Our results show that Alaska's physician reimbursement is approximately 59% higher than the average of the comparison states. Physician reimbursement in Alaska exceeds each of the comparison states for each type of payer and each provider specialty, though the differential varies. The results here should be interpreted with caution, since they only identify the relative reimbursement among states and do not consider reasons for the differences such as staff wages, cost of living, cost of business operation, or provider availability, which may account for some or all of the relative differences in reimbursement. Analysis of the drivers behind the differences will be presented in the third report in this series.

2. RESULTS

For this report, we define physician reimbursement to be the full amounts that providers may collect for a given service, commonly called "allowed amounts". These allowed amounts include member-paid amounts such as co-pays, co-insurance, and deductibles, as well as payments from the insurer (or government entity).

We compared relative allowed amounts for physicians in Alaska to those in the comparison states for procedure codes that were either in the top 25 by utilization rate or the top 25 in total cost (reflecting both utilization rates and the cost per service). The comparison was done separately using 2011 fee schedules for each of the following payers: Medicare, Medicaid, TRICARE, VA, and Workers' Compensation. In addition, we summarized the mean, median, and 80th percentile of 2009 commercial allowed amounts; a single fee schedule does not exist for commercial amounts since each commercial insurer negotiates its own fee schedule with providers and therefore, we have summarized fee levels from a database of health care claims.

Finally, we have included the mean, median, and 80th percentile of provider billed charges. Billed charges are the amounts that providers bill. In many cases, due either to contractual agreements with commercial insurers or government-set fee schedules, allowed amounts are less than billed charges.

We are providing the analysis for the top 25 codes overall across all specialties (including specialties not included in the list below). We have also performed the analysis separately for the top 25 codes for each of the following specialties:

- cardiology
- cardiothoracic surgery
- chiropractic
- DME
- ENT
- Family practice
- gastroenterology
- general surgery
- internal medicine
- interventional cardiology
- lab
- neurology

- ophthalmology
- orthopedics
- pediatrics
- radiology
- urology

For some specialties, such as chiropractic, there were fewer than 25 codes with significant volume and therefore, some of the analyses by specialty include fewer than 25 codes.

Detailed fee information for each state, payer, specialty and procedure code is included in Appendix A to this report.

Relative Reimbursement by Payer across States

Table 2.1 below shows physician relative allowed charges by state and payer. This table is based upon aggregate data across all of the specialties listed above except for DME. The table is calibrated so that the average across the five comparison states for each payer is equal to 100%. As an example, the 127% shown for Alaska Medicare indicates that Medicare reimbursement in Alaska is equal to 127% of the average Medicare reimbursement in the five comparison states. Across all payers, Alaska relative reimbursement is 160% of the comparison states across specialties that were analyzed.

Table 2.1
Physician Reimbursement Levels by State and Payer

	AK	ID	ND	OR [1]	WA [1]	WY
Medicare [1]	127%	96%	98%	100%	105%	101%
Tricare [1]	182%	97%	97%	101%	104%	101%
VA	215%	96%	98%	100%	105%	101%
Medicaid	174%	99%	134%	87%	68%	113%
Workers' Compensation	190%	108%	98%	107%	86%	N/A
Comm Allowed - Mean	169%	96%	96%	112%	92%	105%
Comm Allowed - Median	181%	94%	97%	113%	88%	107%
Comm Allowed - 80th Percentile	176%	98%	89%	110%	92%	111%
Billed - Mean	142%	90%	96%	113%	107%	95%
Billed - Median	147%	89%	98%	114%	105%	93%
Billed - 80th Percentile	135%	93%	93%	112%	104%	98%
All Payers [2]	160%	97%	105%	102%	91%	103%

All values are relative to the average for the five comparison states (excluding AK) for each payer category

[1] For this summary, the Portland, OR and Seattle, WA Medicare and Tricare fee schedules were used.

[2] The All Payers values are weighted by payer, using national health expenditure data from CMS. The weights are: Medicare - 28%, Tricare - 2%, VA - 2.4%, Medicaid - 20.8%, Workers' Compensation - 2.2%, and Commercial - 44.6%.

For Tables 2.1 through 2.3, summary values are not shown if fee schedule amounts were unavailable for more than half of the expected volume of procedures for combinations of state and payer or state and specialty. However, fee schedule amounts for procedure codes in cells marked as "N/A" are still used to determine the relative payment in other states/specialties where available.

Relative Reimbursement by Specialty across States

Table 2.2 below shows physician relative allowed charges by state and specialty, sorted based on the relative charge for Alaska. This is similar to Table 2.1 except that charges have been blended across payers to estimate the average relative reimbursement for each specialty within each state across all analyzed payer types. Alaska relative charges are once again about 50% higher than the comparison states, across all payers.

Table 2.2
Physician Reimbursement Levels by State and Specialty

	AK	ID	ND	OR [1]	WA [1]	WY
Pediatrics	143%	95%	110%	109%	91%	90%
Family Practice	148%	96%	109%	104%	93%	92%
Internal Medicine	150%	96%	109%	104%	93%	93%
Lab	151%	93%	114%	88%	84%	108%
Ophthalmology	152%	98%	98%	109%	97%	94%
OBGYN	157%	94%	100%	102%	94%	106%
Chiropractic	166%	93%	109%	103%	86%	105%
Urology	167%	96%	103%	105%	90%	101%
Gastroenterology	168%	100%	99%	100%	89%	106%
Radiology	170%	102%	95%	90%	84%	122%
Neurology	173%	101%	104%	102%	92%	97%
Orthopedics	177%	96%	101%	101%	90%	107%
ENT	179%	95%	101%	106%	91%	101%
General Surgery	179%	94%	98%	106%	90%	109%
Cardiology	183%	103%	96%	99%	88%	114%
Cardiothoracic Surgery	N/A	N/A	N/A	99%	92%	N/A
Interventional Cardiology	N/A	N/A	N/A	N/A	N/A	N/A
DME	121%	93%	105%	95%	100%	94%

All values are relative to the average for the five comparison states (excluding AK) for each payer category

[1] For this summary, the Portland, OR and Seattle, WA Medicare and Tricare fee schedules were used.

[2] The totals by specialty are weighted by payer using national health expenditure data from CMS. The weights are: Medicare - 28%, Tricare - 2%, VA - 2.4%, Medicaid - 20.8%, Workers' Compensation - 2.2%, and Commercial - 44.6%.

Values are only reported in Table 2.2 if both commercial and Medicare results were available. Appendix A presents summaries similar to Table 2.2, but presented separately for each type of payer. Appendix A also contains detailed information for all categories, including those with N/A in Table 2.2. The procedure codes used for interventional cardiology have changed in 2011 and as a result, fee schedule amounts for many payers no longer exist for the most commonly used procedure codes historically.

Relative Reimbursement by Payer within States

Table 2.3 below shows the relative allowed amounts within each state, sorted by the relative payment within Alaska. This table is based upon aggregate data across all the same specialties included in Table 2.1. Instead of reading this table across rows, it should be read down each column. This table shows, for each state, the relative reimbursement for each payer as compared to other payers in that state. For example, Medicare fees are 69% of the overall average fees across all payers in Alaska. By comparison, Medicare fees are 82% of the average statewide reimbursement in Idaho. However, the 69% and 82% values cannot be compared to conclude that Medicare reimbursement in Idaho is higher than in Alaska, since the overall average across all payers varies by state (and, as shown earlier in this report, is higher in Alaska than in Idaho).

Table 2.3
Relative physician reimbursement within each state (2009)

	AK	ID	ND	OR [1]	WA [1]	WY
Medicare [1]	69%	82%	80%	79%	95%	82%
Medicaid	83%	78%	100%	63%	55%	85%
Tricare [1]	93%	79%	76%	76%	91%	78%
VA	108%	82%	80%	79%	95%	82%
Comm Allowed - Mean	123%	119%	113%	127%	123%	119%
Workers' Compensation	169%	169%	148%	156%	146%	N/A
All Payers [2]	100%	100%	100%	100%	100%	100%

All values are relative to the All Payers value for each state

[1] For this summary, the Portland, OR and Seattle, WA Medicare and Tricare fee schedules were used.

[2] The All Payers values are weighted by payer, using national health expenditure data from CMS. The weights are: Medicare - 28%, Tricare - 2%, VA - 2.4%, Medicaid - 20.8%, Workers' Compensation - 2.2%, and Commercial - 44.6%.

Changes in Relative Reimbursement over Time

It is important to note that reimbursement rates change over time. While allowed charges typically increase each year due to medical inflation, these changes are not uniform across states, payers or specialties (and often vary across procedure codes) so that relative reimbursement will also change among these categories.

As an example, consider Medicare's geographic reimbursement adjustment for physicians, which is composed of three components: work, practice and malpractice. In very broad terms, the work and practice components have roughly the same weight, with the malpractice component forming a much smaller portion of the total payment. Each of the three components has a base nationwide payment amount for each procedure code which is then adjusted using Geographic Practice Cost Index (GPCI) factors to reach the allowed charge for specific geographic areas. The GPCI factors vary for each of the three components by geographic location, with an average of approximately 1.00 nationwide (prior to the adjustments described below). There are approximately 100 areas nationwide, though many states, including Alaska, have only a single set of GPCI factors for the entire state.

CMS updates the GPCI factors annually, leading to changes in relative reimbursement across geographic areas over time. Changes resulting from CMS's annual updates tend to be fairly small from year to year. Larger changes occur as a result of legislative action that overrides the GPCI factors calculated by CMS. Some recent examples are listed below:

- The Patient Protection and Affordable Care Act (PPACA) of 2010 introduced a minimum value of 1.00 for the practice component of the GPCI in "Frontier States", which include North Dakota and Wyoming. This increased the Medicare reimbursement for those states relative to other states. The practice GPCI was also increased halfway toward 1.00 in all other areas where the value was below 1.00.
- A minimum value of 1.00 was introduced for the work component of the GPCI in 2004. This minimum was introduced as a temporary provision, but has been extended in recent years through legislative action. This provision increases reimbursement in lower cost areas, relative to other areas.
- Beginning in 2009, the work GPCI factor in Alaska was set to a minimum value of 1.50. By comparison, the Alaska work GPCI factor in 2008 was 1.017.

Table 2.4 shows a summary of the GPCI factors in the comparison states before and after the 1.00 work GPCI floor and the practice GPCI changes.

Table 2.4
Comparison of GPCI Factors Before and After PPACA Changes

	2010 GPCI Factors Pre PPACA			2011 GPCI Factors Post PPACA			Change from 2010 to 2011		
Locality	Work GPCI	PE GPCI	MP GPCI	Work GPCI	PE GPCI	MP GPCI	Work GPCI	PE GPCI	MP GPCI
Alaska [(1)]	1.50	1.09	0.65	1.50	1.09	0.65	0%	0%	0%
Idaho	0.97	0.88	0.55	1.00	0.94	0.57	3%	7%	5%
North Dakota	0.95	0.84	0.39	1.00	1.00	0.45	6%	18%	17%
Portland, OR	1.00	1.02	0.47	1.00	1.02	0.54	0%	0%	15%
Rest of Oregon	0.97	0.93	0.47	1.00	0.97	0.54	3%	4%	15%
Seattle, WA	1.01	1.09	0.71	1.02	1.10	0.79	1%	1%	11%
Rest of Washington	0.99	0.97	0.69	1.00	0.99	0.77	1%	2%	11%
Wyoming	0.96	0.84	0.89	1.00	1.00	1.05	5%	19%	18%

1) Alaska work GPCI reflects the 1.50 floor established in 2009. In 2008, Alaska had a work GPCI of 1.017.

The changes in GPCI factors have significantly altered the relative Medicare reimbursement rates among the states in this analysis. Very roughly, these provisions increased Medicare reimbursement by approximately 20 – 25% in Alaska, and by approximately 10% – 15% in North Dakota and Wyoming, while having no impact on reimbursement in Portland, Oregon. Therefore, if the analysis had been performed three years ago, we would have found that Medicare reimbursement in Alaska was closer to that in the comparison states.

Similar changes in relative reimbursement have also been seen in other payers. Medicaid, in particular, is prone to significant changes in relative reimbursement across states, since each state sets its own reimbursement rates. Table 2.5 shows the relative changes in aggregate Medicaid reimbursement for physicians from 2003 to 2008.[1] Increases in reimbursement have varied considerably across states, with essentially no changes in New York and Minnesota, but increases of roughly 60% in Oklahoma and Pennsylvania. Alaska, with an increase of only 3% over the 5 year period, had one of the lowest increases. Looking forward, with changes to Medicaid eligibility under PPACA and with many states seeking to cut budgetary expenditures, we expect there to be more changes in relative Medicaid reimbursement.

[1] Statehealthfacts.org. 14 June 2011. The Kaiser Family Foundation. August 2011. http://statehealthfacts.org.

Table 2.5
Cumulative % Change in Medicaid Physician Fees
2003-2008

Minnesota	0%
New York	0%
Wisconsin	1%
California	2%
Alaska	**3%**
Alabama	4%
Arkansas	5%
Florida	5%
Hawaii	5%
West Virginia	5%
Mississippi	6%
Michigan	7%
Iowa	7%
North Carolina	8%
Arizona	9%
Maine	9%
Indiana	10%
Delaware	10%
New Hampshire	11%
Rhode Island	11%
Illinois	11%
Oregon	**14%**
United States	15%
Ohio	16%
New Jersey	18%
Nebraska	18%
Washington	**18%**
Texas	20%
Massachusetts	21%
North Dakota	**22%**
Utah	23%
Nevada	23%
Idaho	**25%**
New Mexico	25%
Connecticut	28%
Georgia	28%
Kentucky	28%
South Carolina	28%
Colorado	29%
Virginia	31%
Maryland	31%
South Dakota	32%
Vermont	33%
Montana	36%
District of Columbia	36%
Louisiana	41%
Kansas	44%
Wyoming	**49%**
Missouri	58%
Oklahoma	59%
Pennsylvania	63%
Tennessee	NA

Source: http://statehealthfacts.org

3. Methodology and Detailed Results

This section describes the methodology used to develop the results in Section 2 and provides more detailed results where appropriate.

General Methodology

The list of the top 25 procedure codes is based upon data from the 2009 Milliman Specialty Database, which estimates the relative frequency of utilization for physician services by specialty and procedure code for a commercially insured population. The actual top 25 codes by volume varies by payer type (for example, Medicare would have significantly fewer maternity and childhood procedures). However, we wanted to use the same distribution for each payer, and the commercial distribution is a reasonable basis to select the top 25 codes for other payers.

Since the comparison is being performed across multiple states, we used the nationwide aggregate frequency for each code. For each specialty, we created lists of the 25 procedure codes with the most utilization in that specialty and lists of the top 25 procedure codes with the highest expected expenditures in that specialty (using relative value units as a proxy, reflecting a combination of utilization and anticipated cost per service); note that many codes appear on both lists in each specialty and therefore, this leads to fewer than 50 unique procedure codes when the lists are combined. We limit these lists to only include codes that made up 1% or more of the total utilization for that specialty. Therefore, some specialties have fewer than 25 codes listed.

Table 3.1 summarizes the percentage of the total utilization and relative value units captured by the "top 25" codes in each specialty.

Table 3.1
Percentage of Total Utilization and RVUs Captured

	% of Total Utils	% of Total RVUs
Cardiology	72.3%	64.1%
Cardiothoracic Surgery	48.5%	47.3%
Chiropractic	95.6%	93.7%
DME	52.4%	56.0%
ENT	80.0%	69.9%
Family Practice	62.0%	68.7%
Gastroenterology	80.9%	87.1%
General Surgery	52.0%	38.5%
Internal Medicine	60.6%	61.4%
Interventional Cardiology	95.6%	93.9%
Lab	48.2%	51.8%
Neurology	73.3%	72.6%
OBGYN	63.5%	65.9%
Ophthalmology	88.8%	82.1%
Orthopedics	64.7%	49.4%
Pediatrics	69.3%	73.9%
Radiology	59.3%	59.4%
Urology	75.4%	67.1%

For each code, we summarized the following:

- The mean, median and 80th percentile of commercial allowed amounts in each state based upon data from the 2009 Thomson Reuters MarketScan™ database. The following is a summary of total allowed dollars for professional services included in the MarketScan™ data by state (in millions).

AK	$95.1
ID	103.9
ND	42.4
OR	524.8
WA	727.2
WY	65.1

  We have not adjusted these charges to estimate changes in reimbursement levels since 2009. To ensure sufficient credibility in the data, we did not use results for any code with fewer than 10 claims in the database.

  Estimated commercial allowed charges by specialty use data from all specialties for each procedure code since the specialty data coding in the database could not support a separate analysis by specialty. For example, CPT 98941 (chiropractic manipulation) is the top code for chiropractors. However, in developing the allowed and billed charge metrics for this

procedure code, we used data for this code from all specialties (though we expect the vast majority of the volume to be from chiropractors). Often, payers do not vary their reimbursement by specialty and therefore, the inclusion of all specialties in the analysis is a reasonable approach.

The MarketScan database contains detailed claims data for commercially insured individuals. The data is submitted by large employer groups and health plans. As a compilation of many payers' data, our results reflect the average payment level for payers in the data, weighted by the volume of data. The payers included vary from market to market.

- Medicare allowed charges. In states where Medicare allowed charges vary by geographic area within the state, we included the Medicare allowed charges for each area.
- TRICARE allowed charges. In states where TRICARE allowed charges vary by geographic area within the state, we included the TRICARE allowed charges for each area. The analysis is based on the published TRICARE fee schedules. TRICARE increases payments in Alaska using Locality Based Waivers for some specialties and geographic areas.
- Medicaid allowed charges. We used publicly available Medicaid fee-for-service fee schedules. Many states have managed Medicaid programs. However, the managed care organizations typically pay providers at roughly similar levels to the FFS levels, although not always. In some cases, payment levels from managed Medicaid organizations may be higher than FFS levels.
- Workers' Compensation allowed charges, based upon publicly available fee schedules, though in the case of Alaska, there is a fee to obtain the fee schedule.
- VA allowed charges paid to external (non-VA) providers. For Alaska, we use the 2010 fee schedule. For all states other than Alaska, these charges are equal to Medicare and use the 2011 Medicare schedule. Note that the majority of VA's health care costs are incurred through salaries paid to staff and therefore, there is no explicit cost for those services. The fee schedule used here is applied to the smaller portion of VA services that are not provided by VA staff or through contracted care.
- The mean, median and 80th percentile of billed charges. Billed charge analyses were conducted using the 2009 Medicare 5% Sample, with no adjustment to reflect increases in billed charge levels since 2009. Like the commercial allowed charge database, we used data across all specialties for each procedure code and did not use results for any code with fewer than 10 claims in the Medicare 5% Sample. Although the billed charges are based on Medicare data, billed charges do not vary by payer and therefore this is also representative of charges billed to other payers including commercial and Medicaid.

The Wyoming Workers' Compensation fee schedule consists of conversion factors that are intended to be used with Ingenix Physician RVP RVUs. These RVUs, which are different than the Medicare RBRVS RVUs, are not publicly available and are calibrated to different conversion factors by service category. Since these values are not publicly available, we are unable to calculate fees for Wyoming Workers' Compensation.

Reimbursement for some procedure codes is impacted by modifiers. For each code, we used the most common associated modifier from the Medicare 5% Sample and MarketScan data. For the majority of codes this led to a blank, or global, modifier, which did not impact the fee schedule amount. However, for radiology services, the most common modifier was frequently the "26" modifier, indicating that only the professional component of the service was performed by the billing physician. Similarly, reimbursement for many DME codes is affected by a modifier indicating whether the equipment is new, used or rental. When comparing against reimbursement from the fee schedules, we have used the same modifier across all states and payers.

Many physician fee schedules vary fees according to the place of service, typically paying lower fees for services that occur in hospitals (referred to as "facility fees") and higher fees for services that occur in the doctor's own office ("non-facility fees"). The following fee schedules do not vary physician fees based on the place of service:

- Alaska Workers' Compensation
- All Medicaid schedules except for Washington
- Alaska VA

The fees reported in this analysis are based upon non-facility fees for all other schedules. As a result, reimbursement from the above schedules may be slightly understated since they effectively represent a blend of the lower facility fees with the non-facility fees.

Many fee schedules include at least some codes that are paid as a percentage of billed charges, paid at "reasonable charges", not covered by the payer, or bundled services (meaning that payment is included with payment for other services, such as surgical supplies). We have excluded any combinations of payer and procedure codes that fall under these categories from this analysis since they do not have an explicit fee schedule amount. There are relatively few such codes and therefore, their inclusion would not materially impact the results.

Development of Summary Results

In order to create a meaningful comparison among the states, results are shown as a percentage of the average across the comparison states; the average across states is calculated as an arithmetic mean, weighting each state equally. If information is not available for a specific combination of payer and state, the average is calculated using only the remaining payers or states. A simplified example for one specialty and payer is shown below.

Table 3.2
Relativity Calculation Example

	AK	ID	ND	OR	WA	WY	ID - WY Average
Medicare Fee	$110	$90	$90	$95	$90	$95	$92
Relative Percentage	120%	98%	98%	103%	98%	103%	

Using the methodology in Table 3.2, we develop a relative payment for each combination of HCPCS code, state and payer. Subtotals by state and payer are then developed by taking a weighted average of the ratios, where the relative weight for each code is based upon the relative utilization rate and relative value units from the Milliman Specialty database.

The All Payers total is based on a weighted average of the relative ratios for each payer in each state. Weighted averages across payers are based on the relative expenditures in the CMS 2009 National Health Expenditures.[2]

A similar process is used to develop relative payment levels across states for each specialty.

We have included the detailed summaries by specialty, state, and payer in Appendix A.

[2] For information about the CMS National Health Expenditures, see http://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp

4. LIMITATIONS AND CONSIDERATIONS

Any opinions expressed in this report are solely those of the authors.

Any reader of this report must possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the approaches and assumptions and the impact of these approaches and assumptions on the results. The reader should be advised by their own actuaries or other qualified professionals competent in the subject matter of this report, so as to properly interpret the material.

This report is not intended to benefit third parties. Regarding the contents of this report, Milliman makes no representations or warranties to third parties. Third parties are to place no reliance upon this report that would result in the creation of any duty or liability for Milliman or its employees to third parties, under any theory of law. Third parties receiving this report must rely on their own experts to draw conclusions about the report's contents.

As documented in the report, this analysis has relied extensively on historical data. The data were reviewed for reasonableness, but no independent audits were performed. Should errors or omissions be discovered in the source data, the results of our analysis would need to be modified. Future results will differ from the historic estimates in this report.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

APPENDIX A

DETAILED FEE DATA BY STATE, PAYER, SPECIALTY AND PROCEDURE CODE

Appendix A-1
Summary of Relative Reimbursement
By State, Specialty, and Payer

	Medicare						Tricare						VA					
	AK	ID	ND	OR [1]	WA [1]	WY	AK	ID	ND	OR [1]	WA [1]	WY	AK	ID	ND	OR	WA	WY
Pediatrics	124%	96%	99%	100%	105%	100%	183%	98%	97%	101%	106%	98%	140%	96%	99%	100%	105%	100%
Family Practice	127%	96%	98%	100%	105%	100%	184%	98%	97%	101%	105%	98%	155%	96%	98%	100%	105%	100%
Internal Medicine	127%	96%	98%	100%	105%	100%	185%	98%	97%	101%	105%	98%	170%	96%	98%	100%	105%	100%
Lab	107%	98%	101%	103%	101%	97%	141%	102%	100%	101%	95%	102%	316%	98%	101%	103%	101%	97%
Ophthalmology	125%	96%	98%	100%	106%	100%	182%	98%	96%	102%	106%	98%	118%	96%	98%	100%	106%	100%
OBGYN	128%	96%	97%	99%	105%	103%	168%	89%	99%	96%	98%	117%	224%	96%	97%	99%	105%	103%
Chiropractic	131%	97%	99%	100%	105%	100%	189%	98%	97%	101%	105%	98%	210%	97%	99%	100%	105%	100%
Urology	123%	96%	98%	100%	106%	100%	181%	98%	96%	102%	106%	98%	250%	96%	98%	100%	106%	100%
Gastroenterology	120%	96%	98%	100%	106%	101%	180%	98%	96%	102%	107%	98%	242%	96%	98%	100%	106%	101%
Radiology	136%	97%	98%	99%	104%	101%	195%	99%	98%	100%	104%	99%	332%	97%	98%	99%	104%	101%
Neurology	127%	97%	99%	100%	104%	100%	188%	98%	97%	101%	105%	98%	250%	97%	99%	100%	104%	100%
Orthopedics	127%	96%	98%	99%	105%	101%	185%	98%	96%	101%	106%	99%	224%	96%	98%	99%	105%	101%
ENT	124%	95%	98%	100%	106%	101%	181%	98%	96%	101%	107%	98%	237%	95%	98%	100%	106%	101%
General Surgery	129%	96%	97%	99%	105%	103%	188%	98%	96%	101%	105%	99%	225%	96%	97%	99%	105%	103%
Cardiology	131%	97%	98%	100%	105%	101%	188%	98%	97%	101%	105%	99%	451%	97%	98%	100%	105%	101%
Cardiothoracic Surgery	131%	96%	96%	98%	105%	104%	190%	98%	96%	100%	105%	101%	246%	96%	96%	98%	105%	104%
Interventional Cardiology	N/A	N/A	N/A	N/A	N/A	N/A	189%	98%	96%	100%	105%	100%	N/A	N/A	N/A	N/A	N/A	N/A
DME	99%	100%	99%	101%	101%	99%	99%	100%	99%	101%	101%	99%	280%	100%	99%	101%	101%	99%

All values are relative to the average for the five comparison states (excluding AK) for each payer category

[1] For this summary, the Portland, OR and Seattle, WA Medicare and Tricare fee schedules were used.

Appendix A-1
Summary of Relative Reimbursement
By State, Specialty, and Payer

	Medicaid						Workers' Compensation						Commercial (Mean Allowed Charge)					
	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Pediatrics	173%	102%	140%	83%	69%	105%	122%	102%	99%	108%	91%	N/A	139%	91%	105%	128%	90%	86%
Family Practice	177%	96%	148%	83%	64%	108%	123%	104%	99%	109%	88%	N/A	147%	96%	100%	118%	98%	88%
Internal Medicine	177%	96%	146%	83%	64%	108%	136%	104%	99%	109%	88%	N/A	149%	96%	100%	117%	98%	90%
Lab	121%	115%	118%	85%	86%	97%	297%	N/A	129%	N/A	77%	N/A	176%	89%	120%	88%	72%	131%
Ophthalmology	200%	107%	102%	96%	76%	120%	132%	107%	99%	105%	89%	N/A	149%	95%	95%	122%	100%	87%
OBGYN	151%	89%	127%	84%	78%	122%	167%	115%	89%	112%	82%	N/A	173%	94%	90%	112%	94%	111%
Chiropractic	194%	105%	135%	88%	70%	N/A	162%	83%	108%	111%	N/A	N/A	172%	85%	105%	113%	89%	108%
Urology	173%	93%	127%	103%	64%	113%	215%	111%	92%	110%	84%	N/A	183%	97%	95%	109%	92%	108%
Gastroenterology	172%	96%	133%	84%	68%	113%	173%	112%	91%	113%	84%	N/A	191%	104%	84%	108%	87%	117%
Radiology	175%	98%	136%	79%	62%	139%	325%	127%	93%	95%	84%	N/A	172%	107%	83%	88%	80%	143%
Neurology	191%	117%	122%	82%	65%	117%	221%	106%	99%	106%	89%	N/A	186%	97%	100%	113%	95%	96%
Orthopedics	179%	95%	133%	99%	65%	109%	213%	122%	88%	105%	83%	N/A	202%	96%	89%	104%	91%	121%
ENT	166%	87%	127%	116%	62%	108%	284%	110%	94%	110%	85%	N/A	210%	98%	91%	106%	94%	109%
General Surgery	176%	85%	121%	122%	66%	108%	228%	111%	91%	110%	84%	N/A	206%	95%	88%	104%	90%	125%
Cardiology	N/A	125%	126%	78%	65%	N/A	437%	106%	100%	105%	90%	N/A	201%	98%	80%	108%	87%	124%
Cardiothoracic Surgery	183%	96%	144%	84%	66%	111%	336%	115%	91%	113%	80%	N/A	N/A	N/A	N/A	106%	94%	N/A
Interventional Cardiology	N/A	91%	119%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	474%	86%	104%	97%	84%	131%
DME	155%	93%	N/A	102%	103%	100%	198%	N/A	96%	N/A	105%	N/A	123%	97%	109%	97%	98%	98%

All values are relative to the average for the five comparison states (excluding AK) for each payer category

(1) For this summary, the Portland, OR and Seattle, WA Medicare and Tricare fee schedules were used.

Appendix A-2
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
All Specialties
Including Specialties Not Listed in Appendices A-3 - A-20

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		10.78%	9.83%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Office/outpatient visit, est	99214		4.63%	6.34%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Psytx, off, 45-50 min	90806		1.62%	2.16%	123.36	86.96	87.82	88.57	87.39	91.97	88.43	89.32	184.30	92.40	91.68	93.90	92.71	96.65	93.63	92.63
Office/outpatient visit, new	99203		1.27%	1.77%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Therapeutic exercises	97110		2.33%	1.63%	38.37	28.62	29.37	29.67	28.96	31.16	29.36	29.58	53.75	28.26	27.95	29.15	28.50	30.29	28.87	28.13
Obstetrical care	59400		0.06%	1.42%	2,354.90	1,749.07	1,754.18	1,791.77	1,757.34	1,928.14	1,834.33	1,916.79	3,181.81	1,661.32	2,203.84	1,955.94	1,955.94	1,983.25	1,983.25	2,984.72
Office consultation	99244		0.44%	1.21%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Office/outpatient visit, est	99215		0.60%	1.10%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Office/outpatient visit, est	99212		1.87%	1.06%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Office/outpatient visit, new	99204		0.49%	1.03%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Chiropractic manipulation	98941		1.99%	1.01%	46.20	33.52	34.08	34.43	33.79	36.02	34.29	34.68	65.97	33.75	33.43	34.51	33.93	35.70	34.34	33.78
Eye exam & treatment	92014		0.64%	0.99%	144.69	110.75	114.00	115.48	112.25	122.39	114.50	116.04	197.82	106.57	105.04	110.57	107.61	115.73	109.53	106.28
Manual therapy	97140		1.81%	0.96%	36.23	26.98	27.67	27.96	27.29	29.35	27.67	27.88	50.51	26.48	26.20	27.29	26.70	28.34	27.04	26.38
Tissue exam by pathologist	88305	26	0.71%	0.76%	49.95	35.61	36.17	36.44	35.86	37.82	36.18	36.37	72.48	36.54	36.29	37.24	36.71	38.30	37.02	36.47
Office/outpatient visit, new	99202		0.67%	0.63%	89.38	67.88	69.71	70.61	68.74	74.76	70.13	71.13	123.19	65.86	64.92	68.16	66.44	71.28	67.62	65.81
Immunization admin	90471		1.27%	0.40%	27.44	21.99	22.92	23.24	22.40	24.81	22.87	23.12	36.58	20.72	20.35	21.80	21.02	23.02	21.47	20.52
Chiropractic manipulation	98940		0.99%	0.36%	33.24	24.28	24.79	25.02	24.51	26.15	24.81	24.99	47.15	24.28	24.06	24.90	24.44	25.76	24.72	24.23
Lipid panel	80061		0.97%	0.27%	18.85	15.96	17.17	18.85	18.85	18.85	18.85	15.67	23.08	17.59	17.23	17.44	17.44	16.01	16.13	17.61
Electric stimulation therapy	97014		1.30%	0.27%	16.07	12.08	12.39	12.53	12.22	13.22	12.44	12.59	24.96	13.44	13.24	13.93	13.56	14.59	13.81	13.42
Percut allergy skin tests	95004		2.59%	0.22%	7.04	5.98	6.27	6.39	6.12	6.96	6.33	6.47	8.99	5.43	5.27	5.78	5.52	6.24	5.72	5.45
Assay thyroid stim hormone	84443		0.61%	0.22%	23.64	22.14	23.64	23.64	23.64	23.56	23.56	23.09	28.94	22.05	21.60	21.86	21.86	20.08	20.22	22.08
Chest x-ray	71020	26	0.68%	0.21%	14.77	10.55	10.69	10.79	10.62	11.25	10.77	10.89	21.87	11.09	10.97	11.30	11.13	11.69	11.28	11.16
Comprehen metabolic panel	80053		0.80%	0.18%	14.87	14.87	14.87	14.87	14.87	12.01	12.01	14.87	18.20	13.87	13.59	13.76	13.76	12.63	12.72	13.89
Complete cbc w/auto diff wbc	85025		1.08%	0.17%	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	13.40	10.21	10.00	10.12	10.12	9.30	9.36	10.22
Mechanical traction therapy	97012		0.80%	0.17%	20.01	14.78	15.10	15.26	14.93	16.02	15.15	15.31	28.14	14.63	14.46	15.03	14.73	15.61	14.94	14.64
Immunotherapy injections	95117		0.70%	0.17%	13.58	11.73	12.39	12.61	12.02	13.70	12.38	12.59	18.34	11.32	11.02	12.15	11.55	13.06	11.92	11.20
Ultrasound therapy	97035		0.74%	0.13%	15.75	11.49	11.71	11.83	11.59	12.39	11.77	11.91	22.79	11.77	11.63	12.05	11.83	12.51	12.01	11.81
Routine venipuncture	36415		2.15%	0.10%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-2
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
All Specialties
Including Specialties Not Listed in Appendices A-3 - A-20

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		10.78%	9.83%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Office/outpatient visit, est	99214		4.63%	6.34%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Psytx, off, 45-50 min	90806		1.62%	2.16%	118.09	86.96	87.82	88.57	91.97	89.32	156.06	60.60	132.84	N/A	53.80	91.39	201.91	166.97	154.85	159.54	138.35	N/A
Office/outpatient visit, new	99203		1.27%	1.77%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Therapeutic exercises	97110		2.33%	1.63%	73.67	28.62	29.37	29.67	31.16	29.58	47.79	26.50	14.44	21.98	17.56	29.71	97.31	39.59	53.89	53.81	48.70	N/A
Obstetrical care	59400		0.06%	1.42%	4,231.13	1,749.07	1,754.18	1,791.77	1,928.14	1,916.79	2,821.81	1,539.21	2,339.40	2,018.09	2,034.50	N/A	5,274.96	4,515.39	3,468.64	4,590.19	3,028.76	N/A
Office consultation	99244		0.44%	1.21%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Office/outpatient visit, est	99215		0.60%	1.10%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Office/outpatient visit, est	99212		1.87%	1.06%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Office/outpatient visit, new	99204		0.49%	1.03%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Chiropractic manipulation	98941		1.99%	1.01%	59.87	33.52	34.08	34.43	36.02	34.68	N/A	32.53	48.16	26.71	21.12	N/A	84.00	47.31	64.42	66.74	Not Covered	N/A
Eye exam & treatment	92014		0.64%	0.99%	101.04	110.75	114.00	115.48	122.39	116.04	176.19	97.40	59.48	83.74	66.47	107.56	188.56	223.27	211.22	217.38	189.82	N/A
Manual therapy	97140		1.81%	0.96%	69.72	26.98	27.67	27.96	29.35	27.88	44.91	24.62	N/A	20.59	16.45	27.46	74.53	37.32	50.79	50.14	45.93	N/A
Tissue exam by pathologist	88305	26	0.71%	0.76%	111.69	35.61	36.17	36.44	37.82	36.37	64.94	65.46	53.27	28.10	22.23	N/A	259.83	TBD	N/A	58.26	59.77	N/A
Office/outpatient visit, new	99202		0.67%	0.63%	121.20	67.88	69.71	70.61	74.76	71.13	109.84	59.02	93.90	51.75	39.31	69.70	171.90	136.85	129.45	142.89	116.21	N/A
Immunization admin	90471		1.27%	0.40%	10.39	21.99	22.92	23.24	24.81	23.12	32.51	19.07	13.90	16.41	13.12	10.00	35.87	30.42	42.12	43.22	38.18	N/A
Chiropractic manipulation	98940		0.99%	0.36%	48.29	24.28	24.79	25.02	26.15	24.99	N/A	23.45	34.62	19.20	15.34	N/A	65.33	34.27	46.46	47.67	Not Covered	N/A
Lipid panel	80061		0.97%	0.27%	43.45	15.96	17.17	18.85	18.85	15.67	19.19	15.85	17.48	14.20	14.58	14.00	121.13	TBD	42.93	80% of billed	26.39	N/A
Electric stimulation therapy	97014		1.30%	0.27%	40.73	12.08	12.39	12.53	13.22	12.59	22.20	N/A	N/A	10.57	8.45	N/A	54.64	19.37	26.63	26.29	23.80	N/A
Percut allergy skin tests	95004		2.59%	0.22%	11.30	5.98	6.27	6.39	6.96	6.47	7.99	5.06	7.47	4.45	3.56	6.39	10.96	12.06	11.77	12.08	10.51	N/A
Assay thyroid stim hormone	84443		0.61%	0.22%	57.55	22.14	23.64	23.64	23.56	23.09	24.06	21.98	24.06	17.80	18.22	20.64	122.82	TBD	59.10	80% of billed	32.98	N/A
Chest x-ray	71020	26	0.68%	0.21%	31.08	10.55	10.69	10.79	11.25	10.89	19.45	10.85	14.71	8.62	6.89	7.88	71.76	27.24	19.82	20.18	17.71	N/A
Comprehen metabolic panel	80053		0.80%	0.18%	49.40	14.87	14.87	14.87	12.01	14.87	15.14	14.77	15.14	11.20	9.29	13.29	91.24	TBD	37.17	80% of billed	16.81	N/A
Complete cbc w/auto diff wbc	85025		1.08%	0.17%	40.35	10.94	10.94	10.94	10.94	10.94	11.14	10.86	11.14	8.24	8.47	9.85	56.86	TBD	27.35	80% of billed	15.32	N/A
Mechanical traction therapy	97012		0.80%	0.17%	48.41	14.78	15.10	15.26	16.02	15.31	25.01	13.67	N/A	11.41	9.11	15.04	55.51	20.44	27.87	27.52	24.90	N/A
Immunotherapy injections	95117		0.70%	0.17%	25.33	11.73	12.39	12.61	13.70	12.59	16.31	11.07	16.01	9.18	7.34	11.28	47.34	23.65	22.92	23.52	21.03	N/A
Ultrasound therapy	97035		0.74%	0.13%	31.84	11.49	11.71	11.83	12.39	11.91	20.26	10.96	12.03	N/A	7.34	12.04	58.27	15.90	21.68	21.40	19.37	N/A
Routine venipuncture	36415		2.15%	0.10%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-2
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
All Specialties
Including Specialties Not Listed in Appendices A-3 - A-20

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Commercial Allowed [5] Mean AK	Mean ID	Mean ND	Mean OR	Mean WA	Mean WY	Median AK	Median ID	Median ND	Median OR	Median WA	Median WY	80th Percentile AK	80th Percentile ID	80th Percentile ND	80th Percentile OR	80th Percentile WA	80th Percentile WY
Office/outpatient visit, est	99213		10.78%	9.83%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Office/outpatient visit, est	99214		4.63%	6.34%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Psytx, off, 45-50 min	90806		1.62%	2.16%	122.82	81.55	119.45	100.13	95.83	95.53	125.00	76.50	104.87	94.00	96.09	95.00	148.00	95.00	139.83	125.00	115.31	120.00
Office/outpatient visit, new	99203		1.27%	1.77%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Therapeutic exercises	97110		2.33%	1.63%	115.96	54.40	66.31	75.29	54.26	81.03	90.00	50.58	44.16	70.00	56.22	80.00	163.80	82.17	88.32	112.18	76.22	120.00
Obstetrical care	59400		0.06%	1.42%	4,704.80	2,457.25	2,500.69	3,183.41	2,601.20	3,061.87	5,000.00	2,454.92	2,661.24	3,203.00	2,474.56	3,352.00	5,000.00	2,600.00	2,661.24	3,612.13	2,867.61	3,390.00
Office consultation	99244		0.44%	1.21%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Office/outpatient visit, est	99215		0.60%	1.10%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Office/outpatient visit, est	99212		1.87%	1.06%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Office/outpatient visit, new	99204		0.49%	1.03%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Chiropractic manipulation	98941		1.99%	1.01%	66.49	37.90	48.24	50.45	38.89	45.93	70.00	38.00	52.00	47.94	38.00	45.00	75.00	39.68	53.21	60.00	44.68	55.00
Eye exam & treatment	92014		0.64%	0.99%	162.63	108.90	121.59	155.09	120.55	100.09	169.00	110.00	120.57	160.53	113.00	99.00	198.00	134.65	161.90	186.02	148.00	118.54
Manual therapy	97140		1.81%	0.96%	119.79	39.28	49.43	57.57	43.86	60.99	112.10	28.47	40.76	44.08	28.44	50.00	180.00	56.94	61.35	79.16	56.80	90.00
Tissue exam by pathologist	88305	26	0.71%	0.76%	226.49	72.40	65.94	77.08	64.43	127.60	250.00	61.60	58.31	68.38	57.17	113.00	260.00	78.75	64.13	74.52	73.76	194.00
Office/outpatient visit, new	99202		0.67%	0.63%	149.21	91.12	86.37	110.70	93.63	87.29	155.00	93.40	99.63	114.79	90.39	88.00	172.00	103.33	99.63	123.60	108.17	97.00
Immunization admin	90471		1.27%	0.40%	26.62	21.70	23.10	31.49	23.59	17.23	26.00	19.00	24.63	35.00	25.00	14.31	32.00	30.14	24.63	41.62	30.45	22.90
Chiropractic manipulation	98940		0.99%	0.36%	53.90	30.39	37.49	39.00	31.33	39.10	55.00	28.27	38.49	34.68	29.50	40.00	60.00	35.00	38.49	49.50	34.68	45.00
Lipid panel	80061		0.97%	0.27%	58.57	29.49	37.31	26.38	20.73	40.22	59.90	27.00	34.93	26.96	19.57	36.00	97.00	40.15	34.93	29.40	22.47	63.00
Electric stimulation therapy	97014		1.30%	0.27%	43.78	14.91	17.73	19.75	15.85	23.47	47.00	14.53	20.00	18.87	14.63	25.00	50.00	15.00	20.95	20.07	15.54	29.00
Percut allergy skin tests	95004		2.59%	0.22%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Assay thyroid stim hormone	84443		0.61%	0.22%	53.09	30.61	49.18	32.56	25.51	46.78	45.00	31.21	48.09	32.86	24.44	41.52	91.00	31.88	48.09	35.09	28.07	68.00
Chest x-ray	71020	26	0.68%	0.21%	43.55	26.15	19.52	21.06	19.22	38.25	43.00	22.50	17.55	19.65	18.83	42.00	54.00	32.00	17.90	21.30	19.94	45.60
Comprehen metabolic panel	80053		0.80%	0.18%	47.74	21.24	31.51	21.74	15.21	38.55	47.26	20.97	30.26	21.27	12.46	34.00	75.00	22.03	30.26	23.20	16.93	62.00
Complete cbc w/auto diff wbc	85025		1.08%	0.17%	34.86	16.34	24.54	16.14	12.43	29.04	40.00	15.42	22.25	15.64	11.35	27.30	50.00	16.38	22.25	20.74	13.03	47.00
Mechanical traction therapy	97012		0.80%	0.17%	43.83	16.61	20.19	21.17	18.11	21.94	50.00	15.00	22.64	20.00	16.26	21.61	55.00	18.61	22.64	25.00	20.00	28.80
Immunotherapy injections	95117		0.70%	0.17%	33.49	20.87	20.27	26.20	22.86	23.06	35.00	20.64	19.81	26.86	22.14	21.00	36.00	21.53	19.81	31.72	24.04	29.00
Ultrasound therapy	97035		0.74%	0.13%	43.54	14.27	17.48	18.59	13.73	27.93	47.50	12.83	18.12	17.33	12.80	26.00	55.00	15.00	18.12	21.05	12.80	35.00
Routine venipuncture	36415		2.15%	0.10%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-2
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
All Specialties
Including Specialties Not Listed in Appendices A-3 - A-20

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Billed Charges[5] Mean AK	Mean ID	Mean ND	Mean OR	Mean WA	Mean WY	Median AK	Median ID	Median ND	Median OR	Median WA	Median WY	80th Percentile AK	80th Percentile ID	80th Percentile ND	80th Percentile OR	80th Percentile WA	80th Percentile WY
Office/outpatient visit, est	99213		10.78%	9.83%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	$98.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Office/outpatient visit, est	99214		4.63%	6.34%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Psytx, off, 45-50 min	90806		1.62%	2.16%	140.60	118.86	149.94	133.06	138.23	106.37	148.00	120.00	144.00	130.00	130.00	100.00	175.00	150.00	170.00	160.00	150.00	125.00
Office/outpatient visit, new	99203		1.27%	1.77%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Therapeutic exercises	97110		2.33%	1.63%	64.21	35.07	47.83	50.70	47.75	39.57	65.00	35.00	48.00	52.00	48.00	40.00	81.00	40.00	50.00	59.00	55.00	50.00
Obstetrical care	59400		0.06%	1.42%	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data
Office consultation	99244		0.44%	1.21%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Office/outpatient visit, est	99215		0.60%	1.10%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Office/outpatient visit, est	99212		1.87%	1.06%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Office/outpatient visit, new	99204		0.49%	1.03%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Chiropractic manipulation	98941		1.99%	1.01%	54.98	40.92	48.97	45.14	51.67	36.19	50.00	40.00	50.00	37.50	53.00	35.00	70.00	47.00	55.00	60.00	60.00	40.00
Eye exam & treatment	92014		0.64%	0.99%	182.11	113.70	132.95	165.50	148.31	109.34	190.00	101.50	135.00	176.00	143.00	103.79	212.00	140.00	178.00	213.00	186.00	120.00
Manual therapy	97140		1.81%	0.96%	61.95	35.68	47.24	49.82	45.33	38.27	64.00	35.51	46.25	50.00	45.00	40.00	70.00	44.00	55.00	57.75	50.00	50.00
Tissue exam by pathologist	88305	26	0.71%	0.76%	203.69	90.67	92.46	106.85	112.96	107.68	210.00	94.20	94.75	86.00	104.00	97.00	260.00	135.00	110.00	150.75	138.00	157.00
Office/outpatient visit, new	99202		0.67%	0.63%	140.22	88.61	96.09	119.68	110.48	93.11	150.00	91.00	105.00	127.00	112.00	98.10	177.00	115.00	120.00	151.30	131.00	116.90
Immunization admin	90471		1.27%	0.40%	27.07	27.47	31.90	34.76	32.20	23.54	25.00	30.00	32.00	38.00	32.00	22.50	36.00	36.25	38.00	46.50	42.00	28.15
Chiropractic manipulation	98940		0.99%	0.36%	42.60	30.86	38.76	35.70	40.16	30.56	35.00	30.00	40.00	28.00	41.00	25.38	58.00	39.00	45.00	50.00	47.00	39.00
Lipid panel	80061		0.97%	0.27%	69.85	45.11	59.69	45.18	49.63	67.63	81.00	39.20	56.00	40.00	40.00	71.00	93.00	57.10	70.00	54.90	68.22	86.00
Electric stimulation therapy	97014		1.30%	0.27%	40.03	16.27	16.88	21.62	24.31	18.10	40.00	15.10	18.00	20.00	20.00	15.00	47.00	20.00	22.00	30.00	31.00	20.00
Percut allergy skin tests	95004		2.59%	0.22%	Not Cred	7.35	Not Cred	9.82	10.50	Not Cred	Not Cred	8.00	Not Cred	9.20	10.00	Not Cred	Not Cred	8.25	Not Cred	13.00	12.00	Not Cred
Assay thyroid stim hormone	84443		0.61%	0.22%	58.37	49.23	64.39	49.42	52.04	72.26	45.00	40.17	62.00	45.00	44.31	72.42	94.00	55.73	67.00	53.00	62.00	85.00
Chest x-ray	71020	26	0.68%	0.21%	49.09	37.03	30.04	32.45	33.55	28.99	43.00	32.50	26.00	34.00	33.00	32.00	56.00	49.28	36.00	38.00	37.20	43.00
Comprehen metabolic panel	80053		0.80%	0.18%	45.03	38.41	61.10	35.30	38.95	48.15	42.85	39.29	61.00	32.63	39.29	53.00	65.00	42.26	65.00	44.31	51.00	56.00
Complete cbc w/auto diff wbc	85025		1.08%	0.17%	33.93	29.96	42.83	26.51	32.26	37.16	27.51	30.00	40.00	24.00	30.00	37.00	46.00	39.10	49.00	32.50	40.03	56.00
Mechanical traction therapy	97012		0.80%	0.17%	33.70	20.38	32.95	26.94	26.33	25.37	36.00	20.00	28.80	28.00	26.00	30.00	40.00	25.00	40.00	35.00	30.00	30.00
Immunotherapy injections	95117		0.70%	0.17%	No Data	20.41	36.11	38.84	29.51	26.91	No Data	24.00	41.00	39.00	29.00	30.00	No Data	24.75	41.00	52.00	38.00	31.00
Ultrasound therapy	97035		0.74%	0.13%	38.53	19.19	25.82	24.79	24.66	25.19	40.00	17.00	23.00	25.00	24.00	21.00	55.00	23.00	35.00	30.00	30.00	40.00
Routine venipuncture	36415		2.15%	0.10%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-3
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Heart image (3d), multiple	78465		2.76%	11.89%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tte w/o doppler, complete	93307	26	5.73%	8.40%	64.24	46.26	47.01	47.44	46.61	49.47	47.19	47.62	94.98	48.57	48.15	49.69	48.85	51.32	49.37	48.50
Office/outpatient visit, est	99214		5.68%	5.35%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Doppler echo exam, heart	93320	26	6.84%	4.38%	26.27	18.87	19.18	19.35	19.02	20.15	19.23	19.38	39.33	20.12	19.93	20.58	20.23	21.27	20.46	20.11
Cardiovascular stress test	93015		3.87%	4.24%	110.86	88.22	91.86	93.08	89.84	99.17	91.59	92.47	159.22	90.08	88.59	94.85	91.44	100.03	93.26	89.08
Office/outpatient visit, est	99213		6.25%	3.91%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Doppler color flow add-on	93325	26	7.10%	3.90%	4.90	3.53	3.55	3.61	3.55	3.81	3.65	3.76	7.45	3.83	3.75	3.89	3.83	4.08	3.93	3.93
Insert intracoronary stent	92980		0.40%	3.42%	1,110.09	811.28	812.98	828.44	814.47	885.03	845.54	878.92	1,626.42	840.98	821.79	854.69	840.25	900.11	865.93	865.59
Office consultation	99244		1.80%	3.37%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Stress tte only	93350	26	1.39%	2.43%	102.59	73.97	75.18	75.87	74.54	79.16	75.49	76.20	152.08	77.91	77.18	79.71	78.34	82.43	79.26	77.89
Tc99m sestamibi	A9500		1.43%	1.94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Heart wall motion add-on	78478		2.72%	1.71%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Office consultation	99245		0.67%	1.54%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	428.34	223.13	220.20	229.02	224.42	238.44	228.17	224.00
Heart function add-on	78480		2.67%	1.43%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Electrocardiogram, complete	93000		5.33%	1.28%	23.57	18.66	19.33	19.62	18.97	20.97	19.43	19.74	34.09	19.18	18.79	20.10	19.41	21.28	19.89	19.15
Subsequent hospital care	99232		1.89%	1.26%	93.75	67.04	67.83	68.52	67.45	71.57	68.51	69.45	134.96	68.09	67.41	69.24	68.29	71.54	69.18	68.50
Office consultation	99243		0.82%	1.05%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Tc99m tetrofosmin	A9502		0.75%	1.02%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Electrocardiogram report	93010		7.62%	0.67%	11.85	8.53	8.65	8.74	8.59	9.14	8.73	8.85	17.44	8.90	8.79	9.08	8.93	9.42	9.08	8.98
Cardiovascular stress test	93016		1.24%	0.31%	31.32	22.53	22.92	23.11	22.71	24.07	22.96	23.12	46.44	23.74	23.54	24.29	23.88	25.09	24.14	23.72
Office/outpatient visit, est	99211		1.27%	0.26%	23.86	18.81	19.52	19.78	19.13	21.05	19.51	19.72	33.40	18.65	18.34	19.55	18.89	20.59	19.28	18.51
Cardiovascular stress test	93018		1.51%	0.24%	20.70	14.87	15.10	15.24	14.98	15.89	15.17	15.31	30.87	15.77	15.62	16.12	15.85	16.67	16.05	15.80
Prothrombin time	85610		1.56%	0.09%	5.53	5.53	5.53	5.53	5.53	5.53	5.53	4.47	6.76	5.15	5.05	5.11	5.11	4.69	4.73	5.16
Routine venipuncture	36415		1.00%	0.03%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-3
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Heart image (3d), multiple	78465		2.76%	11.89%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$2,553.35	N/A	N/A	N/A	N/A	N/A
Tte w/o doppler, complete	93307	26	5.73%	8.40%	141.17	46.26	47.01	47.44	49.47	47.62	N/A	60.66	65.49	37.56	29.79	N/A	292.91	93.26	86.72	88.98	78.03	N/A
Office/outpatient visit, est	99214		5.68%	5.35%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Doppler echo exam, heart	93320	26	6.84%	4.38%	74.47	18.87	19.18	19.35	20.15	19.38	N/A	29.76	26.58	15.58	12.45	N/A	179.38	38.05	35.31	36.23	31.54	N/A
Cardiovascular stress test	93015		3.87%	4.24%	452.52	88.22	91.86	93.08	99.17	92.47	142.08	88.15	128.04	71.22	56.91	N/A	875.40	177.86	168.48	173.52	152.74	N/A
Office/outpatient visit, est	99213		6.25%	3.91%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Doppler color flow add-on	93325	26	7.10%	3.90%	59.75	3.53	3.55	3.61	3.81	3.76	N/A	35.64	4.75	3.06	2.45	N/A	127.14	7.12	6.81	6.99	6.09	N/A
Insert intracoronary stent	92980		0.40%	3.42%	3,639.24	811.28	812.98	828.44	885.03	878.92	1,398.93	775.80	1,189.17	676.03	523.52	N/A	5,295.65	1,635.52	1,591.86	1,634.76	1,394.57	N/A
Office consultation	99244		1.80%	3.37%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Stress tte only	93350	26	1.39%	2.43%	283.49	73.97	75.18	75.87	79.16	76.20	N/A	94.65	104.89	60.37	48.02	N/A	522.23	149.12	138.75	142.37	124.52	N/A
Tc99m sestamibi	A9500		1.43%	1.94%	215.23	N/A	N/A	N/A	N/A	N/A	78.00	64.28	N/A	155.50	121.70	N/A	BR	N/A	N/A	N/A	121.70	N/A
Heart wall motion add-on	78478		2.72%	1.71%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	421.86	N/A	N/A	N/A	N/A	N/A
Office consultation	99245		0.67%	1.54%	371.13	N/A	N/A	N/A	N/A	N/A	380.86	N/A	N/A	N/A	138.05	N/A	601.64	418.17	N/A	434.83	351.96	N/A
Heart function add-on	78480		2.67%	1.43%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	403.35	N/A	N/A	N/A	N/A	N/A
Electrocardiogram, complete	93000		5.33%	1.28%	91.38	18.66	19.33	19.62	20.97	19.74	30.31	18.76	27.21	15.30	12.23	N/A	151.74	37.62	35.93	37.50	32.10	N/A
Subsequent hospital care	99232		1.89%	1.26%	140.57	67.04	67.83	68.52	71.57	69.45	120.29	62.39	97.63	52.86	41.79	N/A	256.48	135.17	126.36	140.16	112.89	N/A
Office consultation	99243		0.82%	1.05%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Tc99m tetrofosmin	A9502		0.75%	1.02%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	58.06	N/A	67.34	121.05	N/A	BR	N/A	N/A	N/A	121.05	N/A
Electrocardiogram report	93010		7.62%	0.67%	42.05	8.53	8.65	8.74	9.14	8.85	15.50	8.15	12.80	6.96	5.56	N/A	60.70	17.20	16.10	16.53	14.39	N/A
Cardiovascular stress test	93016		1.24%	0.31%	145.56	22.53	22.92	23.11	24.07	23.12	41.29	22.96	34.14	18.36	14.67	N/A	218.85	45.43	42.12	43.22	37.63	N/A
Office/outpatient visit, est	99211		1.27%	0.26%	49.04	18.81	19.52	19.78	21.05	19.72	29.70	18.25	26.68	N/A	11.42	N/A	82.18	37.91	35.93	39.65	32.65	N/A
Cardiovascular stress test	93018		1.51%	0.24%	159.36	14.87	15.10	15.24	15.89	15.31	27.46	14.86	22.41	12.24	9.78	N/A	218.85	29.98	27.87	29.24	24.90	N/A
Prothrombin time	85610		1.56%	0.09%	26.68	5.53	5.53	5.53	5.53	4.47	5.62	5.49	5.62	4.16	4.27	N/A	44.87	TBD	13.83	80% of billed	7.74	N/A
Routine venipuncture	36415		1.00%	0.03%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-3
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiology

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Heart image (3d), multiple	78465		2.76%	11.89%	$1,714.16	$843.48	$225.41	$923.35	$779.36	$1,008.56	$2,125.00	$935.27	$123.98	$951.30	$774.80	$928.00	$2,174.00	$1,002.99	$273.77	$1,106.32	$935.20	$1,467.00
Tte w/o doppler, complete	93307	26	5.73%	8.40%	Not Cred	87.46	Not Cred	154.82	82.71	165.85	Not Cred	80.00	Not Cred	104.34	69.49	173.00	Not Cred	102.53	Not Cred	183.65	74.52	179.58
Office/outpatient visit, est	99214		5.68%	5.35%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Doppler echo exam, heart	93320	26	6.84%	4.38%	108.87	51.94	78.68	43.96	46.09	73.23	117.00	33.75	78.85	36.82	33.75	46.00	150.00	45.70	125.41	40.47	36.02	118.75
Cardiovascular stress test	93015		3.87%	4.24%	540.42	186.52	188.13	202.02	165.00	296.26	589.00	160.24	157.38	194.56	153.47	319.00	639.00	165.52	157.38	223.49	184.92	319.00
Office/outpatient visit, est	99213		6.25%	3.91%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Doppler color flow add-on	93325	26	7.10%	3.90%	50.99	47.90	19.79	19.95	11.19	52.88	38.00	6.88	6.40	7.24	6.82	9.00	105.00	165.41	44.64	8.10	7.29	140.00
Insert intracoronary stent	92980		0.40%	3.42%	4,486.68	1,391.33	1,524.52	1,555.88	1,331.22	2,496.38	4,805.00	1,365.79	1,330.90	1,575.09	1,237.06	2,351.50	4,885.00	1,467.40	1,395.67	1,687.00	1,476.53	3,460.80
Office consultation	99244		1.80%	3.37%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Stress tte only	93350	26	1.39%	2.43%	Not Cred	129.83	148.18	157.25	133.34	155.70	Not Cred	132.49	126.24	149.41	135.39	151.00	Not Cred	139.80	128.76	164.72	141.75	167.00
Tc99m sestamibi	A9500		1.43%	1.94%	198.80	119.09	145.83	132.73	132.82	128.02	190.00	114.33	115.29	121.70	121.70	113.00	190.00	136.00	217.78	144.00	134.51	128.11
Heart wall motion add-on	78478		2.72%	1.71%	337.11	132.00	46.82	122.52	110.01	178.77	416.00	130.21	43.02	117.00	108.21	141.49	425.00	145.96	50.38	153.81	132.37	281.00
Office consultation	99245		0.67%	1.54%	512.68	334.98	374.53	411.96	347.70	325.66	575.00	335.00	355.51	410.94	333.92	314.15	640.00	375.00	392.00	453.13	396.43	367.81
Heart function add-on	78480		2.67%	1.43%	326.63	118.35	40.44	105.90	98.41	171.96	400.00	110.85	27.74	97.00	90.95	135.20	410.00	138.31	50.38	139.44	124.44	281.00
Electrocardiogram, complete	93000		5.33%	1.28%	110.60	37.45	46.11	42.34	36.73	68.41	125.00	35.17	32.83	40.61	35.01	67.00	141.12	37.30	37.88	45.00	40.00	85.00
Subsequent hospital care	99232		1.89%	1.26%	198.52	103.04	107.93	121.88	102.61	104.64	228.00	101.84	104.73	123.95	98.82	107.70	237.00	112.67	110.08	133.20	115.53	115.00
Office consultation	99243		0.82%	1.05%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Tc99m tetrofosmin	A9502		0.75%	1.02%	158.30	126.21	Not Cred	131.81	123.59	111.51	118.33	117.00	Not Cred	121.05	115.29	120.70	231.61	145.26	Not Cred	160.00	137.50	127.20
Electrocardiogram report	93010		7.62%	0.67%	48.58	19.21	16.24	24.19	17.90	33.02	52.00	14.47	14.15	19.58	15.26	36.30	56.00	18.05	14.43	30.60	18.00	39.00
Cardiovascular stress test	93016		1.24%	0.31%	157.08	45.02	45.04	52.36	40.44	82.70	140.00	40.26	38.49	46.23	40.08	63.00	192.15	43.63	39.26	50.40	43.89	102.85
Office/outpatient visit, est	99211		1.27%	0.26%	63.99	29.21	29.84	36.72	30.27	31.26	70.00	28.37	29.44	34.95	28.74	32.00	78.00	31.93	29.70	39.96	35.37	34.00
Cardiovascular stress test	93018		1.51%	0.24%	164.25	34.38	33.19	48.64	27.46	73.65	151.00	26.62	25.47	30.82	26.35	69.00	232.00	28.00	26.10	37.26	28.71	122.00
Prothrombin time	85610		1.56%	0.09%	29.59	8.86	13.68	8.62	6.78	15.43	35.00	7.61	11.25	7.69	5.74	15.00	40.00	7.97	11.48	8.24	6.89	23.75
Routine venipuncture	36415		1.00%	0.03%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clair

Appendix A-3
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiology

					Billed Charges [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Heart image (3d), multiple	78465		2.76%	11.89%	$1,884.19	$1,231.63	$610.48	$1,175.99	$1,129.43	$1,488.26	$2,174.00	$1,087.20	$490.07	$1,171.50	$1,087.20	$1,139.75	$2,174.00	$1,400.00	$918.00	$1,412.00	$1,258.00	$2,519.00
Tte w/o doppler, complete	93307	26	5.73%	8.40%	Not Cred	109.28	Not Cred	212.63	225.85	280.29	Not Cred	93.75	Not Cred	131.00	180.00	351.00	Not Cred	161.00	Not Cred	231.00	378.20	351.00
Office/outpatient visit, est	99214		5.68%	5.35%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Doppler echo exam, heart	93320	26	6.84%	4.38%	182.08	61.68	53.62	68.94	86.09	98.26	117.00	58.00	52.00	54.00	56.00	85.00	117.00	80.17	89.00	95.75	128.00	170.00
Cardiovascular stress test	93015		3.87%	4.24%	574.89	253.09	415.91	242.19	262.98	543.30	589.00	241.00	550.83	234.50	242.00	482.00	625.00	302.50	550.83	292.00	313.00	895.00
Office/outpatient visit, est	99213		6.25%	3.91%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Doppler color flow add-on	93325	26	7.10%	3.90%	135.14	30.51	23.68	26.88	38.18	59.70	38.00	11.00	27.00	10.75	10.00	19.50	167.00	72.00	38.00	16.50	40.00	122.00
Insert intracoronary stent	92980		0.40%	3.42%	4,800.84	1,905.47	2,774.34	2,055.52	2,230.35	3,218.71	4,885.00	1,913.00	2,559.00	1,935.00	2,021.50	3,720.50	4,885.00	2,043.00	3,228.00	2,304.00	2,817.00	5,162.00
Office consultation	99244		1.80%	3.37%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Stress tte only	93350	26	1.39%	2.43%	Not Cred	167.39	222.66	224.61	203.39	187.28	Not Cred	172.72	243.00	194.00	191.00	181.38	Not Cred	195.00	243.00	275.00	205.00	192.00
Tc99m sestamibi	A9500		1.43%	1.94%	184.27	152.64	241.51	154.43	179.43	290.30	190.00	134.51	279.36	153.00	149.00	275.00	190.00	192.16	279.36	190.00	206.00	425.95
Heart wall motion add-on	78478		2.72%	1.71%	399.10	181.55	105.71	182.07	182.65	326.99	425.00	191.00	62.00	183.71	187.00	350.00	425.00	223.00	114.00	259.00	210.00	515.36
Office consultation	99245		0.67%	1.54%	544.53	398.49	382.16	496.39	443.42	395.48	563.00	392.00	420.00	500.00	450.00	400.00	660.00	455.00	452.00	591.00	503.00	487.00
Heart function add-on	78480		2.67%	1.43%	378.74	167.36	91.88	170.25	179.57	315.21	410.00	174.00	62.00	158.83	186.00	423.50	410.00	223.00	135.00	238.00	216.00	515.36
Electrocardiogram, complete	93000		5.33%	1.28%	105.88	51.56	64.80	54.14	56.58	96.95	125.00	50.00	66.00	56.00	52.80	90.00	128.00	75.00	78.00	62.00	72.00	175.00
Subsequent hospital care	99232		1.89%	1.26%	208.11	115.76	131.12	141.72	138.76	129.72	234.00	120.00	125.00	144.00	138.80	125.00	238.17	130.00	133.00	167.00	158.00	160.00
Office consultation	99243		0.82%	1.05%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Tc99m tetrofosmin	A9502		0.75%	1.02%	Not Cred	151.46	Not Cred	170.76	183.83	138.04	Not Cred	164.00	Not Cred	151.00	178.00	142.00	Not Cred	191.13	Not Cred	200.00	250.00	142.00
Electrocardiogram report	93010		7.62%	0.67%	56.29	29.67	34.64	33.93	32.06	41.09	52.00	25.70	25.00	34.00	28.00	36.30	60.10	37.00	44.00	43.00	39.00	55.00
Cardiovascular stress test	93016		1.24%	0.31%	172.90	51.82	70.05	75.67	67.33	95.84	199.00	43.00	64.00	61.00	58.00	98.00	199.00	63.00	66.00	100.00	75.00	121.00
Office/outpatient visit, est	99211		1.27%	0.26%	61.45	31.51	36.11	43.78	44.31	33.61	75.00	31.93	37.00	45.00	41.00	35.00	80.00	40.00	37.00	51.00	50.00	45.00
Cardiovascular stress test	93018		1.51%	0.24%	179.99	44.22	91.97	61.84	54.60	104.90	206.56	28.00	82.00	43.00	39.00	70.50	256.00	70.42	161.00	100.00	65.00	165.00
Prothrombin time	85610		1.56%	0.09%	32.22	23.20	25.89	18.04	20.72	26.62	35.00	21.00	28.00	18.00	17.00	28.00	35.00	36.78	28.00	22.00	32.00	31.50
Routine venipuncture	36415		1.00%	0.03%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-4
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiothoracic Surgery

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Medicare [1] AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	TRICARE [2] AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
CABG, arterial, single	33533		4.98%	16.39%	$2,511.98	$1,834.00	$1,833.12	$1,870.13	$1,839.75	$2,002.77	$1,915.64	$1,998.59	$3,622.15	$1,864.48	$1,818.86	$1,889.41	$1,859.86	$1,992.99	$1,921.24	$1,928.84
Replacement of aortic valve	33405		1.10%	4.28%	3,053.32	2,226.28	2,224.22	2,269.11	2,232.86	2,429.63	2,325.06	2,426.11	4,399.19	2,260.84	2,205.56	2,289.75	2,254.74	2,414.81	2,329.19	2,339.87
CABG, arterial, two	33534		0.83%	3.18%	2,950.56	2,151.84	2,150.02	2,193.41	2,158.26	2,348.65	2,247.37	2,344.99	4,252.92	2,186.39	2,132.92	2,214.61	2,180.59	2,335.67	2,252.58	2,262.62
Partial removal of lung	32480		0.59%	1.80%	1,946.13	1,424.06	1,425.49	1,453.72	1,429.25	1,555.97	1,486.66	1,548.82	2,790.30	1,438.31	1,403.80	1,458.81	1,435.43	1,538.11	1,481.80	1,485.75
Repair of mitral valve	33427		0.46%	1.66%	3,281.19	2,388.20	2,384.24	2,432.53	2,394.59	2,604.43	2,494.09	2,603.63	4,733.06	2,428.30	2,368.79	2,457.72	2,421.07	2,591.65	2,501.30	2,514.74
Endovenous laser, 1st vein	36478		0.36%	1.59%	1,670.49	1,375.69	1,438.15	1,461.86	1,404.08	1,574.18	1,441.66	1,465.02	2,297.57	1,344.42	1,315.87	1,425.74	1,366.93	1,517.12	1,402.28	1,332.68
Partial removal of lung	32500		0.51%	1.50%	1,882.49	1,380.83	1,383.43	1,410.79	1,386.35	1,510.38	1,441.79	1,501.47	2,697.10	1,393.76	1,360.31	1,414.91	1,391.47	1,492.25	1,436.36	1,438.74
Replacement of mitral valve	33430		0.32%	1.50%	3,731.52	2,716.49	2,712.12	2,767.08	2,723.82	2,962.74	2,837.03	2,961.64	5,363.86	2,750.54	2,683.04	2,783.28	2,742.10	2,934.92	2,833.13	2,849.09
CABG, artery-vein, three	33519		1.65%	1.45%	732.94	528.74	526.01	536.79	529.44	574.38	551.97	577.29	1,058.51	537.97	524.70	542.52	535.58	571.59	553.56	558.82
Ascending aortic graft	33863		0.24%	1.36%	4,216.10	3,056.85	3,047.47	3,109.34	3,063.35	3,327.81	3,191.51	3,333.82	6,079.29	3,105.69	3,029.58	3,138.37	3,094.52	3,307.83	3,197.38	3,220.20
Office consultation	99245		2.19%	1.34%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	428.34	223.13	220.20	229.02	224.42	238.44	228.17	224.00
CABG, artery-vein, two	33518		2.01%	1.30%	553.06	398.83	396.68	404.83	399.33	433.21	416.37	435.55	798.01	405.34	395.33	408.67	403.49	430.55	417.06	421.15
Repair of mitral valve	33426		0.32%	1.28%	3,184.41	2,320.01	2,317.05	2,363.92	2,326.56	2,531.14	2,422.99	2,528.91	4,584.36	2,353.56	2,295.89	2,382.66	2,346.78	2,512.67	2,424.50	2,436.85
Office consultation	99244		2.46%	1.22%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Extremity study	93970	26	2.73%	1.03%	46.21	33.12	33.35	33.78	33.27	35.51	34.03	34.78	67.27	34.07	33.61	34.60	34.12	35.93	34.73	34.53
Extracranial study	93880	26	1.93%	0.88%	40.73	29.17	29.50	29.81	29.34	31.19	29.85	30.31	59.84	30.37	30.03	30.92	30.46	32.01	30.90	30.58
Office/outpatient visit, est	99213		5.06%	0.84%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Inpatient consultation	99255		1.39%	0.75%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	396.77	201.14	199.02	204.82	201.81	211.86	204.56	202.30
Extremity study	93971	26	2.99%	0.72%	30.49	21.83	22.02	22.29	21.95	23.38	22.40	22.83	44.86	22.76	22.46	23.14	22.80	24.01	23.19	23.01
Office/outpatient visit, est	99214		2.54%	0.64%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Office consultation	99243		1.80%	0.61%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Inpatient consultation	99254		1.37%	0.60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	328.30	166.65	164.98	169.85	167.30	175.60	169.44	167.34
Office/outpatient visit, est	99212		3.28%	0.34%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Inpatient consultation	99253		1.02%	0.31%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	226.70	115.09	113.83	117.22	115.47	121.34	117.11	115.83
Office/outpatient visit, new	99203		1.08%	0.27%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Subsequent hospital care	99232		1.54%	0.27%	93.75	67.04	67.83	68.52	67.45	71.57	68.51	69.45	134.96	68.09	67.41	69.24	68.29	71.54	69.18	68.50
Subsequent hospital care	99231		1.46%	0.14%	51.71	37.05	37.46	37.87	37.27	39.61	37.90	38.48	74.26	37.52	37.10	38.14	37.61	39.46	38.16	37.83
Endoscopic vein harvest	33508		2.31%	0.08%	21.79	15.74	15.69	16.00	15.77	17.09	16.40	17.11	31.29	15.91	15.54	16.06	15.85	16.89	16.35	16.46

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-4
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiothoracic Surgery

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
CABG, arterial, single	33533		4.98%	16.39%	$4,736.81	$1,834.00	$1,833.12	$1,870.13	$2,002.77	$1,998.59	$3,216.32	$1,699.42	$2,631.76	$1,505.34	$1,161.07	N/A	$15,536.23	$4,734.66	$3,617.30	$4,623.98	$3,157.70	N/A
Replacement of aortic valve	33405		1.10%	4.28%	5,456.88	2,226.28	2,224.22	2,269.11	2,429.63	2,426.11	3,907.14	2,040.43	3,191.40	1,825.27	1,407.38	N/A	17,021.05	5,747.35	4,390.93	5,613.65	3,832.30	N/A
CABG, arterial, two	33534		0.83%	3.18%	5,099.52	2,151.84	2,150.02	2,193.41	2,348.65	2,344.99	3,777.36	1,965.15	3,086.30	1,765.18	1,361.14	N/A	17,383.20	5,555.18	4,244.13	5,425.36	3,703.91	N/A
Partial removal of lung	32480		0.59%	1.80%	3,721.88	1,424.06	1,425.49	1,453.72	1,555.97	1,548.82	2,478.16	1,300.29	2,031.03	1,159.82	895.65	N/A	5,890.16	3,676.35	2,804.02	3,583.68	2,451.56	N/A
Repair of mitral valve	33427		0.46%	1.66%	6,077.90	2,388.20	2,384.24	2,432.53	2,604.43	2,603.63	4,203.41	2,200.29	3,427.20	1,960.75	1,511.20	N/A	BR	6,165.36	4,711.78	6,022.64	4,109.55	N/A
Endovenous laser, 1st vein	36478		0.36%	1.59%	7,634.28	1,375.69	1,438.15	1,461.86	1,574.18	1,465.02	2,070.12	1,315.48	1,904.06	1,076.63	Not Covered	N/A	N/A	3,551.68	2,666.52	3,537.22	2,410.06	N/A
Partial removal of lung	32500		0.51%	1.50%	3,439.51	1,380.83	1,383.43	1,410.79	1,510.38	1,501.47	2,395.28	1,260.92	1,968.08	1,123.93	868.53	N/A	4,908.46	3,564.77	2,718.55	3,475.30	2,377.96	N/A
Replacement of mitral valve	33430		0.32%	1.50%	5,226.84	2,716.49	2,712.12	2,767.08	2,962.74	2,961.64	4,763.39	2,397.45	3,881.75	2,221.15	1,711.49	N/A	16,296.75	7,012.88	5,359.67	6,851.72	4,675.12	N/A
CABG, artery-vein, three	33519		1.65%	1.45%	992.94	528.74	526.01	536.79	574.38	577.29	939.71	462.81	759.17	434.55	334.12	N/A	3,911.23	1,364.99	1,044.31	1,381.32	908.68	N/A
Ascending aortic graft	33863		0.24%	1.36%	6,835.43	3,056.85	3,047.47	3,109.34	3,327.81	3,333.82	5,398.64	2,733.52	4,383.24	2,507.69	1,930.90	N/A	19,918.25	7,891.54	6,032.34	7,710.06	5,256.75	N/A
Office consultation	99245		2.19%	1.34%	371.13	N/A	N/A	N/A	N/A	N/A	380.86	N/A	N/A	N/A	138.05	N/A	601.64	418.17	N/A	434.83	351.96	N/A
CABG, artery-vein, two	33518		2.01%	1.30%	677.43	398.83	396.68	404.83	433.21	435.55	708.68	345.48	571.91	327.44	251.64	N/A	2,535.05	1,029.61	787.88	1,041.51	685.11	N/A
Repair of mitral valve	33426		0.32%	1.28%	5,159.56	2,320.01	2,317.05	2,363.92	2,531.14	2,528.91	4,071.18	2,091.94	3,321.57	1,900.38	1,464.96	N/A	16,514.03	5,989.34	4,576.75	5,850.98	3,992.78	N/A
Office consultation	99244		2.46%	1.22%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Extremity study	93970	26	2.73%	1.03%	93.08	33.12	33.35	33.78	35.51	34.78	N/A	47.34	46.51	26.71	20.90	N/A	276.02	66.76	63.18	64.83	55.89	N/A
Extracranial study	93880	26	1.93%	0.88%	129.14	29.17	29.50	29.81	31.19	30.31	N/A	37.66	41.29	23.65	18.67	N/A	304.62	58.81	55.13	56.57	49.25	N/A
Office/outpatient visit, est	99213		5.06%	0.84%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Inpatient consultation	99255		1.39%	0.75%	392.77	N/A	N/A	N/A	N/A	N/A	352.78	N/A	N/A	N/A	123.60	N/A	657.70	376.41	N/A	388.34	313.78	N/A
Extremity study	93971	26	2.99%	0.72%	60.36	21.83	22.02	22.29	23.38	22.83	N/A	18.16	30.85	17.80	14.00	N/A	171.57	44.02	41.50	42.59	37.08	N/A
Office/outpatient visit, est	99214		2.54%	0.64%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Office consultation	99243		1.80%	0.61%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Inpatient consultation	99254		1.37%	0.60%	343.92	N/A	N/A	N/A	N/A	N/A	291.91	N/A	N/A	N/A	102.26	N/A	523.16	311.86	N/A	321.34	260.10	N/A
Office/outpatient visit, est	99212		3.28%	0.34%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Inpatient consultation	99253		1.02%	0.31%	252.38	N/A	N/A	N/A	N/A	N/A	201.58	N/A	N/A	N/A	70.69	N/A	418.53	215.63	N/A	222.89	179.86	N/A
Office/outpatient visit, new	99203		1.08%	0.27%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Subsequent hospital care	99232		1.54%	0.27%	140.57	67.04	67.83	68.52	71.57	69.45	120.29	62.39	97.63	52.86	41.79	N/A	256.48	135.17	126.36	140.16	112.89	N/A
Subsequent hospital care	99231		1.46%	0.14%	85.13	37.05	37.46	37.87	39.61	38.48	66.52	34.77	53.88	29.21	23.12	N/A	188.08	74.69	69.99	77.26	62.53	N/A
Endoscopic vein harvest	33508		2.31%	0.08%	43.26	15.74	15.69	16.00	17.09	17.11	27.83	14.38	22.41	12.80	9.78	N/A	3,549.08	40.63	30.97	40.94	27.12	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-4
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiothoracic Surgery

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Commercial Allowed [5] Mean AK	ID	ND	OR	WA	WY	Median AK	ID	ND	OR	WA	WY	80th Percentile AK	ID	ND	OR	WA	WY
CABG, arterial, single	33533		4.98%	16.39%	Not Cred	Not Cred	Not Cred	$3,413.86	$3,052.43	Not Cred	Not Cred	Not Cred	Not Cred	$3,604.67	$3,114.81	Not Cred	Not Cred	Not Cred	Not Cred	$4,087.21	$3,860.76	Not Cred
Replacement of aortic valve	33405		1.10%	4.28%	Not Cred	Not Cred	Not Cred	3,916.31	3,628.52	Not Cred	Not Cred	Not Cred	Not Cred	4,394.49	4,090.86	Not Cred	Not Cred	Not Cred	Not Cred	5,065.36	4,249.69	Not Cred
CABG, arterial, two	33534		0.83%	3.18%	No Data	Not Cred	Not Cred	3,769.62	3,254.09	No Data	No Data	Not Cred	Not Cred	4,072.26	3,502.09	No Data	No Data	Not Cred	Not Cred	4,863.48	4,466.87	No Data
Partial removal of lung	32480		0.59%	1.80%	No Data	Not Cred	Not Cred	2,841.78	Not Cred	Not Cred	No Data	Not Cred	Not Cred	2,823.83	Not Cred	Not Cred	No Data	Not Cred	Not Cred	2,996.14	Not Cred	Not Cred
Repair of mitral valve	33427		0.46%	1.66%	Not Cred	No Data	Not Cred	Not Cred	2,733.01	No Data	Not Cred	No Data	Not Cred	Not Cred	4,080.70	No Data	Not Cred	No Data	Not Cred	Not Cred	4,187.52	No Data
Endovenous laser, 1st vein	36478		0.36%	1.59%	5,786.99	3,088.44	1,766.18	2,996.21	2,515.34	3,219.48	6,692.00	3,083.43	2,198.17	2,900.00	2,418.51	3,160.00	7,060.40	3,397.54	2,198.17	3,447.04	3,240.30	3,757.50
Partial removal of lung	32500		0.51%	1.50%	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred
Replacement of mitral valve	33430		0.32%	1.50%	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data
CABG, artery-vein, three	33519		1.65%	1.45%	Not Cred	Not Cred	Not Cred	921.16	779.81	No Data	Not Cred	Not Cred	Not Cred	986.91	750.99	No Data	Not Cred	Not Cred	Not Cred	1,107.78	999.60	No Data
Ascending aortic graft	33863		0.24%	1.36%	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred
Office consultation	99245		2.19%	1.34%	512.68	334.98	374.53	411.96	347.70	325.66	575.00	335.00	355.51	410.94	333.92	314.15	640.00	375.00	392.00	453.13	396.43	367.81
CABG, artery-vein, two	33518		2.01%	1.30%	Not Cred	Not Cred	Not Cred	726.23	595.27	Not Cred	Not Cred	Not Cred	Not Cred	744.10	542.26	Not Cred	Not Cred	Not Cred	Not Cred	851.57	755.40	Not Cred
Repair of mitral valve	33426		0.32%	1.28%	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data
Office consultation	99244		2.46%	1.22%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Extremity study	93970	26	2.73%	1.03%	170.73	65.16	62.82	73.59	68.28	99.94	165.00	53.76	54.91	64.99	57.81	70.18	244.04	81.00	56.01	76.63	64.35	86.00
Extracranial study	93880	26	1.93%	0.88%	153.73	58.89	59.01	62.68	54.97	142.47	163.00	46.68	48.68	57.62	50.87	86.00	170.00	70.20	57.21	64.33	56.21	125.10
Office/outpatient visit, est	99213		5.06%	0.84%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Inpatient consultation	99255		1.39%	0.75%	541.40	329.79	318.68	369.11	312.11	323.57	609.50	306.03	317.02	375.20	299.86	281.19	650.00	342.54	320.95	414.17	351.77	390.56
Extremity study	93971	26	2.99%	0.72%	112.51	39.24	42.13	45.20	47.38	106.28	112.00	35.01	36.23	42.88	38.34	43.00	117.00	41.08	39.14	47.83	41.86	86.94
Office/outpatient visit, est	99214		2.54%	0.64%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Office consultation	99243		1.80%	0.61%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Inpatient consultation	99254		1.37%	0.60%	432.27	240.20	262.96	299.70	246.73	232.74	485.00	228.50	259.84	303.34	236.02	218.82	514.00	275.27	267.04	334.50	275.21	273.11
Office/outpatient visit, est	99212		3.28%	0.34%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Inpatient consultation	99253		1.02%	0.31%	345.75	178.41	185.85	211.69	180.03	181.58	383.00	172.00	180.02	209.24	167.04	183.54	404.00	190.29	183.62	230.55	200.91	198.00
Office/outpatient visit, new	99203		1.08%	0.27%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Subsequent hospital care	99232		1.54%	0.27%	198.52	103.04	107.93	121.88	102.61	104.64	228.00	101.84	104.73	123.95	98.82	107.70	237.00	112.67	110.08	133.20	115.53	115.00
Subsequent hospital care	99231		1.46%	0.14%	136.98	60.16	65.27	72.19	61.74	72.72	164.00	56.49	58.31	69.01	57.42	69.00	177.00	64.43	69.00	77.52	66.81	100.00
Endoscopic vein harvest	33508		2.31%	0.08%	Not Cred	Not Cred	Not Cred	31.58	40.04	Not Cred	Not Cred	Not Cred	Not Cred	32.99	27.53	Not Cred	Not Cred	Not Cred	Not Cred	36.05	34.14	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-4
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Cardiothoracic Surgery

					Billed Charges[6]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
CABG, arterial, single	33533		4.98%	16.39%	Not Cred	$6,174.64	Not Cred	$5,038.85	$4,678.82	Not Cred	Not Cred	$6,533.00	Not Cred	$5,487.00	$4,925.00	Not Cred	Not Cred	$6,712.00	Not Cred	$5,508.00	$5,723.00	Not Cred
Replacement of aortic valve	33405		1.10%	4.28%	Not Cred	7,410.80	Not Cred	5,905.67	5,877.24	Not Cred	Not Cred	7,782.00	Not Cred	6,115.00	5,543.50	Not Cred	Not Cred	7,782.00	Not Cred	6,543.00	6,706.60	Not Cred
CABG, arterial, two	33534		0.83%	3.18%	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data
Partial removal of lung	32480		0.59%	1.80%	Not Cred	Not Cred	Not Cred	Not Cred	3,218.09	No Data	Not Cred	Not Cred	Not Cred	Not Cred	3,271.00	No Data	Not Cred	Not Cred	Not Cred	Not Cred	4,280.30	No Data
Repair of mitral valve	33427		0.46%	1.66%	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data
Endovenous laser, 1st vein	36478		0.36%	1.59%	Not Cred	4,044.55	Not Cred	Not Cred	3,993.27	Not Cred	Not Cred	3,850.00	Not Cred	Not Cred	4,000.00	Not Cred	Not Cred	4,250.00	Not Cred	Not Cred	5,209.00	Not Cred
Partial removal of lung	32500		0.51%	1.50%	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data
Replacement of mitral valve	33430		0.32%	1.50%	No Data	Not Cred	Not Cred	Not Cred	8,024.16	No Data	No Data	Not Cred	Not Cred	Not Cred	7,892.00	No Data	No Data	Not Cred	Not Cred	Not Cred	8,916.00	No Data
CABG, artery-vein, three	33519		1.65%	1.45%	No Data	Not Cred	Not Cred	Not Cred	1,248.08	Not Cred	No Data	Not Cred	Not Cred	Not Cred	1,254.00	Not Cred	No Data	Not Cred	Not Cred	Not Cred	1,557.10	Not Cred
Ascending aortic graft	33863		0.24%	1.36%	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data
Office consultation	99245		2.19%	1.34%	544.53	398.49	382.16	496.39	443.42	395.48	563.00	392.00	420.00	500.00	450.00	400.00	660.00	455.00	452.00	591.00	503.00	487.00
CABG, artery-vein, two	33518		2.01%	1.30%	No Data	Not Cred	Not Cred	1,026.99	890.04	Not Cred	No Data	Not Cred	Not Cred	1,018.50	935.00	Not Cred	No Data	Not Cred	Not Cred	1,155.00	1,159.00	Not Cred
Repair of mitral valve	33426		0.32%	1.28%	Not Cred	Not Cred	No Data	Not Cred	Not Cred	No Data	Not Cred	Not Cred	No Data	Not Cred	Not Cred	No Data	Not Cred	Not Cred	No Data	Not Cred	Not Cred	No Data
Office consultation	99244		2.46%	1.22%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Extremity study	93970	26	2.73%	1.03%	186.81	102.52	89.74	128.66	103.10	122.20	165.00	100.50	72.00	102.00	96.00	33.43	257.00	110.00	109.00	167.00	120.00	129.00
Extracranial study	93880	26	1.93%	0.88%	149.98	90.58	98.21	110.40	107.58	134.66	170.00	92.00	80.00	91.03	87.75	84.00	170.00	105.50	135.00	124.00	112.00	201.58
Office/outpatient visit, est	99213		5.06%	0.84%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Inpatient consultation	99255		1.39%	0.75%	477.62	355.21	398.36	443.39	400.14	402.83	477.00	350.00	404.00	446.00	420.00	414.00	628.55	438.47	404.00	523.00	476.00	500.00
Extremity study	93971	26	2.99%	0.72%	123.57	67.78	65.69	75.24	68.87	101.08	117.00	60.00	66.00	65.00	65.00	63.00	160.00	75.86	71.00	96.00	76.80	149.00
Office/outpatient visit, est	99214		2.54%	0.64%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Office consultation	99243		1.80%	0.61%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Inpatient consultation	99254		1.37%	0.60%	459.06	283.58	301.70	356.38	324.02	323.08	493.00	287.00	300.00	362.00	330.00	320.00	552.00	350.00	332.00	431.00	390.00	401.00
Office/outpatient visit, est	99212		3.28%	0.34%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Inpatient consultation	99253		1.02%	0.31%	345.49	202.10	225.00	255.97	234.89	245.19	383.00	204.00	212.00	261.00	234.85	259.65	407.70	247.00	270.00	299.00	270.00	280.00
Office/outpatient visit, new	99203		1.08%	0.27%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Subsequent hospital care	99232		1.54%	0.27%	208.11	115.76	131.12	141.72	138.76	129.72	234.00	120.00	125.00	144.00	138.80	125.00	238.17	130.00	133.00	167.00	158.00	160.00
Subsequent hospital care	99231		1.46%	0.14%	140.10	74.65	79.05	88.72	94.01	88.60	152.00	75.00	78.00	87.00	84.00	88.00	180.00	89.00	98.00	108.00	102.00	109.00
Endoscopic vein harvest	33508		2.31%	0.08%	Not Cred	56.25	Not Cred	97.14	45.52	Not Cred	Not Cred	55.00	Not Cred	47.00	41.00	Not Cred	Not Cred	58.00	Not Cred	47.00	55.00	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-5
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Chiropractic

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Chiropractic manipulation	98941		26.08%	32.73%	$46.20	$33.52	$34.08	$34.43	$33.79	$36.02	$34.29	$34.68	$65.97	$33.75	$33.43	$34.51	$33.93	$35.70	$34.34	$33.78
Chiropractic manipulation	98940		12.96%	11.58%	33.24	24.28	24.79	25.02	24.51	26.15	24.81	24.99	47.15	24.28	24.06	24.90	24.44	25.76	24.72	24.23
Manual therapy	97140		6.49%	6.20%	36.23	26.98	27.67	27.96	27.29	29.35	27.67	27.88	50.51	26.48	26.20	27.29	26.70	28.34	27.04	26.38
Chiropractic manipulation	98942		3.39%	5.56%	60.10	43.36	44.07	44.48	43.69	46.42	44.26	44.67	86.52	44.09	43.71	45.05	44.32	46.50	44.79	44.06
Therapeutic exercises	97110		5.40%	5.53%	38.37	28.62	29.37	29.67	28.96	31.16	29.36	29.58	53.75	28.26	27.95	29.15	28.50	30.29	28.87	28.13
Mechanical traction therapy	97012		8.86%	4.76%	20.01	14.78	15.10	15.26	14.93	16.02	15.15	15.31	28.14	14.63	14.46	15.03	14.73	15.61	14.94	14.64
Electric stimulation therapy	97014		8.89%	4.49%	16.07	12.08	12.39	12.53	12.22	13.22	12.44	12.59	24.96	13.44	13.24	13.93	13.56	14.59	13.81	13.42
Chiropractic manipulation	98943		4.31%	3.55%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	44.59	23.14	22.86	23.74	23.28	24.68	23.64	23.22
Office/outpatient visit, new	99203		0.98%	3.35%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Office/outpatient visit, est	99213		1.45%	3.29%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Neuromuscular reeducation	97112		3.02%	3.23%	39.85	29.90	30.73	31.05	30.27	32.65	30.70	30.94	55.44	29.30	28.98	30.28	29.57	31.49	29.97	29.15
Therapeutic activities	97530		2.20%	2.39%	41.20	31.16	32.09	32.44	31.58	34.17	32.05	32.30	56.91	30.32	29.96	31.40	30.61	32.71	31.05	30.13
Ultrasound therapy	97035		3.25%	1.39%	15.75	11.49	11.71	11.83	11.59	12.39	11.77	11.91	22.79	11.77	11.63	12.05	11.83	12.51	12.01	11.81
Electrical stimulation	97032		2.32%	1.38%	22.61	17.02	17.48	17.68	17.23	18.63	17.51	17.69	30.94	16.36	16.16	16.89	16.50	17.61	16.76	16.34
Office/outpatient visit, new	99202		0.57%	1.30%	89.38	67.88	69.71	70.61	68.74	74.76	70.13	71.13	123.19	65.86	64.92	68.16	66.44	71.28	67.62	65.81
Office/outpatient visit, est	99212		0.90%	1.25%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Massage therapy	97124		1.38%	1.14%	31.04	23.30	23.94	24.19	23.59	25.45	23.94	24.14	43.19	22.83	22.57	23.59	23.03	24.55	23.36	22.74
Hot or cold packs therapy	97010		3.20%	0.57%	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	8.92	4.84	4.73	5.01	4.87	5.30	5.02	4.92

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-5
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Chiropractic

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Chiropractic manipulation	98941		26.08%	32.73%	$59.87	$33.52	$34.08	$34.43	$36.02	$34.68	$59.85	$32.53	$48.16	$26.71	$21.12	N/A	$84.00	$47.31	$64.42	$66.74	Not Covered	N/A
Chiropractic manipulation	98940		12.96%	11.58%	48.29	24.28	24.79	25.02	26.15	24.99	42.79	23.45	34.62	19.20	15.34	N/A	65.33	34.27	46.46	47.67	Not Covered	N/A
Manual therapy	97140		6.49%	6.20%	69.72	26.98	27.67	27.96	29.35	27.88	44.91	24.62	N/A	20.59	16.45	27.46	74.53	37.32	50.79	50.14	45.93	N/A
Chiropractic manipulation	98942		3.39%	5.56%	95.50	43.36	44.07	44.48	46.42	44.67	78.50	42.63	62.70	34.78	27.57	N/A	110.45	61.20	83.00	85.17	Not Covered	N/A
Therapeutic exercises	97110		5.40%	5.53%	73.67	28.62	29.37	29.67	31.16	29.58	47.79	26.50	14.44	21.98	17.56	29.71	97.31	39.59	53.89	53.81	48.70	N/A
Mechanical traction therapy	97012		8.86%	4.76%	48.41	14.78	15.10	15.26	16.02	15.31	25.01	13.67	N/A	11.41	9.11	15.04	55.51	20.44	27.87	27.52	24.90	N/A
Electric stimulation therapy	97014		8.89%	4.49%	40.73	12.08	12.39	12.53	13.22	12.59	22.20	N/A	N/A	10.57	8.45	N/A	54.64	19.37	26.63	26.29	23.80	N/A
Chiropractic manipulation	98943		4.31%	3.55%	62.79	N/A	N/A	N/A	N/A	N/A	39.64	N/A	N/A	N/A	Not Covered	N/A	56.00	32.02	43.98	45.13	Not Covered	N/A
Office/outpatient visit, new	99203		0.98%	3.35%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Office/outpatient visit, est	99213		1.45%	3.29%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Neuromuscular reeducation	97112		3.02%	3.23%	75.67	29.90	30.73	31.05	32.65	30.94	49.59	27.25	14.44	22.81	18.23	N/A	95.24	41.36	56.37	55.65	50.91	N/A
Therapeutic activities	97530		2.20%	2.39%	74.74	31.16	32.09	32.44	34.17	32.30	50.60	27.85	14.44	23.65	18.90	N/A	76.22	43.11	58.84	58.09	53.13	N/A
Ultrasound therapy	97035		3.25%	1.39%	31.84	11.49	11.71	11.83	12.39	11.91	20.26	10.96	12.03	N/A	7.34	12.04	58.27	15.90	21.68	21.40	19.37	N/A
Electrical stimulation	97032		2.32%	1.38%	42.72	17.02	17.48	17.68	18.63	17.69	27.52	15.26	12.03	12.80	10.23	N/A	59.29	23.54	32.21	31.80	28.78	N/A
Office/outpatient visit, new	99202		0.57%	1.30%	121.20	67.88	69.71	70.61	74.76	71.13	109.84	59.02	93.90	51.75	39.31	69.70	171.90	136.85	129.45	142.89	116.21	N/A
Office/outpatient visit, est	99212		0.90%	1.25%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Massage therapy	97124		1.38%	1.14%	58.15	23.30	23.94	24.19	25.45	24.14	38.40	N/A	N/A	17.80	14.23	N/A	64.18	32.23	43.98	43.42	39.84	N/A
Hot or cold packs therapy	97010		3.20%	0.57%	27.14	Bundled	Bundled	Bundled	Bundled	Bundled	7.93	N/A	6.03	N/A	Bundled	N/A	48.57	7.08	N/A	9.78	Bundled	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-5
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Chiropractic

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Chiropractic manipulation	98941		26.08%	32.73%	$66.49	$37.90	$48.24	$50.45	$38.89	$45.93	$70.00	$38.00	$52.00	$47.94	$38.00	$45.00	$75.00	$39.68	$53.21	$60.00	$44.68	$55.00
Chiropractic manipulation	98940		12.96%	11.58%	53.90	30.39	37.49	39.00	31.33	39.10	55.00	28.27	38.49	34.68	29.50	40.00	60.00	35.00	38.49	49.50	34.68	45.00
Manual therapy	97140		6.49%	6.20%	119.79	39.28	49.43	57.57	43.86	60.99	112.10	28.47	40.76	44.08	28.44	50.00	180.00	56.94	61.35	79.16	56.80	90.00
Chiropractic manipulation	98942		3.39%	5.56%	75.77	46.95	55.64	61.98	46.82	50.20	80.00	45.07	56.25	56.25	49.50	50.00	85.00	51.56	69.00	75.00	54.75	50.17
Therapeutic exercises	97110		5.40%	5.53%	115.96	54.40	66.31	75.29	54.26	81.03	90.00	50.58	44.16	70.00	56.22	80.00	163.80	82.17	88.32	112.18	76.22	120.00
Mechanical traction therapy	97012		8.86%	4.76%	43.83	16.61	20.19	21.17	18.11	21.94	50.00	15.00	22.64	20.00	16.26	21.61	55.00	18.61	22.64	25.00	20.00	28.80
Electric stimulation therapy	97014		8.89%	4.49%	43.78	14.91	17.73	19.75	15.85	23.47	47.00	14.53	20.00	18.87	14.63	25.00	50.00	15.00	20.95	20.07	15.54	29.00
Chiropractic manipulation	98943		4.31%	3.55%	44.40	22.38	31.26	33.87	22.16	37.39	49.00	23.22	35.00	30.00	22.25	40.00	55.00	25.71	36.23	41.39	27.27	47.00
Office/outpatient visit, new	99203		0.98%	3.35%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Office/outpatient visit, est	99213		1.45%	3.29%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Neuromuscular reeducation	97112		3.02%	3.23%	105.80	34.12	48.14	48.65	45.17	54.15	74.00	28.84	44.26	40.80	31.60	43.00	160.00	35.00	45.61	52.73	63.20	80.00
Therapeutic activities	97530		2.20%	2.39%	115.09	45.26	109.02	78.92	62.43	47.93	96.00	31.87	92.84	58.00	62.56	43.00	180.00	60.00	185.68	120.00	96.00	55.00
Ultrasound therapy	97035		3.25%	1.39%	43.54	14.27	17.48	18.59	13.73	27.93	47.50	12.83	18.12	17.33	12.80	26.00	55.00	15.00	18.12	21.05	12.80	35.00
Electrical stimulation	97032		2.32%	1.38%	45.45	18.72	21.38	24.30	20.51	26.18	41.80	17.50	22.00	22.62	17.60	25.00	55.00	18.10	25.47	27.63	20.24	35.00
Office/outpatient visit, new	99202		0.57%	1.30%	149.21	91.12	86.37	110.70	93.63	87.29	155.00	93.40	99.63	114.79	90.39	88.00	172.00	103.33	99.63	123.60	108.17	97.00
Office/outpatient visit, est	99212		0.90%	1.25%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Massage therapy	97124		1.38%	1.14%	103.50	64.13	29.78	49.36	63.51	40.90	96.00	50.56	35.00	35.00	59.54	30.00	160.00	114.00	35.10	74.00	81.40	45.00
Hot or cold packs therapy	97010		3.20%	0.57%	27.10	8.14	9.48	9.59	9.04	16.42	32.00	4.98	6.21	8.50	5.51	15.00	40.00	10.93	12.00	10.08	12.90	21.50

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-5
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Chiropractic

					Billed Charges[6]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Chiropractic manipulation	98941		26.08%	32.73%	$54.98	$40.92	$48.97	$45.14	$51.67	$36.19	$50.00	$40.00	$50.00	$37.50	$53.00	$35.00	$70.00	$47.00	$55.00	$60.00	$60.00	$40.00
Chiropractic manipulation	98940		12.96%	11.58%	42.60	30.86	38.76	35.70	40.16	30.56	35.00	30.00	40.00	28.00	41.00	25.38	58.00	39.00	45.00	50.00	47.00	39.00
Manual therapy	97140		6.49%	6.20%	61.95	35.68	47.24	49.82	45.33	38.27	64.00	35.51	46.25	50.00	45.00	40.00	70.00	44.00	55.00	57.75	50.00	50.00
Chiropractic manipulation	98942		3.39%	5.56%	64.81	50.28	58.99	55.66	62.44	48.41	65.00	48.00	54.00	50.00	62.00	45.00	70.00	60.00	79.00	65.00	72.00	56.00
Therapeutic exercises	97110		5.40%	5.53%	64.21	35.07	47.83	50.70	47.75	39.57	65.00	35.00	48.00	52.00	48.00	40.00	81.00	40.00	50.00	59.00	55.00	50.00
Mechanical traction therapy	97012		8.86%	4.76%	33.70	20.38	32.95	26.94	26.33	25.37	36.00	20.00	28.80	28.00	26.00	30.00	40.00	25.00	40.00	35.00	30.00	30.00
Electric stimulation therapy	97014		8.89%	4.49%	40.03	16.27	16.88	21.62	24.31	18.10	40.00	15.10	18.00	20.00	20.00	15.00	47.00	20.00	22.00	30.00	31.00	20.00
Chiropractic manipulation	98943		4.31%	3.55%	Not Cred	25.04	30.52	25.25	35.69	Not Cred	Not Cred	25.00	30.00	20.00	38.00	Not Cred	Not Cred	35.00	45.00	47.00	41.00	Not Cred
Office/outpatient visit, new	99203		0.98%	3.35%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Office/outpatient visit, est	99213		1.45%	3.29%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Neuromuscular reeducation	97112		3.02%	3.23%	71.63	36.38	43.64	48.83	47.00	41.48	89.00	35.00	48.00	45.00	49.00	40.00	89.00	40.00	50.50	63.00	52.02	50.00
Therapeutic activities	97530		2.20%	2.39%	58.37	36.43	45.31	54.82	48.74	35.47	55.00	35.00	48.00	57.00	50.00	29.97	67.00	40.00	51.00	58.91	56.00	41.23
Ultrasound therapy	97035		3.25%	1.39%	38.53	19.19	25.82	24.79	24.66	25.19	40.00	17.00	23.00	25.00	24.00	21.00	55.00	23.00	35.00	30.00	30.00	40.00
Electrical stimulation	97032		2.32%	1.38%	38.89	25.68	28.05	29.19	26.62	25.98	35.00	26.00	28.00	31.00	25.50	15.11	50.00	30.00	29.00	36.00	30.00	54.57
Office/outpatient visit, new	99202		0.57%	1.30%	140.22	88.61	96.09	119.68	110.48	93.11	150.00	91.00	105.00	127.00	112.00	98.10	177.00	115.00	120.00	151.30	131.00	116.00
Office/outpatient visit, est	99212		0.90%	1.25%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Massage therapy	97124		1.38%	1.14%	33.93	25.19	33.95	21.48	29.93	31.25	37.00	25.00	38.00	19.00	26.00	22.25	40.00	28.00	38.00	40.00	43.05	40.00
Hot or cold packs therapy	97010		3.20%	0.57%	25.07	16.13	Not Cred	11.33	16.59	12.23	25.00	15.00	Not Cred	10.00	15.00	10.00	30.00	20.00	Not Cred	15.00	20.00	17.06

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-6
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
DME

					Medicare [1]								TRICARE [3]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Cont airway pressure device	E0601	RR	7.34%	7.80%	$96.13	$101.00	$99.22	$101.00	$101.00	$101.00	$101.00	$101.00	$96.13	$101.00	$99.22	$101.00	$101.00	$101.00	$101.00	$101.00
Oxygen concentrator	E1390	RR	4.00%	7.64%	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31	173.31
Neg press wound therapy pump	E2402	RR	0.26%	4.45%	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85
Ft insert ucb berkeley shell	L3000		1.33%	4.15%	277.33	277.33	287.24	277.33	277.33	277.33	277.33	287.24	277.33	277.33	287.24	277.33	277.33	277.33	277.33	287.24
Nasal application device	A7034	NU	3.28%	3.85%	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35	106.35
Elec osteogen stim spinal	E0748		0.08%	3.43%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pneumati walking boot prefab	L4360		0.97%	2.76%	275.94	312.25	252.72	312.25	312.25	312.25	312.25	252.72	275.94	312.25	252.72	312.25	312.25	312.25	312.25	252.72
Tens four lead	E0730	RR	0.61%	2.52%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CPAP full face mask	A7030	NU	1.14%	2.14%	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55	170.55
RAD w/o backup non-inv intfc	E0470	RR	0.82%	2.00%	224.92	231.99	231.99	227.21	227.21	231.99	231.99	231.99	224.92	231.99	231.99	227.21	227.21	231.99	231.99	231.99
Foot longitud/metatarsal sup	L3020		0.92%	1.81%	175.17	175.17	181.42	175.17	175.17	175.17	175.17	181.42	175.17	175.17	181.42	175.17	175.17	175.17	175.17	181.42
KO adj jnt pos rigid support	L1832		0.25%	1.64%	599.93	514.22	514.22	514.22	514.22	514.22	514.22	514.22	599.93	514.22	514.22	514.22	514.22	514.22	514.22	514.22
Pos airway pressure tubing	A7037	NU	3.85%	1.56%	32.69	37.08	37.08	37.08	37.08	37.08	37.08	37.08	32.69	37.08	37.08	37.08	37.08	37.08	37.08	37.08
Pneum compres w/cal pressure	E0652		0.03%	1.48%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pos airway press headgear	A7035	NU	3.77%	1.43%	35.06	35.93	35.93	35.93	35.93	35.93	35.93	35.93	35.06	35.93	35.93	35.93	35.93	35.93	35.93	35.93
Elec osteogen stim not spine	E0747		0.03%	1.28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Osteogen ultrasound stimltor	E0760		0.03%	1.15%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blood glucose/reagent strips	A4253	NU	2.72%	1.13%	37.87	36.40	36.38	38.75	38.75	36.49	36.49	38.76	37.87	36.40	36.38	38.75	38.75	36.49	36.49	38.76
Humidifier heated used w PAP	E0562	RR	3.28%	0.98%	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22	27.22
Wrist cock-up non-molded	L3908		1.36%	0.85%	86.59	66.12	49.59	66.12	66.12	66.12	66.12	49.59	86.59	66.12	49.59	66.12	66.12	66.12	66.12	49.59
Portable gaseous 02	E0431	RR	2.02%	0.64%	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74	28.74
Nebulizer with compression	E0570	RR	1.90%	0.35%	16.90	16.89	16.90	16.90	16.90	16.89	16.89	16.90	16.90	16.89	16.90	16.90	16.90	16.89	16.89	16.90
Lancets per box	A4259		1.81%	0.24%	12.66	11.41	12.65	12.65	12.65	12.65	12.65	12.65	12.66	11.41	12.65	12.65	12.65	12.65	12.65	12.65
Filter, non disposable w pap	A7039	NU	1.55%	0.22%	11.23	13.86	13.86	13.86	13.86	13.86	13.86	13.86	11.23	13.86	13.86	13.86	13.86	13.86	13.86	13.86
Pos airway pressure filter	A7038	NU	3.98%	0.20%	2.75	4.88	4.88	4.88	4.88	4.88	4.88	4.88	2.75	4.88	4.88	4.88	4.88	4.88	4.88	4.88
Electrodes, pair	A4556		1.36%	0.18%	10.58	10.83	12.74	12.43	12.43	10.83	10.83	12.74	10.58	10.83	12.74	12.43	12.43	10.83	10.83	12.74
Infus insulin pump non needl	A4230		1.63%	0.13%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Surgical trays	A4550		2.07%	0.03%	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-6
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
DME

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Cont airway pressure device	E0601	RR	7.34%	7.80%	$323.38	$101.00	$99.22	$101.00	$101.00	$101.00	N/A	N/A	N/A	$106.68	$101.10	$90.90	271.24	Unknown	$119.06	85% of MSRP	$164.94	N/A
Oxygen concentrator	E1390	RR	4.00%	7.64%	664.17	173.31	173.31	173.31	173.31	173.31	200.40	N/A	N/A	185.73	173.17	155.98	556.30	Unknown	207.97	85% of MSRP	173.31	N/A
Neg press wound therapy pump	E2402	RR	0.26%	4.45%	4,074.37	1,551.85	1,551.85	1,551.85	1,551.85	1,551.85	N/A	N/A	N/A	1,639.22	N/A	N/A	BR	Unknown	1,862.22	85% of MSRP	2,534.10	N/A
Ft insert ucb berkeley shell	L3000		1.33%	4.15%	540.34	277.33	287.24	277.33	277.33	287.24	246.83	220.18	N/A	235.72	277.61	246.46	407.51	Unknown	344.69	85% of MSRP	332.80	N/A
Nasal application device	A7034	NU	3.28%	3.85%	279.24	106.35	106.35	106.35	106.35	106.35	117.64	76.66	N/A	112.35	106.46	117.64	BR	Unknown	127.62	85% of MSRP	N/A	N/A
Elec osteogen stim spinal	E0748		0.08%	3.43%	N/A	N/A	N/A	N/A	N/A	N/A	3,826.27	3,342.55	N/A	N/A	N/A	N/A	BR	Unknown	N/A	85% of MSRP	N/A	N/A
Pneumati walking boot prefab	L4360		0.97%	2.76%	532.15	312.25	252.72	312.25	312.25	252.72	245.59	259.85	N/A	265.39	312.57	N/A	401.32	Unknown	303.26	85% of MSRP	374.70	N/A
Tens four lead	E0730	RR	0.61%	2.52%	211.84	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	32.60	N/A	N/A	177.58	Unknown	N/A	85% of MSRP	N/A	N/A
CPAP full face mask	A7030	NU	1.14%	2.14%	447.78	170.55	170.55	170.55	170.55	170.55	188.64	188.64	N/A	180.15	170.72	188.64	BR	Unknown	204.66	85% of MSRP	N/A	N/A
RAD w/o backup non-inv intfc	E0470	RR	0.82%	2.00%	590.55	231.99	231.99	227.21	231.99	231.99	2,487.90	N/A	N/A	240.00	232.22	N/A	BR	Unknown	278.39	85% of MSRP	378.83	N/A
Foot longitud/metatarsal sup	L3020		0.92%	1.81%	532.15	175.17	181.42	175.17	175.17	181.42	155.91	139.06	N/A	148.89	N/A	N/A	401.32	Unknown	217.70	85% of MSRP	210.20	N/A
KO adj jnt pos rigid support	L1832		0.25%	1.64%	1,316.05	514.22	514.22	514.22	514.22	514.22	533.93	427.92	N/A	437.06	N/A	N/A	992.94	Unknown	617.06	85% of MSRP	617.06	N/A
Pos airway pressure tubing	A7037	NU	3.85%	1.56%	85.83	37.08	37.08	37.08	37.08	37.08	36.16	39.12	N/A	39.17	37.12	41.02	BR	Unknown	44.50	85% of MSRP	N/A	N/A
Pneum compres w/cal pressure	E0652		0.03%	1.48%	N/A	N/A	N/A	N/A	N/A	N/A	6,172.73	4,311.06	N/A	N/A	N/A	N/A	N/A	Unknown	N/A	85% of MSRP	N/A	N/A
Pos airway press headgear	A7035	NU	3.77%	1.43%	92.08	35.93	35.93	35.93	35.93	35.93	38.79	37.92	N/A	37.96	35.97	39.75	BR	Unknown	43.12	85% of MSRP	N/A	N/A
Elec osteogen stim not spine	E0747		0.03%	1.28%	8,870.56	N/A	N/A	N/A	N/A	N/A	3,826.27	3,364.35	N/A	N/A	N/A	N/A	N/A	Unknown	N/A	85% of MSRP	N/A	N/A
Osteogen ultrasound stimltor	E0760		0.03%	1.15%	N/A	N/A	N/A	N/A	N/A	N/A	3,148.10	2,778.50	N/A	N/A	N/A	N/A	BR	Unknown	N/A	85% of MSRP	N/A	N/A
Blood glucose/reagent strips	A4253	NU	2.72%	1.13%	85.69	36.40	36.38	38.75	36.49	38.76	36.10	34.70	N/A	35.28	N/A	36.95	81.37	Unknown	43.66	85% of MSRP	N/A	N/A
Humidifier heated used w PAP	E0562	RR	3.28%	0.98%	71.47	27.22	27.22	27.22	27.22	27.22	N/A	N/A	N/A	28.76	N/A	24.51	BR	Unknown	32.66	85% of MSRP	N/A	N/A
Wrist cock-up non-molded	L3908		1.36%	0.85%	109.50	66.12	49.59	66.12	66.12	49.59	77.07	55.02	N/A	56.20	66.19	47.28	82.74	Unknown	59.51	85% of MSRP	79.34	N/A
Portable gaseous 02	E0431	RR	2.02%	0.64%	113.59	28.74	28.74	28.74	28.74	28.74	32.08	N/A	N/A	30.64	28.77	25.87	95.40	Unknown	34.49	85% of MSRP	28.74	N/A
Nebulizer with compression	E0570	RR	1.90%	0.35%	49.12	16.89	16.90	16.90	16.89	16.90	N/A	N/A	N/A	15.39	N/A	15.21	41.38	Unknown	20.28	85% of MSRP	By Report	N/A
Lancets per box	A4259		1.81%	0.24%	21.49	11.41	12.65	12.65	12.65	12.65	12.07	10.38	N/A	N/A	N/A	12.06	18.01	Unknown	15.18	85% of MSRP	Bundled	N/A
Filter, non disposable w pap	A7039	NU	1.55%	0.22%	29.48	13.86	13.86	13.86	13.86	13.86	12.42	14.62	N/A	14.64	13.87	15.33	BR	Unknown	16.63	85% of MSRP	N/A	N/A
Pos airway pressure filter	A7038	NU	3.98%	0.20%	7.22	4.88	4.88	4.88	4.88	4.88	3.04	5.39	N/A	5.15	4.88	4.39	BR	Unknown	5.86	85% of MSRP	N/A	N/A
Electrodes, pair	A4556		1.36%	0.18%	25.58	10.83	12.74	12.43	10.83	12.74	10.09	9.84	N/A	N/A	Not Covered	12.14	20.78	Unknown	15.29	85% of MSRP	Bundled	N/A
Infus insulin pump non needl	A4230		1.63%	0.13%	N/A	N/A	N/A	N/A	N/A	N/A	By Report	N/A	N/A	N/A	N/A	0.80	BR	Unknown	N/A	85% of MSRP	By Report	N/A
Surgical trays	A4550		2.07%	0.03%	97.22	Bundled	Bundled	Bundled	Bundled	Bundled	15.21	16.98	N/A	26.01	N/A	30.00	80.35	Unknown	N/A	85% of MSRP	Bundled	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-6
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
DME

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Cont airway pressure device	E0601	RR	7.34%	7.80%	$114.07	$92.27	$133.38	$103.86	$95.35	$119.23	$106.33	$85.93	$120.73	$104.33	$94.00	$122.88	$133.00	$100.10	$120.73	$122.25	$111.71	$122.88
Oxygen concentrator	E1390	RR	4.00%	7.64%	286.74	195.86	215.55	174.67	182.73	204.58	346.34	175.79	219.21	158.21	154.07	215.00	350.00	261.50	219.21	200.00	245.15	219.21
Neg press wound therapy pump	E2402	RR	0.26%	4.45%	1,755.94	1,477.99	1,811.05	1,135.70	1,217.70	1,117.10	2,057.50	1,504.20	2,444.00	112.00	119.00	134.00	3,495.00	2,910.00	3,120.00	2,912.00	2,790.00	2,814.00
Ft insert ucb berkeley shell	L3000		1.33%	4.15%	255.65	198.54	201.56	187.15	204.00	172.57	220.00	202.30	182.50	188.87	216.00	162.00	230.00	225.00	240.00	225.00	240.00	209.76
Nasal application device	A7034	NU	3.28%	3.85%	135.48	107.83	121.13	101.28	99.13	120.13	119.00	108.59	129.40	106.46	99.99	129.40	198.00	118.00	129.40	117.35	111.76	129.40
Elec osteogen stim spinal	E0748		0.08%	3.43%	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred
Pneumati walking boot prefab	L4360		0.97%	2.76%	266.49	242.98	189.98	262.14	228.16	183.48	275.00	245.00	220.00	285.00	253.03	175.00	295.39	315.00	265.01	312.57	281.31	258.05
Tens four lead	E0730	RR	0.61%	2.52%	44.30	40.87	41.44	51.86	74.43	42.07	28.95	34.00	41.70	45.00	81.25	33.99	47.65	42.30	42.30	45.00	106.25	52.99
CPAP full face mask	A7030	NU	1.14%	2.14%	219.71	175.32	196.36	173.21	169.90	182.23	200.00	174.13	207.50	179.21	176.78	207.50	265.63	195.15	207.50	188.20	198.00	207.50
RAD w/o backup non-inv intfc	E0470	RR	0.82%	2.00%	204.53	192.74	282.22	226.58	220.52	247.71	223.22	201.03	282.26	204.70	234.66	282.26	279.50	209.70	282.26	266.94	253.55	282.26
Foot longitud/metatarsal sup	L3020		0.92%	1.81%	197.81	160.63	162.37	160.18	153.11	150.55	200.00	174.50	165.00	167.00	152.84	140.13	225.00	187.50	190.25	180.00	167.00	190.25
KO adj jnt pos rigid support	L1832		0.25%	1.64%	522.25	362.94	Not Cred	479.08	379.65	226.69	525.00	420.78	Not Cred	496.89	416.69	182.00	857.90	514.73	Not Cred	514.73	463.26	360.00
Pos airway pressure tubing	A7037	NU	3.85%	1.56%	45.39	38.92	38.14	35.70	34.92	41.71	48.00	35.26	45.12	37.12	38.45	45.12	52.00	37.86	45.12	40.90	41.02	45.12
Pneum compres w/cal pressure	E0652		0.03%	1.48%	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data
Pos airway press headgear	A7035	NU	3.77%	1.43%	47.45	37.26	42.15	37.11	35.65	41.43	45.00	36.69	43.73	38.00	37.37	43.73	60.00	39.50	43.73	41.50	39.75	43.73
Elec osteogen stim not spine	E0747		0.03%	1.28%	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred
Osteogen ultrasound stimltor	E0760		0.03%	1.15%	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data
Blood glucose/reagent strips	A4253	NU	2.72%	1.13%	198.54	157.73	113.22	191.27	214.49	166.49	108.00	126.24	69.25	156.00	174.43	139.64	246.52	217.95	166.98	270.00	328.80	180.52
Humidifier heated used w PAP	E0562	RR	3.28%	0.98%	33.30	29.19	32.78	28.07	27.89	32.34	35.00	23.16	33.12	29.45	28.00	33.12	40.00	31.34	33.12	30.11	30.00	33.12
Wrist cock-up non-molded	L3908		1.36%	0.85%	48.00	44.20	46.30	39.64	42.46	37.47	44.00	45.36	52.01	31.49	47.28	40.50	62.00	65.00	52.01	65.00	59.57	50.32
Portable gaseous 02	E0431	RR	2.02%	0.64%	67.40	34.29	34.63	36.68	52.83	36.79	75.00	28.77	34.97	25.89	38.53	34.97	100.00	43.66	34.97	35.10	88.50	34.97
Nebulizer with compression	E0570	RR	1.90%	0.35%	33.25	17.71	17.98	20.84	20.48	20.33	40.00	14.37	17.72	17.01	12.08	17.72	49.50	22.50	17.72	23.50	18.75	17.72
Lancets per box	A4259		1.81%	0.24%	Not Cred	42.65	13.01	29.17	30.11	38.49	Not Cred	20.44	11.50	22.78	21.82	21.82	Not Cred	42.10	16.00	36.84	45.56	60.64
Filter, non disposable w pap	A7039	NU	1.55%	0.22%	18.36	13.88	14.34	15.10	13.75	15.42	20.00	12.97	16.86	14.56	13.87	16.86	24.00	14.14	16.86	17.10	15.33	16.86
Pos airway pressure filter	A7038	NU	3.98%	0.20%	6.79	5.32	6.79	5.42	5.50	5.79	6.00	4.77	5.93	5.00	5.07	5.93	10.00	5.21	5.93	5.99	6.57	5.93
Electrodes, pair	A4556		1.36%	0.18%	61.37	51.85	152.21	68.90	51.86	66.02	30.00	18.00	45.00	40.00	39.04	12.00	51.15	40.00	382.08	89.60	61.39	58.24
Infus insulin pump non needl	A4230		1.63%	0.13%	241.90	238.66	243.32	264.18	239.55	272.95	125.20	167.20	116.00	168.96	116.00	185.16	399.04	396.00	464.00	390.00	390.00	432.00
Surgical trays	A4550		2.07%	0.03%	86.92	77.75	Not Cred	43.73	31.59	45.44	80.00	46.00	Not Cred	30.72	33.60	45.00	125.25	100.00	Not Cred	49.60	33.60	75.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-6
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
DME

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Cont airway pressure device	E0601	RR	7.34%	7.80%	$180.50	$175.50	$134.84	$168.53	$180.68	$213.27	$140.00	$122.25	$135.00	$150.00	$167.56	$250.00	$195.00	$220.00	$140.00	$203.85	$220.00	$256.24
Oxygen concentrator	E1390	RR	4.00%	7.64%	391.02	409.29	306.23	449.10	474.16	409.59	375.00	410.00	300.00	453.24	453.24	400.00	395.00	453.24	332.80	550.00	550.00	410.00
Neg press wound therapy pump	E2402	RR	0.26%	4.45%	3,870.00	3,828.09	Not Cred	3,871.37	3,835.07	Not Cred	3,870.00	3,870.00	Not Cred	3,870.00	3,870.00	Not Cred	3,870.00	3,870.00	Not Cred	3,870.00	3,870.00	Not Cred
Ft insert ucb berkeley shell	L3000		1.33%	4.15%	No Data	No Data	No Data	Not Cred	251.00	Not Cred	No Data	No Data	No Data	Not Cred	200.00	Not Cred	No Data	No Data	No Data	Not Cred	390.00	Not Cred
Nasal application device	A7034	NU	3.28%	3.85%	164.27	161.69	137.83	172.76	175.44	164.95	125.00	147.05	132.00	169.04	140.59	140.00	162.50	188.00	147.05	176.50	200.00	147.05
Elec osteogen stim spinal	E0748		0.08%	3.43%	No Data	Not Cred	Not Cred	5,122.50	Not Cred	Not Cred	No Data	Not Cred	Not Cred	5,122.50	Not Cred	Not Cred	No Data	Not Cred	Not Cred	5,250.00	Not Cred	Not Cred
Pneumati walking boot prefab	L4360		0.97%	2.76%	Not Cred	293.99	Not Cred	298.12	297.70	Not Cred	Not Cred	292.50	Not Cred	312.57	297.00	Not Cred	Not Cred	385.00	Not Cred	359.77	366.00	Not Cred
Tens four lead	E0730	RR	0.61%	2.52%	Not Cred	43.28	Not Cred	36.27	49.56	Not Cred	Not Cred	38.91	Not Cred	34.13	40.58	Not Cred	Not Cred	40.00	Not Cred	35.84	42.30	Not Cred
CPAP full face mask	A7030	NU	1.14%	2.14%	204.81	294.30	220.68	269.19	294.01	270.43	200.00	260.00	210.00	228.34	280.54	235.35	200.00	271.00	240.28	282.96	284.70	314.00
RAD w/o backup non-inv intfc	E0470	RR	0.82%	2.00%	380.15	377.71	325.63	358.00	416.79	391.09	279.50	378.59	310.00	378.59	408.49	334.21	574.00	378.59	390.00	384.90	439.00	440.00
Foot longitud/metatarsal sup	L3020		0.92%	1.81%	213.78	No Data	Not Cred	Not Cred	210.30	Not Cred	200.18	No Data	Not Cred	Not Cred	200.00	Not Cred	288.00	No Data	Not Cred	Not Cred	236.72	Not Cred
KO adj jnt pos rigid support	L1832		0.25%	1.64%	Not Cred	Not Cred	Not Cred	570.02	518.54	Not Cred	Not Cred	Not Cred	Not Cred	550.00	550.00	Not Cred	Not Cred	Not Cred	Not Cred	690.00	590.00	Not Cred
Pos airway pressure tubing	A7037	NU	3.85%	1.56%	52.90	51.74	46.92	53.54	56.87	60.55	48.00	49.00	48.78	52.55	56.75	65.32	55.98	52.55	52.19	55.00	60.00	65.32
Pneum compres w/cal pressure	E0652		0.03%	1.48%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Pos airway press headgear	A7035	NU	3.77%	1.43%	63.91	58.28	49.08	57.90	62.88	59.13	60.00	50.00	49.69	49.38	53.57	53.45	76.45	51.00	50.00	60.00	60.00	55.00
Elec osteogen stim not spine	E0747		0.03%	1.28%	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data
Osteogen ultrasound stimltor	E0760		0.03%	1.15%	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data	Not Cred	No Data
Blood glucose/reagent strips	A4253	NU	2.72%	1.13%	60.31	50.78	60.34	52.51	54.44	56.52	57.99	53.49	57.99	53.50	55.50	57.05	75.76	60.23	66.94	60.00	61.25	62.94
Humidifier heated used w PAP	E0562	RR	3.28%	0.98%	40.35	57.20	38.73	55.07	65.28	41.33	40.00	60.00	35.50	40.00	50.00	41.22	40.00	60.00	45.00	50.00	65.00	42.66
Wrist cock-up non-molded	L3908		1.36%	0.85%	49.25	52.68	52.09	53.02	55.30	40.27	48.50	63.03	52.00	65.00	65.00	45.00	65.00	72.48	63.50	75.64	71.00	50.00
Portable gaseous 02	E0431	RR	2.02%	0.64%	90.64	78.74	49.88	108.63	122.14	66.74	75.00	57.00	48.00	114.74	114.74	51.25	100.00	114.74	51.00	114.74	160.00	64.00
Nebulizer with compression	E0570	RR	1.90%	0.35%	42.84	49.21	40.05	63.38	61.33	54.18	49.50	30.00	40.00	65.95	65.95	55.70	49.50	65.95	45.00	65.95	92.00	55.70
Lancets per box	A4259		1.81%	0.24%	16.55	17.54	19.27	17.52	17.10	18.25	16.40	17.50	15.95	16.50	16.40	18.00	18.00	20.00	18.00	20.00	19.03	20.00
Filter, non disposable w pap	A7039	NU	1.55%	0.22%	21.20	25.66	17.57	24.87	25.60	21.73	20.00	31.66	18.00	24.20	24.20	21.37	24.20	31.66	19.50	31.66	34.28	21.37
Pos airway pressure filter	A7038	NU	3.98%	0.20%	8.62	6.82	5.40	7.74	8.58	6.84	6.00	7.59	6.00	7.59	8.21	6.53	9.20	7.59	7.00	8.00	8.31	6.74
Electrodes, pair	A4556		1.36%	0.18%	No Data	Not Cred	No Data	12.18	15.16	Not Cred	No Data	Not Cred	No Data	14.00	14.00	Not Cred	No Data	Not Cred	No Data	16.00	28.00	Not Cred
Infus insulin pump non needl	A4230		1.63%	0.13%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Surgical trays	A4550		2.07%	0.03%	74.64	87.16	Not Cred	39.51	45.86	33.92	61.00	56.00	Not Cred	38.00	37.00	22.27	129.00	105.00	Not Cred	50.00	60.00	61.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-7
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
ENT

					Medicare [1]							TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		12.44%	9.11%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Office consultation	99243		4.29%	6.37%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Office/outpatient visit, est	99214		3.80%	4.18%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Resect inferior turbinate	30140		0.72%	3.98%	516.50	410.39	425.52	432.00	417.36	462.15	427.69	434.67	689.77	386.63	379.43	405.24	391.53	428.13	400.55	385.27
Antigen therapy services	95165		1.89%	3.79%	14.41	11.84	12.39	12.58	12.09	13.54	12.40	12.59	19.05	11.10	10.85	11.75	11.27	12.51	11.58	11.03
Office consultation	99244		1.71%	3.73%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Nasal endoscopy, dx	31231		1.77%	3.70%	220.84	179.72	187.70	190.55	183.31	204.35	187.65	190.14	291.87	168.11	164.91	177.69	170.80	188.30	174.74	166.45
Repair of nasal septum	30520		0.56%	3.65%	755.89	582.79	598.93	607.91	590.55	647.84	605.50	617.24	1,026.21	556.58	546.67	577.37	561.44	607.33	574.07	558.58
Create eardrum opening	69436		1.51%	3.41%	203.14	155.37	159.27	161.66	157.28	172.10	161.29	164.57	279.57	150.53	147.87	155.79	151.71	163.71	155.10	151.31
Office/outpatient visit, new	99203		3.05%	3.40%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Nasal/sinus endoscopy, surg	31237		0.71%	2.88%	391.02	307.92	318.43	323.27	312.82	345.45	320.62	326.17	528.74	293.70	288.28	306.97	297.10	323.94	303.92	293.27
Removal of ethmoid sinus	31255		0.44%	2.45%	530.52	388.77	393.40	399.07	391.46	422.13	401.59	411.31	749.46	386.41	380.12	394.22	387.37	411.60	395.65	392.02
Diagnostic laryngoscopy	31575		1.64%	2.17%	139.21	109.23	112.95	114.60	110.95	122.28	113.58	115.39	188.90	104.55	102.70	109.20	105.75	115.08	108.07	104.30
Comprehensive hearing test	92557		3.11%	2.02%	52.02	38.91	39.87	40.33	39.36	42.49	40.03	40.48	75.26	39.90	39.41	41.23	40.25	42.96	40.85	39.76
Remove tonsils and adenoids	42820		0.58%	1.93%	373.66	280.56	286.08	290.27	283.38	308.12	290.58	296.87	519.27	274.26	269.62	282.09	275.78	295.56	281.78	276.72
Office/outpatient visit, new	99204		1.10%	1.87%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Office/outpatient visit, est	99212		3.76%	1.71%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Endoscopy, maxillary sinus	31267		0.35%	1.51%	419.84	308.16	311.99	316.49	310.36	334.86	318.38	326.03	592.63	306.05	301.05	312.41	306.88	326.27	313.45	310.39
Sinus endoscopy, surgical	31276		0.20%	1.41%	670.04	490.39	495.93	503.13	493.68	532.25	506.61	519.13	947.73	488.06	480.05	497.67	489.16	519.62	499.70	495.45
Ct maxillofacial w/o dye	70486	26	0.40%	1.24%	77.01	55.08	55.81	56.34	55.44	58.75	56.20	56.83	112.69	57.08	56.55	58.16	57.31	60.07	58.00	57.27
Tympanometry	92567		4.14%	1.10%	19.32	14.68	15.10	15.28	14.87	16.15	15.14	15.31	28.21	15.22	15.00	15.80	15.37	16.54	15.65	15.18
Immunotherapy injections	95117		5.46%	1.08%	13.58	11.73	12.39	12.61	12.02	13.70	12.38	12.59	18.34	11.32	11.02	12.15	11.55	13.06	11.92	11.20
Removal of tonsils	42826		0.35%	1.00%	321.31	243.04	248.34	252.02	245.70	267.84	251.96	257.30	444.36	236.46	232.40	243.81	237.99	255.74	243.22	238.22
Id allergy test, drug/bug	95024		8.12%	0.68%	8.15	6.94	7.29	7.43	7.10	8.07	7.34	7.49	10.68	6.48	6.29	6.91	6.59	7.44	6.82	6.47
Percut allergy skin tests	95004		9.06%	0.63%	7.04	5.98	6.27	6.39	6.12	6.96	6.33	6.47	8.99	5.43	5.27	5.78	5.52	6.24	5.72	5.45
Immunotherapy, one injection	95115		2.67%	0.42%	10.98	9.49	10.01	10.19	9.72	11.09	10.03	10.21	14.97	9.24	8.99	9.91	9.42	10.67	9.73	9.16
Id allergy titrate-airborne	95027		4.89%	0.32%	5.18	4.38	4.57	4.67	4.47	5.09	4.64	4.77	7.29	4.39	4.25	4.66	4.45	5.03	4.63	4.43
Id allergy test-delayed type	95028		1.27%	0.17%	13.58	11.73	12.39	12.61	12.02	13.70	12.38	12.59	17.21	10.62	10.34	11.40	10.84	12.26	11.18	10.52

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-7
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
ENT

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		12.44%	9.11%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Office consultation	99243		4.29%	6.37%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Office/outpatient visit, est	99214		3.80%	4.18%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Resect inferior turbinate	30140		0.72%	3.98%	813.00	410.39	425.52	432.00	462.15	434.67	614.01	345.08	548.97	685.37	244.09	N/A	4,265.17	1,059.52	790.97	1,014.19	712.78	N/A
Antigen therapy services	95165		1.89%	3.79%	111.12	11.84	12.39	12.58	13.54	12.59	17.44	10.06	15.47	8.90	7.11	N/A	BR	23.88	22.92	23.52	20.48	N/A
Office consultation	99244		1.71%	3.73%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Nasal endoscopy, dx	31231		1.77%	3.70%	314.39	179.72	187.70	190.55	204.35	190.14	260.31	155.10	238.47	133.81	106.70	N/A	1,126.45	463.99	346.24	459.35	313.22	N/A
Repair of nasal septum	30520		0.56%	3.65%	1,172.02	582.79	598.93	607.91	647.84	617.24	912.37	483.99	791.18	720.58	348.79	N/A	3,892.85	1,504.61	1,122.35	1,437.43	1,005.53	N/A
Create eardrum opening	69436		1.51%	3.41%	405.81	155.37	159.27	161.66	172.10	164.57	248.79	139.95	213.93	510.71	94.26	N/A	1,478.07	401.11	299.17	396.30	267.85	N/A
Office/outpatient visit, new	99203		3.05%	3.40%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Nasal/sinus endoscopy, surg	31237		0.71%	2.88%	623.70	307.92	318.43	323.27	345.45	326.17	470.63	273.61	417.20	605.89	185.18	N/A	4,055.20	794.97	593.39	786.87	533.48	N/A
Removal of ethmoid sinus	31255		0.44%	2.45%	1,109.33	388.77	393.40	399.07	422.13	411.31	666.59	360.43	550.04	840.77	239.19	N/A	7,284.34	1,003.68	747.00	989.11	662.97	N/A
Diagnostic laryngoscopy	31575		1.64%	2.17%	199.25	109.23	112.95	114.60	122.28	115.39	168.76	98.71	148.85	82.90	65.80	N/A	701.76	282.01	209.98	278.39	189.26	N/A
Comprehensive hearing test	92557		3.11%	2.02%	69.41	38.91	39.87	40.33	42.49	40.48	66.92	39.03	57.08	31.16	24.68	N/A	195.25	78.45	73.71	75.64	66.41	N/A
Remove tonsils and adenoids	42820		0.58%	1.93%	828.10	280.56	286.08	290.27	308.12	296.87	461.41	248.11	389.99	697.62	170.73	N/A	1,712.78	724.32	539.50	690.63	Not Covered	N/A
Office/outpatient visit, new	99204		1.10%	1.87%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Office/outpatient visit, est	99212		3.76%	1.71%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Endoscopy, maxillary sinus	31267		0.35%	1.51%	871.23	308.16	311.99	316.49	334.86	326.03	526.64	285.04	435.34	801.16	189.62	N/A	6,308.08	795.57	592.15	783.59	525.73	N/A
Sinus endoscopy, surgical	31276		0.20%	1.41%	1,405.23	490.39	495.93	503.13	532.25	519.13	842.08	454.30	694.62	801.16	302.11	N/A	6,308.08	1,266.05	942.73	1,248.67	836.19	N/A
Ct maxillofacial w/o dye	70486	26	0.40%	1.24%	151.16	55.08	55.81	56.34	58.75	56.83	100.19	58.94	77.83	44.23	35.12	N/A	292.10	142.21	103.44	105.33	92.42	N/A
Tympanometry	92567		4.14%	1.10%	31.52	14.68	15.10	15.28	16.15	15.31	25.07	14.89	21.87	11.96	9.56	N/A	76.57	29.59	27.87	28.60	24.90	N/A
Immunotherapy injections	95117		5.46%	1.08%	25.33	11.73	12.39	12.61	13.70	12.59	16.31	11.07	16.01	9.18	7.34	11.28	47.34	23.65	22.92	23.52	21.03	N/A
Removal of tonsils	42826		0.35%	1.00%	722.35	243.04	248.34	252.02	267.84	257.30	395.11	214.44	336.11	720.58	147.61	N/A	1,742.32	627.45	467.65	598.07	417.26	N/A
Id allergy test, drug/bug	95024		8.12%	0.68%	16.42	6.94	7.29	7.43	8.07	7.49	9.49	6.09	9.07	5.29	4.22	N/A	18.60	14.00	13.63	13.98	12.17	N/A
Percut allergy skin tests	95004		9.06%	0.63%	11.30	5.98	6.27	6.39	6.96	6.47	7.99	5.06	7.47	4.45	3.56	6.39	10.96	12.06	11.77	12.08	10.51	N/A
Immunotherapy, one injection	95115		2.67%	0.42%	19.39	9.49	10.01	10.19	11.09	10.21	13.30	9.03	12.80	7.51	6.00	N/A	31.57	19.12	18.58	19.07	16.60	N/A
Id allergy titrate-airborne	95027		4.89%	0.32%	16.42	4.38	4.57	4.67	5.09	4.77	6.49	4.72	6.40	3.62	2.89	N/A	18.60	8.83	8.67	8.90	7.75	N/A
Id allergy test-delayed type	95028		1.27%	0.17%	24.61	11.73	12.39	12.61	13.70	12.59	15.31	9.48	14.94	8.62	6.89	N/A	31.75	23.65	22.92	24.15	21.03	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-7
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
ENT

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		12.44%	9.11%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Office consultation	99243		4.29%	6.37%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Office/outpatient visit, est	99214		3.80%	4.18%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Resect inferior turbinate	30140		0.72%	3.98%	1,718.18	493.61	359.29	478.44	491.05	613.65	1,400.00	381.64	302.02	371.96	422.72	369.73	2,820.00	574.37	328.95	686.44	587.15	977.25
Antigen therapy services	95165		1.89%	3.79%	322.19	266.64	180.97	313.55	255.89	253.78	287.16	230.00	90.00	210.50	145.80	228.00	448.00	393.20	288.00	494.10	435.30	340.00
Office consultation	99244		1.71%	3.73%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Nasal endoscopy, dx	31231		1.77%	3.70%	366.43	303.13	262.99	302.52	278.87	233.55	280.00	317.40	265.50	311.44	254.72	206.05	523.00	333.24	289.58	334.49	336.85	279.00
Repair of nasal septum	30520		0.56%	3.65%	2,498.92	1,000.94	857.60	921.65	829.53	1,528.71	3,200.00	1,048.90	850.85	968.22	775.72	1,663.24	3,400.00	1,151.90	850.85	1,090.56	1,052.57	2,250.00
Create eardrum opening	69436		1.51%	3.41%	1,017.85	389.23	208.77	237.40	274.03	456.68	1,150.00	283.41	236.63	226.95	222.49	426.55	1,300.00	485.50	242.60	302.40	372.30	670.00
Office/outpatient visit, new	99203		3.05%	3.40%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Nasal/sinus endoscopy, surg	31237		0.71%	2.88%	2,101.06	565.17	Not Cred	535.56	509.58	589.82	2,520.00	588.42	Not Cred	562.02	462.20	536.00	2,620.00	680.07	Not Cred	601.62	668.16	562.80
Removal of ethmoid sinus	31255		0.44%	2.45%	3,323.02	653.10	Not Cred	604.32	545.13	1,180.69	3,423.42	404.53	Not Cred	545.72	487.41	880.00	4,899.00	802.88	Not Cred	802.40	679.42	2,000.00
Diagnostic laryngoscopy	31575		1.64%	2.17%	343.79	200.60	188.57	205.45	186.82	261.11	357.00	209.61	165.87	196.59	184.52	302.00	410.00	213.93	182.69	218.28	223.20	305.84
Comprehensive hearing test	92557		3.11%	2.02%	126.30	72.98	74.76	81.95	77.19	85.29	99.00	73.00	70.76	83.75	77.75	95.00	229.44	80.77	70.76	95.00	85.52	105.00
Remove tonsils and adenoids	42820		0.58%	1.93%	1,188.99	616.78	456.46	501.11	468.47	788.17	1,462.00	553.82	424.01	501.83	407.70	880.00	1,486.00	665.84	424.01	531.30	536.97	1,051.00
Office/outpatient visit, new	99204		1.10%	1.87%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Office/outpatient visit, est	99212		3.76%	1.71%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Endoscopy, maxillary sinus	31267		0.35%	1.51%	2,288.95	401.27	Not Cred	424.36	371.12	920.27	1,288.60	319.67	Not Cred	315.40	340.17	754.00	3,100.00	485.50	Not Cred	610.40	453.60	1,508.00
Sinus endoscopy, surgical	31276		0.20%	1.41%	3,373.70	671.02	Not Cred	804.31	766.96	1,071.15	3,220.00	509.58	Not Cred	868.00	668.68	782.73	4,250.00	844.06	Not Cred	1,012.52	1,165.51	1,798.00
Ct maxillofacial w/o dye	70486	26	0.40%	1.24%	203.07	130.98	103.45	104.92	96.85	179.15	221.00	117.73	91.14	102.84	97.50	199.70	221.00	145.37	106.34	109.35	103.12	225.00
Tympanometry	92567		4.14%	1.10%	54.58	28.30	30.44	33.32	31.03	28.76	45.00	27.28	27.74	32.83	31.70	22.00	75.00	31.70	28.29	39.33	35.11	41.00
Immunotherapy injections	95117		5.46%	1.08%	33.49	20.87	20.27	26.20	22.86	23.06	35.00	20.64	19.81	26.86	22.14	21.00	36.00	21.53	19.81	31.72	24.04	29.00
Removal of tonsils	42826		0.35%	1.00%	1,430.24	515.90	408.77	461.57	428.68	802.68	1,622.48	478.09	366.83	434.16	386.67	760.00	1,665.00	546.05	397.29	490.70	499.84	1,073.00
Id allergy test, drug/bug	95024		8.12%	0.68%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Percut allergy skin tests	95004		9.06%	0.63%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Immunotherapy, one injection	95115		2.67%	0.42%	26.32	15.17	17.16	20.88	18.84	17.48	25.00	16.53	16.42	20.46	18.48	16.00	30.00	17.23	16.42	25.01	20.50	21.00
Id allergy titrate-airborne	95027		4.89%	0.32%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Id allergy test-delayed type	95028		1.27%	0.17%	Not Cred	Not Cred	Not Cred	23.55	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	18.20	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	20.93	Not Cred	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-7
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
ENT

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		12.44%	9.11%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	$98.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Office consultation	99243		4.29%	6.37%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Office/outpatient visit, est	99214		3.80%	4.18%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Resect inferior turbinate	30140		0.72%	3.98%	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data
Antigen therapy services	95165		1.89%	3.79%	Not Cred	11.40	25.12	24.50	17.45	9.22	Not Cred	11.27	20.00	20.00	18.00	8.00	Not Cred	12.24	24.00	39.60	21.00	13.00
Office consultation	99244		1.71%	3.73%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Nasal endoscopy, dx	31231		1.77%	3.70%	433.39	341.92	232.57	381.73	360.22	284.84	240.00	350.00	179.78	351.00	350.00	301.00	854.00	504.00	322.00	486.00	401.20	301.00
Repair of nasal septum	30520		0.56%	3.65%	Not Cred	Not Cred	Not Cred	Not Cred	1,117.32	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	983.25	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	1,504.00	Not Cred
Create eardrum opening	69436		1.51%	3.41%	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data
Office/outpatient visit, new	99203		3.05%	3.40%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Nasal/sinus endoscopy, surg	31237		0.71%	2.88%	Not Cred	660.45	Not Cred	691.00	844.09	Not Cred	Not Cred	820.00	Not Cred	697.00	817.50	Not Cred	Not Cred	929.00	Not Cred	873.00	1,028.00	Not Cred
Removal of ethmoid sinus	31255		0.44%	2.45%	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred
Diagnostic laryngoscopy	31575		1.64%	2.17%	450.01	216.22	221.39	267.14	249.37	288.44	374.00	256.00	233.00	257.00	247.00	310.00	688.54	310.00	316.00	314.00	289.85	376.00
Comprehensive hearing test	92557		3.11%	2.02%	133.94	73.68	92.68	103.67	101.18	99.64	95.00	78.00	89.00	108.00	98.25	107.08	245.00	91.00	106.00	124.00	111.00	119.00
Remove tonsils and adenoids	42820		0.58%	1.93%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Office/outpatient visit, new	99204		1.10%	1.87%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Office/outpatient visit, est	99212		3.76%	1.71%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Endoscopy, maxillary sinus	31267		0.35%	1.51%	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred
Sinus endoscopy, surgical	31276		0.20%	1.41%	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred
Ct maxillofacial w/o dye	70486	26	0.40%	1.24%	198.44	183.31	143.45	149.90	174.32	157.76	221.00	165.00	159.00	148.00	175.00	192.00	221.00	250.00	163.00	185.00	194.40	219.53
Tympanometry	92567		4.14%	1.10%	71.66	28.06	39.49	42.91	43.14	40.68	78.00	27.00	39.00	45.00	43.50	39.61	120.00	35.00	48.50	50.00	48.00	50.00
Immunotherapy injections	95117		5.46%	1.08%	No Data	20.41	36.11	38.84	29.51	26.91	No Data	24.00	41.00	39.00	29.00	30.00	No Data	24.75	41.00	52.00	38.00	31.00
Removal of tonsils	42826		0.35%	1.00%	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred
Id allergy test, drug/bug	95024		8.12%	0.68%	Not Cred	9.47	Not Cred	15.61	12.29	Not Cred	Not Cred	9.50	Not Cred	16.00	12.00	Not Cred	Not Cred	11.00	Not Cred	16.00	13.00	Not Cred
Percut allergy skin tests	95004		9.06%	0.63%	Not Cred	7.35	Not Cred	9.82	10.50	Not Cred	Not Cred	8.00	Not Cred	9.20	10.00	Not Cred	Not Cred	8.25	Not Cred	13.00	12.00	Not Cred
Immunotherapy, one injection	95115		2.67%	0.42%	Not Cred	12.98	23.74	21.12	23.36	22.80	Not Cred	9.82	25.00	21.00	23.00	24.00	Not Cred	19.50	25.00	31.00	27.00	24.00
Id allergy titrate-airborne	95027		4.89%	0.32%	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data	No Data	No Data	Not Cred	Not Cred	Not Cred	No Data
Id allergy test-delayed type	95028		1.27%	0.17%	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-8
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Family Practice / General Practice

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		26.75%	30.41%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Office/outpatient visit, est	99214		11.04%	18.84%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Office/outpatient visit, new	99203		2.51%	4.35%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Prev visit, est, age 40-64	99396		1.42%	2.60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	190.02	100.55	99.23	103.78	101.35	108.24	103.01	100.48
Office/outpatient visit, est	99215		0.88%	2.02%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Office/outpatient visit, new	99204		0.76%	2.01%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Office/outpatient visit, est	99212		2.84%	2.00%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Office/outpatient visit, new	99202		1.49%	1.76%	89.38	67.88	69.71	70.61	68.74	74.76	70.13	71.13	123.19	65.86	64.92	68.16	66.44	71.28	67.62	65.81
Prev visit, est, age 18-39	99395		0.86%	1.43%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	173.14	91.99	90.78	95.08	92.78	99.22	94.30	91.85
Immunization admin	90471		2.54%	1.00%	27.44	21.99	22.92	23.24	22.40	24.81	22.87	23.12	36.58	20.72	20.35	21.80	21.02	23.02	21.47	20.52
Ther/proph/diag inj, sc/im	90772		1.65%	0.70%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Strep a assay w/optic	87880		1.26%	0.39%	16.88	16.40	16.88	16.88	16.88	16.88	16.88	16.88	20.66	15.74	15.42	15.61	15.61	14.33	14.44	15.76
Lipid panel	80061		1.08%	0.37%	18.85	15.96	17.17	18.85	18.85	18.85	18.85	15.67	23.08	17.59	17.23	17.44	17.44	16.01	16.13	17.61
Flu vaccine age 3 yo & over, im	90658		1.33%	0.33%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Complete cbc w/auto diff wbc	85025		1.28%	0.26%	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	13.40	10.21	10.00	10.12	10.12	9.30	9.36	10.22
Routine venipuncture	36415		4.34%	0.25%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-8
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Family Practice / General Practice

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		26.75%	30.41%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Office/outpatient visit, est	99214		11.04%	18.84%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Office/outpatient visit, new	99203		2.51%	4.35%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Prev visit, est, age 40-64	99396		1.42%	2.60%	277.45	N/A	N/A	N/A	N/A	N/A	N/A	116.63	143.51	78.73	Not Covered	N/A	298.33	203.03	191.39	211.95	Not Covered	N/A
Office/outpatient visit, est	99215		0.88%	2.02%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Office/outpatient visit, new	99204		0.76%	2.01%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Office/outpatient visit, est	99212		2.84%	2.00%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Office/outpatient visit, new	99202		1.49%	1.76%	121.20	67.88	69.71	70.61	74.76	71.13	109.84	59.02	93.90	51.75	39.31	69.70	171.90	136.85	129.45	142.89	116.21	N/A
Prev visit, est, age 18-39	99395		0.86%	1.43%	251.38	N/A	N/A	N/A	N/A	N/A	154.25	116.63	131.24	72.05	85.48	N/A	273.05	186.08	175.29	193.49	Not Covered	N/A
Immunization admin	90471		2.54%	1.00%	10.39	21.99	22.92	23.24	24.81	23.12	32.51	19.07	13.90	16.41	13.12	10.00	35.87	30.42	42.12	43.22	38.18	N/A
Ther/proph/diag inj, sc/im	90772		1.65%	0.70%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Strep a assay w/optic	87880		1.26%	0.39%	50.15	16.40	16.88	16.88	16.88	16.88	17.18	16.28	17.18	12.71	13.06	N/A	89.05	TBD	42.20	80% of billed	23.63	N/A
Lipid panel	80061		1.08%	0.37%	43.45	15.96	17.17	18.85	18.85	15.67	19.19	15.85	17.48	14.20	14.58	14.00	121.13	TBD	42.93	80% of billed	26.39	N/A
Flu vaccine age 3 yo & over, im	90658		1.33%	0.33%	14.46	N/A	N/A	N/A	N/A	N/A	15.56	13.22	11.34	11.36	N/A	N/A	18.61	N/A	N/A	80% of billed	22.10	N/A
Complete cbc w/auto diff wbc	85025		1.28%	0.26%	40.35	10.94	10.94	10.94	10.94	10.94	11.14	10.86	11.14	8.24	8.47	9.85	56.86	TBD	27.35	80% of billed	15.32	N/A
Routine venipuncture	36415		4.34%	0.25%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-8
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Family Practice / General Practice

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		26.75%	30.41%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Office/outpatient visit, est	99214		11.04%	18.84%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Office/outpatient visit, new	99203		2.51%	4.35%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Prev visit, est, age 40-64	99396		1.42%	2.60%	256.37	150.07	133.83	185.24	155.63	153.26	267.00	146.50	138.69	183.40	147.00	148.12	295.00	162.07	138.69	199.26	177.98	181.00
Office/outpatient visit, est	99215		0.88%	2.02%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Office/outpatient visit, new	99204		0.76%	2.01%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Office/outpatient visit, est	99212		2.84%	2.00%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Office/outpatient visit, new	99202		1.49%	1.76%	149.21	91.12	86.37	110.70	93.63	87.29	155.00	93.40	99.63	114.79	90.39	88.00	172.00	103.33	99.63	123.60	108.17	97.00
Prev visit, est, age 18-39	99395		0.86%	1.43%	238.21	135.53	114.86	167.65	140.03	142.36	250.27	133.33	123.00	166.85	132.84	140.00	275.00	147.51	126.81	181.09	159.87	173.00
Immunization admin	90471		2.54%	1.00%	26.62	21.70	23.10	31.49	23.59	17.23	26.00	19.00	24.63	35.00	25.00	14.31	32.00	30.14	24.63	41.62	30.45	22.90
Ther/proph/diag inj, sc/im	90772		1.65%	0.70%	35.61	21.89	Not Cred	34.28	22.42	21.86	35.00	20.00	Not Cred	35.00	20.04	19.50	50.00	28.00	Not Cred	43.00	30.52	31.50
Strep a assay w/optic	87880		1.26%	0.39%	44.87	23.63	33.38	22.42	18.79	26.55	49.00	23.12	34.34	23.46	17.52	27.00	64.00	24.85	34.34	24.13	20.11	35.00
Lipid panel	80061		1.08%	0.37%	58.57	29.49	37.31	26.38	20.73	40.22	59.90	27.00	34.93	26.96	19.57	36.00	97.00	40.15	34.93	29.40	22.47	63.00
Flu vaccine age 3 yo & over, im	90658		1.33%	0.33%	20.88	13.71	14.06	15.34	13.55	15.07	20.00	13.88	12.29	14.21	14.21	13.94	28.00	16.00	15.00	16.53	15.58	19.74
Complete cbc w/auto diff wbc	85025		1.28%	0.26%	34.86	16.34	24.54	16.14	12.43	29.04	40.00	15.42	22.25	15.64	11.35	27.30	50.00	16.38	22.25	20.74	13.03	47.00
Routine venipuncture	36415		4.34%	0.25%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-8
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Family Practice / General Practice

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		26.75%	30.41%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	$98.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Office/outpatient visit, est	99214		11.04%	18.84%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Office/outpatient visit, new	99203		2.51%	4.35%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Prev visit, est, age 40-64	99396		1.42%	2.60%	Not Cred	125.33	75.68	149.15	144.92	Not Cred	Not Cred	158.50	60.00	177.03	159.50	Not Cred	Not Cred	179.00	116.00	221.00	200.00	Not Cred
Office/outpatient visit, est	99215		0.88%	2.02%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Office/outpatient visit, new	99204		0.76%	2.01%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Office/outpatient visit, est	99212		2.84%	2.00%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Office/outpatient visit, new	99202		1.49%	1.76%	140.22	88.61	96.09	119.68	110.48	93.11	150.00	91.00	105.00	127.00	112.00	98.10	177.00	115.00	120.00	151.30	131.00	116.00
Prev visit, est, age 18-39	99395		0.86%	1.43%	No Data	Not Cred	Not Cred	Not Cred	127.07	No Data	No Data	Not Cred	Not Cred	Not Cred	151.00	No Data	No Data	Not Cred	Not Cred	Not Cred	177.50	No Data
Immunization admin	90471		2.54%	1.00%	27.07	27.47	31.90	34.76	32.20	23.54	25.00	30.00	32.00	38.00	32.00	22.50	36.00	36.25	38.00	46.50	42.00	28.15
Ther/proph/diag inj, sc/im	90772		1.65%	0.70%	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred
Strep a assay w/optic	87880		1.26%	0.39%	Not Cred	32.88	41.83	29.23	37.17	30.74	Not Cred	30.00	46.50	29.00	35.30	29.10	Not Cred	45.00	50.00	36.00	51.00	35.00
Lipid panel	80061		1.08%	0.37%	69.85	45.11	59.69	45.18	49.63	67.63	81.00	39.20	56.00	40.00	40.00	71.00	93.00	57.10	70.00	54.90	68.22	86.00
Flu vaccine age 3 yo & over, im	90658		1.33%	0.33%	16.04	15.50	14.66	16.15	16.31	14.83	13.22	13.50	13.55	13.25	13.22	13.21	23.05	20.00	16.00	20.00	20.00	18.00
Complete cbc w/auto diff wbc	85025		1.28%	0.26%	33.93	29.96	42.83	26.51	32.26	37.16	27.51	30.00	40.00	24.00	30.00	37.00	46.00	39.10	49.00	32.50	40.03	56.00
Routine venipuncture	36415		4.34%	0.25%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-9
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Gastroenterology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Diagnostic colonoscopy	45378		8.93%	13.39%	$474.49	$372.97	$384.86	$391.03	$378.63	$418.56	$388.96	$396.87	$651.17	$361.46	$354.33	$377.35	$365.35	$398.80	$374.37	$362.06
Colonoscopy and biopsy	45380		6.40%	11.42%	567.77	446.13	460.50	467.77	452.94	500.44	465.02	474.14	779.70	432.68	424.30	451.78	437.40	477.25	448.01	433.09
Upper GI endoscopy, biopsy	43239		8.27%	9.84%	410.41	325.79	337.39	342.69	331.20	366.96	339.82	345.94	561.18	314.91	308.79	330.00	318.80	349.01	326.50	314.31
Office consultation	99244		6.09%	7.62%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Infliximab injection	J1745		0.45%	7.56%	60.58	60.58	60.58	60.58	60.58	60.58	60.58	60.58	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lesion removal colonoscopy	45385		3.51%	7.41%	643.54	502.88	518.22	526.39	510.21	562.78	523.91	534.50	886.41	489.00	479.56	509.61	493.97	537.98	505.95	490.18
Office/outpatient visit, est	99213		14.13%	5.94%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Office/outpatient visit, est	99214		8.46%	5.34%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Office consultation	99243		4.76%	4.07%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Lesion remove colonoscopy	45384		1.03%	1.91%	565.27	441.39	454.63	461.86	447.75	493.89	459.93	469.48	777.29	428.33	419.98	446.16	432.57	471.06	443.20	429.71
Uppr gi endoscopy, diagnosis	43235		1.77%	1.82%	352.94	280.95	291.10	295.73	285.68	316.91	293.24	298.63	482.16	271.40	266.04	284.62	274.82	301.22	281.55	270.85
Office consultation	99245		1.13%	1.74%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	428.34	223.13	220.20	229.02	224.42	238.44	228.17	224.00
Subsequent hospital care	99232		3.20%	1.43%	93.75	67.04	67.83	68.52	67.45	71.57	68.51	69.45	134.96	68.09	67.41	69.24	68.29	71.54	69.18	68.50
Gi tract capsule endoscopy	91110		0.23%	1.21%	1,052.62	872.54	916.92	930.46	892.14	998.79	911.64	920.38	1,416.62	834.65	819.07	888.64	850.59	943.23	869.43	820.74
Office/outpatient visit, new	99204		1.16%	1.13%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Inpatient consultation	99254		0.94%	1.03%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	328.30	166.65	164.98	169.85	167.30	175.60	169.44	167.34
Office/outpatient visit, est	99215		1.18%	1.00%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Office/outpatient visit, new	99203		1.24%	0.79%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Office/outpatient visit, est	99212		3.01%	0.78%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Subsequent hospital care	99233		1.08%	0.69%	134.62	96.24	97.32	98.33	96.80	102.73	98.37	99.76	193.87	97.78	96.79	99.41	98.06	102.72	99.36	98.43
Office consultation	99242		1.02%	0.63%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	168.99	89.63	88.24	92.42	90.25	96.72	92.04	90.05
Subsequent hospital care	99231		1.38%	0.34%	51.71	37.05	37.46	37.87	37.27	39.61	37.90	38.48	74.26	37.52	37.10	38.14	37.61	39.46	38.16	37.83
Routine venipuncture	36415		1.54%	0.03%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-9
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Gastroenterology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Diagnostic colonoscopy	45378		8.93%	13.39%	$978.47	$372.97	$384.86	$391.03	$418.56	$396.87	$579.70	$338.69	$512.69	$304.18	$227.86	N/A	$1,494.59	$962.91	$721.60	$956.36	$646.92	N/A
Colonoscopy and biopsy	45380		6.40%	11.42%	1,158.34	446.13	460.50	467.77	500.44	474.14	694.47	404.77	614.06	304.18	272.76	N/A	1,644.05	1,151.78	862.20	1,143.04	773.65	N/A
Upper GI endoscopy, biopsy	43239		8.27%	9.84%	883.20	325.79	337.39	342.69	366.96	345.94	500.27	297.06	446.54	295.56	198.96	N/A	1,393.86	841.10	629.31	834.36	566.13	N/A
Office consultation	99244		6.09%	7.62%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Infliximab injection	J1745		0.45%	7.56%	194.44	60.58	60.58	60.58	60.58	60.58	58.07	55.21	58.66	60.04	N/A	N/A	182.89	N/A	N/A	N/A	71.05	N/A
Lesion removal colonoscopy	45385		3.51%	7.41%	1,368.74	502.88	518.22	526.39	562.78	534.50	788.85	455.78	694.08	304.18	307.89	N/A	2,117.33	1,298.31	971.84	1,287.97	871.05	N/A
Office/outpatient visit, est	99213		14.13%	5.94%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Office/outpatient visit, est	99214		8.46%	5.34%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Office consultation	99243		4.76%	4.07%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Lesion remove colonoscopy	45384		1.03%	1.91%	1,434.91	441.39	454.63	461.86	493.89	469.48	692.14	398.09	607.66	304.18	269.65	N/A	2,117.33	1,139.54	853.53	1,130.76	764.80	N/A
Uppr gi endoscopy, diagnosis	43235		1.77%	1.82%	820.83	280.95	291.10	295.73	316.91	298.63	429.12	258.10	385.19	273.94	171.62	N/A	1,202.55	725.35	543.21	719.73	488.65	N/A
Office consultation	99245		1.13%	1.74%	371.13	N/A	N/A	N/A	N/A	N/A	380.86	N/A	N/A	N/A	138.05	N/A	601.64	418.17	N/A	434.83	351.96	N/A
Subsequent hospital care	99232		3.20%	1.43%	140.57	67.04	67.83	68.52	71.57	69.45	120.29	62.39	97.63	52.86	41.79	N/A	256.48	135.17	126.36	140.16	112.89	N/A
GI tract capsule endoscopy	91110		0.23%	1.21%	3,568.86	872.54	916.92	930.46	998.79	920.38	1,262.80	816.68	1,184.90	663.79	Not Covered	N/A	672.29	1,759.13	1,677.34	1,727.56	1,525.72	N/A
Office/outpatient visit, new	99204		1.16%	1.13%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Inpatient consultation	99254		0.94%	1.03%	343.92	N/A	N/A	N/A	N/A	N/A	291.91	N/A	N/A	N/A	102.26	N/A	523.16	311.86	N/A	321.34	260.10	N/A
Office/outpatient visit, est	99215		1.18%	1.00%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Office/outpatient visit, new	99203		1.24%	0.79%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Office/outpatient visit, est	99212		3.01%	0.78%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Subsequent hospital care	99233		1.08%	0.69%	199.87	96.24	97.32	98.33	102.73	99.76	172.68	89.47	139.78	75.95	60.02	N/A	378.31	194.02	181.48	201.01	162.15	N/A
Office consultation	99242		1.02%	0.63%	180.37	N/A	N/A	N/A	N/A	N/A	150.26	N/A	58.13	N/A	55.80	N/A	285.87	168.33	N/A	176.39	142.78	N/A
Subsequent hospital care	99231		1.38%	0.34%	85.13	37.05	37.46	37.87	39.61	38.48	66.52	34.77	53.88	29.21	23.12	N/A	188.08	74.69	69.99	77.26	62.53	N/A
Routine venipuncture	36415		1.54%	0.03%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-9
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Gastroenterology

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Diagnostic colonoscopy	45378		8.93%	13.39%	$1,199.45	$618.32	$399.59	$587.87	$448.27	$772.43	$1,239.00	$634.57	$326.64	$628.06	$386.59	$855.00	$1,450.00	$758.50	$414.90	$738.72	$564.34	$944.00
Colonoscopy and biopsy	45380		6.40%	11.42%	1,342.63	715.03	456.53	649.83	491.12	873.92	1,462.00	722.08	393.44	581.00	441.72	1,056.00	1,707.00	867.21	450.26	847.70	632.75	1,129.00
Upper GI endoscopy, biopsy	43239		8.27%	9.84%	1,000.84	489.72	314.37	417.77	329.60	544.69	966.00	481.04	259.84	346.24	279.05	540.75	1,359.14	617.02	329.00	600.32	463.98	772.61
Office consultation	99244		6.09%	7.62%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Infliximab injection	J1745		0.45%	7.56%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lesion removal colonoscopy	45385		3.51%	7.41%	1,641.31	826.20	564.41	782.10	617.91	1,101.61	1,780.00	850.00	467.03	836.00	576.21	1,341.00	1,950.00	990.00	607.46	939.08	738.12	1,449.00
Office/outpatient visit, est	99213		14.13%	5.94%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Office/outpatient visit, est	99214		8.46%	5.34%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Office consultation	99243		4.76%	4.07%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Lesion remove colonoscopy	45384		1.03%	1.91%	1,433.53	642.73	428.40	554.76	481.90	1,098.46	1,800.00	653.00	408.72	505.08	408.53	1,240.00	1,976.00	746.00	683.28	760.96	635.34	1,303.64
Uppr gi endoscopy, diagnosis	43235		1.77%	1.82%	893.86	433.23	288.78	369.84	287.69	486.60	944.00	422.69	219.65	300.19	241.90	528.00	1,133.00	606.69	248.67	518.58	406.35	704.00
Office consultation	99245		1.13%	1.74%	512.68	334.98	374.53	411.96	347.70	325.66	575.00	335.00	355.51	410.94	333.92	314.15	640.00	375.00	392.00	453.13	396.43	367.81
Subsequent hospital care	99232		3.20%	1.43%	198.52	103.04	107.93	121.88	102.61	104.64	228.00	101.84	104.73	123.95	98.82	107.70	237.00	112.67	110.08	133.20	115.53	115.00
Gi tract capsule endoscopy	91110		0.23%	1.21%	Not Cred	1,314.67	Not Cred	1,785.81	1,578.13	No Data	Not Cred	1,319.81	Not Cred	1,700.00	1,562.40	No Data	Not Cred	1,323.18	Not Cred	2,006.03	1,929.27	No Data
Office/outpatient visit, new	99204		1.16%	1.13%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Inpatient consultation	99254		0.94%	1.03%	432.27	240.20	262.96	299.70	246.73	232.74	485.00	228.50	259.84	303.34	236.02	218.82	514.00	275.27	267.04	334.50	275.21	273.11
Office/outpatient visit, est	99215		1.18%	1.00%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Office/outpatient visit, new	99203		1.24%	0.79%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Office/outpatient visit, est	99212		3.01%	0.78%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Subsequent hospital care	99233		1.08%	0.69%	264.74	153.13	163.08	171.63	143.35	151.49	300.00	145.81	150.02	174.89	135.85	146.05	340.00	163.44	183.30	189.57	160.32	185.00
Office consultation	99242		1.02%	0.63%	247.89	138.71	144.75	166.52	142.00	143.69	260.00	134.13	142.66	165.82	135.71	147.00	275.00	148.39	145.51	183.96	162.11	161.50
Subsequent hospital care	99231		1.38%	0.34%	136.98	60.16	65.27	72.19	61.74	72.72	164.00	56.49	58.31	69.01	57.42	69.00	177.00	64.43	69.00	77.52	66.81	100.00
Routine venipuncture	36415		1.54%	0.03%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-9
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Gastroenterology

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Billed Charges[5] Mean AK	Mean ID	Mean ND	Mean OR	Mean WA	Mean WY	Median AK	Median ID	Median ND	Median OR	Median WA	Median WY	80th Percentile AK	80th Percentile ID	80th Percentile ND	80th Percentile OR	80th Percentile WA	80th Percentile WY
Diagnostic colonoscopy	45378		8.93%	13.39%	$1,309.21	$684.93	$612.11	$803.51	$717.23	$897.04	$1,380.00	$635.00	$553.50	$810.40	$730.00	$1,016.00	$1,500.00	$1,046.85	$1,020.00	$1,000.00	$883.00	$1,075.00
Colonoscopy and biopsy	45380		6.40%	11.42%	1,514.97	804.05	708.29	1,044.36	817.84	1,084.19	1,589.28	821.00	710.00	1,103.00	919.80	1,129.00	1,910.00	1,200.00	1,153.00	1,289.00	1,063.35	1,185.00
Upper GI endoscopy, biopsy	43239		8.27%	9.84%	1,077.66	565.74	526.56	699.13	564.26	821.36	1,200.00	550.00	367.00	734.40	600.00	877.00	1,400.00	835.00	1,002.00	892.69	699.00	906.00
Office consultation	99244		6.09%	7.62%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Infliximab injection	J1745		0.45%	7.56%	No Data	88.48	131.40	94.54	94.28	118.23	No Data	83.00	131.40	90.00	91.40	103.00	No Data	85.00	131.40	96.00	114.16	136.00
Lesion removal colonoscopy	45385		3.51%	7.41%	1,857.79	923.07	832.60	1,188.03	971.32	1,301.45	2,047.55	885.00	660.00	1,185.00	1,034.20	1,449.00	2,310.00	1,400.00	1,291.00	1,454.00	1,203.00	1,574.00
Office/outpatient visit, est	99213		14.13%	5.94%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Office/outpatient visit, est	99214		8.46%	5.34%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Office consultation	99243		4.76%	4.07%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Lesion remove colonoscopy	45384		1.03%	1.91%	Not Cred	813.31	Not Cred	990.06	781.15	850.97	Not Cred	746.00	Not Cred	1,140.00	786.00	1,147.00	Not Cred	1,225.00	Not Cred	1,284.00	998.00	1,147.00
Uppr gi endoscopy, diagnosis	43235		1.77%	1.82%	1,135.09	544.23	577.66	667.20	523.21	655.08	1,121.98	548.20	525.00	660.00	576.40	740.00	1,279.00	869.80	933.00	813.00	668.00	776.00
Office consultation	99245		1.13%	1.74%	544.53	398.49	382.16	496.39	443.42	395.48	563.00	392.00	420.00	500.00	450.00	400.00	660.00	455.00	452.00	591.00	503.00	487.00
Subsequent hospital care	99232		3.20%	1.43%	208.11	115.76	131.12	141.72	138.76	129.72	234.00	120.00	125.00	144.00	138.80	125.00	238.17	130.00	133.00	167.00	158.00	160.00
Gi tract capsule endoscopy	91110		0.23%	1.21%	Not Cred	Not Cred	Not Cred	2,225.90	2,005.65	Not Cred	Not Cred	Not Cred	Not Cred	2,216.75	2,028.00	Not Cred	Not Cred	Not Cred	Not Cred	2,552.00	2,471.00	Not Cred
Office/outpatient visit, new	99204		1.16%	1.13%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Inpatient consultation	99254		0.94%	1.03%	459.06	283.58	301.70	356.38	324.02	323.08	493.00	287.00	300.00	362.00	330.00	320.00	552.00	350.00	332.00	431.00	390.00	401.00
Office/outpatient visit, est	99215		1.18%	1.00%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Office/outpatient visit, new	99203		1.24%	0.79%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Office/outpatient visit, est	99212		3.01%	0.78%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Subsequent hospital care	99233		1.08%	0.69%	297.97	172.78	186.49	209.46	195.52	189.21	338.00	172.00	188.00	212.00	198.80	188.00	361.00	201.00	195.00	249.00	227.00	236.00
Office consultation	99242		1.02%	0.63%	234.71	147.02	141.55	191.84	170.88	142.85	260.00	149.00	160.00	199.00	175.00	150.00	287.83	175.00	180.00	234.42	201.00	187.00
Subsequent hospital care	99231		1.38%	0.34%	140.10	74.65	79.05	88.72	94.01	88.60	152.00	75.00	78.00	87.00	84.00	88.00	180.00	89.00	98.00	108.00	102.00	109.00
Routine venipuncture	36415		1.54%	0.03%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-10
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
General Surgery

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Laparoscopic cholecystectomy	47562		2.14%	5.81%	$924.42	$681.33	$685.42	$698.08	$684.99	$745.66	$709.90	$735.89	$1,297.66	$671.73	$656.78	$683.24	$671.47	$719.12	$691.43	$690.26
Office consultation	99243		6.24%	3.85%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Laparo cholecystectomy/graph	47563		1.25%	3.45%	938.67	690.16	693.60	706.49	693.61	754.59	719.10	745.91	1,322.02	682.91	667.62	694.02	682.38	730.42	702.84	702.39
Office consultation	99244		3.79%	3.43%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Office/outpatient visit, est	99213		9.53%	2.89%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Laparoscopy, appendectomy	44970		0.97%	2.43%	741.29	546.15	549.48	559.57	549.10	597.54	568.92	589.57	1,041.17	538.80	526.88	548.03	538.61	576.70	554.53	553.55
Lap gastric bypass/roux-en-y	43644		0.47%	2.25%	2,180.33	1,590.45	1,593.75	1,623.54	1,596.59	1,732.81	1,656.25	1,720.34	3,089.52	1,583.85	1,548.40	1,605.15	1,580.90	1,687.89	1,628.53	1,632.56
Prp i/hern init reduc >5 yr	49505		0.96%	2.14%	639.24	472.84	476.42	485.13	475.66	518.23	492.67	510.20	896.18	465.69	455.40	474.39	465.81	499.40	479.51	477.83
Office/outpatient visit, est	99214		4.21%	1.92%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Diagnostic colonoscopy	45378		1.23%	1.31%	474.49	372.97	384.86	391.03	378.63	418.56	388.96	396.87	651.17	361.46	354.33	377.35	365.35	398.80	374.37	362.06
Office consultation	99245		1.13%	1.26%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	428.34	223.13	220.20	229.02	224.42	238.44	228.17	224.00
Office consultation	99242		2.67%	1.20%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	168.99	89.63	88.24	92.42	90.25	96.72	92.04	90.05
Office/outpatient visit, est	99212		6.09%	1.15%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Removal of breast lesion	19120		0.62%	1.11%	574.85	437.54	445.30	453.29	441.89	485.47	456.74	470.74	788.98	421.94	412.62	434.21	423.75	458.53	435.97	429.45
Office/outpatient visit, new	99203		2.13%	0.98%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Office/outpatient visit, new	99204		1.08%	0.76%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Subsequent hospital care	99232		2.15%	0.69%	93.75	67.04	67.83	68.52	67.45	71.57	68.51	69.45	134.96	68.09	67.41	69.24	68.29	71.54	69.18	68.50
Office/outpatient visit, est	99215		1.01%	0.62%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Us exam, breast(s)	76645	26	1.28%	0.53%	36.56	26.17	26.44	26.73	26.32	27.99	26.80	27.25	53.49	27.11	26.80	27.58	27.18	28.57	27.60	27.34
Office/outpatient visit, new	99202		1.23%	0.39%	89.38	67.88	69.71	70.61	68.74	74.76	70.13	71.13	123.19	65.86	64.92	68.16	66.44	71.28	67.62	65.81
Subsequent hospital care	99231		1.85%	0.33%	51.71	37.05	37.46	37.87	37.27	39.61	37.90	38.48	74.26	37.52	37.10	38.14	37.61	39.46	38.16	37.83

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-10
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
General Surgery

					VA[3]						Medicaid[4]						Workers' Compensation[4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Laparoscopic cholecystectomy	47562		2.14%	5.81%	$1,663.71	$681.33	$685.42	$698.08	$745.66	$735.89	$1,152.54	$588.97	$950.16	$1,501.12	$418.15	N/A	$5,566.71	$1,758.94	$1,333.57	$1,704.82	$1,172.10	N/A
Office consultation	99243		6.24%	3.85%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Laparo cholecystectomy/graph	47563		1.25%	3.45%	1,777.83	690.16	693.60	706.49	754.59	745.91	1,173.92	606.26	966.17	1,501.12	425.04	N/A	5,937.81	1,781.75	1,351.53	1,728.55	1,186.49	N/A
Office consultation	99244		3.79%	3.43%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Office/outpatient visit, est	99213		9.53%	2.89%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Laparoscopy, appendectomy	44970		0.97%	2.43%	1,334.12	546.15	549.48	559.57	597.54	589.57	925.09	473.29	762.37	432.32	335.45	N/A	3,642.15	1,409.97	1,068.47	1,367.02	Not Covered	N/A
Lap gastric bypass/roux-en-y	43644		0.47%	2.25%	5,977.30	1,590.45	1,593.75	1,623.54	1,732.81	1,720.34	2,743.41	1,396.58	2,240.17	1,271.65	1,732.81	N/A	N/A	4,105.95	3,116.20	3,983.98	Not Covered	N/A
Prp i/hern init reduc >5 yr	49505		0.96%	2.14%	1,233.97	472.84	476.42	485.13	518.23	510.20	796.46	411.06	658.87	888.93	290.10	N/A	2,695.20	1,220.71	924.76	1,182.69	813.50	N/A
Office/outpatient visit, est	99214		4.21%	1.92%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Diagnostic colonoscopy	45378		1.23%	1.31%	978.47	372.97	384.86	391.03	418.56	396.87	579.70	338.69	512.69	304.18	227.86	N/A	1,494.59	962.91	721.60	956.36	646.92	N/A
Office consultation	99245		1.13%	1.26%	371.13	N/A	N/A	N/A	N/A	N/A	380.86	N/A	N/A	N/A	138.05	N/A	601.64	418.17	N/A	434.83	351.96	N/A
Office consultation	99242		2.67%	1.20%	180.37	N/A	N/A	N/A	N/A	N/A	150.26	N/A	58.13	N/A	55.80	N/A	285.87	168.33	N/A	176.39	142.78	N/A
Office/outpatient visit, est	99212		6.09%	1.15%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Removal of breast lesion	19120		0.62%	1.11%	1,079.86	437.54	445.30	453.29	485.47	470.74	701.65	370.15	596.99	692.50	264.54	N/A	2,734.90	1,461.80	854.15	1,093.30	757.05	N/A
Office/outpatient visit, new	99203		2.13%	0.98%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Office/outpatient visit, new	99204		1.08%	0.76%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Subsequent hospital care	99232		2.15%	0.69%	140.57	67.04	67.83	68.52	71.57	69.45	120.29	62.39	97.63	52.86	41.79	N/A	256.48	135.17	126.36	140.16	112.89	N/A
Office/outpatient visit, est	99215		1.01%	0.62%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Us exam, breast(s)	76645	26	1.28%	0.53%	71.79	26.17	26.44	26.73	27.99	27.25	47.57	33.23	37.02	21.14	16.67	N/A	149.39	67.57	49.55	50.46	44.27	N/A
Office/outpatient visit, new	99202		1.23%	0.39%	121.20	67.88	69.71	70.61	74.76	71.13	109.84	59.02	93.90	51.75	39.31	69.70	171.90	136.85	129.45	142.89	116.21	N/A
Subsequent hospital care	99231		1.85%	0.33%	85.13	37.05	37.46	37.87	39.61	38.48	66.52	34.77	53.88	29.21	23.12	N/A	188.08	74.69	69.99	77.26	62.53	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-10
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
General Surgery

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Laparoscopic cholecystectomy	47562		2.14%	5.81%	$4,012.25	$1,433.64	$1,057.07	$1,253.79	$1,186.86	$2,588.80	$4,671.00	$1,314.60	$1,042.19	$1,240.17	$1,100.61	$3,034.00	$5,278.00	$1,466.00	$1,042.19	$1,399.52	$1,321.92	$3,100.00
Office consultation	99243		6.24%	3.85%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Laparo cholecystectomy/graph	47563		1.25%	3.45%	4,719.96	1,343.73	1,071.29	1,262.83	1,174.66	2,340.52	5,000.00	1,373.86	1,068.23	1,264.29	1,062.77	3,140.00	5,155.50	1,510.57	1,089.59	1,394.90	1,393.60	3,486.00
Office consultation	99244		3.79%	3.43%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Office/outpatient visit, est	99213		9.53%	2.89%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Laparoscopy, appendectomy	44970		0.97%	2.43%	2,891.04	1,059.86	880.96	997.41	928.75	2,255.06	3,015.00	1,038.35	835.56	988.92	870.49	2,430.00	3,383.00	1,169.01	969.00	1,082.62	1,089.40	3,209.00
Lap gastric bypass/roux-en-y	43644		0.47%	2.25%	8,034.15	2,996.43	2,703.45	3,772.65	2,930.59	Not Cred	9,785.00	3,078.12	2,444.99	3,096.72	2,591.40	Not Cred	9,785.00	3,205.02	2,493.89	5,590.00	2,893.73	Not Cred
Prp i/hern init reduc >5 yr	49505		0.96%	2.14%	2,335.27	919.28	745.15	832.44	788.35	1,583.58	2,500.00	906.56	726.87	850.55	717.21	1,642.00	2,900.00	1,060.62	726.87	953.12	957.44	1,786.64
Office/outpatient visit, est	99214		4.21%	1.92%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Diagnostic colonoscopy	45378		1.23%	1.31%	1,199.45	618.32	399.59	587.87	448.27	772.43	1,239.00	634.57	326.64	628.06	386.59	855.00	1,450.00	758.50	414.90	738.72	564.34	944.00
Office consultation	99245		1.13%	1.26%	512.68	334.98	374.53	411.96	347.70	325.66	575.00	335.00	355.51	410.94	333.92	314.15	640.00	375.00	392.00	453.13	396.43	367.81
Office consultation	99242		2.67%	1.20%	247.89	138.71	144.75	166.52	142.00	143.69	260.00	134.13	142.66	165.82	135.71	147.00	275.00	148.39	145.51	183.96	162.11	161.50
Office/outpatient visit, est	99212		6.09%	1.15%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Removal of breast lesion	19120		0.62%	1.11%	Not Cred	626.68	564.92	682.70	644.91	936.35	Not Cred	635.95	561.57	687.97	592.23	1,005.00	Not Cred	715.97	572.80	790.55	722.43	1,073.50
Office/outpatient visit, new	99203		2.13%	0.98%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Office/outpatient visit, new	99204		1.08%	0.76%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Subsequent hospital care	99232		2.15%	0.69%	198.52	103.04	107.93	121.88	102.61	104.64	228.00	101.84	104.73	123.95	98.82	107.70	237.00	112.67	110.08	133.20	115.53	115.00
Office/outpatient visit, est	99215		1.01%	0.62%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Us exam, breast(s)	76645	26	1.28%	0.53%	106.87	71.64	49.02	50.71	47.29	97.38	107.00	57.18	43.02	48.47	46.44	117.00	107.00	102.40	43.88	51.83	48.88	121.00
Office/outpatient visit, new	99202		1.23%	0.39%	149.21	91.12	86.37	110.70	93.63	87.29	155.00	93.40	99.63	114.79	90.39	88.00	172.00	103.33	99.63	123.60	108.17	97.00
Subsequent hospital care	99231		1.85%	0.33%	136.98	60.16	65.27	72.19	61.74	72.72	164.00	56.49	58.31	69.01	57.42	69.00	177.00	64.43	69.00	77.52	66.81	100.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clair

Appendix A-10
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
General Surgery

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Laparoscopic cholecystectomy	47562		2.14%	5.81%	Not Cred	$1,576.46	$1,578.66	$1,713.51	$1,699.91	$2,164.37	Not Cred	$1,703.00	$1,483.00	$1,682.50	$1,619.00	$2,166.50	Not Cred	$1,933.00	$1,713.00	$2,000.00	$2,025.10	$3,387.00
Office consultation	99243		6.24%	3.85%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Laparo cholecystectomy/graph	47563		1.25%	3.45%	Not Cred	1,653.02	Not Cred	1,815.78	1,989.21	Not Cred	Not Cred	1,615.00	Not Cred	1,805.00	1,837.50	Not Cred	Not Cred	1,832.20	Not Cred	2,209.00	2,359.00	Not Cred
Office consultation	99244		3.79%	3.43%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Office/outpatient visit, est	99213		9.53%	2.89%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Laparoscopy, appendectomy	44970		0.97%	2.43%	No Data	Not Cred	Not Cred	Not Cred	1,347.23	Not Cred	No Data	Not Cred	Not Cred	Not Cred	1,255.00	Not Cred	No Data	Not Cred	Not Cred	Not Cred	1,435.00	Not Cred
Lap gastric bypass/roux-en-y	43644		0.47%	2.25%	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data
Prp i/hern init reduc >5 yr	49505		0.96%	2.14%	2,017.86	1,047.86	1,078.27	1,292.15	1,220.36	Not Cred	2,537.78	1,079.00	1,027.00	1,231.00	1,147.00	Not Cred	2,793.00	1,347.00	1,266.00	1,546.00	1,433.00	Not Cred
Office/outpatient visit, est	99214		4.21%	1.92%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Diagnostic colonoscopy	45378		1.23%	1.31%	1,309.21	684.93	612.11	803.51	717.23	897.04	1,380.00	635.00	553.50	810.40	730.00	1,016.00	1,500.00	1,046.85	1,020.00	1,000.00	883.00	1,075.00
Office consultation	99245		1.13%	1.26%	544.53	398.49	382.16	496.39	443.42	395.48	563.00	392.00	420.00	500.00	450.00	400.00	660.00	455.00	452.00	591.00	503.00	487.00
Office consultation	99242		2.67%	1.20%	234.71	147.02	141.55	191.84	170.88	142.85	260.00	149.00	160.00	199.00	175.00	150.00	287.83	175.00	180.00	234.42	201.00	187.00
Office/outpatient visit, est	99212		6.09%	1.15%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Removal of breast lesion	19120		0.62%	1.11%	No Data	681.98	Not Cred	Not Cred	935.38	Not Cred	No Data	658.50	Not Cred	Not Cred	904.50	Not Cred	No Data	920.94	Not Cred	Not Cred	1,190.00	Not Cred
Office/outpatient visit, new	99203		2.13%	0.98%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Office/outpatient visit, new	99204		1.08%	0.76%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Subsequent hospital care	99232		2.15%	0.69%	208.11	115.76	131.12	141.72	138.76	129.72	234.00	120.00	125.00	144.00	138.80	125.00	238.17	130.00	133.00	167.00	158.00	160.00
Office/outpatient visit, est	99215		1.01%	0.62%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Us exam, breast(s)	76645	26	1.28%	0.53%	122.33	94.22	73.89	78.90	89.07	74.68	112.00	92.00	68.00	83.00	91.20	83.00	121.00	128.00	98.00	98.00	98.00	117.00
Office/outpatient visit, new	99202		1.23%	0.39%	140.22	88.61	96.09	119.68	110.48	93.11	150.00	91.00	105.00	127.00	112.00	98.10	177.00	115.00	120.00	151.30	131.00	116.00
Subsequent hospital care	99231		1.85%	0.33%	140.10	74.65	79.05	88.72	94.01	88.60	152.00	75.00	78.00	87.00	84.00	88.00	180.00	89.00	98.00	108.00	102.00	109.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-11
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Internal Medicine

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		20.32%	20.40%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Office/outpatient visit, est	99214		11.31%	17.05%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Office/outpatient visit, est	99215		1.80%	3.66%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Office/outpatient visit, new	99204		1.09%	2.53%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Office/outpatient visit, new	99203		1.51%	2.31%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Prev visit, est, age 40-64	99396		1.40%	2.25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	190.02	100.55	99.23	103.78	101.35	108.24	103.01	100.48
Subsequent hospital care	99232		1.79%	1.92%	93.75	67.04	67.83	68.52	67.45	71.57	68.51	69.45	134.96	68.09	67.41	69.24	68.29	71.54	69.18	68.50
Subsequent hospital care	99233		0.96%	1.46%	134.62	96.24	97.32	98.33	96.80	102.73	98.37	99.76	193.87	97.78	96.79	99.41	98.06	102.72	99.36	98.43
Office/outpatient visit, new	99205		0.49%	1.44%	255.06	188.57	192.05	194.47	190.30	205.10	194.23	197.54	359.60	187.26	184.68	192.09	188.26	200.14	191.58	188.31
Initial hospital care	99223		0.47%	1.35%	260.99	186.77	188.62	190.73	187.80	199.70	191.26	194.52	373.42	188.24	186.12	191.18	188.64	197.80	191.41	189.96
Office/outpatient visit, est	99212		2.07%	1.28%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Office consultation	99244		0.37%	1.12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Infliximab injection	J1745		0.03%	1.07%	60.58	60.58	60.58	60.58	60.58	60.58	60.58	60.58	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Electrocardiogram, complete	93000		1.88%	0.72%	23.57	18.66	19.33	19.62	18.97	20.97	19.43	19.74	34.09	19.18	18.79	20.10	19.41	21.28	19.89	19.15
Immunization admin	90471		1.79%	0.62%	27.44	21.99	22.92	23.24	22.40	24.81	22.87	23.12	36.58	20.72	20.35	21.80	21.02	23.02	21.47	20.52
Lipid panel	80061		1.71%	0.52%	18.85	15.96	17.17	18.85	18.85	18.85	18.85	15.67	23.08	17.59	17.23	17.44	17.44	16.01	16.13	17.61
Ther/proph/diag inj, sc/im	90772		1.19%	0.44%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Complete cbc w/auto diff wbc	85025		1.57%	0.28%	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	13.40	10.21	10.00	10.12	10.12	9.30	9.36	10.22
Flu vaccine age 3 yo & over, im	90658		1.25%	0.28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Routine venipuncture	36415		5.37%	0.27%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Comprehen metabolic panel	80053		1.10%	0.27%	14.87	14.87	14.87	14.87	14.87	12.01	12.01	14.87	18.20	13.87	13.59	13.76	13.76	12.63	12.72	13.89
Percut allergy skin tests	95004		1.18%	0.11%	7.04	5.98	6.27	6.39	6.12	6.96	6.33	6.47	8.99	5.43	5.27	5.78	5.52	6.24	5.72	5.45

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-11
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Internal Medicine

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		20.32%	20.40%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Office/outpatient visit, est	99214		11.31%	17.05%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Office/outpatient visit, est	99215		1.80%	3.66%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Office/outpatient visit, new	99204		1.09%	2.53%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Office/outpatient visit, new	99203		1.51%	2.31%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Prev visit, est, age 40-64	99396		1.40%	2.25%	277.45	N/A	N/A	N/A	N/A	N/A	N/A	116.63	143.51	78.73	Not Covered	N/A	298.33	203.03	191.39	211.95	Not Covered	N/A
Subsequent hospital care	99232		1.79%	1.92%	140.57	67.04	67.83	68.52	71.57	69.45	120.29	62.39	97.63	52.86	41.79	N/A	256.48	135.17	126.36	140.16	112.89	N/A
Subsequent hospital care	99233		0.96%	1.46%	199.87	96.24	97.32	98.33	102.73	99.76	172.68	89.47	139.78	75.95	60.02	N/A	378.31	194.02	181.48	201.01	162.15	N/A
Office/outpatient visit, new	99205		0.49%	1.44%	329.91	188.57	192.05	194.47	205.10	197.54	319.74	167.67	267.28	146.89	110.46	N/A	431.74	380.16	359.25	397.23	320.97	N/A
Initial hospital care	99223		0.47%	1.35%	394.90	186.77	188.62	190.73	199.70	194.52	331.73	169.27	269.42	146.61	115.60	N/A	589.90	376.53	353.68	390.39	314.88	N/A
Office/outpatient visit, est	99212		2.07%	1.28%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Office consultation	99244		0.37%	1.12%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Infliximab injection	J1745		0.03%	1.07%	194.44	60.58	60.58	60.58	60.58	60.58	58.07	55.21	58.66	60.04	N/A	N/A	182.89	N/A	N/A	N/A	71.05	N/A
Electrocardiogram, complete	93000		1.88%	0.72%	91.38	18.66	19.33	19.62	20.97	19.74	30.31	18.76	27.21	15.30	12.23	N/A	151.74	37.62	35.93	37.50	32.10	N/A
Immunization admin	90471		1.79%	0.62%	10.39	21.99	22.92	23.24	24.81	23.12	32.51	19.07	13.90	16.41	13.12	10.00	35.87	30.42	42.12	43.22	38.18	N/A
Lipid panel	80061		1.71%	0.52%	43.45	15.96	17.17	18.85	18.85	15.67	19.19	15.85	17.48	14.20	14.58	14.00	121.13	TBD	42.93	80% of billed	26.39	N/A
Ther/proph/diag inj, sc/im	90772		1.19%	0.44%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Complete cbc w/auto diff wbc	85025		1.57%	0.28%	40.35	10.94	10.94	10.94	10.94	10.94	11.14	10.86	11.14	8.24	8.47	9.85	56.86	TBD	27.35	80% of billed	15.32	N/A
Flu vaccine age 3 yo & over, im	90658		1.25%	0.28%	14.46	N/A	N/A	N/A	N/A	N/A	15.56	13.22	11.34	11.36	N/A	N/A	18.61	N/A	N/A	80% of billed	22.10	N/A
Routine venipuncture	36415		5.37%	0.27%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A
Comprehen metabolic panel	80053		1.10%	0.27%	49.40	14.87	14.87	14.87	12.01	14.87	15.14	14.77	15.14	11.20	9.29	13.29	91.24	TBD	37.17	80% of billed	16.81	N/A
Percut allergy skin tests	95004		1.18%	0.11%	11.30	5.98	6.27	6.39	6.96	6.47	7.99	5.06	7.47	4.45	3.56	6.39	10.96	12.06	11.77	12.08	10.51	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clair

Appendix A-11
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Internal Medicine

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		20.32%	20.40%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Office/outpatient visit, est	99214		11.31%	17.05%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Office/outpatient visit, est	99215		1.80%	3.66%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Office/outpatient visit, new	99204		1.09%	2.53%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Office/outpatient visit, new	99203		1.51%	2.31%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Prev visit, est, age 40-64	99396		1.40%	2.25%	256.37	150.07	133.83	185.24	155.63	153.26	267.00	146.50	138.69	183.40	147.00	148.12	295.00	162.07	138.69	199.26	177.98	181.00
Subsequent hospital care	99232		1.79%	1.92%	198.52	103.04	107.93	121.88	102.61	104.64	228.00	101.84	104.73	123.95	98.82	107.70	237.00	112.67	110.08	133.20	115.53	115.00
Subsequent hospital care	99233		0.96%	1.46%	264.74	153.13	163.08	171.63	143.35	151.49	300.00	145.81	150.02	174.89	135.85	146.05	340.00	163.44	183.30	189.57	160.32	185.00
Office/outpatient visit, new	99205		0.49%	1.44%	375.22	254.81	264.22	292.23	249.90	228.90	400.00	266.00	280.79	315.52	246.88	224.10	435.00	281.00	280.79	344.96	290.00	264.00
Initial hospital care	99223		0.47%	1.35%	474.21	287.32	282.89	338.27	275.24	269.78	530.00	275.64	283.05	335.00	265.00	264.00	586.30	304.95	288.71	358.56	311.27	293.83
Office/outpatient visit, est	99212		2.07%	1.28%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Office consultation	99244		0.37%	1.12%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Infliximab injection	J1745		0.03%	1.07%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Electrocardiogram, complete	93000		1.88%	0.72%	110.60	37.45	46.11	42.34	36.73	68.41	125.00	35.17	32.83	40.61	35.01	67.00	141.12	37.30	37.88	45.00	40.00	85.00
Immunization admin	90471		1.79%	0.62%	26.62	21.70	23.10	31.49	23.59	17.23	26.00	19.00	24.63	35.00	25.00	14.31	32.00	30.14	24.63	41.62	30.45	22.90
Lipid panel	80061		1.71%	0.52%	58.57	29.49	37.31	26.38	20.73	40.22	59.90	27.00	34.93	26.96	19.57	36.00	97.00	40.15	34.93	29.40	22.47	63.00
Ther/proph/diag inj, sc/im	90772		1.19%	0.44%	35.61	21.89	Not Cred	34.28	22.42	21.86	35.00	20.00	Not Cred	35.00	20.04	19.50	50.00	28.00	Not Cred	43.00	30.52	31.50
Complete cbc w/auto diff wbc	85025		1.57%	0.28%	34.86	16.34	24.54	16.14	12.43	29.04	40.00	15.42	22.25	15.64	11.35	27.30	50.00	16.38	22.25	20.74	13.03	47.00
Flu vaccine age 3 yo & over, im	90658		1.25%	0.28%	20.88	13.71	14.06	15.34	13.55	15.07	20.00	13.88	12.29	14.21	14.21	13.94	28.00	16.00	15.00	16.53	15.58	19.74
Routine venipuncture	36415		5.37%	0.27%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00
Comprehen metabolic panel	80053		1.10%	0.27%	47.74	21.24	31.51	21.74	15.21	38.55	47.26	20.97	30.26	21.27	12.46	34.00	75.00	22.03	30.26	23.20	16.93	62.00
Percut allergy skin tests	95004		1.18%	0.11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-11
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Internal Medicine

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		20.32%	20.40%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	$98.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Office/outpatient visit, est	99214		11.31%	17.05%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Office/outpatient visit, est	99215		1.80%	3.66%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Office/outpatient visit, new	99204		1.09%	2.53%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Office/outpatient visit, new	99203		1.51%	2.31%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Prev visit, est, age 40-64	99396		1.40%	2.25%	Not Cred	125.33	75.68	149.15	144.92	Not Cred	Not Cred	158.50	60.00	177.03	159.50	Not Cred	Not Cred	179.00	116.00	221.00	200.00	Not Cred
Subsequent hospital care	99232		1.79%	1.92%	208.11	115.76	131.12	141.72	138.76	129.72	234.00	120.00	125.00	144.00	138.80	125.00	238.17	130.00	133.00	167.00	158.00	160.00
Subsequent hospital care	99233		0.96%	1.46%	297.97	172.78	186.49	209.46	195.52	189.21	338.00	172.00	188.00	212.00	198.80	188.00	361.00	201.00	195.00	249.00	227.00	236.00
Office/outpatient visit, new	99205		0.49%	1.44%	358.00	282.67	282.52	358.57	310.49	277.38	370.00	285.00	314.00	370.00	308.30	271.50	439.00	337.00	333.00	461.00	383.00	350.00
Initial hospital care	99223		0.47%	1.35%	531.64	306.56	324.97	386.93	373.24	321.45	536.00	318.00	317.00	395.00	377.50	333.00	635.00	349.50	354.00	467.00	429.00	377.00
Office/outpatient visit, est	99212		2.07%	1.28%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Office consultation	99244		0.37%	1.12%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Infliximab injection	J1745		0.03%	1.07%	No Data	88.48	131.40	94.54	94.28	118.23	No Data	83.00	131.40	90.00	91.40	103.00	No Data	85.00	131.40	96.00	114.16	136.00
Electrocardiogram, complete	93000		1.88%	0.72%	105.88	51.56	64.80	54.14	56.58	96.95	125.00	50.00	66.00	56.00	52.80	90.00	128.00	75.00	78.00	62.00	72.00	175.00
Immunization admin	90471		1.79%	0.62%	27.07	27.47	31.90	34.76	32.20	23.54	25.00	30.00	32.00	38.00	32.00	22.50	36.00	36.25	38.00	46.50	42.00	28.15
Lipid panel	80061		1.71%	0.52%	69.85	45.11	59.69	45.18	49.63	67.63	81.00	39.20	56.00	40.00	40.00	71.00	93.00	57.10	70.00	54.90	68.22	86.00
Ther/prph/diag inj, sc/im	90772		1.19%	0.44%	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred
Complete cbc w/auto diff wbc	85025		1.57%	0.28%	33.93	29.96	42.83	26.51	32.26	37.16	27.51	30.00	40.00	24.00	30.00	37.00	46.00	39.10	49.00	32.50	40.03	56.00
Flu vaccine age 3 yo & over, im	90658		1.25%	0.28%	16.04	15.50	14.66	16.15	16.31	14.83	13.22	13.50	13.55	13.25	13.22	13.21	23.05	20.00	16.00	20.00	20.00	18.00
Routine venipuncture	36415		5.37%	0.27%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00
Comprehen metabolic panel	80053		1.10%	0.27%	45.03	38.41	61.10	35.30	38.95	48.15	42.85	39.29	61.00	32.63	39.29	53.00	65.00	42.26	65.00	44.31	51.00	56.00
Percut allergy skin tests	95004		1.18%	0.11%	Not Cred	7.35	Not Cred	9.82	10.50	Not Cred	Not Cred	8.00	Not Cred	9.20	10.00	Not Cred	Not Cred	8.25	Not Cred	13.00	12.00	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-12
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Interventional Cardiology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Left heart catheterization	93510	26	16.56%	46.77%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$471.79	$243.76	$238.76	$248.10	$243.85	$260.49	$250.51	$249.61
Imaging, cardiac cath	93556	26	17.19%	8.45%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	86.31	44.20	43.81	45.23	44.46	46.75	44.96	44.16
Rt & Lt heart catheters	93526	26	1.62%	6.41%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	651.66	336.55	329.57	342.42	336.60	359.61	345.90	344.83
Ablate heart dysrhythm focus	93651		1.20%	6.35%	N/A	878.16	879.43	896.17	881.38	957.20	915.10	951.48	1,763.20	909.91	889.17	924.09	908.87	972.96	936.66	937.02
Imaging, cardiac cath	93555	26	15.57%	6.25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	84.21	43.12	42.73	44.12	43.37	45.61	43.86	43.09
Electrophysiology evaluation	93620	26	1.54%	5.30%	859.96	627.59	628.62	640.56	629.94	684.18	653.99	679.90	1,260.88	651.08	636.26	661.40	650.41	696.39	670.25	670.31
Inject for coronary x-rays	93545		17.07%	2.84%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	271.89	163.46	160.20	174.93	166.87	186.30	170.81	160.41
Cath placement, angiography	93508	26	1.08%	2.34%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	447.02	231.01	226.31	235.16	231.12	246.86	237.36	236.42
Transcath closure of asd	93580		0.31%	1.80%	N/A	981.18	983.13	1,001.81	984.99	1,070.16	1,022.54	1,062.91	1,962.98	1,014.10	990.98	1,030.31	1,013.09	1,084.92	1,044.04	1,043.98
Injection for heart x-rays	93543		15.27%	1.67%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	130.83	77.59	76.11	82.75	79.12	87.92	80.90	76.23
Electrophys map 3d, add-on	93613		0.58%	1.32%	N/A	378.53	379.13	386.33	379.94	412.61	394.43	410.06	760.35	392.48	383.53	398.64	392.05	419.73	404.03	404.15
Electrophysiology evaluation	93641	26	0.67%	1.17%	N/A	320.41	320.89	326.99	321.59	349.25	333.88	347.14	643.13	331.89	324.31	337.06	331.50	354.89	341.65	341.80
Biopsy of heart lining	93505	26	0.49%	1.00%	N/A	233.81	234.64	238.77	234.80	254.16	242.92	251.53	470.69	242.53	237.49	246.55	242.48	258.88	249.21	248.71
Stimulation, pacing heart	93623	26	1.02%	0.88%	N/A	154.25	154.44	157.40	154.81	168.17	160.79	167.26	309.74	159.85	156.19	162.33	159.66	170.94	164.56	164.65
Electrophysiology evaluation	93621	26	1.22%	0.80%	N/A	113.42	113.61	115.75	113.84	123.58	118.14	122.77	228.20	117.77	115.12	119.64	117.66	125.92	121.21	121.19
Injection, cardiac cath	93540		1.35%	0.26%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	386.20	233.70	228.96	250.52	238.72	267.05	244.42	229.10
Injection, cardiac cath	93539		1.51%	0.21%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	134.05	78.37	76.91	83.25	79.79	88.29	81.57	77.22
Injection for aortography	93544		1.32%	0.12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	95.66	56.32	55.26	59.94	57.38	63.62	58.66	55.40

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

The procedure codes used for interventional cardiology have changed in 2011 and as a result, fee schedule amounts for many payers no longer exist for the most commonly used procedure codes historically.
For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-12
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Interventional Cardiology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Left heart catheterization	93510	26	16.56%	46.77%	$603.85	N/A	N/A	N/A	N/A	N/A	N/A	$258.22	$307.54	N/A	N/A	N/A	$5,657.83	N/A	N/A	N/A	N/A	N/A
Imaging, cardiac cath	93556	26	17.19%	8.45%	114.09	N/A	N/A	N/A	N/A	N/A	N/A	27.60	56.48	N/A	N/A	N/A	487.32	N/A	N/A	N/A	N/A	N/A
Rt & Lt heart catheters	93526	26	1.62%	6.41%	835.22	N/A	N/A	N/A	N/A	N/A	N/A	369.43	424.29	N/A	N/A	N/A	7,072.30	N/A	N/A	N/A	N/A	N/A
Ablate heart dysrhythm focus	93651		1.20%	6.35%	2,264.67	878.16	879.43	896.17	957.20	951.48	1,516.69	838.09	1,286.27	731.39	566.20	N/A	7,840.11	1,770.33	1,723.17	1,770.15	1,508.57	N/A
Imaging, cardiac cath	93555	26	15.57%	6.25%	112.23	N/A	N/A	N/A	N/A	N/A	N/A	23.77	55.05	N/A	N/A	N/A	320.70	N/A	N/A	N/A	N/A	N/A
Electrophysiology evaluation	93620	26	1.54%	5.30%	1,613.66	627.59	628.62	640.56	684.18	679.90	N/A	678.91	878.01	523.29	405.25	N/A	4,026.48	1,265.21	1,231.37	1,264.84	1,078.02	N/A
Inject for coronary x-rays	93545		17.07%	2.84%	317.20	N/A	N/A	N/A	N/A	N/A	243.27	117.37	231.54	N/A	N/A	N/A	445.27	N/A	N/A	N/A	N/A	N/A
Cath placement, angiography	93508	26	1.08%	2.34%	571.18	N/A	N/A	N/A	N/A	N/A	N/A	300.30	291.40	N/A	N/A	N/A	2,758.19	N/A	N/A	N/A	N/A	N/A
Transcath closure of asd	93580		0.31%	1.80%	2,545.21	981.18	983.13	1,001.81	1,070.16	1,062.91	1,688.35	933.80	1,434.05	815.13	631.33	N/A	30,299.36	1,978.04	1,925.10	1,976.72	Not Covered	N/A
Injection for heart x-rays	93543		15.27%	1.67%	224.61	N/A	N/A	N/A	N/A	N/A	116.82	57.47	109.90	N/A	N/A	N/A	277.64	N/A	N/A	N/A	N/A	N/A
Electrophys map 3d, add-on	93613		0.58%	1.32%	984.23	378.53	379.13	386.33	412.61	410.06	654.24	362.26	554.84	315.48	244.31	N/A	BR	763.11	742.66	763.36	650.25	N/A
Electrophysiology evaluation	93641	26	0.67%	1.17%	826.58	320.41	320.89	326.99	349.25	347.14	N/A	350.48	448.02	266.79	206.52	N/A	2,640.48	645.93	628.69	645.77	550.63	N/A
Biopsy of heart lining	93505	26	0.49%	1.00%	607.51	233.81	234.64	238.77	254.16	251.53	N/A	460.10	327.95	193.91	150.72	N/A	1,728.63	471.36	455.88	468.44	400.66	N/A
Stimulation, pacing heart	93623	26	1.02%	0.88%	396.44	154.25	154.44	157.40	168.17	167.26	N/A	462.57	215.94	128.53	99.59	N/A	1,038.95	310.97	302.89	310.81	265.08	N/A
Electrophysiology evaluation	93621	26	1.22%	0.80%	297.09	113.42	113.61	115.75	123.58	122.77	N/A	1,287.36	158.52	94.59	73.36	N/A	1,145.12	228.65	222.36	228.82	194.80	N/A
Injection, cardiac cath	93540		1.35%	0.26%	296.64	N/A	N/A	N/A	N/A	N/A	345.39	165.96	331.30	N/A	N/A	N/A	429.55	N/A	N/A	N/A	N/A	N/A
Injection, cardiac cath	93539		1.51%	0.21%	296.64	N/A	N/A	N/A	N/A	N/A	119.69	58.95	111.50	N/A	N/A	N/A	387.65	N/A	N/A	N/A	N/A	N/A
Injection for aortography	93544		1.32%	0.12%	34.53	N/A	N/A	N/A	N/A	N/A	85.55	42.16	80.03	N/A	N/A	N/A	277.64	N/A	N/A	N/A	N/A	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

The procedure codes used for interventional cardiology have changed in 2011 and as a result, fee schedu
For fee schedules that adjust payment based on place of service, payment is based on a non-facility clair

Appendix A-12
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Interventional Cardiology

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Left heart catheterization	93510	26	16.56%	46.77%	$2,203.48	$389.01	$416.15	$453.32	$389.54	$605.25	$2,700.00	$408.53	$390.61	$462.30	$366.48	$400.34	$2,700.00	$430.44	$398.42	$497.00	$439.28	$518.00
Imaging, cardiac cath	93556	26	17.19%	8.45%	495.93	79.54	85.16	85.04	73.22	116.55	525.00	74.91	71.90	85.00	66.96	81.39	525.00	76.32	73.34	92.30	79.31	99.00
Rt & Lt heart catheters	93526	26	1.62%	6.41%	2,614.94	505.40	Not Cred	646.09	567.81	1,084.45	3,321.00	552.40	Not Cred	637.17	507.06	648.62	3,375.00	560.27	Not Cred	682.00	593.90	906.00
Ablate heart dysrhythm focus	93651		1.20%	6.35%	5,750.14	1,700.93	2,879.59	1,789.96	1,424.63	2,070.63	6,222.00	1,482.11	1,720.71	1,701.13	1,375.10	1,675.00	6,222.00	1,561.00	5,362.18	1,975.16	1,623.75	2,267.35
Imaging, cardiac cath	93555	26	15.57%	6.25%	370.18	77.08	86.57	83.67	71.20	101.61	465.00	73.08	70.20	83.08	64.74	86.33	473.00	74.43	71.60	90.17	77.21	91.00
Electrophysiology evaluation	93620	26	1.54%	5.30%	3,960.69	1,329.21	2,876.48	995.74	911.01	1,212.04	4,147.00	1,009.74	1,293.07	1,076.26	921.12	1,057.86	4,147.00	1,128.00	4,680.65	1,228.56	1,135.34	1,418.80
Inject for coronary x-rays	93545		17.07%	2.84%	458.37	46.52	48.86	74.60	57.11	103.27	510.00	36.34	34.53	41.85	32.94	43.00	510.00	39.14	36.10	53.20	43.00	192.32
Cath placement, angiography	93508	26	1.08%	2.34%	2,576.92	353.92	Not Cred	391.06	369.49	518.07	2,525.00	380.25	Not Cred	425.75	355.65	419.07	2,525.00	439.36	Not Cred	471.25	442.40	875.51
Transcath closure of asd	93580		0.31%	1.80%	Not Cred	Not Cred	No Data	1,666.16	1,586.69	Not Cred	Not Cred	Not Cred	No Data	1,709.62	1,543.42	Not Cred	Not Cred	Not Cred	No Data	2,004.10	1,764.21	Not Cred
Injection for heart x-rays	93543		15.27%	1.67%	411.69	27.71	35.10	37.19	30.71	74.43	487.00	25.84	24.91	28.80	22.14	43.00	495.00	27.00	41.88	38.27	28.80	95.04
Electrophys map 3d, add-on	93613		0.58%	1.32%	2,612.80	752.30	Not Cred	730.21	627.82	Not Cred	2,738.00	624.50	Not Cred	712.65	591.84	Not Cred	2,738.00	819.00	Not Cred	852.74	681.11	Not Cred
Electrophysiology evaluation	93641	26	0.67%	1.17%	Not Cred	Not Cred	Not Cred	512.66	457.71	Not Cred	Not Cred	Not Cred	Not Cred	550.38	466.48	Not Cred	Not Cred	Not Cred	Not Cred	642.59	553.60	Not Cred
Biopsy of heart lining	93505	26	0.49%	1.00%	No Data	Not Cred	Not Cred	456.25	Not Cred	Not Cred	No Data	Not Cred	Not Cred	473.60	Not Cred	Not Cred	No Data	Not Cred	Not Cred	473.60	Not Cred	Not Cred
Stimulation, pacing heart	93623	26	1.02%	0.88%	830.24	262.47	Not Cred	299.99	253.19	Not Cred	861.00	260.05	Not Cred	291.00	232.73	Not Cred	861.00	284.00	Not Cred	333.26	284.93	Not Cred
Electrophysiology evaluation	93621	26	1.22%	0.80%	969.55	182.08	199.68	223.24	204.54	391.75	1,019.00	187.14	186.25	214.50	190.34	209.56	1,019.00	193.96	222.94	248.64	236.00	255.37
Injection, cardiac cath	93540		1.35%	0.26%	Not Cred	68.22	Not Cred	53.88	53.78	Not Cred	Not Cred	39.58	Not Cred	44.22	34.56	Not Cred	Not Cred	91.81	Not Cred	48.24	43.85	Not Cred
Injection, cardiac cath	93539		1.51%	0.21%	352.21	46.77	Not Cred	48.28	40.73	Not Cred	502.00	36.68	Not Cred	40.55	32.10	Not Cred	502.00	43.75	Not Cred	45.99	39.14	Not Cred
Injection for aortography	93544		1.32%	0.12%	Not Cred	50.98	Not Cred	51.16	38.15	64.79	Not Cred	22.90	Not Cred	27.00	23.01	46.50	Not Cred	96.21	Not Cred	33.00	28.47	113.65

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

The procedure codes used for interventional cardiology have changed in 2011 and as a result, fee schedu
For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-12
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Interventional Cardiology

					Billed Charges [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Left heart catheterization	93510	26	16.56%	46.77%	$2,048.97	$626.66	$741.51	$610.91	$674.95	$1,401.51	$2,657.00	$552.00	$650.00	$568.00	$587.00	$680.00	$2,700.00	$809.00	$945.00	$676.00	$731.40	$2,929.00
Imaging, cardiac cath	93556	26	17.19%	8.45%	408.20	118.45	111.26	111.96	121.66	257.28	517.00	99.20	101.00	102.50	109.20	205.00	525.00	172.48	135.00	124.00	134.60	569.00
Rt & Lt heart catheters	93526	26	1.62%	6.41%	Not Cred	931.58	1,239.68	845.13	945.00	1,961.90	Not Cred	793.00	1,380.00	831.00	948.79	1,515.50	Not Cred	1,599.81	1,884.26	1,155.00	1,182.00	3,661.00
Ablate heart dysrhythm focus	93651		1.20%	6.35%	Not Cred	1,764.62	No Data	2,639.95	2,357.18	Not Cred	Not Cred	1,675.00	No Data	2,761.00	2,156.00	Not Cred	Not Cred	1,838.00	No Data	2,887.50	2,691.30	Not Cred
Imaging, cardiac cath	93555	26	15.57%	6.25%	399.31	107.15	108.53	113.24	111.48	234.25	473.00	96.80	84.00	99.50	100.00	107.25	473.00	168.31	123.00	122.00	120.62	513.00
Electrophysiology evaluation	93620	26	1.54%	5.30%	Not Cred	1,332.21	Not Cred	1,807.43	1,827.31	Not Cred	Not Cred	1,258.00	Not Cred	1,840.00	1,519.50	Not Cred	Not Cred	1,597.00	Not Cred	1,909.00	2,000.00	Not Cred
Inject for coronary x-rays	93545		17.07%	2.84%	468.23	120.91	150.40	160.56	204.45	333.18	510.00	50.00	120.85	60.00	138.00	324.00	510.00	243.00	253.00	300.00	415.00	553.00
Cath placement, angiography	93508	26	1.08%	2.34%	2,622.57	385.95	538.85	552.46	598.25	Not Cred	2,525.00	416.00	465.00	517.00	555.50	Not Cred	3,446.00	556.00	712.00	558.00	599.25	Not Cred
Transcath closure of asd	93580		0.31%	1.80%	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data
Injection for heart x-rays	93543		15.27%	1.67%	No Data	109.49	Not Cred	97.75	108.05	Not Cred	No Data	61.20	Not Cred	72.00	46.60	Not Cred	No Data	218.00	Not Cred	155.00	202.00	Not Cred
Electrophys map 3d, add-on	93613		0.58%	1.32%	Not Cred	Not Cred	No Data	Not Cred	1,046.89	Not Cred	Not Cred	Not Cred	No Data	Not Cred	893.60	Not Cred	Not Cred	Not Cred	No Data	Not Cred	1,057.48	Not Cred
Electrophysiology evaluation	93641	26	0.67%	1.17%	Not Cred	722.02	Not Cred	812.95	845.80	Not Cred	Not Cred	632.00	Not Cred	773.99	754.00	Not Cred	Not Cred	865.00	Not Cred	945.50	981.60	Not Cred
Biopsy of heart lining	93505	26	0.49%	1.00%	Not Cred	Not Cred	No Data	Not Cred	720.20	No Data	Not Cred	Not Cred	No Data	Not Cred	721.90	No Data	Not Cred	Not Cred	No Data	Not Cred	721.90	No Data
Stimulation, pacing heart	93623	26	1.02%	0.88%	Not Cred	315.45	Not Cred	438.06	496.67	Not Cred	Not Cred	304.00	Not Cred	437.00	364.50	Not Cred	Not Cred	323.00	Not Cred	468.00	431.04	Not Cred
Electrophysiology evaluation	93621	26	1.22%	0.80%	Not Cred	231.93	Not Cred	731.68	407.70	Not Cred	Not Cred	220.50	Not Cred	452.00	275.00	Not Cred	Not Cred	280.00	Not Cred	1,865.60	317.90	Not Cred
Injection, cardiac cath	93540		1.35%	0.26%	407.45	127.77	114.22	174.94	230.63	383.14	517.00	54.00	73.00	65.00	132.00	391.50	525.00	216.00	185.00	200.00	465.70	570.00
Injection, cardiac cath	93539		1.51%	0.21%	394.43	82.56	113.00	95.72	146.16	242.23	510.00	52.00	130.00	60.00	140.00	158.84	510.00	76.00	166.00	150.00	264.00	482.50
Injection for aortography	93544		1.32%	0.12%	Not Cred	Not Cred	141.95	92.34	114.90	Not Cred	Not Cred	Not Cred	85.14	41.30	53.00	Not Cred	Not Cred	Not Cred	255.00	110.00	208.00	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

The procedure codes used for interventional cardiology have changed in 2011 and as a result, fee schedu
For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-13
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Laboratory

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Lipid panel	80061		5.94%	6.21%	$18.85	$15.96	$17.17	$18.85	$18.85	$18.85	$18.85	$15.67	$23.08	$17.59	$17.23	$17.44	$17.44	$16.01	$16.13	$17.61
Tissue exam by pathologist	88305	26	0.99%	5.72%	49.95	35.61	36.17	36.44	35.86	37.82	36.18	36.37	72.48	36.54	36.29	37.24	36.71	38.30	37.02	36.47
Assay thyroid stim hormone	84443		3.77%	5.08%	23.64	22.14	23.64	23.64	23.64	23.56	23.56	23.09	28.94	22.05	21.60	21.86	21.86	20.08	20.22	22.08
Cytopath c/v auto fluid redo	88175		2.05%	4.09%	37.28	36.57	37.28	37.28	37.28	37.28	37.28	37.28	45.63	34.77	34.06	34.48	34.48	31.66	31.89	34.81
Comprehen metabolic panel	80053		4.75%	3.94%	14.87	14.87	14.87	14.87	14.87	12.01	12.01	14.87	18.20	13.87	13.59	13.76	13.76	12.63	12.72	13.89
Chylmd trach, dna, amp probe	87491		1.23%	3.28%	49.39	49.39	49.39	49.39	49.39	49.39	49.39	49.39	60.47	46.08	45.14	45.69	45.69	41.95	42.26	46.13
N.gonorrhoeae, dna, amp prob	87591		1.19%	3.16%	49.39	49.39	49.39	49.39	49.39	49.39	49.39	49.39	60.47	46.08	45.14	45.69	45.69	41.95	42.26	46.13
Complete cbc w/auto diff wbc	85025		4.34%	2.64%	10.94	10.94	10.94	10.94	10.94	10.94	10.94	10.94	13.40	10.21	10.00	10.12	10.12	9.30	9.36	10.22
Hpv, dna, amp probe	87621		0.94%	2.51%	49.39	49.39	49.39	49.39	49.39	49.39	49.39	49.39	60.47	46.08	45.14	45.69	45.69	41.95	42.26	46.13
General health panel	80050		2.09%	2.14%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	60.84	46.36	45.42	45.97	45.97	42.21	42.52	46.41
Assay of psa, total	84153		1.21%	1.77%	25.89	25.89	25.89	25.89	25.89	25.89	25.89	25.89	31.68	24.14	23.65	23.94	23.94	21.98	22.14	24.17
Glycosylated hemoglobin test	83036		2.11%	1.62%	13.66	9.84	13.66	13.66	13.66	13.66	13.66	10.69	16.72	12.74	12.48	12.63	12.63	11.60	11.68	12.75
Cytopath, c/v, thin layer	88142		1.03%	1.60%	28.51	28.51	28.51	28.51	28.51	28.51	28.51	28.51	34.91	26.60	26.06	26.38	26.38	24.22	24.40	26.63
Urine culture/colony count	87086		1.99%	1.26%	11.36	11.36	11.36	11.36	11.36	11.36	11.36	5.29	13.92	10.61	10.39	10.52	10.52	9.66	9.73	10.62
Assay of free thyroxine	84439		1.67%	1.19%	12.69	12.69	11.40	12.69	12.69	12.31	12.31	12.69	15.54	11.84	11.60	11.74	11.74	10.78	10.86	11.85
Assay of total testosterone	84403		0.55%	1.12%	36.33	33.06	36.33	36.33	36.33	36.33	36.33	36.33	44.48	33.89	33.20	33.61	33.61	30.86	31.08	33.93
Routine venipuncture	36415		5.67%	0.98%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Culture, bacteria, other	87070		1.13%	0.77%	12.12	12.12	12.12	12.12	12.12	12.12	12.12	5.29	14.84	11.31	11.08	11.21	11.21	10.30	10.37	11.32
Metabolic panel total ca	80048		1.08%	0.71%	11.91	11.91	11.91	11.91	11.91	8.99	8.99	10.82	14.57	11.11	10.88	11.01	11.01	10.11	10.19	11.12
Hepatic function panel	80076		1.08%	0.68%	11.49	11.49	11.49	11.49	11.49	8.99	8.99	10.82	14.07	10.72	10.51	10.63	10.63	9.76	9.84	10.74
Assay of total thyroxine	84436		1.03%	0.56%	9.67	9.67	9.67	9.67	9.67	9.67	9.67	9.67	11.84	9.02	8.84	8.94	8.94	8.21	8.27	9.03
Assay of blood/uric acid	84550		1.04%	0.38%	6.36	6.36	6.36	6.36	6.36	6.36	6.36	6.36	7.79	5.93	5.81	5.88	5.88	5.40	5.44	5.94
Urinalysis, auto w/scope	81001		1.34%	0.34%	4.45	4.45	4.45	4.45	4.45	4.45	4.45	3.60	5.46	4.16	4.08	4.12	4.12	3.79	3.82	4.16

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-13
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Laboratory

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Lipid panel	80061		5.94%	6.21%	$43.45	$15.96	$17.17	$18.85	$18.85	$15.67	$19.19	$15.85	$17.48	$14.20	$14.58	$14.00	$121.13	TBD	$42.93	80% of billed	$26.39	N/A
Tissue exam by pathologist	88305	26	0.99%	5.72%	111.69	35.61	36.17	36.44	37.82	36.37	64.94	65.46	53.27	28.10	22.23	N/A	259.83	TBD	N/A	58.26	59.77	N/A
Assay thyroid stim hormone	84443		3.77%	5.08%	57.55	22.14	23.64	23.64	23.56	23.09	24.06	21.98	24.06	17.80	18.22	20.64	122.82	TBD	59.10	80% of billed	32.98	N/A
Cytopath c/v auto fluid redo	88175		2.05%	4.09%	109.50	36.57	37.28	37.28	37.28	37.28	37.94	36.31	37.94	28.08	37.94	N/A	93.50	TBD	93.20	80% of billed	52.19	N/A
Comprehen metabolic panel	80053		4.75%	3.94%	49.40	14.87	14.87	14.87	12.01	14.87	15.14	14.77	15.14	11.20	9.29	13.29	91.24	TBD	37.17	80% of billed	16.81	N/A
Chylmd trach, dna, amp probe	87491		1.23%	3.28%	145.32	49.39	49.39	49.39	49.39	49.39	50.27	49.04	50.27	37.20	38.21	N/A	203.53	TBD	123.47	80% of billed	69.15	N/A
N.gonorrhoeae, dna, amp prob	87591		1.19%	3.16%	145.32	49.39	49.39	49.39	49.39	49.39	50.27	49.04	50.27	37.20	38.21	N/A	203.53	TBD	123.47	80% of billed	69.15	N/A
Complete cbc w/auto diff wbc	85025		4.34%	2.64%	40.35	10.94	10.94	10.94	10.94	10.94	11.14	10.86	11.14	8.24	8.47	9.85	56.86	TBD	27.35	80% of billed	15.32	N/A
Hpv, dna, amp probe	87621		0.94%	2.51%	145.32	49.39	49.39	49.39	49.39	49.39	50.27	49.04	50.27	37.20	38.21	N/A	203.53	TBD	123.47	80% of billed	69.15	N/A
General health panel	80050		2.09%	2.14%	121.78	N/A	N/A	N/A	N/A	N/A	50.13	51.11	N/A	36.75	36.67	N/A	173.06	TBD	UCR	80% of billed	65.11	N/A
Assay of psa, total	84153		1.21%	1.77%	66.02	25.89	25.89	25.89	25.89	25.89	26.34	25.70	26.34	19.49	20.02	N/A	140.35	TBD	64.72	80% of billed	36.25	N/A
Glycosylated hemoglobin test	83036		2.11%	1.62%	40.83	9.84	13.66	13.66	13.66	10.69	13.90	9.77	13.90	10.29	10.56	N/A	92.23	TBD	34.15	80% of billed	19.12	N/A
Cytopath, c/v, thin layer	88142		1.03%	1.60%	83.92	28.51	28.51	28.51	28.51	28.51	29.02	28.31	29.02	21.47	29.02	N/A	81.51	TBD	71.28	80% of billed	39.91	N/A
Urine culture/colony count	87086		1.99%	1.26%	43.75	11.36	11.36	11.36	11.36	5.29	11.57	11.28	11.57	8.56	8.79	N/A	79.07	TBD	28.40	80% of billed	15.90	N/A
Assay of free thyroxine	84439		1.67%	1.19%	70.00	12.69	11.40	12.69	12.31	12.69	12.92	12.60	11.60	9.56	9.52	N/A	87.74	TBD	28.50	80% of billed	17.23	N/A
Assay of total testosterone	84403		0.55%	1.12%	106.43	33.06	36.33	36.33	36.33	36.33	36.98	32.82	36.98	27.37	28.10	N/A	137.45	TBD	90.83	80% of billed	50.86	N/A
Routine venipuncture	36415		5.67%	0.98%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A
Culture, bacteria, other	87070		1.13%	0.77%	57.91	12.12	12.12	12.12	12.12	5.29	12.34	12.03	12.34	9.13	9.38	N/A	85.40	TBD	30.30	80% of billed	16.97	N/A
Metabolic panel total ca	80048		1.08%	0.71%	48.58	11.91	11.91	11.91	8.99	10.82	12.12	11.83	12.12	8.97	6.95	N/A	66.08	TBD	29.77	80% of billed	12.59	N/A
Hepatic function panel	80076		1.08%	0.68%	49.84	11.49	11.49	11.49	8.99	10.82	11.70	11.42	11.70	8.66	6.95	N/A	62.93	TBD	28.72	80% of billed	12.59	N/A
Assay of total thyroxine	84436		1.03%	0.56%	28.82	9.67	9.67	9.67	9.67	9.67	9.84	9.61	9.84	7.28	7.48	N/A	52.64	TBD	24.18	80% of billed	13.54	N/A
Assay of blood/uric acid	84550		1.04%	0.38%	11.44	6.36	6.36	6.36	6.36	6.36	6.47	6.31	6.47	4.79	4.92	N/A	38.02	TBD	15.90	80% of billed	8.90	N/A
Urinalysis, auto w/scope	81001		1.34%	0.34%	32.35	4.45	4.45	4.45	4.45	3.60	4.54	4.43	4.54	3.36	3.45	N/A	36.49	TBD	11.12	80% of billed	6.23	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-13
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Laboratory

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Commercial Allowed [5] Mean AK	ID	ND	OR	WA	WY	Median AK	ID	ND	OR	WA	WY	80th Percentile AK	ID	ND	OR	WA	WY
Lipid panel	80061		5.94%	6.21%	$58.57	$29.49	$37.31	$26.38	$20.73	$40.22	$59.90	$27.00	$34.93	$26.96	$19.57	$36.00	$97.00	$40.15	$34.93	$29.40	$22.47	$63.00
Tissue exam by pathologist	88305	26	0.99%	5.72%	226.49	72.40	65.94	77.08	64.43	127.60	250.00	61.60	58.31	68.38	57.17	113.00	260.00	78.75	64.13	74.52	73.76	194.00
Assay thyroid stim hormone	84443		3.77%	5.08%	53.09	30.61	49.18	32.56	25.51	46.78	45.00	31.21	48.09	32.86	24.44	41.52	91.00	31.88	48.09	35.09	28.07	68.00
Cytopath c/v auto fluid redo	88175		2.05%	4.09%	61.74	48.01	72.66	48.96	40.68	73.24	49.50	50.25	75.83	51.81	37.01	74.00	90.00	52.73	75.83	54.50	44.47	99.90
Comprehen metabolic panel	80053		4.75%	3.94%	47.74	21.24	31.51	21.74	15.21	38.55	47.26	20.97	30.26	21.27	12.46	34.00	75.00	22.03	30.26	23.20	16.93	62.00
Chylmd trach, dna, amp probe	87491		1.23%	3.28%	59.65	62.76	72.43	54.29	51.32	76.87	50.00	66.14	100.47	50.56	49.94	61.00	80.00	70.12	100.47	59.51	53.94	99.00
N.gonorrhoeae, dna, amp prob	87591		1.19%	3.16%	58.58	62.38	70.31	53.92	50.31	69.77	49.49	66.14	100.47	50.56	49.04	61.00	75.00	70.12	100.47	59.51	53.94	102.48
Complete cbc w/auto diff wbc	85025		4.34%	2.64%	34.86	16.34	24.54	16.14	12.43	29.04	40.00	15.42	22.25	15.64	11.35	27.30	50.00	16.38	22.25	20.74	13.03	47.00
Hpv, dna, amp probe	87621		0.94%	2.51%	89.79	61.23	101.54	65.17	53.18	70.89	66.00	66.14	100.00	68.66	49.04	63.75	157.47	69.64	126.00	72.45	54.91	114.80
General health panel	80050		2.09%	2.14%	134.32	58.64	79.23	66.65	53.59	89.21	140.24	59.27	70.00	64.80	55.00	80.00	212.00	62.70	122.40	81.60	63.27	135.75
Assay of psa, total	84153		1.21%	1.77%	75.92	34.49	55.96	34.50	28.20	48.84	82.24	34.86	52.66	34.80	26.83	40.28	110.00	36.49	53.71	37.01	30.84	72.25
Glycosylated hemoglobin test	83036		2.11%	1.62%	52.59	17.75	28.76	18.67	15.43	27.68	60.65	18.46	27.78	18.46	14.17	27.08	75.00	18.51	27.78	20.12	16.27	36.90
Cytopath, c/v, thin layer	88142		1.03%	1.60%	64.79	38.48	55.00	39.78	32.02	52.41	65.00	39.93	58.00	40.77	28.31	48.00	92.00	42.53	58.00	41.83	40.20	71.25
Urine culture/colony count	87086		1.99%	1.26%	38.70	16.58	23.85	14.84	13.12	16.13	36.10	16.02	23.11	14.15	11.79	11.74	66.00	16.95	23.11	16.24	13.43	32.00
Assay of free thyroxine	84439		1.67%	1.19%	45.71	18.22	24.69	17.88	14.38	29.84	43.35	16.97	23.17	17.40	12.77	20.39	79.00	17.89	23.17	18.62	14.66	48.57
Assay of total testosterone	84403		0.55%	1.12%	77.34	44.60	66.35	49.16	37.98	58.83	70.00	46.90	73.92	50.51	36.80	49.00	126.00	48.85	73.92	63.00	41.03	82.50
Routine venipuncture	36415		5.67%	0.98%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00
Culture, bacteria, other	87070		1.13%	0.77%	48.30	17.45	25.10	15.94	14.18	21.97	50.00	17.08	24.65	13.83	12.57	14.93	75.00	18.08	24.65	17.32	14.18	33.25
Metabolic panel total ca	80048		1.08%	0.71%	38.21	16.00	25.05	17.49	11.89	29.30	40.00	16.69	24.24	17.04	9.33	28.05	62.00	17.75	24.24	19.40	13.01	44.00
Hepatic function panel	80076		1.08%	0.68%	33.79	16.07	23.28	16.60	11.55	26.64	30.00	16.22	23.40	16.44	9.33	20.00	56.00	16.95	23.40	18.20	12.79	42.00
Assay of total thyroxine	84436		1.03%	0.56%	29.26	12.04	17.85	13.37	10.36	17.63	34.17	12.86	19.69	13.65	9.80	12.57	45.00	13.65	19.69	15.08	10.57	25.09
Assay of blood/uric acid	84550		1.04%	0.38%	18.07	8.70	11.38	8.97	6.48	13.47	16.00	8.72	9.12	8.83	6.31	8.24	30.00	8.96	12.93	11.55	6.94	22.07
Urinalysis, auto w/scope	81001		1.34%	0.34%	23.55	7.37	10.17	7.97	6.16	11.33	30.00	6.47	9.08	6.38	4.63	9.33	36.00	6.78	9.08	8.55	5.56	17.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-13
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Laboratory

					Billed Charges [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Lipid panel	80061		5.94%	6.21%	$69.85	$45.11	$59.69	$45.18	$49.63	$67.63	$81.00	$39.20	$56.00	$40.00	$40.00	$71.00	$93.00	$57.10	$70.00	$54.90	$68.22	$86.00
Tissue exam by pathologist	88305	26	0.99%	5.72%	203.69	90.67	92.46	106.85	112.96	107.68	210.00	94.20	94.75	86.00	104.00	97.00	260.00	135.00	110.00	150.75	138.00	157.00
Assay thyroid stim hormone	84443		3.77%	5.08%	58.37	49.23	64.39	49.42	52.04	72.26	45.00	40.17	62.00	45.00	44.31	72.42	94.00	55.73	67.00	53.00	62.00	85.00
Cytopath c/v auto fluid redo	88175		2.05%	4.09%	62.10	60.80	79.42	61.47	71.42	87.58	49.50	58.00	78.00	49.00	70.00	74.00	90.00	61.86	84.00	69.25	90.00	115.00
Comprehen metabolic panel	80053		4.75%	3.94%	45.03	38.41	61.10	35.30	38.95	48.15	42.85	39.29	61.00	32.63	39.29	53.00	65.00	42.26	65.00	44.31	51.00	56.00
Chylmd trach, dna, amp probe	87491		1.23%	3.28%	Not Cred	71.48	Not Cred	66.56	77.62	Not Cred	Not Cred	71.11	Not Cred	59.52	74.31	Not Cred	Not Cred	74.31	Not Cred	80.00	80.00	Not Cred
N.gonorrhoeae, dna, amp prob	87591		1.19%	3.16%	Not Cred	69.76	Not Cred	67.11	77.78	Not Cred	Not Cred	68.56	Not Cred	59.51	74.31	Not Cred	Not Cred	74.31	Not Cred	80.00	82.00	Not Cred
Complete cbc w/auto diff wbc	85025		4.34%	2.64%	33.93	29.96	42.83	26.51	32.26	37.16	27.51	30.00	40.00	24.00	30.00	37.00	46.00	39.10	49.00	32.50	40.03	56.00
Hpv, dna, amp probe	87621		0.94%	2.51%	Not Cred	95.05	Not Cred	103.51	95.98	118.83	Not Cred	75.61	Not Cred	98.57	94.69	102.71	Not Cred	105.00	Not Cred	105.00	105.00	154.00
General health panel	80050		2.09%	2.14%	Not Cred	100.36	Not Cred	103.38	102.29	Not Cred	Not Cred	119.00	Not Cred	112.00	109.00	Not Cred	Not Cred	121.50	Not Cred	121.50	121.50	Not Cred
Assay of psa, total	84153		1.21%	1.77%	65.76	58.92	75.35	60.17	66.33	80.63	54.00	50.00	80.00	51.40	55.10	71.50	115.00	75.00	80.00	72.00	89.00	114.00
Glycosylated hemoglobin test	83036		2.11%	1.62%	50.23	39.10	42.08	36.44	39.00	43.22	40.00	40.70	37.00	33.90	36.00	45.00	78.00	45.84	54.00	41.00	45.84	60.00
Cytopath, c/v, thin layer	88142		1.03%	1.60%	Not Cred	59.90	Not Cred	48.02	69.19	Not Cred	Not Cred	60.00	Not Cred	46.63	73.00	Not Cred	Not Cred	75.00	Not Cred	60.00	80.00	Not Cred
Urine culture/colony count	87086		1.99%	1.26%	34.69	38.38	37.83	32.23	40.26	38.16	35.66	38.00	41.00	32.00	37.50	35.00	37.50	52.40	41.00	37.50	52.68	55.00
Assay of free thyroxine	84439		1.67%	1.19%	62.50	42.77	40.88	36.73	44.05	66.61	63.00	39.56	36.00	31.50	37.40	61.00	75.00	63.00	41.00	40.40	49.00	75.00
Assay of total testosterone	84403		0.55%	1.12%	95.23	82.75	102.07	82.88	84.60	113.33	80.13	61.50	98.00	72.16	72.16	101.20	157.68	99.69	129.75	93.81	99.69	169.00
Routine venipuncture	36415		5.67%	0.98%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00
Culture, bacteria, other	87070		1.13%	0.77%	55.39	44.04	41.47	41.25	49.82	58.05	57.82	42.02	39.00	36.60	42.02	51.00	81.32	50.49	47.00	63.00	77.05	82.00
Metabolic panel total ca	80048		1.08%	0.71%	40.44	32.04	49.24	28.26	32.44	39.27	34.29	34.00	51.00	25.00	33.00	41.00	62.00	38.70	62.00	34.32	38.70	48.00
Hepatic function panel	80076		1.08%	0.68%	28.91	28.74	43.95	27.28	33.52	42.43	14.75	26.00	48.00	26.00	35.00	41.00	48.00	39.53	49.00	32.85	42.40	55.00
Assay of total thyroxine	84436		1.03%	0.56%	31.30	33.98	Not Cred	29.82	33.79	36.09	34.50	34.80	Not Cred	29.00	37.80	37.00	34.50	39.56	Not Cred	39.56	43.00	41.81
Assay of blood/uric acid	84550		1.04%	0.38%	24.99	16.57	24.57	16.79	17.56	23.05	30.00	11.36	19.00	15.34	15.00	24.50	30.00	24.00	38.00	21.00	27.00	27.50
Urinalysis, auto w/scope	81001		1.34%	0.34%	23.70	21.11	19.60	18.93	24.62	20.94	24.00	19.00	21.00	18.50	20.00	20.50	38.00	36.63	21.00	24.00	37.55	26.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-14
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Neurology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99214		14.78%	10.71%	$130.96	$98.08	$100.41	$101.63	$99.18	$107.25	$101.06	$102.45	$182.64	$96.32	$95.07	$99.31	$97.05	$103.52	$98.63	$96.32
Office consultation	99244		5.68%	8.17%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Office consultation	99245		3.80%	6.73%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	428.34	223.13	220.20	229.02	224.42	238.44	228.17	224.00
Polysomnography, 4 or more	95810	26	1.48%	5.38%	170.05	121.81	123.51	124.66	122.63	129.97	124.26	125.55	334.42	167.93	166.58	170.72	168.50	175.82	170.24	168.39
Office/outpatient visit, est	99213		10.83%	5.23%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Polysomnography w/cpap	95811	26	1.17%	4.82%	177.60	127.32	129.10	130.33	128.19	135.94	129.94	131.34	360.49	181.07	179.54	184.03	181.65	189.64	183.62	181.72
Office/outpatient visit, est	99215		4.50%	4.40%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Natalizumab injection	J2323		0.20%	3.11%	10.21	10.21	10.21	10.21	10.21	10.21	10.21	10.21	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mri brain w/o & w/dye	70553	26	0.39%	2.26%	159.35	113.98	115.30	116.49	114.66	121.71	116.51	118.15	233.34	118.21	117.00	120.37	118.62	124.45	120.18	118.82
Ecg, awake and asleep	95819	26	2.25%	2.23%	73.73	52.85	53.62	54.11	53.22	56.40	53.90	54.43	105.45	53.28	52.83	54.27	53.49	55.96	54.07	53.37
Sense nerve conduction test	95904		5.88%	2.22%	62.29	50.39	52.63	53.38	51.39	57.08	52.48	53.04	81.00	46.28	45.46	48.84	47.01	51.64	48.02	45.79
Botulinum toxin a per unit	J0585		0.50%	2.09%	5.48	5.48	5.48	5.48	5.48	5.48	5.48	5.48	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Motor nerve conduction test	95903		3.58%	1.74%	83.77	66.34	68.91	69.86	67.50	74.46	68.91	69.72	110.49	61.63	60.63	64.61	62.46	68.02	63.69	61.14
Muscle test, 2 limbs	95861		1.92%	1.70%	163.66	125.90	130.03	131.60	127.76	139.28	129.99	131.25	218.82	118.23	116.66	122.89	119.51	128.50	121.45	117.52
Muscle test, one limb	95860		2.29%	1.48%	111.40	86.58	89.63	90.76	87.95	96.26	89.56	90.45	148.48	81.16	80.02	84.65	82.13	88.68	83.53	80.53
Eeg, awake and drowsy	95816	26	1.40%	1.46%	73.95	53.05	53.77	54.29	53.40	56.67	54.16	54.79	105.78	53.48	52.97	54.45	53.67	56.22	54.32	53.70
Motor nerve conduction test	95900		3.07%	1.33%	71.19	57.27	59.77	60.59	58.38	64.71	59.58	60.17	92.83	52.71	51.81	55.54	53.51	58.63	54.61	52.14
Subsequent hospital care	99232		2.35%	1.21%	93.75	67.04	67.83	68.52	67.45	71.57	68.51	69.45	134.96	68.09	67.41	69.24	68.29	71.54	69.18	68.50
EEG monitoring/videorecord	95951	26	0.53%	1.14%	414.17	297.75	300.94	304.45	299.51	319.25	305.30	310.71	593.10	300.51	296.92	305.62	301.25	316.69	305.95	303.32
Office consultation	99243		1.07%	1.05%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Inpatient consultation	99255		0.66%	1.03%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	396.77	201.14	199.02	204.82	201.81	211.86	204.56	202.30
Immune globulin, powder	J1566		0.09%	1.01%	31.28	31.28	31.28	31.28	31.28	31.28	31.28	31.28	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Subsequent hospital care	99233		1.32%	0.97%	134.62	96.24	97.32	98.33	96.80	102.73	98.37	99.76	193.87	97.78	96.79	99.41	98.06	102.72	99.36	98.43
Office/outpatient visit, est	99212		1.42%	0.43%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
H-reflex test	95934		1.04%	0.35%	67.99	53.60	55.69	56.41	54.53	59.99	55.56	56.10	88.54	49.08	48.32	51.37	49.72	53.99	50.64	48.66
Subsequent hospital care	99231		1.05%	0.30%	51.71	37.05	37.46	37.87	37.27	39.61	37.90	38.48	74.26	37.52	37.10	38.14	37.61	39.46	38.16	37.83

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-14
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Neurology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99214		14.78%	10.71%	$150.83	$98.08	$100.41	$101.63	$107.25	$102.45	$163.18	$86.45	$137.64	$75.39	$57.10	$95.57	$216.25	$197.74	$186.44	$206.48	$167.13	N/A
Office consultation	99244		5.68%	8.17%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Office consultation	99245		3.80%	6.73%	371.13	N/A	N/A	N/A	N/A	N/A	380.86	N/A	N/A	N/A	138.05	N/A	601.64	418.17	N/A	434.83	351.96	N/A
Polysomnography, 4 or more	95810	26	1.48%	5.38%	464.60	121.81	123.51	124.66	129.97	125.55	N/A	346.87	172.75	129.64	102.70	N/A	1,023.02	245.57	228.56	235.17	204.76	N/A
Office/outpatient visit, est	99213		10.83%	5.23%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Polysomnography w/cpap	95811	26	1.17%	4.82%	499.97	127.32	129.10	130.33	135.94	131.34	N/A	389.47	180.35	139.93	110.71	N/A	1,084.13	256.69	239.09	245.34	214.17	N/A
Office/outpatient visit, est	99215		4.50%	4.40%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Natalizumab injection	J2323		0.20%	3.11%	18.61	10.21	10.21	10.21	10.21	10.21	N/A	7.72	8.24	10.06	N/A	N/A	N/A	N/A	N/A	N/A	Not Covered	N/A
Mri brain w/o & w/dye	70553	26	0.39%	2.26%	394.10	113.98	115.30	116.49	121.71	118.15	207.98	100.14	160.89	91.81	72.47	N/A	826.63	294.28	214.93	219.48	192.03	N/A
Eeg, awake and asleep	95819	26	2.25%	2.23%	152.71	52.85	53.62	54.11	56.40	54.43	N/A	108.41	74.99	41.17	32.68	N/A	272.33	106.55	99.10	101.70	89.10	N/A
Sense nerve conduction test	95904		5.88%	2.22%	132.01	50.39	52.63	53.38	57.08	53.04	72.53	41.71	65.62	36.72	29.34	N/A	257.40	101.59	96.63	99.15	87.44	N/A
Botulinum toxin a per unit	J0585		0.50%	2.09%	13.30	5.48	5.48	5.48	5.48	5.48	N/A	5.26	5.47	5.47	N/A	N/A	14.37	N/A	N/A	N/A	5.67	N/A
Motor nerve conduction test	95903		3.58%	1.74%	169.52	66.34	68.91	69.86	74.46	69.72	98.73	56.06	87.49	48.69	38.90	N/A	402.53	133.75	126.98	130.93	114.55	N/A
Muscle test, 2 limbs	95861		1.92%	1.70%	486.70	125.90	130.03	131.60	139.28	131.25	195.07	108.10	168.59	92.64	73.80	N/A	583.92	253.82	239.09	245.34	215.83	N/A
Muscle test, one limb	95860		2.29%	1.48%	345.69	86.58	89.63	90.76	96.26	90.45	132.32	74.22	115.77	63.71	50.91	N/A	449.17	174.55	164.76	169.71	148.86	N/A
Eeg, awake and drowsy	95816	26	1.40%	1.46%	152.71	53.05	53.77	54.29	56.67	54.79	N/A	99.30	74.99	41.45	32.90	N/A	272.33	106.94	99.72	102.33	89.10	N/A
Motor nerve conduction test	95900		3.07%	1.33%	156.84	57.27	59.77	60.59	64.71	60.17	82.54	47.46	75.22	41.73	33.35	N/A	257.40	115.46	109.63	112.50	99.61	N/A
Subsequent hospital care	99232		2.35%	1.21%	140.57	67.04	67.83	68.52	71.57	69.45	120.29	62.39	97.63	52.86	41.79	N/A	256.48	135.17	126.36	140.16	112.89	N/A
EEG monitoring/videorecord	95951	26	0.53%	1.14%	846.92	297.75	300.94	304.45	319.25	310.71	N/A	660.12	420.50	N/A	184.73	N/A	1,146.92	600.28	564.89	580.94	503.04	N/A
Office consultation	99243		1.07%	1.05%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Inpatient consultation	99255		0.66%	1.03%	392.77	N/A	N/A	N/A	N/A	N/A	352.78	N/A	N/A	N/A	123.60	N/A	657.70	376.41	N/A	388.34	313.78	N/A
Immune globulin, powder	J1566		0.09%	1.01%	61.43	31.28	31.28	31.28	31.28	31.28	N/A	27.67	30.48	31.20	N/A	N/A	N/A	N/A	N/A	N/A	45.45	N/A
Subsequent hospital care	99233		1.32%	0.97%	199.87	96.24	97.32	98.33	102.73	99.76	172.68	89.47	139.78	75.95	60.02	N/A	378.31	194.02	181.48	201.01	162.15	N/A
Office/outpatient visit, est	99212		1.42%	0.43%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
H-reflex test	95934		1.04%	0.35%	322.13	53.60	55.69	56.41	59.99	56.10	78.73	40.43	69.89	38.67	30.90	N/A	290.23	108.06	102.20	105.51	92.42	N/A
Subsequent hospital care	99231		1.05%	0.30%	85.13	37.05	37.46	37.87	39.61	38.48	66.52	34.77	53.88	29.21	23.12	N/A	188.08	74.69	69.99	77.26	62.53	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-14
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Neurology

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99214		14.78%	10.71%	$194.83	$133.62	$140.11	$164.90	$140.23	$117.70	$205.00	$136.59	$144.92	$171.00	$135.16	$118.47	$220.00	$151.91	$144.92	$182.40	$161.20	$130.00
Office consultation	99244		5.68%	8.17%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Office consultation	99245		3.80%	6.73%	512.68	334.98	374.53	411.96	347.70	325.66	575.00	335.00	355.51	410.94	333.92	314.15	640.00	375.00	392.00	453.13	396.43	367.81
Polysomnography, 4 or more	95810	26	1.48%	5.38%	866.91	292.60	270.77	341.51	272.27	381.67	921.00	280.22	265.50	325.89	255.42	397.00	950.00	309.35	265.50	383.58	301.94	500.00
Office/outpatient visit, est	99213		10.83%	5.23%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Polysomnography w/cpap	95811	26	1.17%	4.82%	951.46	312.49	293.35	366.52	291.22	361.34	970.00	301.09	285.32	350.52	274.32	299.88	1,020.00	332.39	285.32	412.09	317.96	432.00
Office/outpatient visit, est	99215		4.50%	4.40%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Natalizumab injection	J2323		0.20%	3.11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mri brain w/o & w/dye	70553	26	0.39%	2.26%	407.64	285.48	226.64	223.92	204.41	360.82	441.00	244.51	188.51	213.53	203.31	379.76	461.00	404.58	204.98	229.43	214.00	495.90
Eeg, awake and asleep	95819	26	2.25%	2.23%	220.57	94.78	84.78	110.48	90.55	87.97	250.00	89.53	84.35	102.27	86.53	86.19	250.00	97.16	84.35	121.68	100.00	106.59
Sense nerve conduction test	95904		5.88%	2.22%	228.41	85.94	101.89	92.45	88.25	90.56	238.00	73.94	72.46	88.76	73.67	86.00	254.00	82.71	94.50	97.88	91.91	93.72
Botulinum toxin a per unit	J0585		0.50%	2.09%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Motor nerve conduction test	95903		3.58%	1.74%	299.81	136.67	131.99	120.82	106.30	124.15	244.00	98.57	96.24	114.63	94.05	117.00	356.00	160.62	136.33	133.65	114.64	149.75
Muscle test, 2 limbs	95861		1.92%	1.70%	425.15	201.18	221.23	225.23	181.68	231.90	494.00	182.75	183.41	217.35	168.90	214.00	577.00	201.75	191.10	240.16	190.62	278.10
Muscle test, one limb	95860		2.29%	1.48%	391.75	164.39	168.59	162.06	135.53	165.51	415.00	128.24	126.24	154.78	124.88	151.00	415.00	143.45	152.10	174.96	151.63	188.10
Eeg, awake and drowsy	95816	26	1.40%	1.46%	236.75	99.28	93.06	106.46	89.61	81.00	270.00	89.53	84.35	101.84	84.90	77.40	297.00	99.00	84.35	122.74	99.39	106.59
Motor nerve conduction test	95900		3.07%	1.33%	222.81	89.12	98.04	103.64	95.99	95.59	238.00	86.35	82.08	101.53	85.69	91.00	258.00	93.47	87.61	112.38	105.39	101.00
Subsequent hospital care	99232		2.35%	1.21%	198.52	103.04	107.93	121.88	102.61	104.64	228.00	101.84	104.73	123.95	98.82	107.70	237.00	112.67	110.08	133.20	115.53	115.00
EEG monitoring/videorecord	95951	26	0.53%	1.14%	626.84	450.45	743.58	601.58	496.77	418.41	554.38	375.00	423.20	599.56	504.49	432.00	554.38	598.23	561.81	699.69	570.05	593.61
Office consultation	99243		1.07%	1.05%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Inpatient consultation	99255		0.66%	1.03%	541.40	329.79	318.68	369.11	312.11	323.57	609.50	306.03	317.02	375.20	299.86	281.19	650.00	342.54	320.95	414.17	351.77	390.56
Immune globulin, powder	J1566		0.09%	1.01%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Subsequent hospital care	99233		1.32%	0.97%	264.74	153.13	163.08	171.63	143.35	151.49	300.00	145.81	150.02	174.89	135.85	146.05	340.00	163.44	183.30	189.57	160.32	185.00
Office/outpatient visit, est	99212		1.42%	0.43%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
H-reflex test	95934		1.04%	0.35%	231.50	78.00	101.15	81.55	61.85	84.03	250.00	59.36	62.70	87.92	63.23	92.50	260.40	75.00	107.50	92.95	66.55	92.50
Subsequent hospital care	99231		1.05%	0.30%	136.98	60.16	65.27	72.19	61.74	72.72	164.00	56.49	58.31	69.01	57.42	69.00	177.00	64.43	69.00	77.52	66.81	100.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-14
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Neurology

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Billed Charges[5] Mean AK	Mean ID	Mean ND	Mean OR	Mean WA	Mean WY	Median AK	Median ID	Median ND	Median OR	Median WA	Median WY	80th Percentile AK	80th Percentile ID	80th Percentile ND	80th Percentile OR	80th Percentile WA	80th Percentile WY
Office/outpatient visit, est	99214		14.78%	10.71%	$196.23	$131.45	$144.89	$184.32	$165.49	$132.65	$208.00	$138.00	$150.00	$190.00	$163.00	$130.00	$220.00	$166.00	$171.00	$221.00	$200.00	$156.00
Office consultation	99244		5.68%	8.17%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Office consultation	99245		3.80%	6.73%	544.53	398.49	382.16	496.39	443.42	395.48	563.00	392.00	420.00	500.00	450.00	400.00	660.00	455.00	452.00	591.00	503.00	487.00
Polysomnography, 4 or more	95810	26	1.48%	5.38%	Not Cred	370.99	402.96	427.86	387.53	520.31	Not Cred	394.00	401.00	404.00	377.00	518.90	Not Cred	468.00	508.00	526.00	457.00	671.00
Office/outpatient visit, est	99213		10.83%	5.23%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Polysomnography w/cpap	95811	26	1.17%	4.82%	1,158.85	398.39	441.86	458.40	403.70	532.91	875.00	397.00	397.00	434.00	398.00	515.00	1,040.00	509.00	590.00	542.00	491.00	739.00
Office/outpatient visit, est	99215		4.50%	4.40%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Natalizumab injection	J2323		0.20%	3.11%	15.00	13.32	No Data	12.00	15.40	13.50	15.00	13.70	No Data	12.00	16.00	13.50	15.00	13.70	No Data	12.00	18.00	13.50
Mri brain w/o & w/dye	70553	26	0.39%	2.26%	529.07	384.67	325.34	334.06	379.68	298.17	461.00	359.00	342.00	362.00	384.00	334.50	632.00	553.00	342.00	400.00	423.00	442.00
Eeg, awake and asleep	95819	26	2.25%	2.23%	No Data	120.91	Not Cred	132.04	224.35	Not Cred	No Data	97.00	Not Cred	124.00	157.60	Not Cred	No Data	148.33	Not Cred	155.00	360.00	Not Cred
Sense nerve conduction test	95904		5.88%	2.22%	159.47	92.83	105.05	112.83	102.34	125.53	143.00	96.00	94.00	113.00	100.00	132.30	254.00	132.00	110.00	134.00	121.00	168.00
Botulinum toxin a per unit	J0585		0.50%	2.09%	Not Cred	8.10	9.86	67.84	8.45	Not Cred	Not Cred	8.00	10.00	8.00	8.00	Not Cred	Not Cred	9.00	11.00	14.00	10.00	Not Cred
Motor nerve conduction test	95903		3.58%	1.74%	189.71	125.90	129.65	139.87	130.75	168.24	176.00	107.50	120.00	139.00	125.00	193.50	348.00	190.24	135.00	170.00	165.00	237.00
Muscle test, 2 limbs	95861		1.92%	1.70%	Not Cred	216.45	Not Cred	265.08	262.49	316.86	Not Cred	205.00	Not Cred	259.00	250.00	320.00	Not Cred	280.00	Not Cred	325.00	308.00	412.00
Muscle test, one limb	95860		2.29%	1.48%	275.74	177.04	176.03	206.64	196.12	210.86	300.00	189.00	197.00	205.20	198.00	220.50	430.00	265.00	200.00	245.00	245.00	270.00
Eeg, awake and drowsy	95816	26	1.40%	1.46%	Not Cred	176.35	112.33	152.96	179.79	Not Cred	Not Cred	150.00	110.00	152.00	131.62	Not Cred	Not Cred	222.00	121.00	176.00	175.00	Not Cred
Motor nerve conduction test	95900		3.07%	1.33%	193.75	104.25	103.76	130.68	113.89	131.89	216.00	105.50	110.00	129.20	111.40	154.00	258.00	149.00	110.00	151.80	141.00	154.80
Subsequent hospital care	99232		2.35%	1.21%	208.11	115.76	131.12	141.72	138.76	129.72	234.00	120.00	125.00	144.00	138.80	125.00	238.17	130.00	133.00	167.00	158.00	160.00
EEG monitoring/videorecord	95951	26	0.53%	1.14%	Not Cred	879.52	No Data	Not Cred	862.62	No Data	Not Cred	782.20	No Data	Not Cred	843.00	No Data	Not Cred	1,380.47	No Data	Not Cred	894.73	No Data
Office consultation	99243		1.07%	1.05%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Inpatient consultation	99255		0.66%	1.03%	477.62	355.21	398.36	443.39	400.14	402.83	477.00	350.00	404.00	446.00	420.00	414.00	628.55	438.47	404.00	523.00	476.00	500.00
Immune globulin, powder	J1566		0.09%	1.01%	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data
Subsequent hospital care	99233		1.32%	0.97%	297.97	172.78	186.49	209.46	195.52	189.21	338.00	172.00	188.00	212.00	198.80	188.00	361.00	201.00	195.00	249.00	227.00	236.00
Office/outpatient visit, est	99212		1.42%	0.43%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
H-reflex test	95934		1.04%	0.35%	Not Cred	Not Cred	Not Cred	124.74	85.19	Not Cred	Not Cred	Not Cred	Not Cred	110.00	85.00	Not Cred	Not Cred	Not Cred	Not Cred	142.64	95.13	Not Cred
Subsequent hospital care	99231		1.05%	0.30%	140.10	74.65	79.05	88.72	94.01	88.60	152.00	75.00	78.00	87.00	84.00	88.00	180.00	89.00	98.00	108.00	102.00	109.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-15
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Obstetrics / Gynecology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Obstetrical care	59400		1.21%	17.83%	$2,354.90	$1,749.07	$1,754.18	$1,791.77	$1,757.34	$1,928.14	$1,834.33	$1,916.79	$3,181.81	$1,661.32	$2,203.84	$1,955.94	$1,955.94	$1,983.25	$1,983.25	$2,984.72
Cesarean delivery	59510		0.54%	9.06%	2,617.84	1,945.38	1,950.39	1,992.71	1,954.41	2,145.78	2,041.39	2,134.78	3,601.43	1,880.73	2,495.44	2,214.32	2,214.32	2,026.87	1,983.25	3,649.01
Office/outpatient visit, est	99213		10.17%	5.34%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Prev visit, est, age 40-64	99396		6.08%	5.13%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	190.02	100.55	99.23	103.78	101.35	108.24	103.01	100.48
Prev visit, est, age 18-39	99395		5.82%	4.49%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	173.14	91.99	90.78	95.08	92.78	99.22	94.30	91.85
Office/outpatient visit, est	99214		5.00%	3.95%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Transvaginal us, non-ob	76830	26	2.46%	2.42%	46.59	33.32	33.76	34.08	33.53	35.53	33.99	34.37	67.61	34.18	33.89	34.82	34.32	35.92	34.70	34.25
Ob us >/= 14 wks, sngl fetus	76805		1.67%	1.95%	171.55	138.22	144.34	146.32	140.93	156.25	143.78	145.15	240.27	137.49	135.18	145.26	139.75	153.41	142.55	135.63
Total hysterectomy	58150		0.39%	1.93%	1,290.86	942.28	948.34	964.04	947.15	1,024.14	977.17	1,008.18	1,831.03	940.18	922.03	955.59	940.32	1,001.09	964.51	961.74
Ob us, detailed, sngl fetus	76811		1.02%	1.79%	237.29	185.87	192.89	195.30	188.99	207.34	192.39	194.11	332.79	184.65	181.94	193.46	187.17	203.17	190.47	182.75
Office/outpatient visit, est	99215		1.62%	1.72%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Prev visit, new, age 18-39	99385		1.59%	1.44%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	197.89	105.41	103.99	109.02	106.33	113.83	108.11	105.23
Office/outpatient visit, new	99204		1.10%	1.34%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Office/outpatient visit, est	99212		4.06%	1.32%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Transvaginal us, obstetric	76817		1.42%	1.19%	118.13	94.50	98.47	99.82	96.27	106.52	98.25	99.28	168.22	95.64	94.03	100.83	97.13	106.43	99.09	94.52
Us exam, pelvic, complete	76856	26	1.09%	1.07%	46.59	33.32	33.76	34.08	33.53	35.53	33.99	34.37	68.17	34.53	34.23	35.20	34.68	36.32	35.06	34.59
Ob us, follow-up, per fetus	76816		1.13%	0.92%	125.08	99.50	103.56	104.96	101.31	111.85	103.33	104.38	177.67	100.37	98.75	105.66	101.89	111.38	103.88	99.23
Ob us, limited, fetus(s)	76815	26	1.08%	0.77%	43.36	30.93	31.41	31.66	31.15	32.87	31.44	31.62	63.04	31.81	31.59	32.42	31.96	33.37	32.24	31.77
Fetal non-stress test	59025		1.84%	0.71%	56.96	43.92	44.81	45.66	44.41	49.07	45.99	47.46	85.81	46.56	57.57	48.08	46.80	53.12	53.12	145.25
Specimen handling	99000		1.15%	0.71%	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ther/proph/diag inj, sc/im	90772		1.22%	0.24%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Office/outpatient visit, est	99211		1.17%	0.20%	23.86	18.81	19.52	19.78	19.13	21.05	19.51	19.72	33.40	18.65	18.34	19.55	18.89	20.59	19.28	18.51
Urine pregnancy test	81025		1.49%	0.11%	8.90	8.90	8.90	8.90	8.90	5.30	5.30	8.90	10.90	8.30	8.13	8.23	8.23	7.56	7.61	8.31
Urinalysis nonauto w/o scope	81002		2.67%	0.08%	3.60	3.60	3.60	3.60	3.60	3.60	3.60	2.89	4.40	3.35	3.28	3.32	3.32	3.05	3.08	3.36
Routine venipuncture	36415		3.09%	0.08%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Smear, wet mount, saline/ink	87210		1.47%	0.08%	6.01	6.01	6.01	6.01	6.01	6.01	6.01	4.63	7.34	5.60	5.48	5.55	5.55	5.10	5.13	5.60
Hemoglobin	85018		1.92%	0.06%	3.33	3.33	3.33	3.33	3.33	3.33	3.33	2.24	4.07	3.10	3.04	3.08	3.08	2.83	2.85	3.11

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-15
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Obstetrics / Gynecology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Obstetrical care	59400		1.21%	17.83%	$4,231.13	$1,749.07	$1,754.18	$1,791.77	$1,928.14	$1,916.79	$2,821.81	$1,539.21	$2,339.40	$2,018.09	$2,034.50	N/A	$5,274.96	$4,515.39	$3,468.64	$4,590.19	$3,028.76	N/A
Cesarean delivery	59510		0.54%	9.06%	4,801.48	1,945.38	1,950.39	1,992.71	2,145.78	2,134.78	3,194.05	1,742.30	2,647.23	2,287.30	2,034.50	N/A	7,129.38	5,022.17	3,862.58	5,111.77	3,032.08	N/A
Office/outpatient visit, est	99213		10.17%	5.34%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Prev visit, est, age 40-64	99396		6.08%	5.13%	277.45	N/A	N/A	N/A	N/A	N/A	N/A	116.63	143.51	78.73	Not Covered	N/A	298.33	203.03	191.39	211.95	Not Covered	N/A
Prev visit, est, age 18-39	99395		5.82%	4.49%	251.38	N/A	N/A	N/A	N/A	N/A	154.25	116.63	131.24	72.05	85.48	N/A	273.05	186.08	175.29	193.49	Not Covered	N/A
Office/outpatient visit, est	99214		5.00%	3.95%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Transvaginal us, non-ob	76830	26	2.46%	2.42%	91.87	33.32	33.76	34.08	35.53	34.37	60.11	41.46	46.99	26.43	20.90	N/A	257.81	86.02	62.56	63.70	55.89	N/A
Ob us >/= 14 wks, sngl fetus	76805		1.67%	1.95%	356.63	138.22	144.34	146.32	156.25	145.15	213.64	131.67	195.79	108.78	87.14	N/A	507.24	368.44	89.19	278.77	247.92	N/A
Total hysterectomy	58150		0.39%	1.93%	2,390.99	942.28	948.34	964.04	1,024.14	1,008.18	1,626.50	872.26	1,334.28	748.64	582.87	N/A	5,327.17	2,432.64	1,828.47	2,337.70	1,612.05	N/A
Ob us, detailed, sngl fetus	76811		1.02%	1.79%	659.78	185.87	192.89	195.30	207.34	194.11	296.40	180.67	263.02	145.22	116.04	N/A	608.97	479.88	170.95	360.76	320.42	N/A
Office/outpatient visit, est	99215		1.62%	1.72%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Prev visit, new, age 18-39	99385		1.59%	1.44%	308.16	N/A	N/A	N/A	N/A	N/A	176.26	134.65	150.45	82.63	103.23	N/A	328.68	212.72	200.69	222.20	Not Covered	N/A
Office/outpatient visit, new	99204		1.10%	1.34%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Office/outpatient visit, est	99212		4.06%	1.32%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Transvaginal us, obstetric	76817		1.42%	1.19%	260.34	94.50	98.47	99.82	106.52	99.28	150.09	93.92	136.58	75.95	60.69	N/A	507.24	255.57	67.51	192.99	171.55	N/A
Us exam, pelvic, complete	76856	26	1.09%	1.07%	91.87	33.32	33.76	34.08	35.53	34.37	60.90	41.59	46.99	26.71	21.12	N/A	225.59	86.02	62.56	63.70	55.89	N/A
Ob us, follow-up, per fetus	76816		1.13%	0.92%	232.79	99.50	103.56	104.96	111.85	104.38	167.48	87.94	152.05	84.57	67.58	N/A	326.70	289.16	76.81	218.85	194.24	N/A
Ob us, limited, fetus(s)	76815	26	1.08%	0.77%	87.09	30.93	31.41	31.66	32.87	31.62	56.06	33.29	43.66	24.48	19.56	N/A	167.58	79.85	57.60	58.66	52.02	N/A
Fetal non-stress test	59025		1.84%	0.71%	108.11	43.92	44.81	45.66	49.07	47.46	69.77	39.93	59.75	34.22	52.20	N/A	260.69	113.39	86.10	113.81	76.37	N/A
Specimen handling	99000		1.15%	0.71%	15.95	Bundled	Bundled	Bundled	Bundled	Bundled	N/A	N/A	3.88	N/A	Bundled	N/A	52.48	N/A	N/A	80% of billed	Bundled	N/A
Ther/proph/diag inj, sc/im	90772		1.22%	0.24%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Office/outpatient visit, est	99211		1.17%	0.20%	49.04	18.81	19.52	19.78	21.05	19.72	29.70	18.25	26.68	N/A	11.42	N/A	82.18	37.91	35.93	39.65	32.65	N/A
Urine pregnancy test	81025		1.49%	0.11%	26.61	8.90	8.90	8.90	5.30	8.90	9.06	8.84	9.06	6.70	4.10	N/A	53.95	TBD	22.25	80% of billed	7.42	N/A
Urinalysis nonauto w/o scope	81002		2.67%	0.08%	20.10	3.60	3.60	3.60	3.60	2.89	3.66	3.57	3.66	2.71	2.78	N/A	28.57	TBD	9.00	80% of billed	5.04	N/A
Routine venipuncture	36415		3.09%	0.08%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A
Smear, wet mount, saline/ink	87210		1.47%	0.08%	17.40	6.01	6.01	6.01	6.01	4.63	6.11	5.96	6.11	4.52	4.64	N/A	37.71	TBD	15.03	80% of billed	8.41	N/A
Hemoglobin	85018		1.92%	0.06%	17.99	3.33	3.33	3.33	3.33	2.24	3.39	3.31	3.39	2.51	2.58	N/A	27.66	TBD	8.32	80% of billed	4.66	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-15
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Obstetrics / Gynecology

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Obstetrical care	59400		1.21%	17.83%	$4,704.80	$2,457.25	$2,500.69	$3,183.41	$2,601.20	$3,061.87	$5,000.00	$2,454.92	$2,661.24	$3,203.00	$2,474.56	$3,352.00	$5,000.00	$2,600.00	$2,661.24	$3,612.13	$2,867.61	$3,390.00
Cesarean delivery	59510		0.54%	9.06%	6,286.66	2,810.42	2,970.73	3,683.44	2,959.66	3,734.23	6,325.00	2,778.70	3,013.92	3,672.18	2,795.90	4,075.00	7,243.54	2,946.03	3,013.92	4,168.80	3,292.22	4,190.00
Office/outpatient visit, est	99213		10.17%	5.34%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Prev visit, est, age 40-64	99396		6.08%	5.13%	256.37	150.07	133.83	185.24	155.63	153.26	267.00	146.50	138.69	183.40	147.00	148.12	295.00	162.07	138.69	199.26	177.98	181.00
Prev visit, est, age 18-39	99395		5.82%	4.49%	238.21	135.53	114.86	167.65	140.03	142.36	250.27	133.33	123.00	166.85	132.84	140.00	275.00	147.51	126.81	181.09	159.87	173.00
Office/outpatient visit, est	99214		5.00%	3.95%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Transvaginal us, non-ob	76830	26	2.46%	2.42%	154.38	84.86	58.77	64.84	61.90	119.04	135.00	72.18	54.35	62.23	59.61	134.62	225.00	129.60	55.44	67.68	66.00	149.00
Ob us >/= 14 wks, sngl fetus	76805		1.67%	1.95%	422.92	254.60	196.38	277.04	243.44	358.20	450.00	265.99	228.14	278.72	224.28	399.00	480.00	272.82	228.14	326.76	304.22	400.00
Total hysterectomy	58150		0.39%	1.93%	4,239.57	1,775.90	1,550.23	1,725.11	1,338.35	2,602.77	4,907.50	1,710.15	1,475.82	1,746.69	1,368.68	3,285.00	5,081.00	2,114.28	1,568.18	2,056.01	1,652.89	3,285.00
Ob us, detailed, sngl fetus	76811		1.02%	1.79%	639.94	399.21	291.32	424.15	411.34	484.26	757.00	409.97	325.51	437.65	365.66	550.00	757.00	427.37	356.63	457.20	536.32	624.00
Office/outpatient visit, est	99215		1.62%	1.72%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Prev visit, new, age 18-39	99385		1.59%	1.44%	273.14	159.18	137.29	196.48	169.22	173.99	294.00	156.79	142.50	195.00	157.80	166.98	324.00	173.28	146.12	210.38	192.33	220.00
Office/outpatient visit, new	99204		1.10%	1.34%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Office/outpatient visit, est	99212		4.06%	1.32%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Transvaginal us, obstetric	76817		1.42%	1.19%	320.94	183.56	150.94	189.11	159.38	249.33	371.16	187.84	157.94	189.74	147.87	283.35	420.00	196.90	157.94	220.45	185.14	295.00
Us exam, pelvic, complete	76856	26	1.09%	1.07%	143.64	85.39	59.31	61.91	60.96	117.88	135.00	71.25	54.91	62.23	59.61	131.40	167.00	121.50	56.74	68.42	64.99	139.00
Ob us, follow-up, per fetus	76816		1.13%	0.92%	312.02	178.57	166.81	217.70	162.88	201.69	325.00	194.03	173.79	218.81	153.92	200.00	341.59	201.56	173.79	264.19	182.08	225.00
Ob us, limited, fetus(s)	76815	26	1.08%	0.77%	148.73	74.15	56.24	60.74	64.62	89.62	144.45	69.32	50.95	58.96	59.15	97.00	155.00	73.82	59.45	63.00	81.47	121.00
Fetal non-stress test	59025		1.84%	0.71%	232.98	62.85	69.63	84.80	68.53	158.47	260.00	62.36	71.33	85.00	65.27	174.00	267.00	65.54	79.61	102.48	74.42	196.00
Specimen handling	99000		1.15%	0.71%	23.61	12.10	13.85	13.42	10.96	19.65	30.00	9.60	10.01	11.00	10.29	23.75	36.00	15.21	17.10	13.87	13.68	26.00
Ther/proph/diag inj, sc/im	90772		1.22%	0.24%	35.61	21.89	Not Cred	34.28	22.42	21.86	35.00	20.00	Not Cred	35.00	20.04	19.50	50.00	28.00	Not Cred	43.00	30.52	31.50
Office/outpatient visit, est	99211		1.17%	0.20%	63.99	29.21	29.84	36.72	30.27	31.26	70.00	28.37	29.44	34.95	28.74	32.00	78.00	31.93	29.70	39.96	35.37	34.00
Urine pregnancy test	81025		1.49%	0.11%	36.69	12.72	18.15	12.25	7.13	14.76	42.00	12.50	18.11	12.38	5.49	10.00	49.00	12.99	18.11	13.06	8.84	23.75
Urinalysis nonauto w/o scope	81002		2.67%	0.08%	18.49	6.15	8.07	5.31	3.98	10.09	21.62	5.05	7.31	5.00	3.57	10.00	26.00	5.08	7.31	5.14	3.74	12.35
Routine venipuncture	36415		3.09%	0.08%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00
Smear, wet mount, saline/ink	87210		1.47%	0.08%	34.72	9.85	12.47	8.81	7.34	19.22	37.00	8.46	12.21	8.34	6.08	20.00	48.00	9.06	12.21	8.97	7.45	25.00
Hemoglobin	85018		1.92%	0.06%	23.76	5.70	7.56	5.12	3.89	10.22	28.00	4.70	6.78	4.63	3.31	11.50	38.00	5.40	6.78	5.00	3.71	12.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-15
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Obstetrics / Gynecology

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Billed Charges[6] Mean AK	Mean ID	Mean ND	Mean OR	Mean WA	Mean WY	Median AK	Median ID	Median ND	Median OR	Median WA	Median WY	80th Percentile AK	80th Percentile ID	80th Percentile ND	80th Percentile OR	80th Percentile WA	80th Percentile WY
Obstetrical care	59400		1.21%	17.83%	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data	Not Cred	No Data	Not Cred	Not Cred	Not Cred	No Data
Cesarean delivery	59510		0.54%	9.06%	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data
Office/outpatient visit, est	99213		10.17%	5.34%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Prev visit, est, age 40-64	99396		6.08%	5.13%	Not Cred	125.33	75.68	149.15	144.92	Not Cred	Not Cred	158.50	60.00	177.03	159.50	Not Cred	Not Cred	179.00	116.00	221.00	200.00	Not Cred
Prev visit, est, age 18-39	99395		5.82%	4.49%	No Data	Not Cred	Not Cred	Not Cred	127.07	No Data	No Data	Not Cred	Not Cred	Not Cred	151.00	No Data	No Data	Not Cred	Not Cred	Not Cred	177.50	No Data
Office/outpatient visit, est	99214		5.00%	3.95%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Transvaginal us, non-ob	76830	26	2.46%	2.42%	Not Cred	108.74	94.48	108.97	108.04	100.11	Not Cred	100.00	77.00	114.00	98.00	92.00	Not Cred	137.00	140.00	142.00	121.00	166.00
Ob us >/= 14 wks, sngl fetus	76805		1.67%	1.95%	Not Cred	No Data	Not Cred	Not Cred	355.97	Not Cred	Not Cred	No Data	Not Cred	Not Cred	317.00	Not Cred	Not Cred	No Data	Not Cred	Not Cred	404.00	Not Cred
Total hysterectomy	58150		0.39%	1.93%	No Data	Not Cred	Not Cred	Not Cred	2,329.15	Not Cred	No Data	Not Cred	Not Cred	Not Cred	2,200.00	Not Cred	No Data	Not Cred	Not Cred	Not Cred	2,736.25	Not Cred
Ob us, detailed, sngl fetus	76811		1.02%	1.79%	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data
Office/outpatient visit, est	99215		1.62%	1.72%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Prev visit, new, age 18-39	99385		1.59%	1.44%	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data
Office/outpatient visit, new	99204		1.10%	1.34%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Office/outpatient visit, est	99212		4.06%	1.32%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Transvaginal us, obstetric	76817		1.42%	1.19%	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred	Not Cred	Not Cred	No Data	Not Cred	Not Cred	Not Cred
Us exam, pelvic, complete	76856	26	1.09%	1.07%	140.50	113.11	99.28	106.85	105.78	106.14	135.00	100.73	99.00	112.00	106.00	120.00	197.00	124.00	117.00	128.00	117.60	166.00
Ob us, follow-up, per fetus	76816		1.13%	0.92%	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data	Not Cred	No Data	No Data	Not Cred	Not Cred	No Data
Ob us, limited, fetus(s)	76815	26	1.08%	0.77%	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred
Fetal non-stress test	59025		1.84%	0.71%	Not Cred	No Data	No Data	No Data	Not Cred	No Data	Not Cred	No Data	No Data	No Data	Not Cred	No Data	Not Cred	No Data	No Data	No Data	Not Cred	No Data
Specimen handling	99000		1.15%	0.71%	42.60	18.22	15.35	14.69	14.51	16.35	38.00	16.90	14.00	11.00	16.00	16.00	80.00	20.00	19.00	20.00	18.00	16.00
Ther/proph/diag inj, sc/im	90772		1.22%	0.24%	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred
Office/outpatient visit, est	99211		1.17%	0.20%	61.45	31.51	36.11	43.78	44.31	33.61	75.00	31.93	37.00	45.00	41.00	35.00	80.00	40.00	37.00	51.00	50.00	45.00
Urine pregnancy test	81025		1.49%	0.11%	Not Cred	Not Cred	Not Cred	23.05	25.28	Not Cred	Not Cred	Not Cred	Not Cred	20.50	21.00	Not Cred	Not Cred	Not Cred	Not Cred	35.00	31.00	Not Cred
Urinalysis nonauto w/o scope	81002		2.67%	0.08%	20.82	10.52	13.41	11.81	12.72	10.69	21.00	10.00	12.00	11.00	11.00	10.00	25.00	13.00	17.00	15.00	16.00	18.00
Routine venipuncture	36415		3.09%	0.08%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00
Smear, wet mount, saline/ink	87210		1.47%	0.08%	Not Cred	24.54	19.02	20.96	25.77	26.33	Not Cred	14.90	18.00	20.00	18.00	29.00	Not Cred	27.50	23.00	27.00	36.00	31.00
Hemoglobin	85018		1.92%	0.06%	Not Cred	22.57	16.85	13.77	19.74	Not Cred	Not Cred	14.00	15.00	8.61	13.05	Not Cred	Not Cred	39.04	22.00	24.00	37.80	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-16
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Ophthalmology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Eye exam & treatment	92014		21.61%	23.52%	$144.69	$110.75	$114.00	$115.48	$112.25	$122.39	$114.50	$116.04	$197.82	$106.57	$105.04	$110.57	$107.61	$115.73	$109.53	$106.28
Eye exam, new patient	92004		10.62%	14.16%	176.28	134.02	137.75	139.49	135.75	147.60	138.38	140.19	242.96	130.05	128.22	134.68	131.23	140.80	133.52	129.82
Eye exam established pat	92012		13.91%	10.41%	98.89	76.19	78.54	79.59	77.28	84.49	78.88	79.97	134.25	72.79	71.69	75.66	73.54	79.31	74.91	72.58
Refraction	92015		14.71%	6.79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52.60	28.31	27.90	29.36	28.58	30.73	29.10	28.25
Cataract surg w/iol, 1 stage	66984		0.78%	4.97%	931.62	699.64	711.72	723.04	706.18	769.71	726.53	745.30	1,284.28	677.29	664.57	695.30	680.17	730.09	696.79	686.68
Office/outpatient visit, est	99213		4.60%	2.94%	87.71	66.04	67.67	68.52	66.81	72.42	68.12	69.10	121.23	64.21	63.34	66.28	64.72	69.17	65.82	64.23
Office consultation	99244		1.27%	2.41%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Office/outpatient visit, est	99214		2.32%	2.23%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Visual field examination(s)	92083		2.78%	2.11%	98.34	79.92	83.52	84.74	81.53	90.77	83.36	84.33	128.62	73.92	72.58	78.13	75.12	82.68	76.76	73.07
Ophth dx imaging post seg	92135		4.38%	1.94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	75.59	42.83	42.08	45.09	43.46	47.61	44.38	42.42
Eye exam, new patient	92002		2.34%	1.66%	93.51	71.95	74.13	75.12	72.96	79.74	74.49	75.55	127.76	69.23	68.18	71.93	69.93	75.41	71.25	69.07
Office/outpatient visit, new	99204		0.98%	1.45%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Treatment of retinal lesion	67228		0.13%	1.32%	1,396.89	1,068.50	1,093.74	1,110.97	1,081.15	1,184.83	1,111.04	1,136.48	1,944.68	1,048.75	1,028.93	1,084.95	1,056.42	1,142.11	1,081.91	1,056.90
Office consultation	99243		0.99%	1.29%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Eye exam with photos	92250		1.75%	1.26%	85.94	69.81	73.02	74.05	71.23	79.20	72.71	73.42	114.07	65.60	64.44	69.37	66.69	73.38	68.10	64.76
Bevacizumab injection	J9035		0.04%	1.11%	59.67	59.67	59.67	59.67	59.67	59.67	59.67	59.67	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Eye exam with photos	92235		0.82%	1.04%	153.10	124.10	129.73	131.55	126.60	140.68	129.24	130.54	201.57	115.57	113.59	122.14	117.47	129.08	119.89	114.05
Office/outpatient visit, est	99212		2.26%	0.89%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Special eye exam, subsequent	92226		1.35%	0.28%	29.28	21.98	22.58	22.82	22.25	24.01	22.59	22.78	40.52	21.40	21.15	22.09	21.58	23.00	21.89	21.32
Special eye exam, initial	92225		1.14%	0.27%	32.64	24.39	24.92	25.24	24.65	26.65	25.14	25.54	45.28	23.79	23.47	24.49	23.95	25.53	24.35	23.83

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-16
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Ophthalmology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Eye exam & treatment	92014		21.61%	23.52%	$101.04	$110.75	$114.00	$115.48	$122.39	$116.04	$176.19	$97.40	$59.48	$83.74	$66.47	$107.56	$188.56	$223.27	$211.22	$217.38	$189.82	N/A
Eye exam, new patient	92004		10.62%	14.16%	87.27	134.02	137.75	139.49	147.60	140.19	216.03	119.56	59.48	102.10	81.14	N/A	206.80	270.19	255.19	262.50	229.66	N/A
Eye exam established pat	92012		13.91%	10.41%	88.80	76.19	78.54	79.59	84.49	79.97	119.86	66.88	59.48	57.31	45.57	N/A	153.20	153.61	145.56	150.00	131.16	N/A
Refraction	92015		14.71%	6.79%	45.74	N/A	N/A	N/A	N/A	N/A	46.77	17.80	40.55	22.26	17.56	N/A	66.78	51.75	48.93	50.21	43.72	N/A
Cataract surg w/iol, 1 stage	66984		0.78%	4.97%	1,770.95	699.64	711.72	723.04	769.71	745.30	1,141.23	585.99	961.37	769.95	422.15	N/A	6,342.27	1,806.26	1,353.39	1,730.93	1,202.54	N/A
Office/outpatient visit, est	99213		4.60%	2.94%	103.12	66.04	67.67	68.52	72.42	69.10	108.29	57.45	91.76	50.35	38.21	67.36	149.22	133.13	125.74	138.79	112.89	N/A
Office consultation	99244		1.27%	2.41%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Office/outpatient visit, est	99214		2.32%	2.23%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Visual field examination(s)	92083		2.78%	2.11%	181.99	79.92	83.52	84.74	90.77	84.33	114.36	68.17	105.10	58.70	46.91	N/A	346.23	161.13	153.61	158.26	139.46	N/A
Ophth dx imaging post seg	92135		4.38%	1.94%	192.25	N/A	N/A	N/A	N/A	N/A	67.22	39.71	60.82	N/A	N/A	N/A	227.52	N/A	N/A	N/A	N/A	N/A
Eye exam, new patient	92002		2.34%	1.66%	103.85	71.95	74.13	75.12	79.74	75.55	113.60	63.24	59.48	54.53	43.35	N/A	157.02	145.06	137.51	141.74	123.96	N/A
Office/outpatient visit, new	99204		0.98%	1.45%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Treatment of retinal lesion	67228		0.13%	1.32%	2,244.02	1,068.50	1,093.74	1,110.97	1,184.83	1,136.48	1,729.14	888.95	1,488.47	169.90	657.12	N/A	3,289.42	2,758.55	2,065.08	2,642.27	1,842.82	N/A
Office consultation	99243		0.99%	1.29%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Eye exam with photos	92250		1.75%	1.26%	117.84	69.81	73.02	74.05	79.20	73.42	101.43	64.15	93.36	52.02	41.57	N/A	212.48	140.74	133.79	137.29	121.19	N/A
Bevacizumab injection	J9035		0.04%	1.11%	137.54	59.67	59.67	59.67	59.67	59.67	N/A	57.46	57.46	59.84	N/A	N/A	N/A	N/A	N/A	N/A	Not Covered	N/A
Eye exam with photos	92235		0.82%	1.04%	305.41	124.10	129.73	131.55	140.68	130.54	179.73	113.08	164.32	91.53	73.14	N/A	672.03	250.19	237.85	244.71	215.83	N/A
Office/outpatient visit, est	99212		2.26%	0.89%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Special eye exam, subsequent	92226		1.35%	0.28%	53.22	21.98	22.58	22.82	24.01	22.78	36.03	19.14	30.41	16.69	13.34	N/A	182.83	44.31	41.50	42.59	37.63	N/A
Special eye exam, initial	92225		1.14%	0.27%	58.89	24.39	24.92	25.24	26.65	25.54	40.26	21.04	34.14	18.64	14.67	N/A	212.48	49.17	46.46	47.67	41.51	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-16
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Ophthalmology

					Commercial Allowed [6]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Eye exam & treatment	92014		21.61%	23.52%	$162.63	$108.90	$121.59	$155.09	$120.55	$100.09	$169.00	$110.00	$120.57	$160.53	$113.00	$99.00	$198.00	$134.65	$161.90	$186.02	$148.00	$118.54
Eye exam, new patient	92004		10.62%	14.16%	186.96	127.41	129.21	184.97	141.96	114.58	190.00	130.00	125.00	206.95	135.20	115.00	235.00	166.88	195.00	232.96	179.11	139.54
Eye exam established pat	92012		13.91%	10.41%	149.24	89.61	89.33	115.44	82.29	74.13	155.00	89.24	94.00	120.00	76.80	70.00	165.00	104.98	110.96	131.32	95.00	86.40
Refraction	92015		14.71%	6.79%	48.62	38.87	22.94	35.87	46.72	26.76	41.73	30.00	22.00	34.00	43.68	25.00	75.00	45.68	29.44	45.00	59.00	30.00
Cataract surg w/iol, 1 stage	66984		0.78%	4.97%	1,888.28	1,174.24	951.32	1,090.36	906.25	1,394.03	994.87	1,295.74	1,002.56	1,133.60	920.81	908.28	4,166.00	1,760.00	1,317.60	1,262.88	1,158.04	2,446.25
Office/outpatient visit, est	99213		4.60%	2.94%	134.15	89.05	92.87	108.87	90.19	79.88	140.00	89.93	96.24	112.52	86.74	83.00	150.00	100.77	96.24	120.96	101.79	86.00
Office consultation	99244		1.27%	2.41%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Office/outpatient visit, est	99214		2.32%	2.23%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Visual field examination(s)	92083		2.78%	2.11%	187.77	95.07	106.23	116.88	105.47	88.58	192.02	97.78	113.79	120.90	105.52	84.00	240.00	105.00	113.79	134.67	108.54	108.00
Ophth dx imaging post seg	92135		4.38%	1.94%	154.18	59.87	66.85	74.79	62.74	74.97	165.00	60.64	66.23	74.24	62.62	75.00	199.00	62.00	66.23	83.53	62.72	86.00
Eye exam, new patient	92002		2.34%	1.66%	153.87	73.84	85.00	117.50	82.02	79.85	170.27	75.00	89.00	116.75	75.85	80.00	175.00	95.26	105.29	131.76	97.44	95.00
Office/outpatient visit, new	99204		0.98%	1.45%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Treatment of retinal lesion	67228		0.13%	1.32%	2,863.61	1,600.77	1,593.65	1,692.87	1,405.58	Not Cred	2,775.00	1,585.49	1,565.27	1,604.10	1,411.64	Not Cred	3,184.99	1,913.95	1,565.27	1,900.60	1,651.95	Not Cred
Office consultation	99243		0.99%	1.29%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Eye exam with photos	92250		1.75%	1.26%	150.42	82.79	86.99	101.78	93.08	82.28	152.10	84.00	100.00	102.52	100.98	82.50	197.00	98.90	102.46	121.27	101.78	105.00
Bevacizumab injection	J9035		0.04%	1.11%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Eye exam with photos	92235		0.82%	1.04%	Not Cred	168.03	216.92	215.46	173.15	185.05	Not Cred	172.82	183.42	218.12	179.22	177.00	Not Cred	181.06	234.65	233.10	181.06	182.40
Office/outpatient visit, est	99212		2.26%	0.89%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Special eye exam, subsequent	92226		1.35%	0.28%	58.25	28.13	Not Cred	40.23	29.16	38.46	55.04	26.77	Not Cred	40.60	29.15	39.00	78.00	30.76	Not Cred	42.92	29.40	39.00
Special eye exam, initial	92225		1.14%	0.27%	101.10	31.47	37.94	40.51	32.26	53.88	94.00	30.00	35.66	40.19	32.18	69.00	150.00	33.93	35.66	44.95	33.17	69.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-16
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Ophthalmology

					Billed Charges [6]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Eye exam & treatment	92014		21.61%	23.52%	$182.11	$113.70	$132.95	$165.50	$148.31	$109.34	$190.00	$101.50	$135.00	$176.00	$143.00	$103.79	$212.00	$140.00	$178.00	$213.00	$186.00	$120.00
Eye exam, new patient	92004		10.62%	14.16%	211.05	135.47	149.72	194.58	171.52	133.26	192.00	122.00	138.00	195.00	160.00	127.52	250.00	150.00	210.00	253.60	219.00	159.00
Eye exam established pat	92012		13.91%	10.41%	158.18	90.89	92.18	122.95	101.33	92.68	165.00	87.00	80.00	128.00	95.30	87.00	188.00	118.00	122.00	157.00	129.00	125.00
Refraction	92015		14.71%	6.79%	52.51	32.44	26.83	35.23	53.41	26.38	45.00	30.00	25.00	35.00	50.00	23.00	60.00	39.00	38.00	45.00	72.00	35.00
Cataract surg w/iol, 1 stage	66984		0.78%	4.97%	4,000.36	1,025.18	1,829.00	1,574.37	1,493.47	2,678.82	4,166.00	658.75	1,871.00	1,417.00	1,434.40	2,665.00	6,325.00	2,023.00	1,871.00	2,100.00	2,165.00	4,139.00
Office/outpatient visit, est	99213		4.60%	2.94%	134.60	84.31	94.91	119.82	107.32	88.42	145.00	83.00	98.00	125.00	107.00	87.00	152.25	110.00	114.00	145.00	128.00	106.70
Office consultation	99244		1.27%	2.41%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Office/outpatient visit, est	99214		2.32%	2.23%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Visual field examination(s)	92083		2.78%	2.11%	205.08	89.10	112.40	130.22	116.99	91.90	225.00	84.00	115.00	135.00	116.00	89.00	240.00	108.00	125.00	161.00	141.00	120.00
Ophth dx imaging post seg	92135		4.38%	1.94%	184.53	69.66	80.11	91.01	84.61	79.87	210.00	62.00	76.16	90.00	86.00	80.00	213.00	87.50	107.00	110.99	104.40	125.00
Eye exam, new patient	92002		2.34%	1.66%	168.55	82.59	95.13	116.76	100.38	93.53	155.19	72.06	99.00	126.48	90.00	70.00	235.00	95.00	127.00	158.00	140.00	160.00
Office/outpatient visit, new	99204		0.98%	1.45%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Treatment of retinal lesion	67228		0.13%	1.32%	Not Cred	1,470.75	Not Cred	1,907.23	1,474.97	Not Cred	Not Cred	1,071.00	Not Cred	1,812.00	1,420.00	Not Cred	Not Cred	2,300.00	Not Cred	2,520.00	1,846.00	Not Cred
Office consultation	99243		0.99%	1.29%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Eye exam with photos	92250		1.75%	1.26%	195.88	84.12	100.64	117.65	115.29	83.30	180.00	84.00	104.00	125.00	115.00	79.00	296.00	100.00	108.50	150.00	130.00	107.00
Bevacizumab injection	J9035		0.04%	1.11%	100.90	83.12	92.01	114.18	99.35	97.05	90.00	66.88	85.00	90.00	94.50	73.00	125.00	150.00	128.00	150.00	125.00	150.00
Eye exam with photos	92235		0.82%	1.04%	651.80	187.22	189.07	255.92	216.47	170.01	680.00	210.00	230.00	250.00	209.00	158.49	680.00	257.00	230.00	279.00	279.00	220.00
Office/outpatient visit, est	99212		2.26%	0.89%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Special eye exam, subsequent	92226		1.35%	0.28%	Not Cred	40.06	31.31	50.40	51.47	41.00	Not Cred	41.00	20.14	50.00	33.00	39.00	Not Cred	50.00	20.14	60.00	108.00	60.00
Special eye exam, initial	92225		1.14%	0.27%	99.21	34.64	43.85	50.85	54.97	59.92	94.00	30.00	23.11	50.00	44.00	45.00	137.50	45.00	89.00	59.32	89.00	85.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-17
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Orthopedics

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		13.31%	7.16%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Office/outpatient visit, new	99203		5.13%	4.19%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Knee arthroscopy/surgery	29881		0.70%	3.47%	793.36	598.43	607.84	618.44	603.84	660.94	623.58	642.44	1,099.32	582.87	570.52	598.43	584.98	630.65	601.20	593.41
Office/outpatient visit, est	99214		4.16%	3.36%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Office consultation	99243		3.07%	3.35%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Total knee arthroplasty	27447		0.32%	2.93%	1,934.46	1,439.14	1,454.54	1,480.23	1,449.34	1,580.12	1,498.41	1,547.54	2,713.06	1,419.21	1,389.02	1,450.06	1,421.59	1,526.07	1,461.56	1,450.69
Drain/inject, joint/bursa	20610		3.80%	2.39%	92.99	72.43	74.56	75.73	73.45	80.94	75.44	77.00	126.07	69.15	67.81	71.92	69.80	75.89	71.50	69.44
Therapeutic exercises	97110		5.27%	2.37%	38.37	28.62	29.37	29.67	28.96	31.16	29.36	29.58	53.75	28.26	27.95	29.15	28.50	30.29	28.87	28.13
Mri jnt of lwr extre w/o dye	73721	26	0.47%	2.22%	91.78	65.75	66.43	67.18	66.13	70.34	67.34	68.47	133.88	67.86	67.10	69.06	68.06	71.50	69.06	68.38
Office/outpatient visit, new	99204		1.51%	1.88%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Office consultation	99244		1.11%	1.78%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Office/outpatient visit, est	99212		5.31%	1.77%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Shoulder arthroscopy/surgery	29826		0.38%	1.77%	822.58	619.18	628.41	639.42	624.59	683.30	645.19	665.04	1,146.05	606.78	593.89	622.64	608.84	656.10	625.77	618.06
Knee arthroscopy/surgery	29888		0.29%	1.74%	1,231.96	921.55	933.28	949.67	928.81	1,014.20	959.80	990.26	1,721.23	905.33	886.11	926.85	907.57	975.96	932.93	923.88
Total hip arthroplasty	27130		0.19%	1.55%	1,810.11	1,346.29	1,360.53	1,384.59	1,355.77	1,478.04	1,401.75	1,447.84	2,537.88	1,327.11	1,298.87	1,355.79	1,329.26	1,426.81	1,366.66	1,356.69
Knee arthroscopy/surgery	29877		0.27%	1.28%	762.17	575.57	584.86	595.06	580.87	636.02	599.81	617.84	1,054.87	559.94	548.08	575.13	562.06	606.15	577.62	569.87
Knee arthroscopy/surgery	29880		0.20%	1.05%	850.33	640.26	649.90	661.27	645.89	706.63	667.12	687.55	1,179.98	624.53	611.28	640.79	626.63	675.19	644.05	636.19
Office/outpatient visit, new	99202		1.35%	0.75%	89.38	67.88	69.71	70.61	68.74	74.76	70.13	71.13	123.19	65.86	64.92	68.16	66.44	71.28	67.62	65.81
Manual therapy	97140		2.18%	0.75%	36.23	26.98	27.67	27.96	27.29	29.35	27.67	27.88	50.51	26.48	26.20	27.29	26.70	28.34	27.04	26.38
X-ray exam of knee, 3	73562		1.87%	0.56%	42.33	34.77	36.29	36.90	35.47	39.76	36.46	37.10	55.45	32.25	31.54	34.12	32.75	36.31	33.63	32.07
X-ray exam of shoulder	73030	26	1.86%	0.51%	13.17	9.58	9.64	9.79	9.63	10.40	9.93	10.25	18.55	9.48	9.31	9.62	9.48	10.06	9.70	9.67
X-ray exam, knee, 4 or more	73564		1.17%	0.40%	48.82	39.97	41.73	42.41	40.77	45.62	41.86	42.54	64.74	37.54	36.75	39.71	38.13	42.21	39.11	37.28
X-ray exam of knee, 1 or 2	73560	26	1.53%	0.39%	12.29	8.92	8.96	9.11	8.96	9.68	9.25	9.57	17.21	8.76	8.60	8.88	8.75	9.28	8.97	8.96
X-ray exam of ankle	73610	26	1.41%	0.38%	11.48	8.21	8.31	8.39	8.26	8.77	8.39	8.51	16.87	8.55	8.45	8.70	8.58	9.02	8.71	8.63
X-ray exam of foot	73630		1.25%	0.34%	36.93	30.19	31.57	32.05	30.81	34.40	31.55	31.97	49.84	28.90	28.31	30.58	29.36	32.48	30.09	28.65
X-ray exam of wrist	73110	26	1.08%	0.31%	11.85	8.53	8.65	8.74	8.59	9.14	8.73	8.85	16.87	8.55	8.45	8.70	8.58	9.02	8.71	8.63
X-ray exam of wrist	73100		1.06%	0.26%	35.75	29.28	30.51	31.04	29.85	33.47	30.73	31.33	47.15	27.34	26.73	28.89	27.75	30.77	28.52	27.26
X-ray exam of finger(s)	73140		1.02%	0.25%	36.01	29.80	31.23	31.72	30.44	34.14	31.20	31.63	46.75	27.43	26.84	29.10	27.89	30.99	28.62	27.18
Electric stimulation therapy	97014		1.22%	0.15%	16.07	12.08	12.39	12.53	12.22	13.22	12.44	12.59	24.96	13.44	13.24	13.93	13.56	14.59	13.81	13.42
Methylprednisolone 40 MG inj	J1030		1.09%	0.06%	2.79	2.79	2.79	2.79	2.79	2.79	2.79	2.79	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hot or cold packs therapy	97010		0.011073925	0.000486685	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	Bundled	8.92	4.84	4.73	5.01	4.87	5.3	5.02	4.92

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-17
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Orthopedics

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		13.31%	7.16%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Office/outpatient visit, new	99203		5.13%	4.19%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Knee arthroscopy/surgery	29881		0.70%	3.47%	1,557.81	598.43	607.84	618.44	660.94	642.44	976.77	531.23	825.32	839.70	364.57	N/A	4,909.00	2,465.71	1,165.71	1,492.01	1,032.64	N/A
Office/outpatient visit, est	99214		4.16%	3.36%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Office consultation	99243		3.07%	3.35%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Total knee arthroplasty	27447		0.32%	2.93%	3,852.63	1,439.14	1,454.54	1,480.23	1,580.12	1,547.54	2,410.07	1,298.57	2,009.69	1,136.17	884.98	N/A	9,278.23	5,929.68	2,806.50	3,589.22	2,476.47	N/A
Drain/inject, joint/bursa	20610		3.80%	2.39%	167.30	72.43	74.56	75.73	80.94	77.00	112.09	62.45	98.16	55.08	43.57	N/A	303.51	186.99	139.98	185.87	125.62	N/A
Therapeutic exercises	97110		5.27%	2.37%	73.67	28.62	29.37	29.67	31.16	29.58	47.79	26.50	14.44	21.98	17.56	29.71	97.31	39.59	53.89	53.81	48.70	N/A
Mri jnt of lwr extre w/o dye	73721	26	0.47%	2.22%	314.48	65.75	66.43	67.18	70.34	68.47	119.04	66.40	93.02	52.86	41.79	N/A	425.65	169.76	124.50	127.40	111.23	N/A
Office/outpatient visit, new	99204		1.51%	1.88%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Office consultation	99244		1.11%	1.78%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Office/outpatient visit, est	99212		5.31%	1.77%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Shoulder arthroscopy/surgery	29826		0.38%	1.77%	1,750.62	619.18	628.41	639.42	683.30	665.04	1,017.74	561.95	859.47	1,270.96	379.24	N/A	4,747.16	2,551.23	1,206.59	1,543.44	1,068.06	N/A
Knee arthroscopy/surgery	29888		0.29%	1.74%	2,565.99	921.55	933.28	949.67	1,014.20	990.26	1,528.86	828.55	1,282.00	2,228.42	565.09	N/A	8,685.16	3,797.07	1,796.26	2,298.15	1,587.70	N/A
Total hip arthroplasty	27130		0.19%	1.55%	3,560.16	1,346.29	1,360.53	1,384.59	1,478.04	1,447.84	2,254.09	1,210.03	1,879.52	1,062.45	827.40	N/A	12,671.59	5,547.09	2,625.64	3,358.22	2,317.09	N/A
Knee arthroscopy/surgery	29877		0.27%	1.28%	1,489.77	575.57	584.86	595.06	636.02	617.84	937.26	510.04	792.78	839.70	350.12	N/A	4,315.61	2,371.54	1,121.11	1,434.26	993.35	N/A
Knee arthroscopy/surgery	29880		0.20%	1.05%	1,680.22	640.26	649.90	661.27	706.63	687.55	1,047.90	570.14	884.54	839.70	390.36	N/A	5,933.96	2,638.08	1,247.47	1,595.65	1,104.03	N/A
Office/outpatient visit, new	99202		1.35%	0.75%	121.20	67.88	69.71	70.61	74.76	71.13	109.84	59.02	93.90	51.75	39.31	69.70	171.90	136.85	129.45	142.89	116.21	N/A
Manual therapy	97140		2.18%	0.75%	69.72	26.98	27.67	27.96	29.35	27.88	44.91	24.62	N/A	20.59	16.45	27.46	74.53	37.32	50.79	50.14	45.93	N/A
X-ray exam of knee, 3	73562		1.87%	0.56%	132.16	34.77	36.29	36.90	39.76	37.10	49.30	29.73	45.88	25.87	20.67	N/A	203.76	89.76	18.58	68.75	60.87	N/A
X-ray exam of shoulder	73030	26	1.86%	0.51%	23.93	9.58	9.64	9.79	10.40	10.25	16.49	8.66	13.29	7.51	5.78	N/A	91.14	24.74	18.58	18.92	16.60	N/A
X-ray exam, knee, 4 or more	73564		1.17%	0.40%	97.41	39.97	41.73	42.41	45.62	42.54	57.56	33.88	53.35	30.05	24.01	N/A	228.82	103.20	21.68	79.47	69.73	N/A
X-ray exam of knee, 1 or 2	73560	26	1.53%	0.39%	36.76	8.92	8.96	9.11	9.68	9.57	15.30	7.95	12.34	6.96	5.34	N/A	68.96	23.03	17.34	17.66	15.50	N/A
X-ray exam of ankle	73610	26	1.41%	0.38%	28.62	8.21	8.31	8.39	8.77	8.51	15.00	8.74	11.39	6.68	5.34	N/A	72.72	21.20	15.49	15.77	13.84	N/A
X-ray exam of foot	73630		1.25%	0.34%	103.98	30.19	31.57	32.05	34.40	31.97	44.32	27.30	41.08	23.09	18.45	N/A	181.81	77.96	15.49	59.29	52.57	N/A
X-ray exam of wrist	73110	26	1.08%	0.31%	23.00	8.53	8.65	8.74	9.14	8.85	15.00	9.27	11.87	6.68	5.34	N/A	67.70	22.03	16.10	16.40	14.39	N/A
X-ray exam of wrist	73100		1.06%	0.26%	75.42	29.28	30.51	31.04	33.47	31.33	41.92	24.92	38.41	21.98	17.34	N/A	149.70	75.60	16.72	58.66	51.47	N/A
X-ray exam of finger(s)	73140		1.02%	0.25%	62.36	29.80	31.23	31.72	34.14	31.63	42.06	23.78	38.95	21.98	17.56	N/A	128.54	76.93	12.39	59.29	52.02	N/A
Electric stimulation therapy	97014		1.22%	0.15%	40.73	12.08	12.39	12.53	13.22	12.59	22.20	N/A	N/A	10.57	8.45	N/A	54.64	19.37	26.63	26.29	23.80	N/A
Methylprednisolone 40 MG inj	J1030		1.09%	0.06%	15.35	2.79	2.79	2.79	2.79	2.79	4.30	4.63	3.76	2.53	N/A	N/A	12.62	N/A	N/A	N/A	3.88	N/A
Hot or cold packs therapy	97010		0.011073925	0.000486685	27.13582237	Bundled	Bundled	Bundled	Bundled	Bundled	7.93	N/A	6.03	N/A	Bundled	N/A	48.57	7.077495	N/A	9.78	Bundled	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-17
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Orthopedics

					Commercial Allowed [5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		13.31%	7.16%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Office/outpatient visit, new	99203		5.13%	4.19%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Knee arthroscopy/surgery	29881		0.70%	3.47%	3,678.57	1,248.61	981.67	1,128.39	1,124.00	2,164.25	4,330.00	1,279.15	927.27	1,097.46	1,008.54	2,581.00	4,534.00	1,349.35	927.27	1,204.00	1,324.26	2,725.19
Office/outpatient visit, est	99214		4.16%	3.36%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Office consultation	99243		3.07%	3.35%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Total knee arthroplasty	27447		0.32%	2.93%	7,264.91	2,566.63	2,269.14	2,461.07	2,288.07	5,406.51	8,600.00	2,824.16	2,285.91	2,680.56	2,305.13	6,368.00	9,037.00	3,185.89	2,285.91	2,883.06	3,255.45	7,259.90
Drain/inject, joint/bursa	20610		3.80%	2.39%	255.79	133.14	105.48	130.55	113.84	117.19	287.00	135.31	109.82	129.72	109.21	101.00	303.51	145.46	109.82	139.72	130.85	151.00
Therapeutic exercises	97110		5.27%	2.37%	115.96	54.40	66.31	75.29	54.26	81.03	90.00	50.58	44.16	70.00	56.22	80.00	163.80	82.17	88.32	112.18	76.22	120.00
Mri jnt of lwr extre w/o dye	73721	26	0.47%	2.22%	283.63	155.22	119.56	126.44	116.51	252.78	298.00	139.45	107.56	122.30	113.05	279.00	298.00	192.00	113.17	133.21	123.42	300.00
Office/outpatient visit, new	99204		1.51%	1.88%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Office consultation	99244		1.11%	1.78%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Office/outpatient visit, est	99212		5.31%	1.77%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Shoulder arthroscopy/surgery	29826		0.38%	1.77%	3,340.87	1,174.05	755.72	940.92	966.41	2,085.43	4,100.00	1,361.37	942.30	1,102.61	917.25	1,980.90	4,907.00	1,549.78	977.65	1,230.49	1,375.00	3,198.60
Knee arthroscopy/surgery	29888		0.29%	1.74%	6,412.01	2,056.59	1,468.03	1,716.17	1,688.61	4,038.88	7,698.00	2,015.06	1,459.97	1,727.93	1,573.80	5,074.00	8,021.00	2,107.32	1,459.97	1,870.50	2,175.70	5,714.00
Total hip arthroplasty	27130		0.19%	1.55%	10,557.38	2,266.18	2,175.36	2,390.15	2,263.44	3,343.42	11,867.00	2,699.91	2,134.20	2,525.90	2,246.72	2,615.86	12,155.00	2,989.25	2,437.91	2,703.68	3,025.08	5,239.85
Knee arthroscopy/surgery	29877		0.27%	1.28%	2,617.42	1,077.64	660.30	840.76	865.56	1,659.14	1,993.00	1,224.31	890.48	952.34	829.92	1,106.03	3,985.00	1,286.25	890.48	1,078.46	1,061.92	2,620.35
Knee arthroscopy/surgery	29880		0.20%	1.05%	5,291.44	1,397.97	995.08	1,195.49	1,178.32	2,667.02	5,255.50	1,372.57	995.77	1,178.53	1,057.10	3,335.00	5,520.00	1,438.14	1,075.43	1,282.51	1,422.57	3,386.04
Office/outpatient visit, new	99202		1.35%	0.75%	149.21	91.12	86.37	110.70	93.63	87.29	155.00	93.40	99.63	114.79	90.39	88.00	172.00	103.33	99.63	123.60	108.17	97.00
Manual therapy	97140		2.18%	0.75%	119.79	39.28	49.43	57.57	43.86	60.99	112.10	28.47	40.76	44.08	28.44	50.00	180.00	56.94	61.35	79.16	56.80	90.00
X-ray exam of knee, 3	73562		1.87%	0.56%	158.96	60.24	46.01	55.63	51.96	73.18	186.00	61.37	52.65	60.72	53.23	71.61	193.00	64.88	52.65	67.68	61.62	97.00
X-ray exam of shoulder	73030	26	1.86%	0.51%	44.76	22.58	16.66	18.02	16.64	33.27	42.00	18.67	14.72	16.49	15.47	38.00	61.00	29.14	15.01	18.00	16.66	38.95
X-ray exam, knee, 4 or more	73564		1.17%	0.40%	156.51	69.59	45.63	67.39	58.29	99.41	193.00	70.48	43.59	72.09	59.41	104.00	210.00	75.65	61.14	79.00	70.47	119.10
X-ray exam of knee, 1 or 2	73560	26	1.53%	0.39%	37.59	20.00	15.08	16.94	15.62	26.33	33.00	17.44	13.59	16.00	14.88	31.00	54.00	23.20	14.68	17.10	15.95	31.00
X-ray exam of ankle	73610	26	1.41%	0.38%	45.98	21.95	15.72	17.10	15.19	30.45	45.00	17.96	13.59	16.01	14.60	34.00	61.00	30.50	14.38	17.28	15.86	35.00
X-ray exam of foot	73630		1.25%	0.34%	113.88	53.11	36.28	49.93	44.52	73.15	105.00	56.48	33.40	54.37	45.34	75.00	154.86	58.37	46.99	59.33	54.60	94.00
X-ray exam of wrist	73110	26	1.08%	0.31%	41.24	21.59	16.71	17.46	15.58	33.24	37.00	17.96	13.59	16.01	14.65	38.00	57.00	29.00	15.85	17.28	16.08	38.95
X-ray exam of wrist	73100		1.06%	0.26%	110.57	52.15	34.23	47.89	42.41	86.38	125.00	53.00	30.57	51.59	42.94	87.00	144.00	54.12	43.59	56.00	51.38	98.80
X-ray exam of finger(s)	73140		1.02%	0.25%	96.52	45.13	34.06	42.98	38.28	61.20	109.00	48.70	42.55	47.57	40.01	57.50	124.00	50.64	44.16	55.00	47.31	73.00
Electric stimulation therapy	97014		1.22%	0.15%	43.78	14.91	17.73	19.75	15.85	23.47	47.00	14.53	20.00	18.87	14.63	25.00	50.00	15.00	20.95	20.07	15.54	29.00
Methylprednisolone 40 MG inj	J1030		1.09%	0.06%	18.06	7.82	8.73	9.01	5.75	9.30	17.00	5.79	5.06	5.36	4.31	6.08	23.00	11.97	10.12	10.00	6.95	12.42
Hot or cold packs therapy	97010		0.011073925	0.000486685	27.1046748	8.143092144	9.480886076	9.594641265	9.042416439	16.42080121	32	4.98	6.21	8.5	5.51	15	40	10.93	12	10.08	12.9	21.5

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-17
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Orthopedics

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		13.31%	7.16%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	598.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Office/outpatient visit, new	99203		5.13%	4.19%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Knee arthroscopy/surgery	29881		0.70%	3.47%	Not Cred	1,774.77	1,257.68	1,521.07	1,598.77	2,241.71	Not Cred	1,780.00	1,522.17	1,556.00	1,554.54	1,694.00	Not Cred	2,375.00	1,623.00	1,852.00	2,048.00	4,011.00
Office/outpatient visit, est	99214		4.16%	3.36%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Office consultation	99243		3.07%	3.35%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Total knee arthroplasty	27447		0.32%	2.93%	8,294.36	3,906.99	4,104.48	4,120.43	4,446.71	5,388.93	8,752.00	4,391.00	3,920.96	4,290.00	4,245.00	4,235.00	9,500.00	5,400.00	5,441.00	4,845.00	5,781.00	8,886.00
Drain/inject, joint/bursa	20610		3.80%	2.39%	274.73	146.86	130.14	167.04	163.20	162.33	281.00	150.00	129.00	173.50	161.00	161.00	305.00	200.00	183.57	211.00	201.00	204.00
Therapeutic exercises	97110		5.27%	2.37%	64.21	35.07	47.83	50.70	47.75	39.57	65.00	35.00	48.00	52.00	48.00	40.00	81.00	40.00	50.00	59.00	55.00	50.00
Mri jnt of lwr extre w/o dye	73721	26	0.47%	2.22%	295.90	199.14	184.96	194.45	206.14	209.08	298.00	189.20	172.00	215.00	201.40	250.00	345.00	240.00	205.00	231.00	241.00	279.00
Office/outpatient visit, new	99204		1.51%	1.88%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Office consultation	99244		1.11%	1.78%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Office/outpatient visit, est	99212		5.31%	1.77%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Shoulder arthroscopy/surgery	29826		0.38%	1.77%	Not Cred	2,151.15	Not Cred	1,691.24	1,724.00	Not Cred	Not Cred	2,395.72	Not Cred	1,762.00	1,587.00	Not Cred	Not Cred	2,708.21	Not Cred	2,045.00	2,156.00	Not Cred
Knee arthroscopy/surgery	29888		0.29%	1.74%	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data
Total hip arthroplasty	27130		0.19%	1.55%	Not Cred	4,415.65	3,590.95	3,774.76	4,296.83	4,175.47	Not Cred	4,991.00	3,586.00	3,941.00	4,019.80	4,302.00	Not Cred	5,800.00	3,778.00	4,378.00	5,409.00	5,473.00
Knee arthroscopy/surgery	29877		0.27%	1.28%	No Data	Not Cred	Not Cred	No Data	1,420.39	Not Cred	No Data	Not Cred	Not Cred	No Data	1,478.52	Not Cred	No Data	Not Cred	Not Cred	No Data	1,658.00	Not Cred
Knee arthroscopy/surgery	29880		0.20%	1.05%	Not Cred	1,795.16	Not Cred	1,751.62	1,924.49	Not Cred	Not Cred	1,625.75	Not Cred	1,885.38	1,791.00	Not Cred	Not Cred	2,504.50	Not Cred	1,999.85	2,201.00	Not Cred
Office/outpatient visit, new	99202		1.35%	0.75%	140.22	88.61	96.09	119.68	110.48	93.11	150.00	91.00	105.00	127.00	112.00	98.10	177.00	115.00	120.00	151.30	131.00	116.00
Manual therapy	97140		2.18%	0.75%	61.95	35.68	47.24	49.82	45.33	38.27	64.00	35.51	46.25	50.00	45.00	40.00	70.00	44.00	55.00	57.75	50.00	50.00
X-ray exam of knee, 3	73562		1.87%	0.56%	179.43	83.98	74.97	76.82	80.18	90.42	193.00	86.00	70.52	76.88	74.00	73.00	203.75	100.00	80.00	97.00	89.38	145.00
X-ray exam of shoulder	73030	26	1.86%	0.51%	50.02	33.91	29.36	29.81	30.21	26.08	42.00	28.00	28.00	29.00	28.00	15.47	63.00	43.00	31.00	39.00	35.00	46.00
X-ray exam, knee, 4 or more	73564		1.17%	0.40%	178.44	81.98	84.24	86.28	92.91	106.79	193.00	89.00	75.00	89.00	83.75	91.00	214.00	103.57	102.00	106.40	109.00	180.00
X-ray exam of knee, 1 or 2	73560	26	1.53%	0.39%	35.08	29.23	27.24	26.13	28.43	28.79	33.00	26.00	29.00	29.00	27.50	28.00	44.00	37.00	34.00	30.00	34.00	40.24
X-ray exam of ankle	73610	26	1.41%	0.38%	47.75	28.79	27.66	27.10	27.53	25.41	45.00	26.00	28.00	28.25	26.00	32.00	63.00	39.00	34.00	31.00	32.00	38.00
X-ray exam of foot	73630		1.25%	0.34%	101.43	67.56	59.72	66.60	69.23	70.46	115.00	70.35	64.78	65.80	65.00	65.00	159.00	90.58	66.00	90.00	80.00	107.90
X-ray exam of wrist	73110	26	1.08%	0.31%	49.13	31.58	31.96	26.25	29.47	23.73	55.00	26.00	32.00	28.00	26.00	22.75	66.60	37.00	39.00	32.00	36.00	37.00
X-ray exam of wrist	73100		1.06%	0.26%	126.89	77.12	No Data	54.90	66.47	Not Cred	125.00	72.00	No Data	58.00	62.00	Not Cred	137.00	149.00	No Data	72.00	75.00	Not Cred
X-ray exam of finger(s)	73140		1.02%	0.25%	Not Cred	62.83	Not Cred	51.80	66.04	89.36	Not Cred	66.38	Not Cred	55.00	61.00	59.00	Not Cred	80.09	Not Cred	66.00	76.03	80.00
Electric stimulation therapy	97014		1.22%	0.15%	40.03	16.27	16.88	21.62	24.31	18.10	40.00	15.10	18.00	20.00	20.00	15.00	47.00	20.00	22.00	30.00	31.00	20.00
Methylprednisolone 40 MG inj	J1030		1.09%	0.06%	20.13	12.13	12.24	15.50	14.95	21.69	22.00	10.00	10.00	11.00	10.00	20.00	22.00	15.00	15.60	19.00	13.00	30.00
Hot or cold packs therapy	97010		0.011073925	0.000486685	25.06521739	16.12978723	Not Cred		11.32696498	16.59119277	12.23248705	25	15	Not Cred		10	15	10	30	20	Not Cred		15	20	17.06

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-18
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Pediatrics

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Medicare [1]								TRICARE [2]							
					AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		20.03%	26.40%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Office/outpatient visit, est	99214		5.44%	10.74%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Prev visit, est, age 1-4	99392		3.24%	5.71%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	156.60	83.64	82.47	86.55	84.38	90.46	85.85	83.54
Per pm reeval, est pat, inf	99391		3.31%	5.23%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	139.73	75.09	74.02	77.85	75.80	81.45	77.14	74.91
Pneumococcal vacc, ped <5, IM	90669		2.52%	4.38%	95.48	95.48	95.48	95.48	95.48	95.48	95.48	95.48	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Prev visit, est, age 5-11	99393		1.97%	3.44%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	156.04	83.29	82.13	86.18	84.02	90.06	85.48	83.20
Immunization admin	90471		6.76%	3.07%	27.44	21.99	22.92	23.24	22.40	24.81	22.87	23.12	36.58	20.72	20.35	21.80	21.02	23.02	21.47	20.52
Prev visit, est, age 12-17	99394		1.27%	2.43%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	172.58	91.64	90.44	94.70	92.42	98.82	93.94	91.51
Chicken pox vaccine, sc	90716		1.16%	1.95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dtap vaccine, < 7 yo, im	90700		2.39%	1.67%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Office/outpatient visit, est	99212		1.74%	1.42%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Office/outpatient visit, est	99215		0.50%	1.33%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Hep a vacc, ped/adol, 2 dose	90633		2.19%	1.29%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Immune admin 1 inj, < 8 yrs	90465		2.46%	1.12%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	36.58	20.72	20.35	21.80	21.02	23.02	21.47	20.52
Poliovirus, ipv, sc/im	90713		1.90%	1.08%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Strep a assay w/optic	87880		2.37%	0.85%	16.88	16.40	16.88	16.88	16.88	16.88	16.88	16.88	20.66	15.74	15.42	15.61	15.61	14.33	14.44	15.76
Immunization admin, each add	90472		3.69%	0.85%	14.54	11.06	11.37	11.51	11.20	12.18	11.42	11.57	19.82	10.59	10.43	10.95	10.68	11.47	10.88	10.61
Immune admin addl inj, < 8 y	90466		1.83%	0.40%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	19.82	10.59	10.43	10.95	10.68	11.47	10.88	10.61
Flu vaccine age 3 yo & over, im	90658		1.21%	0.35%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Visual acuity screen	99173		3.27%	0.19%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	15.95	9.82	9.38	10.40	9.91	11.43	10.49	10.17

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-18
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Pediatrics

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		20.03%	26.40%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Office/outpatient visit, est	99214		5.44%	10.74%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Prev visit, est, age 1-4	99392		3.24%	5.71%	227.40	N/A	N/A	N/A	N/A	N/A	139.24	102.99	119.50	65.66	71.35	N/A	171.92	169.91	160.42	177.08	Not Covered	N/A
Per pm reeval, est pat, inf	99391		3.31%	5.23%	203.38	N/A	N/A	N/A	N/A	N/A	124.24	89.46	107.23	58.98	62.30	N/A	161.80	152.71	144.32	159.99	Not Covered	N/A
Pneumococcal vacc, ped <5, IM	90669		2.52%	4.38%	52.19	95.48	95.48	95.48	95.48	95.48	N/A	78.80	N/A	N/A	N/A	N/A	126.91	N/A	N/A	80% of billed	89.78	N/A
Prev visit, est, age 5-11	99393		1.97%	3.44%	224.33	N/A	N/A	N/A	N/A	N/A	138.74	102.60	118.97	65.38	75.34	N/A	187.09	169.27	159.81	176.39	Not Covered	N/A
Immunization admin	90471		6.76%	3.07%	10.39	21.99	22.92	23.24	24.81	23.12	32.51	19.07	13.90	16.41	13.12	10.00	35.87	30.42	42.12	43.22	38.18	N/A
Prev visit, est, age 12-17	99394		1.27%	2.43%	248.31	N/A	N/A	N/A	N/A	N/A	153.75	116.24	130.71	71.78	82.58	N/A	202.26	185.43	174.67	193.49	Not Covered	N/A
Chicken pox vaccine, sc	90716		1.16%	1.95%	183.18	N/A	N/A	N/A	N/A	N/A	N/A	77.33	N/A	92.57	N/A	N/A	146.91	N/A	N/A	80% of billed	89.66	N/A
Dtap vaccine, < 7 yo, im	90700		2.39%	1.67%	66.52	N/A	N/A	N/A	N/A	N/A	N/A	17.58	N/A	N/A	N/A	N/A	48.29	N/A	N/A	80% of billed	Not Covered	N/A
Office/outpatient visit, est	99212		1.74%	1.42%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Office/outpatient visit, est	99215		0.50%	1.33%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Hep a vacc, ped/adol, 2 dose	90633		2.19%	1.29%	88.01	N/A	N/A	N/A	N/A	N/A	N/A	25.15	N/A	N/A	N/A	N/A	67.60	N/A	N/A	80% of billed	Not Covered	N/A
Immune admin 1 inj, < 8 yrs	90465		2.46%	1.12%	69.45	N/A	N/A	N/A	N/A	N/A	32.51	19.07	13.90	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Poliovirus, ipv, sc/im	90713		1.90%	1.08%	69.59	N/A	N/A	N/A	N/A	N/A	N/A	26.52	26.29	28.13	N/A	N/A	63.46	N/A	N/A	80% of billed	53.30	N/A
Strep a assay w/optic	87880		2.37%	0.85%	50.15	16.40	16.88	16.88	16.88	16.88	17.18	16.28	17.18	12.71	13.06	N/A	89.05	TBD	42.20	80% of billed	23.63	N/A
Immunization admin, each add	90472		3.69%	0.85%	15.40	11.06	11.37	11.51	12.18	11.57	17.63	9.75	11.02	8.35	6.67	N/A	35.87	15.30	21.06	21.61	18.82	N/A
Immune admin addl inj, < 8 y	90466		1.83%	0.40%	41.11	N/A	N/A	N/A	N/A	N/A	17.63	7.52	11.02	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Flu vaccine age 3 yo & over, im	90658		1.21%	0.35%	14.46	N/A	N/A	N/A	N/A	N/A	15.56	13.22	11.34	11.36	N/A	N/A	18.61	N/A	N/A	80% of billed	22.10	N/A
Visual acuity screen	99173		3.27%	0.19%	26.83	N/A	N/A	N/A	N/A	N/A	3.30	26.32	3.20	1.95	Bundled	N/A	53.44	4.91	4.96	5.08	Bundled	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-18
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Pediatrics

Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	Commercial Allowed [6] Mean AK	ID	ND	OR	WA	WY	Median AK	ID	ND	OR	WA	WY	80th Percentile AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		20.03%	26.40%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Office/outpatient visit, est	99214		5.44%	10.74%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Prev visit, est, age 1-4	99392		3.24%	5.71%	178.30	123.31	112.75	151.48	127.82	114.55	183.00	120.96	115.41	149.44	120.96	116.57	195.00	133.82	115.41	158.01	146.72	125.00
Per prn reeval, est pat, inf	99391		3.31%	5.23%	170.54	110.09	100.73	135.60	114.81	105.25	180.00	107.80	103.53	134.07	109.03	108.51	189.15	119.26	103.53	141.08	131.72	120.00
Pneumococcal vacc, ped <5, IM	90669		2.52%	4.38%	47.19	27.72	85.09	98.00	12.52	37.16	18.89	0.01	88.96	95.48	5.96	14.31	99.84	86.69	88.96	116.00	15.60	95.48
Prev visit, est, age 5-11	99393		1.97%	3.44%	174.56	121.04	110.09	151.03	127.10	112.03	188.00	119.95	114.92	149.44	120.64	114.00	195.00	132.70	114.92	158.92	146.28	128.00
Immunization admin	90471		6.76%	3.07%	26.62	21.70	23.10	31.49	23.59	17.23	26.00	19.00	24.63	35.00	25.00	14.31	32.00	30.14	24.63	41.62	30.45	22.90
Prev visit, est, age 12-17	99394		1.27%	2.43%	155.91	117.79	98.70	162.96	135.21	98.63	188.10	130.38	118.95	163.48	131.76	110.00	210.00	144.90	126.31	176.90	159.25	136.80
Chicken pox vaccine, sc	90716		1.16%	1.95%	72.34	31.51	86.14	89.94	14.45	36.31	85.00	0.01	91.58	90.49	5.96	14.31	105.00	89.49	93.98	98.91	15.60	90.21
Dtap vaccine, < 7 yo, im	90700		2.39%	1.67%	13.77	8.53	19.35	26.18	8.55	16.04	15.00	0.01	19.73	23.58	6.38	14.00	27.00	22.99	20.29	31.45	15.60	25.00
Office/outpatient visit, est	99212		1.74%	1.42%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Office/outpatient visit, est	99215		0.50%	1.33%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Hep a vacc, ped/adol, 2 dose	90633		2.19%	1.29%	31.65	10.59	26.53	33.46	9.45	18.46	30.77	0.01	28.80	31.49	6.00	14.31	41.14	31.04	29.41	34.86	15.60	34.69
Immune admin 1 inj, < 8 yrs	90465		2.46%	1.12%	28.19	23.76	23.73	35.70	23.83	15.04	30.00	27.76	24.63	37.00	27.00	14.31	32.00	30.00	24.63	42.09	30.22	14.31
Poliovirus, ipv, sc/im	90713		1.90%	1.08%	31.76	11.73	27.64	30.91	10.06	16.02	32.96	0.01	30.88	29.65	8.00	14.00	49.00	28.85	32.40	33.15	15.60	28.51
Strep a assay w/optic	87880		2.37%	0.85%	44.87	23.63	33.38	22.42	18.79	26.55	49.00	23.12	34.34	23.46	17.52	27.00	64.00	24.85	34.34	24.13	20.11	35.00
Immunization admin, each add	90472		3.69%	0.85%	22.91	13.41	12.81	18.65	15.10	14.25	25.00	14.34	12.31	19.32	15.24	14.31	26.00	16.00	12.31	20.16	16.40	14.31
Immune admin addl inj, < 8 y	90466		1.83%	0.40%	21.99	14.06	13.51	19.04	15.21	14.43	20.50	15.00	12.31	19.43	14.98	14.03	27.00	16.14	12.56	20.01	15.66	14.31
Flu vaccine age 3 yo & over, im	90658		1.21%	0.35%	20.88	13.71	14.06	15.34	13.55	15.07	20.00	13.88	12.29	14.21	14.21	13.94	28.00	16.00	15.00	16.53	15.58	19.74
Visual acuity screen	99173		3.27%	0.19%	13.36	5.01	5.66	6.03	4.57	4.99	15.00	3.38	3.58	4.83	3.92	3.01	16.00	4.00	14.00	5.67	4.37	5.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clair

Appendix A-18
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Pediatrics

					Billed Charges[5]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		20.03%	26.40%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	$98.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Office/outpatient visit, est	99214		5.44%	10.74%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Prev visit, est, age 1-4	99392		3.24%	5.71%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Per prn reeval, est pat, inf	99391		3.31%	5.23%	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data
Pneumococcal vacc, ped <5, IM	90669		2.52%	4.38%	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data
Prev visit, est, age 5-11	99393		1.97%	3.44%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Immunization admin	90471		6.76%	3.07%	27.07	27.47	31.90	34.76	32.20	23.54	25.00	30.00	32.00	38.00	32.00	22.50	36.00	36.25	38.00	46.50	42.00	28.15
Prev visit, est, age 12-17	99394		1.27%	2.43%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Chicken pox vaccine, sc	90716		1.16%	1.95%	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data	No Data	No Data	No Data	Not Cred	Not Cred	No Data
Dtap vaccine, < 7 yo, im	90700		2.39%	1.67%	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data
Office/outpatient visit, est	99212		1.74%	1.42%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Office/outpatient visit, est	99215		0.50%	1.33%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Hep a vacc, ped/adol, 2 dose	90633		2.19%	1.29%	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred	No Data	No Data	Not Cred
Immune admin 1 inj, < 8 yrs	90465		2.46%	1.12%	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data
Poliovirus, ipv, sc/im	90713		1.90%	1.08%	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data	No Data	Not Cred	No Data	Not Cred	Not Cred	No Data
Strep a assay w/optic	87880		2.37%	0.85%	Not Cred	32.88	41.83	29.23	37.17	30.74	Not Cred	30.00	46.50	29.00	35.30	29.10	Not Cred	45.00	50.00	36.00	51.00	35.00
Immunization admin, each add	90472		3.69%	0.85%	Not Cred	18.02	16.10	19.99	20.97	Not Cred	Not Cred	18.13	18.00	21.00	19.50	Not Cred	Not Cred	21.50	20.00	25.00	25.00	Not Cred
Immune admin addl inj, < 8 y	90466		1.83%	0.40%	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Flu vaccine age 3 yo & over, im	90658		1.21%	0.35%	16.04	15.50	14.66	16.15	16.31	14.83	13.22	13.50	13.55	13.25	13.22	13.21	23.05	20.00	16.00	20.00	20.00	18.00
Visual acuity screen	99173		3.27%	0.19%	No Data	Not Cred	No Data	Not Cred	24.59	Not Cred	No Data	Not Cred	No Data	Not Cred	20.00	Not Cred	No Data	Not Cred	No Data	Not Cred	45.00	Not Cred

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-19
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Radiology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Mri brain w/o & w/dye	70553	26	1.22%	6.64%	$159.35	$113.98	$115.30	$116.49	$114.66	$121.71	$116.51	$118.15	$233.34	$118.21	$117.00	$120.37	$118.62	$124.45	$120.18	$118.82
Mri jnt of lwr extre w/o dye	73721	26	1.27%	5.24%	91.78	65.75	66.43	67.18	66.13	70.34	67.34	68.47	133.88	67.86	67.10	69.06	68.06	71.50	69.06	68.38
Mammogram, screening	77057	26	6.70%	4.55%	47.32	33.85	34.25	34.60	34.06	36.14	34.59	35.07	69.29	35.10	34.74	35.75	35.22	36.96	35.69	35.29
Mri lumbar spine w/o dye	72148	26	1.14%	4.48%	100.26	71.77	72.55	73.33	72.19	76.71	73.44	74.58	146.76	74.39	73.59	75.74	74.63	78.37	75.67	74.87
Ct pelvis w/dye	72193	26	2.23%	3.10%	78.47	56.15	56.80	57.39	56.49	59.97	57.41	58.22	115.12	58.36	57.76	59.44	58.57	61.47	59.35	58.67
Ct abdomen w/dye	74160	26	2.11%	3.10%	85.93	61.49	62.23	62.86	61.87	65.65	62.83	63.66	125.89	63.81	63.18	65.00	64.05	67.19	64.86	64.09
Mri neck spine w/o dye	72141	26	0.71%	2.69%	108.23	77.45	78.33	79.15	77.91	82.74	79.20	80.36	158.31	80.21	79.38	81.67	80.48	84.45	81.56	80.65
Screeningmammographydigital	G0202	26	2.43%	2.58%	47.32	33.85	34.25	34.60	34.06	36.14	34.59	35.07	68.71	34.75	34.40	35.37	34.87	36.56	35.32	34.95
Mri joint upr extrem w/o dye	73221	26	0.57%	2.34%	92.15	66.07	66.77	67.52	66.46	70.72	67.68	68.81	133.88	67.86	67.10	69.06	68.06	71.50	69.06	68.38
Ct abdomen w/o & w/dye	74170	26	0.81%	2.10%	94.63	67.70	68.50	69.20	68.12	72.29	69.19	70.13	139.10	70.54	69.82	71.86	70.79	74.31	71.74	70.91
Ct head/brain w/o dye	70450	26	2.23%	1.81%	57.19	40.87	41.39	41.79	41.13	43.58	41.71	42.20	84.27	42.71	42.31	43.53	42.88	44.97	43.40	42.85
Mri brain w/o dye	70551	26	0.52%	1.77%	99.82	71.38	72.24	72.97	71.82	76.18	72.92	73.87	146.43	74.19	73.45	75.56	74.46	78.10	75.42	74.54
Ct thorax w/dye	71260	26	1.07%	1.71%	84.03	60.15	60.88	61.50	60.52	64.24	61.47	62.30	123.00	62.36	61.74	63.53	62.59	65.67	63.39	62.64
Ct abdomen w/o dye	74150	26	1.40%	1.70%	80.37	57.49	58.16	58.76	57.84	61.39	58.76	59.58	118.01	59.82	59.21	60.93	60.04	63.00	60.82	60.12
Chest x-ray	71020	26	8.15%	1.67%	14.77	10.55	10.69	10.79	10.62	11.25	10.77	10.89	21.87	11.09	10.97	11.30	11.13	11.69	11.28	11.16
Ct maxillofacial w/o dye	70486	26	0.91%	1.65%	77.01	55.08	55.81	56.34	55.44	58.75	56.20	56.83	112.69	57.08	56.55	58.16	57.31	60.07	58.00	57.27
Ct pelvis w/o dye	72192	26	1.37%	1.59%	73.35	52.42	53.09	53.60	52.76	55.90	53.49	54.11	108.25	54.89	54.37	55.94	55.11	57.80	55.79	55.09
Us exam, pelvic, complete	76856	26	1.76%	1.51%	46.59	33.32	33.76	34.08	33.53	35.53	33.99	34.37	68.17	34.53	34.23	35.20	34.68	36.32	35.06	34.59
Us exam, abdom, complete	76700	26	1.51%	1.48%	54.41	38.87	39.35	39.73	39.11	41.45	39.68	40.16	80.05	40.55	40.16	41.31	40.70	42.67	41.20	40.70
Mri lumbar spine w/o & w/dye	72158	26	0.23%	1.37%	159.79	114.37	115.60	116.86	115.03	122.24	117.03	118.86	234.01	118.61	117.29	120.72	118.97	124.97	120.69	119.48
Us exam, breast(s)	76645	26	2.02%	1.33%	36.56	26.17	26.44	26.73	26.32	27.99	26.80	27.25	53.49	27.11	26.80	27.58	27.18	28.57	27.60	27.34
Transvaginal us, non-ob	76830	26	1.51%	1.28%	46.59	33.32	33.76	34.08	33.53	35.53	33.99	34.37	67.61	34.18	33.89	34.82	34.32	35.92	34.70	34.25
Mammogram, both breasts	77056	26	1.22%	1.04%	58.80	42.07	42.56	43.00	42.32	44.91	42.99	43.58	86.13	43.65	43.18	44.44	43.79	45.97	44.39	43.91
Mammogram, one breast	77055	26	1.03%	0.67%	47.32	33.85	34.25	34.60	34.06	36.14	34.59	35.07	69.29	35.10	34.74	35.75	35.22	36.96	35.69	35.29
Chest x-ray	71010	26	4.61%	0.58%	11.99	8.55	8.65	8.73	8.60	9.12	8.73	8.85	17.65	8.92	8.82	9.07	8.95	9.39	9.08	9.00
Comp screen mammogram add-on	77052	26	4.46%	0.47%	4.02	2.87	2.87	2.92	2.88	3.09	2.97	3.08	6.10	3.11	3.04	3.14	3.10	3.31	3.20	3.22
X-ray exam of foot	73630		1.40%	0.27%	36.93	30.19	31.57	32.05	30.81	34.40	31.55	31.97	49.84	28.90	28.31	30.58	29.36	32.48	30.09	28.65
Computer dx mammogram add-on	77051	26	2.21%	0.24%	4.02	2.87	2.87	2.92	2.88	3.09	2.97	3.08	6.10	3.11	3.04	3.14	3.10	3.31	3.20	3.22
X-ray exam of ankle	73610	26	1.22%	0.22%	11.48	8.21	8.31	8.39	8.26	8.77	8.39	8.51	16.87	8.55	8.45	8.70	8.58	9.02	8.71	8.63
X-ray exam of abdomen	74000	26	1.28%	0.20%	11.99	8.55	8.65	8.73	8.60	9.12	8.73	8.85	17.65	8.92	8.82	9.07	8.95	9.39	9.08	9.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-19
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Radiology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Mri brain w/o & w/dye	70553	26	1.22%	6.64%	$394.10	$113.98	$115.30	$116.49	$121.71	$118.15	$207.98	$100.14	$160.89	$91.81	$72.47	N/A	$826.63	$294.28	$214.93	$219.48	$192.03	N/A
Mri jnt of lwr extre w/o dye	73721	26	1.27%	5.24%	314.48	65.75	66.43	67.18	70.34	68.47	119.04	66.40	93.02	52.86	41.79	N/A	425.65	169.76	124.50	127.40	111.23	N/A
Mammogram, screening	77057	26	6.70%	4.55%	83.03	33.85	34.25	34.60	36.14	35.07	61.59	31.92	47.93	27.26	21.56	N/A	N/A	87.40	63.80	64.96	57.00	N/A
Mri lumbar spine w/o dye	72148	26	1.14%	4.48%	320.70	71.77	72.55	73.33	76.71	74.58	130.49	72.79	101.56	57.87	45.79	N/A	569.15	185.30	135.65	138.12	121.19	N/A
Ct pelvis w/dye	72193	26	2.23%	3.10%	253.32	56.15	56.80	57.39	59.97	58.22	102.36	57.11	79.26	45.35	35.79	N/A	309.54	144.97	105.92	107.85	94.63	N/A
Ct abdomen w/dye	74160	26	2.11%	3.10%	255.73	61.49	62.23	62.86	65.65	63.66	111.94	65.33	86.85	49.52	39.12	N/A	342.38	158.76	115.83	117.94	103.49	N/A
Mri neck spine w/o dye	72141	26	0.71%	2.69%	336.56	77.45	78.33	79.15	82.74	80.36	141.05	78.48	109.63	62.32	49.13	N/A	549.18	199.96	146.18	148.85	130.60	N/A
Screeningmammographydigital	G0202	26	2.43%	2.58%	95.87	33.85	34.25	34.60	36.14	35.07	N/A	32.84	N/A	26.99	21.34	N/A	N/A	68.25	63.80	N/A	57.00	N/A
Mri joint upr extrem w/o dye	73221	26	0.57%	2.34%	176.77	66.07	66.77	67.52	70.72	68.81	119.04	66.40	93.50	52.86	41.79	N/A	404.37	170.59	125.12	127.40	111.79	N/A
Ct abdomen w/o & w/dye	74170	26	0.81%	2.10%	185.60	67.70	68.50	69.20	72.29	70.13	123.68	71.82	95.87	54.81	43.35	N/A	410.46	174.80	127.60	129.92	114.00	N/A
Ct head/brain w/o dye	70450	26	2.23%	1.81%	112.92	40.87	41.39	41.79	43.58	42.20	75.22	41.79	57.90	33.11	26.23	N/A	276.04	105.52	76.81	78.21	68.62	N/A
Mri brain w/o dye	70551	26	0.52%	1.77%	340.22	71.38	72.24	72.97	76.18	73.87	130.19	72.59	101.09	57.59	45.57	N/A	598.79	184.30	134.41	136.86	120.09	N/A
Ct thorax w/dye	71260	26	1.07%	1.71%	163.53	60.15	60.88	61.50	64.24	62.30	109.37	61.02	84.95	48.41	38.24	N/A	328.40	155.30	113.35	115.42	101.27	N/A
Ct abdomen w/o dye	74150	26	1.40%	1.70%	156.83	57.49	58.16	58.76	61.39	59.58	104.93	50.53	81.16	46.46	36.68	N/A	297.44	148.43	108.40	110.37	96.85	N/A
Chest x-ray	71020	26	8.15%	1.67%	31.08	10.55	10.69	10.79	11.25	10.89	19.45	10.85	14.71	8.62	6.89	7.88	71.76	27.24	19.82	20.18	17.71	N/A
Ct maxillofacial w/o dye	70486	26	0.91%	1.65%	151.16	55.08	55.81	56.34	58.75	56.83	100.19	58.94	77.83	44.23	35.12	N/A	292.10	142.21	103.44	105.33	92.42	N/A
Ct pelvis w/o dye	72192	26	1.37%	1.59%	144.47	52.42	53.09	53.60	55.90	54.11	96.54	53.71	74.04	42.56	33.79	N/A	268.93	135.35	98.48	100.91	87.99	N/A
Us exam, pelvic, complete	76856	26	1.76%	1.51%	91.87	33.32	33.76	34.08	35.53	34.37	60.90	41.59	46.99	26.71	21.12	N/A	225.59	86.02	62.56	63.70	55.89	N/A
Us exam, abdom, complete	76700	26	1.51%	1.48%	108.18	38.87	39.35	39.73	41.45	40.16	71.17	44.71	55.05	31.44	24.90	N/A	224.47	100.36	73.09	74.42	65.30	N/A
Mri lumbar spine w/o & w/dye	72158	26	0.23%	1.37%	313.90	114.37	115.60	116.86	122.24	118.86	208.07	116.06	161.36	92.36	72.91	N/A	785.49	295.28	216.17	220.11	192.58	N/A
Us exam, breast(s)	76645	26	2.02%	1.33%	71.79	26.17	26.44	26.73	27.99	27.25	47.57	33.23	37.02	21.14	16.67	N/A	149.39	67.57	49.55	50.46	44.27	N/A
Transvaginal us, non-ob	76830	26	1.51%	1.28%	91.87	33.32	33.76	34.08	35.53	34.37	60.11	41.46	46.99	26.43	20.90	N/A	257.81	86.02	62.56	63.70	55.89	N/A
Mammogram, both breasts	77056	26	1.22%	1.04%	102.81	42.07	42.56	43.00	44.91	43.58	76.60	41.13	59.33	33.94	26.90	N/A	N/A	108.60	79.28	80.73	70.84	N/A
Mammogram, one breast	77055	26	1.03%	0.67%	83.03	33.85	34.25	34.60	36.14	35.07	61.59	33.32	47.93	27.26	21.56	N/A	N/A	87.40	63.80	64.96	57.00	N/A
Chest x-ray	71010	26	4.61%	0.58%	23.93	8.55	8.65	8.73	9.12	8.85	15.69	8.73	11.87	6.96	5.56	N/A	61.88	22.08	16.10	16.40	14.39	N/A
Comp screen mammogram add-on	77052	26	4.46%	0.47%	7.55	2.87	2.87	2.92	3.09	3.08	5.43	3.04	3.80	2.50	2.00	N/A	N/A	7.42	5.57	5.68	Not Covered	N/A
X-ray exam of foot	73630		1.40%	0.27%	103.98	30.19	31.57	32.05	34.40	31.97	44.32	27.30	41.08	23.09	18.45	N/A	181.81	77.96	15.49	59.29	52.57	N/A
Computer dx mammogram add-on	77051	26	2.21%	0.24%	7.55	2.87	2.87	2.92	3.09	3.08	5.43	3.04	3.80	2.50	2.00	N/A	N/A	7.42	5.57	5.68	Not Covered	N/A
X-ray exam of ankle	73610	26	1.22%	0.22%	28.62	8.21	8.31	8.39	8.77	8.51	15.00	8.74	11.39	6.68	5.34	N/A	72.72	21.20	15.49	15.77	13.84	N/A
X-ray exam of abdomen	74000	26	1.28%	0.20%	23.93	8.55	8.65	8.73	9.12	8.85	15.69	8.73	11.87	6.96	5.56	N/A	60.80	22.08	16.10	16.40	14.39	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-19
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Radiology

					Commercial Allowed [6]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Mri brain w/o & w/dye	70553	26	1.22%	6.64%	$407.64	$285.48	$226.64	$223.92	$204.41	$360.82	$441.00	$244.51	$188.51	$213.53	$203.31	$379.76	$461.00	$404.58	$204.98	$229.43	$214.00	$495.90
Mri jnt of lwr extre w/o dye	73721	26	1.27%	5.24%	283.63	155.22	119.56	126.44	116.51	252.78	298.00	139.45	107.56	122.30	113.05	279.00	298.00	192.00	113.17	133.21	123.42	300.00
Mammogram, screening	77057	26	6.70%	4.55%	82.01	62.98	56.62	64.68	56.91	66.07	91.00	70.92	56.04	64.99	56.69	52.00	96.00	74.35	57.16	67.42	63.75	83.00
Mri lumbar spine w/o dye	72148	26	1.14%	4.48%	315.31	174.76	133.52	140.13	129.81	264.60	298.00	153.51	118.31	134.79	128.01	276.16	365.00	200.00	130.57	146.88	135.13	333.00
Ct pelvis w/dye	72193	26	2.23%	3.10%	223.47	141.94	106.49	111.53	102.01	179.32	226.00	123.17	92.84	105.46	99.82	204.09	246.80	173.05	101.30	115.02	105.66	225.00
Ct abdomen w/dye	74160	26	2.11%	3.10%	246.69	158.75	118.15	122.26	112.66	205.24	250.00	135.71	102.46	115.94	111.01	223.84	288.00	206.64	110.69	123.90	116.74	257.00
Mri neck spine w/o dye	72141	26	0.71%	2.69%	324.62	188.63	145.29	153.57	138.63	262.31	312.00	165.69	127.37	144.76	137.50	276.16	389.00	232.50	134.48	156.63	145.31	333.00
Screeningmammographydigital	G0202	26	2.43%	2.58%	115.21	68.16	57.41	64.10	59.58	54.36	129.00	63.00	54.91	64.00	60.24	48.72	129.00	74.35	56.70	69.60	63.83	70.00
Mri joint upr extrem w/o dye	73221	26	0.57%	2.34%	312.73	161.71	125.83	126.44	117.94	244.33	323.00	139.45	107.56	124.18	113.18	279.00	388.29	217.86	125.51	133.21	124.50	296.00
Ct abdomen w/o & w/dye	74170	26	0.81%	2.10%	253.03	160.79	130.11	145.34	123.76	250.28	273.00	145.45	112.09	130.07	123.90	271.63	289.00	178.20	121.08	140.65	129.33	281.20
Ct head/brain w/o dye	70450	26	2.23%	1.81%	174.25	103.71	77.37	83.73	74.72	147.53	183.00	88.35	68.50	77.59	73.13	160.00	199.00	131.00	74.28	84.49	77.34	187.00
Mri brain w/o dye	70551	26	0.52%	1.77%	295.17	178.21	150.27	137.97	127.38	244.34	298.00	153.51	118.32	134.28	127.50	240.63	322.00	244.50	130.93	142.43	135.56	333.00
Ct thorax w/dye	71260	26	1.07%	1.71%	257.23	149.90	120.14	119.54	108.96	215.55	263.00	128.35	99.07	112.20	108.65	225.95	263.00	189.27	117.52	122.41	113.52	267.00
Ct abdomen w/o dye	74150	26	1.40%	1.70%	220.78	144.27	112.66	111.42	103.96	204.89	231.00	123.73	95.10	108.08	101.17	215.00	248.00	192.00	110.98	117.86	108.08	243.00
Chest x-ray	71020	26	8.15%	1.67%	43.55	26.15	19.52	21.06	19.22	38.25	43.00	22.50	17.55	19.65	18.83	42.00	54.00	32.00	17.90	21.30	19.94	45.60
Ct maxillofacial w/o dye	70486	26	0.91%	1.65%	203.07	130.98	103.45	104.92	96.85	179.15	221.00	117.73	91.14	102.84	97.50	199.70	221.00	145.37	106.34	109.35	103.12	225.00
Ct pelvis w/o dye	72192	26	1.37%	1.59%	204.82	131.62	98.07	104.32	94.52	181.83	213.00	113.11	87.75	99.28	92.22	206.00	233.00	162.00	95.05	108.63	99.15	208.00
Us exam, pelvic, complete	76856	26	1.76%	1.51%	143.64	85.39	59.31	61.91	60.96	117.88	135.00	71.25	54.91	62.23	59.61	131.40	167.00	121.50	56.74	68.42	64.99	139.00
Us exam, abdom, complete	76700	26	1.51%	1.48%	154.66	101.34	68.65	76.33	72.26	132.42	158.00	83.83	64.54	73.36	70.28	166.00	160.00	152.80	64.54	80.50	74.45	169.10
Mri lumbar spine w/o & w/dye	72158	26	0.23%	1.37%	473.30	279.86	209.75	227.55	199.89	435.40	447.00	244.51	187.95	213.53	203.31	414.00	461.00	442.40	198.38	236.16	214.00	520.00
Us exam, breast(s)	76645	26	2.02%	1.33%	106.87	71.64	49.02	50.71	47.29	97.38	107.00	57.18	43.02	48.47	46.44	117.00	107.00	102.40	43.88	51.83	48.88	121.00
Transvaginal us, non-ob	76830	26	1.51%	1.28%	154.38	84.86	58.77	64.84	61.90	119.04	135.00	72.18	54.35	62.23	59.61	134.62	225.00	129.60	55.44	67.68	66.00	149.00
Mammogram, both breasts	77056	26	1.22%	1.04%	107.53	80.62	72.62	75.60	61.85	89.89	121.00	85.77	69.63	76.56	64.31	83.00	129.79	92.04	73.19	83.08	74.40	89.00
Mammogram, one breast	77055	26	1.03%	0.67%	83.93	66.80	58.22	65.87	55.77	67.50	92.00	70.92	56.04	64.99	57.76	49.00	102.51	74.35	57.16	67.50	63.05	122.40
Chest x-ray	71010	26	4.61%	0.58%	36.84	21.70	16.94	17.94	16.01	25.00	37.00	18.67	14.15	16.45	15.69	27.09	44.00	27.00	15.30	17.99	16.56	35.00
Comp screen mammogram add-on	77052	26	4.46%	0.47%	11.77	6.65	5.36	6.97	6.13	9.30	12.00	4.00	5.10	6.08	5.40	7.00	12.00	7.18	5.33	6.66	6.03	10.78
X-ray exam of foot	73630		1.40%	0.27%	113.88	53.11	36.28	49.93	44.52	73.15	105.00	56.48	33.40	54.37	45.34	75.00	154.86	58.37	46.99	59.33	54.60	94.00
Computer dx mammogram add-on	77051	26	2.21%	0.24%	13.15	12.03	5.35	7.46	7.28	8.83	12.00	9.21	5.10	6.03	5.25	7.00	12.00	12.00	5.20	6.57	6.48	10.44
X-ray exam of ankle	73610	26	1.22%	0.22%	45.98	21.95	15.72	17.10	15.19	30.45	45.00	17.96	13.59	16.01	14.60	34.00	61.00	30.50	14.38	17.28	15.86	35.00
X-ray exam of abdomen	74000	26	1.28%	0.20%	38.50	21.37	17.77	17.25	16.09	25.81	39.00	18.67	14.15	16.44	15.63	27.09	39.00	23.50	15.30	17.75	16.51	35.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-19
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Radiology

					Billed Charges[6]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Mri brain w/o & w/dye	70553	26	1.22%	6.64%	$529.07	$384.67	$325.34	$334.06	$379.68	$298.17	$461.00	$359.00	$342.00	$362.00	$384.00	$334.50	$632.00	$553.00	$342.00	$400.00	$423.00	$442.00
Mri jnt of lwr extre w/o dye	73721	26	1.27%	5.24%	295.90	199.14	184.96	194.45	206.14	209.08	298.00	189.20	172.00	215.00	201.40	250.00	345.00	240.00	205.00	231.00	241.00	279.00
Mammogram, screening	77057	26	6.70%	4.55%	97.07	73.76	66.85	80.39	79.68	52.08	96.00	80.00	66.00	75.00	77.00	37.00	107.36	90.00	74.00	97.00	93.00	56.00
Mri lumbar spine w/o dye	72148	26	1.14%	4.48%	327.69	230.46	207.25	228.17	232.23	217.83	298.00	215.00	215.00	246.03	226.00	242.00	374.00	257.00	224.00	281.00	265.00	303.00
Ct pelvis w/dye	72193	26	2.23%	3.10%	250.61	194.59	157.20	167.94	184.60	141.54	226.00	169.00	164.00	175.00	180.00	167.80	307.00	272.00	166.00	197.50	207.00	208.00
Ct abdomen w/dye	74160	26	2.11%	3.10%	273.97	215.80	180.32	191.74	201.83	162.10	250.00	188.60	180.00	203.21	199.50	183.50	327.00	299.00	191.00	217.00	218.40	252.00
Mri neck spine w/o dye	72141	26	0.71%	2.69%	370.34	263.70	211.59	232.67	257.72	213.12	362.50	251.00	219.00	246.00	259.50	238.00	458.27	313.00	233.20	284.00	281.00	296.00
Screeningmammographydigital	G0202	26	2.43%	2.58%	109.61	82.22	79.11	86.33	97.25	67.84	124.00	79.00	82.45	91.00	98.00	74.00	129.00	88.00	94.00	111.00	111.10	82.45
Mri joint upr extrem w/o dye	73221	26	0.57%	2.34%	314.37	201.55	181.36	200.45	192.07	184.26	323.00	200.00	173.00	219.00	188.00	232.50	398.00	253.00	187.00	225.00	227.00	279.00
Ct abdomen w/o & w/dye	74170	26	0.81%	2.10%	299.24	250.87	183.41	196.75	210.04	168.21	289.00	220.19	180.00	194.00	202.30	165.00	360.00	271.00	210.00	238.56	240.00	244.50
Ct head/brain w/o dye	70450	26	2.23%	1.81%	212.20	146.34	126.55	131.91	137.17	121.69	183.00	133.00	119.00	139.00	137.02	136.30	273.00	200.00	154.00	150.00	150.00	175.50
Mri brain w/o dye	70551	26	0.52%	1.77%	341.13	244.48	211.60	234.65	229.40	165.57	298.00	232.00	205.00	244.00	236.00	75.96	374.00	324.00	230.00	281.00	255.00	260.00
Ct thorax w/dye	71260	26	1.07%	1.71%	282.00	214.71	177.77	182.41	200.05	152.05	263.00	194.00	166.00	193.00	202.00	133.00	325.00	291.00	216.00	220.00	227.00	231.00
Ct abdomen w/o dye	74150	26	1.40%	1.70%	259.14	193.99	164.43	173.24	184.16	146.72	248.00	174.00	164.00	184.00	181.00	155.19	297.00	234.00	178.50	203.00	204.00	215.00
Chest x-ray	71020	26	8.15%	1.67%	49.09	37.03	30.04	32.45	33.55	28.99	43.00	32.50	26.00	34.00	33.00	32.00	56.00	49.28	36.00	38.00	37.20	43.00
Ct maxillofacial w/o dye	70486	26	0.91%	1.65%	198.44	183.31	143.45	149.90	174.32	157.76	221.00	165.00	159.00	148.00	175.00	192.00	221.00	250.00	163.00	185.00	194.40	219.53
Ct pelvis w/o dye	72192	26	1.37%	1.59%	239.65	177.29	145.22	158.27	166.77	132.19	233.00	159.00	151.00	164.00	167.00	153.50	281.00	216.00	156.00	186.00	187.20	191.00
Us exam, pelvic, complete	76856	26	1.76%	1.51%	140.50	113.11	99.28	106.85	105.78	106.14	135.00	100.73	99.00	112.00	106.00	120.00	197.00	124.00	117.00	128.00	117.60	166.00
Us exam, abdom, complete	76700	26	1.51%	1.48%	174.73	134.39	94.88	116.87	124.91	101.58	160.00	121.00	88.00	119.75	125.00	100.00	160.00	191.00	112.00	140.00	138.00	177.69
Mri lumbar spine w/o & w/dye	72158	26	0.23%	1.37%	534.09	373.31	310.19	348.06	366.11	293.30	461.00	333.30	292.67	387.00	361.00	328.00	461.00	438.00	400.00	406.00	402.00	414.00
Us exam, breast(s)	76645	26	2.02%	1.33%	122.33	94.22	73.89	78.90	89.07	74.68	112.00	92.00	68.00	83.00	91.20	83.00	121.00	128.00	98.00	98.00	98.00	117.00
Transvaginal us, non-ob	76830	26	1.51%	1.28%	Not Cred	108.74	94.48	108.97	108.04	100.11	Not Cred	100.00	77.00	114.00	98.00	92.00	Not Cred	137.00	140.00	142.00	121.00	166.00
Mammogram, both breasts	77056	26	1.22%	1.04%	Not Cred	112.00	87.07	97.74	89.07	67.58	Not Cred	107.50	87.00	100.66	88.00	50.69	Not Cred	147.00	94.00	119.00	99.00	85.00
Mammogram, one breast	77055	26	1.03%	0.67%	Not Cred	78.84	69.41	76.35	77.01	49.63	Not Cred	75.00	68.00	75.00	75.00	48.76	Not Cred	90.00	74.00	88.00	93.00	65.00
Chest x-ray	71010	26	4.61%	0.58%	44.30	30.08	26.18	27.43	28.29	22.60	37.00	27.00	23.00	30.00	28.25	25.00	52.00	40.00	31.00	32.00	31.20	35.00
Comp screen mammogram add-on	77052	26	4.46%	0.47%	14.04	10.51	7.90	10.09	12.64	8.48	12.00	9.50	7.00	9.50	10.00	9.00	12.00	16.00	9.00	11.25	15.50	12.00
X-ray exam of foot	73630		1.40%	0.27%	101.43	67.56	59.72	66.60	69.23	70.46	115.00	70.35	64.78	65.80	65.00	65.00	159.00	90.58	66.00	90.00	80.00	107.90
Computer dx mammogram add-on	77051	26	2.21%	0.24%	14.88	17.18	8.65	10.98	12.97	8.61	12.00	15.00	7.00	10.00	10.80	10.90	24.00	16.00	10.00	13.00	15.00	11.00
X-ray exam of ankle	73610	26	1.22%	0.22%	47.75	28.79	27.66	27.10	27.53	25.41	45.00	26.00	28.00	28.25	26.00	32.00	63.00	39.00	34.00	31.00	32.00	38.00
X-ray exam of abdomen	74000	26	1.28%	0.20%	49.00	31.04	26.27	27.66	29.08	21.65	39.00	27.00	25.00	29.03	28.25	24.25	63.00	40.00	32.00	32.00	36.00	33.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-20
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Urology

					Medicare [1]								TRICARE [2]							
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	Portland OR	Rest Of OR	Seattle WA	Rest Of WA	WY	AK	ID	ND	Portland OR	Rest of OR	Seattle WA	Rest of WA	WY
Office/outpatient visit, est	99213		13.79%	7.96%	$87.71	$66.04	$67.67	$68.52	$66.81	$72.42	$68.12	$69.10	$121.23	$64.21	$63.34	$66.28	$64.72	$69.17	$65.82	$64.23
Removal of sperm duct(s)	55250		1.54%	6.77%	510.71	407.35	423.33	429.53	414.61	459.11	424.15	430.04	727.55	412.18	404.76	433.71	418.14	458.31	427.31	408.91
Office consultation	99244		3.29%	5.66%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	349.48	182.66	180.28	187.72	183.81	195.50	186.85	183.17
Office/outpatient visit, est	99214		6.06%	5.26%	130.96	98.08	100.41	101.63	99.18	107.25	101.06	102.45	182.64	96.32	95.07	99.31	97.05	103.52	98.63	96.32
Cystoscopy	52000		2.62%	4.97%	260.82	202.95	209.44	212.44	205.97	226.30	210.74	214.12	371.91	205.14	201.60	214.10	207.46	225.43	211.89	204.62
Office consultation	99243		3.84%	4.51%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	232.06	122.65	120.81	126.37	123.48	132.09	125.83	123.16
Fragmenting of kidney stone	50590		0.78%	4.22%	1,087.25	841.26	867.09	879.29	853.31	935.46	872.64	886.42	1,650.32	911.68	896.16	952.13	922.32	1,002.42	941.71	908.55
Repair bladder defect	57288		0.27%	1.77%	931.10	683.01	691.09	701.21	687.75	742.21	705.92	723.45	1,338.95	693.47	681.88	708.42	695.47	740.43	710.68	703.30
Complex cystometrogram	51726		0.53%	1.76%	357.66	291.77	305.01	309.60	297.70	332.03	304.64	308.47	520.73	302.70	296.96	320.89	307.92	340.31	314.94	298.93
Biopsy of prostate	55700		0.82%	1.75%	286.73	221.83	228.59	231.83	224.99	246.69	230.15	233.88	412.05	226.08	222.27	235.61	228.53	247.83	233.32	225.65
Office/outpatient visit, new	99203		1.86%	1.63%	129.99	98.07	100.35	101.71	99.17	107.79	101.40	103.20	180.25	95.71	94.25	98.75	96.40	103.31	98.27	96.05
Office/outpatient visit, new	99204		1.17%	1.56%	203.11	151.11	154.06	156.09	152.58	164.96	155.92	158.74	284.41	148.94	146.76	152.99	149.78	159.69	152.59	149.84
Prostatic microwave thermotx	53850		0.05%	1.55%	2,691.53	2,223.55	2,332.09	2,367.70	2,271.90	2,543.59	2,324.98	2,352.24	3,904.67	2,299.88	2,254.98	2,446.92	2,342.58	2,599.87	2,397.28	2,266.46
Office/outpatient visit, est	99212		4.28%	1.53%	51.32	39.51	40.71	41.26	40.07	43.82	40.92	41.52	70.24	38.10	37.50	39.59	38.48	41.53	39.23	38.04
Laparo radical prostatectomy	55866		0.14%	1.46%	2,355.82	1,714.02	1,735.19	1,757.63	1,725.71	1,851.35	1,764.07	1,799.91	3,455.23	1,777.18	1,752.14	1,814.51	1,783.25	1,888.68	1,815.90	1,794.89
Cystouretero w/lithotripsy	52353		0.33%	1.33%	578.98	420.43	425.53	430.93	423.24	453.56	432.43	441.00	844.91	434.34	428.30	443.44	435.84	461.42	443.70	438.53
Extensive prostate surgery	55845		0.13%	1.30%	2,230.33	1,619.54	1,638.58	1,659.70	1,630.18	1,747.59	1,666.38	1,700.45	3,252.75	1,671.79	1,648.18	1,706.40	1,677.29	1,776.07	1,708.10	1,688.94
Cystoscopy and treatment	52332		0.80%	1.25%	579.38	474.34	496.32	503.83	484.18	540.61	495.48	501.61	815.26	472.24	463.29	500.06	480.16	530.15	491.14	466.79
Echo guide for biopsy	76942	26	0.81%	1.21%	45.42	32.51	32.89	33.23	32.71	34.73	33.24	33.71	66.39	33.64	33.29	34.26	33.76	35.43	34.21	33.84
Leuprolide acetate suspnsion	J9217		0.19%	1.18%	209.11	209.11	209.11	209.11	209.11	209.11	209.11	209.11	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Electro-uroflowmetry, first	51741		1.41%	1.12%	49.17	40.77	42.78	43.44	41.66	46.72	42.66	43.19	153.85	82.49	81.30	85.45	83.24	89.39	84.73	82.37
Urine voiding pressure study	51795	26	0.34%	1.08%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cystoscopy and treatment	52310		0.48%	1.07%	311.73	241.12	248.41	251.95	244.54	268.15	250.20	254.32	449.11	246.43	242.26	256.81	249.10	270.16	254.34	246.00
Office consultation	99245		0.49%	1.04%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	428.34	223.13	220.20	229.02	224.42	238.44	228.17	224.00
Cystoscopy and treatment	52281		0.37%	1.02%	352.53	278.46	288.54	292.76	283.08	312.56	289.68	294.03	527.66	295.04	289.82	309.20	298.84	326.19	305.33	293.51
Office/outpatient visit, est	99215		0.86%	1.00%	177.40	132.08	135.00	136.62	133.47	144.01	135.96	137.85	248.30	130.18	128.52	133.96	131.08	139.50	133.18	130.32
Us urine capacity measure	51798		2.81%	0.57%	21.37	18.46	19.52	19.86	18.93	21.53	19.45	19.72	29.02	17.91	17.48	19.26	18.30	20.66	18.83	17.64
Urinalysis, nonauto w/scope	81000		10.02%	0.43%	4.45	4.45	4.45	4.45	4.45	4.45	4.45	3.60	5.46	4.16	4.08	4.12	4.12	3.79	3.82	4.16
Assay of psa, total	84153		1.40%	0.35%	25.89	25.89	25.89	25.89	25.89	25.89	25.89	25.89	31.68	24.14	23.65	23.94	23.94	21.98	22.14	24.17
X-ray exam of abdomen	74000	26	1.18%	0.30%	11.99	8.55	8.65	8.73	8.60	9.12	8.73	8.85	17.65	8.92	8.82	9.07	8.95	9.39	9.08	9.00
Urinalysis, auto w/scope	81001		2.92%	0.12%	4.45	4.45	4.45	4.45	4.45	4.45	4.45	3.60	5.46	4.16	4.08	4.12	4.12	3.79	3.82	4.16
Urinalysis nonauto w/o scope	81002		3.03%	0.10%	3.60	3.60	3.60	3.60	3.60	3.60	3.60	2.89	4.40	3.35	3.28	3.32	3.32	3.05	3.08	3.36
Assay of urine creatinine	82570		1.34%	0.09%	7.28	7.28	7.28	7.28	7.28	7.28	7.28	7.28	8.92	6.79	6.66	6.74	6.74	6.19	6.23	6.80
Urinalysis, auto, w/o scope	81003		2.88%	0.09%	3.16	3.16	3.16	3.16	3.16	3.16	3.16	2.89	3.88	2.95	2.89	2.93	2.93	2.69	2.71	2.96
Routine venipuncture	36415		2.59%	0.08%	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility claim

Appendix A-20
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Urology

					VA [3]						Medicaid [4]						Workers' Compensation [4]					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		13.79%	7.96%	$103.12	$66.04	$67.67	$68.52	$72.42	$69.10	$108.29	$57.45	$91.76	$50.35	$38.21	$67.36	$149.22	$133.13	$125.74	$138.79	$112.89	N/A
Removal of sperm duct(s)	55250		1.54%	6.77%	1,116.08	407.35	423.33	429.53	459.11	430.04	647.60	403.30	585.78	644.98	260.76	N/A	1,000.62	1,051.68	782.92	1,003.11	Not Covered	N/A
Office consultation	99244		3.29%	5.66%	338.76	N/A	N/A	N/A	N/A	N/A	310.73	N/A	103.88	N/A	113.15	N/A	476.45	342.09	N/A	355.52	288.32	N/A
Office/outpatient visit, est	99214		6.06%	5.26%	150.83	98.08	100.41	101.63	107.25	102.45	163.18	86.45	137.64	75.39	57.10	95.57	216.25	197.74	186.44	206.48	167.13	N/A
Cystoscopy	52000		2.62%	4.97%	423.35	202.95	209.44	212.44	226.30	214.12	330.89	193.42	291.82	235.19	128.93	N/A	883.60	523.96	389.60	516.66	350.30	N/A
Office consultation	99243		3.84%	4.51%	242.81	N/A	N/A	N/A	N/A	N/A	206.34	N/A	74.86	N/A	76.25	N/A	364.35	230.14	N/A	240.66	194.80	N/A
Fragmenting of kidney stone	50590		0.78%	4.22%	2,000.26	841.26	867.09	879.29	935.46	886.42	1,468.81	827.86	1,296.41	1,325.58	573.31	N/A	5,015.77	2,171.92	1,612.92	2,065.56	1,449.91	N/A
Repair bladder defect	57288		0.27%	1.77%	1,920.62	683.01	691.09	701.21	742.21	723.45	1,190.15	678.54	986.44	548.33	429.93	N/A	4,770.74	1,763.33	1,313.75	1,681.09	1,165.46	N/A
Complex cystometrogram	51726		0.53%	1.76%	888.18	291.77	305.01	309.60	332.03	308.47	464.60	296.19	429.47	112.70	192.51	N/A	935.30	753.28	561.80	745.11	509.13	N/A
Biopsy of prostate	55700		0.82%	1.75%	514.72	221.83	228.59	231.83	246.69	233.88	366.58	220.34	321.70	364.97	142.05	N/A	1,016.09	572.71	425.53	563.33	382.40	N/A
Office/outpatient visit, new	99203		1.86%	1.63%	161.06	98.07	100.35	101.71	107.79	103.20	160.27	86.54	136.58	75.39	56.88	99.86	223.86	197.71	187.68	207.84	168.23	N/A
Office/outpatient visit, new	99204		1.17%	1.56%	221.51	151.11	154.06	156.09	164.96	158.74	252.60	133.19	212.33	117.12	88.06	N/A	319.81	304.65	288.64	319.29	257.88	N/A
Prostatic microwave thermotx	53850		0.05%	1.55%	7,415.69	2,223.55	2,332.09	2,367.70	2,543.59	2,352.24	3,477.98	2,250.37	3,262.89	N/A	1,467.40	N/A	BR	5,740.71	4,285.01	5,493.40	Not Covered	N/A
Office/outpatient visit, est	99212		4.28%	1.53%	75.92	39.51	40.71	41.26	43.82	41.52	62.46	35.18	54.42	30.05	22.84	40.33	116.78	79.66	75.57	83.41	68.07	N/A
Laparo radical prostatectomy	55866		0.14%	1.46%	4,208.80	1,714.02	1,735.19	1,757.63	1,851.35	1,799.91	3,070.86	1,584.42	N/A	1,395.17	1,097.94	N/A	10,567.28	4,425.11	3,271.05	4,184.13	Not Covered	N/A
Cystouretero w/lithotripsy	52353		0.33%	1.33%	1,092.64	420.43	425.53	430.93	453.56	441.00	751.77	390.62	619.93	990.66	268.32	N/A	6,744.75	1,085.43	801.50	1,061.16	713.33	N/A
Extensive prostate surgery	55845		0.13%	1.30%	4,179.80	1,619.54	1,638.58	1,659.70	1,747.59	1,700.45	2,890.62	1,492.50	2,384.75	1,312.55	1,032.58	N/A	13,818.75	4,181.18	3,090.19	3,952.34	Not Covered	N/A
Cystoscopy and treatment	52332		0.80%	1.25%	1,959.40	474.34	496.32	503.83	540.61	501.61	726.10	401.78	670.08	698.79	300.33	N/A	1,821.08	1,224.65	913.62	1,092.28	827.89	N/A
Echo guide for biopsy	76942	26	0.81%	1.21%	90.06	32.51	32.89	33.23	34.73	33.71	59.03	62.16	46.04	26.15	20.67	N/A	210.39	83.94	61.32	62.44	54.79	N/A
Leuprolide acetate suspnsion	J9217		0.19%	1.18%	1,809.32	209.11	209.11	209.11	209.11	209.11	648.26	242.79	206.52	215.01	N/A	N/A	1,702.47	N/A	N/A	N/A	443.88	N/A
Electro-uroflowmetry, first	51741		1.41%	1.12%	196.37	40.77	42.78	43.44	46.72	43.19	137.60	74.55	117.90	64.82	51.35	N/A	498.82	105.25	78.66	104.81	71.39	N/A
Urine voiding pressure study	51795	26	0.34%	1.08%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	689.00	N/A	N/A	N/A	N/A	N/A
Cystoscopy and treatment	52310		0.48%	1.07%	763.27	241.12	248.41	251.95	268.15	254.32	399.02	241.13	350.51	485.82	154.72	N/A	1,188.03	622.52	462.69	613.28	415.60	N/A
Office consultation	99245		0.49%	1.04%	371.13	N/A	N/A	N/A	N/A	N/A	380.86	N/A	N/A	N/A	138.05	N/A	601.64	418.17	N/A	434.83	351.96	N/A
Cystoscopy and treatment	52281		0.37%	1.02%	1,102.10	278.46	288.54	292.76	312.56	294.03	469.38	288.69	419.33	494.77	186.07	N/A	1,069.24	718.90	535.16	709.90	482.56	N/A
Office/outpatient visit, est	99215		0.86%	1.00%	303.55	132.08	135.00	136.62	144.01	137.85	221.58	117.01	186.19	101.82	76.86	136.28	346.00	266.29	250.86	277.58	225.23	N/A
Us urine capacity measure	51798		2.81%	0.57%	169.22	18.46	19.52	19.86	21.53	19.72	25.81	17.20	25.07	14.47	11.56	N/A	935.30	47.65	35.93	47.49	32.65	N/A
Urinalysis, nonauto w/scope	81000		10.02%	0.43%	21.17	4.45	4.45	4.45	4.45	3.60	4.54	4.43	4.54	3.36	3.45	N/A	36.49	TBD	11.12	80% of billed	6.23	N/A
Assay of psa, total	84153		1.40%	0.35%	66.02	25.89	25.89	25.89	25.89	25.89	26.34	25.70	26.34	19.49	20.02	N/A	140.35	TBD	64.72	80% of billed	36.25	N/A
X-ray exam of abdomen	74000	26	1.18%	0.30%	23.93	8.55	8.65	8.73	9.12	8.85	15.69	8.73	11.87	6.96	5.56	N/A	60.80	22.08	16.10	16.40	14.39	N/A
Urinalysis, auto w/scope	81001		2.92%	0.12%	32.35	4.45	4.45	4.45	4.45	3.60	4.54	4.43	4.54	3.36	3.45	N/A	36.49	TBD	11.12	80% of billed	6.23	N/A
Urinalysis nonauto w/o scope	81002		3.03%	0.10%	20.10	3.60	3.60	3.60	3.60	2.89	3.66	3.57	3.66	2.71	2.78	N/A	28.57	TBD	9.00	80% of billed	5.04	N/A
Assay of urine creatinine	82570		1.34%	0.09%	33.17	7.28	7.28	7.28	7.28	7.28	7.41	7.23	7.41	5.48	5.63	N/A	58.08	TBD	18.20	19.00	10.19	N/A
Urinalysis, auto, w/o scope	81003		2.88%	0.09%	17.97	3.16	3.16	3.16	3.16	2.89	3.22	3.14	3.22	2.38	2.45	N/A	28.57	TBD	7.90	15.00	4.42	N/A
Routine venipuncture	36415		2.59%	0.08%	11.76	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.88	2.22	2.28	2.70	29.03	N/A	7.50	80% of billed	4.20	N/A

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-20
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Urology

					Commercial Allowed (5)																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		13.79%	7.96%	$134.15	$89.05	$92.87	$108.87	$90.19	$79.88	$140.00	$89.93	$96.24	$112.52	$86.74	$83.00	$150.00	$100.77	$96.24	$120.96	$101.79	$86.00
Removal of sperm duct(s)	55250		1.54%	6.77%	1,005.81	784.27	698.12	836.18	729.58	793.68	959.50	832.89	694.60	840.50	718.12	825.00	1,264.00	875.00	701.99	944.70	822.09	905.00
Office consultation	99244		3.29%	5.66%	427.48	270.95	289.59	334.30	280.32	253.98	450.00	274.61	289.28	339.02	271.46	242.00	490.00	303.80	294.77	367.92	316.60	303.50
Office/outpatient visit, est	99214		6.06%	5.26%	194.83	133.62	140.11	164.90	140.23	117.70	205.00	136.59	144.92	171.00	135.16	118.47	220.00	151.91	144.92	182.40	161.20	130.00
Cystoscopy	52000		2.62%	4.97%	721.72	334.98	333.36	385.05	316.38	337.29	750.00	372.60	337.40	391.95	312.69	335.00	813.00	380.28	338.75	446.96	378.00	354.62
Office consultation	99243		3.84%	4.51%	317.30	187.75	196.04	230.37	195.82	184.07	340.00	184.48	195.87	231.82	190.67	190.00	353.00	204.09	198.00	253.13	222.30	205.87
Fragmenting of kidney stone	50590		0.78%	4.22%	4,714.96	1,227.63	1,058.97	1,344.22	1,127.18	3,548.51	4,500.00	1,011.51	913.69	1,156.00	832.14	4,088.00	7,455.00	1,590.96	1,030.98	1,577.52	1,248.25	5,700.00
Repair bladder defect	57288		0.27%	1.77%	3,610.06	1,158.11	1,065.94	1,232.74	1,046.88	2,132.25	4,150.00	1,413.80	1,105.59	1,340.00	1,115.36	1,984.00	4,500.00	1,438.28	1,105.59	1,565.28	1,316.99	3,180.60
Complex cystometrogram	51726		0.53%	1.76%	957.08	573.79	509.33	606.15	520.20	580.68	1,145.00	576.10	510.62	604.34	503.77	551.90	1,226.00	617.30	510.62	720.00	570.40	783.75
Biopsy of prostate	55700		0.82%	1.75%	765.48	425.41	316.85	423.31	374.64	310.62	800.00	431.52	365.82	438.85	354.59	304.00	865.00	445.00	378.22	499.50	434.92	390.56
Office/outpatient visit, new	99203		1.86%	1.63%	201.36	131.99	135.08	162.64	139.59	123.76	219.00	136.88	144.36	168.30	133.76	128.74	240.00	151.43	144.36	180.34	161.28	134.00
Office/outpatient visit, new	99204		1.17%	1.56%	285.42	204.47	210.35	245.77	207.42	176.24	313.00	212.03	222.48	256.11	200.72	176.36	340.00	234.58	222.48	275.66	239.81	195.16
Prostatic microwave thermotx	53850		0.05%	1.55%	No Data	Not Cred	No Data	Not Cred	4,654.56	Not Cred	No Data	Not Cred	No Data	Not Cred	4,543.75	Not Cred	No Data	Not Cred	No Data	Not Cred	4,715.09	Not Cred
Office/outpatient visit, est	99212		4.28%	1.53%	101.12	55.61	56.69	66.49	56.13	56.92	106.00	54.77	58.31	67.47	53.30	56.00	115.00	60.60	58.31	73.00	64.23	61.75
Laparo radical prostatectomy	55866		0.14%	1.46%	5,540.49	2,826.40	Not Cred	3,417.64	2,551.80	Not Cred	6,115.72	3,181.51	Not Cred	3,362.06	2,581.38	Not Cred	7,855.52	3,231.50	Not Cred	3,830.49	2,991.08	Not Cred
Cystouretero w/lithotripsy	52353		0.33%	1.33%	4,456.78	821.52	Not Cred	811.07	657.52	1,995.07	5,500.00	796.74	Not Cred	817.89	613.74	2,112.00	5,781.00	842.87	Not Cred	945.27	724.66	2,166.82
Extensive prostate surgery	55845		0.13%	1.30%	Not Cred	Not Cred	Not Cred	3,031.66	2,591.07	Not Cred	Not Cred	Not Cred	Not Cred	3,163.74	2,428.52	Not Cred	Not Cred	Not Cred	Not Cred	3,524.95	2,904.32	Not Cred
Cystoscopy and treatment	52332		0.80%	1.25%	654.61	455.60	227.31	417.71	248.36	473.51	622.00	332.67	257.01	304.18	165.51	293.50	904.75	665.18	257.01	695.20	307.92	587.00
Echo guide for biopsy	76942	26	0.81%	1.21%	163.47	108.79	64.22	65.71	60.02	95.19	153.00	71.30	53.78	63.65	57.73	88.00	208.00	142.20	70.76	67.43	61.13	139.00
Leuprolide acetate suspnsion	J9217		0.19%	1.18%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Electro-uroflowmetry, first	51741		1.41%	1.12%	305.72	103.06	172.06	111.67	102.91	101.32	310.00	110.88	136.43	95.76	112.86	98.00	382.24	146.81	139.16	165.82	120.06	151.00
Urine voiding pressure study	51795	26	0.34%	1.08%	Not Cred	Not Cred	Not Cred	80.64	81.56	Not Cred	Not Cred	Not Cred	Not Cred	73.04	71.44	Not Cred	Not Cred	Not Cred	Not Cred	86.18	133.30	Not Cred
Cystoscopy and treatment	52310		0.48%	1.07%	1,064.20	484.42	479.29	495.81	408.19	479.13	1,160.00	477.83	408.72	483.74	393.37	469.00	1,200.00	526.45	412.20	567.64	487.15	554.00
Office consultation	99245		0.49%	1.04%	512.68	334.98	374.53	411.96	347.70	325.66	575.00	335.00	355.51	410.94	333.92	314.15	640.00	375.00	392.00	453.13	396.43	367.81
Cystoscopy and treatment	52281		0.37%	1.02%	No Data	Not Cred	Not Cred	502.64	444.81	510.64	No Data	Not Cred	Not Cred	567.77	495.92	503.00	No Data	Not Cred	Not Cred	601.95	553.32	554.97
Office/outpatient visit, est	99215		0.86%	1.00%	290.64	182.16	192.46	216.11	183.24	162.55	315.00	182.70	195.87	224.67	176.00	161.46	338.10	200.00	197.10	243.53	212.17	187.00
Us urine capacity measure	51798		2.81%	0.57%	135.00	32.52	38.87	39.75	31.17	35.38	120.00	31.62	33.97	39.88	30.80	34.00	218.50	33.73	35.18	47.63	33.55	50.00
Urinalysis, nonauto w/scope	81000		10.02%	0.43%	21.33	8.11	9.27	6.59	5.12	14.93	20.00	6.47	9.08	6.38	4.43	17.00	30.00	7.20	9.08	6.67	5.27	19.00
Assay of psa, total	84153		1.40%	0.35%	75.92	34.49	55.96	34.50	28.20	48.84	82.24	34.86	52.66	34.80	26.83	40.28	110.00	36.49	53.71	37.01	30.84	72.25
X-ray exam of abdomen	74000	26	1.18%	0.30%	38.50	21.37	17.77	17.25	16.09	25.81	39.00	18.67	14.15	16.44	15.63	27.09	39.00	23.50	15.30	17.75	16.51	35.00
Urinalysis, auto w/scope	81001		2.92%	0.12%	23.55	7.37	10.17	7.97	6.16	11.33	30.00	6.47	9.08	6.38	4.63	9.33	36.00	6.78	9.08	8.55	5.56	17.00
Urinalysis nonauto w/o scope	81002		3.03%	0.10%	18.49	6.15	8.07	5.31	3.98	10.09	21.62	5.05	7.31	5.00	3.57	10.00	26.00	5.08	7.31	5.14	3.74	12.35
Assay of urine creatinine	82570		1.34%	0.09%	34.69	10.83	15.18	10.48	8.59	13.41	37.50	9.77	14.81	10.12	7.56	9.76	55.00	10.45	14.81	12.60	8.68	21.25
Urinalysis, auto, w/o scope	81003		2.88%	0.09%	19.29	5.37	7.03	4.93	3.87	10.32	25.00	4.43	6.44	4.40	3.28	7.00	29.00	4.46	6.44	4.72	3.77	19.27
Routine venipuncture	36415		2.59%	0.08%	18.08	9.10	6.81	6.34	5.69	14.42	15.00	8.54	6.15	3.60	3.00	13.44	31.45	9.34	6.27	7.68	5.42	20.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Appendix A-20
Summary of Professional Provider Allowed Amounts by Payer
Alaska and Comparison States
Urology

					Billed Charges [4]																	
					Mean						Median						80th Percentile					
Description	HCPCS	Modifier	% of Total Util	% of Total RVUs	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY	AK	ID	ND	OR	WA	WY
Office/outpatient visit, est	99213		13.79%	7.96%	$134.60	$84.31	$94.91	$119.82	$107.32	$88.42	$145.00	$83.00	$98.00	$125.00	$107.00	$87.00	$152.25	$110.00	$114.00	$145.00	$128.00	$106.70
Removal of sperm duct(s)	55250		1.54%	6.77%	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data	No Data	No Data	No Data	Not Cred	No Data	No Data
Office consultation	99244		3.29%	5.66%	434.24	283.55	294.68	397.81	343.92	301.79	450.00	299.17	318.00	399.00	345.15	305.00	510.50	343.90	362.00	473.00	399.00	363.34
Office/outpatient visit, est	99214		6.06%	5.26%	196.23	131.45	144.89	184.32	165.49	132.65	208.00	138.00	150.00	190.00	163.00	130.00	220.00	166.00	171.00	221.00	200.00	156.00
Cystoscopy	52000		2.62%	4.97%	606.69	388.82	436.17	491.84	430.78	371.02	675.00	400.00	410.00	500.00	440.00	364.00	819.00	600.00	507.00	606.00	479.00	575.61
Office consultation	99243		3.84%	4.51%	328.70	199.94	207.88	271.75	237.14	215.50	349.00	210.00	215.00	273.00	240.00	220.00	366.84	239.00	246.96	329.00	276.00	279.17
Fragmenting of kidney stone	50590		0.78%	4.22%	Not Cred	1,532.35	Not Cred	1,747.66	1,735.75	Not Cred	Not Cred	1,517.34	Not Cred	1,945.50	1,650.00	Not Cred	Not Cred	2,200.00	Not Cred	2,627.50	2,300.00	Not Cred
Repair bladder defect	57288		0.27%	1.77%	Not Cred	1,620.08	Not Cred	1,715.93	1,669.26	Not Cred	Not Cred	1,532.00	Not Cred	1,918.00	1,619.00	Not Cred	Not Cred	2,127.50	Not Cred	2,226.00	1,907.00	Not Cred
Complex cystometrogram	51726		0.53%	1.76%	Not Cred	507.27	Not Cred	752.42	649.77	Not Cred	Not Cred	560.00	Not Cred	812.00	666.80	Not Cred	Not Cred	710.00	Not Cred	909.00	750.00	Not Cred
Biopsy of prostate	55700		0.82%	1.75%	583.77	381.50	448.91	529.73	459.29	366.99	480.00	259.00	449.00	540.00	470.00	348.00	800.00	568.00	557.00	643.00	535.00	653.46
Office/outpatient visit, new	99203		1.86%	1.63%	198.02	136.30	148.65	183.25	169.23	143.50	209.30	145.00	163.00	191.00	171.00	141.00	240.00	171.00	181.00	224.00	196.00	175.00
Office/outpatient visit, new	99204		1.17%	1.56%	294.64	212.66	232.15	285.33	249.37	204.24	318.00	220.00	249.00	295.00	251.00	200.00	350.00	265.00	271.00	363.00	297.00	249.00
Prostatic microwave thermotx	53850		0.05%	1.55%	Not Cred	Not Cred	No Data	Not Cred	6,134.70	No Data	Not Cred	Not Cred	No Data	Not Cred	6,061.00	No Data	Not Cred	Not Cred	No Data	Not Cred	7,244.00	No Data
Office/outpatient visit, est	99212		4.28%	1.53%	92.50	53.09	56.30	72.57	68.63	55.45	102.00	55.00	60.00	75.75	70.00	55.00	117.00	70.00	70.00	90.00	80.00	74.00
Laparo radical prostatectomy	55866		0.14%	1.46%	No Data	Not Cred	No Data	Not Cred	4,355.29	Not Cred	No Data	Not Cred	No Data	Not Cred	4,102.00	Not Cred	No Data	Not Cred	No Data	Not Cred	5,670.00	Not Cred
Cystouretero w/lithotripsy	52353		0.33%	1.33%	No Data	Not Cred	Not Cred	1,378.41	1,064.17	Not Cred	No Data	Not Cred	Not Cred	1,195.00	925.25	Not Cred	No Data	Not Cred	Not Cred	1,964.75	1,136.00	Not Cred
Extensive prostate surgery	55845		0.13%	1.30%	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data	No Data	Not Cred	Not Cred	Not Cred	Not Cred	No Data
Cystoscopy and treatment	52332		0.80%	1.25%	Not Cred	628.85	Not Cred	1,128.93	1,014.81	Not Cred	Not Cred	718.00	Not Cred	1,205.00	1,139.20	Not Cred	Not Cred	965.00	Not Cred	1,549.00	1,448.32	Not Cred
Echo guide for biopsy	76942	26	0.81%	1.21%	170.17	146.24	91.15	116.59	116.11	116.06	153.00	132.00	77.00	95.70	104.00	103.24	208.00	202.50	124.00	115.90	128.00	156.00
Leuprolide acetate suspnsion	J9217		0.19%	1.18%	Not Cred	368.63	661.02	504.35	552.47	379.24	Not Cred	300.00	453.00	400.00	600.00	224.74	Not Cred	550.00	1,224.00	657.00	753.00	660.00
Electro-uroflowmetry, first	51741		1.41%	1.12%	Not Cred	166.47	215.11	202.49	168.92	150.89	Not Cred	162.00	192.00	212.00	165.00	150.00	Not Cred	254.50	261.00	245.31	185.00	182.00
Urine voiding pressure study	51795	26	0.34%	1.08%	Not Cred	Not Cred	146.68	198.98	164.59	No Data	Not Cred	Not Cred	161.00	178.00	147.50	No Data	Not Cred	Not Cred	178.00	239.00	236.40	No Data
Cystoscopy and treatment	52310		0.48%	1.07%	Not Cred	Not Cred	509.59	681.49	619.08	467.70	Not Cred	Not Cred	496.50	705.00	596.00	500.00	Not Cred	Not Cred	782.00	821.00	664.00	750.00
Office consultation	99245		0.49%	1.04%	544.53	398.49	382.16	496.39	443.42	395.48	563.00	392.00	420.00	500.00	450.00	400.00	660.00	455.00	452.00	591.00	503.00	487.00
Cystoscopy and treatment	52281		0.37%	1.02%	Not Cred	Not Cred	Not Cred	699.92	765.71	Not Cred	Not Cred	Not Cred	Not Cred	788.00	762.00	Not Cred	Not Cred	Not Cred	Not Cred	865.00	815.00	Not Cred
Office/outpatient visit, est	99215		0.86%	1.00%	290.58	191.08	207.14	248.24	220.97	180.40	320.00	200.00	232.00	259.00	221.00	186.00	342.00	230.00	232.00	299.07	270.00	231.00
Us urine capacity measure	51798		2.81%	0.57%	91.11	40.97	42.22	54.70	55.17	45.89	120.00	36.00	38.00	56.00	47.00	50.00	120.00	46.00	48.00	67.00	63.60	54.00
Urinalysis, nonauto w/scope	81000		10.02%	0.43%	24.27	11.20	20.05	15.78	14.04	20.49	25.00	12.00	19.00	15.50	14.00	24.00	32.00	14.00	27.00	20.00	18.00	25.00
Assay of psa, total	84153		1.40%	0.35%	65.76	58.92	75.35	60.17	66.33	80.63	54.00	50.00	80.00	51.40	55.10	71.50	115.00	75.00	80.00	72.00	89.00	114.00
X-ray exam of abdomen	74000	26	1.18%	0.30%	49.00	31.04	26.27	27.66	29.08	21.65	39.00	27.00	25.00	29.03	28.25	24.25	63.00	40.00	32.00	32.00	36.00	33.00
Urinalysis, auto w/scope	81001		2.92%	0.12%	23.70	21.11	19.60	18.93	24.62	20.94	24.00	19.00	21.00	18.50	20.00	20.50	38.00	36.63	21.00	24.00	37.55	26.00
Urinalysis nonauto w/o scope	81002		3.03%	0.10%	20.82	10.52	13.41	11.81	12.72	10.69	21.00	10.00	12.00	11.00	11.00	10.00	25.00	13.00	17.00	15.00	16.00	18.00
Assay of urine creatinine	82570		1.34%	0.09%	35.32	25.13	25.46	21.81	26.78	27.95	30.00	24.00	25.00	18.22	25.00	25.00	44.15	35.74	25.00	25.00	35.74	39.00
Urinalysis, auto, w/o scope	81003		2.88%	0.09%	12.77	13.76	13.72	16.47	14.73	16.96	3.28	13.50	13.00	14.00	11.00	17.50	24.00	20.00	13.00	31.00	22.96	24.09
Routine venipuncture	36415		2.59%	0.08%	17.65	13.79	12.44	13.34	16.15	14.06	17.00	14.00	14.56	13.00	15.38	13.00	24.00	19.50	16.00	17.00	19.65	18.00

(1) Medicare fees are from CY2011 schedule.
(2) TRICARE fees are from the current schedules effective 8/1/2010.
(3) Alaska VA fees are from the 2010 schedule. All other states' VA fees are equal to Medicare (2011).
(4) Medicaid and workers' compensation fees are current as of 8/3/2011.
(5) Commercial allowed and billed are based off of CY2009 data.

For fee schedules that adjust payment based on place of service, payment is based on a non-facility clain

Milliman

Facility Payment Rates in Alaska and Comparison States

Prepared for:
Alaska Health Care Commission

Prepared by:
Milliman, Inc.
1301 Fifth Ave.
Seattle, WA 98101-2605

John Pickering, FSA, MAAA
john.pickering@milliman.com
206 504 5884

Edward Jhu, FSA, MAAA
edward.jhu@milliman.com
206 504 5828

November 21, 2011

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY 1

2. DETAILED RESULTS 4

3. METHODOLOGY 7

4. LIMITATIONS AND CONSIDERATIONS 8

EXHIBITS

EXHIBIT 1 COMMERCIAL ALLOWED PER RVU

EXHIBIT 2 MEDICARE ALLOWED CHARGES PER RVU

EXHIBIT 3 BILLED CHARGES PER RVU

EXHIBIT 4 GEOGRAPHICALLY ADJUSTED COMMERCIAL ALLOWED PER RVU

EXHIBIT 5 MEDICARE ALLOWED CHARGES PER RVU

APPENDICES

APPENDIX 1 RBRVS FOR HOSPITALS™

APPENDIX 2 ALASKA HOSPITAL LIST

1. Executive Summary

The Alaska Health Care Commission ("AHCC") engaged Milliman to compare Alaska's health care payment rates and underlying drivers to those in certain other states. The comparison states are Washington, Oregon, Idaho, Wyoming, and North Dakota. For this facility payment report, Hawaii is included as another comparison state.

This report is the second of three reports. This report is focused on how Alaska's facility payment rates compare to other states. The first report analyzed physician payment rates in Alaska. The final report will identify the key drivers of the cost differences across states.

This report focuses on commercial and Medicare hospital payment rates. The results presented in this report are based on analyses of large medical claims databases for claims incurred in 2009. Payments to specific providers, both by commercial payers and by Medicare, can vary significantly from the averages presented here.

Table 1 presents commercial allowed payment levels in Alaska relative to the six comparison states. Table 2 presents similar values for Medicare. The payment levels measure the total payment received by the facility, either paid by the insurer/Medicare or by the patient as copay, coinsurance, or deductible.

Tables 1 and 2 report payment levels relative to the straight (equal-weighted) average in the six comparison states. For example, Table 1 shows that the Alaska total commercial hospital payment level is 37% higher than the average in the six comparison states. Table 2 shows that the Alaska total Medicare hospital payment level is 36% higher than the average in the six comparison states.

Table 1
Commercial Hospital Allowed Unit Cost
Relative to the Comparison State Average

Region	Inpatient Average	Outpatient Average	Total Average
Anchorage/Frbnks/Mat-Su	138%	132%	135%
Non-MSA Area	134%	149%	141%
AK	138%	135%	137%
HI	117%	99%	108%
ID	79%	102%	91%
ND	72%	70%	71%
OR	103%	111%	107%
WA	113%	88%	100%
WY	116%	130%	123%
Comparison States	100%	100%	100%

Table 2
Medicare Hospital Allowed Unit Cost
Relative to the Comparison State Average

Region	Inpatient Average	Outpatient Average	Total Average
Anchorage/Frbnks/Mat-Su	128%	116%	126%
Non-MSA Area	151%	215%	175%
AK	132%	145%	136%
HI	104%	97%	102%
ID	95%	97%	95%
ND	83%	93%	86%
OR	107%	104%	106%
WA	110%	98%	106%
WY	102%	111%	105%
Comparison States	100%	100%	100%

Table 3 presents the ratio of commercial payment levels to Medicare payment levels by state.

Table 3
Hospital Allowed Unit Cost
Commercial / Medicare

Region	Inpatient Average	Outpatient Average	Total Average
Anchorage/Frbnks/Mat-Su	225%	253%	226%
Non-MSA Area	185%	154%	171%
AK	219%	208%	213%
HI	235%	229%	223%
ID	175%	233%	202%
ND	182%	169%	175%
OR	202%	238%	215%
WA	214%	200%	199%
WY	237%	260%	249%
Comparison States	209%	223%	212%

Table 3 shows that commercial payment levels are approximately 213% of Medicare payment levels in Alaska. The relationship in other states varies from 175% in North Dakota to 249% in Wyoming but is similar on average between Alaska and the comparison group.

For a list of Alaska hospitals included in the Medicare portion of this analysis, see Appendix 2. The commercial data did not specifically identify facilities; Alaska facilities were identified and mapped to MSAs using the zip code of the service.

The results in this report should be interpreted with caution since they only identify the relative unit cost reimbursement among states and do not analyze reasons for the differences such as staff wages, cost of living, cost of business operation, or provider availability, which may account for some or all of the relative differences in reimbursement. Analysis of the drivers behind the differences will be presented in the third report in this series.

2. Detailed Results

This report evaluates hospital allowed payment levels. These are the total payment amounts that are either contractually agreed upon by the hospital and a commercial insurer, or administratively set by Medicare. These "allowed amounts" include member-paid amounts such as co-pays, co-insurance, and deductibles, as well as amounts paid by the insurer/Medicare.

This report also includes a summary of the billed charge levels among the states.

To measure relative hospital allowed payment levels among the states, we employ a metric called the "Hospital Allowed per Relative Value Unit (RVU)". Relative value units are assigned to detailed claims data. The RVUs assigned reflect the amount of resources required to perform the given hospital service. Higher intensity services are assigned more RVUs; lower intensity services are assigned fewer RVUs. Both inpatient and outpatient services are assigned RVUs. The RVUs we use are the Milliman *RBRVS for Hospitals*™ RVUs. These provide the best case-mix and severity adjustment available. Appendix 1 presents more in depth information about the Milliman *RBRVS for Hospitals*™ approach.

The commercial results are based on analysis of the 2009 Thomson Reuters MarketScan® Database. The Medicare results are based on analysis of the 2009 Medicare Provider Analysis and Review (MedPAR) file for inpatient services, and the 2009 Medicare Outpatient Prospective Payment System (OPPS) and the Medicare Standard Analytic File 5% Sample (5% Sample) files for outpatient services. The billed charge analysis is also based on the MedPAR, OPPS, and 5% Sample files.

RVUs are assigned to the detailed claims data, and then allowed amounts from the same claims are summed. The total allowed amount divided by the total RVUs results in a conversion factor. The application of the RVUs provides the case-mix and severity adjustment, such that the conversion factors can be compared directly at whatever level of aggregation is desired.

Exhibit 1, at the end of this report, presents the detailed conversion factor results for the commercial allowed level. This presents results by detailed service category within the larger inpatient and outpatient categories. These results are consistent with the summary presented in Table 1 earlier in this report.

Exhibit 2 presents analogous information for Medicare payment levels. Table 2, earlier in this report, is based on the results from Exhibit 2.

Exhibit 3 presents the same for billed charge levels. This exhibit shows that Alaska has approximately 39% higher billed charges than the comparison states. The difference in billed charges is roughly similar to both the difference in commercial (35%) and Medicare (36%) payment levels between Alaska and the comparison states.

Exhibit 4 presents the commercial allowed charge results on a basis that is adjusted for expected geographic cost differences. The geographic adjustment factors are based on the geographic adjustment factors that Medicare uses for IPPS and OPPS hospital payments, including the Wage Index and Capital Geographic Adjustment Factor. These exhibits show that the difference between Alaska and the comparison states shrinks when geographic adjustments are taken into account, indicating that part of Alaska's higher reimbursement is due to area.

Medicare pays many hospitals on a prospective payment basis for both inpatient (IPPS) and outpatient (OPPS) services. However, certain hospitals such as Critical Access Hospitals, Cancer Hospitals and Children's Hospitals are paid on an alternate, cost-based basis. This is one reason why the Medicare geographically adjusted payment levels are still higher in Alaska than in other states. The Medicare geographic adjustment factors are applied to IPPS and OPPS payment, but not to cost-based payments.

Exhibit 5 presents results by state and type of hospital – either paid by OPPS or not. We divided hospitals into two categories based on whether Medicare pays outpatient services based on the Outpatient Prospective Payment System. This was a convenient attribute for us to use to split the data since our data source for Medicare outpatient services was split between OPPS and non-OPPS facilities. It also nicely defines a split between hospitals that are generally paid on a type of cost basis (non-OPPS) versus a prospective payment, fee schedule basis (OPPS).

Exhibit 5 show that, Medicare's inpatient payments tend to be very similar for hospitals that are paid under OPPS compared to those reimbursed on a cost-basis. However payments for outpatient services are considerably higher for those facilities not paid under OPPS, particularly in Alaska.

Other Payers

The above discussion dealt with commercial and Medicare payment levels. No comparable claims databases are available to perform similar analyses for other payers, such as Medicaid, Workers' Compensation, TRICARE, or the Veterans Administration.

However, we have reviewed the fee schedules for other payers in Alaska and the comparison states, where available. We include here more qualitative observations on these fee schedules.

- TRICARE is transitioning payment for hospital outpatient services to use Medicare's payment methodology. For hospital inpatient services, TRICARE pays using a DRG approach that is similar to Medicare, but with some differences. The amount paid for Indirect Medical Education (IME) is similar for both Medicare and TRICARE in each state. However, Medicare makes additional Disproportionate Share (DSH) payments in all states and and cost-of-living adjustment (COLA) payments in Alaska and Hawaii. The combined impact of these payments varies greatly across states. For example, the DSH and COLA payments in Alaska are approximately 17% of the total, while in Wyoming they are only 3%. Overall, TRICARE inpatient reimbursement in Alaska is approximately 125% – 130% of the comparison states average (about 10% lower than the 138% under Medicare).
- Medicaid payments for hospitals in Alaska are based on per diem rates for inpatient services (varying by facility) and on discounts from billed charges for outpatient services. Medicaid in Washington State applies a DRG approach for inpatient services for most payers and a fee schedule approach for outpatient services, so the two states cannot be easily compared.
- For Workers' Compensation, Alaska pays inpatient services on a per diem basis. Washington, Idaho and North Dakota use a DRG based approach, while Wyoming pays on a usual and customary basis, which is likely to produce higher fees than the other methods.

Utilization Efficiency

We note that this report considers only the relative cost per unit of service provided, but does not consider the relative efficiency of resource utilization. More efficient health care systems may discharge equivalent patients with shorter lengths of stay, or may direct more patients to outpatient settings instead of incurring more expensive inpatient care. Better preventive care and community health may avoid medical claims altogether. More efficient use of resources will reduce overall health care costs in an area and could offset higher unit costs. The third report in this series will review some aspects of resource utilization efficiency, among other things.

3. METHODOLOGY

The commercial results are based on analysis of the 2009 Thomson Reuters MarketScan® Database. This database contains detailed claims data for commercially insured individuals. The data is submitted by large employer groups and health plans.

The RVU assignment process is dependent on the quality of diagnosis and procedure coding in the data. As a compilation of claims data from several different sources, the coding quality found in the data varies significantly. We limited our analysis to contributors that we determined to have well-coded diagnosis and procedure code data.

The coding quality can vary between inpatient and outpatient services, even from the same data contributor. After poorly coded data is excluded, the remaining data likely will have an inpatient/outpatient mix that varies from that of the full data. Therefore, to estimate the overall hospital results, inpatient and outpatient combined, we applied a standardized weighting to the inpatient and outpatient categories. We applied a 49% weight to inpatient services and a 51% weight to outpatient services, based on a typical distribution of services for a commercial population.

We assigned Milliman *RBRVS for Hospitals*™ RVUs into both the inpatient and outpatient claims data. The commercial contractual allowed amounts were summed and divided by RVUs from the same claims to create the conversion factors.

As the MarketScan® data is a compilation of many payers, our results reflect the average payment level for payers in the data, weighted by the volume of data. The payers included vary from market to market.

The Medicare inpatient results are based on analysis of the publicly available 2009 Medicare Provider Analysis and Review (MedPAR) file. The Medicare outpatient results are based on analysis of the publicly available 2009 Medicare Outpatient Prospective Payment System (OPPS) data and the publicly available 2009 Medicare Standard Analytic File 5% Sample (5% Sample). The OPPS data only includes data on services paid under the OPPS payment system. We used the 5% Sample data to supplement the OPPS data set, in order to include results for Critical Access hospitals and other hospitals not paid on OPPS. We defined the split of OPPS/non-OPPS on whether a hospital's provider ID appeared in the OPPS data set.

The 5% Sample, not surprisingly, includes data for 5% of Medicare fee-for-service beneficiaries. In order to combine the Medicare outpatient results obtained from the 5% sample with those from the OPPS data (which is a 100% sample), we multiplied the 5% Sample results by a weighing factor of 20 (5% x 20 = 100%).

4. Limitations and Considerations

Any opinions expressed in this report are solely those of the authors.

Any reader of this report must possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the approaches and assumptions and the impact of these approaches and assumptions on the results. The reader should be advised by their own actuaries or other qualified professionals competent in the subject matter of this report, so as to properly interpret the material.

This report is not intended to benefit third parties. Regarding the contents of this report, Milliman makes no representations or warranties to third parties. Third parties are to place no reliance upon this report that would result in the creation of any duty or liability for Milliman or its employees to third parties, under any theory of law. Third parties receiving this report must rely on their own experts to draw conclusions about the report's contents.

As documented in the report, this analysis has relied extensively on historical data. The data were reviewed for reasonableness, but no independent audits were performed. Should errors or omissions be discovered in the source data, the results of our analysis would need to be modified. Future results will differ from the historic estimates in this report.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

Exhibit 1
Commercial Allowed per RVU
By State and Alaska MSA

Region	Average Allowed Conversion Factor												Allowed Amounts (millions)	
	Inpatient (CY 2009)					Outpatient (CY 2009)						Total		
	Med	Surg	Mat	MH/SA	Avg	ER	Surg	Rad	Lab	Other	Avg	Avg	Inpatient	Outpatient
Anchorage/Frbnks/Mat-Su	$136	$132	$95	$110	$125	$128	$86	$136	$156	$109	$116	$120	$12.3	$13.6
Non-MSA Area	$123	$111	$131	$143	$121	$114	$97	$178	$201	$116	$131	$126	$1.1	$2.8
AK	$134	$131	$99	$110	$125	$124	$88	$145	$163	$111	$119	$122	$13.5	$16.4
HI	$128	$93	$93	$120	$105	$117	$59	$70	$118	$103	$87	$96	$4.7	$2.9
ID	$81	$72	$66	$49	$72	$91	$67	$119	$136	$101	$89	$81	$23.1	$36.0
ND	$66	$70	$55	$54	$65	$53	$40	$85	$114	$57	$62	$64	$18.2	$11.5
OR	$115	$88	$97	$55	$93	$116	$81	$105	$105	$94	$98	$96	$67.1	$208.6
WA	$109	$105	$94	$50	$102	$133	$73	$60	$98	$80	$77	$89	$96.9	$276.0
WY	$101	$111	$101	$70	$105	$92	$95	$142	$169	$116	$114	$110	$24.6	$27.6
Comparison States	$100	$90	$84	$66	$90	$100	$69	$97	$123	$92	$88	$89	$234.7	$562.7

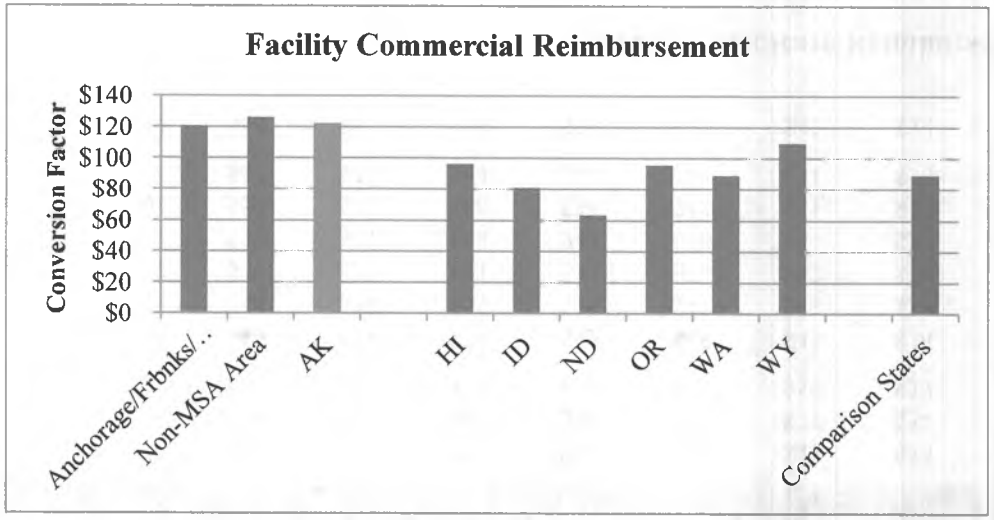


Exhibit 2
Medicare Allowed Charges per RVU
By State and Alaska MSA

Region	Number of Facilities	Average Allowed Conversion Factor											
		Inpatient (CY 2009)					Outpatient (CY 2009)						Total
		Med	Surg	Mat	MH/SA	Avg	ER	Surg	Rad	Lab	Other	Avg	Avg
Anchorage/Frbnks/Mat-Su	9	$57	$54	$71	$48	$55	$48	$34	$41	$36	$72	$46	$53
Non-MSA Area	19	$68	$56	$91	$70	$65	$77	$54	$87	$138	$93	$85	$74
AK	28	$60	$55	$74	$53	$57	$59	$37	$55	$81	$80	$57	$57
HI	62	$46	$44	$74	$42	$45	$43	$34	$40	$44	$40	$38	$43
ID	112	$44	$39	$55	$35	$41	$43	$33	$46	$63	$36	$38	$40
ND	117	$37	$35	$41	$33	$36	$42	$30	$42	$55	$37	$37	$36
OR	152	$49	$44	$58	$44	$46	$44	$37	$49	$59	$38	$41	$44
WA	304	$50	$46	$56	$35	$48	$41	$35	$46	$51	$37	$39	$45
WY	54	$47	$41	$64	$44	$44	$41	$38	$54	$76	$39	$44	$44
Comparison States	801	$46	$41	$58	$39	$43	$42	$34	$46	$58	$38	$39	$42

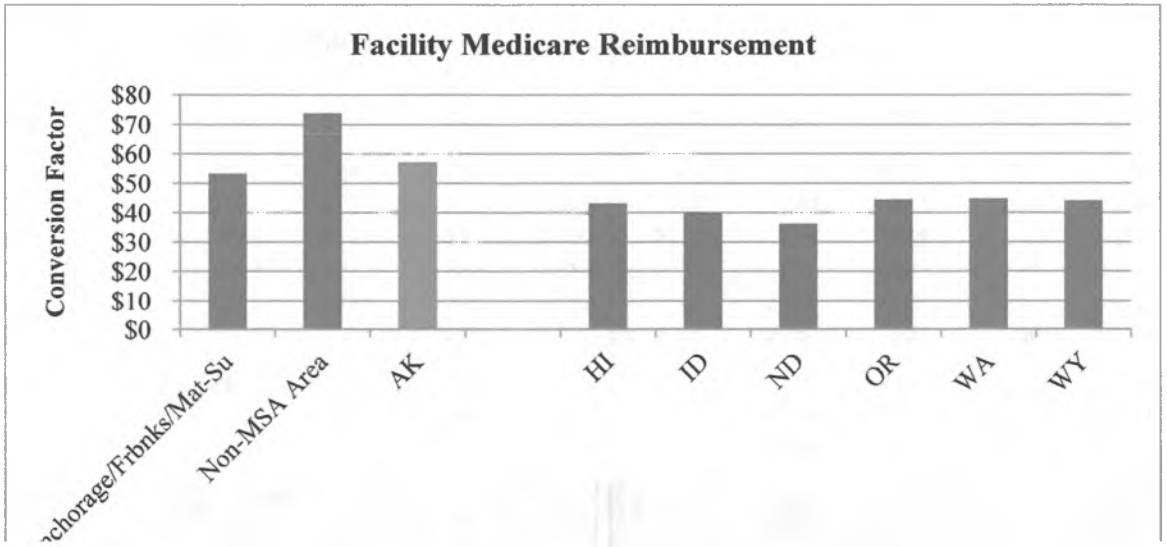


Exhibit 3
Billed Charges per RVU
By State and Alaska MSA

Region	Number of Facilities	Average Allowed Conversion Factor											
		Inpatient (CY 2009)					Outpatient (CY 2009)						Total
		Med	Surg	Mat	MH/SA	Avg	ER	Surg	Rad	Lab	Other	Avg	Avg
Anchorage/Frbnks/Mat-Su	9	$158	$172	$138	$104	$164	$188	$115	$207	$331	$157	$156	$162
Non-MSA Area	19	$110	$112	$150	$116	$111	$148	$111	$197	$266	$134	$152	$128
AK	28	$146	$168	$140	$107	$156	$173	$115	$204	$303	$148	$155	$156
HI	62	$116	$108	$163	$90	$112	$185	$104	$172	$276	$99	$129	$116
ID	112	$91	$101	$100	$70	$95	$115	$90	$143	$180	$84	$102	$98
ND	117	$74	$87	$92	$67	$80	$96	$77	$131	$161	$74	$91	$84
OR	152	$117	$115	$135	$105	$116	$139	$105	$158	$195	$97	$120	$117
WA	304	$138	$148	$178	$75	$141	$170	$132	$211	$221	$111	$145	$142
WY	54	$103	$121	$100	$87	$111	$105	$111	$172	$219	$96	$125	$115
Comparison States	801	$107	$113	$128	$82	$109	$135	$103	$164	$209	$93	$119	$112

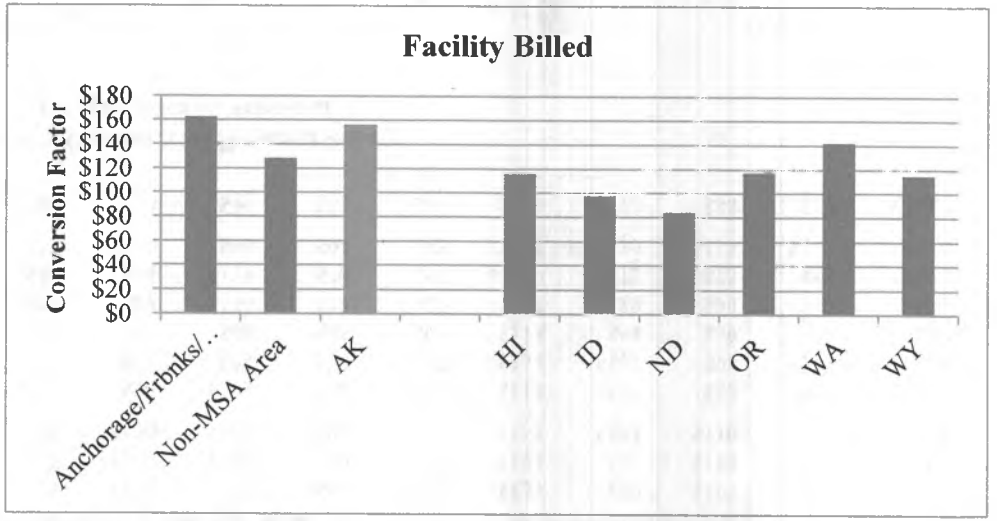


Exhibit 4
Geographically Adjusted Commercial Allowed per RVU
By State and Alaska MSA

	Average Allowed Conversion Factor												Allowed Amounts (millions)		Medicare Geographic Payment Adjustment	
	Inpatient (CY 2009)					Outpatient (CY 2009)						Total				
Region	Med	Surg	Mat	MH/SA	Avg	ER	Surg	Rad	Lab	Other	Avg	Avg	Inpatient	Outpatient	Inpatient	Outpatient
Anchorage/Frbnks/Mat-Su	$121	$117	$84	$97	$111	$117	$80	$125	$151	$100	$107	$109	$12.3	$13.6		
Non-MSA Area	$109	$99	$116	$127	$107	$104	$90	$163	$195	$107	$121	$114	$1.1	$2.8	1.129	1.077
AK	$119	$116	$88	$98	$110	$113	$82	$133	$158	$101	$110	$110	$13.5	$16.4	1.129	1.076
HI	$117	$85	$84	$109	$96	$109	$56	$66	$115	$97	$82	$89	$4.7	$2.9	1.102	1.061
ID	$88	$78	$72	$53	$78	$98	$70	$127	$134	$107	$94	$86	$23.1	$36.0	0.923	0.952
ND	$77	$82	$65	$62	$77	$60	$45	$97	$113	$64	$69	$73	$18.2	$11.5	0.852	0.897
OR	$107	$82	$90	$51	$87	$110	$78	$100	$102	$89	$94	$90	$67.1	$208.6	1.074	1.043
WA	$101	$97	$88	$46	$94	$124	$70	$57	$99	$75	$73	$83	$96.9	$276.0	1.081	1.051
WY	$106	$117	$106	$73	$110	$96	$97	$148	$177	$120	$118	$114	$24.6	$27.6	0.955	0.968
Comparison States	$99	$90	$84	$66	$90	$99	$69	$99	$123	$92	$88	$89	$234.7	$562.7		

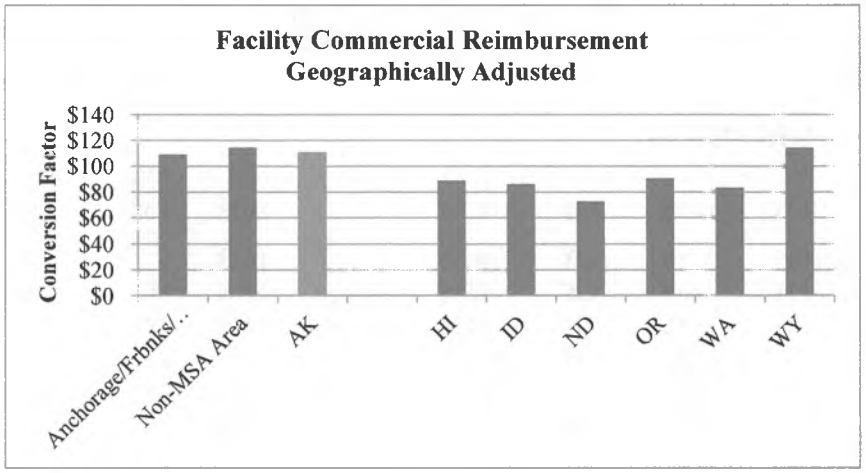


Exhibit 5
Medicare Allowed Charges per RVU
By Facility Type

Region	OPPS Facilities		Non-OPPS Facilities		Ratio: Non-OPPS / OPPS
	# of Facilities	Total	# of Facilities	Total	
Anchorage/Frbnks/Mat-Su	4	$51	5	$63	1.24
Non-MSA Area	2	$52	17	$92	1.78
AK	6	$51	22	$75	1.47
HI	14	$43	48	$55	1.30
ID	18	$38	94	$52	1.37
ND	10	$34	107	$44	1.29
OR	33	$42	119	$53	1.25
WA	51	$44	253	$52	1.18
WY	13	$41	41	$54	1.32
Comparison States	139	$40	662	$52	1.28

APPENDIX 1

RBRVS FOR HOSPITALS™

Milliman RBRVS for Hospitals

Will Fox, FSA, MAAA
Ed Jhu, FSA, MAAA
Charlie Mills, ASA, MAAA

WHAT IS RBRVS FOR HOSPITALS?

The Milliman RBRVS for Hospitals™ Fee Schedule provides a simple solution for comparing hospital contractual allowed amounts, billed charge master levels, efficiency, and patient mix differences. The fee schedule is based on Relative Value Units (RVUs). The RVUs are the same for procedures that require the same relative resources.

ADVANTAGES OF RBRVS FOR HOSPITALS

- RVUs have been developed for all hospital services (inpatient and outpatient), so they reflect the relative resources required to perform the care.
- The concept is similar to Medicare's RBRVS physician fee schedule, in that a conversion factor provides a valid comparison even for widely different provider types and patient populations.
- A single conversion factor can be used to benchmark a hospital contract. Lengthy summaries of hospital contracts with medical/surgical per diems, maternity case rates, ICU per diems, outlier arrangements, and miscellaneous outpatient reimbursement structures are no longer necessary.
- Allows insurers and hospitals to benchmark and compare contractual reimbursement levels, efficiency, billed charge master levels, and benchmark patient mix differences.

DEVELOPING RBRVS FOR HOSPITALS RVUS

All inpatient and outpatient procedures are assigned RVUs. Procedures requiring the same level of resources have the same RVUs. Both the inpatient and outpatient RVUs are developed using Medicare payment rates, which are then converted to RVUs using Medicare's RBRVS conversion factor. Therefore, inpatient and outpatient RVUs are directly comparable.

INPATIENT RVU DEVELOPMENT AND ADJUDICATION

Inpatient RVUs are developed at the most detailed level possible using data commonly available in administrative claims, resulting in a very refined patient severity adjustment

- RVUs are assigned per day, rather than per case. The RBRVS for Hospitals RVUs are comprised of Diagnosis Related Group (DRG) specific First Day and Additional Day RVUs. The First Day RVUs are an estimate of the resources required for the first day of each admission. DRG-specific Additional Day RVUs are assigned for each additional day of acute care. The Additional Day RVUs are an estimate of the resources required for each subsequent day of acute care.
- The Additional Day RVUs are lower than the First Day RVUs, reflecting lower resource use on the additional days. Thus, the RVU fee schedule adjusts for differences in length of stay and patient mix among hospitals. As a result, hospital specific average inpatient conversion factors developed using the RVUs provide a direct comparison of historic or projected fee levels for different hospitals, even if the fee schedules for each hospital are structured differently.
- Using Medicare's average length of stay, the Milliman RVUs and the Medicare RBRVS conversion factor will produce payments that are similar to Medicare's case rates, as demonstrated in Table A.
- For more refined risk adjustment, Milliman has developed RVUs for inpatient services based on APR-DRGs at each severity level within the APR-DRG system (1,266 DRGs/severity levels versus

TABLE A

INPATIENT EXAMPLE #1
FY 2010 MEDICARE RELATIVE WEIGHTS TO MILLIMAN RBRVS FOR HOSPITALS RVUS (V2010.0)
COMPARISON FOR DRG 069 – TRANSIENT ISCHEMIA

MEDICARE (FY 2010)	
RELATIVE WEIGHT	0.7289
CONVERSION FACTOR (NATIONWIDE)	$5,652.40
CASE PAYMENT	$4,120.03

MILLIMAN RBRVS (V2010.0) – MS DRG	
INITIAL DAY RVU	66.848
ADDITIONAL DAY RVU	24.490
MEDICARE ALOS	2.933
TOTAL RVUS FOR ALOS	114.187
RBRVS CONVERSION FACTOR	$36.0846
AVERAGE CASE PAYMENT	$4,120.40

746 MS DRGs). In Table B, we provide a comparison of the MS-DRG RVUs to the APR-DRG RVUs.

The RVUs for any inpatient admission are calculated as:

(First Day RVUs + (Additional Day RVUs))

Note that "Additional Days" includes all days after day 1.

RVUs can be assigned to claims on either a per case or a per day basis. The formula above illustrates the calculation of RVUs using a "per day" approach and incorporates the LOS in estimating the resources used to treat a patient. Alternatively, Case RVUs represent the average resources used for the given service independent of LOS.

Case RVUs are created to be consistent with the characteristics of the population to be measured. For example, resource consumption for a given APR-DRG may differ between commercial and Medicare populations, or potentially between populations in different geographic areas based on LOS management. Milliman develops population-specific case-based RVUs by setting average LOS assumptions using client and/or benchmark data combined with actuarial judgment.

With RVUs assigned on both a per day and per case basis, a LOS efficiency measure can be calculated as:

$$\frac{\text{RVUs on a per day basis}}{\text{RVUs on a per case basis}}$$

Using this method of comparison, a ratio of 1.0 indicates average efficiency. Values lower than 1.0 indicates better than average efficiency, as the hospital required fewer RVUs than average to deliver its mix of services.

Table C shows an example of the implied efficiency for a sample discharge using APR-DRG 047 and Severity Level 1. By summing the RVUs and Case RVUs for each discharge, we estimate the overall efficiency factor for each facility.

OUTPATIENT RVU DEVELOPMENT AND ADJUDICATION

The outpatient case mix and severity adjustment methodology assigns an RVU for each procedure performed by the hospital using HCPCS.

The Milliman RBRVS for Hospitals outpatient RVUs can be viewed as an extension of the Medicare RBRVS schedule. We use the

TABLE B

INPATIENT EXAMPLE #2
COMPARISON OF MEDICARE AND APR-DRG RVUS (V2010.0)

DRG	SEVERITY	DESCRIPTION	FIRST DAY RVUS	ADDITIONAL DAY RVUS
MEDICARE-DRG				
069		TRANSIENT ISCHEMIA	66.848	24.490
APR-DRG				
047	1	TRANSIENT ISCHEMIA	65.682	23.666
047	2	TRANSIENT ISCHEMIA	66.145	23.949
047	3	TRANSIENT ISCHEMIA	70.933	25.383
047	4	TRANSIENT ISCHEMIA	88.064	31.381

* THE FOUR SEVERITY LEVELS AVAILABLE USING APR-DRGS ALLOW FOR A MORE REFINED QUANTIFICATION OF THE RESOURCES REQUIRED FOR SPECIFIC PATIENTS.
* MEDICARE SETS DRG RELATIVE WEIGHTS AT THE CASE RATE LEVEL, NOT ACCOUNTING FOR LOS VARIATIONS.

TABLE C

EXAMPLE OF IMPLIED LOS EFFICIENCY

APR-DRG 047, SEVERITY LEVEL 1 (TRANSIENT ISCHEMIA)

BASE RVUS	BASE LOS	ADDITIONAL DAY RVUS	AVERAGE LOS	CASE RVUS
65.682	1.000	23.666	1.711	82.509

EXAMPLE OF EFFICIENCY CALCULATION

ASSUMED LENGTH OF STAY (LOS)	(1) ACTUAL LOS	(2) LOS-ADJ. RVUS	(3) CASE RVUS	(4) = (2) / (3) EFFICIENCY FACTOR
AVERAGE LOS PATIENT	1.711	82.509	82.509	1.000
SHORT LOS PATIENT	1.000	65.682	82.509	0.796
LONG LOS PATIENT	3.000	113.014	82.509	1.370

RBRVS technical component RVUs as a basis for many procedures, such as X-rays and cardiovascular testing. We utilize many other data sources to create our outpatient RVUs including Medicare fee schedules, proprietary data sources and public data sources. Clinical and actuarial reviews are used to finalize the relative relationships.

Our 2010 outpatient hospital RVU schedule consists of 14,129 procedure codes. The breakdown of codes by source is as follows:

3,537	Medicare Fee Schedules
10,592	Milliman Defined
14,129	Total

There are many areas where publicly available fee schedules are not adequate for creating RVUs. We used other databases and our internal resources to estimate the relative resources to perform each of these services. For example, Medicare APCs include procedures of which the true cost may be as low as half of the APC average or as high as twice the average. Therefore, the actual resources required for a procedure within an APC can vary significantly. Since Medicare APCs do not define homogeneous patient services, Milliman Outpatient RVUs are assigned at the HCPCS level, rather than APC. By assigning RVUs at the HCPCS level for outpatient services, we are able to more precisely reflect the resources required for each specific service.

Table D illustrates the resource differences by HCPCS for a sample Medicare APC.

Most outpatient services have Milliman RVUs; however, the treatment of services with no RVUs is important in calculating conversion factors. The outpatient RVU fee schedule includes an identification field for all services that have no RVUs. Some procedures are not valued (NVS) because a more specific HCPCS should be coded. Some HCPCS are not valued because they are typically not paid to a facility, but to a professional provider type (NVO). Bundled procedures are labeled as NVB. Finally some low volume procedures have not yet been valued (NYV) by Milliman and should be excluded from analysis.

Conditionally packaged codes (status indicator Q) have both an RVU value and a not valued reason (either Q-T or Q-STVX, depending upon the bundling rules applicable to each HCPCS).

Following is a summary of entries for codes with no RVUs:

NYV	=	Not Yet Valued
NVS	=	Not Valued–non-specific procedure code
NVO	=	Not Valued–Other provider type should bill
NVB	=	Not Valued–Bundled procedure
Q-T	=	Bundled if another code with status indicator T is included in the same claim. Otherwise, RVUs are separately assigned.
Q-STVX	=	Bundled if another code with status indicator S, T, V, or X is included in the same claim. Otherwise, RVUs are separately assigned.

Reimbursement analyses can usually be performed with less than perfect data, since we can assume that the calculated conversion factor for the partial data is representative of the complete outpatient data set.

The RVU schedule includes a field labeled "maximum procs," which puts a limit on the number of times a procedure should be performed during a single encounter. This field can be helpful in evaluating reimbursement levels (attaching RVUs) and adjudicating claims. Our adjudication process limits units to the maximum procs for a HCPCS.

RBRVS for Hospitals includes a listing of revenue codes that represent bundled services. No RVUs should be calculated for line items with these revenue codes (unless there is a valid non-bundled CPT/HCPCS code), as the workload is implicitly covered in other lines within the encounter. CPT/HCPCS codes with N status indicators have no RVUs since they are bundled items.

TABLE D

COMPARISON OF 2010 APC VS RBRVS FOR APC 0269
APC 0269 - LEVEL II ECHOCARDIOGRAM WITHOUT CONTRAST

CPT/ HCPC	STATUS INDICATOR	DESCRIPTION	APC	APC RATE	MILLIMAN	MEDICARE FREQUENCY
76826	S	ECHO EXAM OF FETAL HEART	0269	$450.97	$209.44	41
93304	S	ECHO TRANSTHORACIC	0269	$450.97	$251.73	414
93306	S	TTE W/DOPPLER, COMPLETE	0269	$450.97	$470.22	546,266
93313	S	ECHO TRANSESOPHAGEAL	0269	$450.97	$442.72	1,428
93350	S	STRESS TTE ONLY	0269	$450.97	$350.42	103,575
				MINIMUM	$209.44	
				MAXIMUM	$470.22	
				WEIGHTED AVERAGE	$450.96	

TABLE E

SAMPLE OUTPATIENT CLAIM RVU ASSIGNMENT

CLAIM NUMBER	CLAIM LINE	REVENUE CODE	PROCEDURE CODE	STATUS INDICATOR	UNITS	RVUS	ADJUDICATED RVUS	COMMENTS
2004999	1	250			5	-	-	BUNDLED REVENUE CODE AND NO HCPCS.
2004999	2	258			1	-	-	BUNDLED REVENUE CODE AND NO HCPCS.
2004999	3	270	A4649	N	3	-	-	BUNDLED CPT/HCPCS CODE. NO RVUS.
2004999	4	300	88302	X	1	0.354	0.354	PAID IN FULL.
2004999	5	360	49580	T	1	56.505	56.505	1ST "T" PROCEDURE. PAID IN FULL.
2004999	6	360	11100	T	1	2.458	1.229	2ND "T" PROCEDURE. REDUCED TO 50%.
2004999	7	370			4	-	-	BUNDLED REVENUE CODE AND NO HCPCS.
2004999	8	636	J2180	N	1	-	-	BUNDLED CPT/HCPCS CODE. NO RVUS.
2004999	9	636	J2270	N	1	-	-	BUNDLED CPT/HCPCS CODE. NO RVUS.
2004999	10	762			1	-	-	BUNDLED REVENUE CODE AND NO HCPCS.
	TOTAL						58.088	

Multiple procedure discounting follows the CMS rules. The code with the greatest RVUs and with status T is paid at 100%. Other codes with a T status are paid at 50% and, therefore, assigned half of the standard RVUs.

Table E shows the adjudication of a sample claim.

Note that, as a result of the bundling rules implicit in RBRVS for Hospitals, payment amounts should be compared on a claim-by-claim basis and should not use individual service lines. Payment systems that separately pay bundled services will have higher values for those amounts, but lower values for the main procedure(s) within each encounter.

Outpatient claims do not fall into homogeneous case categories as easily as inpatient claims. However, RBRVS for Hospitals supports hospital efficiency evaluations for emergency room and surgeries. In addition to the procedure RVUs, the user can assign a separate single RVU for the entire case, allowing the user to evaluate efficiency by comparing the case RVUs to the service RVUs. The efficiency-adjusted RVUs can be used to create efficiency-adjusted outpatient conversion factors.

Emergency Room case RVUs assume an average level of ancillary diagnostic and minor surgical procedures that varies by emergency room encounter level. The surgery case RVUs include an average level of ancillaries and additional surgeries for each primary surgical procedure. On average, the total RVUs should be approximately the same for procedure RVUs or case RVUs.

Case RVUs are not a standard part of the HECS license and need to be customized for the provider practice patterns in each service area. Customizing case RVUs for each line of business is a highly technical undertaking. Contact Milliman for help creating case RVUs.

CALCULATING CONVERSION FACTORS

Benchmarking contracts is as straightforward as adding up the allowed charges and RVUs for all procedures performed under that contract.

Table F shows an example of calculating an average conversion factor for a data set including one inpatient claim and one outpatient claim.

The procedural basis can be a CPT/HCPCS procedure code (i.e., outpatient hospital services) or a DRG (i.e., inpatient hospital stays). For DRGs, the RVUs vary with the LOS to further reflect the severity within a DRG.

A conversion factor may be calculated for any number and/or mix of services performed under the contract. If a procedure can be performed multiple times in one encounter (i.e., 15-minute physical therapy), then the procedure can either be listed multiple times or with multiple units of service on a single line. In either case, the units will be multiplied by the RVUs per unit of service to show RVUs consistent with the charges on the claim.

The HECS case mix and severity adjusted conversion factors provide a means to compare average per-unit costs among contracts, lines of business, health plans, service categories, hospitals or health

TABLE F

CALCULATING A CONVERSION FACTOR

	ALLOWED CHARGES	LOS	RVUS
APR 047-1	$6,000	3	113.014
82441	$20		0.237
99284	$275		6.185
A4642*	$95		-
74150	$425		5.709
TOTAL	$6,815		125.145
CONVERSION FACTOR [ALLOWED CHARGES/RVUS]			$54.46

* BUNDLED SERVICE. RVUS ARE IMPLICITLY INCLUDED IN RVUS FOR OTHER CPT/HCPCS CODES.

systems. Since the RBRVS for Hospitals RVUs adjust for the relative resources required to perform the services, the calculated conversion factors are comparable regardless of the underlying population, hospital type, or location. See Table G for an example of conversion factors for six contracts and their relative cost differences.

Users interested in developing a better understanding of the components affecting the average conversion factor may drill down to review the results by type of service. Table H expands the six-contract conversion factor summary from Table G to include each major type of inpatient and outpatient service.

A summary like Table H can be useful in identifying where a contract is high or low and allows the user to develop an action plan to change the contract details in order to improve the desired results. For example, assume that Table H represents six contracts for a payer and the payer wants to re-negotiate Contract #3 rates to be more in line with the other contracts. Rather than just ask for an overall rate decrease, the payer may want to focus on a particular area, such as outpatient radiology. The payer may either propose that the contract move to use the RBRVS for Hospitals RVUs and a lower conversion factor, or they may simply negotiate a lower payment using the current payment methodology (e.g., percent of billed charges).

TABLE G

CONTRACT SUMMARY TABLE

	TOTAL CONVERSION FACTOR	CONVERSION FACTOR RELATIVE TO TOTAL
CONTRACT #1	$55.48	1.000
CONTRACT #2	$46.29	0.834
CONTRACT #3	$80.43	1.450
CONTRACT #4	$60.64	1.093
CONTRACT #5	$63.70	1.148
CONTRACT #6	$48.46	0.874
TOTAL	$55.47	1.000

Alternatively, assume that Table H represents six contracts for a hospital and the hospital identifies that Contract #2 is a low outlier. The hospital can use the information in Table G to quantify the amount of increase needed. They may decide that they need a 25% increase in inpatient rates, but the outpatient rates are satisfactory.

RBRVS FOR HOSPITALS USERS AND REVIEWS

There are a large number of companies that have or currently use the RBRVS for Hospitals. They include:

- twenty Blue Cross Blue Shield plans
- many other insurers
- three state Medicaid plans
- hospitals (academic, tertiary, community)
- CalPERS (used to create a high performance network)

The RVUs were first developed in 1994 and are updated and reviewed at least once a year, in accordance with Milliman's strict internal peer-review standards. In addition, the RVUs are receiving continuous outside review as they are used by a wide variety of clients.

At the request of a client, an independent actuarial consulting firm performed a review. This review encompassed not only the RVUs themselves, but also the worksheets used to calculate relative provider costs, and ultimately, determine relative facility rankings.

A complete audit of the RVUs and hospital rankings was performed by the California Bureau of State Audits. The audit was comprehensive, covering all aspects of the hospital ranking process. The audit included an on-site review of the RVU development and documentation by an independent actuary hired by the state.

Will Fox, FSA, MAAA, is a principal and consulting actuary with the Seattle office of Milliman. Contact him at *will.fox@milliman.com*.

Ed Jhu, FSA, MAAA, is a consulting actuary with the Seattle office of Milliman. Contact him at *ed.jhu@milliman.com*.

Charlie Mills, ASA, MAAA, is an associate actuary with the Seattle office of Milliman. Contact him at *charlie.mills@milliman.com*.

TABLE H

CONVERSION FACTORS BY MAJOR TYPE OF SERVICE

	INPATIENT CFS					OUTPATIENT CFS						
CONTRACT	MED	SURG	MH/SA	MAT	AVG	ER	SURG	RAD	LAB	OTHER	AVG	TOTAL AVG
CONTRACT #1	$65	$52	$61	$58	$58	$53	$32	$68	$89	$57	$50	$55
CONTRACT #2	$48	$30	$37	$53	$40	$45	$41	$77	$60	$60	$53	$46
CONTRACT #3	$85	$92	N/A	$79	$86	$49	$77	$95	$94	$80	$77	$80
CONTRACT #4	$54	$41	$70	$53	$53	$36	$50	$81	$83	$74	$67	$61
CONTRACT #5	$58	$44	$75	$57	$57	$42	$49	$87	$88	$79	$69	$64
CONTRACT #6	$51	$33	$56	$53	$45	$38	$47	$54	$58	$68	$50	$48
TOTAL	$62	$48	$59	$57	$55	$47	$41	$72	$77	$67	$56	$55

The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should

1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605
+1 206 504 5569

APPENDIX 2

ALASKA HOSPITAL LIST

Appendix 2 - Alaska Hospital List

Following is the list of facilities included in the analysis of Medicare allowed amounts for this report.

Anchorage / Fairbanks

Alaska Native Medical Center
Alaska Psychiatric Institute
Alaska Regional Hospital
Denali Center
Fairbanks Memorial Hospital
Mat-Su Regional Medical Center
Providence Alaska Medical Center
Providence Extended Care Ctr
St Elias Specialty Hospital

Non-MSA Area

Bartlett Regional Hospital
Central Peninsula General Hospital
Cordova Community Medical Center
Kanakanak Hospital
Ketchikan General Hospital
Maniilaq Health Center
Mt Edgecumbe Hospital
Norton Sound Regional Hospital
Petersburg Medical Center
Providence Kodiak Island Medical Ctr
Providence Seward Hospital
Providence Seward Med & Care Center Ltc
Providence Valdez Medical Center
Samuel Simmonds Memorial Hospital
Sitka Community Hospital
South Peninsula Hospital
Wildflower Court
Wrangell Medical Center
Yukon Kuskokwim Delta Reg Hospital

Milliman

Drivers of Health Care Costs in Alaska and Comparison States

Prepared for:
Alaska Health Care Commission

Prepared by:
Milliman, Inc.
1301 Fifth Ave.
Seattle, WA 98101-2605

Edward Jhu, FSA, MAAA
edward.jhu@milliman.com
206 504 5828

John Pickering, FSA, MAAA
john.pickering@milliman.com
206 504 5884

TABLE OF CONTENTS

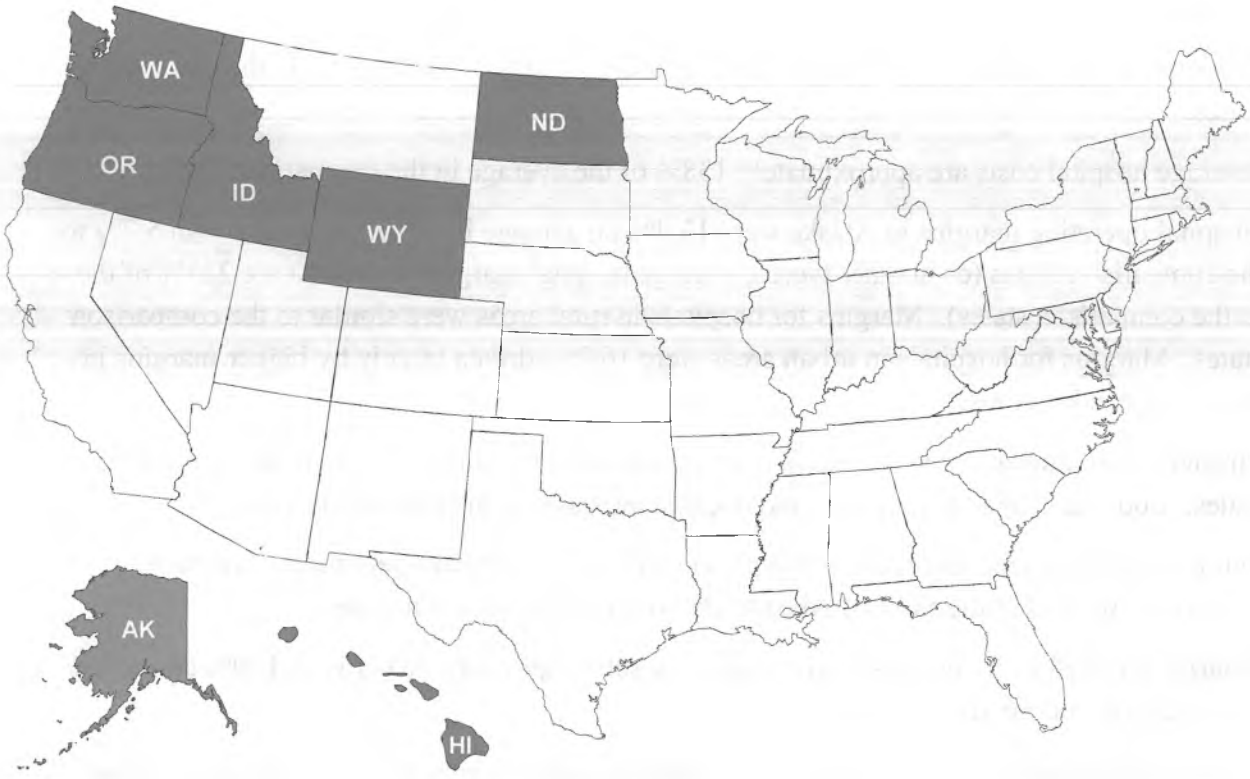
1. EXECUTIVE SUMMARY 1
2. COMMERCIAL HEALTH INSURANCE PREMIUMS 5
3. HEALTHCARE RESOURCE USE 8
4. INPATIENT LENGTH-OF-STAY 12
5. HOSPITAL OPERATING COSTS 14
6. HOSPITAL MARGINS 19
7. OCCUPANCY RATES 24
8. STAFFING RATIOS 26
9. PROFESSIONAL SALARIES 28
10. HEALTH CARE PROFESSIONAL SHORTAGE AREAS 32
11. COMMERCIAL DISCOUNTS 33
12. COST OF LIVING 35
13. LIMITATIONS AND CONSIDERATIONS 37

APPENDIX 1. LIST OF HOSPITALS 38

1. Executive Summary

Background

The Alaska Health Care Commission ("AHCC") engaged Milliman to compare Alaska's health care payment rates and underlying drivers to those in certain other states. The comparison states are Washington, Oregon, Idaho, Wyoming, and North Dakota. Hawaii was also included in the comparison states where practical. The comparison states were selected by the AHCC.



This report is the third of three reports. This report is focused on how Alaska's health care costs and underlying drivers compare to other states. The first report analyzed physician payment rates in Alaska. The second report analyzed facility payment rates in Alaska.

The previous two reports indicated that Alaska's reimbursement exceeds that in the comparison states for both physician and hospital services. Our analysis of the drivers behind those higher reimbursements suggests that some portion results from higher costs incurred by the providers. However, some component of the higher reimbursement is resulting in higher profit for private sector facilities in Alaska, particularly in the urban areas, and higher compensation for physician services relative to the overall cost of living. A brief summary of conclusions is presented below.

Our initial reports showed that the mean physician reimbursement from commercial payers in Alaska is approximately 169% of the average in the comparison states, and that across all payers, physician reimbursement is approximately 160% of the comparison state average. Similarly, commercial reimbursement for facilities in Alaska is approximately 137% of the average in the comparison states.

KEY CONCLUSIONS

- Commercial health care premiums in Alaska are approximately 130% of the average in the comparison states.
- Commercial hospital reimbursement is approximately 137% of the average in the comparison states.
- Average hospital costs are approximately 138% of the average in the comparison states.
- Hospital operating margins in Alaska were 13.4% on average in 2010, compared with 5.7% for the comparison states (or in other words, average hospital margins in Alaska are 233% of those in the comparison states). Margins for hospitals in rural areas were similar to the comparison states. Margins for hospitals in urban areas were 16.2%, driven largely by higher margins in two for-profit hospitals.
- Physician reimbursement in Alaska is approximately 160% of the average in the comparison states. Looking only at commercial payers, this increases to approximately 169%.
- Our analysis of discounts revealed that physicians have significant negotiating leverage relative to insurers in the State of Alaska relative to the comparison states.
- Salaries for health care professionals (excluding self-employed) are between 100% and 110% of those in the comparison states.
- Overall health care utilization rates for Medicare patients are similar to the comparison states. Utilization rates for commercial patients are similar to the comparison states for urban areas, but significantly higher in rural areas.

SUMMARY OF ANALYSES

Section 2 of this report shows that commercial premiums in Alaska are approximately 130% of the average in the comparison states. This is directionally consistent with the higher physician and facility costs, but is likely dampened somewhat by other elements of health care such as prescription drugs, which may have costs that are more similar to the comparison states.

The remaining report can be subdivided into two categories, utilization and unit cost. Sections 3 and 4 compare the utilization of health care services in Alaska against the comparison states. More efficient use of health care resources can offset higher unit costs. Our analyses found that urban areas in Alaska are similar to the comparison states in its resource utilization which makes it more efficient

than the nationwide average. Utilization in rural Alaska areas appears to be higher than in the comparison states. Utilization efficiency in rural areas is likely constrained by the delivery system and the relative lack of population density.

The remaining sections of the report focus on the cost per unit of service. On the hospital side, this can be further subdivided into the operating costs incurred by the facility (Section 5) and the profit margin (Section 6). Operating costs for hospitals in Alaska are approximately 138% of the average operating costs in the comparison states. This ratio increases to 186% when restricting to only the rural Alaska facilities. As a result, Alaska facilities have suffered higher losses from Medicare patients than in the comparison states. However, across all payers, average margins for Alaska facilities exceed those in the comparison states in each year of our analysis. The higher margins are driven primarily by two of the urban facilities, which have margins that are considerably higher than averages elsewhere in Alaska or the comparison states.

Sections 7 and 8 look at hospital occupancy rates and staffing ratios to explore contributors to the higher costs for Alaska facilities. Occupancy rates in Alaska are lower than the comparison states, particularly in the rural areas, consistent with the relationship between rurality and occupancy across the comparison states. As a result, there are fewer admissions over which to spread the fixed costs of operation, raising unit costs. Staffing ratios (measured as nurses per occupied bed) in Alaska are also higher than in the comparison states, further increasing costs.

Section 9 compares compensation for nurses and other employed health care professionals in Alaska against those in the comparison states. The analysis shows that salaries for nurses in Alaska are approximately 100% to 110% of those in the comparison states, as compared to the 160% ratio in commercial professional unit cost reimbursement. Similarly, Section 12 shows that the composite cost of living in Alaska is approximately 120% – 130% of the average in the comparison states excluding Hawaii.

Section 10 compares the relative availability of primary care by state. Approximately 12% of Alaska residents live in medically underserved areas. While this issue is a concern, it is not limited to Alaska, as the nationwide average is similar (and the percentage of medically underserved is higher in three of the six comparison states).

Section 11 compares negotiated discounts for commercial payers by state. Hospital discounts are similar to the comparison states (though the comparison states have a considerable range), but physician discounts are lower than each of the comparison states, which contributes to the higher reimbursement. We believe that the low discounts are indicative of physician negotiating leverage relative to the health plans, which is likely driven in turn by the relative scarcity of physicians (particularly specialists).

Overall, the higher commercial premiums in Alaska are being driven by higher unit costs, rather than by higher utilization of health care resources. The higher physician reimbursement is caused, at least in part, by the relative scarcity of providers. On the hospital side, higher reimbursement can be explained by higher facility costs in the rural areas, but is leading to higher profit margins in urban areas where the reimbursement in Alaska (relative to the comparison states) is greater than the relative cost.

This report did not review the relative quality of care provided to Alaskans, nor the relative health outcomes from treatment. Those issues were beyond the scope of our report but should be considered when evaluating the relative value of health care in Alaska.

2. Commercial Health Insurance Premiums

The level of a state's commercial health insurance premiums is a key indicator of the level of its health insurance costs. In this section we compare the level of Alaska's commercial health insurance premiums to the level in other states, and to the national average.

A. Detailed Results

Health insurance premiums are the amounts that health insurance companies charge individuals and businesses to pay for healthcare expenses. This section compares premiums that insurance companies in various states would have charged in 2010 to cover a typical company with 100 employees, for a Preferred Provider Organization (PPO) healthcare plan with specified benefits, including prescription drug coverage.

2010 Group Health Insurance Survey

Milliman conducts surveys of the premiums charged by the nation's health insurers that serve the commercial large- or small-group markets. Over sixty health insurers participated in the Milliman *2010 Group Health Insurance Survey*, the 17th edition, representing a total enrollment of about one hundred million members.

For the 2010 survey, respondents were asked to provide single employee, family, and per covered member premium rates for a specified group of 100 employees covered by a specified PPO plan, including prescription drug coverage as well as administrative costs and profit, but excluding broker commissions, with a July 1, 2010 renewal date.[1]

Data for the comparison of premiums in this section is from the Milliman 2010 Group Health Insurance Survey (see the sidebar). To learn more about how we compiled the premium data, see Section 2.B: Methodology.

Table 2A.1 below shows 2010 average commercial PPO premium levels for Alaska and the comparison states where there were 3 or more survey responses (states with fewer than 3 respondents are not included to preserve the confidentiality of respondents). The nationwide average premium shown in the table is the weighted average of premiums for all states with 3 or more survey responses, using census bureau data for persons under age 65 as the relative weight for each state.

For each state, the table shows monthly premiums for single employee coverage, family coverage and per member per month (PMPM). Results are shown relative to the average of the comparison states. Alaska's PMPM premiums are approximately 130% of the comparison states' average.

[1] For more information about the survey, see www.milliman.com/news-events/press/pdfs/milliman-group-health-survey.pdf

Table 2A.1
Health Insurance PPO Premium Levels as a Percentage of the Comparison States' Average (2010)

State	Health insurance PPO premiums					
	Single employee coverage		Family coverage		Per member	
	Monthly amount	Relative to comparison state average	Monthly amount	Relative to comparison state average	Monthly amount	Relative to comparison state average
Idaho	$486	91%	$1,358	98%	$451	95%
Washington	552	103%	1,413	102%	482	102%
Oregon	571	106%	1,406	101%	486	103%
Alaska	**684**	**128%**	**1,817**	**130%**	**613**	**130%**
Comparison State Average	$536	100%	$1,392	100%	$473	100%
Nationwide Average	$508		$1,390		$465	

In order to validate the results of the Milliman survey, we compared them to results obtained by the Agency for Healthcare Research and Quality (AHRQ) in their annual Medicare Expenditure Panel Survey (MEPS) for 2010. Results from MEPS are shown in Table 2A.2 and are similar to the Milliman survey results. MEPS showed that Alaska single-employee premiums were 126% of the comparison states' average, and family premiums were 110% of the average. These results include all six comparison states.[2] We suspect that the 110% value for families is driven by a different average family demographic in Alaska relative to the other states (e.g. fewer members per family), and we consider the 126% single-employee value to be the more meaningful value.

[2] For more information on the AHRP MEPS study, see http://meps.ahrq.gov/mepsweb/

Table 2A.2
Premium Levels from AHRQ as a Percentage of the Comparison States' Average (2010)

State	Health Insurance Premiums			
	Single employee coverage		Family coverage	
	Monthly amount	Relative to comparison state average	Monthly amount	Relative to comparison state average
Idaho	$375	94%	$948	88%
Hawaii	358	89%	1,005	93%
North Dakota	393	98%	1,045	97%
Oregon	432	108%	1,146	106%
Wyoming	434	108%	1,158	107%
Washington	415	103%	1,182	109%
Alaska	**507**	**126%**	**1,186**	**110%**
Comparison State Avera	$401	100%	$1,081	100%
Nationwide Average	$412		$1,156	

B. METHODOLOGY

The 2010 Milliman *Group Health Insurance Survey* presents state-specific health insurance premiums for a specified PPO plan for 32 states.[3]

The Milliman *Group Health Insurance Survey* requires three responses before including states. For the state of Washington, PPO premium data was not directly available from the survey, because Milliman received only two relevant responses from Washington healthcare insurers. To supplement the two responses, we used the publicly-available small group PPO rate filing for July 1, 2010 from a large Washington health insurer that was not included in the survey. From this insurer, we used the rate filing for the plan that most closely matches the specified plan for the survey. To put this additional plan on a comparable basis with survey responses, we used Milliman's *Health Cost Guidelines*™ to calculate the actuarial differential between the additional plan and the specified survey plan. We then adjusted the additional plan's premium rates to reflect this differential. Lastly, we averaged three premium rates (two from the survey, and one from the additional plan) to obtain the Washington premiums to compare to other states. We calculated average PMPMs using the specified demographics and the single employee and family rates.

[3] For more information about the survey, see www.milliman.com/news-events/press/pdfs/milliman-group-health-survey.pdf.

3. HEALTHCARE RESOURCE USE

A. DETAILED RESULTS

In this section, we compare the level of Alaska's healthcare resource use and healthcare utilization to the levels in other states and to national averages.

Wide variation in healthcare resource use

As an illustration, consider the rate of hip replacements per 1,000 people. In 2005 – 2006, Bryan, Texas had the nation's lowest rate—1.8 replacements per 1,000 Medicare beneficiaries—while Ogden, Utah had the nation's highest rate—7.2, four times higher than in Bryan, Texas. During the same period, Anchorage had a rate of 3.6.

These results are from the Dartmouth Atlas Project.[4]

In the US, there is wide variation from state to state in healthcare resource use and healthcare utilization. To compare healthcare resource use among the states, we employ a metric called "Adjusted Resource Use". It is the amount of healthcare resources used by Medicare beneficiaries in a particular state, adjusted for demographics (including health status) and the relative cost of health care services so that states are directly comparable. To learn more about the metric, see Section 3B: Methodology.

Table 3A.1 below shows the Adjusted Resource Use for Alaska and each comparison state during the period 2006 – 2008, both as a percent of the national average and relative to the comparison states' average. Alaska's Adjusted Resource Use is 87% of the national average, meaning that Alaska uses 13% fewer services than the nationwide average to treat a similar patient. The comparison states all have below average Adjusted Resource Use as well. Alaska's Adjusted Resource Use is equal to the average of the comparison states.

Table 3A.1
Healthcare Resource Use Among Medicare Beneficiaries (2006-2008)[5]

State	Adjusted Resource Use (% of national average)	Adjusted Resource Use (relative to comparison states)
Hawaii	76%	87%
Oregon	86%	98%
Alaska	**87%**	**100%**
North Dakota	88%	101%
Washington	89%	102%
Idaho	92%	105%
Wyoming	94%	107%
Comparison States	87%	100%
Nationwide	100%	

[4] Fisher, E. S., Bell, J.-E., Tomek, I. M., Esty, A. R., & Goodman, D. C. (2010). Trends and regional variation in hip, knee, and shoulder replacement A Dartmouth Atlas Surgery Report (pp. 24): The Dartmouth Institute for Health Policy & Clinical Practice.

[5] Medicare Payment Advisory Commission (2011), www.medpac.gov/document_TOC.cfm?id=631

Tables 3A.2 and 3A.3 show how Alaska compares to other areas on key healthcare utilization metrics. The utilization results in Table 3A.2 are based on data from Milliman's 2011 Commercial (i.e. Under Age 65) *Health Cost Guidelines*™.

Table 3A.2
Healthcare Utilization Results – Utilization per 1,000 (2011)

	Utilization per 1,000 people (2011)							
	Inpatient bed days		ER Visits		Office/home physician		Prescription drug scripts	
State	Days	Relative to Comparison States	Visits	Relative to Comparison States	Visits	Relative to Comparison States	Scripts	Relative to Comparison States
Washington	202	87%	190	99%	2,828	104%	8,558	100%
Idaho	206	88%	205	106%	2,548	94%	9,034	105%
Oregon	206	88%	205	106%	2,800	103%	8,083	94%
Wyoming	237	102%	214	111%	2,744	101%	8,748	102%
Hawaii	266	114%	135	70%	2,884	106%	7,797	91%
North Dakota	283	121%	206	107%	2,492	92%	9,224	108%
Alaska - Anch/Frbnk/Mat-Su	**193**	**82%**	**221**	**115%**	**2,772**	**102%**	**8,273**	**96%**
Alaska - Non-MSA	**467**	**200%**	**224**	**116%**	**2,884**	**106%**	**8,843**	**103%**
Alaska	**283**	**121%**	**221**	**115%**	**2,800**	**103%**	**8,463**	**99%**
Comparison State Average	233	100%	193	100%	2,716	100%	8,574	100%
National Average	283		178		2,800		9,509	

Table 3A.2 shows that Alaska ranks high in inpatient bed days, and ER visits, which are major components of healthcare resource use. However, a closer look reveals the broad disparity between the urban and rural areas within Alaska. Claims are assigned to geographic areas in Table 3A.2 based on the member's residence. Members in Alaska's urban areas have significantly lower utilization rates than those in rural areas, particularly for inpatient days. This result is not surprising, since the rural areas may not have the health care delivery systems in place to discharge patients quickly. This problem is exacerbated since many rural members receive treatment far from home, particularly for more complex cases, making discharge more difficult.

Table 3A.3
Healthcare Utilization Results – Surgical Replacements per 1,000 Medicare Enrollees (2005-2006)

State	Region	Surgical replacements per 1,000 Medicare enrollees (2005-2006)		
		Hip	Knee	Shoulder
Alaska	**Anchorage**	**3.6**	**9.3**	**0.9**
Hawaii	Honolulu	1.9	4.1	0.4
Idaho	Boise	5.9	11.9	1.7
	Idaho Falls	5.4	12.5	N/A
North Dakota	Bismarck	5.8	13.6	1.4
	Fargo/Moorhead	5.6	12.5	1.0
	Grand Forks	6.3	11.3	N/A
	Minot	4.9	10.1	N/A
Oregon	Bend	5.5	9.5	1.7
	Eugene	4.4	8.1	0.6
	Medford	4.9	8.0	1.3
	Portland	4.7	8.3	0.8
	Salem	6.5	6.9	N/A
Washington	Everett	4.8	8.3	1.0
	Olympia	4.5	10.5	0.8
	Seattle	5.3	8.5	1.0
	Spokane	5.7	11.2	0.9
	Tacoma	4.8	9.0	0.8
	Yakima	3.6	9.9	1.1
Wyoming	Casper	4.4	12.9	1.5
Nationwide Average		4.0	8.8	0.8

Dartmouth Atlas of Health Care

The Dartmouth Atlas of Health Care is a well-known and respected series of reports about unwarranted variation in US healthcare service use (as well as in healthcare expenditures and quality) founded by Dr. Jack Wennberg. Over his forty-year career, Dr. Wennberg has thoroughly demonstrated that the amount of health care one receives in the US varies widely from state to state, city to city, hospital to hospital, and even doctor to doctor, for reasons often unrelated to demographics, health status, or good medical practice.

Dartmouth Atlas reports and articles have included studies of unwarranted variation in:

- Elective surgery
- End-of-life cancer care
- Chronic illness care
- Endoscopic sinus surgery
- Hip, knee, and shoulder replacement
- Prostate-specific antigen screening
- Carotid artery stenting
- Inpatient use of services during the last six months of life[6]

Table 3A.3 shows the frequency of surgical replacements for a number of procedures. Results shown in Table 3A.3 are taken from the Dartmouth Atlas project (see the sidebar).[7]

The number of hip replacements in Anchorage is lower than or equal to every region in the comparison states except Honolulu. The number of knee and shoulder replacements appear about equal to the comparison regions.

[6] See www.dartmouthatlas.org/publications/reports.aspx and www.dartmouthatlas.org/publications/articles.aspx

[7] Fisher, E. S., Bell, J.-E., Tomek, I. M., Esty, A. R., & Goodman, D. C. (2010). Trends and regional variation in hip, knee, and shoulder replacement A Dartmouth Atlas Surgery Report (pp. 22): The Dartmouth Institute for Health Policy & Clinical Practice.

B. METHODOLOGY

To compare healthcare resource use among states, we employed a metric called "Adjusted Resource Use". This metric was developed by the Medicare Payment Advisory Commission (MedPAC), in order to identify geographic variation in the volume and intensity of services that comparable Medicare beneficiaries use.[8] MedPAC starts with fee-for-service Medicare expenditures for beneficiaries. It then adjusts the result to remove geographic variation in provider reimbursement levels, beneficiary health status, and beneficiary demographic characteristics.

The MedPAC report presents results for most states by Metropolitan Statistical Areas (MSAs). To obtain the Adjusted Resource Use for each comparison state, we weighted the MedPAC results for each of the MSAs in each state using the Census Bureau's count of people age 65 and over. For example, as shown in the following table, we calculated Washington's Adjusted Resource Use, expressed as a percentage of the national average, to be 89 percent. Note that some states, such as Alaska, were reported at the state level in the MedPAC report, and therefore no summarization was needed.

Table 3B.1
Calculation of the Washington Adjusted Resource Use as a Percent of the National Average

Metropolitan statistical area (MSA)	Adjusted Resource Use (percent of national average)	Population age 65 and over
Bellingham, WA	85	23,117
Bremerton-Silverdale, WA	85	28,979
Kennewick-Pasco-Richland, WA	88	22,651
Lewiston, ID-WA	83	3,797
Longview, WA	87	13,933
Mount Vernon-Anacortes, WA	94	16,942
Olympia, WA	84	28,059
Portland-Vancouver, OR-WA	85	43,027
Seattle-Bellevue-Everett, WA	90	265,880
Spokane, WA	91	55,894
Tacoma, WA	90	82,264
Wenatchee, WA	85	14,936
Yakima, WA	83	26,321
Non-MSA areas	89	128,549
Weighted average/total	89	754,349

[8] MedPAC calls the metric "Medicare Service Use". For details about this metric, see Medicare Payment Advisory Commission (2011). The report is found at www.medpac.gov/document_TOC.cfm?id=631. Its Appendix B contains the Adjusted Resource Use for Medicare beneficiaries in each US Metropolitan Statistical Area (MSA) and in non-metropolitan areas, expressed as a percentage of the national average.

4. INPATIENT LENGTH-OF-STAY

A. DETAILED RESULTS

When trying to explain variations in health care costs for inpatient services, analyses typically focus on inpatient days (as we did in Section 3), rather than admissions, since facilities continue to incur costs for each day of a patient's stay. However, it is also informative to disaggregate the utilization of inpatient days into the portions driven by admissions and by the average length of stay (LOS) per admission.

In order to create a valid comparison of LOS across states, we compared the actual average LOS in each state to a benchmark based on the nationwide average LOS by APR-DRG. The benchmark is adjusted for each state to reflect the mix of admissions. This methodology ensures that states are not penalized for having a greater percentage of higher severity cases, such as cardiology, while also ensuring that each state is evaluated based on a mix of cases appropriate to that state. For more information on how this metric is calculated, see Section 4B: Methodology.

Table 4A.1 shows the relative length of stay for urban (i.e. Anchorage, Fairbanks and Mat-Su) and rural areas within Alaska and for each of the comparison states.

Table 4A.1
Inpatient Average LOS Relative to Benchmark for Medicare Beneficiaries (2009)[9]

Region	Admits	Days	ALOS	Benchmark Days	Benchmark ALOS	Actual to Benchmark	Relative to Comparison State Average
Anchorage/Frbnks/Mat-Su, AK	9,617	50,189	5.2	50,558	5.3	0.99	112%
Non-MSA, AK	3,269	14,974	4.6	14,507	4.4	1.03	116%
Alaska	**12,886**	**65,163**	**5.1**	**65,066**	**5.0**	1.00	**113%**
Hawaii	21,793	142,018	6.5	118,056	5.4	1.20	135%
Idaho	34,011	145,842	4.3	176,881	5.2	0.82	93%
North Dakota	34,516	158,818	4.6	185,123	5.4	0.86	96%
Oregon	79,163	368,803	4.7	422,281	5.3	0.87	98%
Washington	178,270	833,226	4.7	952,459	5.3	0.87	98%
Wyoming	16,837	73,213	4.3	80,987	4.8	0.90	102%
Comparison State Average	364,590	1,721,920	4.7	1,935,787	5.3	0.89	100%
Nationwide Average	11,357,376	61,135,387	5.4	61,135,387	5.4	1.00	112%

[9] Medicare Provider Analysis and Review (MedPAR) file (2010), https://www.cms.gov/IdentifiableDataFiles/05_MedicareProviderAnalysisandReviewFile.asp

This table shows that Alaska's LOS is 113% of the comparison state average after adjusting for case mix. It is higher than all of the comparison states except Hawaii. However, it is also interesting to note that the length of stay in Alaska relative to the benchmark is close to the nationwide average, which is 112% of the average in the comparison states.

We note that Table 4A.1 shows similar results for both urban and rural areas within Alaska, in contrast to the large difference in total bed days shown in Table 3A.2. This can be partly explained by a difference in methodology. Whereas Table 3A.2 allocated admissions to areas based on the member's location, Table 4A.1 is based on the location of the facility where the admission occurs. Therefore, admissions for members in rural areas who are being transported to facilities in Fairbanks and Anchorage are counted within the urban areas. To the extent that the lengths of stay for those admissions are higher than average (even for those facilities) due to either the lengthy travel required for those members to return home or the need to find adequate care upon returning, those additional days of stay are being attributed to those urban facilities.

B. Methodology

We used publicly available data from the 2010 Medicare Provider Analysis and Review (MedPAR) file. Data was restricted to include only short term acute care hospitals, including critical access hospitals and sole community hospitals and to include only Medicare FFS admissions (removing those that occurred in Medicare Advantage plans). We retained admissions for all hospitals in the data, including tribal health facilities.

Each admit was grouped to APR-DRG and severity level using 3M's All Payer Refined DRG grouper. For each APR-DRG and severity level, we calculated the nationwide average LOS. The nationwide average LOS for each APR-DRG and severity level was used as the benchmark. For each region, we then summed up the actual days of stay and the benchmark days. The relative LOS statistic was then calculated as the ratio of the actual days of stay to the benchmark days based on the region-specific case mix.

5. HOSPITAL OPERATING COSTS

Hospital operating costs have a significant impact on commercial reimbursement levels. Higher operating costs have a direct impact on commercial reimbursement, and lead to greater losses for Medicare and Medicaid patients, thus leading to even higher commercial reimbursement. In this section, we compare the level of Alaska's non-federal hospital operating costs to the level in comparison states.

A. DETAILED RESULTS

Hospital operating costs are the expenses a hospital must pay to stay in business. They include staff wages and benefits; buildings, equipment, supplies, utilities and other items.

To measure relative hospital operating costs among the states, we employ a metric called the "Adjusted Hospital Costs per Relative Value Unit". For a state, the Adjusted Hospital Costs per RVU is the average amount of total operating costs per RVU for all hospitals located within the state. The cost per RVU is shown with or without a geographic adjustment to level out differences among states in wages and capital costs. Because the metric reflects costs per resource unit, it levels out differences in patient and service mix.

For this metric, operating costs are the expenses hospitals report to the Centers for Medicare and Medicaid Services (CMS) as part of the annual Medicare Cost Reports (see the sidebar), and "relative value units" for healthcare services are determined with the Milliman *RBRVS for Hospitals*™. For a complete description of the way we calculated this metric, see Section 5B: Methodology.

Medicare Cost Reports

Every year, each non-federal hospital that treats Medicare patients provides an extensive financial report, called the Medicare Cost Report, to the Centers for Medicare and Medicaid Services (CMS). In the report, the hospital provides data about its billed charges, operating expenses, net income, patient visits, and patient mix. A report is typically several hundred pages long.

The Medicare Cost Reports are publicly available through CMS.

To develop the Adjusted Hospital Costs per RVU for each hospital, we extracted the ratio of operating costs to billed charges by department.

Because tribal hospitals and government hospitals (i.e. military and VA) do not file cost reports in the same manner as other facilities, they are excluded from this analysis. The tribal health system is unique to Alaska and therefore, comparing costs at those facilities against acute care facilities in the other states would not necessarily be an appropriate comparison even if cost information were available.

Table 5A.1 reports payment levels relative to the cost per RVU weighted average in the six comparison states. For example, it shows that the Alaska total non-federal hospital operating cost is 138% of the average in the six comparison states. As with other analyses, there is a considerable difference in the costs for facilities in urban areas compared with rural areas. At least some of this difference can be attributed to the higher costs of living in more rural areas of Alaska, as well as necessary inefficiencies resulting from the operation of smaller facilities.

Table 5A.1
Cost per RVU Relative to the Comparison State Average

Region	Inpatient Average	Outpatient Average	Total Average
Anchrg/Frbanks/Mat-Su, AK	132%	114%	129%
Non-MSA Area, AK	182%	202%	186%
AK	137%	139%	138%
HI	95%	99%	97%
ID	92%	89%	90%
ND	73%	79%	74%
OR	109%	104%	107%
WA	103%	106%	104%
WY	109%	110%	110%
Comparison States	100%	100%	100%

Table 5A.2 is similar to table 5A.1, but adjusts costs to reflect anticipated differences in input costs based on the geographic adjustment factors that Medicare uses for Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) hospital payments, including the Wage Index and Capital Geographic Adjustment Factor. Table 5A.2 is included for informational purposes only; our analysis focuses primarily on Table 5A.1 since it is consistent with other analyses in this report which do not reflect geographic differences in Medicare payment. Relative to Table 5A.1, the costs for Alaska are lower in Table 5A.2.

Table 5A.2
Geographically Adjusted Cost per RVU Relative to the Comparison State Average

Region	Inpatient Average	Outpatient Average	Total Average
Anchrg/Frbanks/Mat-Su, AK	122%	108%	120%
Non-MSA Area, AK	168%	161%	160%
AK	127%	124%	126%
HI	89%	95%	91%
ID	102%	93%	98%
ND	88%	86%	87%
OR	105%	101%	104%
WA	100%	104%	101%
WY	119%	114%	118%
Comparison States	100%	100%	100%

Table 5A.3 presents results by state and type of hospital – either paid by OPPS or not. We divided hospitals into two categories based on whether Medicare pays outpatient services based on OPPS. This was a convenient attribute for us to use to split the data since our data source for Medicare outpatient services was split between OPPS and non-OPPS facilities. It also nicely defines a split between hospitals that are generally paid on a cost-related basis (non-OPPS) versus a prospective payment, fee schedule basis (OPPS).

Table 5A.3
Geographically Adjusted Cost per RVU

Region	OPPS Facilities # of Facilities	OPPS Facilities Total	Non-OPPS Facilities # of Facilities	Non-OPPS Facilities Total	Ratio: Non-OPPS / OPPS
Anchrg/Frbanks/Mat-Su, AK	4	$55	2	$44	0.81
Non-MSA Area, AK	2	$50	11	$86	1.72
AK	6	$55	13	$65	1.20
HI	14	$41	10	$53	1.30
ID	16	$44	25	$50	1.13
ND	8	$38	33	$49	1.26
OR	33	$47	18	$53	1.13
WA	49	$46	27	$39	0.83
WY	13	$53	15	$58	1.10
Comparison States	133	$45	128	$48	1.05

Table 5A.3 shows that operating costs tend to be higher for hospitals that are paid on a cost-basis compared to those reimbursed under OPPS. Part of the differential is likely driven by the higher cost of living in rural Alaska areas and also by efficiencies lost by needing to maintain access to services for a much more variable patient load. The cost level may also be influenced by the Medicare payment system; facilities that are reimbursed on a cost basis have less incentive to reduce costs than those paid on a fixed fee schedule. While the higher costs for Medicare patients are reimbursed by Medicare, the higher costs incurred in the treatment of Medicaid and commercial patients will be passed along to payers in Alaska.

B. Methodology

The following table illustrates how we calculated Adjusted Hospital Costs per RVU for each hospital (including the geographic adjustment). The total within each state (and across the comparison states) was calculated by dividing the total adjusted costs across all facilities in each state by the total RVUs in that state.

Table 5B.1
Illustration of Adjusted Hospital Costs per RVU calculation

Medicare claim codes for state A	Billed amount	Ratio of costs to billed amounts	Geographic adjustment factor	Adjusted costs	Relative value unit	Adjusted hospital costs per RVU
Service 1	B_1	R_A	G_A	$AC_1 = (B_1 * R_A)/G_A$	RVU_1	
Service 2	B_2	R_A	G_A	$AC_2 = (B_2 * R_A)/G_A$	RVU_2	
...	...	...	...	...	...	
Service n	B_n	R_A	G_A	$AC_n = (B_n * R_A)/G_A$	RVU_3	
Total				$\sum_n AC_i$	$\sum_n RVU_i$	$\frac{\sum_n AC_i}{\sum_n RVU_i}$

The inpatient results are based on analysis of the publicly available 2009 Medicare Provider Analysis and Review (MedPAR) file. The outpatient results are based on analysis of the publicly available 2009 Medicare OPPS data and the publicly available 2009 Medicare Standard Analytic File 5% Sample (5% Sample) [10]. The OPPS data only includes data on services paid under OPPS. We used the 5% Sample data to supplement the OPPS data set, in order to include results for Critical Access hospitals and other hospitals not paid on OPPS. We defined the split of OPPS/non-OPPS on whether a hospital's provider ID appeared in the OPPS data set.

The 5% Sample, not surprisingly, includes data for 5% of Medicare fee-for-service beneficiaries. In order to combine the Medicare outpatient results obtained from the 5% sample with those from the OPPS data (which is a 100% sample), we multiplied the 5% Sample results by a weighing factor of 20 (5% x 20 = 100%).

For each hospital, we used the cost-to-charge ratio from the CMS 2009 Medicare Inpatient Provider Specific (IPPSF) file[11] when available, and otherwise directly from 2009 Medicare Cost Reports.[12] Next, for each hospital we adjusted its operating cost amounts for geographic differences in staff wages and capital costs using the CMS 2009 Medicare Wage Index and Capital Geographic Adjustment factors.[13] We then calculated an adjusted cost amount for each service, as the billed amount times the cost-to-charge ratio, divided by the geographic adjustment factor.

[10] All data sources are publicly-available through CMS. For information about OPPS data, see www.cms.gov/LimitedDataSets/06_HospitalOPPS.asp.
For MedPAR, see www.cms.gov/IdentifiableDataFiles/05_MedicareProviderAnalysisandReviewFile.asp.
For the 5% Sample, see https://www.cms.gov/LimitedDataSets/12_StandardAnalyticalFiles.asp

[11] IPPSF data is publicly available through CMS. For information about this data source, see www.cms.gov/AcuteInpatientPPS/FFD.

[12] Medicare Cost Reports are publicly available through CMS. For information about them, see www.cms.gov/CostReports.

[13] For information about the Medicare Wage Index and Capital Geographic Adjustment factors, see www.cms.gov/AcuteInpatientPPS/03_wageindex.asp#TopOfPage.

The following table shows the relative geographic adjustments by service type.

Table 5C.1
Geographic Adjustment Factors

State	Geographic Adjustment Factor IP	OP
North Dakota	0.832	0.888
Idaho	0.901	0.942
Wyoming	0.932	0.958
Oregon	1.049	1.033
Washington	1.056	1.040
Hawaii	1.076	1.051
Alaska	**1.102**	**1.065**
Nationwide	1.000	1.000

We assigned Milliman *RBRVS for Hospitals*™ RVUs to both the inpatient and outpatient claims data. Lastly, we divided the sum of adjusted cost amounts by the sum of RVUs. We did this for the total of all hospital services, as well as separately for inpatient and outpatient services. The total cost amount divided by the total RVUs results in a conversion factor. The application of the RVUs provides the case-mix and severity adjustment, such that the conversion factors can be compared directly at whatever level of aggregation is desired.

6. HOSPITAL MARGINS

This section compares the level of Alaska's non-federal hospital margins to the level in other states, and to the national average. Higher margins contribute to higher commercial reimbursement levels and higher commercial premiums.

A. DETAILED RESULTS

A hospital margin is its gain or loss divided by revenue, for a particular time period. We developed hospital margins from data in the Medicare Cost Reports (see the sidebar about Medicare Cost Reports in the previous section). For details about the methodology we used to determine this metric, see Section 6B: Methodology.

The table below shows the average non-federal hospital margins for Alaska and each comparison state for the period 2008 – 2010. The All Payer margins are calculated for all patients, including Medicare. Medicare operating margins are also shown separately. In order to compare to the Medicare operating margin, the All Payer Operating Margin is approximated by removing investment income and contributions from the All Payer Total Margin.

Medicare cost shifting

In many states, Medicare hospital reimbursements do not fully cover the costs of treating Medicare patients, and thus lead to hospital operating losses. Hospitals often cover these losses by negotiating higher reimbursements from other payers, such as from health insurers covering employer populations. This phenomenon is called Medicare "cost shifting".

A similar phenomenon occurs with Medicaid reimbursements, and is called Medicaid cost shifting.

The average All Payer margin for non-federal hospitals in Alaska is approximately 13.8%, compared to 6.9% in the comparison states in 2010. This means that the Alaska margin for non-federal hospitals is 6.9 percentage points higher than the comparison state average, or stated differently, that the average margin in Alaska is 200% of that in the comparison states. When restricting to operating margins for all payers, the average margin in Alaska is approximately 7.7 percentage points higher than the average in the comparison states (13.4% in Alaska vs 5.7% in the comparison states, meaning that All Payer operating margins in Alaska are 233% of those in the comparison states). For Medicare patients, the operating margin is more negative (by 2.6 percentage points) than the comparison state average (-11.5% vs. -8.9%). As demonstrated in the attached exhibits, the margins vary considerably across facilities.

Such markedly negative Medicare margins in Alaska cause upward pressure on commercial premiums, in order to offset hospital losses from Medicare business. This phenomenon is called "Medicare cost shifting".

Table 6A.1
All Payer and Medicare Hospital Margins (2008-2010)

Region	FY10 Number of Hospitals	All Payer Total Margin			All Payer Approximate Operating Margin			Medicare Operating Margin		
		2008	2009	2010	2008	2009	2010	2008	2009	2010
Anchrg / Frbnks / Mat-Su, AK	4	9.9%	12.7%	16.5%	11.5%	13.4%	16.2%	-18.4%	-18.1%	-9.1%
Non-MSA Area, AK	12	5.8%	5.4%	6.8%	5.4%	5.2%	6.1%	-20.6%	-17.8%	-17.4%
AK	**16**	**8.8%**	**10.7%**	**13.8%**	**9.8%**	**11.2%**	**13.4%**	**-19.0%**	**-18.0%**	**-11.5%**
HI	24	1.0%	-2.0%	4.7%	-1.3%	-2.7%	3.4%	-11.8%	-8.3%	-2.7%
ID	40	6.9%	6.9%	7.8%	5.8%	6.8%	6.1%	-15.1%	-9.4%	-9.2%
ND	41	-0.7%	2.2%	5.4%	-0.6%	2.1%	4.0%	-5.6%	-0.6%	-1.7%
OR	56	2.8%	4.1%	7.5%	2.9%	3.7%	6.1%	-13.9%	-11.5%	-10.5%
WA	87	4.4%	6.1%	6.7%	4.2%	4.9%	5.8%	-9.9%	-9.5%	-9.9%
WY	27	8.0%	3.7%	10.9%	6.5%	2.6%	9.4%	-20.1%	-21.6%	-10.8%
Comparison State Average	275	3.7%	4.6%	6.9%	3.3%	3.9%	5.7%	-11.5%	-9.6%	-8.9%
Nationwide Average	4,135	1.9%	4.4%	6.3%	1.5%	3.8%	5.3%	-5.3%	-3.3%	-2.1%
Ratio of Margins (AK / Comparison States)		239%	232%	200%	297%	289%	233%	166%	187%	129%
Anchrg / Frbnks / Mat-Su, AK										
Alaska Regional Hospital		21.3%	26.8%	29.5%	21.3%	26.7%	29.4%	-14.8%	-15.3%	-10.0%
Fairbanks Memorial Hospital		4.3%	7.3%	5.0%	4.1%	7.1%	4.8%	-47.5%	-19.8%	-13.2%
Mat-Su Regional Medical Center		21.1%	24.4%	25.8%	21.1%	24.4%	25.8%	2.6%	-0.2%	4.0%
Providence Alaska Medical Center		4.7%	6.4%	13.7%	8.0%	7.9%	13.0%	-17.6%	-23.4%	-10.9%
Non-MSA Area, AK										
Bartlett Regional Hospital		3.6%	6.2%	7.3%	2.5%	5.3%	6.5%	-22.4%	-22.1%	-26.5%
Central Peninsula General Hospital		2.2%	2.4%	2.7%	2.2%	2.4%	2.7%	-26.4%	-22.1%	-15.4%
Cordova Community Medical Center		1.7%	4.6%	-2.9%	1.7%	4.6%	-9.2%	-22.5%	-22.8%	-14.6%
Ketchikan General Hospital		1.2%	2.6%	8.9%	1.2%	2.6%	6.4%	-14.3%	-11.2%	-13.6%
Norton Sound Regional Hospital		20.7%	13.2%	13.8%	20.2%	12.8%	13.1%	1.0%	1.0%	1.0%
Petersburg Medical Center		6.4%	-4.3%	2.6%	5.3%	2.0%	2.6%	-34.0%	-30.3%	-23.2%
Providence Kodiak Island Medical Ctr		11.5%	7.3%	4.8%	11.4%	7.2%	4.8%	-13.7%	-9.5%	-16.4%
Providence Seward Hospital		-7.6%	1.4%	12.2%	-8.0%	1.4%	12.2%	-33.9%	-20.6%	-27.9%
Providence Valdez Medical Center		-14.2%	-1.2%	-0.8%	-14.6%	-1.2%	-0.8%	-41.3%	-33.1%	-32.9%
Sitka Community Hospital		-2.0%	-4.4%	6.2%	-2.0%	-4.4%	6.2%	-20.9%	-21.1%	-18.3%
South Peninsula Hospital		3.3%	7.3%	3.9%	1.9%	5.3%	3.6%	-9.2%	-7.8%	-9.8%
Wrangell Medical Center		1.7%	13.9%	6.2%	1.4%	13.9%	6.2%	-16.2%	-20.8%	-26.2%

Notes:
1) Based on Medicare Cost Reports.
2) All Payer Approximate Operating Margin removes investment income and contributions from the All Payer Total Margin.
3) Medicare values based on cost report allocation process and Medicare allowed costs. This typically leads to better margins than if all costs are included and allocated by LOB.

Separating results in Alaska into the urban and rural areas reveals that the higher margins in Alaska are caused mostly by the urban areas. Margins in the rural areas are similar to those in the comparison states and nationwide. However, margins in the urban areas are significantly higher than elsewhere. Even within the urban areas, there is considerable variance in the margins by hospital. The higher average margin for urban Alaska facilities can be largely explained by high margins at two for-profit facilities (Alaska Regional Hospital and Mat-Su Regional Medical Center).

It is important to remember that hospital margins have a leveraged effect on commercial reimbursement. Since payment from Medicare is on a fixed fee schedule (or fixed percent of cost), a 1% increase or decrease in commercial reimbursement will lead to a smaller change in a hospital's total operating margin.

The negative Medicare margins in the non-MSA areas were a somewhat surprising result. Many of these facilities are critical access facilities and therefore are reimbursed at a rate 1% above cost for inpatient and outpatient services. A closer examination of these cost reports revealed that the losses were being incurred on swing-bed skilled nursing services.

B. METHODOLOGY

For this report, we define hospital margin as a hospital's revenue minus expenses divided by revenue, for a particular period of time. To calculate the hospital total margin (for revenue and expenses related to all patients) and the Medicare operating margin (for Medicare patients only) for each state, we used data from the Medicare Cost Reports.

The following table shows how we calculated the 2010 margins for Alaska and the comparison states. The dollar amounts in the table are aggregate amounts for all hospitals in the state. As the table shows, margins are equal to income divided by net revenue.

Table 6B.1
Calculation of the Hospital Total Margin and Medicare Margin for Alaska and Comparison States (2010)
(dollar amounts in millions)

		All Payer							Medicare			
Region	FY10 Number of Hospitals	A Total Net Revenue	B Total Expenses	C=A-B Total Income	D=C/A Total Margin	E Contributions	F Investments	G = (C-E-F)/(A-E-F) Approximate Operating Margin	H Operating Revenue	I Operating Expenses	J=H-I Operating Income	K=J/H Operating Margin
Anchrg / Frbnks / Mat-Su, AK	4	1,208	1,009	199	**16.5%**	0	5	**16.2%**	184	201	(17)	**-9.1%**
Non-MSA Area, AK	12	463	431	32	**6.8%**	0	3	**6.1%**	73	86	(13)	**-17.4%**
AK	16	1,671	1,440	231	**13.8%**	1	8	**13.4%**	257	287	(29)	**-11.5%**
HI	24	2,826	2,693	132	**4.7%**	14	24	**3.4%**	443	454	(12)	**-2.7%**
ID	40	3,160	2,914	246	**7.8%**	14	42	**6.1%**	617	674	(57)	**-9.2%**
ND	41	2,088	1,976	113	**5.4%**	3	27	**4.0%**	510	519	(8)	**-1.7%**
OR	56	8,478	7,841	637	**7.5%**	8	120	**6.1%**	1,440	1,592	(152)	**-10.5%**
WA	87	15,977	14,908	1,069	**6.7%**	39	108	**5.8%**	3,150	3,462	(312)	**-9.9%**
WY	27	1,380	1,230	151	**10.9%**	7	17	**9.4%**	291	322	(31)	**-10.8%**
Comparison State Average	275	33,908	31,560	2,348	**6.9%**	85	338	**5.7%**	6,451	7,023	(572)	**-8.9%**
Nationwide Average	4,135	667,210	625,210	42,000	**6.3%**	1,431	5,825	**5.3%**	153,408	156,671	(3,263)	**-2.1%**
Anchrg / Frbnks / Mat-Su, AK												
Alaska Regional Hospital		207	146	61	**29.5%**	0	0	**29.4%**	32	35	(3)	**-10.0%**
Fairbanks Memorial Hospital		217	206	11	**5.0%**	0	0	**4.8%**	33	37	(4)	**-13.2%**
Mat-Su Regional Medical Center		169	125	44	**25.8%**	0	0	**25.8%**	25	24	1	**4.0%**
Providence Alaska Medical Center		615	531	84	**13.7%**	0	4	**13.0%**	95	105	(10)	**-10.9%**
Non-MSA Area, AK												
Bartlett Regional Hospital		78	72	6	**7.3%**	0	1	**6.5%**	10	13	(3)	**-26.5%**
Central Peninsula General Hospital		98	96	3	**2.7%**	0	0	**2.7%**	19	22	(3)	**-15.4%**
Cordova Community Medical Center		8	8	(0)	**-2.9%**	0	0	**-9.2%**	1	1	(0)	**-14.6%**
Ketchikan General Hospital		65	60	6	**8.9%**	0	2	**6.4%**	10	11	(1)	**-13.6%**
Norton Sound Regional Hospital		77	66	11	**13.8%**	0	1	**13.1%**	3	3	0	**1.0%**
Petersburg Medical Center		10	10	0	**2.6%**	0	0	**2.6%**	2	3	(0)	**-23.2%**
Providence Kodiak Island Medical Ctr		36	35	2	**4.8%**	0	0	**4.8%**	6	7	(1)	**-16.4%**
Providence Seward Hospital		18	16	2	**12.2%**	0	0	**12.2%**	2	3	(1)	**-27.9%**
Providence Valdez Medical Center		11	11	(0)	**-0.8%**	0	0	**-0.8%**	3	4	(1)	**-32.9%**
Sitka Community Hospital		19	18	1	**6.2%**	0	0	**6.2%**	5	6	(1)	**-18.3%**
South Peninsula Hospital		35	33	1	**3.9%**	0	0	**3.6%**	9	10	(1)	**-9.8%**
Wrangell Medical Center		8	8	1	**6.2%**	0	0	**6.2%**	2	3	(1)	**-26.2%**

Notes:
1) Based on Medicare Cost Reports.
2) All Payer Approximate Operating Margin removes investment income and contributions from the All Payer Total Margin.
3) Medicare values based on cost report allocation process and Medicare allowed costs. This typically leads to better margins than if all costs are included and allocated by LOB.

For total margins, we extracted total revenue and total expenses from the G series of the Medicare Cost Reports. These results include both operating and non-operating revenue and expense amounts. An approximate All Payer Operating Margin is calculated by removing investment income and contributions from the All Payer Total Margin.

For the Medicare margins, to obtain Medicare revenue amounts we extracted Medicare allowed amounts reported in the E series of the Medicare Cost Reports, and we obtained Medicare expenses from the D series. These are operating revenue and expenses, and do not include non-operating income and expenses. The Medicare expenses are limited to Medicare allowable expenses (e.g. excluding physician practice expenses and other items not allowed by Medicare). Thus, the financial basis of the two margins is different.

Since the margin analysis is based on Medicare Cost Reports, federal government facilities are excluded from the analysis as are all but one tribal health facility.

7. Occupancy Rates

A. Detailed Results

The number of occupied bed days divided by total bed days for a hospital is called the occupancy rate. These rates show the percent of staffed beds that are occupied, as reported by the Medicare cost reports. For more information on the Medicare cost reports, see the sidebar in Section 5A.

Higher occupancy rates will lead to lower costs per admission and higher margins. The expenses of the building and equipment will not vary as the occupancy rate fluctuates, but the revenue earned from occupied beds will help to offset those expenses. Table 7A.1 below shows the occupancy rates for Alaska and the comparison states from 2008 to 2010. The table includes only acute care hospitals (including critical access facilities) but includes sub-providers (i.e. psych and rehab units) within those facilities.

Table 7A.1
Occupancy Rates for Alaska and Comparison States (2008-2010)

Region	FY10 Number of Hospitals	Total		
		2008	2009	2010
Anchrg / Frbnks / Mat-Su, AK	4	55.5%	53.7%	53.6%
Non-MSA Area, AK	12	39.4%	38.4%	38.8%
AK	16	51.3%	49.5%	49.9%
HI	24	67.8%	64.2%	62.4%
ID	40	48.8%	46.6%	45.9%
ND	41	49.9%	48.8%	49.5%
OR	58	62.3%	61.4%	60.2%
WA	87	65.7%	64.3%	62.9%
WY	27	43.0%	41.3%	39.1%
Comparison State Average	277	60.6%	59.1%	58.1%
Nationwide Average	4,318	62.2%	61.2%	60.2%

Alaska's average occupancy rate for all providers was 49.9% in 2010, lower than the 58.1% average for the comparison states (which was in turn slightly below the nationwide average). The 58.1% average was calculated by summing total occupied bed days in comparison states and dividing by total available bed days in those states, so states with more bed days, like Washington, have more weight. Comparison state total rates range from 39.1% to 62.9%, with higher occupancy rates in the more densely populated states. In general, we expect to see higher occupancy rates in larger facilities (which typically coincide with urban settings) since those facilities should have more stable inpatient demand and therefore, would require less of a buffer in order to accommodate periods of high demand.

The Anchorage and Fairbanks areas have a significantly higher occupancy rate than the non-MSA areas, consistent with the higher occupancy rates in more densely populated states.

B. METHODOLOGY

For this report, we define occupancy rate as a hospital's occupied bed days divided by their available bed days, for a particular period of time. To calculate the rates for each state, we used data from the Medicare Cost Reports.

The following table shows how we calculated the 2010 occupancy rates for Alaska and the comparison states. The amounts in the table are aggregate amounts for all hospitals in the state that completed Medicare cost reports. Of note, as with other analyses based on the cost reports, federal government and tribal health hospitals are excluded.

Table 7B.1
Calculation of Occupancy Rates for Alaska and Comparison States (2010)

Region	FY10 Number of Hospitals	Total		
		A Available Bed Days	B Occupied Bed Days	C=B/A Occupancy Rate
Anchrg / Frbnks / Mat-Su, AK	4	271,375	145,365	**53.6%**
Non-MSA Area, AK	12	91,250	35,442	**38.8%**
AK	16	362,625	180,807	**49.9%**
HI	24	913,830	569,977	**62.4%**
ID	40	1,021,657	469,429	**45.9%**
ND	41	763,341	377,998	**49.5%**
OR	58	2,344,186	1,412,196	**60.2%**
WA	87	3,874,019	2,438,222	**62.9%**
WY	27	467,660	182,822	**39.1%**
Comparison State Average	277	9,384,693	5,450,644	**58.1%**
Nationwide Average	4,318	244,628,574	147,354,738	**60.2%**

8. Staffing Ratios

A. Detailed Results

A significant component of facility operating costs is the number of nurses per hospital bed. In this section we compare Alaska's staffing ratios to the level in the comparison states.

Staffing ratios are a measure of the number of full time equivalent (FTE) professional staff in a hospital relative to the size of the facility. The number of staff for a given hospital is divided by the number of occupied beds for the hospital, resulting in a ratio that is comparable across hospitals and across states. For example, a nurse ratio of 2.0 indicates that on average, each bed is staffed by two nurses. This does not imply that there are two nurses on duty per bed at any given time. The nurse count is based on FTEs (where "full time" represents a typical work week) but hospitals are open at all times and therefore, require multiple FTEs per occupied bed.

Data for the staffing ratios in this section are from the CMS Provider of Services file from the second quarter of 2011[14] (the most recently available data period at the time to the analysis). To learn more about how we calculated the staffing ratios, see Section 8B: Methodology.

Table 8A.1 below shows 2011 FTE registered nurse staffing ratios for Alaska and the comparison states. Overall, Alaska' ratio of registered nurses per occupied bed is 129% of the ratio in the comparison states, though the ratio is similar to that in four of the six comparison states. Staffing ratios for the comparison states range widely from 1.67 (Washington) to 2.90 (Wyoming). Within Alaska, staffing ratios are fairly similar between urban and rural areas. We note however, that when comparing staffing ratios per bed (regardless of occupancy) the lower occupancy rates in the rural areas lead to a lower staffing ratio per bed.

We are not aware of a broadly accepted consensus on the ideal staffing ratio. Higher staffing ratios may lead to higher quality care (up to a certain point), but also lead to higher costs. Therefore, our analysis should not be used to conclude that Alaska's staffing ratio should be reduced to that of the comparison states. However, we can state that the higher staffing ratio adds to the higher facility costs in Alaska.

[14] For more information on this file, see https://www.cms.gov/nonidentifiabledatafiles/04_providerofservicesfile.asp

Table 8A.1
FTE Registered Nurses per Occupied Bed (2nd Quarter of 2011Q2)

State	FTE Registered Nurses Per Occupied Bed	
	Ratio	Relative to comparison state average
Anchrg/Frbnks/Mat-Su, AK	2.74	136%
Non-MSA, AK	2.34	116%
Alaska	2.59	129%
Hawaii	2.47	122%
Idaho	2.70	134%
North Dakota	1.69	84%
Oregon	2.26	112%
Washington	1.67	83%
Wyoming	2.90	144%
Comparison State Average	2.01	100%

B. METHODOLOGY

The Provider of Services (POS) file is a publicly available file from CMS that contains data on providers. The file is updated quarterly and contains information such as type of hospital, staffing, beds, and services offered by each Medicare-approved provider. For this analysis, we used the latest version of the file, updated through the second quarter of 2011. This file includes all types of facilities (including tribal health and federal government facilities). We estimated occupancy rates for facilities that did not report that information using the statewide average occupancy rate (or the averages by MSA within Alaska).

After calculating the ratio of nurses to total beds for each area, we divided this ratio by the occupancy rate discussed in Section 7 of this report. Since the occupancy rate is the number of occupied beds divided by total beds, this results in the number of nurses per occupied bed.

9. Professional Salaries

A. Detailed Results

Professional salaries are a significant driver of health care costs for both professional and facility services. We have summarized statistics on annual base salary from both a Milliman salary survey and data from the Bureau of Labor and Statistics (BLS) for several health care jobs.

Milliman data are compiled from salary survey responses in Alaska, Idaho, Oregon, and Washington. Comparable information is not available for Wyoming, North Dakota or Hawaii and therefore, those states are excluded from this analysis.

In Table 9A.1, the "Number of Firms" statistic represents how many responding companies surveyed employed that occupation. The "Number of Employees" is the total number of people with that occupation across all respondents. The "Average" is a straight average across companies. "Weighted Average" is weighted by number of employees in the position, so larger companies have a larger weight. We have also reported various percentile estimates based on the survey responses.

Over half of the employees represented by the surveys are Registered Nurses (RNs). The results show that Alaska's RNs are paid approximately the same amount as RNs in the Pacific Northwest states. The other occupations range from 98% of the comparison states (Radiology Technician) to 112% (LPN and Nurse Practitioner) with an average of approximately 105%.

The results reported on Table 9A.1 reflect base salaries only. The Alaska survey also summarizes total cash compensation, though those results were very similar to the base salary information.

Table 9A.1
Health Care Salaries for Alaska and Select Comparison States (2010)

State	Job Title	Number of Firms	Number of Employees	Base Salary						
				Average (1)	Weighted Average (1)	1st Quartile	Median	3rd Quartile	Minimum	Maximum
Alaska	Certified Nursing Assistant	6	399	33,627	34,452	31,918	34,120	35,535	29,842	41,367
	LPN - Acute Care	8	89	52,277	53,532	46,043	54,281	57,697	40,548	54,687
	RN - Acute Care	8	870	77,061	76,910	69,345	73,940	82,811	56,683	88,290
	Physician Assistant	6	12	100,221	101,520	91,198	96,669	113,458	79,563	109,268
	Physical Therapist	6	20	79,607	82,845	72,102	80,529	88,700	60,609	84,410
	Social Worker - Master's	9	29	65,027	69,496	59,702	65,106	68,650	50,680	74,630
	Medical Lab Technician	5	16	46,966	47,624	42,648	48,103	50,715	38,244	52,388
	Pharmacy Technician	7	76	40,287	40,755	36,918	40,914	42,845	33,374	45,849
	Pharmacist	6	35	120,465	122,155	114,213	121,147	124,526	90,737	125,940
	Radiology Technologist - Registe	5	27	55,552	56,655	52,364	57,037	57,999	47,243	68,677
	Ultrasonographer	6	21	76,966	77,448	72,290	77,713	80,955	58,444	85,989
	Nursing Manager	7	44	102,031	111,158	86,995	105,680	117,413	76,854	113,358
	Nurse Practitioner - General	8	36	101,245	113,065	91,364	103,132	115,151	71,877	107,943
Northwest (2)	Certified Nursing Assistant	92	7,451	30,659	31,678	27,706	30,243	32,802	25,979	37,981
	LPN - Acute Care	73	1,217	47,757	47,778	43,472	47,882	52,000	35,797	54,309
	RN - Acute Care	96	37,442	75,213	77,730	69,950	77,376	80,829	54,766	94,328
	Physician Assistant (3)		684	99,766	98,054	86,413	97,880	109,770	73,390	111,626
	Physical Therapist	95	1,911	80,226	78,478	74,422	79,040	84,843	61,630	90,563
	Social Worker - Master's	89	1,263	60,507	63,419	55,827	60,174	66,040	47,715	71,178
	Medical Lab Technician	79	609	47,445	47,986	43,389	47,112	51,605	37,398	56,160
	Pharmacy Technician	99	2,171	38,646	39,978	35,672	39,000	41,226	31,491	46,030
	Pharmacist	102	2,147	113,568	117,104	109,762	113,672	118,685	90,147	124,592
	Radiology Technologist - Registe	115	2,059	55,557	57,949	51,230	55,411	59,758	45,323	67,267
	Ultrasonographer	94	949	75,442	76,544	69,576	75,088	79,706	58,635	86,798
	Nursing Manager (3)		880	100,172	104,553	93,445	101,329	108,388	75,924	115,425
	Nurse Practitioner - General	73	985	92,976	101,379	83,346	92,622	100,256	72,446	107,245
Alaska vs Northwest	Certified Nursing Assistant			110%	109%	115%	113%	108%	115%	109%
	LPN - Acute Care			109%	112%	106%	113%	111%	113%	101%
	RN - Acute Care			**102%**	**99%**	**99%**	**96%**	**102%**	**103%**	**94%**
	Physician Assistant			100%	104%	106%	99%	103%	108%	98%
	Physical Therapist			99%	106%	97%	102%	105%	98%	93%
	Social Worker - Master's			107%	110%	107%	108%	104%	106%	105%
	Medical Lab Technician			99%	99%	98%	102%	98%	102%	93%
	Pharmacy Technician			104%	102%	103%	105%	104%	106%	100%
	Pharmacist			106%	104%	104%	107%	105%	101%	101%
	Radiology Technologist - Registered			100%	98%	102%	103%	97%	104%	102%
	Ultrasonographer			102%	101%	104%	103%	102%	100%	99%
	Nursing Manager			102%	106%	93%	104%	108%	101%	98%
	Nurse Practitioner - General			109%	112%	110%	111%	115%	99%	101%
	Average			104%	102%	102%	100%	104%	105%	97%

(1) "Average" is a straight average across firms. "Weighted average" is weighted by number of employees, so larger firms have a larger weight.
(2) Includes Washington, Oregon, and Idaho. Hourly figures are multiplied by 2,080 to approximate yearly salary.
(3) Physician Assistants and Nursing Managers were both separated into multiple "sub-occupations" in the Northwest survey. Total statistics for these lines were weighted together by the number of employees in each sub-occupation. The number of firms for these jobs is not able to be calculated, since there is overlap between the sub-occupations.

The second source of compensation data is from BLS's May 2010 Occupational Employment and Wages estimates. Although the data include over 40 healthcare occupations, we have simplified the results by combining all physician and surgeon categories and excluding occupations with fewer than 200 estimated full time equivalents in Alaska.

Table 9A.2 shows the salaries in Alaska and the comparison states for each occupation. BLS wage information includes incentive pay and production bonuses, but does not include overtime, shift differentials or the employer cost of benefits.

Table 9A.2
Health Care Salaries (excluding Self Employed) for Alaska and Comparison States (2010 – from BLS)

	Mean Annual Income								
Job Title	AK	HI	ID	ND	OR	WA	WY	Comparison St Avg	AK vs Avg
Physicians and Surgeons	195,864	177,817	179,810	170,131	178,393	173,006	190,044	178,348	110%
Physician Assistants	91,810	78,870	89,720	79,310	93,580	98,620	97,890	93,870	98%
Pharmacists	118,060	106,360	102,540	99,700	111,160	107,060	105,200	107,159	110%
Registered Nurses	79,350	82,130	62,720	57,020	75,350	73,680	58,750	72,201	110%
Physical Therapists	92,720	71,940	69,130	62,490	75,150	75,180	75,130	73,546	126%
Speech-Language Pathologists	85,440	58,850	61,980	50,400	73,290	69,660	62,030	67,139	127%
Medical and Clinical Laboratory Technologists	63,920	61,550	53,510	48,280	63,270	62,250	56,900	60,472	106%
Medical and Clinical Laboratory Technicians	44,520	42,500	36,650	33,600	43,220	39,840	28,630	39,360	113%
Radiologic Technologists and Technicians*	64,870	65,220	50,000	44,550	61,550	62,670	51,090	59,712	109%
Emergency Medical Technicians and Paramedics	48,050	47,920	39,670	29,720	44,570	43,530	32,190	41,810	115%
Pharmacy Technicians	39,210	34,920	29,500	31,820	34,080	37,290	31,960	34,927	112%
Psychiatric Technicians	32,120	0	28,410	27,330	39,030	36,790	29,510	34,865	92%
Licensed Practical and Licensed Vocational Nurses	47,100	44,640	38,120	35,320	45,370	45,400	39,810	42,479	111%
Medical Records and Health Information Technicians	39,300	42,430	30,910	30,730	35,970	37,630	34,450	36,329	108%

Consistent with Table 9A.1, salaries in Alaska are higher than in the comparison states. The BLS data indicates a slightly higher relative reimbursement in Alaska. However, in both cases, the relative salaries in Alaska are lower than the relative facility and professional unit cost reimbursement identified in our initial reports.

B. Methodology

Salary statistics were taken from the 2011 Alaska Cross-Industry Survey and the 2011 Northwest Health Care Industry Salary Survey, both administered by Milliman, Inc.

The data for the Alaska survey were compiled from 50 major employers with operations located throughout the state. The survey includes data on many occupations not related to health care, but we have included only the health care occupations in our analysis. Specific health care respondents include Alaska Native Tribal Health Consortium, Alaska VA Healthcare System, Fairbanks Memorial Hospital, PeaceHealth Ketchikan General Hospital and Providence Health & Services Alaska. The data is effective June 2011.

The data for the Northwest survey was compiled from 161 major hospital, clinic, home care, and long-term care organizations across Washington, Oregon, and Idaho. The data is effective January 2011. Since the Northwest salaries were reported on an hourly basis, and the Alaska survey was reported on an annual basis, we multiplied the hourly pay rates by 2,080 (52 weeks times 40 hours per week) to approximate annual salaries for the Northwest.

Physician Assistants and Nursing Managers were both separated into multiple "sub-occupations" in the Northwest survey. Total statistics for these lines were weighted together by the number of employees in each sub-occupation. The number of firms for these jobs cannot be calculated, since there is overlap between the sub-occupations.

The average salary across all listed positions is an average of the salary ratios by position, weighted based on the number of jobs in Alaska for each position.

BLS data contain mean salaries for each position. These numbers are reported directly in our results with the exception of the "physician and surgeon" category, which aggregates results from seven separate jobs included in the BLS data. The average salary for physicians and surgeons in each state is based on the relative number of employees for each position in Alaska.

The comparison states average salary for each job position is weighted across states in proportion to the number of employees in each state for that job. For the physician and surgeon subtotal, the comparison states average is calculated for each of the seven jobs, then weighted together using the distribution of those jobs within Alaska, so that differences in the mix of physician and surgeon jobs would not skew the comparison.

Note that the BLS data excludes self-employed individuals (which may therefore exclude any independently practicing physicians[15]).

[15] See http://www.bls.gov/oes/

10. Health Care Professional Shortage Areas

Health care prices are subject to the laws of supply and demand, like most other goods and services. While those market forces are somewhat hampered for hospitals due to the high cost of opening a new facility, they can be applied to professional health care services. Anecdotally, it is broadly accepted that the relative scarcity of health care professionals in Alaska is part of the reason for the high cost of services.

In order to compare supply and demand, we used data on Health Professional Shortage Areas (HPSAs), which are developed by the Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration (HRSA).[16] HPSAs are identified for primary care, mental health and dental services, but we have focused on the primary care physician shortages for this study.

Table 10A.1 below shows the percentage of the population in each state living in primary care HPSAs, indicating that they have a shortage of primary care providers.

Table 10A.1
Underserved Population in Primary Care HPSAs (2008)

	Estimated Underserved Population (2008)
United States	11.8%
Alaska	12.1%
Hawaii	2.6%
Idaho	17.4%
North Dakota	22.0%
Oregon	7.1%
Washington	9.5%
Wyoming	20.3%

The percentage of the population in primary care shortage areas in Alaska, at 12.1%, is close to the nationwide average of 11.8%, while the comparison states range from 2.6% (Hawaii) to 22.0% (North Dakota). Looking only at this information would suggest that reimbursement for primary care physicians in Alaska is at a level that attracts enough primary care providers to generate a reasonable HPSA population percentage. Of note, Alaska's underserved population percentage is lower than that of the two comparison states without medical schools (Idaho and Wyoming), suggesting that Alaska is attracting more physicians from out of state, possibly because of the relative difference in reimbursement.

In the bigger picture, this result does point out the nationwide shortage of primary care doctors.

[16] For more information, see http://statehealthfacts.org/comparemaptable.jsp?ind=682&cat=8

11. COMMERCIAL DISCOUNTS

A. DETAILED RESULTS

Commercial discounts represent the difference between provider charges (the "billed" amount) and provider reimbursement (the "allowed" amount). While discounts without billed charge level information cannot be used to compare absolute reimbursement levels, discount levels may be indicative of the degree to which commercial payers have negotiating leverage relative to providers.

The Milliman Discount Benchmark Model shows discount information for carriers in each state, excluding Blue Cross and Blue Shield (BCBS) plans. Although much of the commercial care in Alaska is through Premera Blue Cross Blue Shield, there is a sufficient volume of Alaska commercial data in our database (over $30 million in billed charges) to produce credible discounts estimates.

Using the model, we calculated average provider commercial discounts for Alaska and each of the comparison states (where data was sufficiently credible). For more information on this model, please see Section 11B: Methodology. Results are shown in Table 11A.1 below.

Table 11A.1
Commercial discounts by major category of service (2008-2009)

State	Provider Discounts			
	Inpatient Hospital	Outpatient Hospital	Professional	Overall
Alaska	**32%**	**35%**	**20%**	**28%**
Idaho	27%	20%	29%	25%
Oregon	36%	35%	32%	34%
Washington	46%	49%	35%	42%
Wyoming	19%	16%	26%	21%

Overall, hospital discounts in Alaska are higher than Idaho and Wyoming, similar to Oregon and below Washington. Professional discounts are lower than the comparison states.

The lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.

The relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payments to be at least equal to the 80th percentile of charges by geographic area. We are not aware of similar provisions in other states. Since many providers have over 20% of their

market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges.

A separate state law in Alaska requires payers to reimburse even non-contracted providers directly (instead of reimbursing them through the patient). This provision removes another incentive typically used by payers to encourage providers to join their networks.

Indeed, at least one major commercial payer sets its contractual fee schedule using a percentile of charge approach, and a high percentile, presumably in order to ensure sufficient physician participation. This approach and fee level is unique to Alaska; we have not seen a similar approach used for a PPO product in the rest of the United States.

B. Methodology

Beginning in 2001, Milliman started collecting employer group historical medical claims data to determine the lowest cost solution from a network reimbursement perspective. We typically collect more than a billion dollars of health care data each year. This data becomes the basis for our annual market reimbursement benchmarking.

The data we have compiled for the 2010 benchmark analysis includes employer group data collected during 2009 and 2008 and represents primarily 2008 – 2009 incurred dates. By combining two years worth of data, we were able to benchmark 158 Metropolitan Statistical Areas ("MSAs") amounting to approximately $3.41 billion in billed charges. Discounts reflect claim reimbursement for major national carriers/networks and several self-administered networks and TPAs; however, BCBS data is not included in the benchmark data.

Claims are mapped to MSAs (and states) based on the residential zip code of the patient when provided in the claims data; otherwise, the provider zip code is used. The benchmarks are measured using discounts off of billed charges.

12. Cost of Living

A. Detailed Results

The overall cost of living in a given region affects the cost of health care. Hospitals and physicians in more expensive areas will need to pay higher salaries. In addition, non-staff costs such as property, construction/leasing, utilities and transportation will affect the relative cost to provide health care in each area (and therefore, provider reimbursement).

The Council for Community and Economic Research calculates the ACCRA Cost of Living Index (COLI) for select urban areas, which is referenced in the US Census Bureau's Statistical Abstract of the US.[17] The COLI is a measure of prices for consumer goods and services in a certain area. Taxes are excluded from the calculation. The composite COLI is calculated from smaller components, such as health care, that are weighted together based on each component's share of consumer spending. Weights are based on nationwide results from the Bureau of Labor Statistics' 2004 Consumer Expenditure Survey.

The COLI for urban areas in Alaska and the comparison states is shown below. The COLI is restricted to urban centers and therefore, no equivalent values are available for rural areas. Note that each number is to be read as a percentage over or under the nationwide average.

[17] http://www.census.gov/compendia/statab/cats/prices/consumer_price_indexes_cost_of_living_index.html

Table 12A.1
Cost of Living Index (2010)[18]

Urban Area	Cost of Living Index (2010)						
	Composite Index (100%)	Grocery Items (13%)	Housing (29%)	Utilities (10%)	Transportation (12%)	Health Care (4%)	Miscellaneous Goods and Services (32%)
Anchorage, AK	**128.4**	**134.5**	**142.9**	**94.1**	**122.0**	**135.7**	**124.8**
Fairbanks, AK	**137.4**	**127.9**	**148.5**	**193.1**	**118.7**	**144.9**	**118.8**
Juneau, AK	**136.5**	**133.1**	**165.7**	**135.1**	**121.2**	**144.4**	**116.1**
Kodiak, AK	**128.7**	**149.4**	**127.8**	**131.9**	**143.4**	**130.7**	**115.4**
Honolulu, HI	165.7	160.1	249.0	146.6	126.2	120.0	117.9
Boise, ID	97.2	98.5	84.0	99.6	108.0	106.6	103.3
Idaho, Falls, ID	90.6	99.5	78.0	84.9	102.1	93.2	96.3
Twin, Falls, ID	91.5	95.5	81.4	97.0	99.2	93.3	94.6
Bismarck-Mandan, ND	95.3	105.9	91.5	70.1	102.6	100.5	99.4
Fargo-Moorhead, ND-MN	92.7	99.8	87.4	78.7	95.8	102.4	96.6
Minot, ND	99.9	99.3	95.9	73.5	98.2	91.0	113.6
Eugene, OR	109.8	93.8	132.3	85.3	110.0	118.2	102.9
Portland, OR	111.3	105.8	130.8	87.1	105.8	113.6	105.1
Bellingham, WA	113.0	114.9	135.9	83.8	113.2	115.3	100.8
Everett, WA	111.3	112.0	128.1	85.4	110.4	129.1	102.1
Kennewick-Richland-Pasco, WA	92.6	90.9	85.9	85.1	106.1	109.9	95.2
Olympia, WA	104.1	107.4	102.2	82.1	114.9	120.5	106.0
Seattle, WA	121.4	115.1	140.3	85.7	118.8	119.9	119.1
Spokane, WA	93.9	92.4	85.7	89.5	109.1	110.0	96.5
Tacoma, WA	109.5	111.3	116.6	83.1	109.0	115.1	110.2
Vancouver, WA	94.8	96.9	82.2	91.8	106.1	114.3	100.1
Yakima, WA	95.8	99.8	86.9	86.8	105.5	117.1	99.2
Cheyenne, WY	100.5	101.7	107.9	96.3	95.0	98.3	96.5
Laramie, WY	97.0	105.1	102.3	90.5	91.6	97.5	92.7
Nationwide	100.0	100.0	100.0	100.0	100.0	100.0	100.0

The composite COLI for the four Alaska areas range from 128% to 137% of the nationwide average. The health care component is 130% to 145% of the nationwide average. These high costs are roughly consistent with the hospital operating cost results seen in Table 5A.1.

[18] http://www.census.gov/compendia/statab/cats/prices/consumer_price_indexes_cost_of_living_index.html

13. Limitations and Considerations

Any opinions expressed in this report are solely those of the authors.

Any reader of this report must possess a certain level of expertise in areas relevant to this analysis to appreciate the significance of the approaches and assumptions and the impact of these approaches and assumptions on the results. The reader should be advised by their own actuaries or other qualified professionals competent in the subject matter of this report, so as to properly interpret the material.

This report is subject to the terms of the contract between the Alaska Health Care Commission and Milliman. This report is not intended to benefit third parties. Regarding the contents of this report, Milliman makes no representations or warranties to third parties. Third parties are to place no reliance upon this report that would result in the creation of any duty or liability for Milliman or its employees to third parties, under any theory of law. Third parties receiving this report must rely on their own experts to draw conclusions about the report's contents.

As documented in the report, this analysis has relied extensively on historical data. The data were reviewed for reasonableness, but no independent audits were performed. Should errors or omissions be discovered in the source data, the results of our analysis would need to be modified. Future results will differ from the historic estimates in this report.

This report did not review the relative quality of care provided to Alaskans, nor the relative health outcomes from treatment. Those issues were beyond the scope of our report but should be considered when evaluating the relative value of health care in Alaska.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

APPENDIX 1. LIST OF HOSPITALS

Following is the list of hospitals included in each of the analyses in this report. The list differs across analyses due to the availability of data. For each analysis, we have included all hospitals with sufficient data.

Alaska Hospitals Included in Analysis						
	Reimbursement (From Previous Report)	ALOS	Cost	Margin	Occupancy Rates	Staffing Ratios
Anchorage / Fairbanks / Mat-Su						
Alaska Native Medical Center	✓	✓				✓
Alaska Psychiatric Institute	✓		✓			
Alaska Regional Hospital	✓	✓	✓	✓	✓	✓
Denali Center	✓					
Fairbanks Memorial Hospital	✓	✓	✓	✓	✓	✓
Mat-Su Regional Medical Center	✓	✓	✓	✓	✓	✓
Providence Alaska Medical Center	✓	✓	✓	✓	✓	✓
Providence Extended Care Ctr	✓					
St Elias Specialty Hospital	✓		✓			✓
Non-MSA Area						
Bartlett Regional Hospital	✓	✓	✓	✓	✓	✓
Bristol Bay Area Health Corp						✓
Central Peninsula General Hospital	✓	✓	✓	✓	✓	✓
Cordova Community Medical Center	✓	✓	✓	✓	✓	✓
Faith Hospital						✓
Hospice & Home Care of Juneau						✓
Kanakanak Hospital	✓	✓				✓
Ketchikan General Hospital	✓	✓	✓	✓	✓	✓
Maniilaq Health Center	✓	✓				✓
Mt Edgecumbe Hospital	✓	✓	✓			✓
Norton Sound Regional Hospital	✓	✓	✓	✓	✓	✓
Petersburg Medical Center	✓	✓	✓	✓	✓	✓
Providence Kodiak Island Medical Ctr	✓	✓	✓	✓	✓	✓
Providence Seward Hospital	✓	✓	✓	✓	✓	✓
Providence Seward Med & Care Center Ltc	✓					
Providence Valdez Medical Center	✓	✓	✓	✓	✓	✓
Samuel Simmonds Memorial Hospital	✓	✓				✓
Sitka Community Hospital	✓	✓	✓	✓	✓	✓
South Peninsula Hospital	✓	✓	✓	✓	✓	✓
Valdez Community Hospital						✓
Wildflower Court	✓					
Wrangell Medical Center	✓	✓	✓	✓	✓	✓
Yukon Kuskokwim Delta Reg Hospital	✓	✓				✓

Appendix C

Overview & Update
Federal Health Care Reform
(ChartPack)

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

Overview & Update
Federal Health Care Reform

Alaska Health Care Commission Meeting

Deborah Erickson
Alaska Health Care Commission
October 11, 2011
UPDATED 12-14-11

Presentation Overview

- Legal Challenges & Political Realities
- Status of Federal Implementation
- Structure of the Affordable Care Act
- Key Provisions in the Act (with Alaska Updates)
- Alaska Impact
- Timeline for Implementation

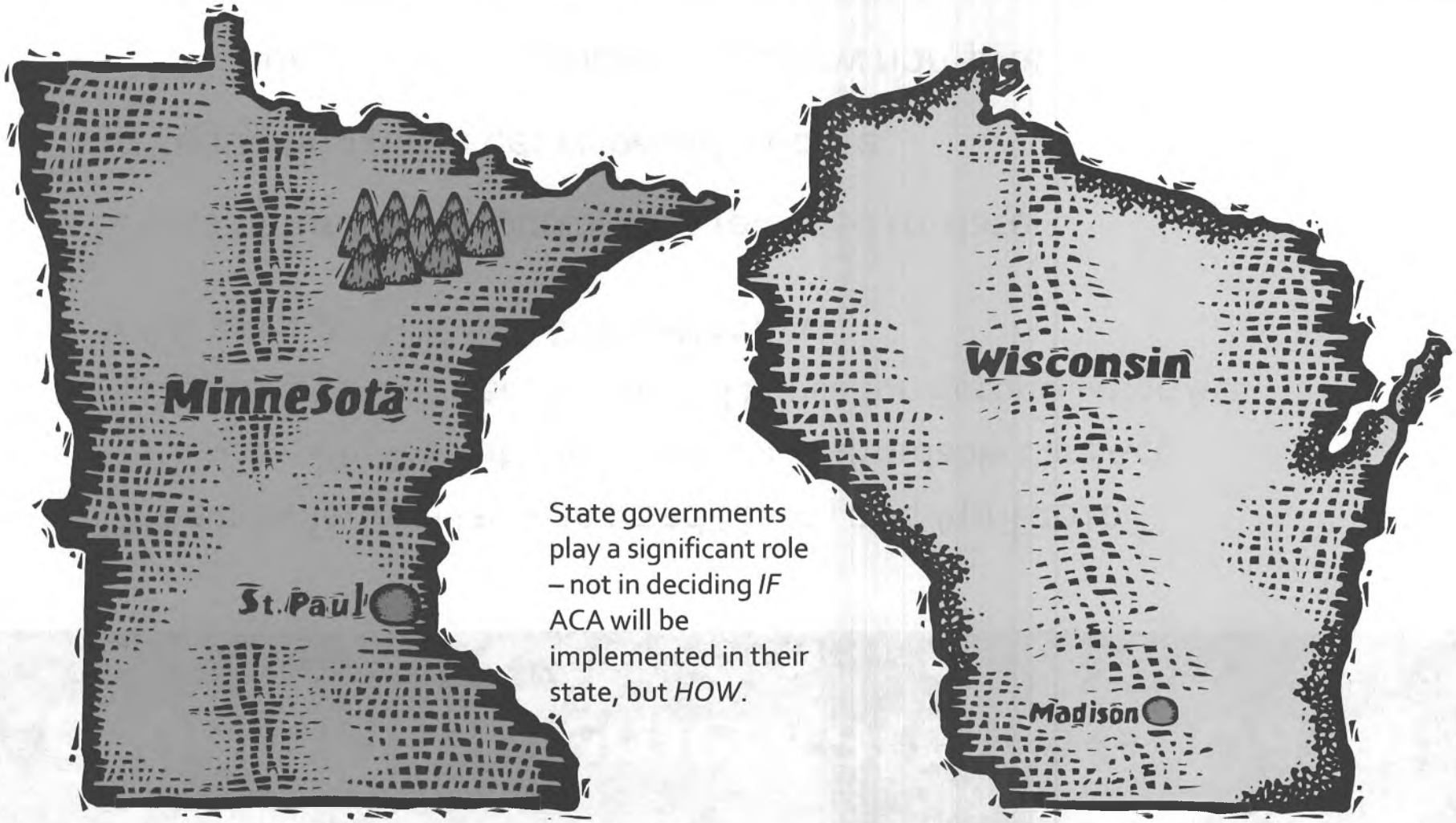
Legal Challenges & Political Realities

- Alaska is participating as a plaintiff in the 26-state lawsuit led by Florida. (11th Circuit)
- Challenging the Constitutionality of:
  - The individual mandate requiring individuals to purchase health insurance
  - Unfunded mandates imposed on state governments (Medicaid Expansion)
  - Question regarding severability
- Appellate Court Ruling Scorecard:
  - 2 rulings upheld ACA (6th and D.C. Circuits)
  - 1 ruling against individual mandate, but upheld Medicaid expansion (11th Circuit)
  - 1 ruling avoided merits of the case; ruled against plaintiffs on jurisdictional grounds (4th Circuit)
  - Supreme Court will Review this year – ruling expected June 2012

Legal Challenges & Political Realities

- **What has the 2010 election meant for the ACA?**
  - There's a big difference between campaigning and legislating….
  - Wholesale repeal unlikely
  - Increased congressional oversight of implementation
  - Provisions with no appropriation in original bill may not be funded
  - Some provisions are supported by GOP (e.g., fraud and abuse)
  - Repeal of some provisions would increase deficit

Legal Challenges & Political Realities



State governments play a significant role – not in deciding *IF* ACA will be implemented in their state, but *HOW*.

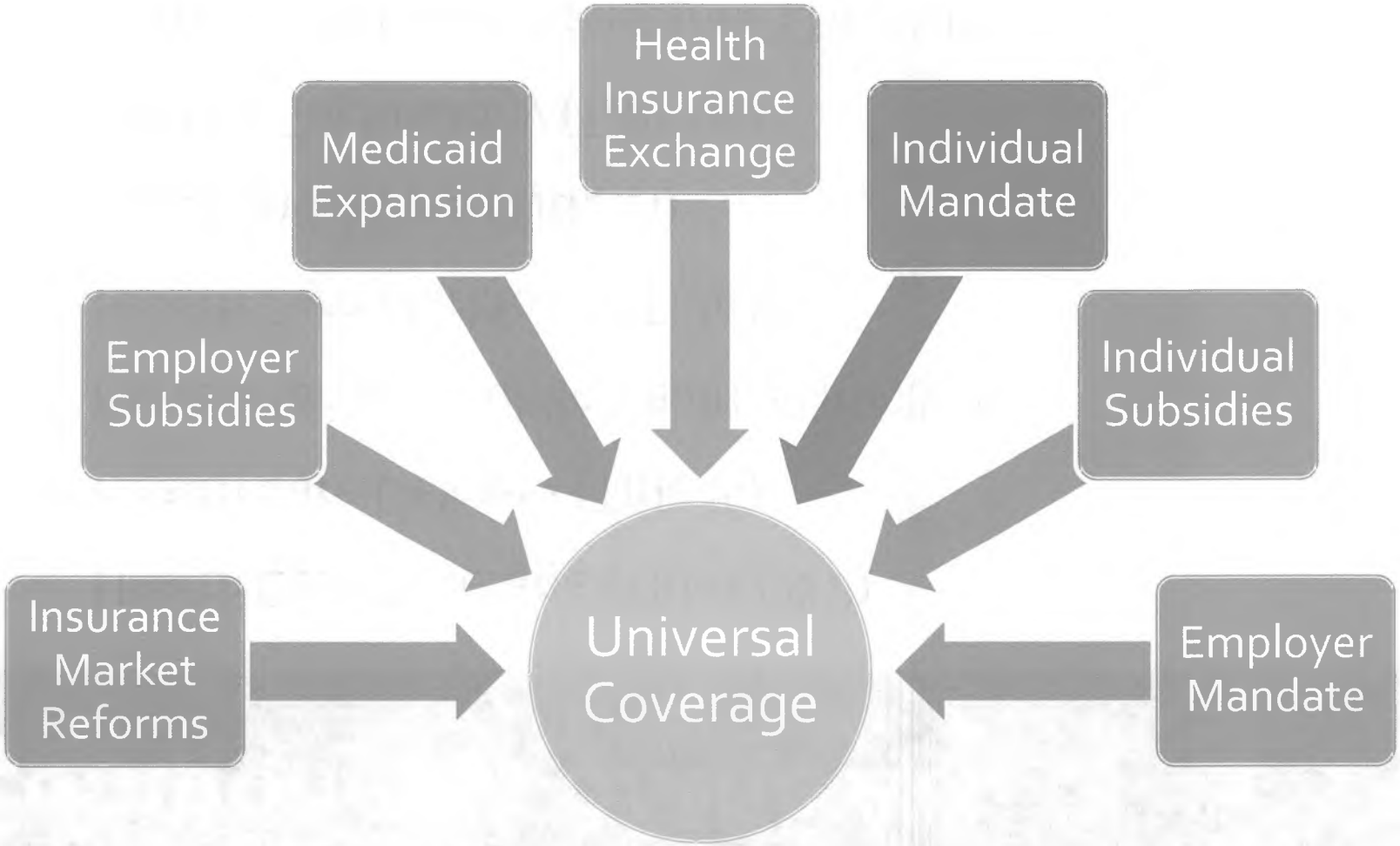
Federal Implementation To-Date

- Three new federal laws enacted March and April 2010
  - P.L. 111-148: The Patient Protection & Affordable Care Act
  - P.L. 111-152: The Health Care and Education Reconciliation Act
  - P.L. 111-159: TRICARE Affirmation Act
- Scores of funding opportunities released to-date
- 34 Regulation packages released to-date
- 4 New federal offices established; 1 new non-profit
- 4 New councils/boards/committees formed
- New website live – www.healthcare.gov

Components of the Act

- Health Care Coverage (Titles I & II)
- Health Care Delivery (Title III)
- Prevention and Public Health (Title IV)
- Health Care Workforce (Title V)
- Fraud and Abuse (Title VI)
- Medical Technology (Title VII)
- Community Living Assistance (Title VIII)
- Taxes and Fees (Title IX)
- Amendments (Title X)

Move Towards Universal Coverage



Insurance Market Reforms

- New Private Insurance Market Rules
  - Exclusions for pre-existing conditions prohibited
    - For children in 2010
    - For adults in 2014
  - Dependent coverage extended to 26 years of age (2010)
  - Lifetime limits prohibited (2010)
  - Annual limits restricted (2010), then prohibited (2014)
  - Prohibition on rescissions (2010)
  - Medical Loss Ratio: Reporting (2010); Restricted (2011)
  - Guaranteed issue and renewal rules (2014)
  - Adjusted community rating rules limit variations in premiums to region, tobacco use, age, and family composition (2014)
  - Gender discrimination prohibited

Insurance Market Reforms

- New Insurance Plan Options
  - Temporary high-risk health insurance pool (2010 - 2014)
    - *Alaska Update: Alaska's ACHIA Fed Pre-Existing Conditions Plan started 8/1/10; there were 46 Alaskans enrolled on 12/02/11*
  - Health Care Cooperatives ("Co-Ops") (2013)
    - Non-profit member-operated health insurance companies created through loans and grants
  - Multi-state health plans (2014)
  - Health Choice Compacts (2016)

Insurance Market Reforms

- State Insurance Oversight and Consumer Assistance
  - Review of Health Plan Premiums (2010)
    - *Alaska Update: SOA declined fed funds as unnecessary and potentially burdensome; HB 164 passed during 2011 legislative session expanded authority of AK Division of Insurance to pre-approve rate increases for all private health insurers operating in Alaska; Alaska was deemed by US DHHS as having an effective review program in July 2011.*
  - State Consumer Assistance Programs (2010)
    - *Alaska Update: SOA declined fed funds as unnecessary and potentially burdensome; AK Division of Insurance maintains an adequately staffed consumer assistance program.*

Employer Subsidies

- Tax Credit (2010)
  - For businesses with <= 25 employees and average annual wages < $50,000
  - *Unable to determine participation by Alaskan employers at this time*
- Temporary Early Retiree Reinsurance Program (2010 - 2014)
  - Employers reimbursed 80% of retiree claims between $15,000 and $90,000 until 2014
  - *Alaska Update: 8 employers enrolled; $1.1 million in reimbursement received as of Sept 2011*

Medicaid Expansion

- Eligibility expanded to all individuals/families under 65 years of age up to 133% FPL (2014)
- State share phased in 2017-2020 (max 10%)
- Alaska preliminary mid-range estimate
  - 30,000 new enrollees
  - Cost to State = $20 M/year
- State option to implement immediately (2010)

Health Insurance Exchange (HIX)

- Electronic Market Place for Purchasing Insurance
  - State-based; Multi-state option
  - May be administered by gov't agency or non-profit
  - State gov't opt-out provision (fed gov't will then establish state's exchange) (2013)
  - For individuals and small business (<100 employees) (2014)
    - Federal subsidies for individuals will be applied through the exchange
    - Interface with State's Medicaid eligibility and enrollment system required
    - Large businesses allowed to participate starting 2017
  - Required to be self-sustaining (2015)
- Grants to states for planning and implementation (2010)
  - *Alaska Update: SOA declined fed funds as unnecessary and potentially burdensome, but is utilizing available funds to solicit contract with consultant to advise on design – RFP released Sept 2011, contract to be awarded Dec 2011, report due Apr 2012; Alaska Medicaid's Children's Health Insurance Program (CHIP) has won a number of financial awards from US DHHS for high performance in CHIP enrollment, and is being used as a model at the national level in the design of streamlined eligibility process and outreach templates for HIXs.*
- State innovation waiver (2017)

Individual Mandate

- Individuals must have a qualified health plan or pay a tax penalty (2014)
  - Tax penalty $695/year (Family capped at 3x individual penalty ($2,085)) or 2.5% of household income, whichever is greater (phased in)
  - Exemptions include
    - Financial hardship
    - Religion
    - American Indians/Alaskan Natives
    - Lowest cost option exceeds 8% of income

Individual Subsidies

- Premium Credits (2014)
  - Refundable/Advanceable credits for purchase of insurance through the Exchange
  - Individuals/families with incomes between 133%-400% FPL
  - Amounts tied to cost of plan and set on sliding scale based on income level
- Cost Sharing Subsidies (2014)
  - Individuals/families between 100% - 400% FPL

Employer Mandate

- < 50 employees: Exempt
- > 50 employees - if 1 or more employee receives subsidy:
  - And employer does not offer coverage, employer required to pay fee of $2,000/FTE (1st 30 FTEs excluded)
  - And employer provides coverage, employer required to pay fee of $2,000/FTE or $3,000 per subsidized employee (whichever is less)
- > 200 employees: Required to auto-enroll new employees
- Provide voucher to employees with incomes less than 400% FPL who chose to participate in Exchange
- Report value of health care benefits on employees' W-2 (2011)
  - IRS issued notice making this requirement optional for large employers (>250 employees) until 2012 and for small employers until 2013.

Health Care Delivery

- Evidence-Based Practice (Comparative Effectiveness Research)
  - New non-profit Patient-Centered Outcomes Research Institute was established Sept 2010
- Quality Improvement (National Strategy)
  - National Health Care Quality Strategy report was issued March 2011
- Care Coordination and Service Integration
  - Community-Based Care Transitions Program *at least 1 AK HC provider intends to apply*
  - Primary Care & Behavioral Health Service Integration *grants to AICS (Wrangell) & SCF*
- Trauma System Enhancement *(funds not appropriated)*
- Enhanced funding for Community Health Centers
  - *Alaska Update: $9.5 million in new and increased community health center funds awarded in Alaska as of Aug 2011; plus 13 Akn CHCs awarded $35k each Sept 2011 for PCMH transition*
- Primary Care Enhancement
  - Medicare 10% bonus to primary care physicians (2011–2015)
  - Medicaid Medical Home State Plan Option (90% FMAP for 2 years) (2011) *AK Medicaid program will wait until medical home program fully operational to exercise option, as there is no expiration date on the option, and the 2-year clock on the enhanced FMAP starts ticking as soon as the State's application is approved by feds*
  - Increase Medicaid payment to Medicare rate *(n/a in AK)*

Payment Reform

- Center for Medicare & Medicaid Innovation (2011)
- Multi-Payer Advanced Primary Care Practice Demo (2011)
- Medicare Payment Reform ACA Provisions
  - Independent Payment Advisory Board (2011; 1st rpt due 2014)
  - FQHC Advanced PCP Demo (2011)
  - Hospital readmission reduction program (2012)
  - Shared savings program (Accountable Care Organizations) (2012)
  - Hospital value-based purchasing program (2012)
  - Bundled payment (episodes of care) pilot (2013)
  - Physician fee schedule value-based payment modifier (2015)
  - Payment adjustments for hospital-acquired conditions (2015)
- Medicaid Payment Reform ACA Provisions
  - Non-payment for healthcare-acquired conditions (2011)
  - Pediatric ACO demonstration (2012)
  - Hospital bundled payment (episodes of care) demonstration (2013)

Prevention & Public Health

- National Prevention Council and Fund
- Coverage of clinical preventive services
- Nutrition labeling on menus
- Community wellness grants
- Healthy lifestyles incentives (Medicare and Medicaid)
- Immunization program
- Epidemiology & PH laboratory capacity
- Childhood obesity demonstration project
- Maternal and child health programs

Alaska Update: Approximately $7 M in grants for public health, prevention, workforce development, and programs for aged/disabled have been awarded to-date in AK; it's important to note that a number of these grants were previously authorized and funded but were reauthorized under and now appear as ACA programs

Health Care Workforce

- National HC Workforce Commission
- National health care workforce assessment
- National Health Service Corps increased
- State health care workforce plans
  - *Alaska Update: AK Dept of Labor and WF Development awarded grant last year, which was used to support AK Health Workforce Coalition and development of their recently released Action Plan*
- Recruitment and retention programs
- Training and education programs
  - Rural physician training grants
  - Area Health Education Center (AHEC) expansion
  - GME (graduate medical education) improvements
    - Resident training in community-based settings
    - Redistribution of GME slots

Fraud & Abuse

"2011 will be a turning point for compliance programs…."

Report on Medicare Compliance
January 17, 2011

"The stress level for compliance professionals will go off the charts this year."

Roy Snell, President
Health Care Compliance Association
January 17, 2011

ACA includes 32 sections on health care fraud and abuse and program integrity

Fraud & Abuse

- New Provider Enrollment Processes
- Data Sharing Across Federal Programs
- Overpayment Recovery Expanded
- Increased Penalties
- Disclosure of Financial Relationships Required
- Compliance Plans Required

Fraud & Abuse

- New Medicaid RAC Program
  - Federal regulations released September 2011
  - State Medicaid Program required to implement RAC Program by January 2012
  - *Alaska Update: AK DHSS is evaluating how to align new Medicaid RAC program with Medicaid audit program mandated under State law to minimize impact on providers.*

Community Living Assistance

- New long-term care insurance program (2011)
  - Voluntary
  - 5-year vesting
  - Cash benefit
    - to help aged/disabled stay in home or
    - cover nursing home costs

How the Act Pays for Itself

New Fees & Taxes

- 10% sales tax on indoor tanning (2010)
- $2.8 billion annual fee on pharmaceutical industry (2012; increasing over time)
- 2.3% sales tax on medical devices (2013)
  - Glasses, contacts, hearing aids exempt
- Medicare payroll tax increased from 1.45% to 2.35% for individuals >$200K and couples >$250K; no increase to employer share (2013)
- New 3.8% Medicare tax on unearned income for individuals >$200K and couples >$250K (2013)
- Tax deduction for employers receiving Medicare Part D retiree subsidy eliminated (2013)
- $8 billion annual fee on health insurance industry (2014; increasing over time)
- Excise tax on employer-sponsored high-value insurance plans (2018)
  - "Cadillac Plans" tax imposed on plans valued at more than $10,200 for an individual plan and $27,500 for family coverage

Other Provisions

- Amends FLSA to require break times/locations for nursing mothers
- Alaska Federal Health Care Access Task Force
  - *Alaska Update: Convened Jul-Aug 2010, produced report Sept 2010, dissolved with production of report.*
- Medicare "Donut Hole" Closure
  - *2,329 Alaskans received $250 rebate in 2010; in 2011 those in the donut hole are receiving a 50% discount on covered brand name prescription drugs*
- Elder Justice Act
- Indian Health Care Improvement Act Reauthorized

Alaska Impact 2019 (MAFA Projections)

- Increase in health care spending: +$289 M
  - State of Alaska: +41 M
  - Alaska Households: $124 M
  - Federal Gov: $124 M

- Increase in insurance coverage: +53,000 Alaskans
  - Medicare: 0
  - Medicaid: +38,000
  - Employer sponsored: - 45,000
  - Exchanges: +78,000 (60% supported by fed subsidies)
  - Other Private: - 18,000
  - Other Public: 0

Timeline

- **2010**
  - Smallest employers (<=25 FTEs) eligible for tax credits
  - Medicaid Maintenance of Effort imposed (March)
  - Temporary high-risk insurance pool program established (June)
  - Temporary reinsurance program for early retirees established (June)
  - Feds establish website to facilitate insurance information (July)
  - Grants to states for
    - Exchange planning and implementation
    - Assistance with insurance premium review requirements
    - Establishing an office of health insurance consumer assistance
    - Numerous public health and workforce programs
  - Insurance Market Reforms Implemented (new plans for plan years beginning after 9/23/10)
    - Pre-existing condition exclusion prohibited for children
    - Lifetime limits prohibited; annual limits restricted
    - Prohibition on rescission of coverage
    - Dependent coverage to 26 years of age
    - Medical loss ratio reporting required
    - Coverage of clinical preventive services required

Timeline

- **2011**
  - Medicaid Options & Requirements
    - States eligible for 1% FMAP increase if certain preventive services covered with no cost-sharing
    - Required to cover tobacco cessation for pregnant women
    - New state option for home and community-based services for disabled
  - Insurance Market Reforms
    - Medical Loss Ratio requirement imposed: Large group plans required to spend 85% of premium revenue on medical claims (80% for insurers covering individuals and small business)
  - New Fraud & Abuse Rules Implemented

- **2013**
  - U.S. DHHS determines State readiness to establish Exchange
  - Fed regulations for health care choice compacts issued

Timeline

- **2014**
  - Insurance Exchanges implemented
  - Medicaid changes implemented
    - Expansion to 133% FPL takes effect
    - Required to implement enrollment simplification and coordination with Exchanges
    - Required to offer premium assistance for employer-sponsored insurance.
    - DSH funding reduced
    - Prohibition on exclusion of coverage for barbiturates, benzodiazepines, and tobacco cessation products
  - States required to establish at least one reinsurance entity
  - Insurance Market Reforms Implemented
    - Pre-existing condition exclusion prohibited for adults
    - Guaranteed issue and renewal required
    - Adjusted community rating rules take effect
  - Individual and employer mandates and subsidies implemented

Timeline

- **2015**
  - Insurance Exchanges must be self-sustaining
  - Medicaid programs required to begin annual enrollment reporting
  - States eligible for 23% FMAP increase on regular CHIP match (FFY 16 – FFY 19)
- **2016**
  - Health Care Choice Compacts may take effect
- **2017**
  - States will begin funding share of Medicaid expansion
  - States may operate an alternative program in lieu of federal coverage reforms if waiver obtained in previous year
  - States may allow large companies (>100 employees) to participate in Exchange
- **2018**
  - Excise tax on high-value health insurance plans imposed

Thank You

For More Information Please Visit:

Alaska's federal health care law information website at:

http://hss.state.ak.us/fedhealth/

Alaska Health Care Commission's website at:

http://hss.state.ak.us/healthcommission/

Appendix D

Voting Records

Summary of Public Comments

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

Department of Health & Social Services

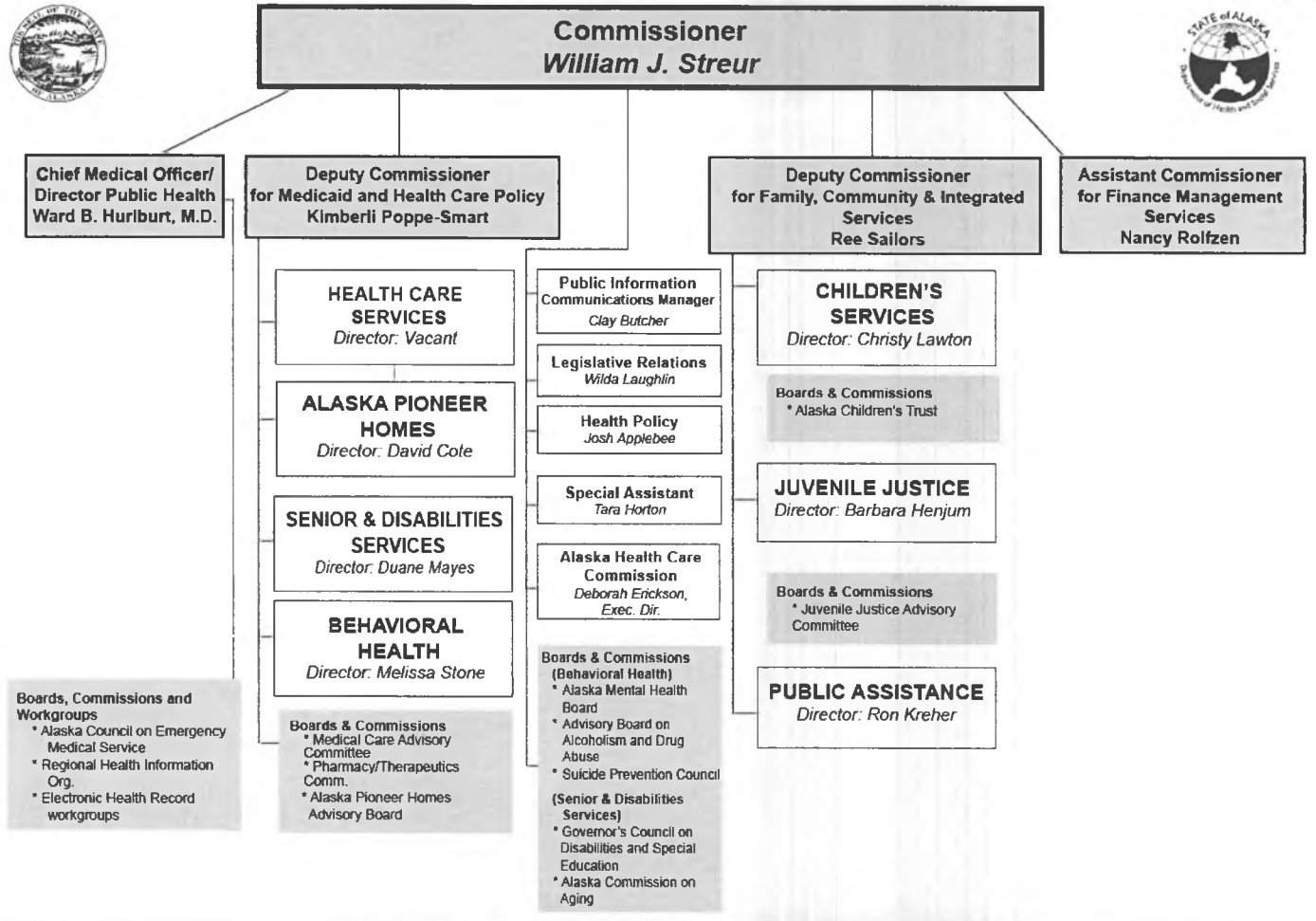
Department Overview

Partnerships

Commissioner William Streur

2012 Department Overview

Department of Health & Social Services
Organization



Mission: to promote and protect the health and well-being of all Alaskans

Core Services

- Provide the highest quality of life in a safe home environment for older Alaskans and veterans.
- Manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and open partnerships.
- Promote safe children and strong families.
- Manage health care coverage for Alaskans in need.
- Hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote the independence of Alaskan seniors and persons with physical and developmental disabilities.
- Provide quality administrative services in support of the department's mission.

Priorities

- Integrated Health and Wellness
- Health Care Access and Delivery
- Sustainable Long-Term Care Delivery System
- Safe and Responsible Families and Communities

Priorities

- **Integrated Health and Wellness**
- Adult Preventative Dental Care: 14,821 Individual recipients over the age of 21
- H1N1 Pandemic Influenza vaccinations and distribution to providers
- Alaskans Taking on Childhood Obesity (ATCO)

Priorities

Health Care Access and Delivery

Medicaid Task Force

- Patient-centered medical homes
- Pharmacy – effective use of generic and formula drugs
- Community First Choice

Priorities

Sustainable Long-Term Care Delivery System

- Alaska Seniors and Veterans in the Pioneer Homes
- Served ~ 30,000 recipients through Senior and Disabilities service programs
- Partnering with Native Organizations for Nursing Home Care

Priorities

Safe and Responsible Families and Communities

- Support Child Advocacy Centers
- Child Welfare system Family-to-Family (F2F)
- Families First
- Bring the Kids Home

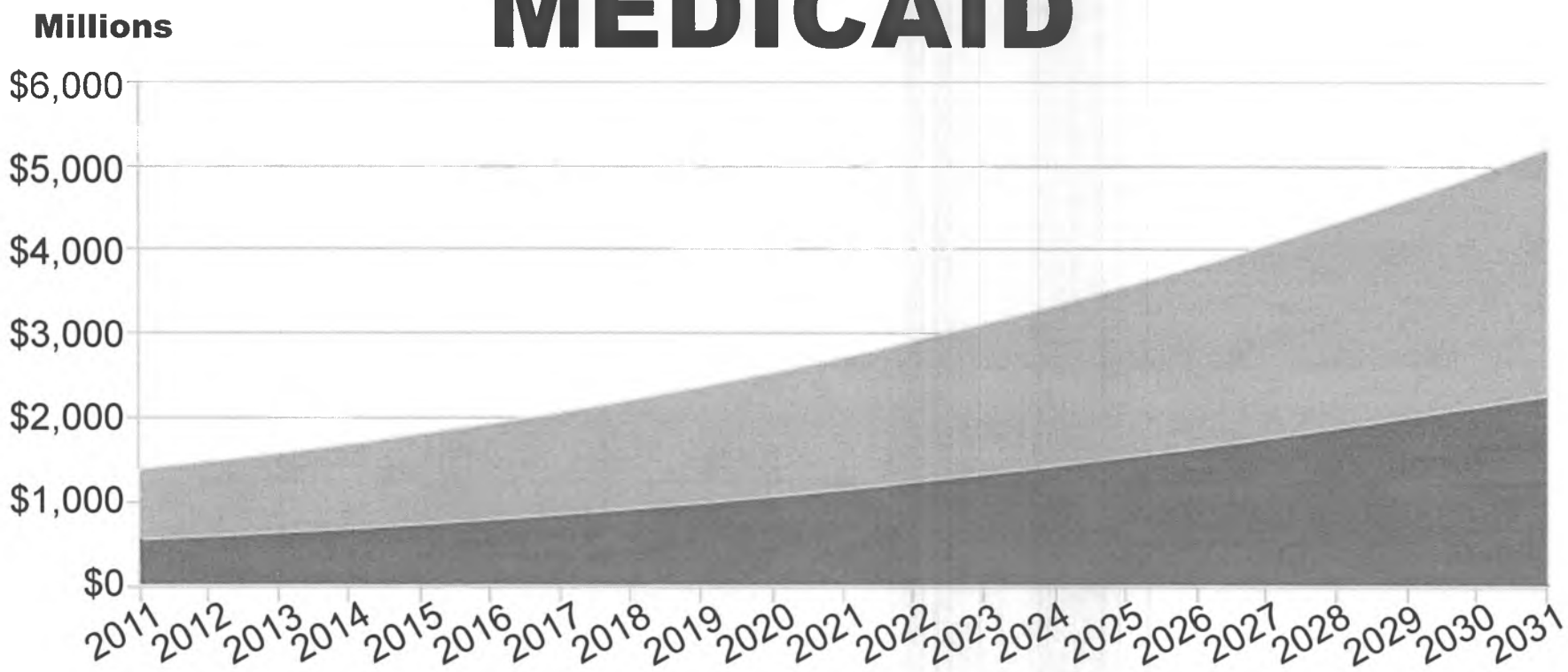
Priorities

Safe and Responsible Families and Communities Cont.

- Juvenile Justice
  - Alaska Native Recidivism Committee
  - Behavioral Health Services for Juveniles within detention and treatment facilities
- Heating Assistance Grants – Over 14,500 during 2010-2011 heating season
- Home and Community-based senior and disabilities services

Challenge:

MEDICAID

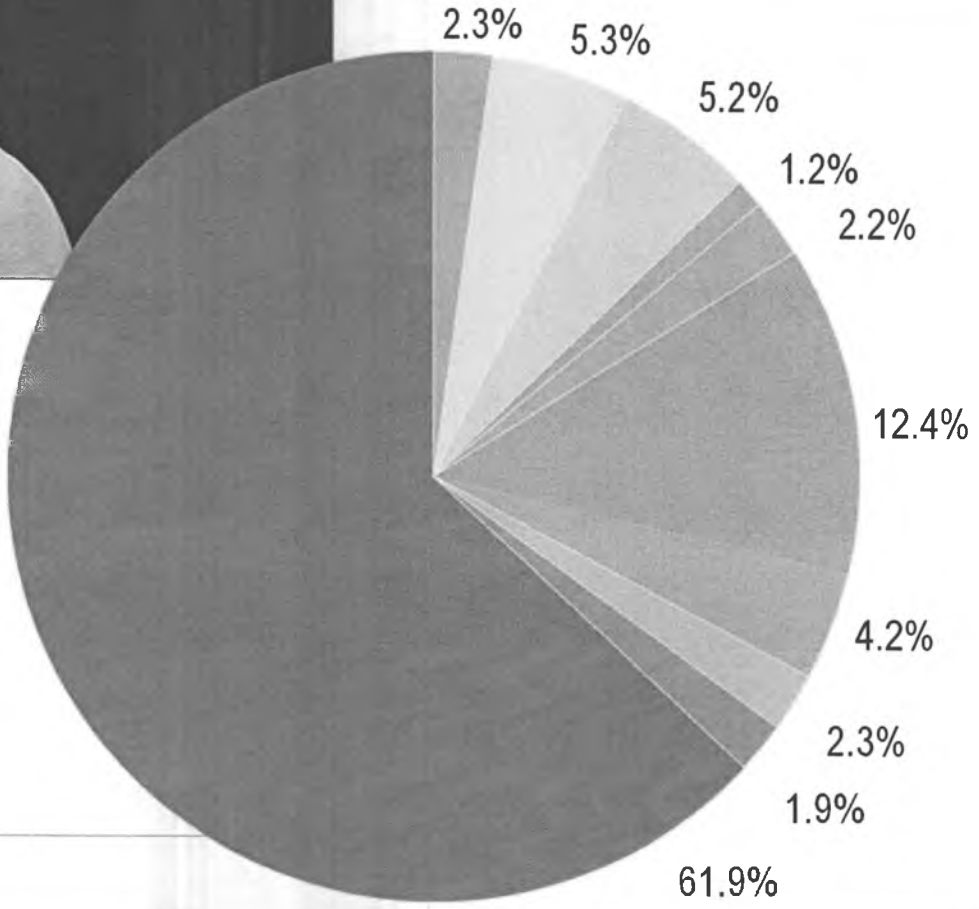


Mission: to promote and protect the health and well-being of all Alaskans

Partnerships

Department of Health & Social Services
Budget Overview

Alaska Pioneers Homes	61,061.4
Behavioral Health	138,935.6
Office of Children's Services	135,470.0
Health Care Services	32,254.4
Juvenile Justice	58,175.2
Public Assistance	323,996.0
Public Health	109,935.7
Senior & Disabilities Services	61,173.8
Finance & Management Services	51,218.2
Medicaid Services	1,645,471.9
	2,617,692.2



Mission: to promote and protect the health and well-being of all Alaskans

Partnerships

Goals

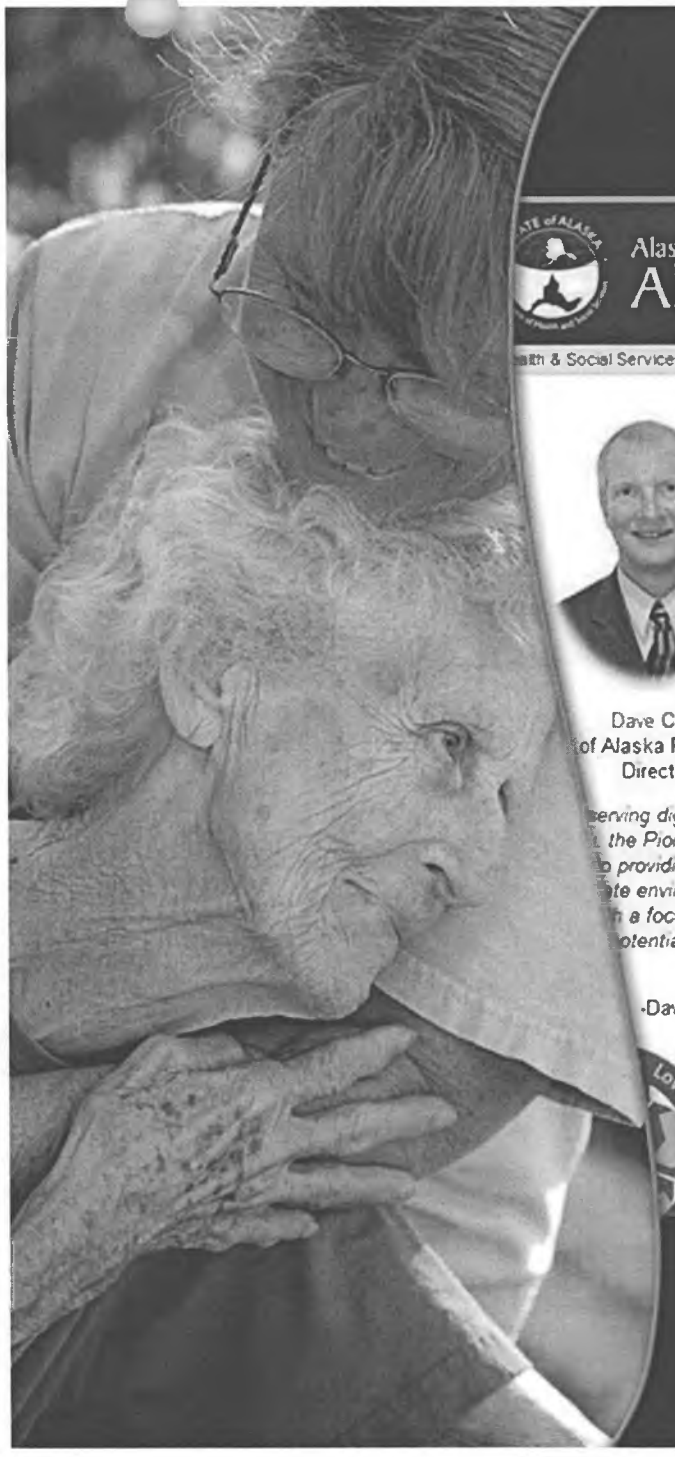
- **Vulnerable Populations**
  - Increase the percentage of at-risk individuals who are able to live safely in their homes in Alaska.
- **Substance Abuse**
  - Decrease the negative impacts of alcohol and substance abuse in Alaska.
- **Long Term Care**
  - Increase the percentage of adults 65 and older living independently in Alaska.
- **Health and Wellness**
  - Improve the health status of Alaskans.
- **Health Care Reform**
  - Improve access to quality health care in Alaska.

Strategies

- **INTEGRATED SERVICES**
- Maximize resources for effective service delivery.
- Promote rural infrastructure development and standardization of regional structure.
- Promote accountability at all levels of the organization.
- Leverage technology in strategic ways to accomplish the department's goals.

Strategies

- Promoting and responding to overall health and wellness of Alaskans
- System Development/Improvements
- Partnerships
- Recruitment and retention of qualified employees



Department of Health & Social Services

Alaska Pioneer Homes

Alaska Department of Health and Social Services

Alaska Pioneer Homes

search

DHSS State of Ala

...lth & Social Services > Alaska Pioneer Homes

Dave Cote
...of Alaska Pioneer Homes
Director

...serving dignity and ... the Pioneer Homes are ...o providing a safe and ...te environment to ...h a focus on people's ...otential for personal

-Dave Cote, Director

NEWS

December 2011-Anchorage

Master Gardeners honored for their service

December 9th, the Anchorage Pioneer Home honored Judy Christinson and Mary Shier for their 20 years of volunteer service at our home through the Master Gardener Program. They were responsible for all the beautiful flowers in the front of our home each summer for the past two decades. They have grown the flowers from seeds, planted and cared for them each summer and prep everything for winter. Both Judy and Mary have volunteered thousands of hours of their time over the years taking care of the Anchorage Pioneer Home's gardens. We can't thank them enough.

From left to right, Judy Christinson and Mary Shier are presented their awards.

December 2011-Fairbanks

Our Statewide Homes

Our Main Number

1-888-355-3117

- Anchorage
- Fairbanks
- Juneau
- Ketchikan
- Palmer
- Sitka
- Pioneer Homes Pharmacy

Important links

- Resident & Family Information
- Admission Forms
- Q & A
- Payment Assistance
- Waitlist Information
- Locations Map
- ...Advisory Board...

Mission: assist older Alaskans to have the highest quality of life by providing assisted living in a safe home setting which promotes positive relationships, meaningful activities, and physical, emotional, and spiritual growth.

Department of Health & Social Services

Behavioral Health

Alaska Department of Health and Social Services

Division of Behavioral Health

DHSS State of

ith & Social Services > Behavioral Health

Melissa Witzler Stone
Director

ers promoting healthy communities."

ssion & Values

INE BEHAVIORAL HEALTH
ioral Healthcare Services

ed about a
NERABLE
ULT?
00-478-9996

IDE
URTS

CURRENT EVENTS & ANNOUNCEMENTS

Use this link for New Integrated Behavioral Health Regulations Implementation

- NEW Statewide suicide prevention plan now open for comment 10/2011
- Treatment and Recovery Grantees 12/2011
- Prevention and Early Intervention Grantees 12/2011
- SFY2011 Comprehensive Behavioral Health Treatment & Recovery (CBHTR) Grant Program Funding Summary and CBHTR PBF Letter
- Medicaid Billing and Provider Enrollment Information
- Alaska Scorecard: Key Issues Impacting Alaska Mental Health Trust Beneficiaries
- Individual Service Agreement Grants

Behavorial Health Block Grant Application 2012

The Alaska - 2012 Combined Behavioral Health Block Grant is available for comment. Persons wishing to comment on the draft plan are also invited to call or e-mail their suggestions to the Division Operations Manager Stacy Toner (907) 465-3370 or stacy.toner@alaska.gov Access the Block Grant application at the following:

https://bgas.samhsa.gov
User name: citizenak
Password: citizen

SECTIONS

- Home
- Division Contacts

Programs

- Alaska Psychiatric Ins
- Policy & Planning
- Prevention & Early Intervention
- Program Integrity
- Treatment & Recovery

Resources

- Advisory, Advocacy, & Planning Boards
- Division Initiatives
- Documents & Publica
- Forms
- Frequently Asked Questions (FAQ's)
- Grants & Contracts – Public Notice
- Lending Library
- Performance Manager System
- Provider Jobs
- Policies & Procedures

Mission: to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices and partnerships.

STATE of ALASKA
Department of Health and Social Services

Department of Health & Social
Office of Children's Services

Alaska Department of Health and Social Services
Office of Children's Services

DHSS State of Al

> Office of Childrens Services

, Director

ns of healthy
oment here:
tion.alaska.gov

children safe
people strong

HEADLINES

- NEW OCS Response to Citizens Review Panel (CRP) Report
- NEW January Newsletter: The Pipeline
- **Alaska Staff Survey Report - 2011**
- **Tribal Survey Report - 2011**
- **Foster Parent Survey Report - 2011**
- OCS Comprehensive Assessment Process - 2011 Logic Model
- Indian Child Welfare (ICWA) Desk Guide to ICWA Law & Culture
- Television: **New Foster Care PSA**
- Report: **Early Intervention: A Powerful Investment**
- **Foster Parent Survey Results**
- Radio PSA "It's My Job to Prevent Child Abuse"
- **2010 Tribal Report**
- **Protective Capacity Assessment Stakeholder Edition**
- **2010-2014 Supervisors' Strategic Plan**
- **Children's Trust Annual Report**
- 2010 Alaska Staff Survey Final Report
- 2010 Alaska Staff Survey Comparison Report
- Alaska Citizen Review Panel 2011 Report
- 2010 Annual Progress & Service Report
- Foster Care Rate Schedule
- Social Services Block Grant FY11
- Parent's Rights Brochure
- Become a Foster Parent (Commercial)
- Alaska 2-1-1
- Requesting Adam Walsh Checks from Alaska

Anchorage: 1-800-478-4444

Southcentral: 1-855-352-893

Northern Alaska: 1-800-353-2

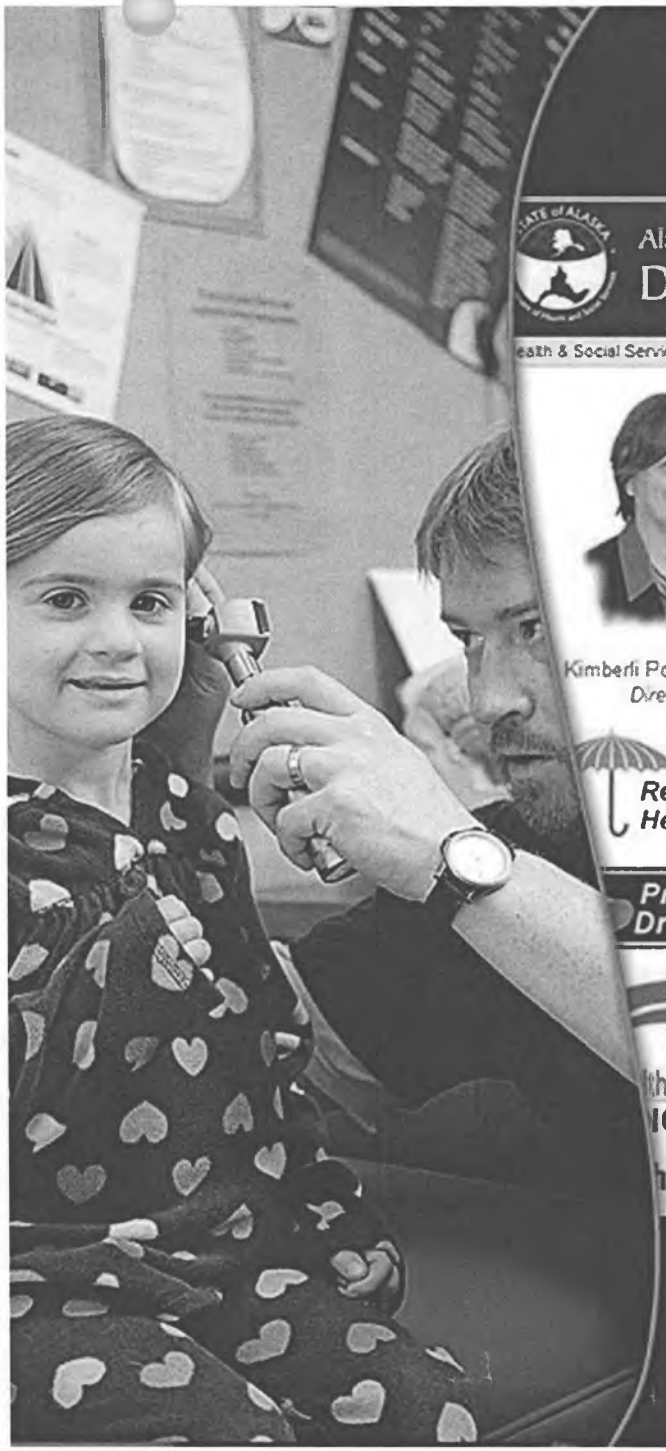
Southeast: 1-888-622-1650

Western Region: 1-800-557-3

PROGRAMS

- Adoption & Guardiansh
- Alaska Early Interventio Infant Learning Progran
- Children's Justice Act
- Children's Trust
- Early Childhood Comprehensive System Grant (ECCS)
- Family Preservation

Mission: to protect and serve Alaska's children and families.



Department of Health & Social Services

Alaska Department of Health and Social Services

Division of Health Care Services

DHSS State of

ealth & Social Services > Health Care Services

Kimberli Poppe-Smart
Director

Recipient Help Lines

Preferred Drug List

alaska
th Information
NOLOGIES

here to
more

USEFUL LINKS

- **Alaska Medicaid Recipient Handbook**
- Contacts
- Director's Office
- Directory of Alaska's Health Care Sites
- Certificate of Need
- Health Facilities Certification
- Help Beyond Medicaid
- HIPAA Information
- Medicaid State Plan
- Medical Care Advisory Committee
- Orthodontia guidelines
- Payment Error Rate Measurement (PERM)
- Physician Supply Taskforce Report
- Planning Links and Resources
- Provider Information
- Publications/Reports
- Prior Authorization
- Rate Review
- **Recipient Help Line**
- Resources
- Rural hospitals
- School Medicaid Administrative Claiming
- Tribal Health
- Useful Links

PROGRAMS

- Adult Dental Care Pro
- Case Management Services
- Certificate of Need
- Certification and Licer
- Chronic & Acute Med Assistance (CAMA)
- Denali KidCare
- Early & Periodic Scre Diagnosis & Treatmer (EPSDT)
- Medicaid
- Medicare Part "D"
- **Preferred Drug List**
- Transportation

Health Care Provide
PEP Provider Enrollment Portal
now available for new
Medicaid provider enrollm
Click Here
ALASKA MEDICA

Mission: to provide health coverage to Alaskans in need.

STATE of ALASKA
Department of Health and Social Services

Department of Health & Social Services

Juvenile Justice

Alaska Department of Health and Social Services

Division of Juvenile Justice

DHSS State of

ealth & Social Services > Juvenile Justice

Barbara Henjum
DIRECTOR

ployment portunities

sion of Juvenile Justice
ccess Stories

OF INTEREST

- Come work for us! Check out our new recruitment videos!
- AJJAC 2010 Annual Report
- Gang Reduction & Intervention Network (GRAIN) assesses Fairbanks gang activity with survey
- Fact Sheet: Preventing abuse at McLaughlin Youth Center
  Our plan for addressing victimization in state youth facilities
- Disproportionate Minority Contact in Alaska
- Success Stories
- *Threat Security and Safety.*
  An Assessment of Security Needs for Alaska's Juvenile Detention Facilities
- Restorative Justice System
- Who's Who in the DJJ State Office
- Who's Who in DJJ

The mission of the Division of Juvenile Justice is:

- Hold juvenile offenders accountable for their behavior.
- Promote the safety and restoration of victims and communities.
- Assist offenders and their families in developing skills to prevent crime.

FOR MORE INFORMATION

State of Alaska
Division of Juvenile Justice
240 Main Street, Suite 701
P.O. Box 110635
Juneau, AK 99811-0635

OUR LOCATIONS

- Map of DJJ Locations
- List of DJJ Locations
- Youth Facilities
- Probation Services

WHAT WE ARE DOING

- Statistics
- Publications
- Performance Measure
- Capital Projects

ABOUT US

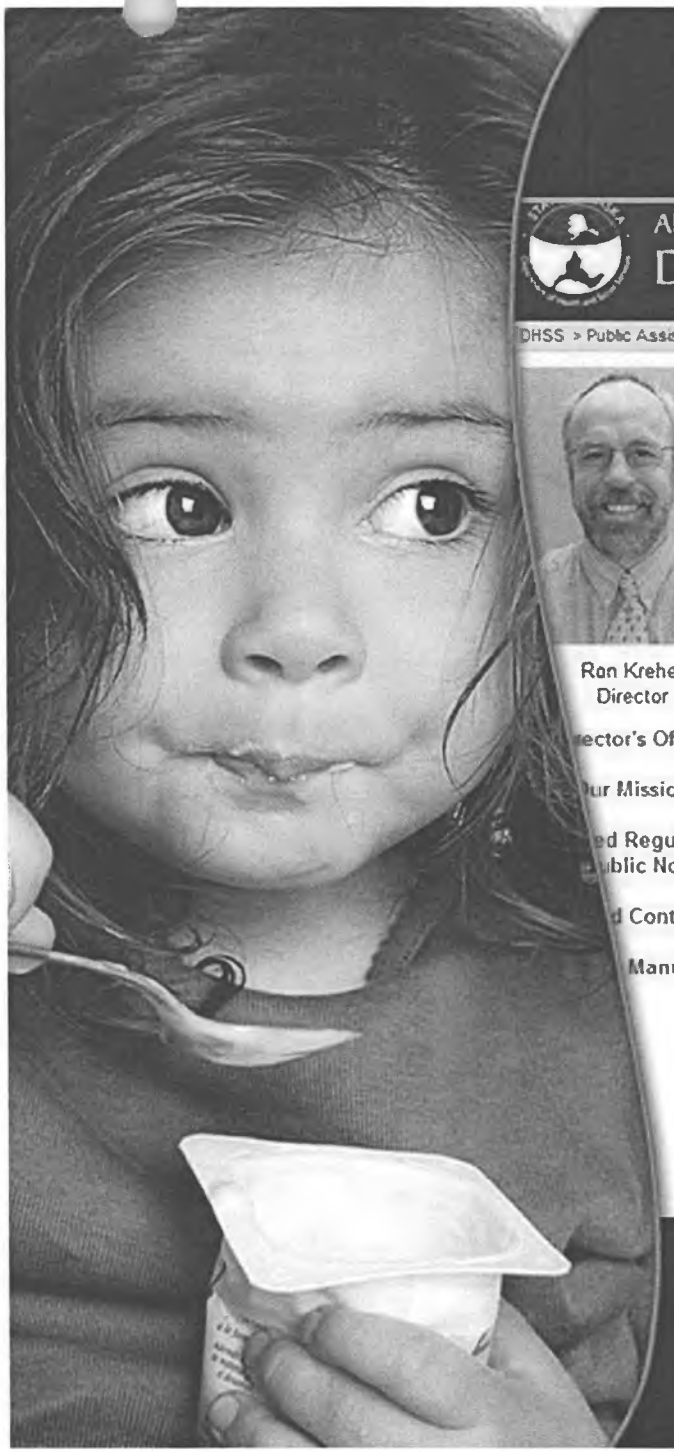
- The Director
- DJJ Contacts
- AJJAC and DMC
- JOMIS
- Staff Training

RESOURCE LINK OUTSIDE OF DJ

- Alaska Court System
- ICJ Forms

Mission: We are committed to holding youths accountable for their actions while also protecting communities, repairing the harm to victims and working to ensure that youths gain necessary skills to function successfully in society

STATE of ALASKA
Department of Health and Social Services



Department of Health & Social Services
Public Assistance

Alaska Department of Health and Social Services
Division of Public Assistance

DHSS > Public Assistance

Ron Kreher
Director

ector's Office

ur Mission

d Regulations
ublic Notices

d Control

Manuals

HEADLINES...

- **HHS awards $5.6 million to Alaska as 'performance bonus'**
- **Child Care Assistance Program Transition for the Fairbanks North Star Borough Service Area Effective July 1, 2011.**
- **Text4Baby** is a new resource for pregnant mothers. This is a service designed to provide free, health –related text messages to pregnant women and new mothers. Women who sign up for this service by texting BABY to 511411 will receive free SMS text messages each week, timed to their due date or baby's date of birth.
- View increased Food Stamp Benefits effective April 1, 2009
- Flyer for customers: Food Stamp Benefit Increase
- Poster: Food Stamp coupons expire June 17, 2009
- Poster: Stimulus Act increases Food Stamp benefit
- Native Family Assistance Program Guide
- State Response Team Travels to Emmonak
- Facing the Final Countdown: A Study of

FOR EMPLOYERS

- Job Start - Money for your Business!
- Tax Credits for Employers
- Calendar of Job Fairs

FOR CUSTOMERS

- Contact Us!
- Work for us!
- AK Job Centers Phone/Fax/TDD
- Alaska Quest Card
- Prescription Drug Resource List
- Printable Application for Public Assistance
- Printable Application for Senior Benefits
- What changes should be reported
- Program Manuals
- 2011 Alaska TANF State Plan (6/11), Certification and Appendices (6/11)
- Try our Food Stamps Eligibility Calculator!
- The Government may owe you money!!
- Consider Direct Deposit! Receive Public Assistance benefits easily and quickly through Direct Deposit.
- Register to vote online! Or print out a registration form.

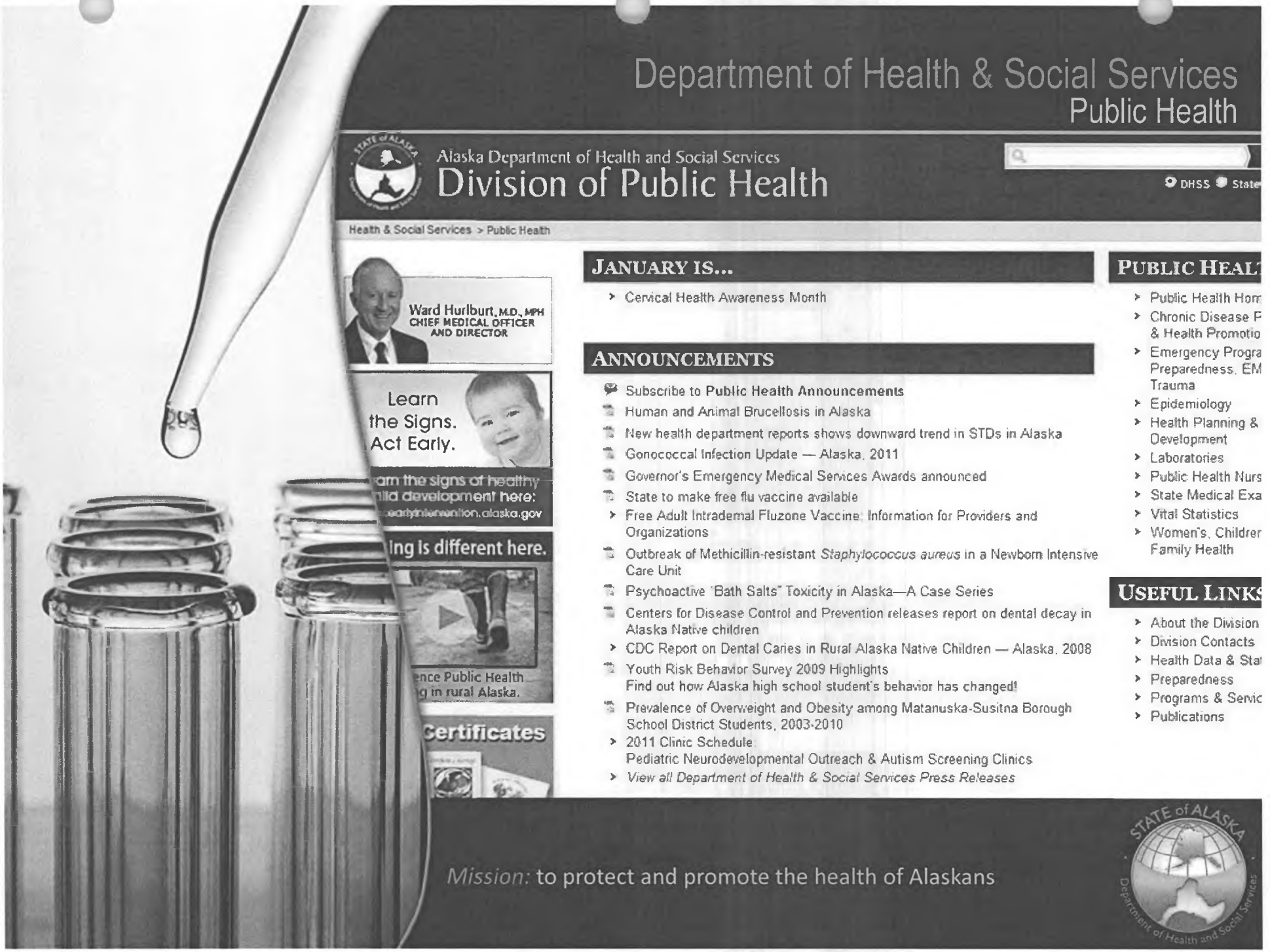
PROGRAMS

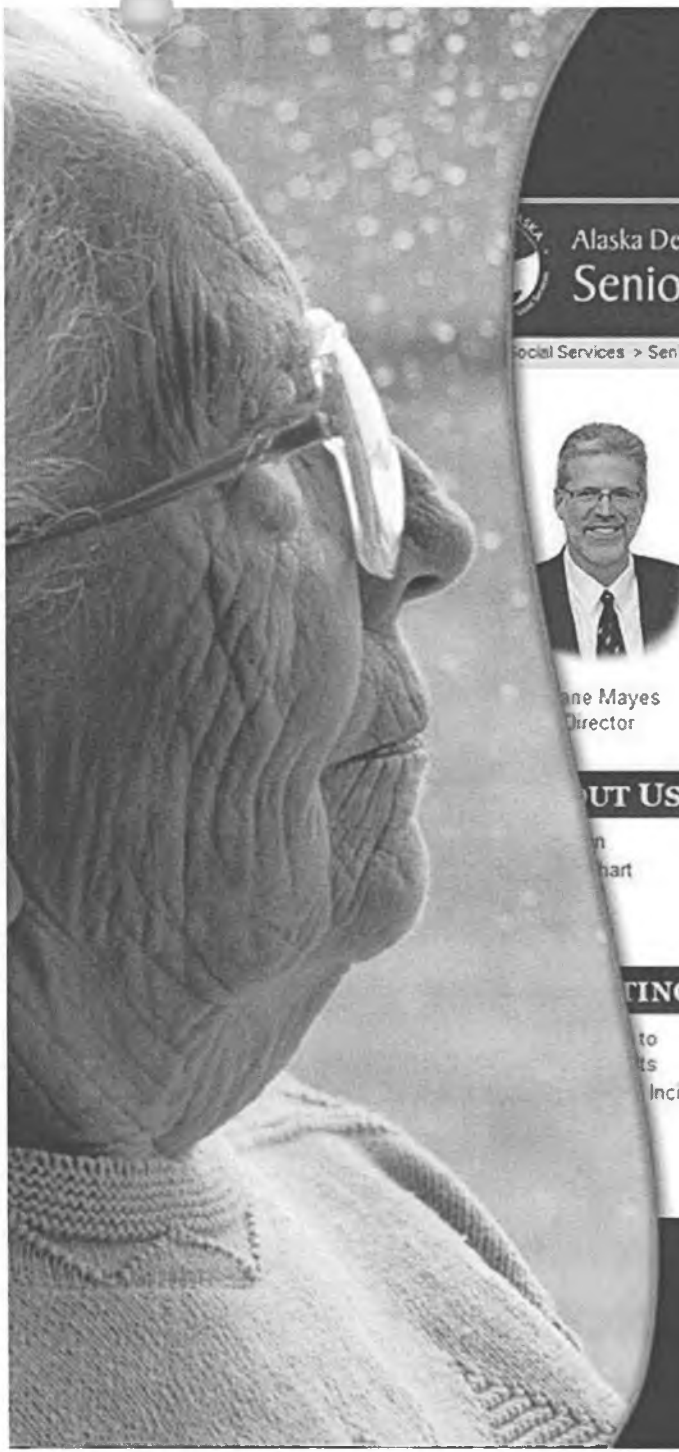
- Adult Public Assista
- Child Care
- Chronic and Acute M Assistance
- Denali Kidcare
- Family Nutrition
- Food Stamps
- General Relief Assis
- Heating Assistance
- Medicaid
- SeniorBenefits
- Temporary Assistan

GET HELP...

- ...finding a job?
- ...with Child Care?
- ...with Child Support
- ...with heating bills?
- ...with Food Assista
- ...for elderly or disab
- ...with cash assistar families?
- ...with medical?
- ...with the WIC progr

Mission: We promote self sufficiency and provide basic living expenses to Alaskans in need.


Department of Health & Social Services
Public Health
Alaska Department of Health and Social Services
Division of Public Health
DHSS
Health & Social Services > Public Health
Ward Hurlburt, M.D., MPH
CHIEF MEDICAL OFFICER
AND DIRECTOR
Learn
the Signs.
Act Early.
ing is different here.
Certificates
JANUARY IS...
Cervical Health Awareness Month
ANNOUNCEMENTS
Subscribe to Public Health Announcements
Human and Animal Brucellosis in Alaska
New health department reports shows downward trend in STDs in Alaska
Gonococcal Infection Update — Alaska, 2011
Governor's Emergency Medical Services Awards announced
State to make free flu vaccine available
Free Adult Intradermal Fluzone Vaccine: Information for Providers and Organizations
Outbreak of Methicillin-resistant Staphylococcus aureus in a Newborn Intensive Care Unit
Psychoactive "Bath Salts" Toxicity in Alaska—A Case Series
Centers for Disease Control and Prevention releases report on dental decay in Alaska Native children
CDC Report on Dental Caries in Rural Alaska Native Children — Alaska, 2008
Youth Risk Behavior Survey 2009 Highlights
Find out how Alaska high school student's behavior has changed!
Prevalence of Overweight and Obesity among Matanuska-Susitna Borough School District Students, 2003-2010
2011 Clinic Schedule:
Pediatric Neurodevelopmental Outreach & Autism Screening Clinics
View all Department of Health & Social Services Press Releases
PUBLIC HEAL
Public Health Hom
Chronic Disease P
& Health Promotio
Emergency Progra
Preparedness, EM
Trauma
Epidemiology
Health Planning &
Development
Laboratories
Public Health Nurs
State Medical Exa
Vital Statistics
Women's, Childrer
Family Health
USEFUL LINKS
About the Division
Division Contacts
Health Data & Stat
Preparedness
Programs & Servic
Publications
Mission: to protect and promote the health of Alaskans
STATE of ALASKA
Department of Health and Social Services



Department of Health & Social Services
Senior & Disabilities Services

Alaska Department of Health and Social Services
Senior and Disabilities Services

search

DHSS State of Alaska

Social Services > Senior and Disability Services

ne Mayes
Director

UT US

n
hart

TING

to
ts
Incident

Welcome to Senior and Disabilities Services

Our mission is to promote health, well being and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity.

HEADLINES

- NEW! **Alaska Community First Choice Council (CFCC).** For more information about a new program allowed under the authority of federal legislation (Affordable Care Act), **visit here.**
- NEW! **Proposed Home and Community-Based Waiver Service Regulations Available for Public Comment Until January 23, 2012. Follow this link for forms and information.**
- **Medicare Part D sign up ended Dec. 7. For more information, visit here.**

Go to SDS News Archives

Alaskan Core Competencies
for **Direct Care Workers** *and* **Human Services**

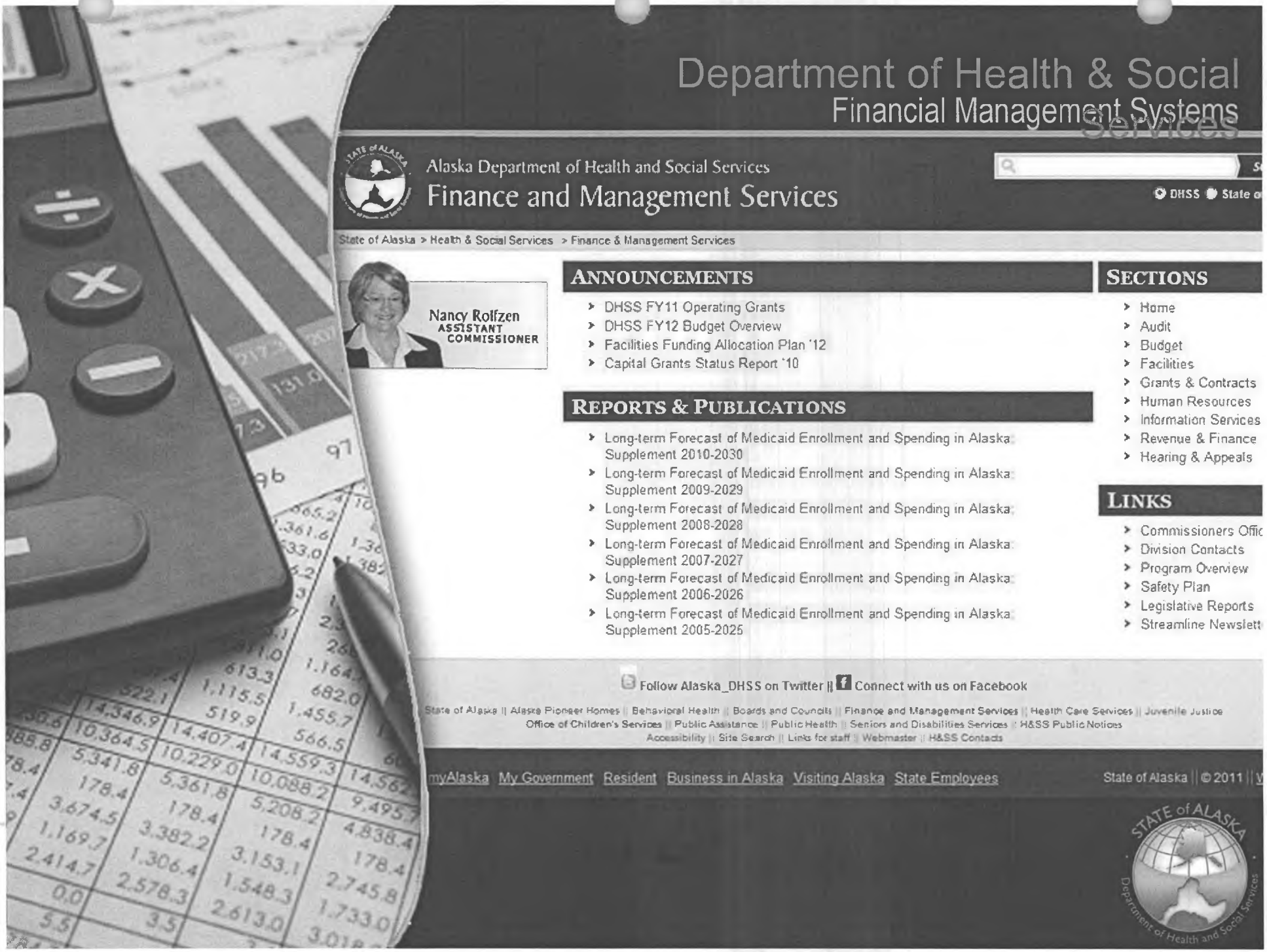
SECTIONS

- Adult Protective Services
- Aging and Disability Resource Centers
- Developmental Disabilities
- Grant Services
- Medicare Information Office
- Nursing Facility Transition Program
- Personal Care Assistant Program
- Policy and Program Development Unit
- Quality Assurance Program
- Research and Analysis Team
- Rural Long-Term Care Development
- Skilled Nursing Facilities
- SDS Training

OF INTEREST

Mission: We serve Seniors • Adults with Physical Disabilities and Seniors on Medicaid Waivers • Persons with Developmental Disabilities • Vulnerable Adults • Assisted Living Providers

STATE of ALASKA
Department of Health and Social Services


Department of Health & Social
Financial Management Systems
Services
Alaska Department of Health and Social Services
Finance and Management Services
DHSS
State o
State of Alaska > Health & Social Services > Finance & Management Services
Nancy Rolfzen
ASSISTANT
COMMISSIONER
ANNOUNCEMENTS
DHSS FY11 Operating Grants
DHSS FY12 Budget Overview
Facilities Funding Allocation Plan '12
Capital Grants Status Report '10
REPORTS & PUBLICATIONS
Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2010-2030
Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2009-2029
Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2008-2028
Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2007-2027
Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2006-2026
Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2005-2025
SECTIONS
Home
Audit
Budget
Facilities
Grants & Contracts
Human Resources
Information Services
Revenue & Finance
Hearing & Appeals
LINKS
Commissioners Offic
Division Contacts
Program Overview
Safety Plan
Legislative Reports
Streamline Newslett
Follow Alaska_DHSS on Twitter || Connect with us on Facebook
State of Alaska || Alaska Pioneer Homes || Behavioral Health || Boards and Councils || Finance and Management Services || Health Care Services || Juvenile Justice
Office of Children's Services || Public Assistance || Public Health || Seniors and Disabilities Services || H&SS Public Notices
Accessibility || Site Search || Links for staff || Webmaster || H&SS Contacts
myAlaska My Government Resident Business in Alaska Visiting Alaska State Employees
State of Alaska || © 2011 ||
STATE of ALASKA
Department of Health and Social Services

The overriding theme for future direction of the Alaska Department of Health and Social Services is ***helping individuals and families create safe and healthy communities.***

Conclusion

- Questions?

2/08/12 PRESENTATION ALASKA CHILDREN'S JUSTICE ACT TASK FORCE

<TARGET><BILL></BILL><SUBJECT>2-08-12 PRESENTATION ALASKA CHILDREN'S JUSTICE ACT TASK FORCE</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska Children's Justice Act Task Force

Presentation to Joint Senate Judiciary and HSS Committees, Alaska Legislature

February 8, 2012

hss.state.ak.us/ocs/ChildrensJustice/default.htm

OVERVIEW OF 2012 PRESENTATION

- Background on CJA: Who we are and what we do
- Child maltreatment in Alaska
- Proposed legislative changes

OVERVIEW OF CJA TASK FORCE

- Background: Founded 2002
  - Federal mandate: Child Abuse Prevention and Treatment Act (CAPTA) 42 U.S.C. 5101 and Victims of Crime Act 42 U.S.C. 10601
  - Multidisciplinary/statewide representation
  - Federally funded based on population

Mission

- Identify areas where improvement is needed in the statewide response to child maltreatment, particularly child sexual abuse, make recommendations and take actions to improve the system

Task Force Projects

- Develop and distribute better data
  - Collaboration with DHSS, Maternal Child Health Epidemiology Unit - Surveillance of Child Abuse and Neglect (SCAN) program
- Improve system response
  - Support the development of Child Advocacy Centers (CACs) and Multidisciplinary Teams (MDTs)
  - Support innovative programs
  - Support education and training
- Make recommendations for law changes

IMPROVE THE SYSTEM RESPONSE

Support the development of CACs and MDTs

- Alaska now has 10 regional CACs and 2 satellite centers
- Publications:
  - Guidelines for the Multidisciplinary Response to Child Abuse in Alaska
  - Standardized medical documentation forms

Support Innovative Programs

- Pathway to Hope
  - Tribal facilitator curriculum to assist community healing from intergenerational trauma due to sexual abuse
- Sexual exploitation of children protection
  - Internet Crimes Against Children
  - NetSmartz
  - In-school education programs

Education and training

- Educate mandatory reporters
  - Developed Mandatory Reporter Training CD
- Encourage professional development
  - Scholarships for trainings
  - Sponsor biennial Alaska Child Maltreatment Conference (collaboration with the Alaska Children's Alliance)
- Yearly legislative presentations

Yearly legislative presentations

- Children's Caucus
- Legislative committee presentations
- 2012 presentation to Senate Judiciary & HSS
  - Child maltreatment in Alaska
  - Proposed legislation

Child maltreatment in Alaska

- Data
- Fiscal impact

Maltreatment-Related Child Deaths

Deaths occurring between 2000-2008,
children ages 0 – 9 years

- Approximately **1 out of every 5** (20%) Alaskan child deaths is maltreatment-related
  - ~ **1 out of every 4** (25%) for Alaska Native children
- Nearly **3 out of every 4** (~75%) maltreatment-related deaths occur in infants

Maltreatment - All Types

- In 2008 ~ **12,400 Alaskan children** were likely victims of at least one incident of maltreatment
  - **24%** had at least one incident confirmed
    - Substantiated or conviction
    - "Tip of the iceberg"
  - As many as **34 children a day** are likely maltreated, or **3,000** during this 90 day legislative session

Maltreatment - Neglect

- In 2008 ~ **8,900 Alaskan children** were the likely victims of at least one incident of neglect
  - **25%** had at least one incident confirmed
  - As many as **25 children a day** ,or **2,200** during this 90 day legislative session

Maltreatment – Physical Abuse

- In 2008 ~ **2,700 Alaskan children** were likely victims of at least one incident of physical abuse
  - **22%** had at least one incident confirmed
  - As many as **7 children a day**, or **630** during this 90 day legislative session

Maltreatment – Sexual Abuse

- In 2008 ~ **1,900 Alaskan children** were likely victims of at least one incident of sexual abuse
  - Among the children experiencing sexual abuse, **16%** had at least one incident confirmed
  - ~ **As many as 5 children a day**, or **450** during this 90 day legislative session

What does this cost?

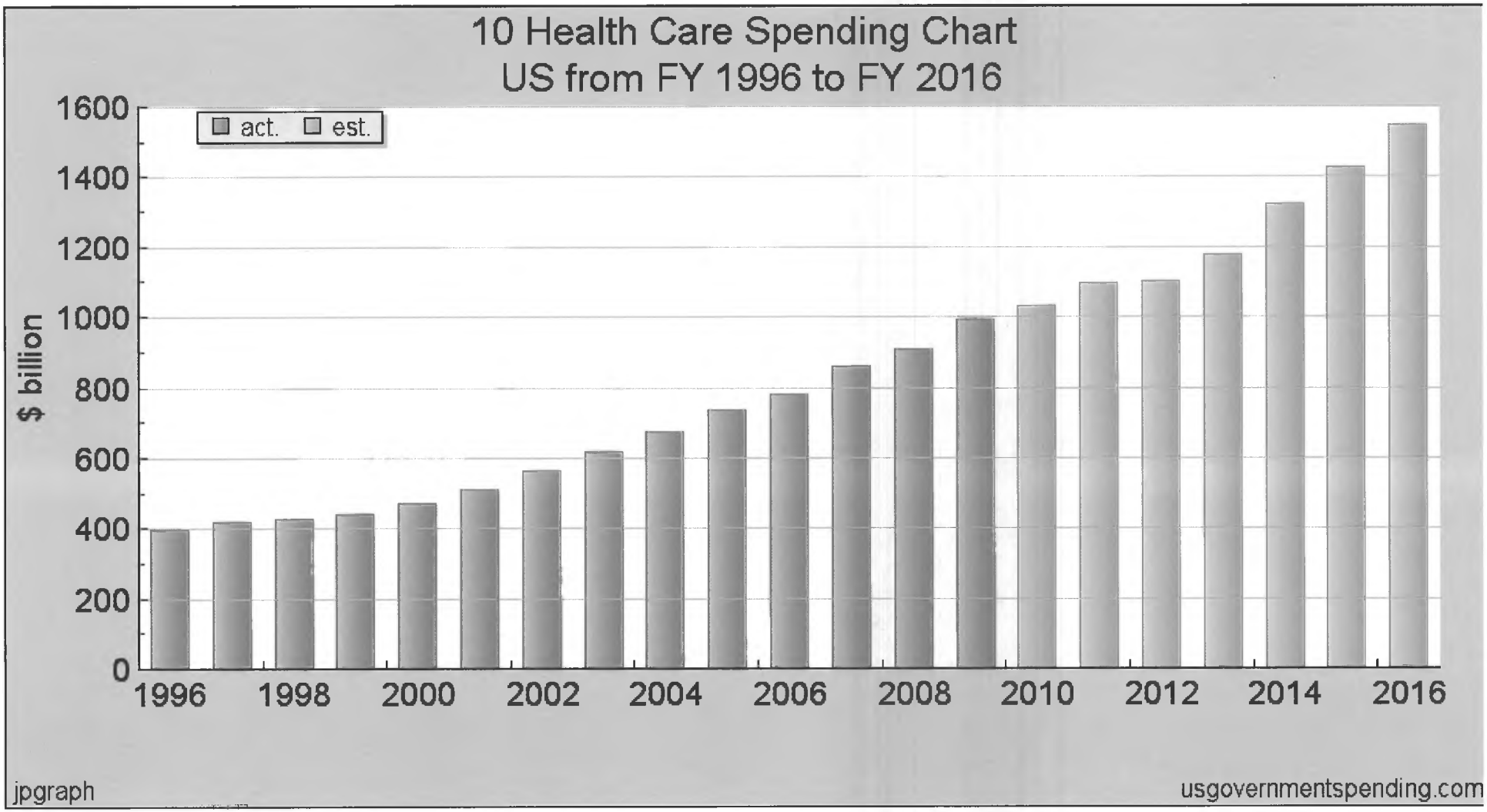
- Medical & mental health care
  - Short and long term
- Child protection system
- Criminal justice system
- Future earnings
- Quality of life

Health Care Costs

- Adverse Childhood Experiences Studies: "Turning Gold Into Lead"
- "…much of what is recognized as common in adult medicine is the result of what is not recognized in childhood."
- Link to ALL most common causes of adult disease and death in US today

www.cdc.gov

Health Care Costs



Average lifetime cost per case of fatal child maltreatment

• Medical costs	• $ 14,000
• Productivity losses	• $1,258,800
• Total	• $1,272,900

2012 The economic burden of child maltreatment in the United States Child Abuse and Neglect

Annual economic burden to Alaskans: fatal child maltreatment (infants only)

• Medical costs	• $ 140,000
• Productivity losses	• $12,588,000
• Total	• $12,729,000

Average lifetime cost per case of nonfatal child maltreatment

• Short-term health care costs	• $ 32,648
• Long-term health care costs	• $ 10,530
• Productivity losses	• $144,360
• Child welfare costs	• $ 7,728
• Criminal justice costs	• $ 6,747
• Special education costs	• $ 7,999
• Total	• $210,012

Estimated annual economic burden for Alaskans

• Short-term health care costs	• $97 – 405 million
• Long-term health care costs	• $31 - 130 million
• Productivity losses	• $430 million -1.8 billion
• Child welfare costs	• $23 – 96 million
• Criminal justice costs	• $20 -84 million
• Special education costs	• $24 – 99 million
• Total	• $625 million - 2.6 billion

based on ~3000 - 12,400 children annually

SYSTEM IMPROVEMENT THROUGH CHANGES TO OUR CRIMINAL STATUTES

RECOMMENDATION #1

Modify assault statutes to create broader criminal liability for assaults to children

Problem: Required for felony prosecution

- Serious physical injury OR
- Multiple events OR
- Reasonable caregiver would seek medical diagnosis and treatment

Problem: Definition of "serious physical injury"

- "**(A)** physical injury caused by an act performed under circumstances that create a substantial risk of death; or
- **(B)** physical injury that causes serious and protracted disfigurement, protracted impairment of health, protracted loss or impairment of the function of a body member or organ, or that unlawfully terminates a pregnancy."

Solutions: New definition "serious bodily injury to a child"

- "Serious bodily injury to the child" includes, but is not limited to, second- or third-degree burns, a fracture of any bone, a concussion, subdural or subarachnoid bleeding, retinal hemorrhage, cerebral edema, brain contusion, strangulation, injuries to the skin that involve severe bruising or the likelihood of permanent or protracted disfigurement, including those sustained by striking children with objects, or other physical injury that results in significant physical injury to the child

Solutions

- Apply the proposed "serious bodily injury" definition to
  - children under 12
  - children under age 16 who are mentally or physically impaired
- Add new theories to all three felony assault statutes that incorporate the definition of serious bodily injury to a child

Post-conviction recommendation:

- To recognize mental harm resulting from physical injury:
- Create a sentencing aggravator if the serious bodily injury caused to a child resulted in significant mental injury to the child

RECOMMENDATION #2

STRENGTHEN STATUTES REGARDING EXPOSURE OF CHILDREN TO DRUGS

Problem:

- Difficult to prosecute person who has exposed a child to drugs to extent that child tests positive for drug
- Examples: meth lab, leaving drugs laying around, using drugs around child

Solution:

- Amend endangering the welfare of a minor statute by creating 2 new subsections to:
  - Penalize reckless exposure of child to controlled substance and, because of exposure, the child tests positive for the controlled substance
  - Penalties vary depending on dangerousness of drug

Section 5, subsections (b)(2) and (g)

Problem:

- Inability to prosecute for indirect exposure to dangerous chemicals used in drug labs

Solution

- Penalize reckless exposure of child to chemicals used in meth labs

RECOMMENDATION #3

INCREASE PENALITES WHEN A PARENT INTENTIONALLY WITHHOLDS ADEQUATE FOOD OR LIQUIDS

Problem:

- Current punishment for criminal nonsupport is a misdemeanor
- Intentional failure to provide adequate food or liquids to a child should be a felony

Solutions:

- Modify criminal nonsupport to create a class C felony for parent or guardian who intentionally fails to provide adequate food and liquids to the child
- Standard for determination: "a reasonable person would conclude the child was not receiving adequate food or liquids"

RECOMMENDATION #4

CREATE A CRIMINAL LAW THAT PROHIBITS AN INCARCERATED PERSON FROM CONTACTING A VICTIM OR WITNESS

Problem:

- Current statutes do not fully protect a child victim from influences and pressure prior to trial and sentencing
  - Only after sentencing
- Examples:
  - Incarcerated accused sex offender can contact under age victim
  - 3rd party can forward phone calls, letters from defendant to victim

Solutions:

- Add two new theories to unlawful contact statute to:
  - Penalize a person incarcerated before trial or sentencing for contacting a victim or witness of the offense in violation of no-contact order
  - Penalize person who assists the defendant in engaging in such contact

Alaska Children's Justice Act Task Force

- Problem: need legislative changes to enhance safety of Alaskan children
- Solution: introduce and pass proposed legislation

We need champions for children!

2/15/12 PRESENTATION BY NCSL: SUICIDE AWARENESS

<TARGET><BILL></BILL><SUBJECT>2-15-12 PRESENTATION BY NCSL SUICIDE AWARENESS</SUBJECT><COMM>SHSS27</COMM></TARGET>

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Presentation to the Alaska State Legislature: Suicide Rates and Options for Prevention

Hollie Hendrikson
National Conference of State Legislatures

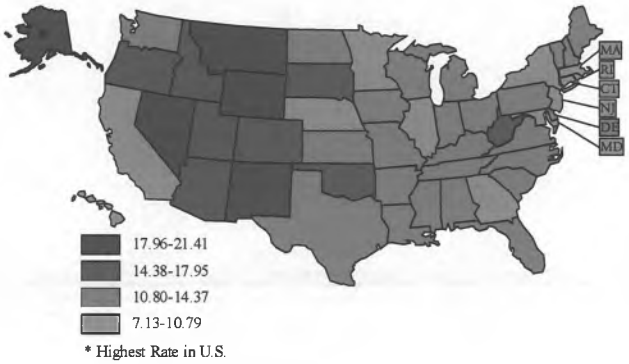
10 Leading Causes of Fatal Injuries in Alaska, by Age Group (2005-2009)

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
1	Suffocation 41	MV Traffic 6	Drowning 8	MV Traffic 12	Suicide 179	Suicide 130	Suicide 132	Poisoning 156	Suicide 82	Suicide 26	Falls 33	Falls 15
2	Assault 6	Fire 5	Fire 7	Suicide 7	MV Traffic 87	Poisoning 93	Poisoning 118	Suicide 136	MV Traffic 39 Poisoning 39	MV Traffic 25	Suicide 13	Suicide 10
3			MV Traffic 6	Poisoning 5	Poisoning 59	MV Traffic 57	MV Traffic 51	MV Traffic 56	Drowning 13	Falls 15	Suffocation 8	Suffocation 6
4					Assault 47	Assault 36	Assault 41	Assault 29	Assault 12	Poisoning 12	MV Traffic 7	
5					Drowning 27	Drowning 28	Drowning 30	Drowning 27	Aircraft 11 Falls 11	Fire 7	Hypothermia/ Frostbite 5 Poisoning 5	
6					Snow machine 19	Snow machine 17	Snow machine 14	Hypothermia/ Frostbite 22	Pedestrian 8			
7					ATV 14	Falls 10 Fire 7 Hypothermia/ Frostbite 10	ATV 13	Falls 15	Hypothermia/ Frostbite 7 Suffocation 7			
8					Hypothermia Frostbite 12	Aircraft 7	Hypothermia/ Frostbite 11	Fire 13	Fire 5			
9					Fire 7	Aircraft 6	Pedestrian 10	Pedestrian 12				
10					Aircraft 6		Aircraft 9	Aircraft 8 Snow machine 8				

Source: Division of Public Health, Dept. of Health & Social Services, Alaska Bureau of Vital Statistics. occurrences less than 5 not listed. * ATV and snow machine deaths may be included in drowning and/or exposure pedestrian, bicycle, ATV, and snow machine deaths may be included in MV Traffic death counts. Poisonings include accidental poisoning by exposure to alcohol. Created January 4, 2012

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Suicide Rates, per 100,000 (2004-2009)

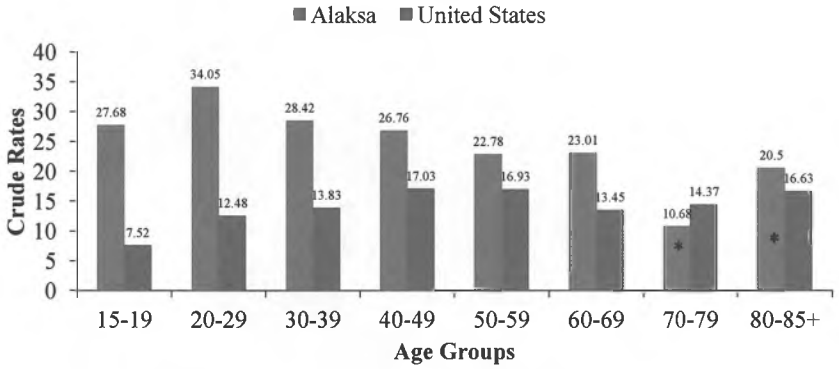


* Highest Rate in U.S.

Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Suicide Rates, All Ages, by Age Group per 100,000 (2004-2009)

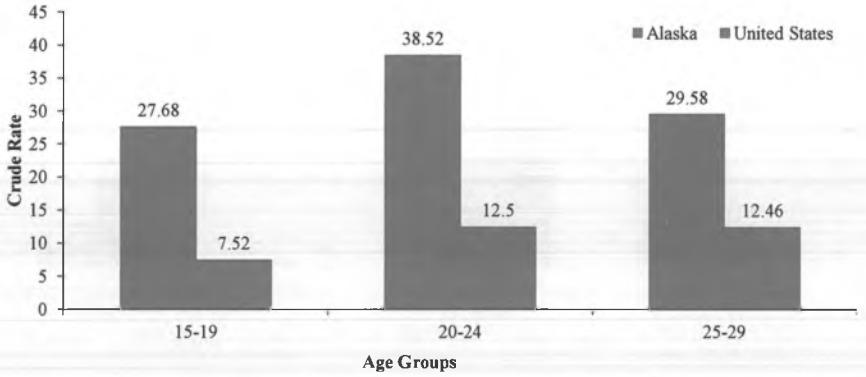


*Rates based on 20 or fewer deaths may be unstable.

Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

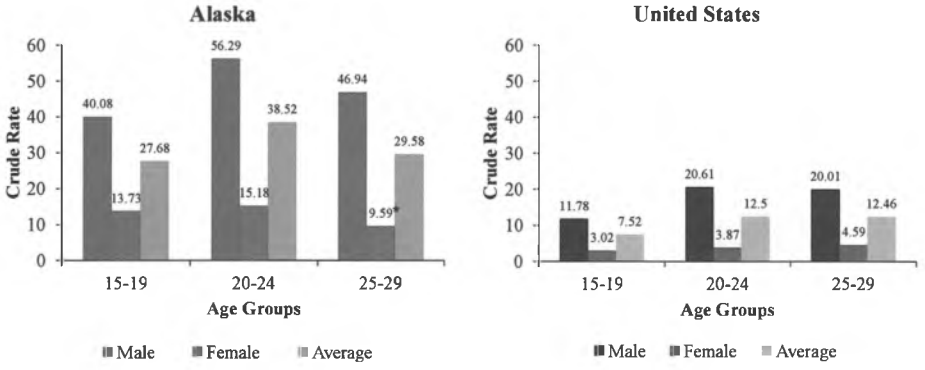
Suicide Rates, All Ages, by Age Group per 100,000 (2004-2009)



Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

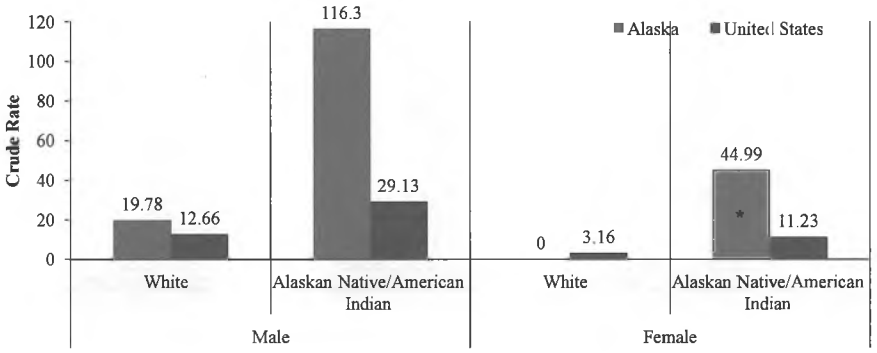
Suicide Rates, by Age and Sex per 100,000 (2004-2009)



*Rates based on 20 or fewer deaths may be unstable.
Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

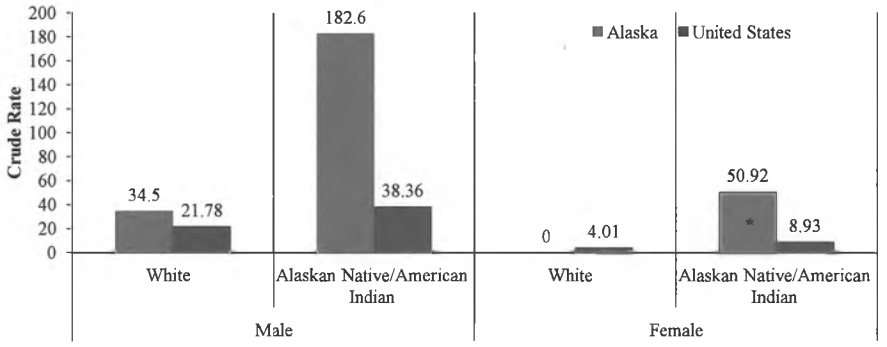
Suicide Rates, Ages 15-19, by Sex and Race/Ethnicity, per 100,000 (2004-2009)



*Rates based on 20 or fewer deaths may be unstable.
Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

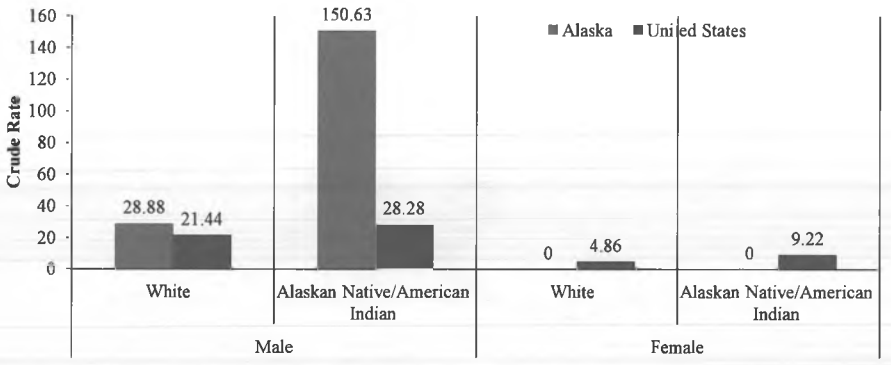
Suicide Rates, Ages 20-24, by Sex and Race/Ethnicity, per 100,000 (2004-2009)



*Rates based on 20 or fewer deaths may be unstable.
Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

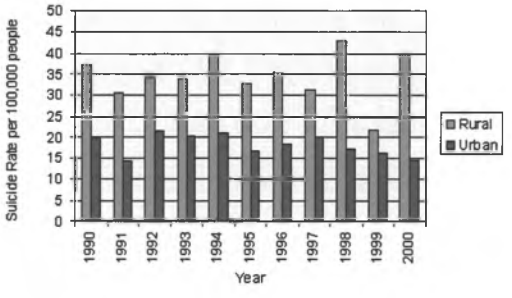
Suicide Rates, Ages 25-29, by Sex and Race/Ethnicity, per 100,000 (2004-2009)



*Rates based on 20 or fewer deaths may be unstable.
Source: Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/ncipc/wisqars.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

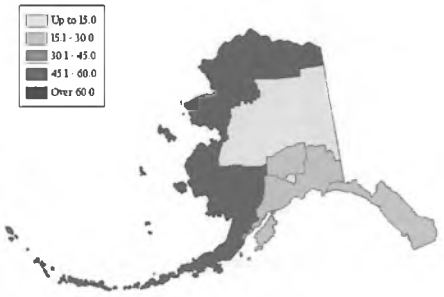
Rural and Urban Suicide Rates for Alaskans, per 100,000 (1990-2000)



Source: Alaska Suicide Prevention Council; Alaska Bureau of Vital Statistics.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Alaska Suicide Rate, by Region per 100,000 (2009)



Source: Alaskan Suicide Prevention Council; Alaska Bureau of Vital Statistics.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Suicide Attempts: Alaska Suicide Hospitalization Study 2001-2002

- The Alaska Injury Prevention Center conducted a thorough analysis of the 1,223 hospitalized suicide attempts in Alaska for 2001 and 2002.
- This analysis looks at the epidemiology and costs associated with hospitalizations for self inflicted injuries
  - http://www.alaska-ipc.org/documents/Hospital_Suicide_report.pdf

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

A few facts revealed by this study:

- The average age for the patients was 30 years.
- The average length of hospital stays was 4 days.
- The average hospital costs per year were $5,508,363.
- The average cost per case was $8,986.
- Over 75% of the hospital costs were paid through public funding sources.
  - More than $4 million in "public funds" is spent each year to pay for hospitalizations for suicide attempts.
- The hospital cases were over-represented by people from rural communities.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Learning from Others: Policy Options to Prevent Suicide

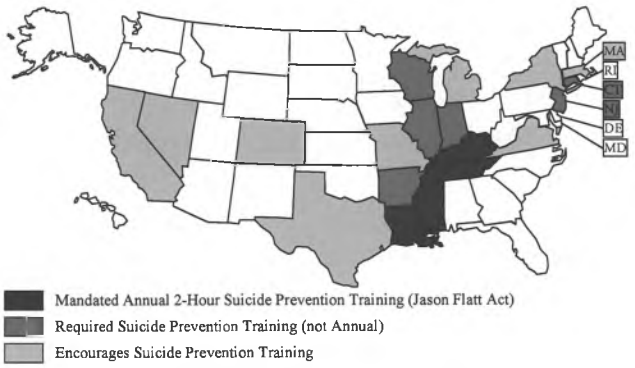
NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

State Laws: Gatekeeper Training for Key School Personnel

- At least 19 states have laws that either mandate or encourage some type of gatekeeper training.
  - Laws in KY, LA, MS, and TN require a 2-hour annual in-service training for certain school personnel on suicide prevention (*Jason Flatt Act)*.
  - Laws in AR, CT, IL, IN, NJ, and WI require similar training, but not on an annual basis.
  - CA, CO, MA, MI, MO, NV, NY, TX, and VA encourage suicide prevention training, sometimes as an option for professional development.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

State Laws: Gatekeeper Training



NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

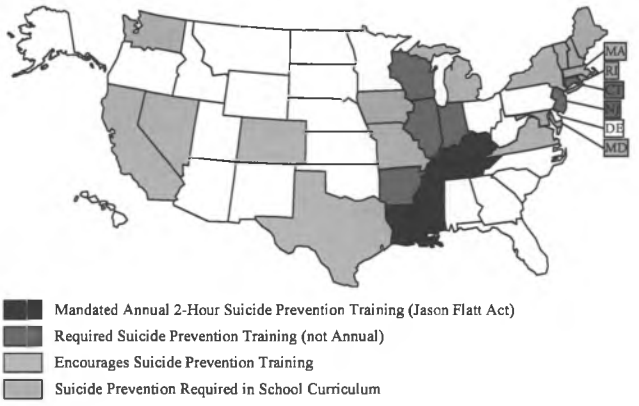
State Laws: Suicide Prevention Education Required in School Curriculum

- At least seven states have laws that require school curriculum to include suicide prevention education or awareness.
  - IA, ME, MD, NH, RI, VT, and WA
- Controversy?
  - "Many experts share the view that it is unwise to teach young people about suicide explicitly."

-World Health Organization, 2000

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

State Laws: Gatekeeper Training and Suicide Prevention in Curriculum



NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Other Examples of State Laws Addressing Suicide Prevention

- Appropriations: in 2011 at least 10 state legislatures appropriated funding for suicide prevention activities.
- Delaware: requires the Department of Transportation to display on variable message signs information regarding missing senior citizens, suicidal persons, or persons with a disability (2011).
- Colorado: allows taxpayers to contribute a part of their state income tax refund to the Families in Action for Mental Health Fund.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Suicide Prevention Proposed Legislation: 2012

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Suicide Risk Factors

- About 90 percent of people who kill themselves have a diagnosable and treatable psychiatric illness
- Access to mental health services
- Alcohol or drug abuse, particularly when combined with depression
- Posttraumatic Stress Disorder, or some other anxiety disorder
- Past History of Attempted Suicide
- Family history of suicide, suicide attempts, depression or other psychiatric illness.
- Demographics

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Reinventing the Wheel?
Suicide Prevention Resources

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Alaska Suicide Prevention Resources

- Alaska Department of Health and Social Services' Statewide Suicide Prevention Council
  - http://www.hss.state.ak.us/suicideprevention/default.htm
- 5-year Suicide Prevention Plan
  - http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/SSPC_2012-2017.pdf
- Alaska Injury Prevention Center
  - Alaska Suicide Follow-back Study
  - Alaska Suicide Hospitalization Study 2001-2002

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Federal Suicide Prevention Resources

- The National Action Alliance for Suicide Prevention was launched in Sept 2010 by HHS Secretary Sebelius and Defense Secretary Gates
  - http://actionallianceforsuicideprevention.org/
  - American Indian/Alaskan Native Task Force
    - Goal: In partnership with Tribes, the American Indian/Alaska Native (AI/AN) Task Force will implement suicide prevention strategies to reduce the rate of suicide in AI/AN communities.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Indian Health Service Suicide Prevention Initiative

- The National Suicide Prevention Initiative addresses the tragedy of suicide in American Indian and Alaska Native communities.
- The IHS National Suicide Prevention Initiative builds on the foundation of the HHS "National Strategy for Suicide Prevention" and the 11 goals and objectives for the Nation to reduce suicidal behavior and its consequences, while ensuring we honor and respect Tribal traditions and practices.
  - Available at: www.ihs.gov/MedicalPrograms/Behavioral

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

Thank You!
Hollie Hendrikson
Hollie.Hendrikson@ncsl.org
303-856-1525

10 Leading Causes of Fatal Injuries in Alaska by Age Group, 2005-2009

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
1	Suffocation 41	MV Traffic 6	Drowning 8	MV Traffic 12	Suicide 179	Suicide 130	Suicide 132	Poisoning 156	Suicide 82	Suicide 26	Falls 31	Falls 15
2	Assault 6	Fire 8	Fire 7	Suicide 7	MV Traffic 87	Poisoning 93	Poisoning 118	Suicide 136	MV Traffic 39 Poisoning 39	MV Traffic 25	Suicide 13	Suicide 10
3			MV Traffic 6	Poisoning 5	Poisoning 59	MV Traffic 57	MV Traffic 51	MV Traffic 56	Drowning 13	Falls 15	Suffocation 8	Suffocation 6
4					Assault 47	Assault 36	Assault 41	Assault 29	Assault 12	Poisoning 12	MV Traffic 7	
5					Drowning 27	Drowning 28	Drowning 39	Drowning 27	Aircraft 11 Falls 11	Fire 5	Hypothermia/ Frostbite 5 Poisoning 5	
6					Snow machine 19	Snow machine 17	Snow machine 14	Hypothermia/ Frostbite 22	Pedestrian 8			
7					ATV 16	Falls 10 Fire 10 Hypothermia/ Frostbite 10	ATV 13	Falls 15	Hypothermia/ Frostbite 7 Suffocation 7			
8					Hypothermia/Frostbite 12	Avalanche/ Landslides 7	Hypothermia/ Frostbite 11	Fire 13	Fire 6			
9					Fire 7	Aircraft 6	Pedestrian 10	Pedestrian 12				
10					Aircraft 6		Aircraft 9	Aircraft 8 Snow machine 8				

Source: Division of Public Health, Dept. of Health & Social Services, Alaska Bureau of Vital Statistics, occurrences less than 5 not listed. * ATV and snow machine deaths may be included in drowning death counts; pedestrian, bicycle, ATV, and snow machine deaths may be included in MV Traffic death counts. Poisonings include accidental poisoning by exposure to alcohol. Created January 4, 2011

2/29/12 ALASKA'S HOSPITALS AND NURSING HOMES

<TARGET><BILL></BILL><SUBJECT>2-29-12 ALASKA'S HOSPITALS AND NURSING HOMES</SUBJECT><COMM>SHSS27</COMM></TARGET>

Overview of Alaska's Hospitals and Nursing Homes

Senate HSS Committee
February 29, 2012

ASHNHA

ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION

Alaska Hospital and Nursing Homes Testifying Today

PeaceHealth Ketchikan Medical Center – Patrick Branco

Fairbanks Memorial Hospital – Mike Powers

Alaska Regional Hospital – Annie Holt

Central Peninsula Hospital – Rick Davis

Wildflower Court – Millie Duncan

ASHNHA

ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION

Alaska is Beyond Rural when compared to other States

DISTRIBUTION OF ALASKA HOSPITALS 2011

	LAND AREA *miles²*	POP DENSITY *miles²*	BED DENSITY *1,000 miles²*
AK	571,951	1.2	3.4
HI	6,423	211.8	576.5
ID	82,747	18.9	48.7
MT	145,552	6.8	34.4
ND	68,976	9.8	55.9
OR	95,997	39.9	83.3
WA	66,544	101.1	211.97
WY	97,100	5.8	27.5

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

78% of Health Facilities in Alaska have Special Federal Designation

ALASKA HOSPITALS AND NURSING HOMES

	NUMBER	PERCENT
Critical Access Hospitals (CAH)	9	33%
Tribal Hospitals[1]	6	22%
Sole Community Hospitals	4	15%
Military/Veterans Hospitals	2	7%
SUBTOTAL	21	78%
Tertiary Hospitals	3	11%
Psychiatric/BH Hospitals	2	7%
Long Term Acute Hospitals	1	4%
TOTAL ALASKA HOSPITALS	27	
STAND ALONE NURSING HOMES	3	

13. 50 of 70

[1] *Includes 4 Tribal CAH*

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Critical Access Hospital - CAH

- Minimum 35 miles to another hospital
- Rural area
- Limited bed size – 25 or less
- < 96 hours annual average length of stay
- 24 hour emergency and nursing services
- Participate in a rural health network
- Established credentialing and quality assurance agreements with a fellow hospital

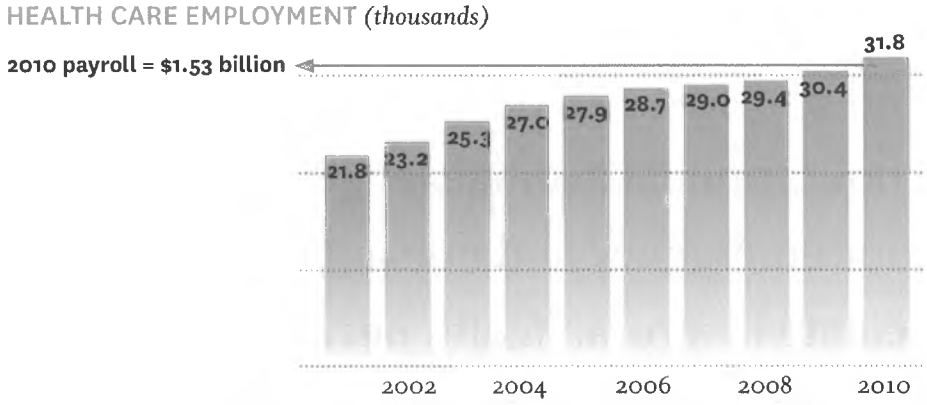
ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Critical Access Hospitals in Alaska

- 13 hospitals in Alaska designated Critical Access Hospital (48% of Alaska hospitals)
- Health Strong Index Awards "Top 100 Critical Access Hospitals"
  - South Peninsula Hospital, Homer
  - Ketchikan General Hospital, Ketchikan
- Valuable part of Community
  - Economic Engines
  - Charity Care

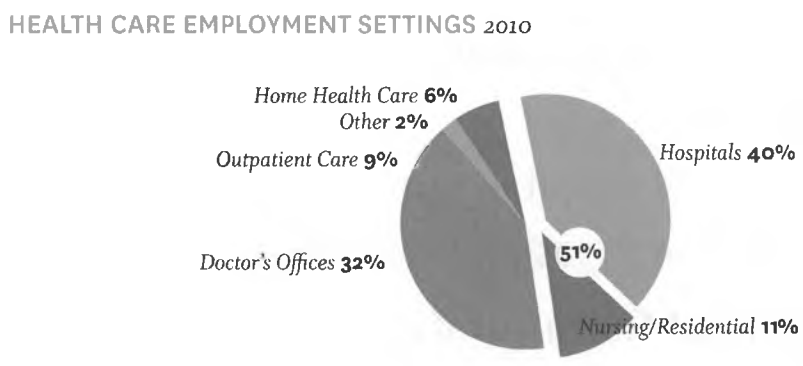
ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Health Care is a Major Employer in Alaska



ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Half of all Health Care Employment is in Hospitals & Nursing Homes



ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Health Care Employment is throughout the State

HEALTH CARE'S EMPLOYMENT AND TOTAL WAGES 2010

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Health Facilities are Impacted by Higher Costs

COST OF LIVING INDEX 2010

URBAN AREA	COMPOSITE INDEX	GROCERY ITEMS	HOUSING	UTILITIES	TRANSPOR-TATION	HEALTH CARE	MISC.
Anchorage	128.4	134.5	142.9	94.1	122.0	135.7	128.4
Fairbanks	137.4	127.9	148.5	193.1	118.7	144.9	118.8
Juneau	136.5	133.1	165.7	135.1	121.2	144.4	116.1
Kodiak	128.7	149.4	127.8	131.9	143.4	143.4	115.4

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Alaska Costs Compared to Comparison States

Alaska's Cost of Living: 30% higher

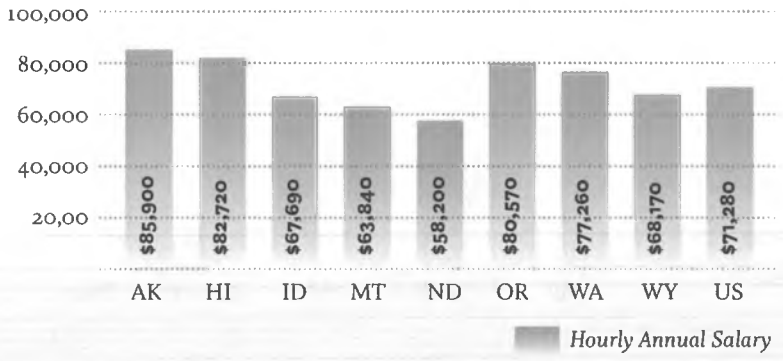
Alaska's Hospital Costs: 38% higher

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Cost Drivers Impacting the Cost of Care in Alaska

Alaska Pays More for Health Care Practitioners than 8 Comparison States

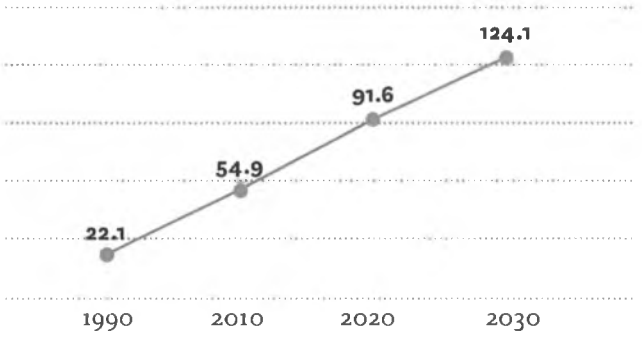
STATE WAGE COMPARISONS FOR HEALTH CARE PRACTITIONERS AND TECH OCCUPATIONS *2010*



ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

The Silver Tsunami

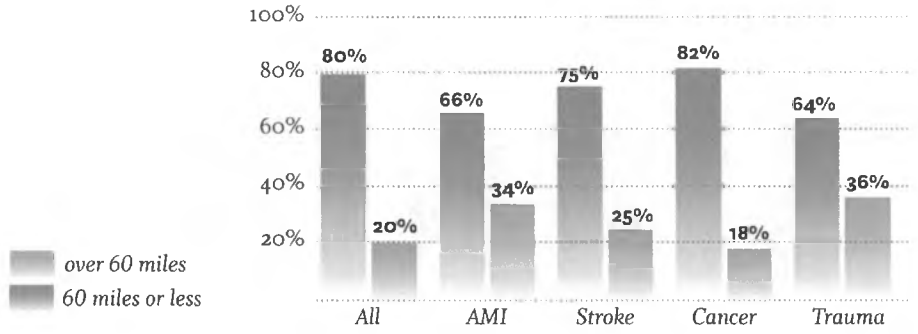
ALASKA SENIORS *(thousands)*



ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Patients Must Travel to Receive Care

DISTANCE TRAVEL BY SELECT CONDITIONS 2009



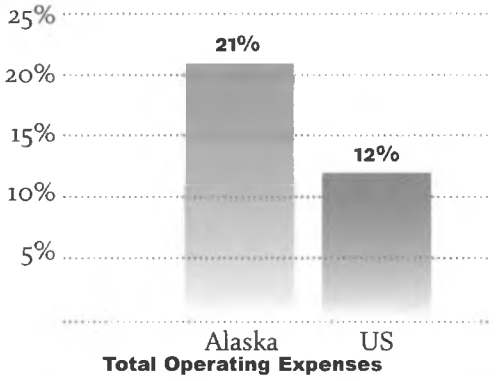
ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Hospital Must Serve All Who Need Care

UNCOMPENSATED CARE 2009

Uncompensated care in Alaska = $178M

Lost revenue = $410M



Total Operating Expenses

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

PeaceHealth Ketchikan Medical Center

25-bed critical access hospital and 29-bed long-term care facility
City of Ketchikan owns the building and property
Non-profit PeaceHealth operates the medical center and clinics

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

WHO DO WE SERVE - PeaceHealth Ketchikan

COMMUNITIES

Ketchikan
Saxman
Metlakatla
Prince of Wales Island
Wrangell
Petersburg

POPULATIONS

Year-Round Residents
Seasonal Workers
Cruise Ship Passengers and Crew
Native Beneficiaries

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

ECONOMIC IMPACT- PeaceHealth Ketchikan

- Serving SE Alaska since 1923
- Largest private employer locally with 450 full-time employees
- Annual payroll of $28 million
- Annual operating budget of $65 million
- Provided $6.5 million in uncompensated care in FY11

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

SPECIAL CHALLENGES- PeaceHealth Ketchikan

- Physician Recruitment to an Island
- Logistics (Supplies, Oxygen, Equipment)
- Rainforest
- First Year Turnover
- Workforce Availability and Skill Levels
- Competition with Seattle (Nordstrom's)

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

PeaceHealth Ketchikan is HealthStrong™

SIXTH
out of 1,325
Critical Access
hospitals nationwide

HOSPITAL STRENGTH INDEX

All Eligible Hospitals

HEALTH STRONG AWARD

Top Performing Hospitals

Market Strength

What is the hospital's market position, level of competition and the future healthcare demand of its service area?

- Competitive Strength Index — Market Position
- + Competitive Intensity Index — Market Diffusion
- + Market Size and Growth Index — Future Healthcare Demand

Value-Based Strength

Does the hospital provide high quality and safe clinical services, and are its patients loyal and satisfied?

- Quality Index — Market Position
- + Outcomes Index — Clinical Results
- + Patient Perception Index — Attitudes
- + Cost and Charges Index — Pricing and Efficiency

Financial Strength

What is the hospital's long-term financial position and does it generate adequate margin and return on capital?

- Financial Stability Index — Financial Position
  - Balance Sheet Ratios
  - Income Statement Ratios

PeaceHealth
Ketchikan Medical Center

The *spirit* of healing™

Your Health, Your Future: Addition and Renovation Project

Designed to meet the most critical medical needs of the southern Southeast Alaska region well into the future.

PHASE 1: 3-story addition with new surgery, sterile supply and clinic with additional parking .....$62 million

PHASE 2-4: Series of remodels within existing building. Creates new main entry, dedicated emergency entry, expands Diagnostic Imaging, Laboratory and Emergency Department. Improves patient privacy and flow inside hospital corridors. .....$14 million

Meeting modern operating room configuration requirements, expanding clinic office space, and offering added covered parking.

Dive Their own Doctors

Physician Integration

The New Imperative

- Why are Physicians seeking employment with Hospitals?
- Why are Hospitals considering employment of Physicians?
- Who benefits?
- What are the realities?

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Fairbanks Memorial Hospital

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

WHO DO WE SERVE - Fairbanks Memorial Hospital

Sole community provider for 250,000 sq miles

- 67% White, 21% AK Native, 12% Other
- 90% admissions from within 30 mile radius
- …and Native & Military unique relationships

Top diagnoses:

- normal delivery
- psychoses,
- alcohol abuse
- Pneumonia

ECONOMIC IMPACT- Fairbanks Memorial Hospital

1. 1350 employees
2. Salaries/benefits: $107M
3. Gross revenues: $360M
4. Relentless Capital Campaign
5. 8,000 – 10,000 employees over the years

Fairbanks Memorial Hospital

CHALLENGES

- "Niche" providers
- DET Beds
- Chronic Inebriates
- Assisted Living
- Evolving medical practice model
- Aging surgery facilities
- High Alaska cost structure
- Adolescent behavioral health services

SOURCES OF PRIDE

- Community Owned
- Native partnership
- Military partnership
- No deferred maintenance
- "Growing our own" – focus on perioperative nursing.
- Physician recruitment
- Continuum of care
- Disaster planning

GOING FORWARD – Fairbanks

- Physician Integration
- Continuum of Care improvement
- Growth in Specialty Services
- Behavioral Health & "A community model"
- The "mile wide – inch deep" challenge
- 4 yr RNs and increasing certifications

150 Beds

Carreen

Alaska Regional Hospital

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Who Do We Serve?

- Inpatient & outpatient care for all surgical and medical specialties
- Primary service area is Anchorage 290,000+ people
- Secondary service area is Eagle River / Wasilla
- Specialty care for entire state of Alaska

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

ALASKA REGIONAL HOSPITAL

Economic Impact

- Second largest hospital in Alaska, serving entire state
- $3M paid in Alaska State and local taxes
- 823 employees
- Direct payroll $53M, benefits additional $13M
- $3M annual utilities expenditures
- $37M unfunded care

D a C Contract

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

SOURCES OF PRIDE

ALASKA REGIONAL HOSPITAL

- Community partner for 49 years
- Rated #1 in Alaska: orthopedic services 2009 - 2012, joint replacements 2007- 2012 spine surgery 2012*
- Meet or exceed all national quality standards for patient care
- US News & World Reports' "Best Regional Hospitals"
- Only Alaska facility with hospital-based fixed wing air ambulance program – AND runway to hospital doors
- American College of Surgeons certified cancer program
- First certified stroke center in Alaska

*per HealthGrades

2nd largest

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

ALASKA REGIONAL HOSPITAL

Going Forward

- Enhancement and expansion of core services
- Continued free public services, such as health fairs and monthly health education programs
- Partnerships with non-profit community providers such as Alaska Medicare Clinic and Anchorage Neighborhood Health Center
- Alaska Regional employee health clinic opening in 2012

Medical Homes

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Central Peninsula Hospital

Soldotna Alaska

- 49 Bed acute care
- 8 outpatient clinics
- 60 bed long term care
- Planetree affiliated Pt Focused
- 720 Employees
- 50 Active Medical Staff (25 Employed MDs)

Pay for Service

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

WHO DO WE SERVE
Central Peninsula Hospital

- Kenai Peninsula Borough Residents
- 37,000 Primary Service Area
- 50,000 Secondary Service Area
- Owned by KPB, managed by the Assembly through a Lease Operating Agreement with CPGH, Inc.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

SOURCE OF PRIDE/SPECIAL CHALLENGES
Central Peninsula Hospital

- Community Owned/Community Pride
- 25 employed/25 independent physicians
- Current Challenges
  - Competing entities moving in to break off profitable services
    - Ambulatory Surgery Center
    - Off-site Cancer Center
    - Outpatient Imaging Center

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

GOING FORWARD
Central Peninsula Hospital

- Preparing for Health Care Reform by Clinically Integrating (25 employed physicians)
- Hardwiring Quality and Patient Satisfaction processes
- Implementing EHR to hard-wire Quality and Patient Satisfaction processes throughout care continuum
- Exploring contracting possibilities beyond hospital only services managed care

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Affordable Care Act
Value Based Purchasing
(AKA Pay for Performance)

- In January 2011, the Centers for Medicare & Medicaid Services officials established value-based purchasing incentives for hospitals by identifying which metrics will generate payment after Oct. 1, 2012.
- These CMS guidelines incorporate 17 clinical process-of-care measures used in five health categories, acute myocardial infarction, heart failure, pneumonia, healthcare associated infections and surgical care improvement. They also will use eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that reflects how patients view their care experiences.
- These 25 measures will be used to generate FY 2013 DRG payments.
- The regulations will apply to discharges at 3,000 acute care hospitals. All these hospitals will have their funding reduced starting with 1% in fiscal year 2013, rising to 2% by FY 2017, but will have a chance to earn that money back, and perhaps more, under the incentives algorithm.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Two Specific Categories of Value Based Purchasing

- Quality of care
  - Core Measures
- Patient Satisfaction
  - HCAPS Surveys

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Core Measures

The Centers for Medicare and Medicaid (CMS) developed several measurements to reflect the Quality and Safety of care in hospitals.

- Pneumonia
- Surgical care improvement project (SCIP)
- Heart failure
- Heart attack (AMI)
- Obstetrical care
- Children's Asthma
- Stroke
- Vaccination rates

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Core Measures
Current Pay for Performance Pieces

- Elements of the PN, AMI, HF, and SCIP core measures
- Perfect Care Score is a composite score of these elements
- Applicable to Medicare patients
- Pay for performance is calculated based on compliance with these elements.

CMS will [illegible] back 1% of pay

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

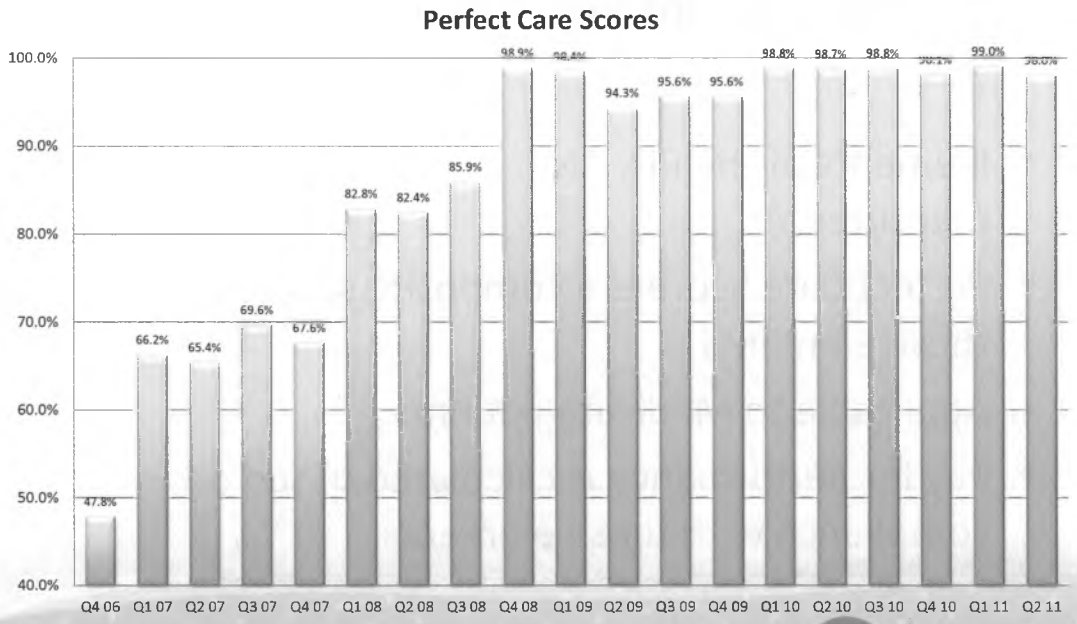
Why are they Important?

- Reflect evidence based-standardized care
- Associated with better outcomes
- Publicly reported
- Allow systematic comparison of hospitals by consumers. This information is available publicly on http://www.hospitalcompare.hhs.gov
- Associated with Value Based Purchasing payments

[illegible]

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Central Peninsula Hospital



ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Patient Experience

- Based on HCAHPS scores (Hospital Consumer Assessment of Healthcare Providers and Systems)
  - How well nurses communicated with patients
  - How well doctors communicated with patients
  - How responsive hospital staff were to patients' needs
  - How well caregivers managed patients' pain
  - How well caregivers explained patients' medications to them
  - How clean and quiet the hospital was
  - How well caregivers explained the steps patients and families need to take to care for themselves outside of the hospital (i.e., discharge instructions)
  - Overall rating of the hospital
- Publicly reported

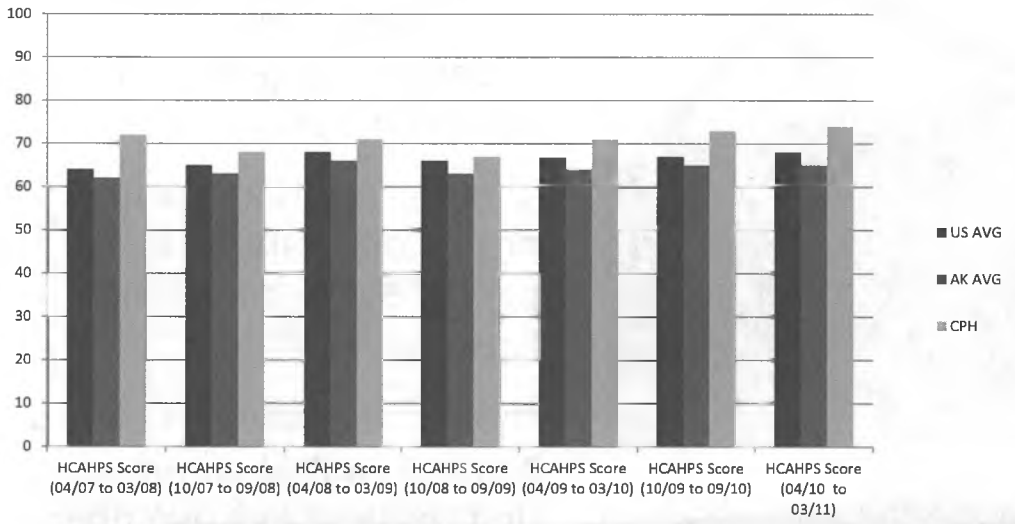
ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Strategies to Improve the Patient Experience

- Review all patient satisfaction data at an administrative level each week.
- Follow up phone call to address all patient concerns
- Hourly nursing rounds
- Management rounds
- Address specific problem areas
  - Quiet environment Night

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Percentage of patients rating the hospital 9 or 10



ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Awards and Recognition

- Received Mountain Pacific Commitment to Quality award in 2008
- Received Mountain Pacific Quality achievement awards in 2009, 2010, and 2011.
- Named as the top hospital for CMS core measures compliance in the State of Alaska in 2011.
- Recognized as a Joint Commission Top Performer in 2010 for excellence in key indicators which is the top 14% of hospitals in quality in the nation and the only hospital in Alaska to be recognized.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Wildflower Court

Wildflower Court is a nursing home providing a high level of care for long-term or acute illnesses.

The organization is a non-profit corporation. It is not a part of Bartlett Regional Hospital.

Wildflower Court (St. Ann's Nursing Home) admitted it's first resident in November 1977.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

WHO DO WE SERVE - Wildflower Court

	Wildflower Court	State Average	National Average
<54 years old	15.3%	7.3%	6.2%
55-64 years old	15.3%	10.1%	8.5%
65-74 years old	16.7%	21.6%	14.7%
75-84 years old	31.9%	28.6%	29.8%
85+ years old	20.8%	32.4%	40.8%

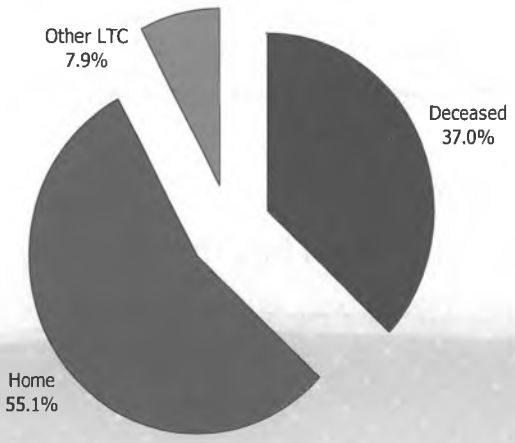
	Wildflower Court	State Average	National Average
Needs assistance or assistive device for ambulation	16.6%	38.8%	29.9%
Requires assistance for eating	22.2%	41.3%	39.4%
Needs staff assistance for transfer	35.1%	52.8%	58.6%
Dependent on staff for bathing	14.8%	29.1%	34.8%
Needs staff assistance for toileting	42.5%	54.9%	57.2%
Dependent on staff for dressing	11.1%	23.25	24.5%

- A younger population than the state and national averages.
- A more physically capable population than the state and national averages

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

WHO DO WE SERVE - Wildflower Court

	Wildflower Court	State Average	National Average
Residents receiving specialized rehabilitative services	37%	22%	23.7%
Residents with pressure sores on admission	7.4%	3.4%	3.6%



- 66.5% of admissions are for rehabilitation and/or wound care
- 55.1% are discharged home

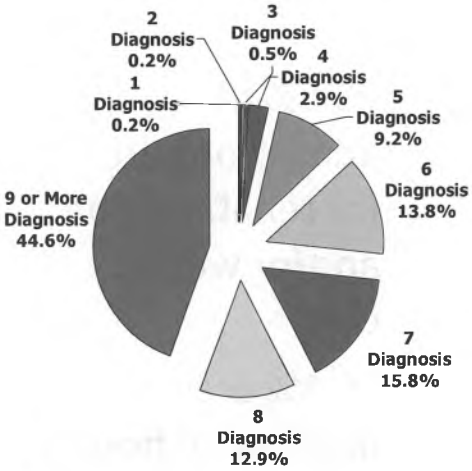
ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

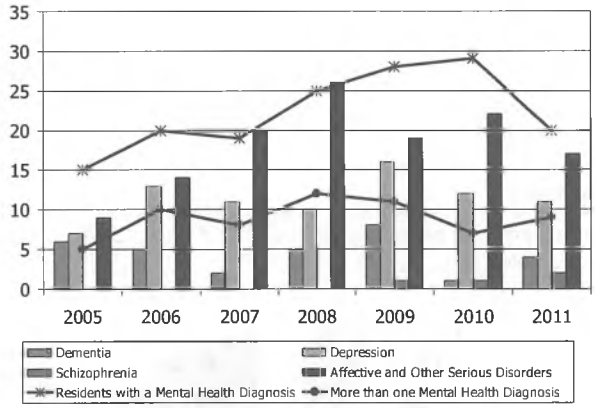
ECONOMIC IMPACT- Wildflower Court

- 105 employees
- $6.7M in wages and benefits
- $172,000 in professional contracted services
- $1M in locally purchased supplies & equipment
- Licensed for 57 beds
- Provide services for an average of 100 individuals per year.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

SPECIAL CHALLENGES- Wildflower Court





- Complexity of residents conditions
- Growing number of residents with mental health diagnosis.
- Providing quality of life for a relatively young population

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

SOURCES OF PRIDE - Wildflower Court

- Bronze Quality Award by the American Health Care Association
- Recipient of My Innerview Excellence in Action Award for ranking in the top 10% of the nation for Staff, Resident, & Family Satisfaction Surveys for two years
- Recipient of Mountain-Pacific Quality Health's Excellence in Care Award & Quality in Care Award
- Achieved Milestone 1 of The Path to Mastery™: The Art of Creating a Caring Community awarded by The Eden Alternative®

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

GOING FORWARD - Wildflower Court

- Malcolm Baldridge Quality Award
- Well Workplace Award
- Employer of Choice Award

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Nursing Homes: Confronting Today's Challenges

- Present day nursing homes have evolved, in response to new medical approaches, higher health care cost, and restrictions by payor sources, into a multiple process health care delivery system providing subacute care, long term nursing care for the chronically ill, and terminal care for those near the end of life.

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Nursing Homes: Confronting Today's Challenges

- Quality of Life
- Mental Health
  - Complex Behaviors Collaborative
- Treating Acute Conditions in the Nursing Home rather than Hospitalizing the Resident

ASHNHA ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Questions?

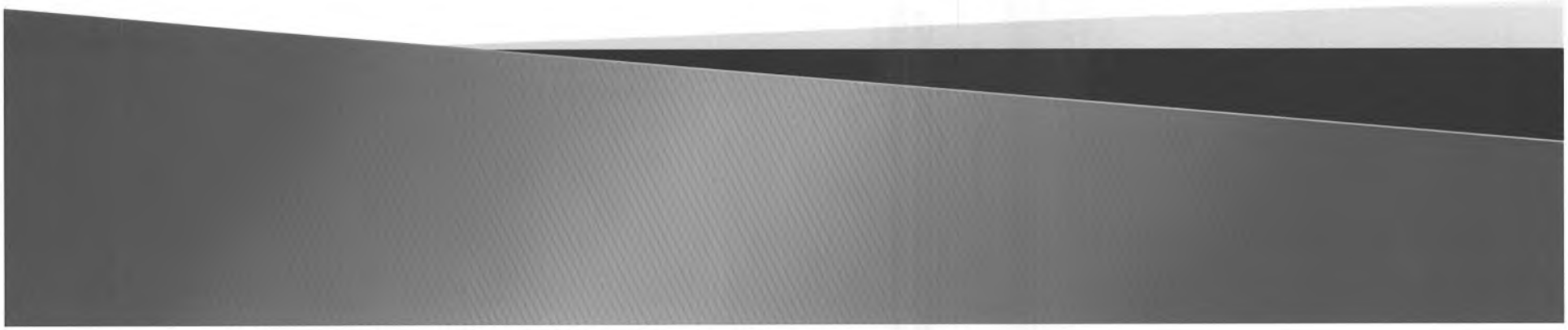
3/05/12 OVERVIEW: GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL EDUCATION

<TARGET><BILL></BILL><SUBJECT>3-05-12 OVERVIEW GOVERNOR'S COUNCIL ON DISABILITIES and SPECIAL EDUCATION</SUBJECT><COMM>SHSS27</COMM></TARGET>

Overview

Governor's Council on Disabilities & Special Education

Senate HSS Standing Committee
March 5, 2012



Council Mission

- Create change that improves the lives of people with disabilities
  - Capacity building
  - Systems change
  - Advocacy

Council Members

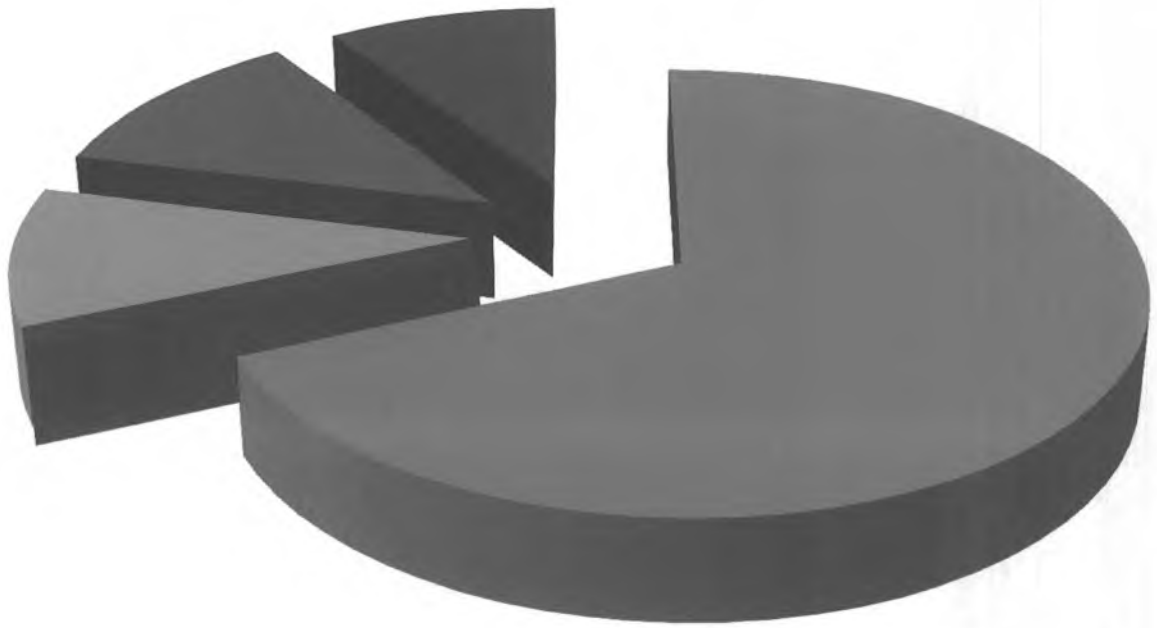
- 27 members appointed by the Governor
- Primary consumers or self-advocates
  - Individuals with disabilities
- Secondary consumers
  - Parents or family members of people with disabilities
- State agency representatives
- Other representatives designated in federal law
  - Center for Human Development
  - Disability Law Center
  - Non-profit agencies
  - Public education systems
  - Higher education

The Council – A Unique "Beast"

- Located within State of Alaska government
  - Boards and Commissions
  - Designated State Agency: DHSS
- Different from most boards and commissions
  - "Freedom to Act"
- Different from other states
  - Roles and responsibilities
  - No granting authority
  - "Working" board

FY12 Funding Sources

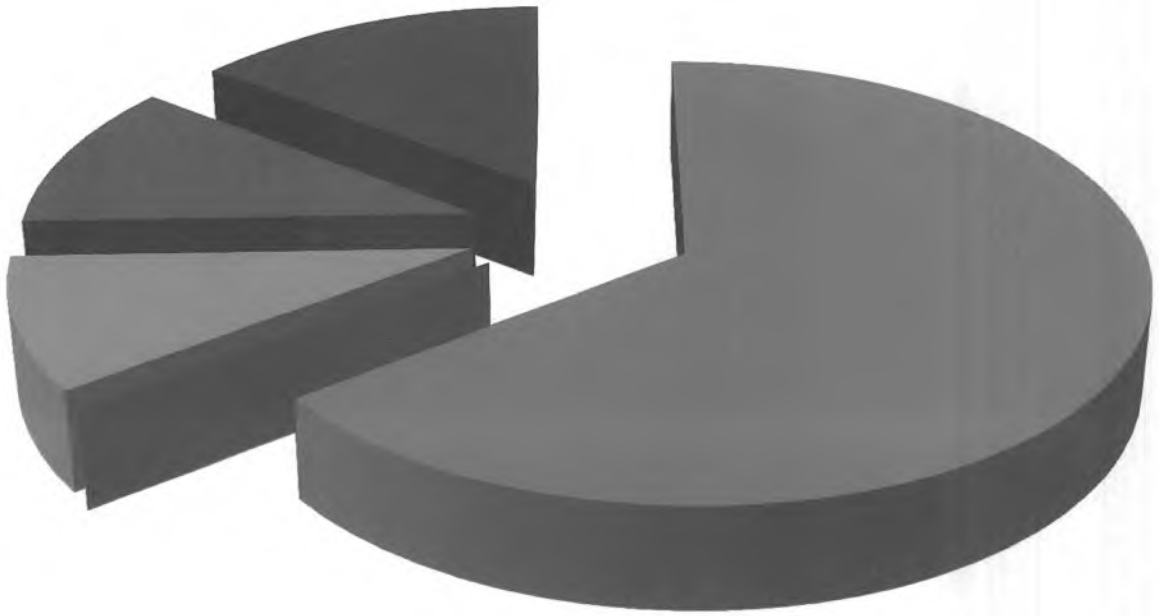
$2,536.8 Total



- Federal Receipts $1,739.2
- General Fund Receipts $0
- Inter-Agency Receipts $261.9
- GF/MH $297.0
- MHTAAR $238.7

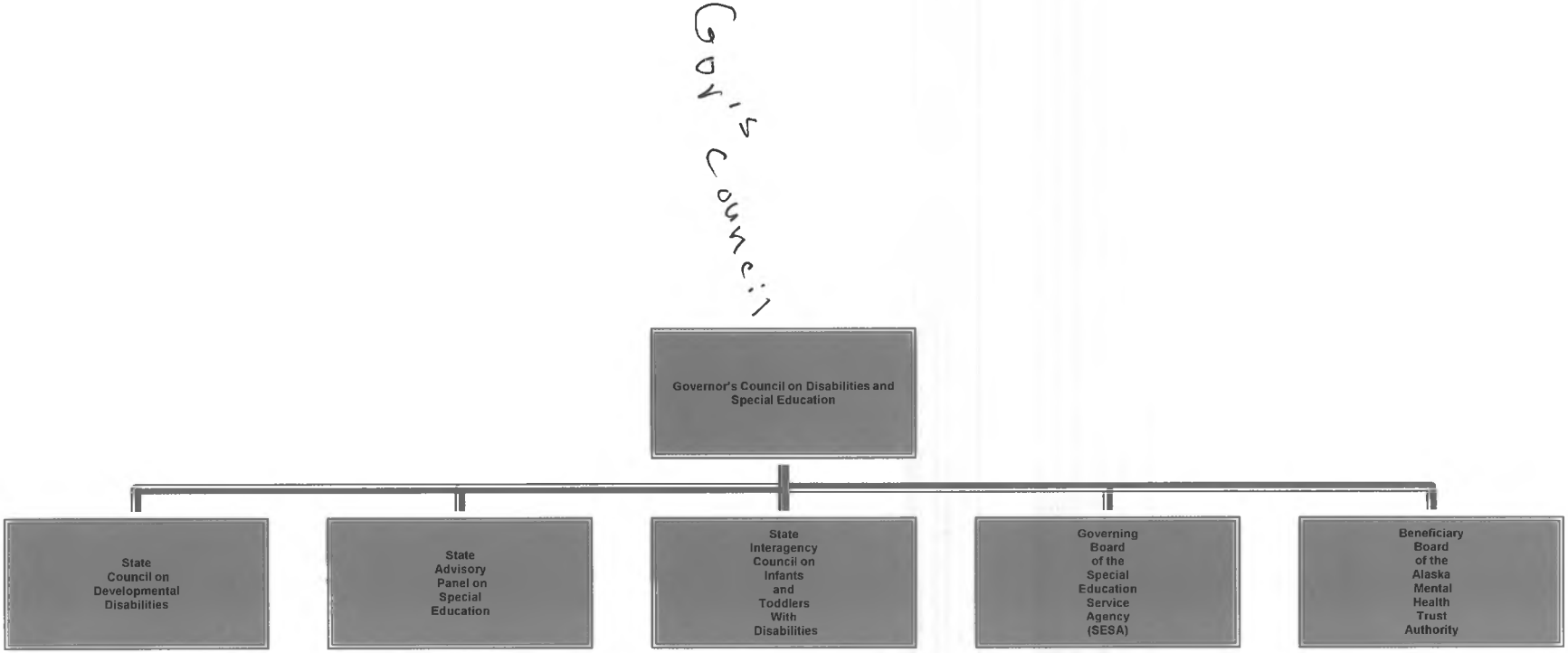
FY13 Funding Sources

$2,709.9 Total



- Federal Receipts $1,753.8
- General Fund Receipts $0
- Inter-Agency Receipts $266.3
- GF/MH $297.0
- MHTAAR $392.8

Council Responsibilities



KEY FACTS ABOUT DEVELOPMENTAL DISABILITIES

- Severe, chronic disabilities that occur at birth or before age 22 and are likely to continue indefinitely
- Result in substantial function limitations in 3 or more areas of major life activity
  - Self-care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency

KEY FACTS ABOUT DEVELOPMENTAL DISABILITIES

- Reflect individual's need for a combination and sequence of special, interdisciplinary or generic assistance, supports or other services that are of lifelong or extended duration and are individually planned and coordinated
- Examples of developmental disabilities
  - Intellectual disabilities
  - Cerebral palsy
  - Seizure disorders
  - Autism
  - **Note:** mental illness and FAS or FASD may be developmental disabilities ***IF*** all criteria in the definition are met
- Approximately 12,784 Alaskans have a developmental disability

Ongoing Challenges

- Developing actions and policies that will improve the lives of thousands of Alaskans with disabilities in the future
- Properly equipping Alaskans with disabilities with tools, skills and opportunities they need to successfully live the same everyday lives as Alaskans without disabilities

5-Year State Plan Goal Areas

- Advocacy and Leadership
  - Foundation of all Council work
- Community Inclusion and Supports
  - Home and community-based services
  - Housing
  - Transportation
- Employment
- Early Intervention
- Education
- Healthy Living

Tools Used to Achieve Mission

- Gathering community and stakeholder input
- Conducting research and data gathering
- Preparing policy papers and issue reports
- Providing legislative testimony
- Providing policy recommendations and advice
- Helping people connect with the political process
- Educating and providing information to the public

Example of Council in Action

- Heard considerable public testimony about barriers to employment
  - Lack of policy that promotes work as an expectation
    - Fear of losing health benefits
    - Financial disincentives
    - Lack of knowledge of existing work incentives
  - Lack of access to needed resources/fragmented services
    - Lack of holistic vocational services
    - Work incentives counseling, 1-stop job center resources, assistive technology, asset building, transportation and housing
  - Limited employment opportunities
    - Limited access to employment and training programs
    - Self-employment often viewed as "option of last resort"

Overall Strategies

- Secured Trust and federal funding
- Worked within existing systems, initiatives and partnerships
- Gathered variety of information to prioritize activities
- Identified and leveraged resources to strategically address areas of need
- Took comprehensive approach
  - Strategic planning ("Summits R Us")
  - Capacity building (training, technical assistance and outreach)
  - Policy assessment
- Built on what's learned

Some Outcomes to Date

- Division of Vocational Rehabilitation policy changes
  - Work Incentives Counseling reimbursement
  - *Discovery* as a reimbursable service
  - Self-employment policy more friendly to would-be entrepreneurs
- Establishment of microenterprise and virtual business coaching program
- Slow but steady increase in number of participants in Working Disabled Medicaid Buy-in Program

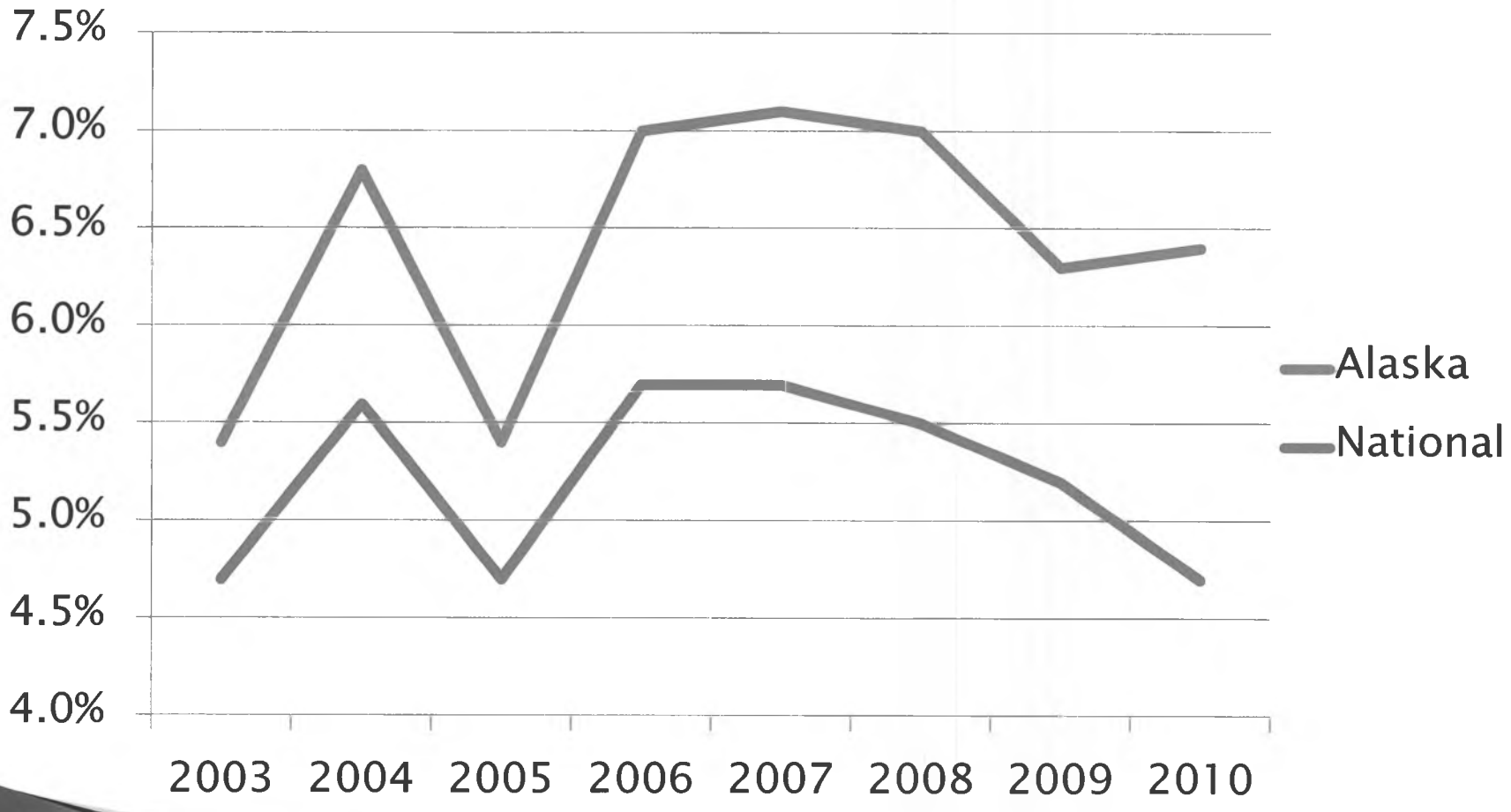
Some Outcomes to Date

- Annual *Full Lives Conference* includes employment track
- Establishment of 3 Project SEARCH sites
  - Providence Hospital – Anchorage
  - Mat-Su Regional Medical Center
  - Fairbanks Memorial Hospital
- One-stop job center policy changes
  - Disability Resource Coordinators located within job centers
- Development of curriculum on customized self-employment

Some Outcomes to Date

- Division of Vocational Rehabilitation policy changes
  - Work Incentives Counseling reimbursement
  - *Discovery* as a reimbursable service
  - Self-employment policy more friendly to would-be entrepreneurs
- Establishment of microenterprise and virtual business coaching program
- Annual *Full Lives Conference* includes employment track
- Establishment of 3 Project SEARCH sites
- One-stop job center policy changes
  - Disability Resource Coordinators located within job centers

Percent on SSI Who Work

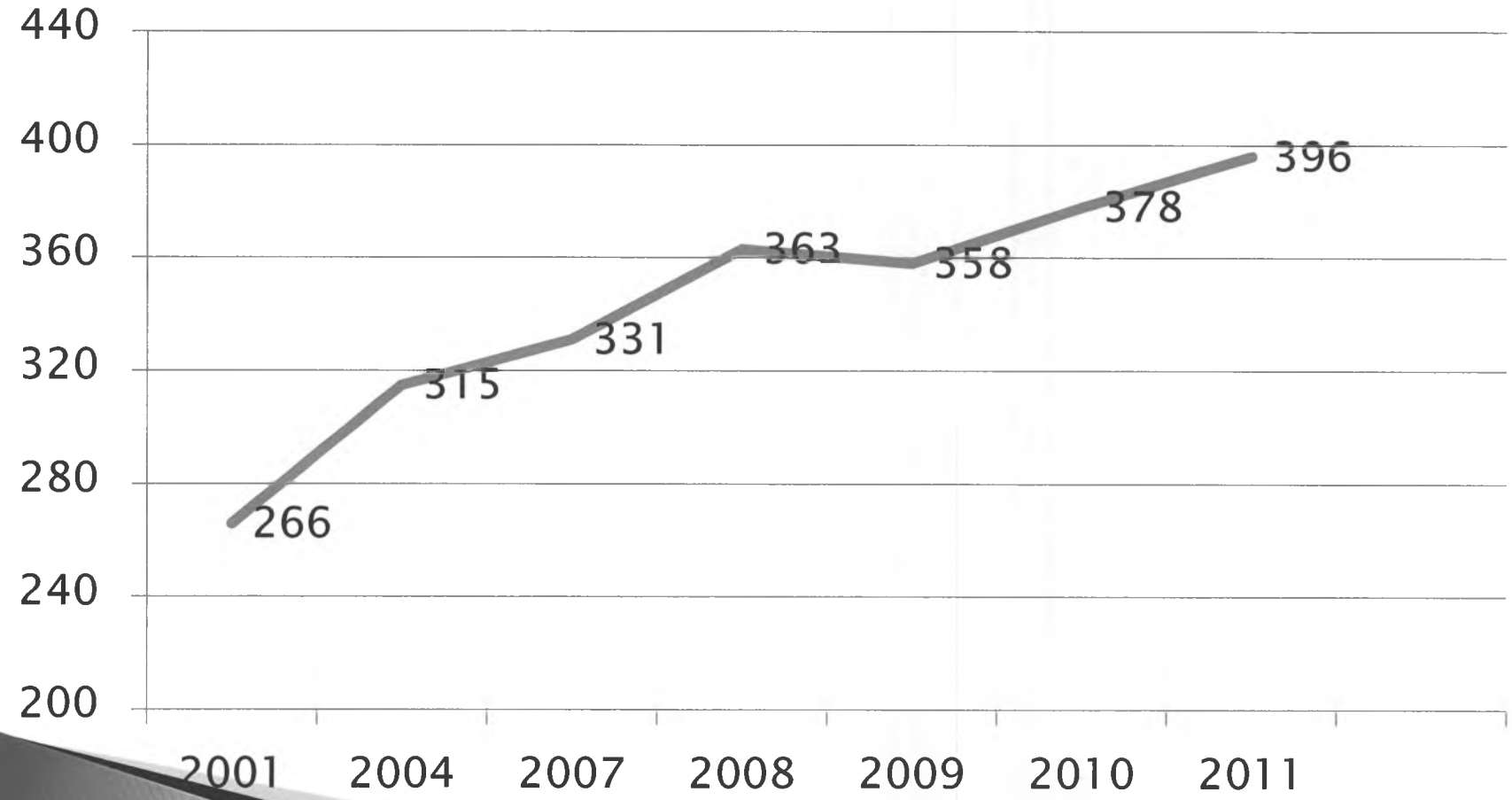


*recorded annually in December

Source: www.*SocialSecurity.gov*

Number in Integrated Employment

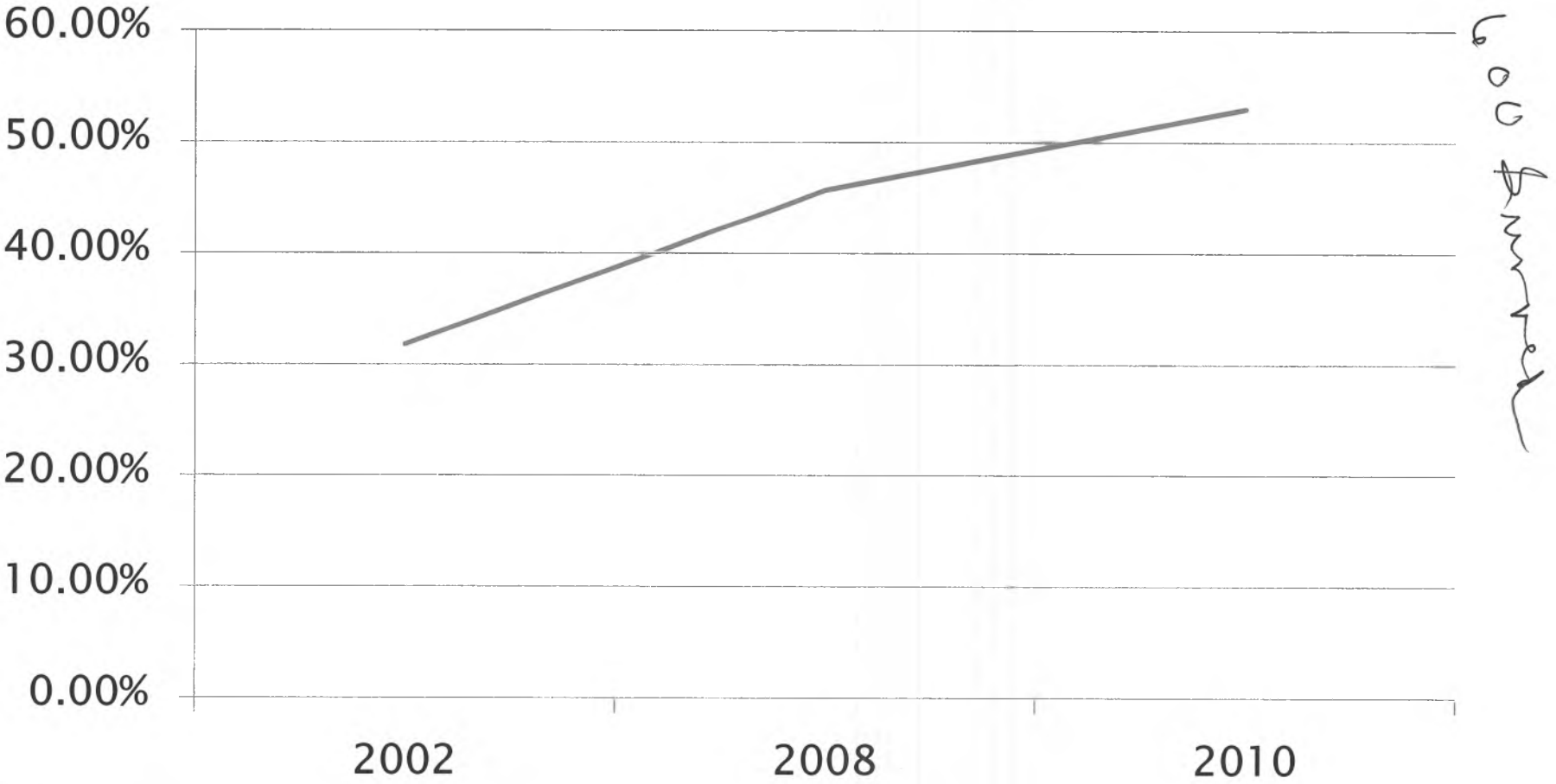
(Includes: Competitive Employment, Individual Supported Employment and Group Supported Employment)



Source: *Institute for Community Inclusion*

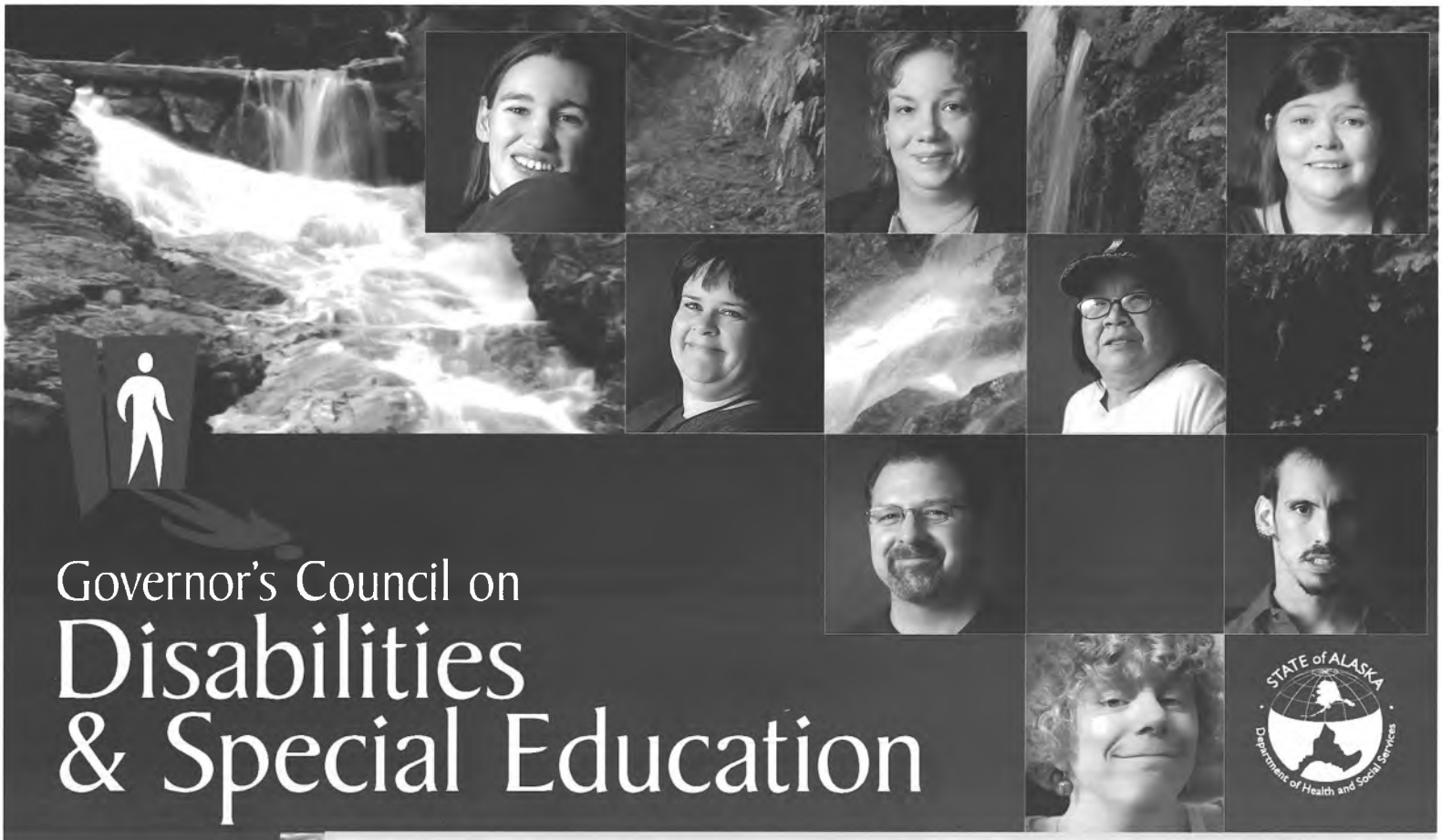
Ability to Hold Down a Job

Source: Alaska Mental Health Trust Authority



Thank You!

Questions?



Governor's Council on Disabilities & Special Education

1 ROLE

2 MISSION

3 THE COUNCIL IN ACTION

4 MOVING TOWARDS EMPLOYMENT

5 OUTCOMES

6 PRIORITIES

1. Role of the Council

- State Council on Developmental Disabilities
- Special Education Advisory Panel
- Interagency Coordinating Council for Infants and Toddlers with Disabilities
- Governing Board of the Special Education Service Agency
- Beneficiary Board for the Alaska Mental Health Trust Authority

2. Mission

Creating change that improves the lives of Alaskans with disabilities

3. Making Sustainable Change — An Example of the Council in Action

The Council manages the Alaska Works Initiative, a strategic effort funded by the Centers for Medicare & Medicaid Services to improve Medicaid programs and employment infrastructures. The Council works with state agencies, business & industry, service providers and the university to improve employment outcomes for Alaskans with severe disabilities. The Council also receives funding from the Alaska Mental Health Trust Authority to manage the microenterprise grant program, which helps Trust beneficiaries start their own businesses. In addition, the Council received funding from the Department of Education & Early Development to start a Project SEARCH program, which provides internship opportunities to youth with intellectual or developmental disabilities in their last year of school at a host business.

- From 2009 to 2010, there was a ***5.6% increase*** in the number of Alaskans on social security who worked (Note: nationally, there was an average ***4.8% decrease*** in the number of people on Social Security who worked).

State of Alaska • Department of Health & Social Services • Governor's Council on Disabilities & Special Education
3601 C Street, Suite 740, P.O. Box 240249, Anchorage, Alaska 99524-0249 • 907-269-8990

3. Continued … Sustainable Change

- In fiscal year 11, the number of people with developmental disabilities who were employed increased by 10.6% (358 to 396).
- In fiscal year 11, 13 Trust beneficiaries started their own businesses.
- Three Project SEARCH sites were established at Mat-Su Regional Medical Center, Providence Hospital and Fairbanks Memorial Hospital; other partners include the Division of Vocational Rehabilitation, local school districts and disability service providers.

4. Moving toward Employment: Stories of people who have benefited from the work of the Council

- Katie, age 21, was the first student to be hired by one of the host hospitals participating in Project SEARCH. Katie was in the program at Mat-su Regional Medical Center (MRMC) only five months before she was hired to work as a technician in Environmental Services. She works 20-25 hours per week, is a union member and makes over $13 an hour. One of the goals of Project SEARCH is to change the culture of a workplace into one that accepts disability in the workplace. At MRMC, Katie and the other Project SEARCH students have certainly accomplished this.
- Becca is starting Becca's Alpacas in the Mat-Su valley, thanks to start-up funding from the microenterprise grant program. Her business will primarily raise, breed, and sell alpacas. She may also collect and sell alpaca waste as fertilizer for local gardeners, and shear alpaca fleece and have it made into yarn to sell locally and/or online.

5. Other Outcomes for Alaskans with Intellectual or Developmental Disabilities in Fiscal Year 2011

As a result of the Council's work with 119 entities participating in partnerships or coalitions, the following number of people benefited:

- 627 people have needed health services.
- 3,019 people received formal or informal supports.
- 3,297 people have transportation for work, medical and personal needs.
- 81 individuals got and kept employment consistent with their interests and abilities.
- 2,301 students have the education and support they need to reach their educational goals.
- 1,821 infants and young children have services and supports needed to reach developmental goals.
- 384 individuals have homes of their choice.
- 928 people have information, skills, opportunities and supports to live independently, productively and included in all aspects of community life.

6. Fiscal Year 2012-13 Priorities

- Ensuring the continuation of complex behavior collaborative consultation and training services to meet the needs of individuals with cognitive disabilities and challenging behaviors
- Implementing autism insurance reform
- Changing the funding formula for the Special Education Service Agency (SESA) and removing its sunset clause in state statute
- Increasing the employment and self-employment rate of people with disabilities
- Improving services and supports to women with disabilities who are victims of sexual or physical assault
- Increasing access to services for people residing in rural and remote areas of the state

3/19/12 PRESENTATION: ALASKA BRAIN INJURY NETWORK

<TARGET><BILL></BILL><SUBJECT>3-19-12 PRESENTATION ALASKA BRAIN INJURY NETWORK</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

Committee

AGENDA

MONDAY, MARCH 19, 2012 - 1:30 PM

BUTROVICH ROOM #205

1:30 PM – Call to Order

Time:

Members Present: (PLEASE TURN OFF CELL PHONES)

OTHER BILLS PREVIOUSLY SCHEDULED/HEARD

- **SB5 – DENALI KIDCARE – ADOPT LS0057\I**

  (Senator Bettye Davis)

- **PRESENTATION - ALASKA BRAIN INJURY NETWORK**

  (Dr. Heather Macomber, Board Member)

ADJOURNMENT:

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

ImPACT
Sports Concussion Management

Heather Macomber, PhD

Alaska Neuro
ASSOCIATES

Learning Objectives

- Define sports concussion and describe symptoms
- Describe ImPACT Post-Concussion system and research
- Describe ImPACT assessment protocol for ASD
- Describe sideline assessment for coaching and/or medical staff
- Review standard concussion management guidelines

Sports Concussion Definition

At the 2004 International Symposium on Concussion in Sport, the following definition and criteria for concussion was adopted:

"*Sports concussion is defined as a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces*"

Sports Concussion Characteristics

- Approximately 90% of sport-related concussions occur without loss of consciousness (LOC)
- An athlete who sustains concussion is 4-6 times more likely to sustain a second concussion
- 10% of all contact-sport athletes sustain concussions yearly
- 63% of all concussions occur in football
- Estimated that up to 20% of football players will sustain a concussion per season

Sports Concussion Data

- An estimated 1.6 - 3.8 million sports-related concussions occur each year in the US, leading the CDC to conclude that sports concussions have reached an "epidemic level"
- For those 15-24 years old, sports are the 2nd leading cause of traumatic brain injury (motor vehicle crashes are 1st)
- According to research by *The New York Times*, at least 50 youth football players (high school or younger) from 20 different states have died or sustained serious head injuries on the field since 1997
- According to the CDC, during 2001-2009 athletes ages 5-18 years increased 62% to a total of 2.6 million sports-related emergency department (ED) visits annually, of which 6.5% (173,285) involved a traumatic brain injury, including concussion. The rate of TBI visits increased 57%, likely due to increased awareness of the importance of early diagnosis of TBI

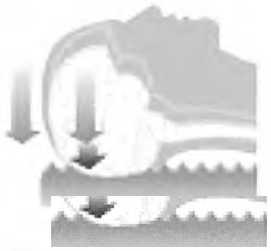
Mechanisms of Concussion

Concussions: Causes and Recovery

A concussion is a change in mental status caused by a blow to the head, neck or upper body. Symptoms may include confusion, amnesia, nausea, dizziness, blurred vision or loss of consciousness.

How it Happens

There are two types of injuries that can lead to concussions.



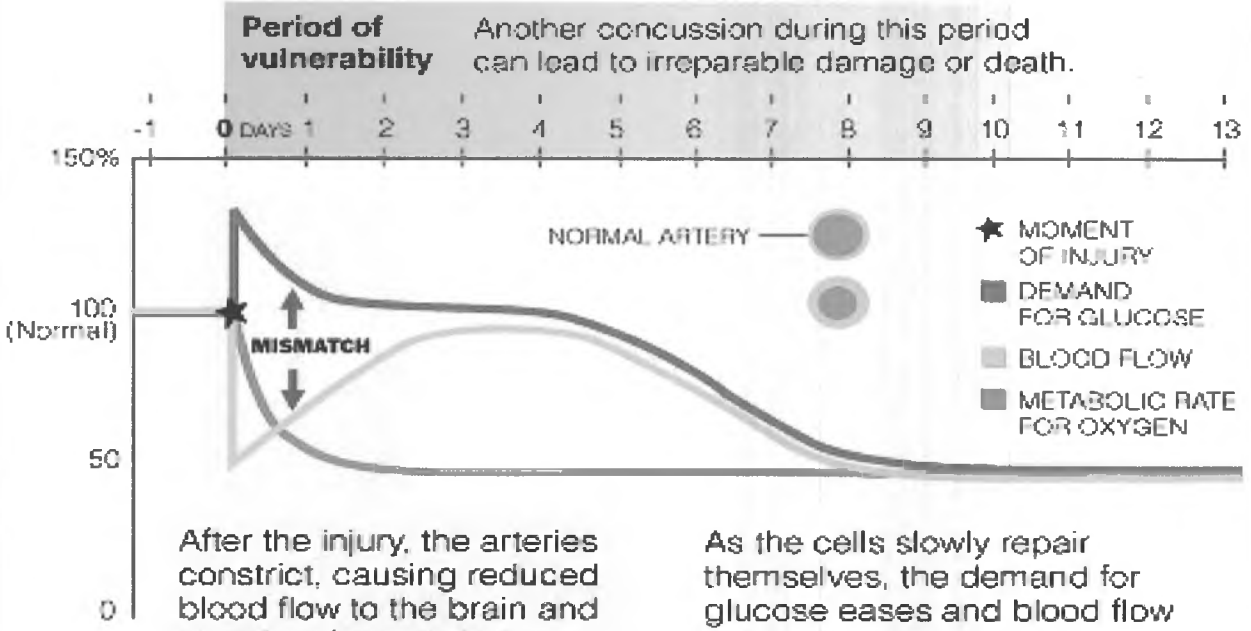
IMPACT
When the head slams into a hard surface, the skull stops abruptly while the brain, floating in cerebral fluid, continues to move and is shaken and sometimes bruised when it finally hits the skull.

SPIN
A blow to the head can cause the head to snap rapidly. When the head stops abruptly, the brain continues to rotate, potentially causing cell damage.

Neurometabolic Changes of Concussion

The Crisis and the Healing

At the moment of injury, the brain goes through an initial period of crisis followed by an undetermined period of healing. The rate of recovery varies according to the severity of the injury.



After the injury, the arteries constrict, causing reduced blood flow to the brain and lowering the rate that oxygen is metabolized. The demand for glucose also rises to provide cell energy for healing. But the high demand for glucose cannot be met by the constricted arteries. This mismatch creates a metabolic crisis.

As the cells slowly repair themselves, the demand for glucose eases and blood flow returns to normal as vessels become less constricted. But the brain remains in a state of metabolic depression, a quiet state akin to rest, for a long period before returning to normal.

Source: David A. Hovda, Ph.D., U.C.L.A. Brain Injury Research Center

Why Concussion Management is Important…

- Prevent against cumulative effects of injury
  - Cumulative neurobehavioral deficits
  - Lowered threshold to injury
- Concussion management allows players to return quickly and safely to play
- Sideline assessment helps identify when to seek immediate medical attention (ER visit)

Why Concussion Management is Important…

- Second Impact Syndrome
  - Additional concussion while still in recovery
- NOTE: Second hit does not need to be severe
  - Second impact has been shown to occur up to 14 days post-injury or when athlete returns to play before resolution of symptoms
- Catastrophic increase in intracranial pressure
  - Vasomotor paralysis, edema, massive swelling, herniation, death
- Most often occurs in athletes <21 years old
  - Neurochemical processes appear to differ in developing brain

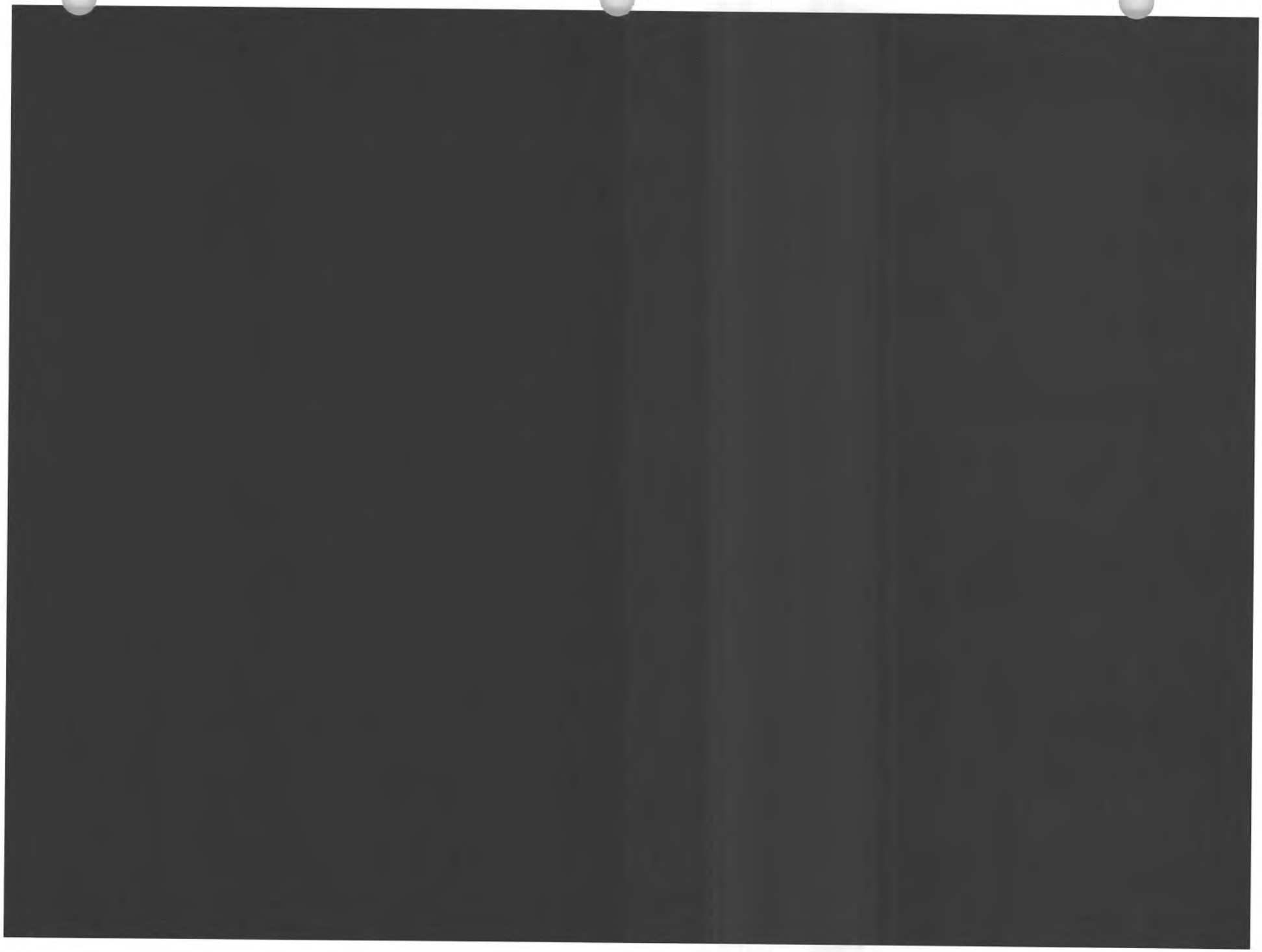
Why Concussion Management is Important…

Increased risk of concussion:

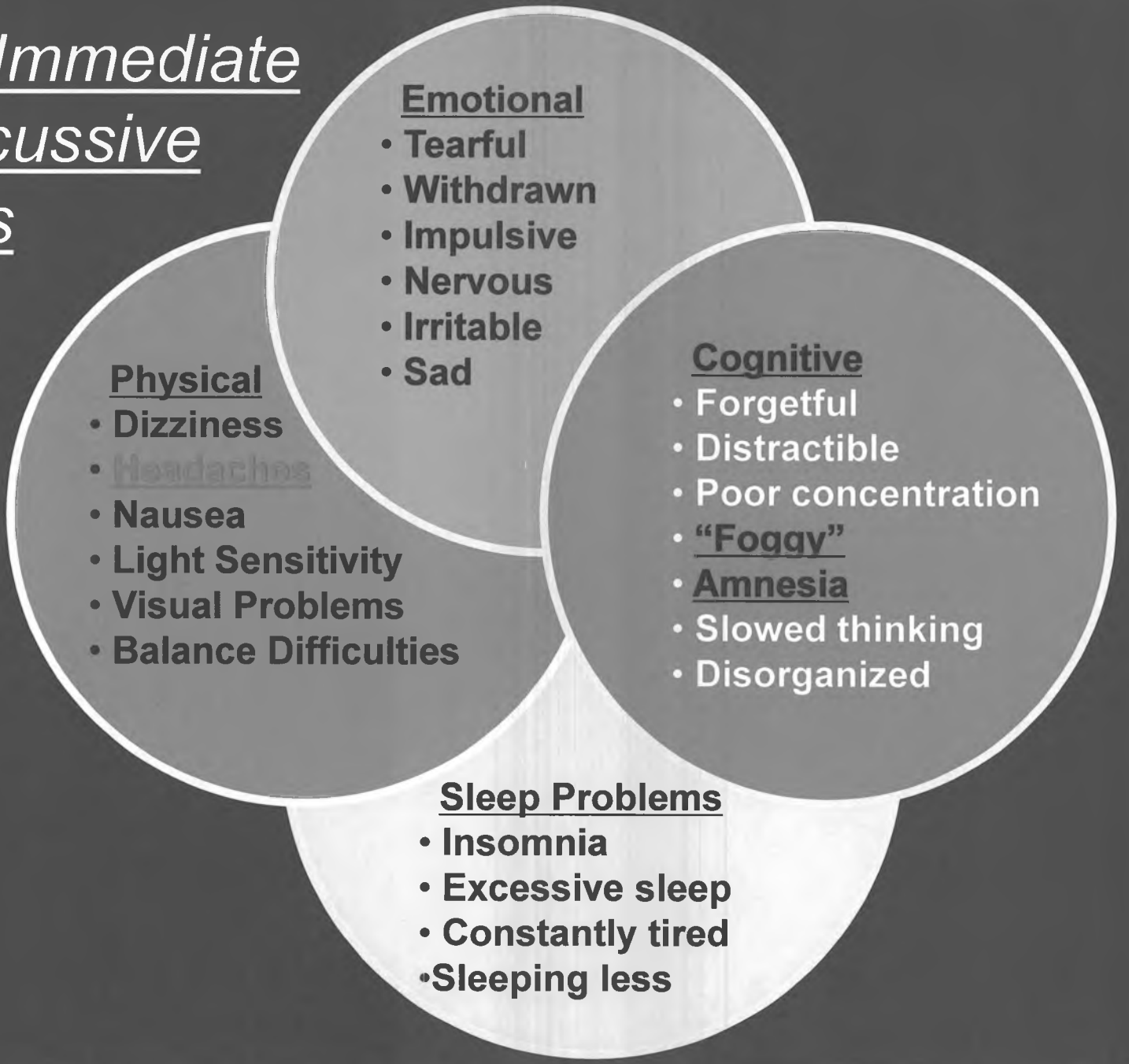
- players with 1 previous: 1.5x risk
- players with 2 previous: 2.8x risk
- players with 3+ previous concussions, are 3.5x more susceptible to concussion than a player with no concussion history

High school athletes with ≥3 concussions are at increased risk for the following with subsequent concussion:

- LOC (8-fold greater risk)
- anterograde/post-traumatic amnesia/PTA (5.5-fold greater risk)
- confusion (5.1-fold greater risk)



Common Immediate Post-Concussive Symptoms

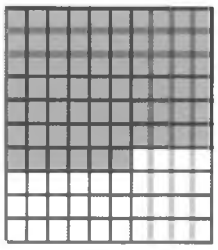


Can an athlete's self-report be trusted?

Keeping the Injuries to Themselves

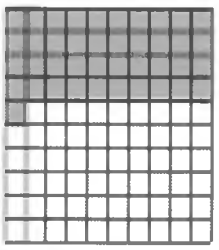
High school football players often do not report concussions, according to a 2004 study presented in the Clinical Journal of Sports Medicine. The survey of 1,532 varsity players in Wisconsin revealed that 47 percent of players who sustained concussions continued to play without reporting the injuries to anyone. They listed their principal reasons:

Did not think a concussion was serious enough to report.



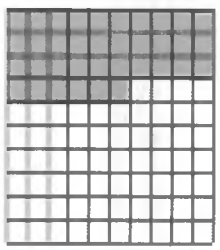
66%

Did not want to leave the game.



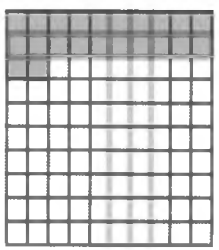
41%

Did not realize a concussion was sustained.



36%

Did not want to let down their teammates.



22%

Can an athlete's self-report be trusted?

"Anonymous questionnaires that ask specifically about concussions have reported rates among high school football players at about 15% each season; when the word concussion is omitted and a description of symptoms is provided instead, close to ***50%*** of players say they had one, with ***35%*** reporting two or more." *New York Times, Nov 14, 2007*

Former AAN Concussion Guidelines

- Tremendous variability
- Up to 14 different scales
- Assumes same standard for all age groups
- Poor job distinguishing “mild” concussion
- Assigns too much importance to LOC
- Management guidelines not based on cognitive test data are arbitrary

NEW CONCUSSION MANAGEMENT GUIDELINES
CIS Group, Vienna (2001), Prague (2004)

"Cornerstones of Management"

- Removal of symptomatic athletes from play
- Restriction from play while symptomatic
- Graduated return to play (following exertion)
- *Neurocognitive testing*
- Recognition of differences in children

Aubry, Cantu, Dvorak, Graf-Baumann, Johnston, Kelly, Lovell, McCrory, Meeuwisse, Schasmasch, 2001. *Clinical J. Sports Med.*

The Unique Role of Neuropsychology

- Specific training in cognitive assessment in general and brain injury in particular
- Identify pre-existing cognitive/learning disorders that could result in misdiagnosis
- Identify co-existing psychiatric issues that affect recovery
- Identify poor effort/invalid test performances
- Capable of successfully managing atypical recovery
- Familiarity with a wide array of providers when additional care is needed
- Of the two recognized professions that are trained to evaluate for brain injury, neurologists typically refer patients to neuropsychology to assess concussion/mTBI

ImPACT

Immediate Post-Concussion Assessment and Cognitive Testing

Computerized Neurocognitive Testing

Mark Lovell, Ph.D.-UPMC Dept. of Orthopedic Surgery

Micky Collins, Ph.D.-UPMC Dept. of Orthopedic Surgery

Joseph Maroon, M.D.-UPMC Dept. of Neurological Surgery

What is ImPACT?

Post-Concussion Evaluation & Management

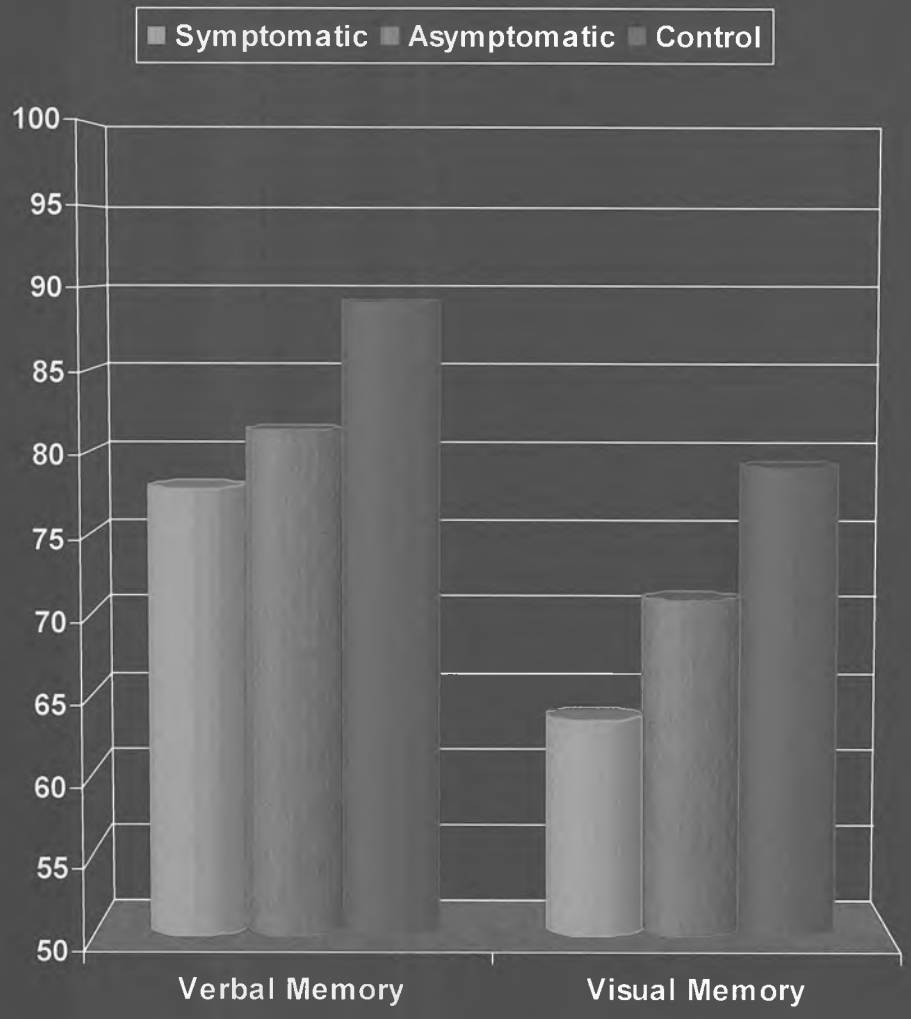
- Demographic/Concussion history questionnaire
- Concussion Symptom Scale
  - 21 Item 5-point scale (e.g. headache, dizziness, nausea, etc.)
- Multiple neurocognitive measures
  - Measures domains of memory, working memory, attention, reaction time, mental speed
- Detailed clinical report
  - Outlines demographic, symptom, neurocognitive data
  - Computer scored

Who's using ImPACT?

- Army, Navy
- NFL, MLB, NBA, NHL
- All MLB umpires
- USA Olympic Training Center
- Cirque du Soleil
- U.S. Soccer Federation
- U.S. Ski Team
- NFL Europa, South African Rugby
- More than 300 colleges and universities
- More than 1,000 school districts

UNIQUE CONTRIBUTION OF NEUROCOGNITIVE TESTING TO CONCUSSION MANAGEMENT

Testing reveals cognitive deficits in asymptomatic athletes within 4 days post-concussion



N=215, MANOVA p<.000000 (Lovell et al., AJSM, In Press 2006)

ImPACT "Bell-Ringer" Study

- 64 high school athletes with "mild" concussion and no loss of consciousness
- Two groups compared in terms of outcome
  - Athletes with <5 min of signs/symptoms recovered completely within 7 days
  - Athletes with 5-15 min of signs/symptoms had cognitive deficits at 7 days

Lovell, Collins, Iverson, Field, Podell, Cantu, Fu; J Neurosurgery; 98:296-301,2003
Lovell, Collins, Iverson, Johnston, Bradley; Amer J Sports Med; 32;47-54,2004

Post-Traumatic Migraine

PTM symptoms following sports concussion are related to a greater decline in cognitive performance and increased symptoms

- Post-traumatic headache is most common symptom
- Headaches occurs more often with mild brain injury than with more severe TBI (Yamaguchi et al, 1992)
- Headache with photosensitivity, phonosensitivity, and/or nausea likely leads to prolonged recovery

Cumulative Effect of Concussion

- 867 Male High School and College Athletes
  - Mean age 17.7 years
  - 86.7% football,10% hockey, 2.3% soccer
- No long-term effects of one or two prior concussions
- Evidence exists that ≥3 concussions is associated with ongoing adverse effects in some athletes (Collins et al, Guskiewicz et al, Iverson et al)

Additional ImPACT Research

- Concussed high school athletes have slower recovery from neurocognitive & other symptoms than college athletes (Field, Collins, Lovell et al. J. Pediatrics, April 2003).
- Amnesia is up to 10X better than loss of consciousness in predicting deficits on ImPACT following concussion (Collins et al., Clinical Journal of Sport Medicine, July 2003)
- Symptom of "fogginess" highly predictive of neurocognitive deficits and prolonged recovery as measured by ImPACT (Iverson, Lovell, Collins et al, JINS, 2004)
- "General" mouthguard use demonstrated no effect in reducing neurocognitive/symptom deficits related to sports concussion (Mihalik, Pardini, Guskiewicz, Collins, Lovell et al. Dental Traumatology, In Press)

Clinical Protocol

Neurocognitive Testing

1st assessment
w/n 24-72
Hours

Repeat
assessment
Day 5-10

Concussion

Baseline
Testing

Repeated assessment
Beyond if necessary

Baseline (Pre) Testing

- The best point of comparison is the student's own baseline scores
- Typically, the first step is a sports physical and ImPACT baseline at the beginning of the season
- Establishes a "starting point" for students with a prior history of concussions
- Helps accelerate return to play for students with learning disability
- Allows neuropsychologists to track the student's path back to their "normal" level

Sideline Assessment

- For signs of severe head trauma--Send directly to ER if you observe:
  - Any loss of consciousness, fixed pupil, vomiting, can't stand, can't respond, can't move limbs, immediate severe head pain
- For students without signs of severe head trauma, use the ImPACT sideline assessment tool:
  - Look for listed concussion signs
  - Ask athlete about listed concussion symptoms

Principles of Sideline Assessment

- Take athlete away from distracting activity and people
- Try to maintain their full attention
- Speak in loud and clear voice
- Have athlete perform all tasks listed on card
- If they fail any questions, the protocol says that they cannot return to play--refer to nurse
- No “do-overs” or hints--if they cannot do these simple tasks, then they are not safe to be on the field

The Best Approach To Concussion Management

Concussion Signs and Symptoms Evaluation

Signs observed by staff

- appears to be dazed or stunned
- is confused about assignment
- forgets plays
- is unsure of game, score, or opponent
- moves clumsily
- answers questions slowly
- loses consciousness ***(even temporarily)***
- shows behavior or personality change
- forgets events prior to hit ***(retrograde)***
- forgets events after hit ***(anterograde)***

Symptoms reported by athlete

- headache
- nausea
- balance problems or dizziness
- double or fuzzy vision
- sensitivity to light or noise
- feeling sluggish
- feeling "foggy"
- change in sleep pattern
- concentration or memory problems

Symptoms may worsen with exertion.
Athlete should not return to play until symptom-free.

On-field Cognitive Testing

Orientation

Ask the athlete the following questions.

What stadium is this?
What city is this?
Who is the opposing team?
What month is it?
What day is it?

Anterograde amnesia

Ask the athlete to repeat the following words.

Girl, dog, green

Retrograde amnesia

Ask the athlete the following questions.

What happened in the prior quarter/period?
What do you remember just prior to the hit?
What was the score of the game prior to the hit?
Do you remember the hit?

Concentration

Ask the athlete to do the following.

Repeat the days of the week backward (starting with today).
Repeat these numbers backward:
63 ***(36 is correct)*** 419 ***(914 is correct)***

Word list memory

Ask the athlete to repeat the three words from earlier. (Girl, dog, green)

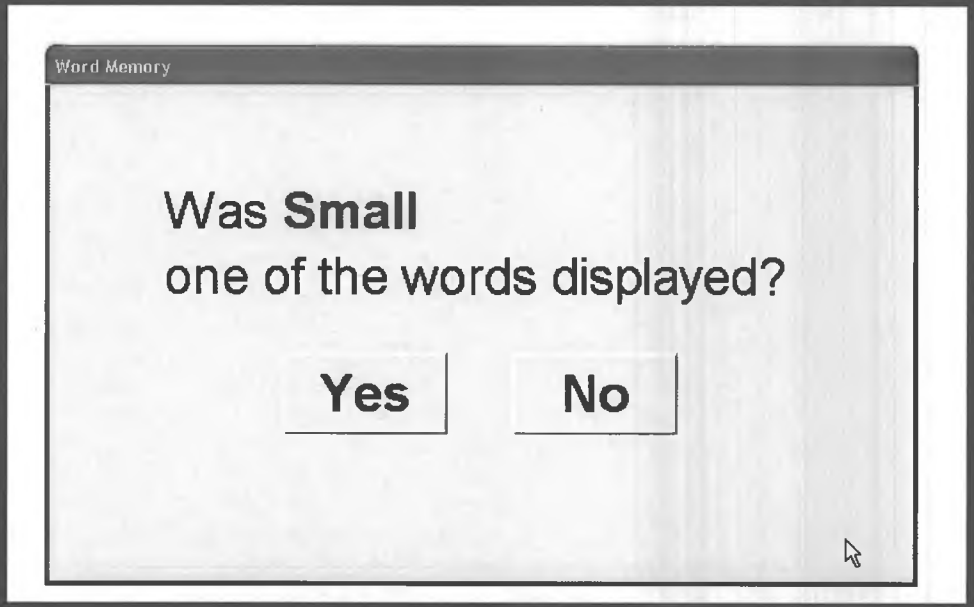
Any failure should be considered abnormal.
Consult a physician following a suspected concussion.

Module 1 *(Word Memory)*

ImPACT
The Best Approach To Concussion Management

There are five different forms of the word list.

Recall Condition: Following the administration of all other test modules (approximately 20 minutes), the subject is again tested for recall

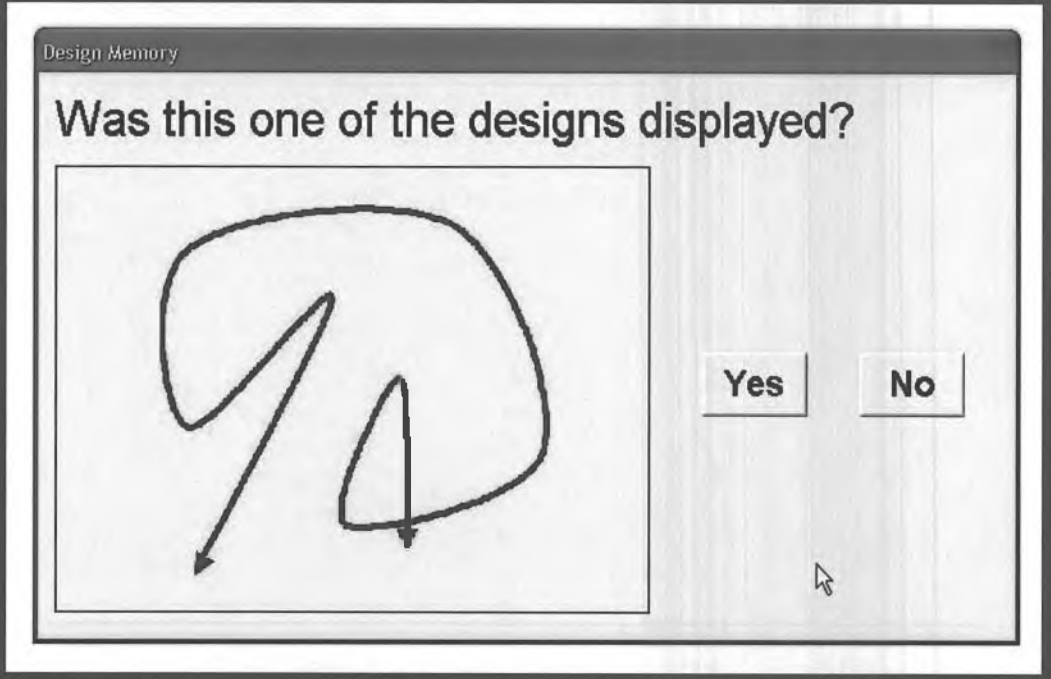


Module 2 (Design Memory)

ImPACT©
The Best Approach To Concussion Management

There are five different forms of this task

Recall Condition: Following the administration of all other test modules (approximately 20 minutes), the subject is again tested for recall



ASD Post-Injury Protocol

- Student is injured and has signs/symptoms
- Coach pulls student from activity and completes sideline assessment
- If protocol is positive:
  - Coach alerts Nurse
  - Nurse meets with student, refers for ImPACT assessment
  - Neuropsychologist evaluates student and manages post-concussion recovery and return to play decision
  - Student's post-concussive "team" works together for fastest and safest possible return to play

Return to Play Protocol

- Students are not returned to play on the day of injury if they have any signs or symptoms of concussion.
- The following guidelines are for symptomatic students:
  - Rest until symptom free
  - No *physical or mental* activity if symptoms are present, including headaches
  - Light physical/mental activity at first
  - If symptom free with light physical/mental activity, increase intensity of activity and re-test
  - Repeat until athlete is symptom-free with physical/mental exertion
- A concussed player is a POOR player

When Used by Properly Trained Professionals, ImPACT will…

- Determine severity of concussion
- Provide valuable information to the athlete, parents, athletic trainers, physicians
- Provide information on academic deficits associated with concussion
- Determine safe return to play
- Reduce liability for school districts

“Team” Collaboration

- Coordination between parents, coaches, nurses, teachers, counselors, and the student is critical
- Team approach keeps everyone informed about the student’s recovery process, so adjustments can be made for academic work, physical activity, and level of rest/general activity at home
- Allows for multiple parties to monitor and supervise the student’s recovery process. Good concussion management is the result of a good team effort.

Why Schools Choose ImPACT

- Concussions are one of the most serious medical problems at the high school level
- Proper management of concussion is the best form of prevention of serious injury
- To avoid litigation for improper concussion management
- Alerts teachers, nurses, and counselors to student's injury and helps create team approach to concussion management

Current ASD Data

ASD Middle and High School students completed (July 2011 – present):

- 8,354 Baselines
- 30 Post-injury Tests

< 1% concussion rate is highly implausible

Challenges to Program

- Under-reporting of concussions
  - Expected rate for football alone is 20%
  - Current reported rate is <1% (est. 0.008)
  - Hockey is slightly better at 2%
- Poor roll-out of program by schools
  - Limited or no information provided to parents
  - Some parents felt schools were overstepping bounds
  - Some coaching staff disagreed with program and have undermined effectiveness

Challenges to Program

- Mixed messages from coaches/school personnel regarding need for removal or follow up
- Students underreporting injuries due to fear of prolonged/excessive restriction
- Teachers/support staff unwilling to meet students' needs or grant accommodations
- A few coaches directed students to re-take baselines to assess concussion themselves, despite having no training in this regard
- Students deliberately performing poorly on baseline, with the goal of being returned to play faster after concussion
- Baselines conducted in suboptimal conditions, resulting in low scores that do not reflect students' true ability

Challenges to Program

- Financial and insurance constraints
  - Under-insured or uninsured students
  - High co-pays
  - Codes denied or insurance unwilling to pay for assessment
  - No additional financial source available to alleviate patients' financial burden (e.g., grants, waiver program)
  - In particular, Tricare has regular intervals in which they consistently deny pre-authorization for all evaluations, which prevents families from receiving needed services
  - No assistance available in rural areas due to inability to use/bill for telemedicine codes

Key Points

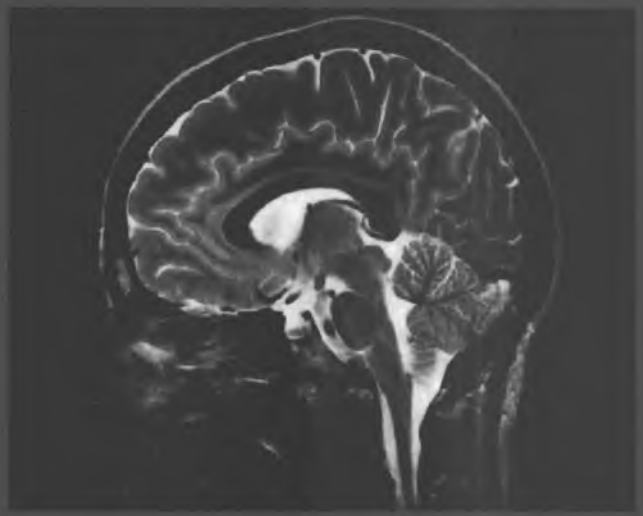
- Sports concussion is a hidden epidemic for student athletes
- A "bell-ringer" *is* a concussion
- Amnesia, headaches, and "fogginess" are better predictors for concussion related problems than loss of consciousness
- Concussed athletes should avoid physical/mental exertion while in the early stages of recovery
- Failure of sideline testing means that athletes do not return to play-following the protocol keeps them safe

Key Points

- Always have someone with the concussed athlete after injury
- Send the athlete to the ER if you observe signs of severe head trauma (LOC, vomit, fixed pupils)
- Keep the injured athlete's "team" members well informed to make accommodations - this approach leads to a faster, safer recovery and return to play

REMEMBER…

A CONCUSSION IS A BRAIN INJURY…TAKE IT SERIOUSLY!!!



Phone: 907-277-0100
Fax: 907-222-0566
email: info@alaskaneuro.com
www.alaskaneuro.com

Alaska **Neuro**

ASSOCIATES

ImPACT™

The Best Approach to Concussion Management

Concussion Signs and Symptoms Evaluation

Signs observed by staff

- Appears to be dazed or stunned
- Is confused about assignment
- Forgets plays
- Is unsure of game, scores, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness ***(even temporarily)***
- Shows behavior or personality change
- Forgets events prior to hit ***(retrograde)***
- Forgets events after hit ***(anterograde)***

Symptoms reported by athlete

- Headache
- Nausea
- Balance problems or dizziness
- Double or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish
- Feeling "foggy"
- Change in sleep pattern
- Concentration or memory problems

Symtoms may worsen with exertion.
Athlete should not return to play until symptom-free

www.impacttest.com

On-field Cognitive Testing

Orientation

Ask the athlete the following questions.

What stadium is this?
What city is this?
Who is the opposing team?
What month is it?
What day is it?

Anterograde amnesia

Ask the athlete to repeat the following words.

Girl, dog, green

Retrograde amnesia

Ask the athlete the following questions.

What happened in the prior quarter/period?
What do you remember just prior to the hit?
What was the score of the game prior to the hit?
Do you remember the hit?

Concentration

Ask the athlete to do the following.

Repeat the days of the week backward (starting with today).
Repeat these numbers backwards:
63 (36 is correct) 419 (914 is correct)

Word list memory

Ask the athlete to repeat the three words from earlier. (Girl, dog, green)

Any failure should be considered abnormal.
Consult a physician following a suspected concussion.

4/09/12 PRESENTATION: ALASKA E-HEALTH NETWORK (HEALTH INFORMATION MANAGEMENT AND SYSTEMS SOCIETY)

<TARGET><BILL></BILL><SUBJECT>4-09-12 PRESENTATION ALASKA E-HEALTH NETWORK (HEALTH INFORMATION MANAGEMENT AND SYSTEMS SOCIETY)</SUBJECT><COMM>SHSS27</COMM></TARGET>

Health Information Management and Systems Society

Bill Sorrells

HI-AK HIMSS Chapter

Transforming healthcare through IT™

HIMSS
transforming healthcare through IT

HIMSS Strategic Direction

Vision

Advancing the best use of information and management systems for the betterment of health care.

Mission

To lead healthcare transformation through the effective use of health information technology.

HIMSS
transforming healthcare through IT

Society Today

- 43,000 Individual Members, of which 60+% work in healthcare, governmental and not-for-profit organizations
- 500+ Corporate Members
- 90+ committees, task forces, & work groups
- 54 Chapters including the HI-AK HIMSS Chapter
- 150+ not-for-profits
- Offices: Chicago IL, Arlington VA, Ann Arbor MI, Brussels, Singapore, Leipzig

HIMSS
transforming healthcare through IT

HIMSS Resources

HIMSS
transforming healthcare through IT™

Health Information Technology (HIT)
Policy Guidance for State-Level Decision-Makers

- Reference for development of state health policy, executive orders and legislation
- Goal to help streamline care delivery by leveraging HIT
- HIMSS can help state officials through legislative analyses, forecasting and HIT specific information

HIMSS
transforming healthcare through IT

Provides State Officials Guidance On:

- Protecting and supporting funding and incentives
- Supporting consumer engagement
- Privacy and security
- Role of publicly funded programs
- Government relations and regional affairs

HIMSS
FEDERAL HEALTH COMMUNITY

- The Federal Health Community is a complimentary networking platform and community of profession for HIMSS members who are also Federal Government employees

- The Federal Health Community works to foster cross-agency information sharing and for members to network, share new ideas on how health IT can be used to improve healthcare delivery by the federal government, and provide leadership, guidance and domain expertise to HIMSS activities, industry initiatives.

- The Federal Health Community meets monthly via teleconference focused on collaborating on activities and HIMSS updates, coupled with networking events at HIMSS Annual Conference and the Annual Government Health IT Conference in Washington DC

HIMSS
transforming healthcare through IT

HIMSS Global Conferences

- HIMSS12 – February 20-24th, Las Vegas, NV
- World of Health IT– May 7-9th , Copenhagen
- HIMSS AsiaPac – September 17-19th, Singapore
- HIMSS Middle East – May 20-21st, Abu Dahbi
- GHIT12 – June, Washington, DC
- National Health IT Week – September 10-14th

HIMSS
transforming healthcare through IT

REGULATORY TRACKING

Agency		Key Dates	HIMSS Content and GR POCs
CMS -- Released	Electronic Funds Transfer Standard – **Interim Final Rule Released**	**Anticipated** **Released:** January 5, 2012 **Comments due:** March 2012 **Compliance Date:** January 1, 2014	Business Centered Systems/Federal Affairs HU
CMS -- Released	Physician Payment Sunshine Act – **Notice of Proposed Rule Making (NPRM)**	**Released**: December 14, 2011 Comments Due: February 17, 2012; **Final Rule**: Summer 2012	Content Team/Federal Affairs
ONC	Nationwide Health Information Network Governance (NwHIN) – *Advanced **NPRM***	**Anticipated** **Release:** Jan-Feb 2012 **Comments due:** March-April 2012; **Final NPRM:** Late Spring 2012	Content Team/Federal Affairs
CMS	Meaningful Use Stage 2 – **NPRM**	**Anticipated** **Release:** Feb 2012 **Comments due:** April 2012; **Final Rule:** July-August 2012	Content Team/Federal Affairs
ONC	Standards and Certification Criteria for Meaningful Use Stage 2 – **NPRM**	**Anticipated** **Release:** Feb 2012 **Comments due:** April 2012; **Final Rule:** July- August 2012	Content Team/Federal Affairs

Slide 10

HU1 This is a new row
HIMSS USER, 12/21/2011

Agency		Key Dates	HIMSS Content and GR POCs
CMS	Health Plan Identifier – **NPRM**	**Anticipated** **Release:** Winter 2012; **Comments due:** Before May 2012 **Final Rule:** Before Oct. 2012	Business Centered Systems/Federal Affairs
CMS	Compliance Certification and Audit Program for Health Plans	**Anticipated** **Release:** TBD 2012 **Comments due:** Before Autumn 2012 **Final Rule:** TBD	Business Centered Systems/Federal Affairs
OCR	Pending final rules forthcoming from ARRA – these final rules will be issued together: Final Breach Notification, Final HIPAA Modifications, Final Enforcement, and Intended Effect: •Minimizes staggered compliance dates •Minimizes changes to notices of privacy practices	**Anticipated** **Release:** TBD 2012 **Comments due:** TBD **Final Rule:** TBD	Privacy Security/Federal Affairs
OCR	Accounting of Disclosures	**Anticipated** **Release:** TBD 2012 **Comments due:** TBD **Final Rule:** TBD	Privacy Security/Federal Affairs

HIMSS
transforming healthcare through IT™

More Information on HIMSS and the State Health IT Policy Guidance:

Thomas S. Keefe, Senior Director of HIMSS
State Government Affairs
(703)562-8813
tkeefe@himss.org

HIMSS
transforming healthcare through IT

Questions?

www.himss.org
bill@ak-ehealth.org

Health Information Technology
Policy Guidance for State-level Decision-makers

May 23, 2011

I. Purpose

This State Health Information Technology (health IT) Policy Guidance document serves as a reference for state legislators and executives for how health IT might be used in the development of state health IT policy, executive orders and legislation. Whether newly elected or experienced, as legislators, you all grapple with how to best enact policies that promote quality healthcare delivery for your constituents. The goal of delivering highly effective and quality healthcare is supported by streamlining the care delivery process and leveraging health IT. With the current healthcare landscape in transition and as healthcare delivery varies in each state, this State health IT Policy Guidance document is a valuable resource focused on key topics, issues and concepts on the adoption, deployment and utilization of health IT.

While this document does not prescribe exact methods to implement and support health IT, it does provide key information for state officials on widely accepted concepts in the current health IT arena. Whether through the development and/or operation of health information exchanges (HIEs), Regional Extension Centers (RECs), reimbursement structures for health IT, electronic health record (EHR) adoption and implementation, or telehealth, health IT activities underway within states are affecting healthcare delivery and patient safety and care quality outcomes throughout the United States. When developing health IT policy, state legislators and executives should appropriately address support of currently available funding, consumer engagement, privacy and security, and the role of the publicly-funded health programs and other policy issues affecting the deployment and use of health IT. State health IT policy should be aligned with federal health IT initiatives, policy, regulations and compliance efforts to share the common goal of transforming healthcare in our nation by harnessing the potential of information technology and applying it in a uniform manner.

Note that the State health IT Policy Guidance document reflects the HIMSS 2011-2012 Public Policy Principles. Please refer to these principles for direction and definition from the federal government on health IT.

II. State Health IT Policy Guidance for Protecting and Supporting Funding and Incentives

The 2011-2012 HIMSS Public Policy Principles provide the basis for many of the policy and funding issues going forward in the states. Furthermore, the basis for developing many of these funding principles arose from The American Recovery and Reinvestment Act of 2009 (ARRA). ARRA included billions of dollars in Medicare and Medicaid incentive payments for the "meaningful use" of certified EHR technology and will help to close the health IT adoption gap in the United States. In addition, ARRA provides funding to states for the development of statewide health information exchanges which are a key component encouraging EHR adoption by providing information sharing to support effective healthcare delivery and increased patient care quality outcomes. HIMSS agrees with Dr. David Blumenthal, former National Coordinator for Health IT that "these are historic times".

ARRA is bringing the power of EHRs into the hands of healthcare providers at the point of patient care delivery. However, these new initiatives should not create a new form of "digital divide." Our goal is to ensure that all constituencies benefit from these efforts and that healthcare is provided in an effective and efficient manner across all patient care settings.

Each state has the capability to protect funding and prioritize their dollars to ensure that money is put to best use, which includes supporting the betterment of healthcare. ARRA committed unprecedented public funding with the intention of stimulating the economy through methodical purchase, implementation and use of EHRs. Focus is now directed on the administration of these funds in an efficient and effective and transparent manner, and development of initiatives to assure the durability of these investments over time. In addition, clinician reimbursement methodologies must appropriately reflect the evolving use of health IT over time.

III. State Health IT Policy Guidance for Supporting Consumer Engagement

State health IT policy can encourage, facilitate, and drive consumer engagement so that consumers have access to information and become active participants in their healthcare decisions. Consumer engagement can increase effective patient/provider communications, lead to reduction of medical errors, increase patient safety, and facilitate improvements in public and population healthcare. In today's electronic environment, various health IT applications, such as personal health records (PHRs) and EHRs, serve as tools for consumers to manage their personal health information and lifestyles, bolstered by the widespread use of mobile technology and social media. These new technologies facilitate increased consumer awareness and engagement with their providers that facilitates and aids privacy decisions and management of advance directives. The overall effect of consumer engagement is anticipated to result in transparency of price, cost and quality; foster trust and collaboration among stakeholders; and positively impact the health and quality of life for all individuals residing in the U.S.

IV. State Health IT Policy Guidance for Privacy and Security

The privacy and security of protected health information is best achieved when state health IT policy aligns with related federal and state privacy laws and regulations as designated by HIPPA. Consumers and their authorized providers should have access to PHI in a timely, private and secure manner, as protected by law.

HIMSS continues its 10 year history of producing privacy and security tools that have helped shape the discussion and prepare the healthcare community for regulatory compliance and today's most pressing security implementation challenges. Featured tools include the HIMSS Privacy and Security Toolkit and the recently released HIMSS Privacy and Security Toolkit for Small Provider Organizations, published in partnership with the Medical Group Management Association (MGMA).

For additional information on HIMSS' privacy and security activities, please contact Lisa A. Gallagher, HIMSS Senior Director of Privacy and Security at lgallagher@himss.org.

V. State Health IT Policy Guidance for the Role of Publicly Funded Health Programs

States have the ability to directly affect and participate in health IT initiatives through select publicly funded health programs such as Medicaid, public health initiatives, and State Employee Health Benefits programs. As payers, providers and regulators of these programs, states can leverage their role to not only provide grants, loans and tax incentives to support health IT initiatives, but also require the use of select health IT strategies and applications, and adherence to nationally recognized health IT standards and interoperability frameworks.

Additionally, states can support federal, state and private programs that assist providers with health IT implementation and support programs such as Regional Extension Centers (REC). The RECs focus on training the workforce to support the selection, implementation and management of EHRs to improve quality, safety and health outcomes and encourage scholarships matching grant funding and loan repayment programs to support this effort.

States can also expand or establish new workforce development and training programs that not only provide resources to support health IT curricula, but require the programs to engage in "pipeline" channels (e.g., technically focused middle/high schools, community colleges, AmeriCorps, veterans' employment and training programs). These programs support informatics competencies, particularly in underserved communities, through which potential skilled workers can be identified, engage in internships, be recruited and prepare for health IT related careers.

VI. HIMSS Government Relations and Regional Affairs

Developed by HIMSS, the State health IT Policy Guidance is an excellent resource for state executives and legislators when developing health IT policy. HIMSS is a cause-based, not-for-profit organization exclusively focused on providing global leadership for the optimal use of health IT and management systems for the betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the United States. HIMSS represents more than 35,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 520 corporate members and more than 120 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through health ITs content expertise, professional development, and research initiatives designed to promote information and management systems' contributions to improving the quality, safety, access and cost-effectiveness of patient care.

In developing and supporting state health IT policy, HIMSS is a resource for analytical and public policy expertise. HIMSS Analytics, a subsidiary of HIMSS, is a valuable resource for health IT data and analytic needs. HIMSS Analytics supports HEALTH IT decision making by collecting and analyzing healthcare organization data relating to IT processes, environments, products, information systems department management, healthcare delivery trends and purchasing- related decisions.

HIMSS serves as an instrumental component in developing and supporting state health IT policy on the local level. Our members and staff help educate federal and state officials with the health IT knowledge and resources needed to develop and implement appropriate health IT- related policy. State officials can request legislative analyses, forecasting and health IT-specific information through HIMSS. Such activities are conducted in conjunction with the appropriate HIMSS committees and roundtables. On the local level, state officials have the opportunity to collaborate with 50 U.S.-based HIMSS Chapters on health IT initiatives. If a state official is not already a HIMSS State Government Member, he or she can reach out to a local HIMSS Chapter to connect with health IT experts. Facilitated by HIMSS Chapters, and supported by HIMSS, State Advocacy Days are the most prominent advocacy activities at the local level. During State Advocacy Days, HIMSS members and other health IT stakeholders have an opportunity to participate in health IT education, as well as visit and educate state legislators on health IT policy. Additional advocacy and public policy activities among HIMSS Chapters include monitoring state health IT legislative activities and fostering relationships with industry experts and state officials.

For additional information on HIMSS and our State Health IT Policy Guidance, please call Thomas S. Keefe, Senior Director of HIMSS State Government Affairs at (703) 562 – 8813 or tkeefe@himss.org.

AKEELA PRESEN-TATION 2011

<TARGET><BILL></BILL><SUBJECT>AKEELA PRESENTATION 2011</SUBJECT><COMM>SHSS27</COMM></TARGET>

AKEELA, INC.

TABLE OF CONTENTS

1. Communities in Which Programs are Located
2. Program Descriptions
3. Akeela House Grants
   - FY-92 - $682,239
   - FY-10 - $681,225
   - FY-11 - $696,225
4. Consumer Price Calculator
5. Comparison of Indirect Cost to Direct Program Expenses
6. Cost Reduction Through Consolidation
7. Prison Cost Effectiveness Study

2011 12.5m

AKEELA, INC. PROGRAMS

COMMUNITIES IN WHICH PROGRAMS ARE LOCATED

1. ANCHORAGE
2. KENAI
3. HOMER
4. KETCHIKAN
5. NOME
6. BETHEL
7. FAIRBANKS
8. SUTTON
9. PALMER
10. SEWARD
11. JUNEAU
12. CORDOVA
13. PETERSBURG
14. WRANGELL
15. KODIAK
16. UNALASKA
17. SAVOONGA
18. STEBBINS

AKEELA, INC.
PROGRAM DESCRIPTIONS

TREATMENT PROGRAMS

ANCHORAGE

Akeela House Recovery Center – Akeela House is a 48-bed adult, co-ed, long-term, residential therapeutic community treatment program serving clients with an ASAM III.5 assessment. The majority are also dually diagnosed so we also provide services for co-occurring disorders. The State funds 20 beds and we have contracts that support an additional five to seven beds. **Funding:** State grant, Federal grant, contract with Federal Parole and Probation, third-party payment and cash including donations supports the program. Address: 2805 Bering St., Anchorage, AK 99503. 907-561-5266.

Stepping Stones Residential Program – Stepping Stones is a long-term treatment program serving women assessed at an ASAM III.3 level and the children who live with their mothers in 15 individual apartments. It serves individuals with co-occurring disorders and it provides day care for the children while mothers are attending treatment. Most of the women are involved with OCS and are working to regain and retain custody of their children. **Funding:** State grant, augmented by Medicaid. Address: 611 W. 47th Avenue, Anchorage, AK, Mailing address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Akeela Women and Families Program – This program provides outpatient services to women who are assessed at the ASAM I or II.1 level. It offers group and individual counseling for 12 to 18 weeks with an emphasis of relapse prevention. Included is intensive case management for families under the supervision of the Office of Children's Services. **Funding:** State grant augmented by Medicaid and third-party payors. Address: 505 W. Northern Lights Blvd., Anchorage, AK 99503. 907-565-1200.

Akeela Outpatient Program – This is a fee for service program serving men and women who assess at the ASAM I or II.1 level. Available are outpatient and intensive outpatient services that offers group and individual counseling for 12 to 18 weeks with an emphasis on relapse prevention. **Funding:** Third-party payors, contracts with the Federal Bureau of Prisons and Federal Probation and Parole, and self payors augmented by an occasional Medicaid payment. There is no grant support for this program. Address: 3935 Reka Dr., Anchorage, AK 99508. 907-564-7483.

Family Care Court – A division of the Therapeutic Court System, Family Care Court serves women in need of substance use disorder services whose children are wards of the State's Office of Children's Services. They are admitted for treatment at either our women's outpatient or our women's residential program. Family services are provided through this program. **Funding:** Grants support the primary program with treatment

grants and occasional Medicaid augmentation. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Mental Health Outpatient Services – We provide mental health assessments, individual and group counseling and rehabilitation services for all ages. Included are psychiatric services and play and drama therapy with an emphasis on providing a family trauma program serving women and children suffering from trauma. This small program – two staff members – also provides services to treatment clients in our Anchorage based substance abuse programs that need mental health services. **Funding:** Small State grant, Medicaid, and some third-party and cash payments. Address: 3935 Reka Drive, Anchorage, AK 99508. 907-562-7438.

Transitional Housing – Fourteen apartments providing 29 bedrooms are available providing affordable, safe, and drug and alcohol free living for clients coming out of our treatment programs. We support these units with a case manager who works to make sure they are staying clean and sober, coordinates other services for them and assists them to find employment. **Funding:** Rental fee the clients pay augmented by some donations. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

KETCHIKAN

Outpatient Substance Use Treatment – The Gateway Center for Human Services provides outpatient services for men, women and juveniles. Service for clients assessed at the ASAM I to II.1 level are provided along with continuing care following treatment. **Funding:** A combination of grant, third-party payors, fees, and Medicaid. Address: 3052 5th Avenue, Ketchikan, AK 99901. 907-225-4135.

KAR House Residential Program – This program serves clients who are assessed at an ASAM III.1 to III.5 level. It is long-term treatment based on the individual progress of each client. KAR House is a small, 12 beds, co-ed program that provides a modified Therapeutic Community modality of therapy, and services for co-occurring disorders. **Funding:** Primarily grant with some donations. Address: 3134 Tongass Avenue, Ketchikan, AK 99901. 907-225-4135.

Gateway Mental Health Services – Gateway serves as a full-service community mental health service for the rural, southeastern section of the State of Alaska. Services include: children, youth and family services with in-school and wrap around services, adult and couples services, individual and group therapy, rehabilitation services, and community support programs for seriously mentally ill with a drop-in day treatment program. **Funding:** A combination of State grant, third-party payors, cash, and Medicaid. Address: 3052 5th Avenue, Ketchikan, AK 99901. 907-225-4135.

Gateway Psychiatric Emergency Services – On-call mental health clinicians are available 24/7 to respond for all ages suffering behavioral health emergencies. The hospital, police and private providers call on them. **Funding:** Primarily the grant.

Address: 3052 5th Avenue, Ketchikan, AK 99901. 907-225-4135.

Horizon House – Mental health services transitional housing is provided in two duplex style apartments providing a total of six bedrooms. The goal is to provide stable housing for mentally fragile adults pending acceptance into permanent housing. **Funding:** Grant, donations, and Medicaid. 1356 Peyton Place, Ketchikan, AK 99901. 907-225-4135.

SPECIALIZED DEPARTMENT of CORRECTIONS TREATMENT PROGRAMS

Intensive Outpatient Programs – Akeela provides intensive outpatient programs to inmates with a substance use disorder who assess at an ASAM II.1 level, at least. The programs is approximately 90 days in length with continuing care coordinated by the primary counselors either at their discharge location or in the prison if they have more time to serve. This service is provided in the following institutions and communities: Anvil Mountain Correctional Center, Nome; Yukon-Kuskokwim Correctional Center, Bethel; Fairbanks Correctional Center, Fairbanks; Palmer Correctional Center, Sutton; Spring Creek Correctional Center, Seward; and Lemon Creek Correctional Center, Juneau. In addition, an intensive outpatient program is provided by our Anchorage outpatient program to inmates living in halfway houses in Anchorage. **Funding:** State contract. Address: 4111 Minnesota Ave., Funding for all are contracts with DOC. Anchorage, AK 99503. 907-565-1200.

Assessment and Referral – We provide assessment and referral services to inmates located in the correctional facilities in Anchorage and in Palmer. Inmates can receive an assessment followed by referral either to institutional located programs if they are facing long term sentences, or they may be referred to substance use programs in the communities to which they will be released. **Funding:** A DOC contract. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Mental Health Emergency Services – Akeela's Gateway Center provides mental health services to inmates of the Ketchikan Correctional Center. The emergency nature of the services makes it an on-call service, so we respond to calls from the institution for support. **Funding:** A DOC contract. Address: 3052 5th Avenue, Ketchikan, AK 99901. 907-565-1200.

INTERVENTION AND PREVENTION PROGRAMS

Alcohol Safety Action Programs (ASAP) – Provided as an intervention program, ASAP addresses driving offenses involving a mind altering substance. Individuals found guilty of a driving offense are screened and referred to a treatment program for an assessment with treatment to follow if the assessment indicates it is needed, or to an alcohol/driving training program. Staff provides case management for the program participants. The program is available to both adults and juveniles. It is provided by us in

Kenai, Homer, and Ketchikan. **Funding:** A small grant augmented by client fees. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Alcohol and Drug Information School – A certified school program is provide to educate individuals found to be driving while impaired or to juveniles involved in underage drinking. The goal is to provide individuals with information that will prevent them from re-offending. The program is provided in Ketchikan and Anchorage. **Funding**: client fees. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Senior Behavioral Health – Started in Anchorage, this program has developed a broad coalition aimed at addressing the use and abuse of drugs and alcohol by senior citizens. Community development is the primary focus of this program with the goal of helping communities all over the State to develop programs to assist seniors in their communities. A major voluntary drug collection effort was a significant project this year. **Funding:** A State grant and donations. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Harmful Legal Product – This program is a NIDA funded project that operates in 16 rural communities in Alaska from Stebbin in the Northwest to Petersburg in the Southeast. The goal is to work with communities and schools to identify the numerous aerosol products that can be harmful if misused and to develop methods of discouraging and decreasing usage. **Funding** is a Federal grant that comes to us as a contract under the primary grant operated by the Pacific Institute of Research and Evaluation. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

Tobacco Prevention – Akeela operates a program in Anchorage aimed at providing cessation activities for programs such as substance abuse treatment programs in which tobacco use is prevalent. Educational efforts and aids such as patches and supportive medical assistance are made available. **Funding:** A State grant augmented by donations. Address: 4111 Minnesota Dr., Anchorage, AK 99503. 907-565-1200.

State treatment grants all require the grant recipient to provide a 33% match that cannot be provided by another State or Federal grant. The prevention grants require a minimum of a 10% match depending on the specific grant. This means that minimally all treatment grants are leveraged up to a third; $100 becomes $133 in service. State grants also provide the base from which we can contract to provide services thereby increasing the amount of services available throughout the State.

STATE OF ALASKA

Department of Health & Social Services

NOTIFICATION OF GRANT AWARD

PROGRAM	Community Services	GRANT NUMBER	06-2461

Approved Budget Period for FY-92; Start: 7-1-91 - End: 6-30-92

Type of Grant or Action:

New or Renewal [X] Revision of Earlier Grant [ ]

Name and Address of Project	*	Name and Address of Grantee
Akeela House, Incorporated	*	Akeela House, Incorporated
2804 Bering Street	*	2804 Bering Street
Anchorage, Ak 99503	*	Anchorage, Ak 99503
	*	
(907) 561-5266	*	(907) 561-5266

APPROVED BUDGET

Cost Category	State Grant Award*	Required State Match Cash	Required State Match In-Kind	Grant Income Cash	Grant Income In-Kind	Total Project Cost
Personal Services	527,801	15,000				542,801
Travel	8,700					8,700
Facility Expense	44,308		12,000			56,308
Supplies	14,900		43,504			58,404
Equipment	12,169		4,300			16,469
Other Direct Exp	74,361		1,000			75,361
Total Direct	682,239	15,000	60,804	0	0	758,043
Indirect Expense N/A	0					0
Total Cost	682,239	15,000	60,804	0	0	758,043

*This may include Federal funds appropriated by State Legislature.

GRANT CALCULATION

State Funds *	$	682,239
Total Match	$	75,804
Total	$	758,043

Ref: FY 91 Boards' Minutes and Commissioner's final decision dated: 6/24/91

FUNDING SOURCE	CODE	AMOUNT	PERCENTAGE	COMMENT
MHT/GF	06-33-7-300-77520	$52,989	7.77%	
FED/DRUG	06-33-7-525-77520	$154,590	22.66%	
FED/IV-SET	06-33-7-526-77520	$59,591	8.73%	
FED/DRUG	06-33-7-225-77520	$324,680	47.59%	
FED/IV-SET	06-33-7-226-77520	$90,389	13.25%	

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
GRANTS & CONTRACTS
GRANT AGREEMENT

Program Name		Grant Number	602-10-230
Comprehensive Behavioral Health Treatment and Recovery Program		State Fiscal Year	2010
Approved Grant Project Budget Period			
Beginnning	07/01/2009	Issue Date	06/29/2009
Ending	06/30/2010	Amount	$681,225
Grant Duration	Year 1 of 3	Grant Administrator	Myra Pugh
Name and Mailing Address of Grantee		**Facility/Project Location**	
Akeela, Inc. 4111 Minnesota Drive Anchorage, AK 99503		Anchorage	
Phone Number	907/565-1215	Grantee Project Director	Rosalie Nadeau
Fax Number	907/258-6052	Email Address	rnadeau@akeela.org

APPROVED GRANT PROJECT BUDGET

Cost Category	Grant Award		Match		Total Project Cost
	Primary Award	Secondary Award	Required Match	Additional Match / Project Support	
Personal Services	$681,225	$0	$227,075	$0	$908,300
Travel	$0	$0	$0	$0	$0
Facility	$0	$0	$0	$0	$0
Supplies	$0	$0	$0	$0	$0
Equipment	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0
Total Direct Costs	$681,225	$0	$227,075	$0	$908,300
Indirect	$0	$0	$0	$0	$0
Total Costs	$681,225	$0	$227,075	$0	$908,300

Agencies expending $500,000 or more total federal financial assistance in a fiscal year may be required to comply with the Federal Single Audit Act. This grant contains $267,566 in federal funds, identified by CFDA number below.

I certify that I am authorized to negotiate, execute, and administer this agreement on behalf of the agency named above, and hereby consent to the terms and conditions of this agreement including all articles listed on all pages, and all appendices and attachments.

Authorized Grantee Representative: Rosalie Nadeau, Executive Director	Date
X Rosalie Nadeau	7-9-09
Authorized DHSS Representative: Darla Madden, Chief Grants and Contracts Support Team	**Date**
X	

STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
GRANTS & CONTRACTS
GRANT AGREEMENT

Program Name		**Grant Award Number**	602-11-230
Comprehensive Behavioral Health Treatment and Recovery Program		**Fiscal Year**	2011
Approved Grant Project Budget Period			
Beginning	7/1/2010	**Issue Date**	7/6/2010
Ending	6/30/2011	**Amount**	$696,225
Grant Duration	Year 2 of 3	**Grant Administrator**	Myra Pugh
Name and Mailing Address of Grantee		**Facility/Project Location**	
Akeela, Inc. 4111 Minnesota Drive Anchorage, AK 99503		Anchorage	
Phone Number	(907) 565-1200	**Grantee Project Director**	Patrick Ventgen
Fax Number	(907) 258-6052	**Email Address**	pventgen@akeela.org

APPROVED GRANT PROJECT BUDGET

Cost Category	Grant Award		Match		Total Project Cost
	Primary Award	Secondary Award	Required Match	Additional Match / Project Support	
Personal Services	$344,357	$0	$5,000	$110,341	$459,698
Travel	$0	$0	$12,000	$7,605	$19,605
Facility	$115,012	$0	$112,000	$1,466	$228,478
Supplies	$41,887	$0	$86,142	$38,813	$166,842
Equipment	$26,819	$0	$1,500	$0	$28,319
Other	$28,438	$0	$3,000	$20,830	$52,268
Total Direct Costs	$556,513	$0	$219,642	$179,055	$955,210
Indirect	$139,712	$0	$12,433	$47,486	$199,631
Total Costs	$696,225	$0	$232,075	$226,541	$1,154,841

Agencies expending $500,000 or more total federal financial assistance in a fiscal year may be required to comply with the Federal Single Audit Act. This grant contains $267,566 in federal funds, identified by CFDA number below.

I certify that I am authorized to negotiate, execute, and administer this agreement on behalf of the agency named above, and hereby consent to the terms and conditions of this agreement including all articles listed on all pages, and all appendices and attachments.

Authorized Grantee Representative: Rosalie Nadeau, Executive Director	Date
X	7.7.10
Authorized DHSS Representative: Darla Madden, Chief Grants and Contracts Support Team	**Date**
X	7/9/10

UNITED STATES DEPARTMENT OF LABOR

A to Z Index | Site Map | FAQs | About BLS | Contact Us

Subscribe to E-mail Updates GO

BUREAU OF LABOR STATISTICS

What's New | Release Calendar

Home | Subject Areas | Databases & Tools | Publications | Economic Releases | Beta |

Search BLS.gov

Databases, Tables & Calculators by Subject

FONT SIZE: PRINT:

TOP PICKS
SERIES REPORT
DISCONTINUED DATABASES
FAQS
SPECIAL NOTICES
MORE SOURCES OF DATA

CPI Inflation Calculator

CPI Inflation Calculator

$ 682,239.00

in 1992

Has the same buying power as:

$1,065,805.14

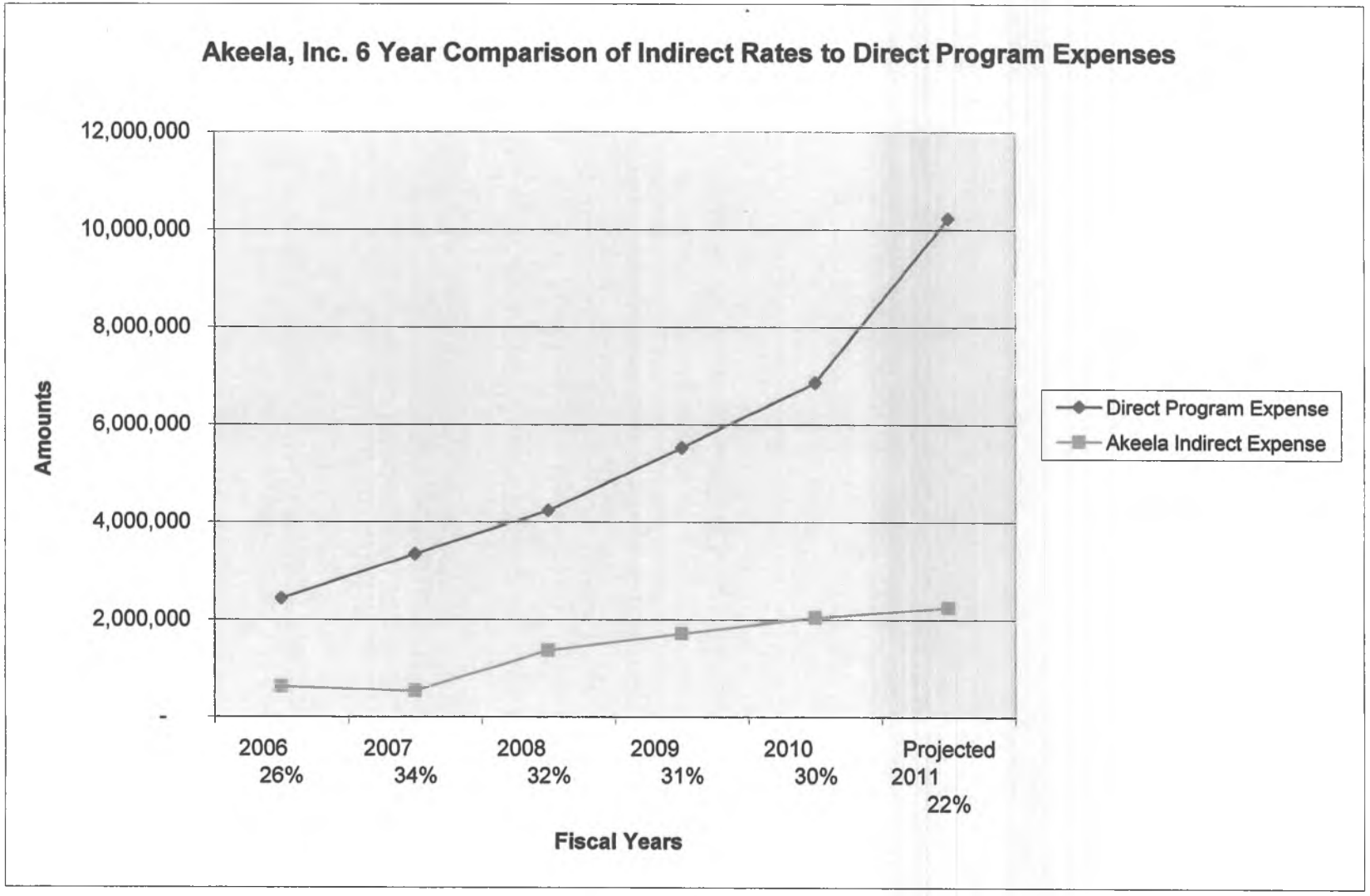
in 2010

Calculate

About this calculator
Mobile Browser? View full screen.

About the CPI Inflation Calculator

The CPI inflation calculator uses the average Consumer Price Index for a given calendar year. This data represents changes in prices of all goods and services purchased for consumption by urban households. This index value has been


Akeela, Inc. 6 Year Comparison of Indirect Rates to Direct Program Expenses
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
-
Amounts
2006
26%
2007
34%
2008
32%
2009
31%
2010
30%
Projected
2011
22%
Fiscal Years
Direct Program Expense
Akeela Indirect Expense

COST REDUCTION THROUGH CONSOLIDATION

The Governor, Commissioner of Health and Social Services, and the Legislature have all expressed concerns about budget containment. Let me offer, to quote a famous author, "A Modest Proposal." Let's look at creative and targeted consolidation of services. By that I do not mean move services out of small communities, but instead move to a system of distance management by which administrative costs can be significantly reduced.

Consolidation has been a key factor in the growth of Akeela over the last 12 years. We believe we have something to add to a conversation on this issue through our experience. In 1999 our Board of Directors' and that of the Alaska Council on the Prevention of Alcoholism and Drug Abuse agreed to merge. That brought two organizations that each had a budget of a little over $1,000,000 under one umbrella. Akeela was the remainder corporation. One executive director and one whole finance office went away leaving us more funds to spend on program. We spent about five years solidifying our services, learning to manage related but different programs, and upgrading systems to make it easier to manage the very diverse programs.

In 2005, we were approached by the Alaska Women's Resource Center (AWRC) about assuming management of its programs. We did so under a contract in early FY-2006 and in the spring of that year after significant analysis, their Board agreed that the best way to preserve their programs was to dissolve the corporation and asked the State to move those grants to us because we had been operating them for most of the year. That was done on April 1, 2006. In the meantime, we had purchased a small, for-profit outpatient substance abuse program in Anchorage in the fall 2005. That meant two executive directors and two financial operations disappeared allowing more funds to be spent on services.

Last fiscal year – May 1, 2010 – we assumed the operation of the Gateway Center for Human Services in Ketchikan. Again, like with AWRC, we worked closely with the Division of Behavioral Health and the City of Ketchikan, the manager of the Gateway programs. We moved all fiscal management under our corporate finance office and retained one administrator and a clinical director thereby eliminating several high cost positions.

We believe we have developed a process that can allow the same funds to serve more clients by using fewer on-site administrators. One Executive Director and one finance director now run the business and financial operation of what were five different corporate entities. Too often small, rural providers have too little money to provide the necessary administration and program services. They attempt to do so by having their administrators double as direct service staff. Most cannot do both jobs, and the agencies suffer as do the clients they serve. In addition, as we look at reductions in funding, small organizations will be forced out of business because they have no place to cut. Add to this dilemma the issue of increasing demands for positive outcomes. With the demand for administration and direct service, small organizations are pressed to demonstrate that they do produce positive outcomes. Thoughtful consolidation could preserve services.

Adding to the pressures all Behavioral Health corporations, especially small ones, feel is the State's demand, as written into the proposed Behavioral Health Regulations that every agency achieves accreditation from a National accrediting agency. This is a $20,000 plus unfunded mandate. While I understand the importance of National Accreditation – Akeela has been nationally accredited since 1997 – for organizations that have seen their funding either flat or reduced for years, funding the effort is a major fiscal hit. We face the same expense, but because our programs are the result of significant consolidation, we pay much less than if all five organizations had a separate accreditation review. We also are better staffed to successfully negotiate the demands of accrediting organizations.

Another factor in adding to the costs, especially for substance abuse providers, is adoption of the new Behavioral Health Regulations. Ten years ago we were mental health services or substance abuse services, not behavioral health services. The staff qualifications for each were very different as were the salary scales. Substance abuse programs with flat or reduced budgets have struggled to employ clinical staff that can serve the more complex clients we are all beginning to see. Akeela has been working to employ staff that meet the higher qualifications required to provide services to dually diagnosed clients, but the Division has never moved to provide specific substance abuse increases to allow agencies to upgrade the staff. That makes us one of the few organizations with a large substance abuse programs that has aggressively move to add increasingly better prepared staff. We believe our move to consolidation has made upgrading staff possible.

COST EFFECTIVENESS STUDY

"A study in Washington State found that drug treatment in the community produces $18.52 in public safety benefits in terms of reduced crime for every dollar spent, whereas treatment in prison produced only $5.88 in benefits, and drug courts less than $2.10 in benefits for every dollar spent."
Tracy Velazquez, Executive Director, Justice Policy Institute [December 27, 2010]

Treatment or Incarceration? National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment by Doug McVay, Vincent Schiraldi, and Jason Ziedenberg January 2004, pages 6-7:

"The Washington State Institute for Public Policy (WSIPP), which does an annual analysis of Washington state and other jurisdictions' criminal justice programs, frames the question of cost-benefits for the state policy makers as, what is the benefit of each dollar of criminal justice programming spending as measured for taxpayers by program costs, and for crime victims by lower crime rates, and less recidivism.

"Drug treatment in prison-such as in-prison therapeutic community programming, or that same program with community aftercare after the person leaves prison-yields a benefit of between $1.91 and $2.69 for every dollar spent on them. By contrast, therapeutic community programs outside of prison-typically work release facilities-yielded $8.87 of benefit for every program dollar spent. The reason for the difference versus in prison treatment programs was mainly due to higher program completion rates and lower recidivism. In writing of the non-prison therapeutic community option, WSIPP writes "the economics of this approach appear quite attractive." Other kinds of non-prison programs also yielded significant benefits. Community-based substance abuse treatment generated $3.30 of benefit for every dollar spent, while drug courts yielded $2.83 for every dollar spent. Treatment oriented intensive supervision programs yielded $2.45 worth of benefit for every dollar spent, and was far more cost effective than simple supervision without treatment."

Here's the link to the study:
http://www.justicepolicy.org/images/upload/04-01_REP_MDTreatmentorIncarceration_AC-DP.pdf ;

Experience our

Culture of Caring

Alaska Health Programs

Office of Health
Programs Development
UNIVERSITY of ALASKA ANCHORAGE

Jan Harris, MSHA, FACHE
Vice Provost, Health Programs

T 907.786.4595 • F 907.786.6511
anjch1@uaa.alaska.edu
www.uaa.alaska.edu/hpd

Physical Address
Diplomacy Building, Suite 402
4500 Diplomacy Drive

Mailing Address
3211 Providence Drive
Anchorage, AK 99508-4614

Training Collaborative

The following organizations provide support, training and education for the workforce and provider agencies serving Trust beneficiaries.

Trust Training Cooperative (TTC)

The TTC promotes career development opportunities for direct service workers and their supervisors by ensuring that technical assistance and training is accessible and coordinated. To learn more, visit **www.trusttrainingcoop.org**. The TTC also provides a Learning Management System, a web-based, one-stop shop for professional training opportunities with an on-line training catalog, registration and tracking of a user's training, conferences and educational participation in an E-Portfolio. See **www.ttclms.org** for details.

Alaska Rural Behavioral Health Training Academy

Alaska Rural Behavioral Health Academy (ARBHA)
ARBHA's mission is to develop and provide training for the behavioral health workforce primarily working in or serving rural Alaska. This University of Alaska Fairbanks based program offers training activities statewide via face-to-face, telebehavioral health, and hybrid delivery models and modalities. While the ARBHTA serves an array of service providers, its target group includes mid and upper-level clinicians, supervisors, and program directors. For more information, visit **www.uaf.edu/arbhta**

Alaska Alliance for Direct Service Careers

Alaska Alliance for Direct Service Careers (AADSC)
AADSC works to improve the flow of information to direct service professionals and the organizations that employ them. AADSC is focused on increasing the awareness of the industry statewide; working to help agencies recruit via a statewide job bank; and helping agencies reduce turnover via technical assistance on recruitment and retention issues. For more information, visit **www.aadsc.org**

Workforce Crisis

Alaska is experiencing a workforce crisis that affects home and community-based health and behavioral health services. Issues pertaining to wages and benefits, recruitment and retention, and training and education impact the accessibility and effectiveness of these services to all Alaskans, especially beneficiaries of the Alaska Mental Health Trust. These beneficiaries include people with:

- Mental illness
- Developmental disabilities
- Chronic alcoholism
- Alzheimer's disease and related dementia.

Growing Alaska's Workforce

To address these problems, The Trust has developed and funds the Workforce Development Focus Area, which aims to develop a capable, culturally competent workforce that can support the communities and families of Trust beneficiaries. The Trust has partnered with the University of Alaska, Alaska Department of Health & Social Services, Alaska Department of Labor & Workforce Development and service providers from across the state to address workforce issues.

For more information, contact Kathy Craft:
907-450-8048
kathryn.craft@alaska.gov

The TRUST
The Alaska Mental Health Trust Authority
www.mhtrust.org

Alaska Psychiatry Residency

- Alaska currently has a critical shortage of at least 25-30 psychiatrists, a deficit of 30%-40%. 40% of Alaska psychiatrists are 50 years of age or older and 29% may retire within five years.

- Four Anchorage health care organizations spent $2.9 million in 2009 for temporary psychiatrists.

- This critical shortage adversely impacts health care access, quality, cost, and outcomes across the continuum of care.

- A coalition of federal and state agencies, hospitals and providers, and the University of Alaska recommend partnering with the University of Washington to create the Alaska Psychiatry Residency.

- The Alaska Psychiatry Residency will emphasize primary care integration, telebehavioral health, and rural consultation.

- There will be 11 residents in training with three graduating annually. The final two years will be in Alaska increasing the likelihood graduates remain in Alaska.

- Stakeholders have promised $2.88 million for the first five years (FY12 – FY16) and more than $500,000 annually beginning year six (FY17). The Governor has included $202,000 in FY12.

- The balance remaining is $3.62 million across the first five years (FY12 – FY16) and $1.62 million annually beginning year six (FY17).

- Alaska is ineligible for new Medicare graduate medical education funding because a cap was imposed in 1997. Medicare is the largest funder of graduate medical education ($8.8 billion in 2007).

- Partners include:
  - Alaska Family Medicine Residency
  - Alaska Federal Health Care Partnership
  - Alaska Mental Health Trust Authority
  - Alaska Psychiatric Foundation
  - Alaska Psychiatric Institute
  - Alaska Veterans Affairs Healthcare System
  - Anchorage Community Mental Health Services
  - Fairbanks Memorial Hospital
  - Joint Base Elmendorf Richardson
  - North Star Behavioral Health Systems
  - Providence Health & Services Alaska
  - Southcentral Foundation
  - Southeast Alaska Regional Health Corporation
  - Tanana Chiefs Conference

Summary: HB 78 Incentives for Certain Medical Providers

Sponsored by Representative Bob Herron

Health Care Professions Loan Repayment & Incentive Program

The following organizations support the loan repayment and incentive solution as outlined in HB 78 Incentives for Certain Medical Providers:

Alaska State Medical Association • Alaska Dental Society • Alaska Primary Care Association • Alaska Osteopathic Medical Association • Alaska State Hospital and Nursing Home Association • Alaska Mental Health Trust Authority • Alaska Native Health Board • Alaska Pharmacists Association • Alaska Physical Therapy Association • AARP-Alaska • Advisory Board on Alcoholism and Drug Abuse • Alaska Behavioral Health Association • Alaska Mental Health Board • Alaska Mental Health Trust Authority • Alaska Public Health Association • Alaska Hygienists Association • Commonwealth North • Iliuliuk Family and Health Services, Inc. • Maniilaq Association • Municipality of Anchorage Senior Citizens Advisory Board • Mary Willard, DDS, Clinical Site Director, Alaska Native Tribal Health Consortium • Alaska Chapter National Association of Social Workers • Nome Eskimo Community • SEARHC • School of Social Work-UA • Dental Hygiene Program-UA • Sunshine Community Health Center

Problem:

Having a sustainable and competent practitioner workforce is vital to the health of Alaskans. However, Alaska is at a serious disadvantage as it competes in the national health care labor market. In other states, "support-for-service programs" (SFSPs) have shown substantial and long-standing success as a cost-effective strategy to address shortages (e.g., loan repayment and direct incentive). A key problem is that Alaska does not have a robust SFSP while 47 other states have one or more SFSPs.

Solution:

The Health Care Professions Loan Repayment and Incentive Program, as outlined in Representative Herron's HB 78 will make Alaskan health care employment competitive and attractive enough for practitioners to want to work in Alaska, particularly in hard-to-fill localities. State funds will be used to ensure that Alaskans with the greatest difficulty in obtaining care due to limited financial resources, cultural barriers, and geography will have access to professional health care services.

Program Description:

1) **Practitioner Eligibility**
   - DHSS Commissioner will annually prioritize the 10 eligible practitioner types:
     - Tier-1: Dentists, Pharmacists, Physicians (MD and DO)
     - Tier-2: Dental Hygienists, Nurse Practitioners, Nurses (RN), Physical Therapists, Physician Assistants, Psychologists, Social Workers (LCSW)
   - A practitioner's clinical duties must constitute at least 50% of duties to be eligible.
   - A part-time practitioner may participate and be eligible for pro-rated payments.
   - Preference may be given to current Alaskan residents.

2) **Payment Detail**
   - Placement Type

		Regular		Hard-to-Fill
Tier 1:	up to	$35,000/year	up to	$47,000/year
Tier 2:	up to	$20,000/year	up to	$27,000/year

   - Duration of award is for a 3-year period of service.
   - Payments will be made every quarter following a completed full quarter of service.

3) **Site Eligibility**
   - DHSS Commissioner will rank eligibility of sites annually and determine any area and/or population in Alaska as a "shortage priority." These may include, but are not limited to, federally defined Health Professional Shortage Areas.
   - Preference will be given to sites that provide care to individuals regardless of insurance status, including persons who are uninsured or have Medicare and/or Medicaid.

4) **Oversight Entity**
   - Department of Health & Social Services will serve as the Oversight Entity.
   - DHSS Commissioner will appoint an advisory body to make recommendations regarding program administration including the identification of shortages, eligible sites, payment priorities and program evaluation.

5) **Program Evaluation**
   - By January 1, 2019, DHSS will submit a report to the Legislature on the program: the participation rates, costs, and the effect on the health care profession shortage areas.

6) **Fiscal Agent**
   - DHSS will serve as Fiscal Agent. DHSS will make loan repayments to the lending institution or eligible practitioners and will make incentive payments to eligible practitioners.

7) **Funding**
   - An in-cash "employer match" is required and is paid on a quarterly basis by eligible sites to DHSS. The level of required match will be adjusted according to the ability of the eligible site to contribute and may be set between 0% and 50%.
   - Program funds will not be used to offset current or expected provider supports.
   - The DHSS Commissioner will reserve funding for not fewer than three very-hard-to fill positions in each of the tier 1 and tier 2 categories.
   - The fiscal note has not yet been released but the expected funding for FY12 is $2.7 million to fund 90 participants for year 1 of their 3 years of service; that is, approximately 9 practitioners in each of 10 occupational categories.

For more information re: HB 78, please contact Shelley Hughes / Alaska Primary Care Association at Shelley@alaskapca.org or 907-841-1634.

RRANN

Recruitment and Retention of Alaska Natives into Nursing

MEETING A NEED

In rural Alaska, the ongoing, well documented shortage of qualified nursing professionals is compounded by a need for nurses who speak indigenous Native languages and are attuned to the cultural traditions and sensibilities of their patients. Honoring the past while working toward the future, RRANN plays an integral part in meeting Alaska's burgeoning need for qualified nurses, and is the key to helping many individual Alaskans to achieve their dreams.

UAA recognizes that Alaska Native students, while deeply motivated to succeed, face unique challenges on their way to meeting their goals. The RRANN program was initiated to increase the number of Alaska Native and American Indian nurses in the state by providing assistance and support, beginning with advice on preparing for college, and following through to include creating a sense of community on campus.

In just its first two years, the program had already successfully doubled the percentage of Alaska Native nurses in the state. But there's still a long way to go.

"I can honestly say that if it had not been for the support of the RRANN program, I would have given up ... "

Michelle Cooper ('08, B.S. Nursing), RRANN graduate

"Recruitment and Retention of Alaska Natives into Nursing opened a door for me to be involved with the community at UAA. It made me feel like a part of a community, like I did in the Kotzebue community. I was able to form lasting relationships and share my culture with other nursing students. I also spent time talking to pre-major nursing students about the program, mentoring them and encouraging them not to give up. The only way to get through the program is to have a sense of community and support."

Marjorie Bolton-Baldwin ('10, B.S. Nursing), RRANN graduate

ACHIEVING A BALANCE

Alaska Natives and American Indians account for about 16 percent of Alaska's population, yet less than 3 percent of nursing professionals fall into that group. To address this disparity, RRANN offers help to prospective students in planning for admission to UAA, as well as information about nursing degree programs and course requirements. Through RRANN, students have access to tutoring, financial aid and on-campus housing options tailored to their needs.

"I now find myself encouraging others to enter the nursing field. I tell them, 'Your hard work will pay off in the end.'"

Andrea Moses ('08, B.S. Nursing) RRANN graduate, currently working at Alaska Native Medical Center

SHOWING THE WAY

In the RRANN program, individual success breeds success for the entire community, with program graduates not only serving as role models for new recruits, but also going on to actively mentor new students in the program.

"My incentive to become a nurse derived from my relationship with my grandmother ... I firmly believe there is more happiness in giving than receiving and I'm ready to spend the rest of my life giving to people as a nurse."

Debra Snider ('05, A.A.S. Nursing), RRANN graduate

"A lack of educational resources in rural Alaska puts many intelligent students at a disadvantage for pursuing their dreams of college and careers. RRANN's pre-nursing support services are designed to help level that playing field, and expand opportunities for success."

Jackie Pflaum, RNC, DNSC, RRANN Project Director/Associate Vice Provost for Health Professions Development

SUCCESS BY THE NUMBERS

Over 120 Alaska Native and American Indian students have graduated from UAA's nursing programs since the inception of RRANN. Looking toward the future, 35 RRANN students are currently in the clinical portion of their nursing studies and are on track to obtain their degrees in the next three years. At least 70 additional students are immersed in their pre-clinical studies.

"My goal is to return to rural Alaska and promote healthier lifestyles, as well as spread awareness about the various diseases that are devastating our villages."

Chelsea Royal, Upper Kuskokwim Athabaskan Pre-nursing Student, RRANN program

UAA
UNIVERSITY *of* ALASKA
ANCHORAGE

For more information about UAA's Office of Health Programs Development, visit http://www.uaa.alaska.edu/hpd/.
To learn how to support UAA's health programs, contact Ivy Spohnholz at (907) 786-1944 or anias2@uaa.alaska.edu

UAA

Health Programs

Health Sciences Building

Health Sciences Building Operating & Maintenance

$591.0 - Regents Budget

Health Sciences Building Staffing

$392.6 - Regents Budget

Above: UAA's HSB will open in August 2011. FY12 request ensures building is fully operational with funding to ensure there is adequate funding for utilities, cleaning and all-season ground maintenance. This is included in the govenor's budget.

Right: Also needed are four positions in support of interdisciplinery clinical simulation laboratories onsite and the distance delivery of simulation statewide. This is not included in the govenor's budget.

Demand for health care workers in Alaska is expected to grow faster than any other employment sector over the next decade. According to the Anchorage Economic Development Corporation's annual report regarding employment, 45 percent of Anchorage's net job growth occurred in health care since 2002 (that's 4,600 new jobs). The same report states that health care jobs increased by 500 in 2010 alone, and forecasts that growth of 300 more in 2011.

In response to the state's growing need for well educated and trained health care professionals, UAA will open its new Health Sciences Building (HSB) in August 2011.

About the HSB

This 66,000-square-foot facility will provide much-needed laboratory space as well as education and instructional space for the health sciences programs.

The building is situated across Providence Drive from the Anchorage campus and will house the following programs:

- medical
- nursing
- clinical laboratory
- physician assistant

Co-location of these programs will provide for efficiency of scale, as well as provide opportunities for interdisciplinary education.

The building will feature:

- Distance classrooms to connect students from rural communities
- Clinical and instructional laboratories and classrooms
- Faculty and staff offices
- Instructional spaces designed for interactive learning, simulation of real-life clinical situations and collaborative hands-on experiences

The facility will allow students an opportunity to integrate theory and practice, think critically and ensure patient safety.

This request covers maintenance and repair needs and the operations component, which are undeniably critical to the building's opening.

Also needed are several positions included in the FY12 High-Priority Program requests.

UAA
UNIVERSITY *of* ALASKA
ANCHORAGE

For more information about UAA's Office of Health Programs Development, visit http://www.uaa.alaska.edu/hpd/.
To learn how to support UAA's health programs, contact Ivy Spohnholz at (907) 786-1944 or ivys@uaa.alaska.edu.

Alaska's AHEC Program

2011 Legislative Session Talking Points

Engage

Train

Recruit

Retain

Summary of request

Alaska's Area Health Education Centers, known as AHEC, with our supporting partners request $500,000 to continue healthcare workforce development activities. As part of the Federal AHEC funding awarded to Alaska in 2005, there is an expectation that states will pick up the funding as federal monies diminish – beginning in September 2011. ($125,000 x 4 Centers; excluding Northwest AHEC)

Background

AHEC is a statewide university-healthcare industry partnership focused on strengthening Alaska's health workforce across the spectrum from "pipeline to placement."

- Since 2005, host organizations have invested a 1:1 match with federal HRSA funds in the Alaska AHEC. **In FY2011, this investment totals more than $1.6 million dollars.** Partners are:
  - Yukon Kuskokwim Health Corporation (YK AHEC)
  - Providence Health & Services Alaska (South Central AHEC)
  - Fairbanks Memorial Hospital (Interior AHEC)
  - Southeast Alaska Regional Health Consortium (Southeast AHEC)
  - Ilisagvik College (Northwest AHEC)

Program highlights

- **Engaging Alaskans into health careers & guiding them into the workforce.**
  - In 2010, *Alaska's AHEC Program touched 4,907 K-12 students, adults, educators and parents in part through partnerships with*:
    - Secondary Career & Technical Education Programs i.e. Alaska Health Careers Academy
    - UAA & UAF programs i.e. U/DOC Della Keats, Pre-Med Summit, Alaska Summer Research Academy
    - Teacher-Industry Externships with UAA & Department of Labor
    - Health Occupations Students of America (HOSA)
    - Maintaining the http://www.healthcareersinalaska.info website
- **Training health professions students through on-site clinical rotations and exposing them to Alaska's hardest-to-fill vacancies**
  - Since 2005, *AHEC supported clinical rotations for 2,419 non-duplicated health programs students*
  - Multi-disciplinary support: allied health, behavioral health, physicians, pharmacy, nursing, therapies, and social work
- **Retaining Alaska's rural health workforce by assessing their needs and increasing access to Continuing Education opportunities**
  - In 2010, *AHEC supported over 6,000 contact hours of CE/CME*
  - Developing preceptor/mentor certification in coordination with UAS & the Alaska Coalition of Educators (ACE)

Contact: Katy Branch, Director, Alaska's AHEC Program Office, 907.786.6705 or ankeb@uaa.alaska.edu

Alaska Commission on Aging
2010 SURVEY OF OLDER ALASKANS

(Do you have access to a computer? If so, you may complete this survey online by going to our website, www.alaskaaging.org, and clicking on the SURVEY button. Otherwise, mail your completed survey to us in the enclosed postpaid envelope, or send to Alaska Commission on Aging, P.O. Box 110693, Juneau, AK 99811-0693.)

1. Your Age: 72
2. Your Gender: ____ Female ✓ Male
3. Your Race: (Check all that apply.)
   ____ African-American / Black ____ Asian / Pacific Islander
   ____ Alaska Native / American Indian ✓ Caucasian / White
   ____ Other, please specify: _____
4. Your Zip Code: 99577
5. How long have you lived in Alaska?
   ____ All my life (born here) ____ 11 to 20 years
   ✓ More than 40 years ____ 5 to 10 years
   ____ 31 to 40 years ____ Less than 5 years
   ____ 21 to 30 years
6. Would you recommend your community as a good place to live for seniors?
   ✓ Yes, unconditionally ____ Yes, with a few reservations ____ No
7. *Please rate the following senior concerns from 1 to 10 based on how much they affect Alaskan seniors in your opinion. A rating of 10 indicates the issue is of great importance. A rating of 1 indicates the issue is of minor importance. For example, if you feel that fuel costs are a very minor concern, you would circle "1"; if you feel it's a very important issue for seniors, you would circle "10". (You may use the same number more than once.*

	Minor Importance									*Great Importance*
Health care	1	2	(3)	4	5	6	7	8	9	10
Financial security	1	2	(3)	4	5	6	7	8	9	10
Fuel costs	(1)	2	3	4	5	6	7	8	9	10
Transportation	(1)	2	3	4	5	6	7	8	9	10
Having enough food to eat	(1)	2	3	4	5	6	7	8	9	10
Affordable, accessible housing options	(1)	2	3	4	5	6	7	8	9	10
Assisted living facilities providing 24-hour care	(1)	2	3	4	5	6	7	8	9	10
Availability of in-home services for seniors	(1)	2	3	4	5	6	7	8	9	10
Information about programs and services	(1)	2	3	4	5	6	7	8	9	10
Mental health and substance abuse problems	(1)	2	3	4	5	6	7	8	9	10
Help for isolated or depressed seniors	(1)	2	3	4	5	6	7	8	9	10
Senior center with a variety of programs and activities	(1)	2	3	4	5	6	7	8	9	10
Other, please specify: _____	1	2	3	4	5	6	7	8	9	10

8. Do you provide home care for a family member or friend? (Check all that apply.)
   ✓ No
   ___ Yes, a spouse or partner age 60 or older
   ___ Yes, a parent age 60 or older
   ___ Yes, a disabled family member under age 60
   ___ Yes, one or more children or grandchildren under age 18
   ___ Yes, a friend age 60 or older
   ___ No, but I am a long-distance caregiver for an elder who lives elsewhere
   ___ Other, please specify: _____

9. Do you visit your senior center?
   - ___ Yes, regularly – at least twice a month
   - ✓ Yes, occasionally – once a month or less
   - ___ No, I would like to but have difficulty getting to the senior center
   - ___ No, I am not interested in what the senior center offers
   - ___ There is no senior center in my community
10. Your estimated net MONTHLY household income from all sources: $ 4500
11. Total number of people living in your household (including yourself): 2
12. Besides yourself, who lives in your household? (Check all that apply.)
   - ___ Just myself
   - ✓ My spouse or partner
   - ___ One or more adult children
   - ___ Other, please specify: _____
   - ___ One or more adult grandchildren
   - ___ One or more grandchildren under age 18
   - ___ Roommate(s) or renter(s)
13. Is your monthly income enough to meet all your monthly expenses?
   - ✓ Yes, with some left over for extras like vacations
   - ___ Yes, but there is very little money left for extras in the budget
   - ___ No, my income is not enough to pay for food, housing, fuel, clothing, medicine, and other necessities
14. At any time in the past 30 days, have you had difficulty paying for any of the following? (Check all that apply.)
   - ___ Food to prepare meals
   - ___ Medications or medical bills
   - ___ Rent or mortgage payment
   - ___ Other, please specify: _____
   - ___ Energy costs – utilities, fuel oil, gas
   - ___ Credit card bill
   - ___ None of the above
15. What are the sources of your household's income? (Check all that apply.)
   - ✓ Social Security
   - ___ Disability payments
   - ___ Pension from employer or union
   - ✓ Wages from employment
   - ___ Income from self-employment
   - ___ Personal savings or investments
   - ___ Senior Benefits program
   - ✓ Rental income
   - ___ Permanent Fund Dividend
   - ___ Native corporation dividends
   - ___ Food Stamps
   - ___ Adult Public Assistance
   - ___ Cash from relatives
   - ___ Rent subsidy (voucher, etc.)
   - ___ Other, please specify: _____
16. What type of housing do you live in?
   - ✓ House/condo that I or a family member own (or have a mortgage on)
   - ___ House/condo that I rent
   - ___ Apartment in senior housing complex
   - ___ Apartment that I rent, not in senior complex
   - ___ Assisted living facility
   - ___ Nursing home
   - ___ Rooming house or hotel
   - ___ Homeless shelter
   - ___ Other, please specify: _____
17. Is your home in need of modification in order for you to be safe and comfortable (example: insulation, ramp installation, grab bars, elevator, etc.)?
   - ___ Yes
   - ✓ No
18. Where do you expect to be living five years from now?
   - ✓ Same home as I live in now
   - ___ Same community, but smaller living space
   - ___ Living independently in a larger community in Alaska
   - ___ Living independently in a smaller community in Alaska
   - ___ Other, please specify: _____
   - ___ Living independently in a different state
   - ___ Move to an assisted living or nursing facility in Alaska
   - ___ Move to an assisted living or nursing facility outside Alaska

19. Are you currently employed or self-employed?
___ Yes, full-time ___ No, but I am seeking work
___ Yes, part-time ___ No, I am retired

20. If you are currently still working, when do you expect to retire? (Skip this question if you are already retired.)
___ Within the next year or two
___ Within the next two to five years
___ More than five years from now
___ I can't afford to retire
___ I don't plan to retire even if I can afford to

21. Do you participate in subsistence activities (hunting, fishing, gathering) during subsistence season?
___ Yes, for an average of less than two hours a week
___ Yes, for an average of two to five hours a week
___ Yes, for an average of more than five hours a week
___ No

22. Do you do volunteer work in your community? (Check all that apply.)
___ Yes, with my church or house of worship
___ Yes, with a civic organization (example: Rotary)
___ Yes, with a charitable organization (example: Red Cross)
___ Yes, with a non-profit organization (example: senior center)
___ Yes, with a library, school, or educational institution
___ No, I do not volunteer because I don't have time right now
___ No, I do not volunteer at this time due to disability or ill health
___ No, I do not volunteer at this time due to difficulties with transportation
___ No, I do not volunteer at this time because I don't know how to find the right opening
___ Other, please specify: _____

23. Total hours per week you spend in volunteer work (estimate an average): 2

24. Where do you go when you have questions about the services available for seniors? (Check all that apply.)
___ Local senior center
___ Other local non-profit agency
___ Aging & Disability Resource Center
___ Independent Living Center
___ Pamphlets or handouts
___ Printed directory showing services by community
___ Dial 2-1-1
___ Internet search or specific website with service information
___ Senior housing staff
___ Hospital social services department
___ Check the phone book for possible information sources
___ Ask a friend or relative for help finding the information
___ Other, please specify: _____

25. What would be the BEST way for you to get the information you need about programs and services?
___ Toll-free number to call, with live answer
___ Toll-free number to call, with push-button options
___ Website with search features
___ Pamphlets, handouts, or printed directory
___ Speak to someone in person at senior center or other agency
___ Speak to someone in person in my housing complex or neighborhood
___ Other, please specify: _____

26. In the last TWO WEEKS, on how many occasions have you gotten together with family, friends, or a group you belong to for an event or activity, either outside your home or at your home? (For example: parties, movies, concerts, games, classes, dinners, senior center meals....)

___ None
___ Once
✓ Two or three times
___ Four or five times
___ More than five times

27. In the past year, have you had trouble finding a primary care doctor to see you when you needed to see a doctor?

___ Yes, because of Medicare payment issues
___ Yes, because there are not enough doctors in my community
___ Yes, for another reason (tell us below)
✓ No
___ Haven't needed to see a doctor in the last year
___ Other reason for trouble finding doctor: _____

28. Do you experience an illness or disability that limits the range of activities you can enjoy? (Check all that apply.)

✓ No
___ Yes, a chronic disease such as heart disease, diabetes, etc.
___ Yes, a physical disability such as low vision, knee or hip problems, etc.
___ Yes, other physical health problems
___ Yes, Alzheimer's or other type of dementia
___ Yes, a mental or emotional problem such as depression, anxiety, etc.

29. *If you have used any of the following services in the past year, please tell us how satisfied you were. For example, if you were "very satisfied" with home-delivered meals you received, check "4." If you were "very unsatisfied," check "1". A "5" indicates that you didn't use the service in the past year, and a "6" means that the service isn't available in your community. Use the "additional comments" space to tell us how the service made a difference to you, or how it* could *be improved.*

	1=very unsatisfied	2=mostly unsatisfied	3=mostly satisfied	4=very satisfied	5=did not use	6= not available in my community
Meals at a senior meal site	1	2	3	4	5	6
Home-delivered meals	1	2	3	4	5	6
Senior transportation	1	2	3	4	5	6
Information & referral	1	2	3	4	5	6
Care coordination	1	2	3	4	5	6
Chore service	1	2	3	4	5	6
Respite care	1	2	3	4	5	6
Personal care attendant	1	2	3	4	5	6
Adult day program	1	2	3	4	5	6
Caregiver support program	1	2	3	4	5	6

30. ***Additional Comments: Please add any specific comments you have on the services you have used, OR ANY OTHER TOPIC THAT IS IMPORTANT TO YOU. What is working well? What needs improvement?***

I BELIEVE THAT PEOPLE ARE DESIGNED TO WORK AT MEANING-FULL TASKS - WE WILL NOT BE FULFILLED LAYING AROUND
I BELIEVE THAT GOOD HEALTH NEED LOTS OF VERY ACTIVE EXCERCISE AND MENTAL STIMULATION
I BELIEVE THAT "SENIOR CARE" SHOULD COME FROM WELL RAISED KIDS

UNIVERSITY
of ALASKA
Many Traditions One Alaska

Health Programs

PO Box 755010
Fairbanks, AK 99775-5010

Tel: 907-450-8016
Fax: 907-450-8002

www.akhealthcareers.org

ALASKA HEALTH WORKFORCE PLAN

Prepared by the Health Workforce Planning Coalition for presentation to the Alaska Workforce Investment Board

May 2010

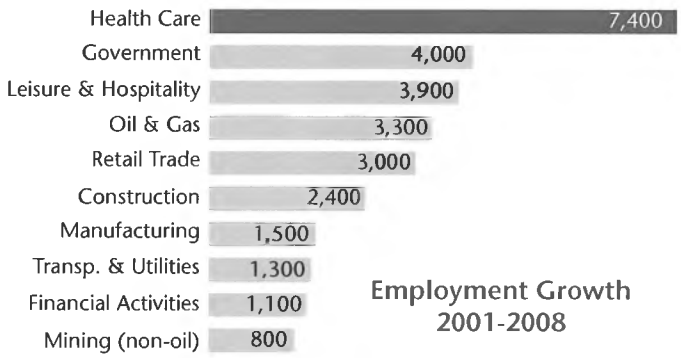
Executive Summary

Health care is one of the largest and most dynamic industries in Alaska, accounting for eight percent of total employment and around 16 percent of the value produced by the state's economy. Between 2000 and 2009, health care employment increased 46 percent, about five times as fast as the state's population and three times as fast as all other sectors of the economy.

This plan is a consensus of the strategies that must be employed to meet Alaska's most pressing health workforce needs. It is a result of a year-long, industry-led process with active involvement from education and governmental sectors. While there have been many large health workforce expansions and plans around specific occupations, this plan is the most comprehensive statewide effort to date, targeting key occupations with severe shortages.

This growth is expected to continue. Department of Labor and Workforce Development (DOLWD) data indicate a 30 percent growth rate between 2004 and 2014, twice that of the overall economy. Currently, 11 of the top 15 fastest growing jobs in Alaska are in this sector.

Additionally, federal health reform is expected to significantly increase the demand for providers.



Source: Alaska Department of Labor and Workforce Development, Research and Analysis

The Need:

While job growth is good news for the economy, it also places heavy strains on an industry already burdened by unacceptably high vacancy rates in key occupations. State rates for primary care professions, as determined by the 2009 Health Workforce Vacancy Study conducted by the Alaska Center for Rural Health, range from 12.9 percent for community health aides and practitioners to 37.4 percent for pediatric nurse practitioners. Though registered nurses had a comparatively moderate vacancy rate at 10.1 percent, this relatively large profession was calculated to have over 320 vacant positions.

The above vacancy rates are statewide averages; rates in rural Alaska are even more dramatic. These vacancy figures coupled with anticipated high increases in demand for workers indicate a significant skills gap in the health care workforce at the present time, a gap that without increased attention can only worsen.

The Promise:

Health care positions are found in all regions of the state, offering close-to-home employment for many Alaskans. Although some positions require advanced training, many jobs are entry-level, requiring limited preparation. Often, these entry-level positions are the start of a career ladder or lattice that can—with additional experience and education—lead to life-long, meaningful careers.

Through public and private postsecondary education institutions in the state, Alaskans currently have access to education and training in more than 80 health care occupations. This combination of local jobs, opportunity for advancement and access to in-state training makes the health care industry a primary mover in putting Alaskans to work.

The Strategy:

The Health Care Workforce Development Plan addresses the challenge of assuring a well-prepared and sufficient workforce to meet Alaskans' health care needs through four strategies: Engage, Train, Recruit, Retain.

Alerting Alaskans to the opportunities available in the health care field is a first step in securing the necessary workforce. Public information campaigns, K-12 career awareness and exploration and outreach to Alaskan job seekers are elements of the Engage strategy.

Preparation for a health care career often starts at the secondary level, where prerequisite math, science and communications skills are developed. Quality, standards-based postsecondary education delivered as close to home as possible is a next step

along a career path in health care. As the practice of health care changes through technology, health reform, or new care models, those employed in the industry must upgrade skill levels. Finally, experienced teachers must be available to deliver the necessary education and training at all levels. Strengthening secondary math, science and career education, expanding access to training programs in priority occupations, providing continuing education and securing the necessary faculty are elements of the Train strategy.

Although the plan speaks to significant expansion of health care career training and education in the state, the size and complexity of the industry indicate that recruitment from outside of Alaska will continue to be needed to fill some positions. Alaska can improve its competitiveness with others seeking similar skilled professionals by more widely disseminating information about employment opportunities and offering more post-graduate experiences within the state. State and federal-supported loan repayment and other financial and quality-of-life incentives can sway the decision to locate or stay in Alaska. Finally, more coordination in recruitment by health care providers could reduce costs. All of these approaches are elements of the Recruit strategy.

The final plank in the health care plan is to retain the workforce that has been educated and recruited. To do so requires successful transitioning from training into the world of work and employment that offers sufficient remuneration, adequate supervision and opportunities for professional growth. Assisting employers to provide these workplace elements make up the Retain strategy.

Plan Phases:

The Steering Committee considered several time horizons in developing the plan strategies: short term (within the next two years), medium term (within three to five years) and long term (five years or more in the future). A key focus of the plan is in training for and development of specific occupations. From data collected by the Departments of Labor and Health and Social Services, the University of Alaska and other sources, the planning group identified 15 occupational groupings encompassing 26 individual occupations and careers requiring action in the short term.

The following occupational groups are included in this plan:

Behavioral Health Aide/Village Counselor
Primary Care Physician
Advanced Nurse Practitioner
Substance Abuse Counselor
Registered Nurse
Community Health Aide/Practitioner
Social Worker
Oral Health Practitioner
Psychiatrist
Human Services Worker
Pharmacist
Therapist and Therapist Assistant
Nurse Educator
Health Informatics Staff
Direct Care Worker

Details for applying the plan to these priority occupational groups are found in Section 4. Here, the occupations are described with relevant data on vacancy rates, educational qualifications and training opportunities, followed by suggested strategies under the four broad strategies of Engage, Train, Recruit, Retain. Occupational and training data will be reviewed and updated annually, at which time—due to changes brought about by reform efforts, population shifts and/or adoption of new models of care—additional occupations may emerge as high priority.

The Role of AWIB:

Endorsement by the Alaska Workforce Investment Board (AWIB) of this health workforce plan is essential for assuring a coordinated approach to implementation. Representatives of the three key state departments involved in delivering plan elements—Health and Social Services, Labor and Workforce Development and Education and Early Development—sit on the Board as do representatives from health industry employers. The University of Alaska, the major training provider for health care careers, is also a member. This mix of government agencies, industry and training institutions provides a mechanism for collaborative efforts in addressing the workforce strategies outlined in the plan. In addition, AWIB's stewardship responsibilities for federal and state workforce development funds can direct needed resources to support the plan. Data collected from public and private training providers as part of the Board's oversight duties will allow for annual checks of progress toward meeting training goals and targets.

Purpose:

The heath care plan is anchored in collaboration and builds on earlier successful cooperative efforts, such as the expansion of the UA nursing program, the addition of slots at the University of Washington Medical School through WWAMI, participation in the National Health Service Corps and Indian Health Service loan repayment programs

and the creation of a Health Care Commission. Under the governance structure that is being developed to oversee plan implementation and monitoring, these collaborations will be made more formal through memoranda of understanding among stakeholders.

The Alaska Health Workforce Development Plan is indeed a call for action: a call that has already been heeded by industry, education and training institutions, state government and professional organizations. Successfully directing the energies and resources of these stakeholders through the steps outlined in the plan will not only increase the size and quality of the health care workforce but will be reflected in a higher standard of health for all Alaskans.

Table of Contents

Section 1
Steering Committee Members **2**

Section 2
Introduction **3**

Section 3
Overall Health Workforce Development Strategies **8**

Section 4
Occupation-Specific Strategies for Priority Occupations **23**

Section 5
Alaska Occupational Forecast **43**

Section 6
Appendix **44**
Acronym List
Documents Cited in the Plan

Steering Committee Members

Industry Members

Kitty Farnham
Regional Director Strategic Planning
Providence Health and Services
(907) 212-8423
Katherine.Farnham@providence.org

Jim Lynch
Chief Financial Officer, Chair, Alaska Workforce Investment Board
Fairbanks Memorial Hospital
(907) 458-5305
jim.lynch@bannerhealth.com

Dennis Murray
Director of Long Term Care and Workforce Development
Alaska State Hospital and Nursing Home Association
(907) 646-1444
dennis@ashnha.com

Ellen Maling
Manager, Regional Grants Program
Providence Health and Services
(907) 212-8386
Ellen.Maling@providence.org

Training & Education Members

Karen Perdue
Associate Vice President for Health
University of Alaska
(907) 450-8017
karen.perdue@alaska.edu

Jan Harris
Vice Provost for Health Programs
University of Alaska Anchorage
(907) 786-4595
anjch1@uaa.alaska.edu

Rick Rios
Coordinator, Office of Career & Technology Education
Anchorage School District
(907) 742-8942
Rios_Rick@asdk12.org

State Agency Members

Helen Mehrkens
Administrator of Career and Technical Education
Department of Education & Early Development
(907) 465-8730
helen.mehrke0ns@alaska.gov

Patricia Carr
Section Chief, Health Planning & Systems Dev.
Dept. of Health and Social Services
(907) 465-8618
PCarr@health.state.ak.us

Kathryn Craft
Workforce Development Coordinator; Alaska Workforce Investment Board
Dept. of Health and Social Services
(907) 450-8048
kathryn.craft@alaska.gov

Louise Dean
Program Coordinator
Alaska Workforce Investment Board
(907) 269-7487
louise.dean@alaska.gov

Consultant/Writer

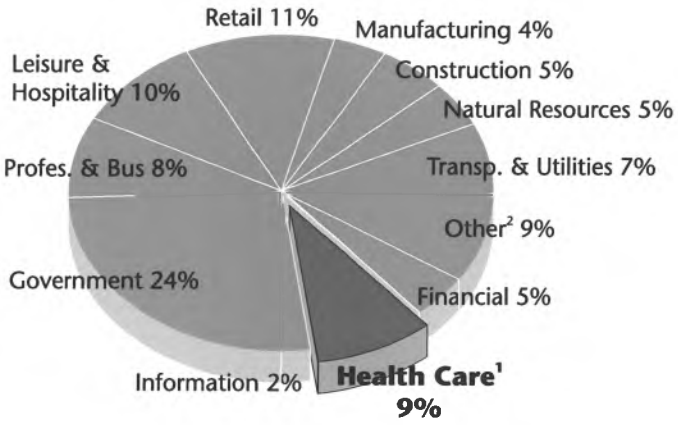
Mary Lou Madden
President
Madden Associates
(907) 523-7783
madden@alaska.com

Introduction

The health care industry is important to Alaska and Alaskans

Health care is one of the largest and most dynamic industries in Alaska, accounting for eight percent of total employment and around 16 percent of the value produced by the state's economy. One out of every 12 employed Alaskans works in the industry; one out of every six dollars spent in Alaska is spent on health care. The industry also accounts for a significant portion of economic growth. Between 2000 and 2009, health care employment increased 46 percent, about five times as fast as the state's population and three times as fast as all other sectors of the economy. With a payroll of more than $1.4 billion in 2008, it employed more people than state government, oil industry or most other industries.[1]

Health Care: One of the Biggest Players in Alaska's Labor Market



[1]Includes the private and public sectors, 2008
[2]Includes other services, private education services, social assistance and wholesale trade
Source: Alaska Department of Labor and Workforce Development, Research and Analysis

This growth is estimated to continue. Department of Labor and Workforce Development (DOLWD) data indicate a 30 percent growth rate between 2004 and 2014, twice that of the overall economy. Around 15 percent of the state's new jobs in that period will come from health care; currently, 11 of the top 15 fastest growing jobs in Alaska are in this sector.

While job growth is good news for the economy, it also place heavy strains on an industry already burdened by unacceptably high vacancy rates in key occupations. For example, state rates for primary care occupations as reported by 747 surveyed employers for a 2009 University of Alaska study[2] range from 12.9 percent (community health aide/practitioner) to 37.4 percent (pediatric nurse practitioner). Other troubling rates include occupational therapist and physical therapist at 22.8 and 15.8 percent respectively. Though registered nurses had a comparatively moderate vacancy rate at 10.1 percent, this relatively large profession was calculated to have over 320 vacant positions. These rates indicate a significant skills gap in the health care workforce at the present time, a gap that without increased attention can only worsen.

Recognizing these conditions, the Alaska Workforce Investment Board (AWIB) has targeted health care as one of the industries critical to Alaska's workforce and economic needs. The Alaska Health Care Commission and many other agencies and groups, such as the Department of Health and Social Services, The Alaska Mental Health Trust and the Alaska State Hospital and Nursing Home Association (ASHNHA), have identified health care workforce development is one of the most critical priorities in assuring health care access in Alaska.

The health care industry has unique features

Health care has unique features that distinguish it from other industries—features of Impact, breadth, scope and outlook. These characteristics add to the urgency of assuring that Alaska has a well prepared and sufficient health care work force.

Impact—The health care industry touches almost every Alaskan, from the newborn infant in Ketchikan General Hospital to the elder in Barrow's assisted living facility. The overall health of the state's citizenry is intimately tied to the adequacy and competence of the health care workforce. Meeting Alaska's targets for improved health as envisioned in Healthy Alaskans 2010[3] in the areas of health promotion, health protection, preventative services and access to health care requires attention to the development, upgrading and retention of workers who can address these targets.

Breadth—Health care industry employment can be found in almost every location in the state.

[1] Alaska Department of Labor and Workforce Development, *Alaska's Health Care Industry*, Alaska Economic Trends, March 2010, p.
[2] Alaska Center for Rural Health, University of Alaska Anchorage, *2009 Alaska Health Workforce Vacancy Study (Draft)*, January 2010.
[3] Alaska Department of Health and Social Services, Division of Public Health, *Healthy Alaskans 2010, Targets and Strategies for Improved Health*, November 2005

Although about half of the jobs are in hospitals and nursing homes, the other half are with small health care provider offices, outpatient and community health centers and home health care. The State of Alaska also provides many career opportunities in the health care field. This breadth indicates that job opportunities are available close to home for many Alaskans.

Scope—Perhaps no other industry employs front-line workers with such a wide range of educational backgrounds, from high school diploma or GED through post-doctoral specialization. Although the industry utilizes many highly-skilled professionals, a large portion of health care is provided by direct service workers, who assist Alaskans dealing with mental health problems, substance abuse, medical illnesses, developmental delays and disabilities, elder care and social stressors. Career ladders and lattices exist that can move workers to higher-level positions. This wide scope of employment allows many Alaskans to access the industry through entry-level jobs and to construct meaningful, life-long careers.

Outlook—Demand for health care is not cyclical, unlike that for most Alaskan industries. This has distinct advantages. As reported by DOLWD, health care is one of a handful of industries expected to grow in 2010—adding about 500 jobs—while most other sectors will continue to experience a decline.[4] Because it is not subject to sudden downward shifts in demand, the output from training programs can more easily be matched to current and future industry needs.

While health care is relatively free from the effects of economic fluctuations, it is highly susceptible to other influences. At least four factors are currently driving higher demand for health care services and therefore increasing the need for workforce development: reform efforts, demographics, changes in care models and technology.

Health care reform will greatly expand demand for care, adding coverage for tens of thousands of Alaskans who were previously un- or underserved. The increased demand from this population is likely to be in areas such as primary care, therapies and behavioral health that currently experience high job vacancy rates throughout the state. Reforms will also spur the growth of new classes of health care positions such as continuum of care managers and health information technicians.

An aging Alaskan population also contributes to increased demand for services. In the decade between 1996 and 2006, the number of Alaskans 65 years and older increased 50 percent, from 30,440 to 45,489. In the latter year, older Alaskans accounted for 6 percent of the total population. DOLWD estimates indicate that this age segment will reach around 134,400 persons by 2030, or about 16 percent of the population. This demographic shift has tremendous implications for workforce development, not only in numbers but also in types of workers needed, such as geriatric nurses, nurse practitioners, psychiatrists, licensed practical nurses (LPNs) and certified nursing assistants (CNAs).

Changes in care models and care objectives will also change the face of the workforce. For example, the move to more outpatient services increases the demand for home health care workers. An emphasis on prevention requires increases in occupations such as health educator and wellness trainer.

Technology influences the health care workforce in many ways. First, access to higher levels of medical technology within the state has an "import substitution" effect on demand as an increasing share of Alaskans can meet their health care needs locally rather than going out of state. Generally, this effect heightens the need for highly-trained specialists. Increasing uses of technology in all areas of care also require continuing skill attainment and development on the part of the existing workforce at all levels, from direct service worker through specialist. Implementation of electronic health records will require the creation of new job classes and related training. Finally, technology—in particular simulation and the Internet—can vastly increase access to health care career education and training.

Because of the above factors, several of the strategies identified for successful workforce development in health care will differ from those in other industries. Recruitment of health care providers that cannot be trained or trained in adequate numbers in the state will remain a central activity. Retention, while a significant concern in all industries, assumes greater importance when high turnover can affect Alaskans' access to critical medical and therapeutic services.

The health care workforce planning process is collaborative

To begin to address these workforce issues and to craft a statewide plan for workforce development, a Health Care Workforce Coalition made up of health care providers, agencies, educators and associations was formed in August, 2009. A steering team from the larger coalition, comprised of

[4] Alaska Department of Labor and Workforce Development, *Employment Forecast for 2010*, Alaska Economic Trends, January 2010, p. 11

representatives from industry, state government and the University of Alaska met regularly to work on the plan. The basic plan strategies were presented to the larger provider community for discussion and further refinement at the ASHNHA Health Care Workforce Summit in November, the Alaska Public Health Association Health Summit in December, 2009, and to various smaller groups. Audio-conferences with the Coalition allowed member input throughout plan development.

The planning group early on agreed on several underlying principles. First, although health care workforce development is a statewide issue, the need is especially acute in rural Alaska. The difficulties involved in training, recruiting and retaining health care workers in the more remote parts of the state require increased attention to distance education that trains people to work in their home community, financial and other incentives for attracting needed specialists, community involvement in recruitment and retention and opportunities for professional growth.

Second, because the training needs of the health care industry are substantial and relatively costly, the planning group recognized that particular care must be taken to assure that resources—both public and private—are allocated to areas of highest need, avoid needless duplication and utilize existing institutions wherever possible. The priority occupations treated in Section 4 of the plan have been identified as needing immediate attention for one or more of the following reasons: high vacancy rate, high number of vacancies or criticality to health care delivery. The governance structure that will be developed to oversee plan implementation will be a major tool for assuring coordinated, effective and efficient resource use.

Finally, the group agreed that all training under the plan must be directed at meeting industry standards, state and national licensing requirements and the quality benchmarks established by educational program accreditation agencies. These principles of access, efficiency and quality permeate the plan document.

Because the health care industry in the state is so diverse and covers so many disparate occupations, many of the overall strategies in the following plan are broad and general in nature. Several of the strategies and many of the action steps echo those in other industry plans, particularly the call for broad public awareness and support for developing a pipeline of new workers through the revitalization of K-12 career awareness and technical education programs. To achieve these goals will require a cooperative, coordinated effort by many industries and agencies.

Health care workforce planning builds on successful partnerships

The planning group acknowledged the considerable cooperative effort that has already been made in developing the health care workforce. For example, a strong partnership between industry and the University of Alaska School of Nursing succeeded in doubling the number of nursing graduates between 2003 and 2007. Industry/university collaboration has also led to the introduction, expansion or revision of more than 80 health care-related UA certificates and degrees over the past ten years. New UA programs such as the bachelor degree in nutrition are coming on line to address emerging critical needs.

A coordinated effort by industry resulted in a doubling of medical school slots for Alaska students at the University of Washington through the WWAMI program. Combined industry, government and association advocacy has also spurred the creation of a Health Care Commission and the introduction of several pieces of legislation to provide loan repayment and other financial incentives for health care professionals practicing in Alaska. The Behavioral Health Initiative partnered the University of Alaska, the Alaska Mental Health Trust Authority and the Department of Health and Social Services to address the severe workforce shortages experienced in the behavioral health field at all levels of licensure and credentialing.

Implementing the health care-specific strategies and action steps in the plan will require the continued participation and coordination of many partners: industry/employers, education and training providers, government and professional associations. Each group contains many stakeholders.

Industry/employers include the broad range of health care providers—public, private and nonprofit—that extend health care services to Alaska's residents. Among these are hospitals, health clinics, tribal health organizations, private practice offices, state and local public health agencies and mental/behavioral health programs and treatment centers.

Education and training providers include the University of Alaska, Alaska Pacific University, the Alaska Vocational Technical Center (AVTEC), the Alaska Technical Center (ATC), Yuut Elitnaurviat and other regional training centers, private training providers and out-of-state institutions that have partnered with an Alaskan institution to offer a specific program within the state.

Government agencies involved in health care workforce development include the state departments of Health and Social Services, Labor and Workforce Development, Education and Early Development and Commerce, Community and Economic Development (Licensing), the Alaska Mental Health Trust Authority and local government public health offices. With the passage of health care reform, the federal government is also assuming a larger role in supporting health workforce planning and training.

Professional organizations encompass a variety of groups such as the Alaska Public Health Association, the Alaska Primary Care Association, the Alaska Nurses Association and other health care membership organizations such as ASHNHA.

In addition to the above groups, health care is served by the Alaska Area Health Education Center (AHEC) network—a university-industry partnership directed at strengthening Alaska's health workforce serving rural and other underserved populations. The AHEC network plays an important role in encouraging Alaskans to pursue careers in health and behavioral health care, providing clinical rotation sites and delivering continuing education to health care practitioners.

In the following plan, the first partner category listed under "Responsible Parties" in any sub-strategy is assumed to be the prime mover for that particular strategy, although the support and involvement of other listed partner groups is essential for success.

Health care workforce planning is on-going

The plan is intended to encompass rather than replace the workforce development efforts of other professional groups and health care organizations. The strategies outlined in the plan become real through application to a specific occupation, as can be seen in Section 4 that links strategies to the top priority occupations identified by vacancy data and other information.

The plan is not complete; rather it is a work-in-progress that will be revisited and revised over time as occupation-specific action plans are developed, successes are achieved and circumstances change.

The health care workforce development plan embraces AWIB principles

In preparing the plan, the steering group was cognizant of the need to address the following principles found in Alaska's Future Workforce Strategic Policies and Investment Blueprint, which was adopted by AWIB in 2000 to serve as the comprehensive guide for alignment of public policy and resource investments in vocational and technical education and training programs statewide.[5]

The plan is needs driven, based on data provided by the Research and Analysis Section of DOLWD, the Alaska Center for Rural Health, the Office of the Associate Vice Provost for Health Programs, University of Alaska Anchorage and DHSS Health Planning and Systems Development Section. Occupational supply and demand data were distributed to participants of the ASHNHA, Alaska Public Health and Behavioral Health conferences and to members of the Alaska Medical Group Management Association and the Alaska Native Tribal Health Consortium to gain consensus on the priority occupations detailed in Section 4. Strong industry leadership and involvement in the planning process assured that both current and emerging workforce needs would be addressed.

The plan extends access to health care occupations by creating awareness of career opportunities, utilizing distance delivery and simulation in health workforce education and training programs and increasing financial support for pursing health care careers. As mentioned above, the need to strengthen training, recruitment and retention of health care workers in rural Alaska was at the forefront of the planning effort.

The plan is interconnected, extending the use of career pathways to link secondary and post-secondary education and expanding post-employment training and advancement. It incorporates the state's job center system both to advertise job openings and to counsel job-seekers into training for health care positions.

The plan is accountable. All of the training and education under the plan is based on industry standards and most programs lead to state or national certification. Programs offered under the plan that utilize state or federal workforce development funds will report annually on the outcomes of the training in terms of number of participants and completers, placement of graduates and gains in income.

The plan will be collaboratively governed. The governance structure to be developed in a sustainability plan will include industry, tribal health organizations, appropriate government agencies, the University of Alaska and other training partners. The plan closely aligns with the AWIB emphasis on training Alaskans for high demand, high wage jobs.

[5] Alaska Workforce Investment Board, *Alaska's Future Workforce: Strategic Policies and Investment Blueprint, 2002, p. 1*

The plan will be sustained. The sustainability plan will detail the linkages between plan strategies and the mission and operational responsibilities of the involved partners. These linkages will be made concrete through memoranda of understanding outlining such activities as shared staffing, joint grant applications and other mechanisms to assure that parties carry through with assigned responsibilities for implementing the plan. The sustainability plan will call for an annual review of accomplishments and modifications to the plan as new opportunities and challenges arise.

Endorsement by AWIB is a critical step in moving the plan forward and securing the financial and other support necessary to assure that plan strategies are actualized.

Overall Health Workforce Development Strategies

Strategy 1

Engage Alaskans in health care workforce development

Alaskans need information about career opportunities afforded by the health care industry in the state—careers that are in demand in all regions, provide stable employment and encompass all educational levels, from on-the-job training through postgraduate programs. Alaskans also should be aware of the link between a well-trained, sufficient health care workforce and the overall health of the state's citizenry. Finally, voters and policy makers need reliable information about public policy and financing options that can impact health care work force development.

This strategy can be implemented by:

- Conducting public awareness campaigns on general workforce development issues and the full continuum of jobs available
- Expanding career awareness and counseling that highlight health career pathways in Alaskan schools
- Developing targeted marketing for high need professions
- Utilizing the existing one-stop information system to disseminate information on training opportunities and job openings in Alaska to job seekers

Funding

- Industry/employers
- Private foundations (e.g., the Robert Wood Johnson nationwide nursing career promotion)
- Alaska School Foundation funding
- State General Fund
- Youth Workforce Development funds
- Alaska Native Health Corporations
- Alaska Mental Health Trust Authority (AMHTA)

Strategy 1.1 Create public awareness

Rationale: Health occupations comprise 11 of the 15 fastest growing occupations in the state and employers report difficulty in attracting qualified workers. The most recent Alaska Health Workforce Vacancy Study[6] identified a range of vacancy rates in various occupations, with generally higher rates in rural Alaska. The demand is expected to increase as a result of health care reform, changes in care models, demographic shifts and retirement of older workers. Alaskans need accurate and timely information not only for career counseling and planning but also to develop and support the policy and funding initiatives needed to address critical health care workforce shortages.

Action Steps

- Develop a consistent, multi-faceted public awareness campaign that highlights the link between an adequate health care workforce and the overall health of Alaskans
- Implement communication strategies for the full continuum of job opportunities, with particular emphasis on reaching rural, Alaskan Native and minority residents
- Provide opportunities for public dialog on policy and funding issues around health care workforce development

Timeline

- Short term

Responsible Parties

- Industry/employers
- Government (DHSS)
- Education and training providers
- Professional organizations and boards
- AHEC

Resources

- Publications and data
  - *Healthy Alaskans 2010*
  - *Alaska Health Care Data Book*
  - *Alaska Health Workforce Vacancy Study 2007 and 2009 update*
  - Alaska DOLWD employment projections

[4] Alaska Center for Rural Health, *2009 Alaska Health Workforce Vacancy Study*, (Draft) January 2010.

- Alaska Center for Rural Health studies and publications
- Securing an Adequate Number of Physicians for Alaska's Need, Physicians Task Force Report

- Funding
  - Industry
  - Private Foundations
  - State General Fund
  - State and federal grant funds
  - University of Alaska general funds
  - Alaska Native Health Corporations
- People
  - State and industry public information staff

Evaluation: Public awareness/communications plan is in place and being implemented as planned

Strategy 1.2 Expand career awareness and counseling

Rationale: Career decision-making begins early in a child's educational career. Research indicates that students begin to rule out certain career options as early as the third grade. Often career choices are guided by what a student is familiar with rather than a careful consideration of alternatives. Many health careers require substantial preparation at the secondary level in math and science. In addition, choices made while still in school, such as teenage drinking and drug use, are not only dangerous in themselves but can be lifelong barriers to entry into careers that require extensive background checks. A sound career awareness and guidance program beginning in early elementary grades can open up many more career options to Alaskan students and can assist them in developing both their secondary and postsecondary academic plans.

Action Steps

- Reinforce job readiness skills through the use of WorkKeys™, Youth Employability Skills (YES) or other programs that develop the soft skills necessary for success in the workplace
- Expand the use of health career pathways and DOLWD Health Career Guides in local school districts and for postsecondary academic counseling
- Identify "best practices" for use in elementary and middle schools to introduce students to careers in health care
- Establish an incentive program to encourage schools to adopt these practices
- Provide training for high school counselors and postsecondary academic advisors in using health care career pathways to advise students into health care occupations
- Secure sustainable state and industry funding for the Alaska AHEC network

Timeline

- Short term

Responsible Parties

- Government (DEED, K-12 districts)
- Industry/Employers
- AHEC
- Education and training providers

Resources

- Models
  - Best practices from Alaskan school districts
  - Alaska Career Information System (AKSIS)
  - Hot Jobs in Health Care (DOLWD) publications and teacher guides
  - State and national health career pathway models
- Funding
  - Alaska School Foundation Program (for K-12 district programs)
  - State and federal grant funds
  - Industry
  - Private Foundations
- People
  - K-12 and postsecondary career and academic advisors

Evaluation: By 2012, 50 percent of all Alaskan school districts will have incorporated healthcare career pathways into a career awareness/counseling program that begins in elementary school and continues through high school with demonstrated connections/transitions to postsecondary programs.

Strategy 1.3 Market high need professions

Rationale: There are several occupations in the health care industry that are in constant and high demand and that can be prepared for in Alaska. A full-scale media campaign, modeled after such nationwide efforts as the successful Robert Wood Johnson (RWJ) Nursing campaign, could attract considerable numbers of Alaskans into these careers.

Action Steps

- Identify two top priority, high demand professions across the full continuum, from direct service workers to doctors
- Prepare and widely disseminate ads, TV spots and other materials to encourage Alaskans to prepare for these professions
- Target under-represented minorities and populations for recruitment

Timeline

- Mid-term

Responsible Parties

- Industry/Employers
- Government (DHSS, DOLWD)
- Education and training providers
- Professional organizations
- AHEC

Resources

- Models
  - RWJ Nurse Campaign
  - The Alaska Mental Health Trust You Know Me anti-stigma campaign
- Publications
  - *Securing an Adequate Number of Physicians for Alaska's Need*, Alaska Physician Supply Task Force, August 2007
- Funding
  - Industry
  - Private Foundations

Evaluation: Enrollment in preparation programs for the selected occupations will double by 2015. Recruitment and enrollment of Alaskan Natives and underserved minorities will reflect the make-up of the total population.

Strategy 1.4 Attract Alaskan job seekers into health careers

Rationale: The health care industry offers many opportunities for job-seekers such as retiring active duty military, underemployed individuals, persons undergoing job loss/transitions, out-of-school youth and women returning to the workforce to prepare for and secure entry-level employment in a relatively short period of time. Many of these jobs are the first step in a career ladder than leads to long-term, stable and well-paid employment.

Action Steps

- Utilize the existing one-stop information system to disseminate information on health care training opportunities and job openings in Alaska
- Encourage health care providers to utilize the Alaska Labor Exchange System (ALEXsys) and 3RNet (Rural Recruitment and Retention Network) to post job openings
- Establish mechanisms for networking between DOLWD job counselors and local health care provider human resources offices
- Target market to persons who are undergoing transition due to economic downturn and/or job losses
- Increase coordination among vacancy posting services to disseminate information to a broad array of potential applicants

Timeline

- Short term

Responsible Parties

- Government (DHSS, DOLWD)
- Industry/Employers

Resources

- Information Systems
  - ALEXsys
  - AKCIS
  - EarnAndLearnAK.org
  - 3RNet (national)
  - Alaska Alliance for Direct Service Careers
- Funding
  - State and Federal Employment Security funds
  - Workforce Investment Act (WIA) Youth funds
  - Industry
  - Alaska Native Tribal Health Corporations
- People
  - DOLWD employment counselors

Evaluation: Health care job openings are posted in ALEXsys and 3RNet. Employment security counselors are aware of health care training and employment opportunities.

Strategy 2

Train Alaskans for health care employment

Almost three-quarters of the fifteen fastest growing occupations in Alaska are in the health care field. Taken as a group, these occupations are estimated to account for over 6,000 job openings between now and 2016[7]. These projections are based on the current level of health care provision and do not take into account the increased demand for health care workers that will result with the aging of the Alaskan population or from expansion of health care access. Filling these positions with Alaskans requires creating a pipeline for people seeking the necessary credentials, providing appropriate training and educational opportunities and allowing for those already employed to upgrade their skills and to advance professionally. Delivering training as close to home as possible through expanded distance education is essential to assuring that rural workforce development needs are addressed.

This strategy can be implemented by

- Strengthening secondary school offerings in mathematics, sciences, communications, job readiness and entry-level training in health care occupations
- Providing postsecondary health care occupational training and education programs that are effective, cost-efficient and lead to employment in Alaska
- Delivering post-employment training opportunities that allow practitioners to gain new skills and advance in their profession
- Developing the faculty needed at the secondary, postsecondary and continuing education levels to deliver education and training programs

Funding

- Alaska Public School Foundation Program
- University of Alaska general funds
- DOLWD
- State of Alaska General Fund
- Industry
- State and federal grants
- Private foundations
- The Alaska Mental Health Trust
- Alaska Native Tribal Health Consortium

[7] DOLWD, *Alaska's 10-year Occupational Forecast*, Alaska Economic Trends, January 2009, p. 22

Strategy 2.1 Strengthen secondary school offerings and programs

Rationale: Preparation for many health care careers begins at the secondary level, where fundamental academic and job readiness skills are acquired. Ideally, students with knowledge of what is required in their fields of interest will select the appropriate math, science and other high school courses that support their career interests. Individual learning plans based on career pathways greatly assist secondary students to easily transition to postsecondary education and training. Applied academics—where the student experiences real-life applications of math, science and communications—improve student success in these subjects. Training programs that lead to national certification can provide an avenue to post-high school employment and onto a career ladder.

Action Steps

- Encourage Alaska's secondary schools to develop and deliver foundation programs that support health career pathways, include advanced math, science and communications courses and articulate to postsecondary certificates and degrees (Career and Technical Education Programs of Study)
- Develop a framework to provide Work-based Learning Experiences (WBLEs) in health care settings that clearly delineates the responsibilities of the educational and health care provider and supports the interests of all parties in the health care setting
- Develop short-term exploratory programs in health care sciences that spark student interest in pursuing careers in the industry and that can be conducted with local resources in rural as well as urban settings
- Expand the use of health career academies modeled on the construction academies conducted throughout the state
- Deliver high school programs that lead to entry-level employment such as CNA and EMT or to certificates that are widely accepted, such as First Aid, CPR and OSHA Safety
- Expand the use of dual credit/Tech Prep/School-to-Apprenticeship/Early College programs that provide secondary students the opportunity to earn university credit
- Establish four additional career/technical magnet high schools that deliver training in health occupations and other careers
- Utilize distance education to expand access to students in small, rural high schools
- Work with health care providers and organizations to secure on-going support through scholarships, internships and mentoring programs

Timeline

- Short term

Responsible Parties

- Government (DEED, K-12 districts, DHSS)
- Education and training providers
- Industry/Employers
- AHEC

Resources

- Models
  - National health career pathways
  - Alaska-specific health career pathways
  - Tech Prep, early college and dual enrollment programs
  - Existing secondary career high schools and centers: Mat-Su Career and Technical High School, King Career Center, Hutchison Career Center
  - Construction academies
- Funding
  - Alaska State Foundation Program
  - Federal Perkins IV funding
  - Industry

Evaluation: Alaska's secondary schools have programs of study based on health career pathways. Four career/technical high schools are established and operational.

Strategy 2.2 Provide health care occupational training and education programs

Rationale: Between 2001 and 2009, aggressive program development at the University of Alaska added instruction and training in a variety of health occupations resulting in more than 80 certificates/degrees in primary care, nursing, and allied, behavioral and public health. The UA system now serves around 4,200 Alaskans each year who are preparing for and enrolled in health care training and education programs. Half of the programs are accessed by students via distance education technology. APU provides undergraduate degrees in behavioral health and health administration. AVTEC, regional training centers and several private training providers serve additional students, generally with entry-level training. Meeting the anticipated workforce needs, however, will require additional effort—to expand access to existing programs particularly to rural sites, to develop new programs where demand and cost-considerations dictate and to partner with out-of-state institutions when programming by an Alaskan institution is not feasible.

Action Steps

- Develop and deliver occupation specific training at all levels (work-based, certificate, Associate, Bachelor and graduate) for occupations that are high demand and/or are critical to health care delivery, as indicated in Section 4
- Continue to refine and develop the UA academic plan for health care occupation certificates and degrees
- Provide adequate financial support for training and education programs
- Increase access through program expansion, distance delivery and simulation
- Expand the capacity of community campuses of the UA system to support local students in health care programs
- Strengthen the dialog among employers, labor and education/training institutions concerning registered apprenticeship and other work-based learning opportunities in health care, create and evaluate pilot apprenticeship projects and disseminate the results
- Explore credit-for-experience or other mechanisms that allow practitioners to challenge introductory and lower level coursework in a certificate/degree program
- Develop partnerships with institutions in other states to provide certificate and degree programs in Alaska that cannot be cost-effectively delivered by in-state institutions
- Assure that all health care training and education programs delivered by any institution in Alaska meet industry standards, are accredited by a regional or national body and lead to certification or licensure as required for employment
- Periodically assess Alaska's capacity to deliver high need/high cost programs in-state and initiate programs that are deemed viable
- Research national and international best practices in health care professional training for possible adoption in Alaska

Timeline

- Short term for high priority occupations
- Mid and long term for other occupations

Responsible Parties

- Education and training providers (Alaska and elsewhere)
- Government
- Industry

Resources

- Programs
  - Existing health care occupational training programs at UA, APU, AVTEC, ATC, regional training centers and private training providers
  - Washington, Wyoming, Alaska, Montana and Idaho (WWAMI) regional school of medicine based at University of Washington
  - Western Interstate Commission on Higher Education (WICHE) and Western Undergraduate Exchange (WUE)
  - Distance delivered programs in Alaska and in other states
- Funding
  - UA general funds
  - Tuition and fees (UA, APU, AVTEC ATC, other)
  - Technical and Vocational Education Program (TVEP) state dollars
  - Scholarships and loan repayment programs
  - State and federal grant funds (STEP/WIA)
  - Industry

- People
  - UA, APU, technical center and private provider faculty

Evaluation: Programs are available in-state that train Alaskans for high need occupations in a cost-effective manner. Training is available as close to home as possible for most Alaskans.

Strategy 2.3 Deliver post-employment training opportunities

Rationale: Changes in health care access, care models and technology mandate that the workforce engage in continuing education and acquisition of new skills. Professional development is most effective when it is based on developing or strengthening commonly-accepted competencies and promotes career advancement. Adopting core competencies for various health care occupations and utilizing these competencies to build on-the-job training and career ladders are proven methods of assuring comparable skill levels around the state. Greater economies of scale can be achieved by sharing professional development programs and resources among health care providers.

Action Steps

- Define priority occupations for competencies and career ladders and lattices
- Develop and adopt standardized core competencies in critical health care occupational clusters
- Assist in developing and supporting occupation-specific industry/education consortia that will address the professional development needs within the occupation, including competencies and career ladders
- Encourage health care providers—including state and local governments—to establish professional development programs and career ladders/lattices based on competencies
- Extend the use of registered apprenticeships and other work-based post-employment training for career development
- Provide post-employment academies and other intensive training to accelerate skills and achieve advanced certifications, including nursing specialties
- Utilize the AHEC network to provide continuing education to practitioners in underserved areas
- Establish mechanisms for sharing high-cost, effective training tools such as simulation and distance delivery among health care institutions around the state
- Increase opportunities for health care professionals to obtain continuing education and continuing medical education credits (CEUs/CMEs)

Timeline

- Short term for competencies, career ladders, apprenticeships and continuing education
- Short/mid-term for expansion of simulation

Responsible Parties

- Industry/Employers
  - Education and training providers
  - Professional associations
  - Government (licensing boards)
  - AHEC

Resources

- Models
  - Alaska Coalition of Educators-Health Care (ACE-HC) Nurse Competencies
  - Alaska Mental Health Trust Authority (AMHTA) Credentialing and Quality Standards Subcommittee (CQSS) – Alaska Core Competencies for Direct Care Workers
  - Providence Hospital Academies to accelerate skills and advanced certifications
  - Registered Apprenticeships
- Facilities
  - Community and university-based simulation facilities
- Funding
  - Industry
  - AMHTA
  - UA general funds
  - State and federal grants
- People
  - Education personnel in health care facilities
  - Training program faculty

Evaluation: Core competencies are developed and adopted for the major occupational groups in the health care workforce. Employers conduct professional development programs based on competencies. Training programs and resources are shared among Alaskan health care providers in all areas of the state.

Strategy 2.4 Develop needed faculty

Rationale: High quality education and training programs are built on strong faculty who not only know the content but who also have practical experience in the field. Increasingly, faculty members need to be conversant with technology and distance-delivery methodologies. Because the demand for persons who are skilled health care program educators is high throughout the country, Alaska will need to consider "grow your own" strategies to develop this workforce internally.

Action Steps

- Provide opportunities for secondary academic and career/technical teachers to increase their understanding of how academic skills are applied in various health care occupations using the Teacher-Industry Externship (TIE) program or other successful models
- Develop additional secondary faculty from industry and elsewhere that can deliver heath career-related instruction
- Prepare/secure the necessary postsecondary faculty through better utilization of national health care educator loan repayment programs, sabbaticals/release time for faculty pursuing the necessary credentials and/or aggressive recruitment
- Assure salaries, benefits and other incentives for faculty that are comparable to practicing health care professionals in their area of instruction
- Increase opportunities for health care professionals to serve as adjunct or part-time faculty by identifying and addressing current workplace and training institution policy or practice barriers
- Establish training and incentives for practicing professionals to assume responsibility for continuing education in their facilities, for example, as nurse educators
- Assist health care faculty and educators to effectively utilize technology, including simulation, and distance methodologies in their instruction

Timeline

- Short term for programs such as faculty externships and adjuncts
- Mid-term for master/doctoral degree-prepared faculty development

Responsible Parties

- Education and training providers
- Industry/Employers
- Professional Associations

Resources

- Models
  - Alaska Process Industry Careers Consortium Teacher Industry Externships (TIE) programs
  - ACE-HC
- Funding
  - K-12 Foundation Program
  - UA general funds
  - Industry
  - State and federal grants

Evaluation: Alaska has skilled and well-prepared faculty at all levels to deliver the training, education and continuing skill development necessary to support the health care workforce. The health care industry supports a teacher in industry program modeled after APICC's TIE program.

Strategy 3

Recruit qualified candidates to fill health care positions

Even with expansion of programs through in-state training facilities and distance delivery, Alaska's population and resources alone will not be able to fill all of the health care workforce needs. In some cases—such as medical education—preparation program are prohibitively expensive; in others—such as pharmacy—positions are critical but needed in relatively small numbers. For the foreseeable future, therefore, Alaska will need to attract health care providers to the state.

This strategy can be implemented by

- Promoting health care employment opportunities in the state
- Expanding post-graduate programs, residencies and fellowships
- Establishing financial and other incentives to attract needed professionals
- Coordinating recruitment among health care providers
- Creating a positive community, policy and economic environment for health care providers

Funding

- Industry
- State and federal loan repayment/incentive dollars
- State marketing dollars
- Federal grants and programs that address recruitment

Strategy 3.1 Promote health care employment opportunities in Alaska

Rationale: A widespread campaign to advertise health care opportunities in Alaska can assist in developing a pool of qualified applicants for open positions. An untapped resource is Alaskan students who have gone out-of-state for education in health care fields and who may return if provided information about career opportunities. Identifying institutions that have a high number of graduates practicing in Alaska for targeted recruitment can also increase the applicant pool. Greater use of existing resources such as the ALEXsys system and state marketing efforts can be a cost-effective means of attracting needed expertise to the state.

Action Steps

- Refine the ALEXsys system to more accurately identify the occupations and specialties that are being recruited
- Partner with state marketing groups to advertise health care provider opportunities in Alaska
- Reach out to Alaskan students who are pursing health care education outside of Alaska to inform them of opportunities in Alaska and encourage them to return after graduation
- Develop partnerships with institutions in other states with strong health care preparation programs and/or which have a large number of graduates already practicing in Alaska to directly recruit program completers

Timeline

- Short term

Responsible Parties

- Industry/Employers
- Government (DOLWD, DHSS, DEED, Alaska Commission on Postsecondary Education)
- Professional Associations
- Education and training providers (Alaska and other states)

Resources

- Models
  - *Status of Recruitment Resources and Strategies 2005-06 (DHSS)*
  - Seafood Marketing Institute
  - Office of Tourism marketing materials
- Funding
  - State employment security dollars
  - State marketing dollars
  - Industry
  - National Health Service Corps (NHSC) and Indian Health Service (IHS) Loan Repayment programs

Evaluation: ALEXsys information accurately reflects the nature and qualifications of open positions. Alaska's health care system and workforce needs are highlighted in the state's promotional materials. Recruiting networks are established with select institutions in other states.

Strategy 3.2 Expand post-graduate opportunities

Rational: Research indicates that health care professionals frequently choose to practice in an area where they have completed a rotation, residency, internship, fellowship or other postgraduate experience. In Alaska, the rate of return on its one residency program—the Alaska Family Medicine Residency—is extremely high: 70 percent of the 55 graduates have remained in Alaska.[8] There is widespread agreement that Alaska has additional capacity for residencies and rotations; however, at the current time, there are policy and fiscal barriers to such expansion.

Action Steps

- Change Medicaid and Medicare policy to allow increased support for in-state teaching hospitals and the use of residents
- Increase funding for Alaskan and rural rotations through AHEC and other agencies that support rotations
- Develop an American Psychology Association (APA) approved residency in conjunction with the UA PhD in psychology
- Establish residencies in psychiatry, pediatrics and internal medicine
- Support the development of a plan to expand graduate medical education (GME) to additional specialties and regions
- Implement strategies to identify medical interns and residents working with Alaskan physicians and to encourage them to practice in the state upon graduation

Timeline

- Short term for APA, pediatric, internal medicine and psychiatry residencies
- Mid term for other specialties
- Short term for changes in Medicaid/Medicare reimbursement policies

Responsible Parties

- Industry/Employers
- Education and training providers
- Government (DHSS, state legislature for Medicaid/Medicare policy changes)
- AHEC

Resources

- Programs
  - NHSC Student/Resident Experiences and Rotations in Community Health
  - AHEC network
  - Alaska Family Practice Medical Residency
  - Alaska Center for Rural Health Rural/Underserved Opportunities Program
- Funding
  - Medicaid and Medicare Graduate Medical Education (GME) funds
  - NHSC and IHS federal funding
  - Federal Health Resources and Services Administration (HRSA) for AHEC, NHSC and IHS funding
  - Industry
  - State funds

Evaluation: Medicaid/Medicare policies support the use of residents in Alaskan hospitals. Residency opportunities are available in all regions of the state. Rural rotations are available at all rural hospitals, in most community health centers and tribal clinics and in a number of private practices.

[8] DHSS, *Securing an Adequate Number of Physicians for Alaska's Need*, Report of the Alaska Physician Supply Task Force, August 2006, p. 42

Strategy 3.3 Improve coordination in recruitment among health care providers

Rationale: Recruitment in the health care industry is an expensive business. According to a 2005 study, state health care facilities—hospitals, community health centers and rural mental health centers—spent over $24 million on recruitment in the prior year. Many times, more than one institution is recruiting for a similar skill set. Often searches at one institution yield multiple qualified candidates, some of whom at least could be good fits for other open positions in the state. A more coordinated recruitment system would allow hiring agencies to spread the costs of recruitment, share promising recruitment practices and develop a pool of applicants that are interested in relocating to Alaska in general and rural Alaska in particular.[9]

Action Steps

- Inventory existing recruiting practices among health care providers and facilities to identify "best practices"
- Create and maintain a single website that links health care organizations and is a repository for open positions
- Actively market Alaska health care employment opportunities in selected regions and with selected institutions in other states
- Explore a coordinated recruitment consortium that can serve multiple agencies and can share applicant information/applicant pools
- Pilot the use of non-traditional recruitment strategies such as posting on Craig's List and other web sites

Timeline

- Short term

Responsible Parties

- Industry/Employers
- Government (DHSS)
- Professional associations and membership organizations

Resources

- Programs
  - 3RNET technical assistance and web page
  - DHSS Alaska Primary Care Office and State Office of Rural Health
  - ASHNHA
- Funding
  - Industry

Evaluation: A coordinated recruitment effort exists that shares information and recruiting resources.

Strategy 3.4 Establish incentives to attract needed professionals

Rationale: Financial incentives of various types—loan repayment, moving costs, housing assistance and tax breaks—can influence a provider's decision to practice in Alaska. Research on support-for-service programs indicates that these programs bring health care providers to needy communities where they remain in practice for many years. Of all types of programs, loan repayment and direct financial incentives that target the practitioner after training show the broadest success.[10] Currently, a small number of health care providers—primarily physicians—who locate to Alaska are eligible for a variety of federal loan repayment programs, but these programs have limited slots and are generally targeted at underserved areas of the state. Incentives are needed for additional categories of high-need health care professionals, for all areas of the state and for those for whom loan repayment is not appropriate.

Action Steps

- Maximize use of federal loan repayment programs through dissemination of information and application assistance to health care providers and potential applicants
- Continue to submit the Health Professional Shortage Area (HPSA) designation application to HRSA to assure that sites are eligible to have loan repayors through HRSA-funded National Health Service Corps and State Loan Repayment programs
- Create and fund a state-supported loan repayment program
- Provide funds for non-loan incentives
- Explore federal tax breaks and other economic incentives to practice in underserved areas

[9] Alaska DHSS, *Status of Recruitment Resources and Strategies 2005-06*, p. iii and Recommendations, pp. 40-41

[10] Donald E. Pathman, M.D., et al. *Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians*. Medical Care. Vo. 42, No. 6, p. 567

Timeline
- Short term for state loan repayment and incentive program
- Mid-term for tax incentives

Responsible Parties
- Government (DHSS, State Legislature, Alaska Congressional delegation)
- Industry/Employers

Resources
- Programs
  - HRSA NHSC Loan Repayment
  - National Institutes of Health loan repayment programs
  - Military LR
  - HRSA State Loan Repayment Program
  - HRSA Nursing Faculty Loan Repayment
  - IHS Loan Repayment Program
  - Alaska Mental Health Trust Authority
- Funding
  - Federal loan repayment, including stimulus funds
  - State dollars
  - Industry
- People
  - DHSS health Planning and Systems Development Section staff, including the Alaska Primary Care Office and the State Office of Rural Health
  - Alaska Native Tribal Health Consortium staff for IHS loan repayment

Evaluation: State loan repayment and incentive program is in place and funded. Federal loan repayment programs are utilized to maximum effect. Support system for non-loan incentives is in place.

Strategy 3.5 Create a positive environment for health care providers

Rationale: While financial considerations can greatly influence the success of recruiting efforts, other factors can also come into play. The ease with which a relocating professional can become licensed or certified in Alaska can significantly affect a successful placement. Hurdles such as multiple background checks for the same position and with the same state agency can sour an applicant. Community amenities such as quality schools, housing and opportunities for spousal employment are important, particularly when a family is relocating.

Action Steps
- Align state regulations and licensure requirements with clinical workforce needs
- Develop and support the utilization of tools that promote community-based approaches to recruitment and retention
- Create Alaskan-specific practice environment assessments and comparison tools for selected profession

Timeline
- Short term for alignment of licensure and regulatory requirements
- Mid-term for community-based approaches and practice environment assessments

Responsible Parties
- Government (DCCED, Division of Corporate, Business and Professional Licensing, DHSS Criminal Background Check Unit)
- Industry/Employers
- Professional organizations

Resources
- Models
  - National Health Service Corps Site Development Manual
  - Examples from other states, such as the Massachusetts Medical Society index for physicians
- Funding
  - State GF and professional fees for licensing
  - Industry/state funds for community grants
  - Professional organizations
  - Federal/state grant funds
  - Private foundations

Evaluation: State licensure requirements are in line with national standards and reflect the needs of the health care workplace. Communities are involved in and take appropriate responsibility for the recruitment of needed health care professionals.

Strategy 4

Retain a skilled health care workforce

While recruiting skilled health care workers is a major task, keeping this workforce is even more critical. Some health care occupations and some locations report annual double-digit turnover rates. A 2006 study by DHSS found that the average cost for a physician hire was $126,782. Urban costs for recruiting registered nurses were $10,527 per hire; rural costs for the same position topped $42,500.[11] Clearly, replacement of lost workers represents huge costs in terms of both recruitment and retraining—costs that can be avoided by better retention.

This strategy can be implemented by

- Supporting and disseminating effective orientation and on-boarding programs for new employees
- Providing opportunities for professional development and advancement
- Promoting positive work environments

Funding

- Industry
- Private Foundations
- State/federal grants

Strategy 4.1 Support and disseminate effective orientation programs for new employees

Rationale: Much of the turnover in the health care workforce occurs during the first year of employment, particularly among new graduates who are entering the profession. As health care worker shortages in Alaska and the nation continue to grow, the state's health care employers are hiring and are willing to hire newly-trained workers in ever higher numbers.[12] Even seasoned professionals who are new to Alaska or to more rural conditions require assistance to be successful in their positions. Both health care organizations and the wider community have a responsibility for assuring that entering employees receive the support they require to succeed.

Action Steps

- Assist employers to implement preceptorship/mentorship programs based on standardized core competencies
- Encourage employers to provide cultural awareness/competencies training
- Establish industry/education consortia to share competencies, models and best practices in inducting new employees
- Identify community support initiatives

Timeline

- Short term for competency-based preceptorship programs
- Mid-term for community-based initiatives

Responsible Parties

- Industry/Employers
- Professional Organizations

Resources

- Models
  - ACE-HC competency-based nurse preceptorship programs
  - AMHTA – Alaska Core Competencies for Direct Service Workers
  - AHEC network
- Funding
  - Industry
  - AMHTA
  - Professional organizations

Evaluation: Competency-based preceptorship/mentorship/apprenticeship programs are established in all health care facilities and available to new employees.

[11] DHSS, *Status of Recruitment Resources and Strategies 2005-2006*, June 2006, pp. 31-32

[12] Alaska Center for Rural Health, *2007 Alaska Health Workforce Vacancy Study Research Summary*, August 2007, p. 4

Strategy 4.2 Provide opportunities for professional development and advancement

Rationale: The health care industry provides many career pathways both for those who come to the industry with entry-level skills and for those with more advanced training who wish to specialize. Work-based training directed at competencies and tied to career ladders is an effective method for retaining employees and for developing an increasingly-skilled workforce. Sharing training and continuing education opportunities among health care facilities through state/regional workshops or distance delivery can increase the reach of limited resources. Professional networking opportunities can assist with on-going skill development, encourage collaboration and lessen the sense of isolation that frequently occurs in Alaska among health care professionals, particularly those serving in rural areas.

Action Steps

- Share existing competency-based career ladders among employers
- Identify emerging roles and competencies resulting from health care reform and changes in care models
- Encourage apprenticeships and work-based experiences tied to career ladders and lattices
- Sponsor in-state professional development events
- Expand access to continuing education coursework through the UA system
- Assist with networking among health care occupational groups

Timeline

- Short term

Responsible Parties

- Industry/Employers
- Education and training providers
- Professional organizations

Resources

- Models
  - ACE-HC nursing group
  - Alaska Primary Care Association
- Funding
  - Industry
  - State/federal grants
  - Private foundations

Evaluation: Competency-based career ladders are established for high demand occupational groupings. Appropriate work-based and credit-bearing training opportunities support the career ladders. Professional workshops and networking opportunities are available to practitioners throughout the state.

Strategy 4.3 Promote positive work environments

Rationale: Health care positions place a high degree of responsibility on individual workers and often demand long hours and non-standard shifts. A major cause of turnover among direct care workers is the lack of appropriate supervision that supports and develops the employee. For all health care providers, changes in care models, technology and record-keeping systems can increase stress levels if adequate information and training is not provided. Finally, although compensation is usually not at the top of the list of reasons for leaving the industry, salary and benefits for the entry-level workforce need to recognize the importance of these positions and their contributions to the quality of health care in Alaska.

Action Steps

- Strengthen supervisory and leadership skills in health care occupations and facilities
- Assure competitive salary rates and employee benefits for health care workers, particularly those in entry-level and direct care positions
- Provide training in supervision and leadership to front-line supervisory personnel
- Inventory and disseminate best practices such as flexible schedules
- Establish organizational models that reflect changes in care management and that utilize technology to improve patient care and employee effectiveness
- Explore cross-industry leadership training programs that can be delivered collaboratively to both urban and rural site

Timeline

- Short term for supervisory and leadership training
- Mid-term for new organizational models

Responsible Parties

- Industry/Employers
- Professional organizations
- Education and training providers

Resources

- Programs
  - ACE-HC Nurse leadership competencies
  - UA/APU management/supervisory training programs
  - State of Alaska supervisory training
  - Private sector consultants/training
- Funding
  - Industry
  - UA general funds
  - Fees and tuition for management/supervisory training courses and programs

Evaluation: Turn-over in Alaskan health care facilities is reduced to at least the national average. Employees receive appropriate supervision and competitive wages and benefits.

Occupation-Specific Strategies for Priority Occupations

The health workforce is exceedingly complex to describe, evaluate and project. While overarching strategies to engage, train, recruit and retain health care workers are useful—even essential—to address the overall workforce picture, individual occupations and professions require their own detailed action plans comprised of strategies tailored to their unique needs.

In order to begin to develop these action plans, the health workforce planning process included an initial assessment of occupational priorities for Alaska, utilizing data and information from a variety of sources including the following:

DOLWD

Ten-Year Projections

Industry-Specific Studies

Occupational Information, Ranking and Demographics

DHSS

Health Professional Shortage Area (HPSA) Analysis

Physician Task Force Report

Special Topics (e.g. dental, pharmacy, licenseholders, loan repayment/

employee incentives options)

University of Alaska (Alaska Center for Rural Health/Alaska's AHEC and Office of Health Programs Development)

Vacancy Studies

Recruitment Studies

Special Topics (e.g. rural allied health, CHA/P, nursing, health information technology, pharmacy, geriatric education)

On the basis of the above information, which is compiled in the Occupational Forecast (Section 5), the planning group initially identified 35 occupations that appeared to be in most critical need of attention because of high vacancy rates, high number of vacancies and/or criticality to health care delivery. This initial listing was then distributed to various health-related groups either in a conference setting—Behavioral Health, Alaska State Hospital and Nursing Home Association (ASHNHA) and Alaska Public Health Association (ALPHA)—or through surveys to the participants/members of those groups as well as to the Alaska Medical Group Management Association (which represents many doctor's offices and clinics) and the Alaska Native Tribal Health Consortium. In all, 151 Alaskans participated in the survey prioritization process.

Conference and survey respondents were asked to select their top five from the list of priority occupations and to add occupations that they felt should be on the list. Results were reviewed by the coalition's Assessment and Priorities Committee. From these processes, occupations/occupational groupings were identified as those most in need of immediate attention. The 15 top priority groupings listed below include a total of 26 occupations and professions:

Behavioral Health Aide/Village Counselor

Primary Care Physician

Advanced Nurse Practitioner

Substance Abuse Counselor

Registered Nurse

Community Health Aide/Practitioner

Social Worker

Oral Health Practitioner

Psychiatrist

Human Services Worker

Pharmacist

Therapist and Therapist Assistant (Physical, Occupational, Speech-Language)

Nurse Educator

Health Informatics Staff

Direct Care Worker

Once priorities were identified, an initial set of strategies for each occupation on the list was developed. These strategies were then circulated to educators and practitioners in the occupation for review, verification and revision.

The revised strategies for each of the 15 priorities, together with descriptions of the occupations and pertinent data, make up the remainder of this section. The format used is similar to that found in the Physician Supply Task Force report cited elsewhere in this plan. An estimated time frame for the strategies is provided: Short Term (within the next two years), Medium Term (within three to

five years) and Long Term (five years or more in the future).

Priority strategies will be identified in the next step of the planning process and action plans utilizing these strategies will be drafted in the coming months for each of the identified priority occupations. These plans will include the following sections: Strategy, Problem Statement, Action Steps, Target Outcomes, Timeframe, Benefits, Costs, Responsibility, Area of Impact, and Rationale. During action planning, budget projections will be made for each strategy.

It is anticipated that those responsible for working on strategies for a particular health occupation will maintain regular communication, collaborate, and share ideas, information and results. Also, it is expected that work will continue on occupations beyond those included in the plan until a full set of health occupations strategies is completed.

Industry Occupations by Priority

Priority 1 *Most critical; requires immediate attention*

Behavioral Health Aide/Village Counselor
Certified Nurse Assistant
Community Health Aide/Practitioner
Dental Health Aide/Therapist
Dental Hygienist
Dietitian/Nutritionist
Disabilities Specialist/Worker
Family Nurse Practitioner/Advanced FNP
Family Physician (M.D., D.O.)
General Internal Medicine Physician/Internist
Health Educator
Health Informatics Staff
Healthcare Managers/Supervisors
Home Health Aide
Human Services Worker
Medical Assistant
Nurse Educator
Nurse Manager/Executive
Nurse Specialist (e.g. Critical Care, ER, OB)
Occupational Therapist
Personal Care Assistant
Pharmacist
Pharmacy Technician
Physical Therapist
Physical Therapy Assistant
Physician Assistant
Psychiatric Nurse
Psychiatric Nurse Practitioner
Psychiatrist
Public Health Nurse
Registered Nurse
Social Worker (BSW, MSW, LCSW)
Sonographer
Speech-Language Pathologist
Substance Abuse Counselor

Priority 2

Accountant (Health Care)
Behavioral Health Case Manager
Behavioral Health Clinician
Billing/Coding Clerk/Technician/Specialist
Clinical Psychologist/Psychologist
Community Health Representative
Community Wellness Advocate
Compliance Officer/Auditor
Dental Assistant
Dentist
Geriatrician
Gerontologist
Health Information Administrator/Manager
Healthcare Quality Professional
Hospital Administrator
Licensed Practical Nurse
Limited Radiographer
Mammographer
Marital/Family Therapist
Medical Director
Medical Laboratory Technician
Medical Technologist
Nuclear Medicine Technologist
Nurse Case Manager
Nurse Midwife/Women's Health Nurse Practitioner
Nursing Home Manager
Occupational Therapy Assistant
Optician
Pediatric Nurse Practitioner
Pediatrician
Physician Specialist
Radiation Therapist
Radiographer/Radiologic Technician
Rehabilitation Counselor
Residential Aide
Safety Officer
Sanitarian
Speech Therapist
Surgical Technologist
Veterinary Technologist/Technician
Village Health Educator

Priority 3

Anesthesia Technologist/Technician
Anesthesiologist Assistant
Art Therapist
Athletic Trainer
Audiologist
Billing Supervisor
Biomedical/Health Researcher
Blood Bank Technology Specialist
Cardiovascular Technologist
Chaplain
Clinical Assistant (Lab)
Cytogenic Technologist
Cytotechnologist
Dance/Movement Therapist
Dental Laboratory Technician
Diagnostic Molecular Scientist
Echocardiography Technician
Electrocardiography Technician (EKG)
Electroencenphalography Technician (EEG)
Electroneurodiagnostic Technologist
Emergency Medical Services Technician (EMT/ETT)
Epidemiologist
Exercise Physiologist
Exercise Science Professional
Genetic Counselor
Health Advocate
Health Care Manager/Supervisor
Health Information Clerk/Technician
Histotechnologist
Horticultural Therapist
Kinesiotherapist
Low Vision Therapist
Magnetic Resonance Technologist (MRI/CT)
Massage Therapist
Medical Biller/Billing Clerk
Medical Coding Clerk/Specialist/Certified Coder
Medical/Dental Receptionist
Medical Dosimetrist
Medical Illustrator
Medical Librarian
Medical Transcriptionist
Music Therapist
Nurse Anesthetist
Orientation and Mobility Specialist
Ophthalmic Assistant
Ophthalmic Dispensing Optician
Ophthalmic Medical Technician/Technologist
Optometric Technician
Optometrist
Orthoptist
Orthotist and Prosthetist
Paramedic
Pathologist's Assistant
Perfusionist
Personal Fitness Trainer
Phlebotomist
Podiatrist
Polysomnographic Technologist
Privacy Officer/Specialist
Professional Counselor
Psychiatric Aide/Technician
Public Health Administrator
Respiratory Therapist
Surgical Assistant
Sterile Processing Technician
Therapeutic Recreation Specialist
Teacher of the Visually Impaired
Veterinarian
Veterinary Assistant/Lab Animal Caretaker
Vision Rehabilitation Therapist

Behavioral Health Aide/Village Counselor

Description:

Behavioral Health Aides/Practitioners are employed by Alaska tribal health organizations to address local mental health and substance abuse issues and to promote healthy individuals, families and communities in rural and remote Alaska Native Villages. Behavioral health aides work under the supervision of licensed professionals.

Overview:

Programs are in place to train behavioral health workers for rural and urban Alaska, and there is an articulated behavioral health pathway available through distance delivery. Attracting individuals to these demanding positions and retaining them is challenging.

Workforce Data:

There were an estimated 39 vacancies in 2009 (15% vacancy rate).[13]

Education and Training:

UAF Rural Human Services; Regional Alcohol and Drug Abuse Counselor Training (RADACT), Alaska Native Tribal Health Consortium (ANTHC) Behavioral Health Aide Training; certification by Community Health Aide Program Certification Board; behavioral health career ladder (BHA I, II, III and BHA Practitioner) with participation by many UA campuses and tribal health organizations; courses are a combination of distance delivered and in person.

Strategies	Timescale
Engage	
Develop awareness of behavioral health occupations, especially in rural Alaska, using public service announcements on radio and television and other methods.	Short
Conduct culturally appropriate anti-stigma campaigns.	Medium
Engage local elders and leaders in introducing children and adults to the role of a village counselor.	Short
Provide information about, access to and funding for training and career opportunities in behavioral health.	Medium
Support continued ANTHC/University of Alaska/Alaska Mental Health Trust Authority cooperative efforts on the further development of BHA training opportunities and outreach.	Short
Train	
Enlist the help of local Alaska Native elders and leaders to assist with teaching healthy lifestyles and coping skills development in elementary schools.	Short
Continue to provide competency-based, culturally sensitive education for behavioral health workers at the village level; expand as needed. Ensure local Alaska Native elders and leaders co-teach and story-tell.	Medium
Expand access to continuing education for the village behavioral health workforce by promoting UA cross-campus coordination.	Medium
Consider strengthening work-based learning approaches to BHA education.	Medium
Present training materials and information at the Annual BHA Forum.	Short
Recruit	
Identify youth with peer helping skills and abilities in consultation with Native elders and community leaders, and support and nurture their growth.	Medium
Educate the legislature and advocate for increases in funding for sustaining these positions across the state.	Medium
Ensure that BHA certifications and endorsements are reciprocal and can be used at all levels of the career ladder in all rural areas.	Medium

[13] Unless otherwise noted, vacancy data are taken from the *2009 Alaska Health Workforce Vacancy Study*, conducted by the Alaska Center for Rural Health at the University of Alaska Anchorage. Licensing data have been provided by the Division of Occupational Licensing at the Department of Commerce, Community and Economic Development and by Department of Health and Social Services. Non-resident and age data for the current workforce are from Department of Labor and Workforce Development studies and projections.

Provide support to the Tribal BHA Training Academy to recruit and support training staff.	Short
Provide recruitment materials through tribal health organization communication channels and at tribal events around the state	Short

Retain

Ensure Native elder and community leader support for behavioral health workers through mentoring, guidance and leadership.	Short
Make general and targeted skills enhancement available for village behavioral health workforce.	Medium
Improve supervision of village workers.	Medium
Develop community understanding of and support for behavioral health workers in local areas, including personal expressions of appreciation.	Short

Primary Care Physician

Description:

Primary Care Physicians diagnose, treat, and help prevent diseases and injuries that commonly occur in the general population and may be trained as either Doctors of Medicine (MD) or Doctors of Osteopathy (DO). Areas of practice include Family Practice, General Internal Medicine, and Pediatrics. Obstetricians/Gynecologists are sometimes includec in this group, as are General Surgeons.

Overview:

In 2005 a task force was convened to analyze and provide recommendations regarding Alaska's physician workforce. These recommendations included expanding the size of the WWAMI medical school class, considering establishment of a medical school in Alaska, and various recruitment and retention measure. Several of these strategies, and some others represented in this section, have already commenced. Further planning is needed to develop strategies specific to each type of primary care physician.

Workforce Data:

In 2009, there were an estimated 67 family practice vacancies (11% vacancy rate) and 1,583 licensees, up 2% from 2007; 24% of the workforce is non-resident, 41% over age 50.

Education and Training:

Alaska WWAMI program (20 graduates per year); Alaska Family Medicine Residency (10 completers per year).

Strategies	Timescale
Engage	
Strengthen pipeline programs to medical and other health professions, particularly for minority and disadvantaged/under-represented populations.	Short
Support school districts in offering health occupations awareness and exploration activities.	Short
Incentivize consideration of family rather than specialty practice.	Medium
Engage hospitals/physicians in the community to help develop student awareness and interest.	Short
Train	
Expand the WWAMI program to include the second year in Alaska and additional students as resources allow.	Medium
Remove requirement to repay the public fund portion of medical education.	Short
Increase the use of distance delivery, simulation and other technologies to strengthen medical education in Alaska.	Medium
Implement a post-baccalaureate program to prepare college graduates and mid-career individuals for successful application to medical school.	Short

Provide excellent continuing medical education opportunities for family physicians throughout the state.	Medium
Develop a plan for Graduate Medical Education (GME) across the state that includes reducing barriers to financing GME.	Short
Explore community partnerships for GME programs, DO rotations, etc.	Medium
In conjunction with nurse practitioner and physician assistant programs, work to expand clinical practice opportunities for medical students and residents.	Short-Medium
Consider development of a medical school in Alaska.	Long
Infuse interdisciplinary teamwork, quality improvement and evidence-based practice concepts and applications in all health programs including medical.	Medium

Recruit

Work collaboratively to recruit primary care physicians to Alaska.	Short
Offer information and incentives to attract physicians to Alaska, particularly to areas of shortage.	Medium
Establish a robust loan repayment and employment incentives program that rewards physicians in family practice.	Long

Retain

Sustain and improve the practice environment in Alaskan communities.	Long
Assess and meet market wages and benefits for employed staff physicians.	Medium
Offer incentives for physicians and their families to remain in Alaskan communities.	Long

Advanced Nurse Practitioner (Family, Psychiatric/Mental Health)

Description:

Advanced nurse practitioners (ANPs) are Registered Nurses who have specialized formal, post-basic education and who function in highly autonomous and specialized roles working with all ages of patients.

Overview:

Nurse practitioner programs in the state have been in existence for many years. There is growing interest in these programs and class size in the UAA Family NP program has increased. Maintaining current enrollment and evolving the programs will require additional faculty. Recruitment, especially for other specialties, will continue to be required.

Workforce Data:

In 2009, there were an estimated 58 vacancies for Family Nurse Practitioners (17% vacancy rate) and 490 licensees, 9% increase from 2007. In that same survey, there were 2 vacancies (18% vacancy rate) reported for Psychiatric/Mental Health Nurse Practitioners.

Education and Training:

UAA Master of Science in Nursing Science, Family Nurse Practitioner track (15 graduates per year); Psychiatric/ Mental Health Nurse Practitioner Track (6 graduates every other year); these programs are offered primarily through distance delivery with some clnical intensives.

Strategies	Timescale
Engage	
Inform the public and prospective students about advanced practice nursing and the need for primary care providers in Alaska through media, role modeling, job shadows, and other means.	Short
Target nurses from minority and disadvantaged/underrepresented groups for encouragement and assistance in becoming advanced practice nurses.	Medium

Train

Hire more faculty for the UAA SON Advanced Nurse Practitioner programs.	Short
Identify additional practice sites for the education of advanced nurse practitioners in Alaska; consider innovative solutions such as offering a business tax credit to practices that agree to serve as a training site.	Short
Allow for evolution of advanced nursing practice education in Alaska toward national norms to ensure continued graduation and certification of Alaska ANPs, including the development of a Doctorate in Nursing Practice (DNP) program.	Medium
Provide continuing education in essential and advanced skills and knowledge for nurse practitioners across the state.	Medium
Update audio/video equipment to improve program delivery; add capacity for clinical simulation throughout the state.	Short

Recruit

Include advanced nurse practitioners in the professions eligible for loan repayment and other employment incentives.	Short
Examine the feasibility of subsidies for establishing advanced nursing practices in communities experiencing a primary care shortage; consider housing support.	Medium
Identify other strategies for external recruitment of ANPs through consortia of providers.	Medium

Retain

Sustain and improve the practice environment in Alaskan communities.	Medium
Ensure continuation of a robust scope of practice for advanced nurse practitioners in Alaska.	Short
Subsidize continuing education offerings by providing financial support for continuing education conferences to keep attendee costs affordable.	Medium

Substance Abuse/Behavioral Health Counselor

Description:

These positions counsel and advise individuals, families or groups with alcohol, tobacco, drug, or other co-occurring mental health and associated problems, such as domestic violence, criminal justice involvement, gambling, eating disorders, etc. Counselors may also provide life skills development and engage in education, harm reduction and prevention programs.

Overview:

There is an established process in Alaska for training and certifying these workers . As with other behavioral health fields, attracting and retaining individuals as substance abuse counselors is challenging.

Workforce Data:

There were an estimated 48 vacancies (15% vacancy rate) in 2009. An additional 110 positions are expected to be created in the ten-year period ending 2016. Currently, 8% of the workforce is non-resident; 39% is over 50 years of age.

Education and Training:

Alaska certifications and continuing education in the chemical dependency field; pertinent content included in behavioral health degree programs such as social work, psychology and human services. (Behavioral Health Technicians - 151 contact hours; Behavioral Health Counselor I - 304 contact hours; BH Counselor II - 6 years of work in chemical dependency or a bachelor's in human services or a minimum of 436 contact hours. An advanced BH Counselor II must have 6 years of full time work and experience supervised by a chemical dependency supervisor.)

Strategies	Timescale
Engage	
Develop awareness and educate the public about occupations and professions dedicated to decreasing the effects of alcohol, tobacco, substance use, eating disorders, and gambling in Alaska.	Short
Engage in a dialog with elders, local community leaders, businesses and civic organizations, as well as prospective students, about these roles.	Short
Train	
Inform practitioners at all levels about certification requirements and training opportunities such as Regional Alcohol and Drug Abuse Counselor Training (RADACT) and university programs.	Short
Encourage and assist substance abuse staff to receive required levels of training in the field.	Short
Ensure that Behavioral Health Technicians through Advanced Behavioral Health Counselors have access to the hours needed for training to keep their certification; provide financial assistance as necessary.	Short
Recruit	
Identify with community elders and leaders youth that show helping skills and abilities; ensure they have access to further their interest through formal education; support them as necessary to complete their training.	Medium
Work with all post secondary and vocational training programs to disseminate information to students who may be interested in an addiction treatment professional career.	Short
Partner with regional Native corporations to provide scholarships targeted to the addiction treatment field.	Medium
Create a Tech Prep pathway for high school students interested in this career area, allowing them to take one or more courses from the university as a way to build toward a career and future training.	Medium
Retain	
Create opportunities for certified Behavioral Health Technicians through Advanced Behavioral Health counselors to have daily access to not only a clinical supervisor but also to community leaders and advisors.	Short
Support the development and delivery of evidence-based continuing education critical to the professional development of counselors in the areas of substance abuse and related disorders, such as specific assessment tools, interventions and treatment modalities.	Short
Institute a loan repayment program for paraprofessionals in the addiction treatment field to enable them to seek postsecondary education that will allow them to assume leadership positions in their agencies.	Medium
Facilitate the development of a rural substance abuse and behavioral health counselor network to connect these individuals through video or live web-conferencing on a regular basis.	Medium
Ensure individuals just entering the behavioral health field have regular and consistent access to a clinical supervisor for support, using distance delivery as a prime method for education and/or transitioning into private practice.	Medium

Registered Nurse (RN)

Description:

RNs assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. They administer nursing care to ill, injured, convalescent, or disabled patients in many venues and may advise patients on health maintenance and disease prevention or provide case management. Licensing or registration is required in order to practice. DOLWD data include advance practice nurses in this category.

Overview:

Progress has been made on increasing the number of new graduate registered nurses in Alaska. Over time, the extension of the associate's degree program to many locations across the state, and improvement of the distance delivered RN-to-bachelor's degree, will allow for significant headway in most regions. Distribution remains a challenge—though less than in the past—and should improve further as new training sites are added. A continuing challenge is the process of orienting new graduates into their workplace roles and augmenting their skills in specialty areas. Considering the size of this workforce, it is anticipated that recruitment from outside the state will continue to be a factor, especially for nurse specialists.

Workforce Data:

There were 307 estimated vacancies (10% vacancy rate) in 2009 with only 63 vacancies for new graduates. By 2016 DOLWD estimates that the state will have 6,328 nursing positions, up from 4,817 in 2006. There were 6,334 licensees in 2009, a 9% increase from 2007; 16% of the current workforce is non-resident, 40% over age 50.

Education and Training:

AAS and BS nursing degrees at UAA SON (180-200 graduates per year); currently 12 locations in Alaska, 2 more to be added in 2011.

Strategies	Timescale
Engage	
Inform the public about nursing as a career, including K-12 awareness activities and working with AHEC Centers.	Short
Expand awareness of nursing opportunities to include specialty, rural and long-term care areas, as well as advanced practice.	Short
Educate the public about career lattice opportunities, including the ability to grow into the profession from a direct services background. Include information to those with other bachelor's degrees.	Short-Mediun
Broaden the field of nursing applicants, reaching out to students with degrees in other fields.	Short
Train	
Encourage relevant knowledge and skills development during K-12 education.	Short
Sustain and improve UA School of Nursing basic programs; solidify AAS program at the community level; strengthen and market advanced and specialty education, including the nurse educator distance-delivered master's program.	Short-Medium
Identify specialty priories; achieve statewide process for specialty training.	Medium
Continue development and support for accelerated specialty and rural generalist preceptorships and other post-employment continuing education opportunities; fund coordinating/development consortium; find funding for coordination/development consortium.	Medium
Engage all levels of nursing students in interdisciplinary teamwork and quality improvement/evidence-based practice education and clinical opportunities.	Short

Recruit	
Identify nursing specialists and nurse educators as beneficiaries of loan repayment and employment incentives programs.	Short
Use a coordinated approach to developing a strong pool of nursing candidates in the state.	Medium
Develop a comprehensive plan including financial incentives to attract nursing faculty to Alaska and engage local nurses in educational roles as preceptors and faculty members.	Medium
Retain	
Structure the workplace environment to maximize retention of incumbent nurses; consider factors such as shared governance, fair salary/benefits, highest attention to patient care quality and safety, reasonable and flexible workloads and schedules, etc.	Medium
Incentivize nursing staff to welcome and mentor new graduates and employees.	Short
Identify methods of attracting and retaining nurses later in their careers as productive members of the workforce.	Short
Encourage the delivery of continuing education that is financially feasible and readily available to nurses residing in rural settings.	Short

Community Health Aide/Practitioner (CHA/Ps)

Description:

A profession unique to Alaska, Community Health Aides and Practitioners provide preventive, primary and emergency care to rural Alaskans. CHA/Ps work under the supervision of licensed physicians employed by one of the tribally-managed hospitals or clinics and communicate regularly with these providers by telemedicine, telephone, email and other means.

Overview:

CHA/Ps are employed by the tribal system in Alaska. Certification is provided by the Community Health Aide Program Certification Board. Village councils typically participate in selection of individuals for CHA/P training.

Workforce Data:

In 2009, there were an estimated 43 vacancies (12.9% vacancy rate). Quarterly program surveys most recently revealed 103 vacancies out of 583 positions, for a 17.6% vacancy rate.

Education and Training:

Tribal Training Centers provide required session training, with field experience between sessions. UAF assists with advanced courses and provision of credits and degree progression for those interested in academic credentials.

Strategies	Timescale
Engage	
Include CHA/Ps in career awareness activities for K-12 and the public, especially in rural Alaska.	Short
Engage local elders and leaders in introducing children and adults to the role of health aides.	Short
Provide job shadowing and basic skills strengthening for those interested in these occupations; work with AHECs on this strategy.	Short
Train	
Continue to assess and seek support for provision of sufficient sessions to meet needs in the state.	Medium
Provide continuing education opportunities on a variety of pertinent topics.	Short
Provide smooth and subsidized access to university credits and relevant degrees, including a career ladder to the physician assistant program and other health professions.	Medium

Recruit	
Seek and encourage likely candidates for CHA/P positions to apply and proceed through levels of session training.	Short
Retain	
Provide respite for those working with little assistance in small villages.	Short
Ensure reasonable wages, benefits, and schedules.	Medium
Work to provide adequate supervision and support.	Medium
Consider housing stipends for community health aides and practitioners.	Short

Social Worker

Description:

Social workers provide services to improve client well-being and functioning. Particular focus is placed on assisting bulnerable populations and providing psycho-social supports to help clients cope with health/public health, behavioral health, abuse and neglect, education and basic need-related issues. Interventions may include individual, family and group therapy, crisis intervention, case management, advocacy, prevention and education.

Overview:

While the overall vacancy rate for social workers in the 2009 study was very low, there are critical pockets of vacancies, particularly in rural areas, that seriously affect critical functions. In some organizations, the inability to find social workers has resulted in positions being discontinued and filled by other types of workers. There may also be a need to provide additional resources to increase numbers of positions.

Workforce Data:

The 2009 vacancy rate was 3%, with 5 estimated vacancies. DOLWD data indicate a need for an additional 70 positions by 2016. Of the current workforce, 3% is non-resident, 33% is over age 50.

Education and Training:

Social work bachelor's degrees are delivered by UAA and UAF (distance), master's in social work at UAA (distance). Graduate about 58 per year (35 bachelors and 23 masters). Career pathway from rural human services certificate through associates in human services, bachelor's in social work, human services or psychology, master's in social work, now PhD in psychology.

Strategies	Timescale
Engage	
Include behavioral/mental health occupations in career awareness activities for K-12 students and educate the public on the role of the clinical social worker.	Short
Train	
Continue to develop and maintain a smoothly articulated career pathway in social work.	Short
Recruit	
Include clinical social workers in loan repayment and employment incentives programs, especially for Alaskan students.	Medium
Retain	
Increase numbers of positions in social work to lessen workload burden and associated burn out, decision errors and other problems.	Medium
Provide continuing education for social workers.	Short-Medium
Provide respite to decrease burn out.	Medium
Improve salary/benefits for social workers, as well as supervision and support.	Medium

Oral Health Practitioner

Description:

Dental Hygienists – The role of the dental hygienist is to assist members of the dental profession in providing oral health to the public. A person licensed in this profession may clean and remove stains from teeth, apply topical preventive agents (i.e. fluoride and sealants), and examine oral areas, head and neck for signs of oral disease. They may educate patients on oral hygiene and take and develop x-rays.

Dental Health Aides and Therapists (DHA/Ts) are only employed by Alaska's tribal organizations. They provide oral health care to individuals in remote communities without regular access to dentists. DHAs provide dental disease prevention and education services. Depending on level of training, DHAs may also provide additional basic level dental services. DHA Therapists are advanced practitioners who provide prevention services and a limited scope of basic restorative dental procedures such as cavity removal, fillings and simple extractions. DHATs practice under the direct, indirect or general supervision of a dentist.

Overview:

Dental Hygienists - Program expansions have recently been implemented in the UA system. The University will assess the effect in next few years and consider if additional changes are necessary. Recruitment to rural areas needs considerable attention.

DHA/T – The several levels of DHAs function similarly to dental assistants and dental health educators in non-tribal organizations. In many other developed nations, there is a tradition of a DHAT mid-level role, similar to physician assistants and nurse practitioners.

Workforce Data:

Dental Hygienists: In 2009, there were an estimated 41 vacancies statewide (8% vacancy rate); 16 (4.6%) urban and 24 (15.8%) rural. According to DOLWD estimates, an additional 210 will be needed over the 10-year period ending 2016. There were 444 licensees in 2009, up 4% from 2007. The current workforce is 7.5% non-resident, 26% over age 50.

DHA/T s: The DHA/T roles have only recently been developed in Alaska and their potential employment opportunities are evolving. The 2009 vacancy study, which included all tribal organizations except one small one, found an estimated 48 positions statewide, with 2 vacancies, a 4.2% rate.

Education and Training:

Dental Hygienists - Dental hygiene programs exist in Anchorage and Fairbanks; combined 17-20 graduates per year.

DHA/T - Training sessions for DHAs are organized by tribal health organizations. DHATs are educated in Anchorage and Bethel, in a partnership between ANTHC and the University of Washington MEDEX program. Formerly DHATs were educated in New Zealand. DHA/Ts receive certification from the Community Health Aide Program Certification Board.

Strategies	Timescale
Engage	
Include oral health practitioner occupations (Dental Hygienists and Dental Health Aides/Therapists, as well as Dentists) in career awareness activities with K-12 students and the public.	Short
Work with high schools, especially in rural areas, to provide adequate science education supportive of careers in oral health.	Medium-
Inform public about new expanded functions role for dental hygienists.	Short
Train	
Evolve educational programs for DHA/Ts.	Medium
Develop crosswalk of training in hygiene and dental assisting with that for dental health aides; collaborate where feasible.	Medium
Ensure continued funding for the cost intensive DHA/T program.	Short
Provide training in expanded dental hygiene functions.	Medium
Explore ways to give college credit for DHA/T program work.	Medium

Continue dental hygiene programs in Anchorage and Fairbanks; expand when resources and space permit; offer a Bachelor of Science in Dental Hygiene (BSDH) degree to prepare dental hygienists for entry into ADHP programs.	Medium
Recruit	
Identify and encourage likely candidates for DHA/T positions.	Short
Educate tribal dental directors about employment of DHAs and encourage appropriate support of training.	Short
Include dental hygiene in loan repayment and employment incentives programs, especially for Alaskan students.	Short
Include dental hygiene in efforts to recruit collaboratively, especially to rural Alaska.	Short
Retain	
Provide adequate compensation for oral health practitioners.	Medium
Improve supervision of village-based DHAs, including training for the dental team.	Medium
Provide meaningful, appropriate continuing education for Dental Hygienists and DHA/Ts.	Short
Improve workplace conditions and compensation and exercise other retention strategies for oral health practitioners.	Medium

Psychiatrist

Description:

A psychiatrist is a physician who specializes in the prevention, diagnosis, and treatment of mental, emotional and addictive disorders.

Overview:

While the total number of vacancies was fairly low in the 2009 study, the population of psychiatrists in Alaska over age 50 is quite high. Considering the extent of behavioral health issues in the state, it is important to address this medical specialty.

Workforce Data:

The 2009 vacancy study estimated 11 vacancies (13% vacancy rate); 16% of current practitioners are non-resident, 57% over age 50.

Education and Training:

A psychiatry residency being worked on at this time with the University of Washington.

Strategies	Timescale
Engage	
Include behavioral/mental health occupations in career awareness activities for K-12 students and the public.	Short
Train	
Develop psychiatric residency in Alaska.	Medium
Expand the third year WWAMI psychiatry clerkship for medical students.	Medium
Create and maintain a robust psychiatry resident elective until a psychiatry residency is operational; add matriculating psychiatrists to the workforce.	Medium
Recruit	
Cover psychiatrists in loan repayment and employment incentives programs.	Medium
Include psychiatrists in efforts to recruit collaboratively for physicians.	Short

Retain	
Develop and deliver continuing education opportunities for psychiatrists, particularly those in more rural areas of the state.	Shortt
Create supportive practice environments; assist in establishing practices and transitioning into the workforce.	Short

Human Service Worker

Description:

The primary purpose of the human service worker is to assist individuals and communities to function as effectively as possible in the major domains of living.

Overview:

Human service workers hold jobs with many titles. Examples include: Case Worker, Family Support Worker, Life Skills Instructor, Probation Officer, Group Home Worker, Mental Health Worker, Community Outreach Worker, Residential Manager, and Care Coordinator. Human service workers are found in diverse settings such as group homes, correctional facilities, community mental health centers, and a wide variety of other social service programs. In rural Alaska, employment opportunities include regional health corporations and federal, state and local governmental agencies.

Workforce Data:

In a large workforce of about 1,000, the number of vacancies among human service workers was 176 in 2009 (12% vacancy rate). Non-residents made up 11% of the workforce in 2006; 26% of workers were over age 50. DOLWD projects a need for about 250 additional workers in the period from 2006-2016.

Education and Training:

Some human service workers require only a high school education. The University of Alaska provides various levels of human service education, from certificate to graduate coursework. Several campuses provide education in human services, and it is possible to access programs in this field via in distance education.

Strategies	Timescale
Engage	
Include behavioral/mental health occupations in career awareness activities for K-12 students and the public.	Short
Target under-represented and other non-traditional students for human services occupations.	Short
Train	
Develop and maintain a smoothly articulated career pathways in human services across UA campuses.	Short
Seek improvements in educational programs, including complying with national standards and trends, meeting accreditation requirements, and providing access via distance education.	Short
Recruit	
Provide incentives for students to enroll in human services programs, including financial aid and scholarships for part-time, working students, workplace learning and distance education.	Medium
Retain	
Deliver continuing education for human service workers.	Short
Provide respite and sufficient staffing to decrease burn out.	Medium
Strengthen supervision through education and incentives.	Medium
Improve salary/benefits for human service workers.	Medium

Pharmacist

Description:

Pharmacists dispense drugs prescribed by physicians and other health practitioners and provide information to patients about medications and their use. Pharmacists may advise physicians and other health practitioners on the selection, dosage, interactions, and side effects of medications.

Overview:

The demand for pharmacists in Alaska has diminished somewhat in the past two years, probably helped by the recession and the recent increase in the number of pharmacy schools in the rest of the country. With anticipated retirements and potential expanded functions for pharmacists, it is expected that attention will need to be paid to ensuring that the number and distribution of this profession are adequate to meet state needs. Recruitment and retention will be important, as well as expanding viable options for educating pharmacists in state.

Workforce Data:

There were an estimated 37 vacancies (8.6% vacancy rate) in 2009 and 471 licensees, up 12% from 2007. Of the current workforce, 26% is non-resident and 34% over age 50.

Education and Training:

Currently there is no program in Alaska. Several options for pharmacy education recommended by a consultant are being discussed. An average of fewer than 10 Alaskans enroll in pharmacy schools in other states each year. The Creighton University distance delivered pharmacy program is available for those who want to stay in state for school.

Strategies	Timescale
Engage	
Inform the public about pharmacy as a career; include in K-12 career awareness activities.	Short
Target college majors in chemistry, biology and biochemistry for information about opportunities in pharmacy.	Short
Consider pharmacy technology program at the high school level.	Medium
Train	
Develop a strategy for pharmacy education for Alaska.	Short
Explore partnership options through an RFP process.	Medium
Develop a clear pre-pharmacy track at all three UA Major Administrative Units (MAUs).	Short
Work with Creighton University to set aside slots and provide tuition discount for Alaska students.	Short
Recruit	
Continue successful recruitment efforts; target new schools for information about Alaska.	Medium
Include pharmacists in loan repayment and employment incentives programs.	Short
Retain	
Creative attractive workplaces and exercise other retention strategies.	Long
Assure continuing education opportunities for pharmacists, especially in rural areas.	Medium

Therapists

Description:

A Physical Therapist assesses, treats, plans, organizes, and participates in developmental, restorative, and rehabilitative programs that improve mobility, relieve pain, increase strength, and decrease or prevent deformity of patients suffering from disease or injury.

An Occupational Therapist assesses, treats, plans, organizes, and participates in developmental, restorative and rehabilitative programs that help restore vocational, homemaking, and daily living skills, as well as general independence, to disabled persons.

A Speech-Language Pathologist assesses and treats persons with speech, language, cognition, voice, and fluency disorders to develop or regain the ability to communicate. The therapist may select alternative communication systems and teach their use and work with those with swallowing disorders to optimize nutritional intake and decrease risk of aspiration.

A Physical Therapist Assistant assists physical therapists in providing physical therapy treatments and procedures. The PT Assistant may, in accordance with State laws, assist in the development of treatment plans, carry out routine functions, document the progress of treatment, and modify specific treatments in accordance with patient status and within the scope of treatment plans established by a physical therapist.

An Occupational Therapist Assistant assists occupational therapists in providing occupational therapy treatments and procedures. The OT Assistant may, in accordance with State laws, assist in development of treatment plans, carry out routine functions, direct activity programs, and document the progress of treatments.

A Speech Therapy Assistant assists speech-language pathologists in carrying out services for individuals requiring these services.

Overview

Therapist professions in Alaska are in short supply, and pressures will continue to grow on this workforce as the population continues to rapidly age. Training for these professions tends to be expensive and complex to deliver. At present, programs in two critical therapy professions (OT and Speech-Language) are offered in Alaska through partnership arrangements and partners are being sought for physical therapy. There is some need to expand the use of occupational therapists across the state, as well as assistants in both PT and OT. That has not been the typical practice pattern to date but could serve the state well. Local development of the assistant occupations is being considered, but will require resources. There will be a continued need for recruitment into the state and for attention to distribution within Alaska.

Workforce Data:

The 2009 vacancy study estimates the following for the various therapies: PT: 45 (rate 16%), OT: 29 (rate 23%), Speech-Language Pathologists: 16 (rate 10%), PTA: 17 (rate 28%). The current workforce has considerable non-resident and older workers: OT: 17% out-of-state workers; 32% age 50+; PT: 22% out-of-state, 22% age 50+; Speech-Language: 18% out-of-state, 44% age 50+; PTA: 11% out-of-state, 19% age 50+.

Education and Training:

There is an OTD program at UAA with Creighton University, currently admitting up to ten per year in Anchorage. UA is exploring partnerships for an Alaska-offered DPT. The University is also looking into requirements for development of PTA and OTA programs. There is a speech-language master's program available in Alaska, a partnership with East Carolina University's distance program, with post-baccalaureate bridge courses offered by UAA. There is a speech pathology assistant distance option available through the UAA Center for Human Development.

Strategies	Timescale
Engage	
Elevate public awareness of therapies occupations and professions.	Medium
Provide information to K-12 students, including job shadows, role models, and mentors.	Short
Advise students on educational opportunities within and outside Alaska.	Medium
Raise awareness and acceptance of the use of mid-level PTAs and OTAs in the Alaska healthcare community.	Long

Train	
Maintain OT partnership with Creighton University and Speech-Language partnership with East Carolina University; develop PT partnership with an external institution.	Medium
Seek expanded/alternate approaches to therapies education in Alaska over time, where feasible and needed.	Long
Assist UA to move aggressively to develop programs for both PTA and OTA, with a goal of admitting a cohort of PTA students in the fall of 2011.	Short-Mediu
Consider potential for the speech therapy assistant program to be developed as an apprenticeship (may be registered or non-registered).	Short
Assist non-traditional students to enter professional programs; give credit for relevant past experience; provide mentors.	Medium
Recruit	
Address wage disparity for mid-levels (PTAs and OTAs).	Medium
Identify schools in the Lower 48 that would like to offer clinical rotations in Alaska facilities and develop relationships, after giving first preference to students in programs in Alaska.	Medium
Include PTs, OTs and Speech Pathologists in loan repayment/employment incentive programs and recruitment collaborations.	Medium
Consider industry provision of financial assistance in exchange for service.	Medium
Develop additional appropriate clinical rotations for therapy students.	Medium
Retain	
Assess retention factors for therapy professionals in Alaska; plan retention strategies.	Medium
Work on a re-entry strategy for those who have left the profession to raise children, etc.	Long
Provide affordable, high quality and pertinent continuing education in a format easily accessed by therapists, especially those in rural Alaska.	Medium

Nurse Educator

Description:

Nurse educators teach nursing students in basic and advanced nursing programs. They may also provide education to patients, families, communities and health care workers, in a variety of settings.

Overview

There is a national shortage of nurse educators and current faculty is older on average than the overall nursing workforce. Recruitment and retention require attention to salary/benefits issues. Accreditation standards are high for schools of nursing. Regular faculty are required to have earned master's or doctoral degrees. This is a challenging role, combining expertise in clinical skills and instruction. UAA established a master's track several years ago and interest is increasing. Sustaining and marketing this program is important to allow Alaska to grow its own nurse faculty and to also prepare nurse educators to work with patients and communities.

Workforce Data:

Currently there are 4 faculty vacancies in the UA SON AAS program (vacancy rate 16%) . The overall nursing faculty vacancy rate is 7.8%. One to two additional FTEs are needed for the MS program. The average age of current faculty is 54.9 years: 4% at 30-39, 17% at 40-49, 49% at 50-59, and 30% at 60-69 years.

Education and Training:

UAA has an online master's degree track for nursing education.

Strategies	Timescale
Engage	
Expand awareness of nursing opportunities in the education of students, patients, families, others.	Short
Engage local nurses in educational roles as preceptors and faculty members.	Short
Encourage health care providers to identify members of the workforce to serve as educators.	Short
Train	
Market nurse educator distance-delivered master's program at UAA.	Short
Provide scholarships and other incentives for nurses to achieve advanced education and to participate as educators of the next generation of nurses.	Medium
Encourage continued involvement of current nursing faculty as preceptors of graduate nurse educator students.	Short
Recruit	
Identify nursing specialists and nurse educators as beneficiaries of loan repayment and employment incentives programs.	Short
Develop a comprehensive plan and provide incentives to attract nursing faculty to Alaska.	Medium
Encourage and incentivize aspirations for advanced degrees in nursing, including master's and doctoral degrees.	Short
Assess salaries for nursing faculty and find ways to enhance salary/benefits to improve recruitment and retention.	Short
Retain	
Provide incentives to nursing staff to welcome and mentor student nurses, new graduates and employees.	Short
Ensure School of Nursing workplace is collegial and congenial place to work; provide resources, mentoring and support needed to become/be an effective faculty member.	Short
Identify methods of attracting and retaining nurses later in their careers as productive members of the nurse educator workforce.	Medium
Establish faculty compensation at levels found in the industry.	Medium

Health Informatics Staff

Description:

Modern definitions of Health Informatics encompass the two broad interrelated fields of Health Information Management (HIMS) and Clinical Informatics. Personnel operate at many levels to design, develop, implement, use and manage information technology in health care organizations. Related HIMS occupational titles include medical records technicians, medical coders, and medical and health services managers. In the evolving field of Clinical Informatics, occupational titles are not yet standardized but encompass the spectrum of information technology (IT) titles in a clinical setting: clinical informatics specialist, programmer, and analyst.

Overview

Health Informatics is a swiftly growing and evolving field in Alaska. A combination of education and on-the-job training is usually required for these occupations. IT professionals need an augmented health background, and health professionals require IT knowledge. Alaska is presently working to develop a Health Information Exchange to enable the electronic sharing of patient records between medical providers and all medical providers are working to implement or enhance electronic health record systems and interface them with point-of-care medical devices such as glucometers, ventilators, EKGs, etc.

Workforce Data:

There are many types of workers involved in health informatics, from administrative assistants and billing/coding staff to health care and IT professionals. The common denominator is that they function in support of health IT, inclu ing electronic medical records. The future growth in jobs in this broad and complex field is not yet accurately measured but it is expected to be dramatic due to the proliferation of hi-tech devices in direct patient care, and federal mandates t expand the meaningful use of electronic health records.

Education and Training:

The University of Alaska has several programs in billing, coding, health records and related topics. A work group is planning to add HIT components to these existing programs and to expand coursework in this area, especially at certificate and associate degree levels. Collaborations with other universities and colleges are being developed in this area, particularly to make graduate level education available to Alaskans. Charter College also offers health information technology programming.

Strategies	Timescale
Engage	
Include health informatics careers when providing career awareness to K-12 students.	Medium
Inform existing health care workers and administrative staff about health informatics.	Short
Advise current students in health programs and computer science/IT programs to study HIT.	Medium
Train	
Assess HIT training needs with industry.	Short
Develop a comprehensive plan for HIT education needed by the Alaska health care industry.	Short
Participate in consortia to develop curricula and share HIT courses at all levels.	Short
Provide HIT-related coursework in-state for health and IT staff pertinent to individual knowledge gaps.	Medium
Recruit	
Encourage interested employees to gain additional education and skills in the area of HIT.	Medium
Retain	
Provide sufficient support and continuing education to health care staff to allow them to be comfortable as health informatics evolves and becomes more prevalent in the workplace.	Medium

Direct Care Worker

Description:

Direct care workers are the backbone of the health care delivery system, providing routine, personal healthcare and assistance with daily living in a variety of settings. Common titles for these workers are Personal Care Assistant or Attendant, Home Health Aide, Nurse Aide or Certified Nurse Assistant (CNA), Disabilities Services Worker, Direct Support Professional, Direct Service Worker.

Overview

CNAs fall under the Board of Nursing in Alaska which ensures that educational standards are met by programs and that the CNA scope of practice is defined and enforced. In January 2010 a proposal was put forth by a collaborative Credentialing and Quality Standards group outlining core competencies for direct care workers in health and human services. These competencies are intended to be used to further educate and strengthen the direct care workforce in the state.

Workforce Data:

The direct care workforce in Alaska is quite large. In 2006, DOLWD identified 2,337 Personal and Home Care Aides, 1,859 Home Health Aides and 1,940 Nurses Aides, Orderlies and Attendants, for a total in these three occupations of 6,136 workers. 2009 vacancy data for Personal Care Attendants showed 33 positions (6%, vacancy rate) with 8% non-residents and 31% over 50 years of age. DOLWD projects a need for an additional 1,210 PCAs in the 2006-2016 timeframe. There were 12 vacancies for home health aides identified in 2009, a 16% vacancy rate. DOLWD projects needing an additional 830 HHAs by 2016. Certified Nurse Aides showed 116 vacancies, an 8% rate. DOLWD projects a need for 850 more nurse aides, orderlies and attendants by 2116. While only 6% of the current nurse aide workforce is non-residents, 21% is over 50 years of age. There is a high turnover in these entry-level occupations.

Education and Training:

There are a number of training providers for CNAs across the state, including university campuses, AVTEC and several hospitals (some in partnership with campuses and/or high schools). PCAs are required to have minimal training and, if hired directly by a consumer rather than an agency , there is very little required training or oversight. In part because home health aides do not have special certification in Alaska at this time, there is no specific training program for HHAs in the state.

Strategies	Timescale
Engage	
Encourage awareness of these entry-level careers, including providing programs at the high school level.	Short
Ensure potential and current workers understand this can be an entry point into a career ladder.	Short
Train	
Work with the Board of Nursing to remove barriers that impede the provision of CNA training programs in a large number of communities and in various training sites.	Short
Continue to work on common core curricula for PCA and CNA education, as well as advanced practice specialties with the Board of Nursing and others.	Short
Strengthen, support and expand the long-term care and direct/disabilities support apprenticeship programs, working with federal and state DOLWD staff.	Short
Continue work on standardization of occupational core competencies and strategies for implementation.	Medium
Recruit	
Increase efforts to attract underrepresented individuals to participate in the direct care workforce.	Short
Develop and support recruitment strategies that focus on the non-traditional and under-represented worker, i.e. retirees, family & friends, Alaskan Natives, etc.	Short
Retain	
Work on improving wages and benefits for direct care workers through a focus on credentialing.	Long
Provide continuing education to allow direct care workers to add to their competencies and advance in their field.	Medium
Increase skills of supervisors and ensure delivery of supervision of Direct Care Workers; integrate instruction on the supervision and support of direct care workers into the educational preparation for registered nurses or related occupations.	Medium
Seek opportunities to facilitate participation of direct care workers in educational programs and the annual conference to advance their credentials; augment career ladders.	Short

Notes

Notes

Documents Cited in the Plan

Alaska Center for Rural Health, 2009 Alaska Health Workforce Vacancy Study, (Draft) January 2010.

Alaska Department of Health and Social Services, Division of Public Health, Healthy Alaskans 2010, Targets and Strategies for Improved Health, November 2005

Alaska Department of Health and Social Services, Securing an Adequate Number of Physicians for Alaska's Need, Alaska Physicians Supply Task Force Report, August 2006

Alaska Department of Health and Social Services, Status of Recruitment Resources and Strategies 2005-06, June 2006

Alaska Department of Labor and Workforce Development, Employment Forecast for 2010, Alaska Economic Trends, January 2010

Alaska Department of Labor and Workforce Development, Alaska's 10-year Occupational Forecast, Alaska Economic Trends, January 2009

Alaska Department of Labor and Workforce Development, Alaska's Health Care Industry, Alaska Economic Trends, March 2010

Alaska Workforce Investment Board, Alaska's Future Workforce: Strategic Policies and Investment Blueprint, 2002

Donald E. Pathman, M.D., et al, Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians, Medical Care, Vo. 42, No. 6

Appendix

3RNET	Rural Recruitment and Retention Network
ACE-HC	Alaska Coalition of Educators in Health Care
AHEC	Area Health Education Center
AKCIS	Alaska Career Information System
ALEXsys	Alaska Labor Exchange System
AMHTA	Alaska Mental Health Trust Authority
ANTHC	Alaska Native Tribal Health Consortium
APICC	Alaska Process Industry Careers Consortium
APU	Alaska Pacifc University
ASHNHA	Alaska State Hospital and Nursing Home Association
AVTEC	Alaska Vocational Technical Center
AWIB	Alaska Workforce Investment Board
DCCED	Department of Commerce, Community and Economic Development
DEED	Department of Education and Early Development
DHSS	Department of Health and Social Services
DOLWD	Department of Labor and Workforce Development
HOSA	Health Occupations Student Association
HRSA	Health Resources and Services Administration
IHS	Institutes of Health
MAU	Major Administrative Unit
NHSC	National Health Service Corp
RWJ	Robert Wood Johnson Foundation
STEP	State Training and Employment Program
TIE	Teacher Industry Externships
UA	University of Alaska
VTEP	Technical Vocational Education Program (state funds)
WBLE	Work-based Learning Experiences
WIA	Workforce Investment Act
WICHE	Western Interstate Commission on Higher Education
WWAMI	Washington, Wyoming, Alaska, Montana and Idaho (regional school of medicine based at University of Washington)
YES	Youth Employment Skills

Alaska Occupational Forecast 2006 to 2016, Vacancy Rates and Supply Data–Health Occupations

DOL and UAA sources

SOC Code	Occupation	Employment			Openings			Alaska Mean Wage	Percent Non-Resident Workers
		2006	2016	Pct Chg	Growth	Replacement	Total for 10 Year Period		
	Healthcare Practitioners and Technical								
	Behavioral Health Aides/Village Counselors								
	Behavioral Health Case Managers								
	Behavioral Health Clinicians								
	Child, Family and School Social Workers	749	847	13.1	100	160	260	20.87	7.0%
	Community Health Aides/Practitioners								
	Community Health Representatives								
	Critical Care/Emergency Room/Intensive Care Unit Nurses								
29-2021	Dental Hygienists	532	643	20.9	111	99	210	$44.38	7.5%
29-1021	Dentists, General	121	135	11.6	14	16	30	$97.60	19.1%
29-1031	Dietitians and Nutritionists	100	118	18	18	32	50	$27.41	6.1%
29-2041	Emergency Medical Technicians and Paramedics	260	329	26.5	69	31	100	n/a	14.3%
	Family Nurse Practitioners								
	Family Physicians/General Practitioner							66.53	23.7%
29-1199	Health Diagnosing and Treating Practitioners, All Other	147	180	22.5	33	27	60	$37.88	
	Health Educator/Village Health Educator/Community Wellness Advocate	230	281	22.2	50	30	80	$19.84	5.0%
	Health Information Managers								
29-2099	Health Technologists and Technicians, All Other	477	581	21.8	104	36	140	$25.20	
29-9099	Healthcare Practitioners and Technical Workers, All Other	344	413	20.1	69	71	140	$24.39	
	internists, General							$68.25	41.7%
29-2061	Licensed Practical and Licensed Vocational Nurses	593	700	18	107	163	270	$23.01	15.5%
	Marital/Family Therapists							$28.54	
29-2012	Medical and Clinical Laboratory Technicians	272	336	23.5	64	36	100	$20.16	15.6%
29-2011	Medical and Clinical Laboratory Technologists	255	297	16.5	42	38	80	$30.23	17.9%
	Medical and Public Health Social Workers (BA/BSW, MSW, LCSW)	188	221	17.6	30	40	70	$24.92	3.2%
29-2071	Medical Records and Health Information Technicians	419	512	22.2	93	107	200	$18.41	9.4%
	Mental Health and Substance Abuse Social Workers	321	401	24.9	80	70	150	$22.47	8.9%
	Mental Health Counselors	232	287	24.8	60	30	90	$24.69	9.9%
	Nurse Case Managers								
	Nurse Managers/Executives								
	Nurse Midwives/Women's Health Nurse Practitioners								
29-9011	Occupational Health and Safety Specialists	200	221	10.5	21	39	60	$38.64	
29-1122	Occupational Therapists	142	180	26.8	38	22	60	$33.38	17.2%
29-2081	Opticians, Dispensing	126	145	15.1	19	41	60	$18.51	9.6%
	Optometrists							$55.02	15.2%
29-1051	Pharmacists	294	393	33.7	99	51	150	$53.18	26.1%
29-2052	Pharmacy Technicians	460	622	35.2	162	138	300	$17.42	11.6%
29-1123	Physical Therapists	307	410	33.6	103	37	140	$37.71	22.0%
29-1071	Physician Assistants	352	460	30.7	108	52	160	$46.99	22.8%
29-1060	Physicians and Surgeons	822	996	21.2	174	146	320	n/a	
	Psychiatric Nurses								
	Psychiatric Nurse Practitioners								
29-2053	Psychiatric Technicians	182	222	22	40	60	100	n/a	11.2%
	Psychiatrists							$ 94.09	15.5%
	Psychologists/Clinical Psychologists								
	Public Health Nurses								
29-2034	Radiologic Technologists and Technicians	400	501	25.3	101	49	150	$29.03	15.2%
29-1125	Recreational Therapists	141	184	30.5	43	17	60	$20.78	10.4%
29-1111	Registered Nurses	4,817	6,328	31.4	1,511	799	2,310	$35.01	16.0%
	Rehabilitation Counselors	402	499	24.1	100	80	180	$23.15	6.4%
29-1126	Respiratory Therapists	149	197	32.2	48	22	70	$28.75	19.1%
	Social and Human Services Assistants/Human Services Workers	989	1131	14.4	1240	110	250	$16.10	11.3%
	Sonographers							$35.23	32.6%
	Speech Therapists								
29-1127	Speech-Language Pathologists	164	181	10.4	17	33	50	$34.87	17.9%
	Sterile Processing Technician								
	Substance Abuse and Behavioral Disorder Counselors	259	320	23.6	60	50	110	$23.71	8.1%
	Surgical Technologist							$20.55	23.1%
29-2056	Veterinary Technologists and Technicians	119	135	13.5	16	44	60	$14.87	
	Healthcare Support								
31-9091	Dental Assistants	1,003	1,215	21.1	212	168	380	$20.11	11.5%
	Disabilities Services Workers								
31-9099	Healthcare Support Workers, All Other	1,933	2,217	14.7	284	236	520	$17.80	
31-1011	Home Health Aides	1,859	2,515	35.3	656	174	830	$13.58	8.9%
31-9011	Massage Therapists	181	221	22.1	40	20	60	$38.70	12.9%
31-9092	Medical Assistants	800	1,132	41.5	332	98	430	$16.95	8.3%
31-9094	Medical Transcriptionists	143	168	17.5	25	25	50	$19.43	9.8%
31-1012	Nursing Aides, Orderlies, and Attendants	1,940	2,629	35.5	689	171	860	$15.53	6.3%
	Pharmacy Aides							$15.17	15.0%
	Physical Therapist Aides							$15.67	8.60%
	Physical Therapy Assistants							$17.18	11.10%
31-1013	Psychiatric Aides	120	133	10.8	13	7	20	$17.58	90.00%
31-9096	Veterinary Assistants and Laboratory Animal Caretakers	195	219	12.3	24	16	40	$12.25	
	Personal Care and Service								
39-9021	Personal and Home Care Aides	2,337	3,146	34.6	809	401	1,210	n/a	8%
	Management								
11-9111	Medical and Health Services Managers	903	1,076	19.2	173	167	340	$41.33	5.8%
11-9151	Social and Community Service Managers	478	542	13.4	64	86	150	$29.15	7.5%
	Office and Administrative Support - Not Only Healthcare								
43-3021	Billing and Posting Clerks and Machine Operators	1,118	1,209	8.1	91	139	230	$17.88	11%
43-4199	Information and Record Clerks, All Other	1,808	1,722	-4.8	0	290	290	$19.51	
43-6013	Medical Secretaries	337	410	21.7	73	47	120	$15.76	10%

Note:

*All Nurse Practitioners

**All Physicians

***Physical and Occupational Therapists

Percent Residents Age 50+	Active Alaska Licensees August 2009	Percent Change in Licensees from 2007 to 2009	2009 Vacancies (Estimated)	2009 Vacancy Rate	2007 Vacancy Rate	Estimate # Graduates in AK in 10 Year Period	Comments
			39	15%	18%	?	Occupational endorsement in Rural Human Services
			49	6%			Human Services graduates often perform this function
			47	10%	0%		Social workers, psychologists, human services workers educated in AK
26.2%							See Medical and Public Health Social Workers
			44	13%	12%	40 AAS +	Tribal Training Centers provide Session Training - ? # per year
			7	10%	0%		
			42	15%	14%		
26.0%	444	4%	41	8%	13%	170-200	Anchorage and Fairbanks sites
43.3%	486	4%	15	3%	7%		Looking at options for education
27.3%			11	17%	33%	50	
14.3%			0 E/11 P	0%/4%	26%/14%	2330 E/400 P	Many EMTs needed as volunteers
	490*	9%	58	17%	14%	150	DOL data included in RNs
40.8%	1,583**	2%	67	11%	14%	~200	Alaska WWAMI program - see Physicians and Surgeons below
						na	
25.6%			10	5%	13%	20	Community Wellness Advocate program at Sitka; working on health education BSHS
			6	6%		80	
						na	
						na	
41.9%							
42.2%			67	12%	14%	200-400	AVTEC has 40 slots per year
			5	10%	0%		
30.4%			6	4%	8%	10-40	New lab in 2011 will allow expansion
42.5%			15	7%	12%	125	New lab in 2011 will allow expansion
33.1%			5	3%	12%	580	BA/BSW (35/year)and MSW (23/year) programs; available through distance delivery
24.9%			57	5%	9%	100	Billing/coding and health information management
37.0%							See Medical and Public Health Social Workers
36.7%	417	17%					See Psychologists, Medical and Public Health Social Workers, Social/Human Services Assistants
			31	11%	14%		DOL data included in RNs
			18	13%	13%		DOL data included in RNs
			21	22%	6%		DOL data included in RNs
						70	
31.9%			29	23%	28%	80	Creighton partnership - 10 slots per year if continues past 3rd cohort
30.9%					18%	0	No program in state
35.7%							
34.0%	471	12%	37	8%	11%	50	Looking at options with consultant
13.1%	1,246	30%	31	3%	6%	70	Unused program capacity - state does not require formal training
21.6%	607***	2%	45	16%	18%		Looking at options
43.8%	320	13%	42	13%	24%	200	Doubled program; all offered in Alaska
			102	10%	11%	250	Alaska WWAMI - see Family Physicians above
			10	13%	9%	See R.N.s	
			8	18%	27%	30	
28.9%			2	4%	6%		2009 number includes Psychiatric Aides
57.4%			11	13%	29%		Residency program being discussed
	132	-4%	18	12%	27%	100	Master's level education, will also have PhD graduates
			21	22%	9%	See R.N.s	
30.7%			7	4%	9%	260	In 6 locations
34.7%							
40.2%	6,334	9%	307	10%	9%	2000	New graduates; but many positions require experience/specialty training
27.3%							
39.5%			4	6%	4%	0	Considering this program
26.5%			176	12%	10%	1080	Certficate, AHS, BHS
46.9%			9	14%	13%		Program being planned
			10	16%	0%		
44.1%			16	10%	23%	65	Alaska cohort of 5-8 per year in East Carolina U distance program
			6	6%	7%		
39.4%			48	15%	13%		
23.0%			6	9%	14%		
						0	
13.8%			62	6%	11%	180	Formal training not required in Alaska; programs in Anchorage and Fairbanks
						110	
26.4%			12	16%	33%	ee Nursing Aide	Not distinguished from CNAs in Alaska by certification
19.2%			3	4%	0%		UAA has advanced CE only at present
13.8%			30	4%	14%	210	
38.8%			2	1%	7%	70	
21.3%	2,880	14%	116	8%	12%	870+	Certified Nursing Assistants - AVTEC and UA programs; ? counts from others
12.3%							
9.30%							
8.80%			17	28%	25%		Program being planned
9.90%			With Psych Techs		6%		
						100	New program at Mat-Su Community Campus
31%			33	6%	8%	30-110	Could train many more if state required
12.0%			86	5%	5%	?	APU and UA
38.3%			13	6%		30+	Graduate certificate in social work management
18%			58	5%	7%	40	The DOL occupational information is not just for health care
			37	6%	0%		The DOL occupational information is not just for health care
23%					13%		

Alaska Occupational Forecast

Fold-Out Chart

ALASKA CHILDREN'S ALLIANCE UPDATE ON CAC'S 2011

<TARGET><BILL></BILL><SUBJECT>ALASKA CHILDREN'S ALLIANCE UPDATE ON CAC'S 2011</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska Children's Alliance Update on CACs 2011

- **Pam Karalunas**

Chapter Coordinator, Alaska Children's Alliance

- **Cory Bryant**

Program Manager, CARES, Anchorage

- **Elena Aluskak**

Program Manager, TWC The Children's Center, Bethel

Alaska Children's Alliance

The mission of the Alaska Children's Alliance is to promote a culturally appropriate multidisciplinary response to child maltreatment throughout Alaska

ACA - State Chapter of National Children's Alliance which:

- Sets minimum standards for CACs
- Sets minimum standards for State Chapters
- Provides
  - Limited funding for Chapters
  - Support, Training and Technical Assistance
  - National recognition
  - Accreditation

Alaska Children's Alliance provides:

- **Technical assistance & support to existing and developing:**
  - **Children's Advocacy Centers**
  - **Multidisciplinary Teams**
  - **Child Protection Teams**
- **State representation at the regional and national levels**
- **Limited funding through national grants**

Alaska Children's Alliance provides:

- **Statewide Projects to enhance services**
  - **TeleCam Medical Peer Review & Consultation – based at CARES**
  - **Biennial Alaska Child Maltreatment Conference**
  - **Forensic Photography Equipment & Medical Training for each CAC**
- **Coordination of statewide efforts**
  - **Data Collection in collaboration w/CJA & SCAN (Suspected Child Abuse & Neglect)**
  - **Statewide protocols to ensure high & consistent level of service**

Alaska Children's Alliance provides:

- **Development of Alaska specific projects**
  - Pilot Project: *Honoring, Protecting & Nurturing Our Children* Community Outreach Project
  - Specialized training for natural support people in villages served by CACs (in development in collaboration with Western Region CAC)
  - Training for Tribal entities on use of Child Advocacy Centers in their Regions (in development)
  - Training on development of satellite CACs (in development in collaboration with Western Region CAC)

Alaskan Child Advocacy Centers

- Anchorage – Alaska C.A.R.E.S.
- Bethel – TWC The Children's Center
- Copper River Basin – Copper River Basin CAC
- Dillingham – Nitaput Child Advocacy Center
- Fairbanks – RCPC Stevie's Place
- Kenai Peninsula – Kenai Peninsula CAC
- Juneau – S.A.F.E. CAC
- Kodiak–Kodiak Area Native Assoc. CAC – *Developing*
- Mat-Su – The Children's Place
- Nome – Kawerak CAC

Anchorage:

Est. 1996
served 8,854 children through FY10

- A program of the Children's Hospital at Providence
- Co-located with state & local law enforcement, OCS
- Part time mental health services on-site
- Alaska Native Unit on-site
- Serves children 0-18
- Re-accredited by National Children's Alliance
- Serves 27 communities

Bethel:

Est. 2001
served 1,063 children through FY10

- A program of the Tundra Women's Coalition
- Yupik name: "Irniamta Ikayurviat"
- Recently moved to a new building funded by the State of Alaska, the Rasmuson Foundation & the Paul G. Allen Family Foundation
- Serves children 0-18
- Serves 35 communities

Copper River Basin

Est. 2009
served children 29 through FY10

- Independent non-profit
- Housed in a recently closed rural school
- Co-located with OCS
- Serves children 0-18
- Serves 17 communities
- Have Polycom capabilities for mental health services

Dillingham:

- A program of Bristol Bay Area Health Corporation
- "Nitaput" – *We hear them*
- *Serves children 0-18*
- *Serves 32 communities*

Est. 2003
served 222 children through FY10

Fairbanks:

Est. 2003
served 1,105 children through FY10

- A program of Resource Center for Parents & Children
- Co-located with the ABI Crimes Against Children Unit
- Serves children 0-18
- Serves 83 communities
- Community Care contract with Fairbanks Memorial Hospital to provide services on-site at Stevie's Place
- Community presentations done by MDT

Juneau:

Est. 2001
served 1,047 children through FY10

- A program of Catholic Community Services
- S.A.F.E. – Southeast Alaska Family Evaluation
- Accredited by National Children's Alliance
- Serves children 0-18
- Serves 19 communities

Kenai Peninsula:

Est. 2008
served 210 children through FY10

- A program of South Peninsula Haven House, Homer
- Satellite CAC in Kenai is co-located with the Sexual Assault Response Team in the Health Center
- Satellite CAC developing in Seward
- Serves 30 communities with 3 locations

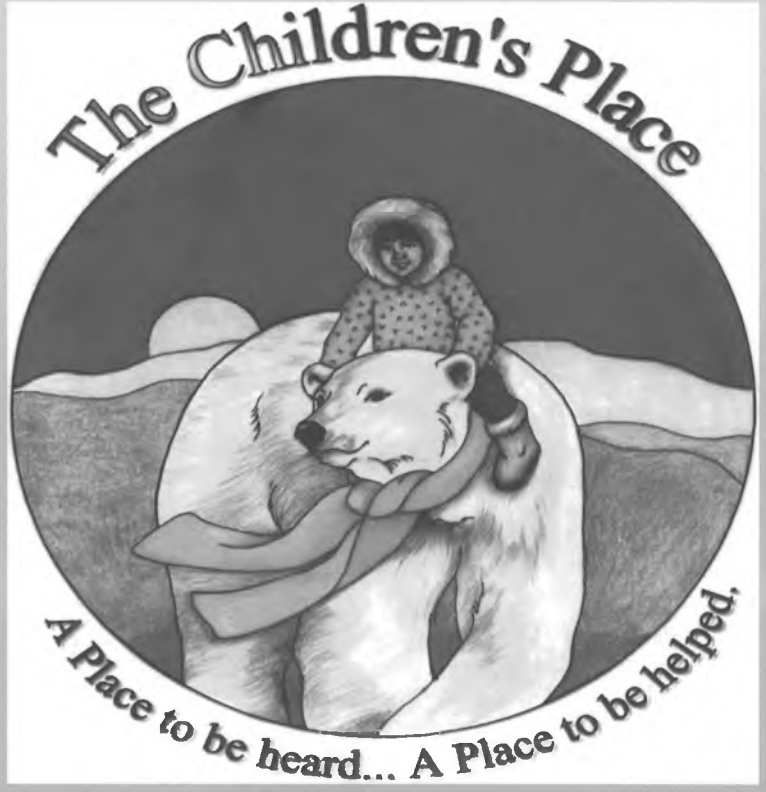
Kodiak:

Developing – to open early summer 2011

$250 000
Start up money

- A program of Kodiak Area Native Association
- Working closely with ACA, OCS, community partners
- Governor's budget includes funding for development
- Currently drafting MDT policy and protocol to begin services

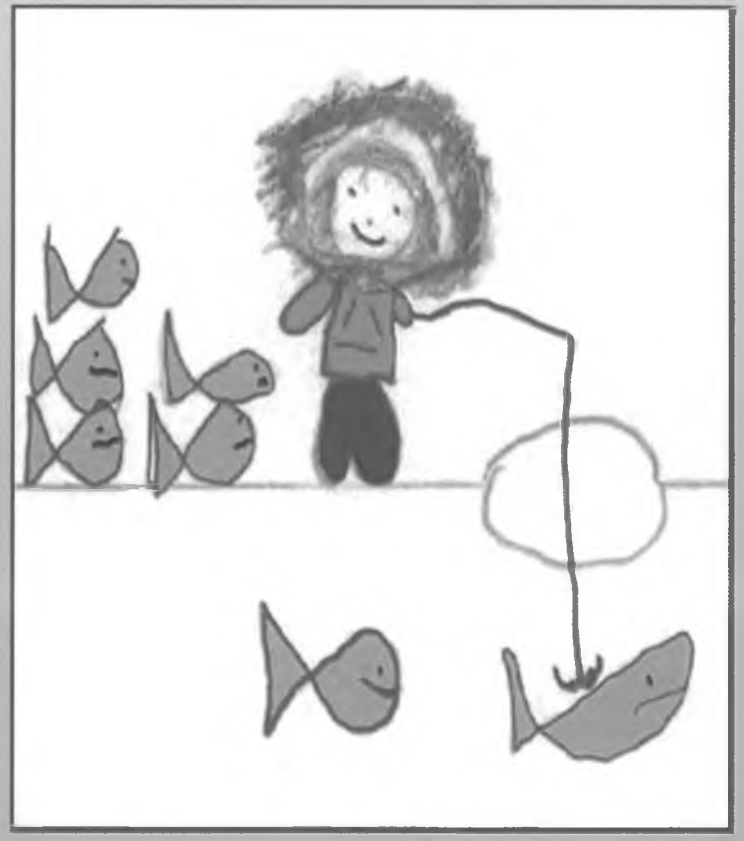
Mat-Su:



Est. 1999
served 1,678 children through FY10

- Independent non-profit
- Recently expanded building to co-locate Alaska State Troopers ABI Child Abuse Investigation Unit
- Serves children 0-18
- Re-accredited by National Children's Alliance
- Serves 11 communities

Nome:



Est. 2002
served 219 children through FY10

- A program of Kawerak Native Association
- "annaktuq" – *is sheltered, is safe*
- Serves children 0-18
- 3 CAC Educators fly to villages in the Region to provide education on child sexual abuse and support services to victims
- Serves 17 communities

Child Advocacy Centers provide:

- **A child and family friendly environment for coordination of investigative process in child abuse cases, specifically child sexual abuse**

"nice people, cozy, homey, - I felt safe here"

Child Advocacy Centers provide:

- **Specialized Forensic Interview**

"They said I'm not in trouble and I did do the right thing on telling someone what my uncle was doing."

Child Advocacy Centers provide:

Multidisciplinary response/investigation reduces duplicative interviews

MDT "Watching Room"

The best part was:

~"Telling what my dad did to us."

~"Talking to people I trust and that care for me."

Child Advocacy Centers provide:

- **Specialized, Non-traumatic Medical Exam**

"My favorite part (of being at the CAC) was finding out my body is OK"

Child Advocacy Centers provide:

- **On-going support and follow up for family throughout the system process and beyond**

"Everything was well explained-you guys are doing a great job. Thank you."

"I am happy there is such a place as the CAC, for me as a child I did not have anyone or anywhere to go for my experience."

Child Advocacy Centers provide:

- **Culturally competent services**

"I am so thankful for this place, where my grandchild is safe to talk to familiar people in a familiar language."

"Thank you so much for your help in the start of our long battle."

Child Advocacy Centers provide:

"(The CAC) added to our healing. They didn't add to our hurt."

- **Collaboration with mental health services for earlier response to referrals**
- **Identification of risks and assessment of needs of child and family and referrals to address those issues**

Child Advocacy Centers provide:

- **Case review:**
  - **to ensure the well-being of the children and family**
  - **to monitor and assess the effectiveness of the MDT**

once a month

Child Advocacy Centers provide:

- **Case Tracking**
  - **CACs in Alaska use a uniform data collection system, NCATrak**
  - **Provides essential demographics, case information & investigation outcomes**
  - **Useful for program evaluation**

"All the caring personalities was very comforting. Everyone kept us apprised of what was happening and were giving us very helpful information. It was nice to be treated so respectfully and I think everyone here helped my daughter find a little peace in this terrible situation."

Child Advocacy Centers provide:

Community Awareness, Education, Outreach:

- ♥presentations
- ♥Classes
- ♥Radio shows, interviews, etc

Did you know?

- **History of child sexual abuse is linked with increased risk for:**
  - alcoholism and alcohol abuse
  - suicide attempts
  - intimate partner violence
  - chronic obstructive pulmonary disease
  - depression
  - fetal death
  - illicit drug use
  - ischemic heart disease
  - liver disease
  - multiple sexual partners
  - sexually transmitted diseases
  - smoking
  - unintended pregnancies

Cost of Child Abuse & Neglect In Alaska:

- estimates the annual cost of child abuse in Alaska to be **$500,503,200** (06 incidents, 07 costs)
  - Medical Care $ 2,540,500
  - Mental Health 55,724,600
  - Property Damage 50,000
  - Public Programs 27,131,900
  - Future Earnings 23,666,000
  - Quality of Life 391,390,200

Children's Safety Network, National Injury & Violence Prevention Center, 2007

Why the CAC Model? Cost

- NCAC Cost-Benefit Analysis
  - Per Case – traditional investigations were 36% more expensive than CAC investigation. Average cost: $2,902 compared to $ 3,949, more than $1,000 savings per case.

Why the CAC Model? Prosecution Timelines

How long to prosecute child sexual abuse for a community using a CAC and two comparison communities? Walsh, W.A., Lippert, T., Cross, T.E., Maurice, D.M., & Davison, K.S. (2008) *Child Maltreatment*, 13(1), 3-13

- Charging decision in child sexual abuse cases:

  Cases seen at the CAC had a significantly faster charging decision

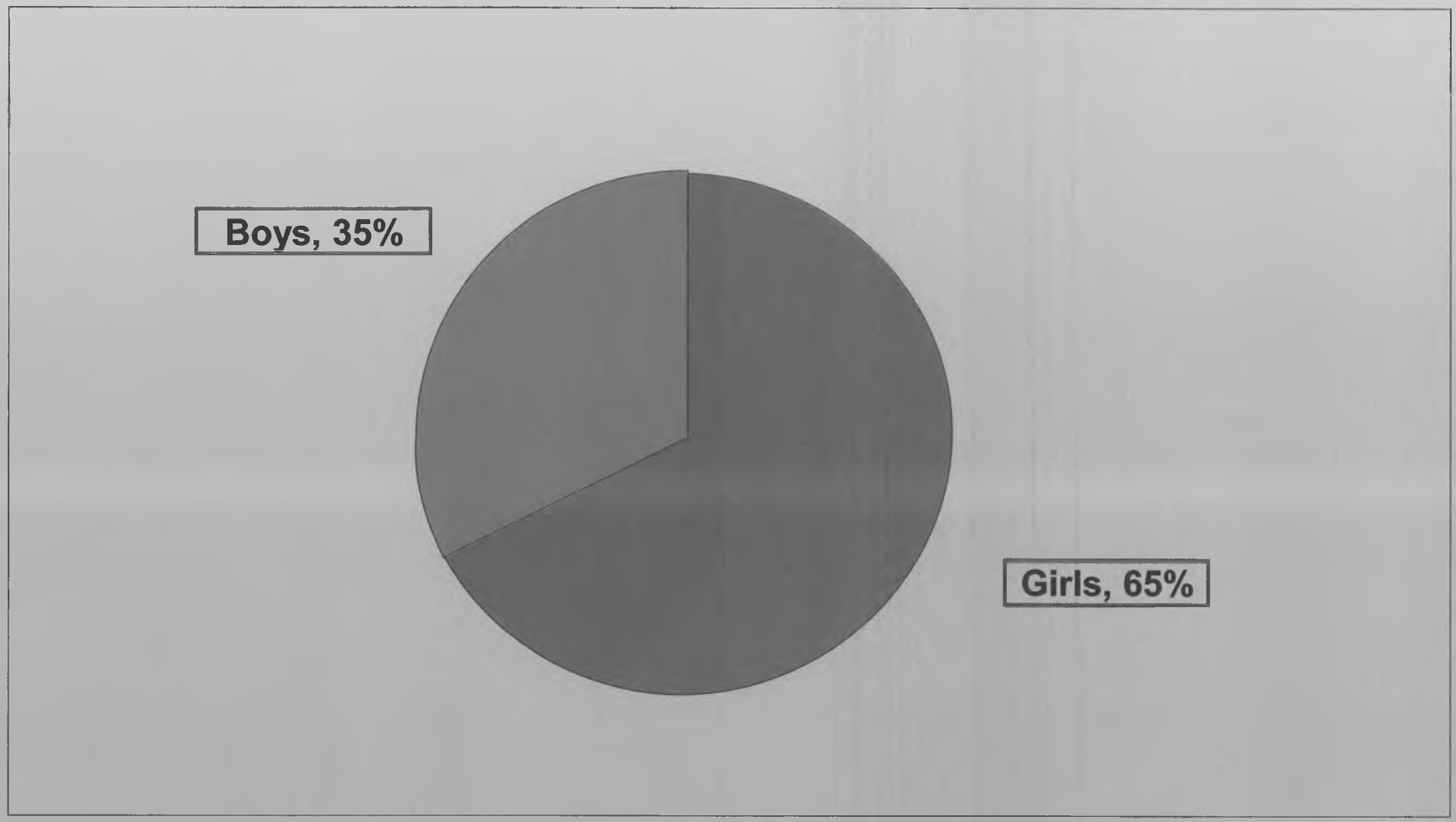
- Case Resolution Time
  - CAC 20% were resolved within 180 days
  - Comparison 30% took more than two years after indictment or were still pending

Why the CAC Model?

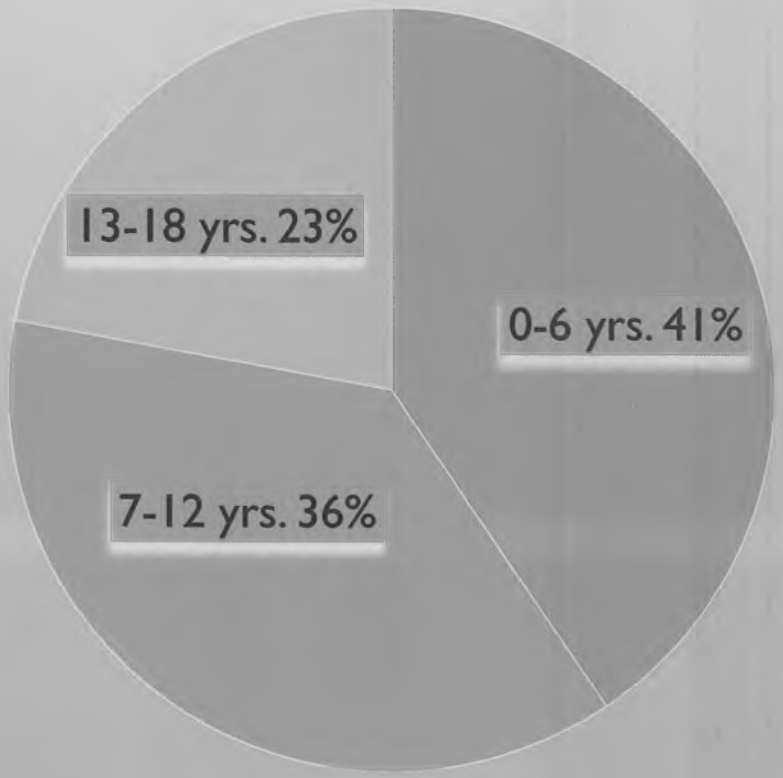
OUR CHILDREN DESERVE NOTHING LESS!

Research suggests that one in four girls and one in seven boys will be the victim of some type of sexual abuse/assault before age 18

Gender of children seen at Alaska CACs in FY10



Ages of children seen at Alaska CACs in FY10



Numbers of children served

Location of CAC & year opened	# of comm-unities	FY 05	FY06	FY 07	FY08	FY 09	FY10	Total seen since open
Anchorage 96	27	601	756	740	921	823	837	8,854
Bethel 01	35	131	161	137	184	121	128	1,063
Copper River Basin 09	17					12	17	29
Dillingham 03	32	15	28	40	45	28	40	222
Fairbanks 03	83	126	163	140	142	213	225	1,105
Juneau 01	19	102	89	100	90	87	99	1,047
Kenai Peninsula 08	30				37	47	126	210
Mat-Su 99	11	142	98	152	145	167	199	1,678
Nome 02	17	16	37	24	23	29	23	219
TOTALS	271	1,133	1,332	1,333	1,587	1,527	1,694	14,427

THANK YOU!

- While none of our CACs rely 100% on state funding for their existence (16% to 85%), that funding is essential for sustainability and to leverage other funding.
- Need is increasing, as the number of CACs and children and families served increases.

Current needs:

- Nome – Nurse examiner - there has not been a SART coordinator for almost a year now, so the child exams at the CAC are hit and miss. A nurse on staff would allow for consistent service delivery.
- Copper River Basin – an additional FTE position would expand the capacity of the Center to provide full community outreach, a continuum of community based therapeutic support services to child victims and their non-offending family members, structured community education, and full mobility/access of Center services

Current needs:

- Anchorage – partial funding for a part time medical director who also provides services across the state and funding for a FTE mental health provider for children and families with no insurance or who have Medicaid and are on a 3 month wait list for these services.
- Fairbanks - .5FTE, increase in contract medical services and supplies to meet increased need
- Kenai Peninsula CACs – support for the satellite CAC in Seward

THANK YOU FOR HELPING US MAKE ALASKA A SAFER PLACE FOR CHILDREN!

Children's Safety Network

National Injury and Violence Prevention Resource Center

Cost of Child Abuse and Neglect in Alaska (Year 2006 Incidence, Year 2007 Costs)							
Abuse Type	**Future Earnings**	**Medical Care**	**Mental Health**	**Property Damage**	**Public Programs**	**Quality of Life**	**Total**
Sexual Abuse	$1,025,300	$386,600	$4,504,500	$0	$586,300	$45,068,500	$51,571,200
Physical Abuse	$5,082,200	$1,849,600	$6,315,800	$39,000	$3,126,200	$86,580,900	$102,993,700
Mental Abuse	$6,816,800	$0	$31,579,100	$0	$15,601,000	$158,987,800	$212,984,700
Serious Neglect	$224,900	$43,800	$13,250,300	$0	$7,805,000	$74,111,200	$95,435,200
Fatal	$10,516,800	$260,500	$74,900	$11,000	$13,400	$26,641,800	$37,518,400
Total	$23,666,000	$2,540,500	$55,724,600	$50,000	$27,131,900	$391,390,200	$500,503,200

Definitions:

Medical Care includes payments for hospital and physician care, as well as emergency medical transport, rehabilitation, prescriptions, allied health services, medical devices, and insurance claims processing. For fatalities, also include coroner and premature burial costs.

Mental Health Care includes payments for services by psychiatrists, psychologists, social workers, and pastoral counselors. Also includes insurance claims processing.

Future Earnings includes wages, fringe benefits, schoolwork, and housework lost by the injured. This estimate excludes earnings lost by family and friends caring for the injured.

Public Programs include police, fire, paramedic, ambulance, and helicopter transport costs. Social services and victim assistance costs are also included in this category. It excludes mental health services costs.

Property Damage and Loss is the value of property damage and of property taken and not recovered.

Quality of Life places a dollar value on pain, suffering and lost quality of life to the victim and their family. The value is computed from jury awards for pain, suffering, and lost quality of life due to physical injuries and fear. For murders, this value is computed from the amount people routinely spend (in dollars or time) to reduce their risk of death.

Source:

Children's Safety Network-Economics and Data Analysis Resource Center, at the Pacific Institute for Research and Evaluation, Calverton, MD, 2009. The costs were adapted to Alaska using a state-specific price adjusters. All costs were calculated using incidents reported in the Child Maltreatment 2006, National Center on Child Abuse and Neglect Data Set. For more information contact Monique Sheppard at msheppard@pire.org.

CSN (www.childrenssafetynetwork.org) is funded by the Health Resources and Services Administration's Maternal and Child Health Bureau (U.S. Department of Health and Human Services).

A project of the Education Development Center, Inc.

CONFIR-
MATIONS
2011

<TARGET><BILL></BILL><SUBJECT>CONFIRMATIONS
2011</SUBJECT><COMM>SHSS27</COMM></TARGET>

Official Business

Alaska State Legislature

Senate

Office of the Secretary

State Capitol, Room 213
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

Celeste,
We know you are aware of this resignation, but for the record/your files...
-Julianna

TO: Senator Davis, Chair
Health & Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: March 28, 2011

SUBJECT: Withdrawn Governor's Appointment
Jennifer "Robin" Allen - Board of Nursing

The following appointee has resigned for personal reasons and should not be considered by your committee:

Board of Nursing
Jennifer "Robin" Allen - Palmer
Appointed: 3/1/2011 Term Expires: 3/1/2015

President Stevens referred the appointment to the Health & Social Services Committee on February 2, 2011.

Attachment: Governor's 3/26/11 Withdrawal Letter

KW:bbr
gl #6

(6)

STATE CAPITOL
PO Box 110001
Juneau, Alaska 99811-0001
907-465-3500
fax: 907-465-3532

MAR 28 2011

550 West 7th Avenue #1700
Anchorage, Alaska 99501
907-269-7450
fax 907-269-7463
www.Gov.Alaska.Gov
Governor@Alaska.Gov

Governor Sean Parnell
STATE OF ALASKA

March 26, 2011

The Honorable Gary Stevens
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Stevens,

I withdraw the appointments of Jennifer "Robin" Allen to the Board of Nursing and Jerrad "Shea" Hutchings to the State Commission for Human Rights. Since my letter dated February 1, 2011, both individuals have asked to resign from their respective boards for personal reasons.

Best regards,

Sean Parnell
Governor

cc: Kirsten Waid, Senate Secretary, Alaska State Senate

SENATE
CONFIRMATION COMMITTEE REPORT

Date: 3/21/11

In accordance with AS 39.05.080, the Health and Social Services Committee reviewed the following and recommends the appointments be forwarded to a joint session for consideration:

Commissioner – Department of Health and Social Services
William Streur

Board of Dental Examiners
Cheryl Fellenberg – Wasilla
Dr. Thomas Kovaleski – Chugiak
Dr. Paul Silveira – Valdez
Dr. Robert Warren – Anchorage

Board of Marital and Family Therapy
Leon Webber – Anchorage
JoAnn Young – Anchorage

Alaska Mental Health Trust Authority Board of Trustees
✓ Mike Barton – Douglas
✓ Russell Webb – Anchorage

Board of Certified Direct-Entry Midwives
Dr. Peggy Downing – Wasilla

Board of Nursing
~~Jennifer "Robin" Allen – Palmer~~ Resigned
Beth Farnstrom – Anchorage
Julie Gillette – Wasilla
Erin Pringle – Anchorage

Board of Examiners in Optometry
Dr. Paul Barney – Anchorage

Board of Pharmacy
Lori DeVito – Soldotna
Dirk White – Sitka

State Physical Therapy and Occupational Therapy Board
Valerie Phelps – Anchorage

Board of Psychologist and Psychological Associate Examiners
Dr. John DeRuyter – Fairbanks

Board of Social Work Examiners
Jen Syzdek – Anchorage

This does not reflect an intent by any of the members to vote for or against the confirmation of the individuals during any further sessions.

Signature:	**Printed Last Name**
	meyer
	Ellis
	Egan
Chair:	DAVIS

Please return to the Senate Secretary's Office (Room 211).

Celeste Hodge

From: robin allen [dave_robin1@yahoo.com]
Sent: Friday, March 18, 2011 10:22 AM
To: Celeste Hodge
Subject: Fw: Resignation

--- On **Fri, 3/11/11, robin allen <*dave_robin1@yahoo.com*>** wrote:

From: robin allen <dave_robin1@yahoo.com>
Subject: Resignation
To: brandon.maitlen@alaska.gov, "Sanders Nancy" <nancy.sanders@alaska.gov>
Date: Friday, March 11, 2011, 10:15 AM

To All Concerned,

I would like to thank-you for the honor and opportunity to serve on the Board of Nursing. However, due to family and financial hardships that serving on the Board will create for me, I feel that it is best for me to resign my appointment effective immediately, Friday March 11, 2011.

I hope that you will appreciate that this has been a difficult decision. I do feel that I would bring a value to the Board and hope that perhaps the future will bring this opportunity around again. My first responsibility is to my family. I feel that it would be a dis-service to all involved for me to try to continue to serve and that its best to resign now, rather than later.

I will return all the materials given to me at orientation last week.

Respectfully,
J Robin Allen LPN.

She Resigned

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

AGENDA

MONDAY, MARCH 21, 1:30 PM

Butrovich Room #205

1:30 PM – Call to Order

Time:

Members Present:

- **SENATE CONFIRMATION COMMITTEE REPORT**

State Physical Therapy & Occupational Therapy Board
Valerie Phelps – Anchorage (Valerie is catching a flight – moved her to top of agenda)
Board of Dental Examiners: Cheryl Fellenberg – Wasilla; Dr. Thomas Kovaleski – Chugiak; Dr. Paul Silveria – Valdez; Dr. Robert Warren – Anchorage.
Board of Marital & Family Therapy – Leon Webber – Anchorage; JoAnn Young – Anchorage
Alaska Mental Health Trust Authority Board of Trustees: Mike Barton – Douglas; Russell Webb – Anchorage
Board of Certified Direct-Entry Midwifes – Dr. Peggy Downing – Wasilla
Board of Nursing - ~~Jennifer "Robin" Allen – Palmer~~; Beth Farnstrom – Anchorage; Julie Gillete – Wasilla; Erin Pringle – Anchorage;
Board of Examiners in Optometry – Dr. Paul Barney - Anchorage
Board of Pharmacy – Lori DeVito – Soldotna; Dirk White – Sitka
Board of Psychologist & Psychological Associate Examiners – Dr. John DeRuyter – Fairbanks;
Board of Social Work Examiners – Jen Syzdek - Anchorage
Commissioner, Department of Health and Social Services William Streur

ADJOURNMENT:

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

Board	F Name	L Name	Address	City	State	Zip	Phone	Email
HSS								
Dental Examiners	Thomas	Kovaleski	P.O. Box 671574	Chugiak	AK	99567	907-223-5396	tkovaleski@scf.cc
Dental Examiners	Paul	Silveira	P.O. Box 335	Valdez	AK	99686	907-835-4940	drpaul@cvinternet.net
Dental Examiners	Cheryl	Fellenberg	4520 W. Lakeside Drive	Wasilla	AK	99654	907-376-6530	n/a
Dental Examiners	Robert	Warren	1343 Bannister Drive	Anchorage	AK	99508	907-277-3402	drbob@alaska.net
Marital and Family Therapy	Leon	Webber	1013 East Fireweed Lane	Anchorage	AK	99508	907-646-7600	ltw@alaska.net
Marital and Family Therapy	JoAnn	Young	625 N Lane St	Anchorage	AK	99508	907-317-2402	JoAnn.Young@PREMERA.com
Mental Health Trust Authority Board of Trustees	Mike	Barton	P.O. Box 240070	Douglas	AK	99824	907-364-3153	mikebarton@gci.net
Mental Health Trust Authority Board of Trustees	Russell	Webb	1138 F Street	Anchorage	AK	99824	907-440-6098	russwebb@acsalaska.net
Midwives	Peggy	Downing	3223 E. Palmer-Wasilla Highway, Ste. 1	Wasilla	AK	99654	907-357-4963	n/a
Nursing	Erin	Pringle	6051 Spruce Meadows Loop	Anchorage	AK	99507	907-250-3963	epringle@gci.net
Nursing	Beth	Farnstrom	18751 Villages Scenic Parkway	Anchorage	AK	99516	907-349-6074	bkfarnstrom@gci.net
Nursing	J. Robin	Allen	830 W Josh Drive	Palmer	AK	99645	907-745-1957	dave_robin1@yahoo.com
Nursing	Julie	Gillette	4301 South Well Site Road	Wasilla	AK	99654	907-376-5455	loggiemonster@hotmail.com
Optometry	Paul	Barney	1600 A Street, Suite 200	Anchorage	AK	99501	(907) 272-2423	paul.barney@pcli.com
Pharmacy	Dirk	White	106 Lincoln St	Sitka	AK	99835	907-738-6337	dirkrph@ptialaska.net
Pharmacy	Lori	Devito	P.O. Box 3943	Soldotna	AK	99669	907-262-2398	homeiv1@alaska.net
Physical Therapy and Occupational Therapy Board	Valerie	Phelps	18000 Spain Drive	Anchorage	AK	99516	907-301-7594	valerie@aptak.com
Psychologists and Psychological Associate Examiners	John	DeRuyter	3899 Murphy Dome Road	Fairbanks	AK	99709	907-452-4753	ideruyter@hopecounselingcenter.org
Social Work Examiners	Jennifer	Syzdek	P.O. Box 200424	Anchorage	AK	99520	218-839-5366	ntaboutu@yahoo.com

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 2, 2011

SUBJECT: Confirmation of Governor's Appointments

Pursuant to AS 39.05.080, the President has referred the following names for legislative confirmation to your committee for a hearing, recommendation and report:

Board of Dental Examiners

Cheryl Fellenberg – Wasilla
Appointed: 3/1/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Dr. Thomas Kovaleski – Chugiak
Appointed: 3/1/2011 Term Expires: 3/1/2015

Dr. Paul Silveira – Valdez
Appointed: 3/1/2011 Term Expires: 3/1/2015

Dr. Robert Warren – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

Board of Marital and Family Therapy

Leon Webber – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

JoAnn Young – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2014

Alaska Mental Health Trust Authority Board of Trustees
Mike Barton – Douglas
Appointed: 12/9/2010 Term Expires: 3/1/2014

Russell Webb – Anchorage
Appointed: 12/9/2010 Term Expires: 3/1/2013

Board of Certified Direct-Entry Midwives
Dr. Peggy Downing – Wasilla
Appointed: 5/31/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Board of Nursing
Jennifer "Robin" Allen – Palmer
Appointed: 3/1/2011 Term Expires: 3/1/2015

Beth Farnstrom – Anchorage
Appointed: 3/1/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Julie Gillette – Wasilla
Appointed: 3/1/2011 Term Expires: 3/1/2015

Erin Pringle – Anchorage
Appointed: 8/26/2010 Term Expires: 3/1/2014

Board of Examiners in Optometry
Dr. Paul Barney – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

Board of Pharmacy
Lori DeVito – Soldotna
Appointed: 3/1/2011 Term Expires: 3/1/2012

Dirk White – Sitka
Appointed: 3/1/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

State Physical Therapy and Occupational Therapy Board
Valerie Phelps – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2013

Board of Psychologist and Psychological Associate Examiners
Dr. John DeRuyter – Fairbanks
Appointed: 6/6/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Board of Social Work Examiners
Jen Syzdek – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

Resume(s) will be transmitted electronically.

KW:jcs
gl #2

Phelps, Valerie
State Physical Therapy and Occupational Therapy Board

Valerie Ann Phelps, PT, OCS, FAAOMPT

EXPERIENCE

1981 to 1982 **Sr. Kinney Institute / Abbott-Northwestern Hospitals**
Minneapolis, Minnesota
Staff physical therapist; worked with neurologically impaired, post-surgical orthopedic and general orthopedic patients

1982 to 1983 **Arizona Health Sciences Center**
Tucson, Arizona
Staff physical therapist; worked with neurologically impaired, post-surgical orthopedic and general orthopedic patients.

1983 to 1985 **University of Minnesota**
Minneapolis, Minnesota
Staff physical therapist; worked with neurologically impaired, post-surgical orthopedic and general orthopedic patients.

1985 to 1989 **Two Rivers Physical Therapy Center**
Coon Rapids, Minnesota
Senior physical therapist, personnel director, worked with post-surgical orthopedic and general orthopedic patients, occupational health, and sports injuries.

1989 To present **American Academy of Orthopedic Medicine**
Tucson, Arizona DBA: International Academy of Orthopedic Medicine—US
Director of Education, National and International Instructor

1990 to 1994 **International Academy of Orthopedic Medicine**
Bonaire, Netherlands Antilles
Austrian Society for physical Medicine
Vienna, Austria
Assistant instructor in nonoperative orthopedic medicine and manual therapy of the spine and Extremities.

1993 to 1994 **(Verband fur Physikalische Therapie, VPT)**
Association for Physical Therapy
Stuttgart, Germany
Assistant instructor in nonoperative orthopedic medicine and manual therapy of the spin and extremities.

1994 To present
International Academy of Orthopedic Medicine.
Göettingen, Germany
Austrian Society for Physical Medicine
Vienna, Austria
Association for Physical Therapy
Stuttgart, Germany
Instructor in nonoperative orthopedic medicine and manual therapy of the spine and extremities.

July 1994 to June 1997
Tucson Physical Therapy
Tucson, Arizona
Staff physical therapist, worked with post-surgical orthopedic, general orthopedic and occupational medicine patients. Clinical instructor for physical therapy students from Northern Arizona University and from Southwest Baptist University. Clinical instructor for physical therapy tech students from Pima Community College.

July 1997 to Jan. 1999
ProActive Physical Therapy
Tucson, Arizona
Clinical director: Supervised the clinical staff, worked with patients in an out-patient orthopedic setting. Clinical instructor for physical therapy students from Northern Arizona University and from Southwest Baptist University.

October 1999 to July 2000
University of Arizona
Athletic Treatment Center
Tucson, Arizona
Consultant in evaluation and treatment of university and Olympic- caliber athletes with chronic orthopedic problems.

October 1999 to July 2000
University of Arizona
Pain Center
Tucson, Arizona
Consulted with physicians in evaluation and treatment of patients with chronic pain syndromes.

January 1999 to June 2001
OrthomEd, LLC
DBA: ProActive Physical Therapy
DBA: International Academy of Orthopedic Medicine-U.S.
Tucson, Arizona
Partner, Clinical Director: Supervised the clinical staff, worked with patients in an orthopedic and chronic pain out-patient population. Director/Instructor in seminars on nonoperative orthopedic medicine and manual therapy. Presented approved courses to physical therapists, physicians, occupational therapists and athletic trainers.
Clinical instructor for physical therapy students from Northern Arizona University and from Southwest Baptist University.

July 2000 To present
Advanced Physical Therapy, Inc.
Anchorage, Wasilla, and Fairbanks Alaska
Majority Owner, Practice Director: Lead and guide executive team of clinical and administrative directors for a staff of 34 individuals working in 3 sites. Treat patients in an orthopedic out-patient population. Clinical Mentor for IAOM-US Fellowship Program in nonoperative orthopedic medicine and manual therapy.

EDUCATION

1976 to 1979 **College of St. Benedict & St. John's University**
St. Joseph & Collegeville, Minnesota
Undergraduate study

1979 to 1981 **University of Minnesota**
Minneapolis, Minnesota
Bachelor of Science Degree in Physical Therapy

1989 **International Academy of Orthopaedic Medicine**
Glarus, Switzerland
Certification in orthopaedic medicine and manual therapy of the spine and extremities.

1993 **International Academy of Orthopaedic Medicine**
Schoten, Belgium
Certified instructor in the teaching and knowledge of the theory and practice of Orthopaedic Medicine based on the work of James Cyriax M.D., M.R.C.P., under the mentorship of Dos Winkel, physical therapist.

1994 **International Academy of Orthopaedic Medicine- Europe**
Goettingen, Germany
(Verband fur Physikalische Therapie) Association for Physical Therapy,
Stuttgart, Germany
Certified instructor in manual therapy of the spine and extremities.

2002
to present **Texas Tech University**
Lubbock, Texas
Doctor of Science program for Orthopedic Physical Therapy (will be graduating, ScD, in spring 2012)

PROFESSIONAL LICENSURE

1981-1994	State of Minnesota	
1994-present	State of Arizona	#2905
2000-present	State of Alaska	#1255
2003	Board Certified Orthopedic Specialist, American Board of Physical Therapy Specialties (OCS)	

PROFESSIONAL ORGANIZATIONS

1981 to Present	American Physical Therapy Association Member of orthopedic medicine and private practice special sections.
1986-1989	Minneapolis Orthopedic Study Group
1988 to present	International Academy of Orthopaedic Medicine US and EUR
2001 to present	American Academy of Orthopedic Manual Therapists, Member
October 2002	Fellow, American Academy of Orthopedic Manual Therapists (FAAOMPT)

March 2002 to present Adjunct Faculty/Instructor
ScD Program in Physical Therapy
Texas Tech University Health Science Center, Lubbock TX
School of Allied Health Sciences, Department of Rehabilitation Sciences

PROFESSIONAL AWARDS

2002 Ball Dynamics Award for Excellence in a Published Case Study

PUBLICATIONS

Books

Diagnosis and Treatment of the Spine, Nonoperative Orthopaedic Medicine and Manual Therapy Dos Winkel, Geert Aufdemkampe, Omer Mattthis, Onno G. Meijer, **Valerie Phelps**; Gaithersburg, Maryland: Aspen, Publishers, 1996.

Diagnosis and Treatment of Upper Extremities: Nonoperative Orthopaedic Medicine and Manual Therapy. Dos Winkel, Omer Matthijs, and **Valerie Phelps**, Gaithersburg, Maryland: Aspen Publishers, 1997.

Diagnosis and Treatment of Lower Extremities: Nonoperative Orthopaedic Medicine and Manual Therapy. Dos Winkel, Omer Matthijs, and **Valerie Phelps**, Gaithersburg, Maryland: Aspen Publishers, 1997.

Stabilization and Functional Exercise. Peter Burke, **Valerie Phelps**, Omer Matthijs OPTP:Minneapolis MN; 2004.

Diagnosis-Specific Orthopedic Management of the Hip. Phil Sizer, **Valerie Phelps**, Jean-Michel Brismée, Didi vanParidon, Omer Matthijs. OPTP:Minneapolis MN; 2007.

Diagnosis-Specific Orthopedic Management of the Knee., Jean-Michel Brismée, **Valerie Phelps**, Phil Sizer, Omer Matthijs, Didi van Paridon. OPTP:Minneapolis MN; 2009.

Book Chapter

Racz GB, Anderson SR, Sizer P, **Phelps V.** Atlantooccipital and atlantoaxial injection in the treatment of Headache and Neck Pain. In Waldman S (Saunders) *Interventional Pain Management* (2nd Ed 2000; 200:296-305)

Peer Reviewed Journal Articles

Sizer P, Matthjis O, **Phelps V.** Influence of Age on the development of spinal pathology. *Cur Rev Pain.* 2000; 4:362-373.

Sizer P, **Phelps V,** Brismée J. Differential diagnosis of local cervical syndrome as compared to cervico-brachial syndrome. *Pain Practice.* 2001; 1,(1): 21-35.

Sizer P, **Phelps V,** Azevedo E. Disc-related and non-disc related disorders of the thoracic spine. *Pain Practice.* 2001; 1,2: 136-149.

Sizer P, **Phelps V,** Matthjis O. Pain generators of the lumbar spine. *Pain Practice.* 2001; 1, 3:255-273.

Sizer P, **Phelps V,** Thompsen K. Disorders of the Sacroiliac Joint, *Pain Practice,* 2002; 2(1),17-34.

Sizer P, **Phelps V,** Dedrick G, Matthijs O. Differential Diagnosis and Management of Spinal Nerve Root-related Pain. Pain Practice 2002; 2(2),98-121.

Sizer P, **Phelps V,** Brismée J. Diagnosis and Management of Cervicogenic Headache and Local Cervical Syndrome with Multiple Pain Generators. Journal of Manual & Manipulative Therapy, 2002; 10(3):136-152.

Sizer P, **Phelps V,** Gilbert K. Diagnosis and Management of the painful shoulder. Part 1: Clinical Anatomy and Pathomechanics. Pain Practice, 2003; 3:152-85.

Sizer P, **Phelps V,** Gilbert K. Diagnosis and Management of the painful shoulder. Part 2: Examination and management. *Pain Practice* 2003; 3:39-57.

Sizer P, **Phelps V,** James R, Matthijs O. Diagnosis and Management of the Painful Ankle/Foot. Part 1: Clinical Anatomy and Pathomechanics. *Pain Practice,* 2003; 3:238-262.
Sizer P, **Phelps V,** Dedrick G, James R, Matthijs O. Diagnosis and Management of the Painful Ankle/Foot. Part 2: Examination, Interpretation, and Management *Pain Practice,* 2003; 3:343-374.

Brismée JM, Sizer PS, **Phelps V.** Differential Diagnosis and Treatment of Chronic Neck and Upper Trapezius Pain and Upper Extremity Paresthesia: A Case Study Involving the Management of an Elevated First Rib and Uncovertebral Joint Dysfunction. Journal of Manual & Manipulative Therapy, 2004.

Sizer PS, Poorbaugh K, **Phelps V.** Whiplash Associated Disorders: Pathomechanics, Diagnosis, and Management. *Pain Practice.* 2004;4(3):249-266.

Sizer P, Brismée JM, Cook C, Dedrick L, **Phelps V.** Ergonomic pain, part 1: Etiology, epidemiology & prevention. *Pain Practice* 2004; 4:41-52.

Sizer P, **Phelps V,** Brismée JM, Cook C, Dedrick L. Ergonomic pain part 2: Differential diagnosis and management considerations. *Pain Practice.* 2004; 4(2):136-162.

Sizer P, **Phelps V,** Azevedo E, Hay A, Vaught M. Diagnosis and management of cervicogenic headache. *Pain Practice* 2005.

Brismée JM, Atwood K, Fain M, Hodges J, Sperle A, Swaney M, **Phelps V,** van Paridon D, Matthijs O, Sizer P. Interrater Reliability of palpation of three-dimensional segmental motion of the lumbar spine. *Journal of Manual and Manipulative Therapy,* 2005;13(4):216-221.

Brismée JM, Sizer PS, **Phelps V.** Differential Diagnosis and Treatment of Chronic Neck and Upper Trapezius Pain and Upper Extremity Paresthesia: A Case Study Involving the Management of an Elevated First Rib and Uncovertebral Joint Dysfunction. *Journal of Manual & Manipulative Therapy*, 2005;13(2):79-90.

Brismée JM, Gipson D, Ivie D, Lopez A, Matthijs 0, Moore M, **Phelps V**, Sawyer S, Sizer P. Interrater Reliability of a Passive Physiological Intervertebral Motion Test in the Mid-Thoracic Spine. *Journal of Manipulative and Physiological Therapeutics,* 2006 June;29(5):368-73.

ELECTRONIC PUBLICATIONS

Sizer P, **Phelps V,** Hay A, Azevedo E. Thoracic Spine disorders part I: History, inspection and clinical examination. *MD Consult* 2005.

Sizer P, **Phelps V,** Hay A, Azevedo E. Upper cervical disorders part II: Differential Diagnosis and Management. *MD Consult* 2004

Hay A, Azevedo E, **Phelps V,** Sizer P. Lower cervical disorders: Differential diagnosis and management. *MD Consult* 2003

Sizer P, **Phelps V,** Vaught M. Lower cervical disorders: Differential diagnosis and management. *MD Consult* 2003.

Fellenberg, Cheryl
Board of Dental Examiners

CHERYL FELLENBERG

OBJECTIVE

To apply for a position on the Board of Dental Examiners

SUMMARY OF QUALIFICATIONS

- Thirty years experience in the dental field.
- Three years experience in medical records management.
- Thorough knowledge of medical terminology, anatomy and physiology.
- Excellent clerical skills, word processing, typing 60 wpm, spreadsheet applications, basic accounting skills.
- Exceptional organizational and customer service skills.

RELEVANT SKILLS AND EXPERIENCE

Data Management

- Entered data on over 5000 primates pertaining to medical research and health status. Compiled statistical data for daily, weekly and monthly reports.
- Composed Federal accountability reports using charts on a quarterly, semi-annual and annual basis. Also conducted technical assistance and needs assessment for medical and dental records review for State of Alaska licensure requirements.

Teaching /Training/Organization

- Organized, compiled and created training and educational materials for college level coursework and professional educational seminars.
- Served as an adjunct instructor for dental hygiene courses; lecture, lab and clinical skills instruction.

Administrative and Technical Support

- Drafted correspondence, medical transcription.
- Bookkeeping; managed accounts receivable and payable, payroll and account management.
- Ordering of medical office supplies.
- Operation of computers; MAC, IBM; use of Excel and Word programs.

EMPLOYMENT HISTORY

Donald McLean, DDS *Dental Hygienist*	Wasilla, Alaska	8/2002 to present
Brett Bass, DDS *Dental Hygienist*	Kodiak, Alaska	9/2000 to 5/2002
Providence Kodiak Medical Center *Admitting*	Kodiak, Alaska	9/2000 to 5/2002
Paul Biederman, DDS *Dental Hygienist*	Anchorage, Alaska	9/1983 to 9/1999
Indian Public Health Service *Private Contractor, Dental Support Personnel*	Anchorage, Alaska	9/1989 to 9/1999
University of Alaska, Anchorage *Adjunct instructor, Dental Program*	Anchorage, Alaska	9/1981 to 9/1999

SUMMARY OF OTHER EMPLOYMENT

Dental Hygienist from 1976 to 1981, Medical records supervisor at University of Washington 1970 to 1973, Bookkeeper/Secretary for Caterpillar Company, Libby Montana 1968 to 1969.

PROFESSIONAL INVOLVEMENT

Alaska State Dental Hygienists Association 1991 to 1999. *Association Continuing Education committee member and Chairman of State Employment committee. Various other officer and committee member positions.* Victims for Justice 1987 to 1992 *Treasurer and Board member.* Anchorage Community College Dental Programs 1985 to 1987 *Advisory Board member.* Alaska State Dental Hygiene Association 1982 to 1986 *Treasurer.*

EDUCATION AND TRAINING

University of Alaska, Juneau, Alaska *Master of Science, Vocational Education Administration*
Carroll College, Helena Montana *Bachelor of Arts, Dental Hygiene*
CPR Training and Certificate, expiration November 2008.
Current Dental Hygiene license.

Kovaleski, Thomas
Board of Dental Examiners

THOMAS J. KOVALESKI D.D.S.

LICENSURE: Alaska 1991-present
Wisconsin 1978-present

PROFESSIONAL EXPERIENCE:

October 1,1999- Present: Dental Director Alaska Native Medical Center/Southcentral Foundation
-Expand program to fifty chairs and one hundred sixty- five staff.
-Responsible for Statewide referrals for trauma,infections,and pediatric full mouth reconstruction.
-Manage an 17.5 million dollar budget.
-Implement accredited Pediatric Dental Residency for Alaska Staewide shortages
-Build twenty seven chair "state of the art" dental facility Fireweed Dental Clinic
-Remodel and equip a full time dental operating room for Statewide services.
-Enhance dental assistant training program to thirty six students per year.
-Develop efficiency models that remarkably increase production in all clinics.
-Service Center Medical Director in Hospital for Dental responsible for all credentials and quality - assurance of professional staff.
-Co-authored white paper with solutions related to Alaska's dental manpower.
-Establish agreement with U of Washington School of Dentistry and Univrersity of Alaska
for externships in dentistry and hygiene
-Provide general dentistry in hospital and villages.
-Supervise field program to 23 villages
-Western Regional Board Examiner 2006-present
-Adjunct Faculty member University of Washington School of Dentistry 2005-present

December 31,1997-Oct 1,1999: Director of Staff Development
Southcentral Foundation
-Help transition IHS Direct program to Tribal program.
-Facilitate operations of the new twenty-three chair clinic.

July 91-December 31,1997: Dental Director/ Chief Service Unit Complex
Billet#02HG066 Alaska Native Medical Center
O-6 Anchorage, Alaska
-Leader in building the new Alaska Native Medical Center 23 chair dental clinic.
-Leader in facilitating the move from the old hospital to the new.
-Supervise an staff of twelve dentists and twenty dental assistants.
-Supervise ADA accredited two year Advanced General Practice Residency Program(AGPR).

-Manage 3.5 million dollar dental budget and 250K contract care budget.
-Provide general dentistry for the Alaska Native Medical Center hospital dental clinic.
-Provide itinerant dental care to five villages in the Iliamna Area,1984-present.
-Team Leader in technical assistance and planning for the new ANMC dental clinic(1996).
-Design and implement an in house dental assisting training program for volunteers.
-Acting Alaska Area Dental Officer
-EvaluatorEmeritus for Clinical Research Associates(CRA), Dr. Gordon Christensen
1981-present

April 89-July 91: Director, IHS Advanced General Practice Residency
Billet#02HG501 Alaska Native Medical Center
O-6 Anchorage, Alaska
- Supervise three AGPR dentists, two IHS, and one funded by NHSC.
- Co-ordinate all rotations and objectives to maintain accreditation for the two year program by the American Dental Association.
- Provide general dentistry for the Alaska Native Medical Center hospital dental clinic.
- Village dentist for five isolated villages in Iliamna,Alaska area.
- Anchorage Service Unit Fluoridation Dental team leader
- Acting for Chief Anchorage Service Unit Dental Chief Complex
- U.S. Public Health Service Associate Recruiter, University of Minnesota.
- COSTEP Program recruiter and clinical supervisor.
- University of Alaska Dental Programs clinical instructor for hygiene clinic and development of ANMC and village rotations.
- Co-developed prevention public service announcement videos for Rural Alaska Television Network(RATNET).
- Author of Dental Chapter of The Community Health Aide/Practioner Manual.

1/86-4/89 Director Dental Staff Development Alaska Area
Billet# HGO3788 Anchorage, Alaska
O-6
- Co-ordinate all training activities in the Alaska Area.
- Develop CHALLENGES course agenda and courses for "rookie" dentists in the Alaska 1986-89.
- General dentistry for three isolated villages and the ANMC hospital dental clinic.
- Plan, manage, and coordinate Alaska Area Dental Officer annual meetings.
- Host Indian Health Service Area Dental Officers meeting 1988.
- Teach "Dental Problems" portion of Community Health Aide Program(CHAP).

- Radiology training and certification for dental assistants
1/84-1/86 Advanced General Practice Resident (IHS)
Billet# Alaska Native Medical Center (ANMC)
O-4 Anchorage,Alaska
- Sucessfully completed all criteria accredited by the A.D.A.
- Nitrous oxide grant funded and project completed.
- Paper presented at "Information Technology in Community Health" conference in Victoria, British Columbia on "Computer Direct Entry of Oral Examination Data in Rural Alaska". 1986
- Conducted quality assurance program reviews of Kodiak Native Association and
Tanana Chiefs Native Association dental programs.
- Planned,organized,and conducted the annual Alaska Area Dental Officers meeting.

7/78-1/84 Chief Service Unit Basic
Billet # Lac Courte Oreilles/St. Croix
O-4 Hayward,& Hertel,Wisconsin
-Provided comprehensive dental care to two P.L.638 tribes 40 miles apart.
-Instituted flouridated water supplies to five community systems.
-Provided community prevention on the 100,000 watt Public Radio station.
-Developed treatment based puppet show for pre-school children.
-Provided 65 days of dental care in Manua Islands, American Samoa while on annual leave. 1979/80.
6/77-10/77 COSTEP Alaska Native Medical Center
O-1 Anchorage, Alaska

U.S. Public Health Service Duties
- Director of PHS wide residency program 1986-1991.
-Member IHS Dental national committees in Materials and Infection Control.
-Member IHS national supply and facilty design committee.
- Associate Recruiter 1987-present.
- COSTEP recruiter and clinical supervisor.
- Publicity Chairman for the highly successful 25th Annual Commissioned Officer's
(COA) meeting in Anchorage,Alaska in 1990.
- Alaska Area Training Co-ordinator (IHS wide) 1986-1991.
- Community Health Aide Program consultant (Alaska) 1986-present.

Awards: PHS
-Nominated Outstanding Service Medal 1993(pending)
-Exceptional Capability Promotion to O-6 nomination 1993.
-IHS National Prevention Award 1991 PHS Citation

-Unit Citation 1991 Oral Health Status
-Unit Citation 1990 COA Meeting Publicity Chairman.
- Unit Citation 1990 Dental Fluoride Team leader.
- Achievement Medal 1988.
- Hazardous Duty Award 1986.
NON-PHS
- Nominated Alaska Federal Employee of the year 1991
- Eagle Award 1989-94 Combined Federal Campaign
- Marine Corps Good Conduct Medal 1970.
- National Defense Ribbon 1967.

Educational Experience
- Clinical Instructor University of Alaska Dental Programs 1986-1992
- Advanced General Practice Residency, Anchorage,Alaska 1984-1986
- University of Minnesota School of Dentistry 1974-1978. U.S. Public Health Service scholarship recipient 1977-78.
- University of Alaska Aviation School, Private Pilot, Single engine land/sea 1986.
- Hennepin Technical School, Biomedical Electronics 1973.
- Winona State University ,1971-72.
- U.S. Naval Aviation Electronics School, Memphis, Tennessee, 1967-68.
Professional Membership
- American Dental Association 1984-present.
- Commissioned Officers Association 1978-present.
- Alaska Airmens Association, 1986-present.
- Airplane Owners and Pilots Association,1986-present
Military
-United States Marine Corps 1967-1971, Meritorious Staff Sergeant(E-6).
- Qualified Crew Chief CH-53A Helicopter.
- Avionics training and expertise/attached HMX-1 Presidential Squadron 1970-71.
- Expert marksmanship M-14,M-1,.44,.38.
- Instructor CH-53A systems & .50 cal. machine gun 1970-71.
- Honorable Discharge 1973.
Interests
- Canoeing, worked as a guide for Charles L. Sommers Wilderness Canoe Base, Ely,Minnesota 1966-1972.
- Whitewater rafting and camping.
- Aviation, flying, and repairing aircraft.
- Native village culture, history, and lifestyles.

Silveira, Paul
Board of Dental Examiners

Paul Silveira DMD

Education:
UAA Natural Sciences 1984-1988
Oregon Health Sciences University Portland OR 1988-1992 DMD awarded

Family:
Married 25 years 4 children

Public service:
Alaska Dental Society member since 1992 currently Member at Large
Valdez Rotary past president twice
Valdez Airmen's Assoc. Past president
Bayside Community Church; church council member 1998 to present
Mayor's hospital task force 2003
Valdez Fly-in Assoc committee member

Professional:
Private practice Valdez, AK 1995 to present
Associate 1992-1995 Anchorage, AK

Warren, Robert
Board of Dental Examiners

Curriculum Vitae

Robert E. Warren, DDS

Private Business: 1976-Present

Robert E. Warren, DDS, a professional corporation
Dba Denali Dental Care

1. Education/Training

University of the Pacific, School of Dentistry	DDS	1969-1973
Womack Army Hospital, Fort Bragg (General Dental Residency)		1973-1974
Fort Richardson Dental Clinic (Post endodontist)		1974-1975
Fort Richardson Dental Clinic (Prosthodontic Mentorship)		1975-1976

2. Relevant Dental Board Experience/Appointments

Alaska Board of Dental Examiners 1984
Appointed: Governor Sheffield

The Board restructured the clinical examination, insuring candidate anonymity and testing on procedures more relevant to current private clinical practice. The Board developed new regulations and procedures to process applications for licensure by credential. Warren appointed liaison between the State of Alaska and the American Association of Dental Examiners. In 1986-1988, Warren elected President by the Board. In 1987, Alaska invited to attend a Western Regional Examining Board exam and Board of Directors meeting at Loma Linda University. Warren attended the meeting and returned to convince the Alaska Board that joining a regional board would be in our best interest of the State. It would remove the burden of administering a clinical exam and put that function the hands of a professional third party that does nothing else but examine licensing candidates. With support from the State Legislature, Alaska became WREB's sixth member state in the spring of 1987. Warren was appointed to serve on the WREB Board of Directors.

Alaska Board of Dental Examiners (reappointment) 1988
Appointed: Governor Cowper

From 1988-1992, Warren served a second term on the Board of Dental Examiners. Our Board members participated in giving multiple clinical examinations each year to dental and dental hygiene candidates for initial licensure. The exams were given at dental schools in Los Angeles, San Francisco, Portland, Seattle, and Omaha,

giving a much larger candidate pool an opportunity to take and pass the exam and become eligible for licensure in Alaska. With WREB now handling the clinical examination process, the Board was more able to focus its meeting time on its regulatory and disciplinary functions. The Board also continued its work to clarify its policies and regulations on licensure by credentials.

President of Western Regional Examining Board (WREB) 1989-1990

WREB expanded its membership to ten states: Oregon, Washington, Texas and Oklahoma became new members. These states joined Utah, Idaho, Montana, Arizona, New Mexico, and Alaska.

American Dental Association-Council on Dental Education and Commission on Dental Accreditation 1990-1994

Appointed: Am Association of Dental Examiners

The Commission accredits all U.S. dental schools, all dental hygiene programs, all dental graduate programs, and all dental assistant and dental laboratory technician training programs. The Commission writes the education curriculum standards for each discipline and conducts periodic institution site visits to award initial and continued accreditation. Recognized by the U.S. Department of Education as the official and only accrediting body. Warren chaired Committee C (dental hygiene). In second year, Warren chaired Committee D (dental laboratory technology). During his third and forth year on the Commission, Warren served and chaired Committee A (dental school accreditation). Education and curriculum standards for each discipline were revised and rewritten. The commission also processed four applications of recognition for new specialty areas in dentistry.

Vice-Chairman-ADA Commission on Dental Accreditation 1991-1992

Third Vice-President-Am. Association of Dental Examiners 1993-1994

Alaska is required by statute to be a member of the AADE. All fifty States and U.S. possessions are members. Acts as a forum for regional and individual state boards to exchange ideas and procedures. Have two national meetings per year where formal programs are presented on a variety of current issues and topics.

Second Vice-President-Am. Association of Dental Examiners 1994-1995
First Vice-President-Am. Association of Dental Examiners 1995-1996
President-Elect-Am. Association of Dental Examiners 1996-1997
President of American Association of Dental Examiners 1997-1998

ADA national conferences on Dental Licensure 1998-1999

Appointed: by AADE

Met three times and developed the "Agenda For Change" in Chicago. The "Agenda" concentrated on standardizing the entry-level examination process for dentists on a national level. Developing calibration and examination guidelines for all regional and state testing agencies. Laying the ground work for recognition of multiple regional board examinations by licensing agencies.

Grading Examiner for WREB at various dental schools 1999-2010

3. Presentations/Papers

Lecturer and presenter at Western Conference of Dental Examiners
And Dental School Deans-Denali National Park 1993
Author and contributor to American Dental Association Publication
"The Future of Dentistry" section on licensure 1999-2001

4. Awards

Omicron Kappa Upsilon (OKU)-Dental School Honors Society 1973
United States Army Commendation Medal for meritorious service
In U.S. Army Dental Corps-Ft. Richardson 1976
Fellow of the International College of Dentists (FICD) 1991
"President's Award"-Alaska Dental Society for "Outstanding
Service to Dentistry in Alaska" 1998
"Honorary Life Membership"-American Association of Dental
Examiners 1999

5. Professional Affiliations

Anchorage Dental Society	1976-Present
Alaska Dental Society	1976-Present
American Dental Association	1973-Present
American Association of Dental Examiners	1985-Life
Crown Council	1998-Present
American Academy of Cosmetic Dentistry	2000-Present
Dental Organization for Conscious Sedation	2000-Present

6. Community Service/Charitable Activities

"Doctors with a Heart" 1987
Provided dentistry at no charge for those in need that could not afford dental treatment.
Anchorage Opera "Board of Directors" 1997-Present
"Smiles for Life Campaign" of the Crown Council-In partnership
with Garth Brooks' "Touch'em All Foundation has raised
over $14 million for St. Jude's Children's Research Hospital
in Memphis and numerous other children's charities 1998-Present
911 Harvest Fair-Together with Dr. Josh Wright, or offices raised
$10,000 for American Red Cross to help the families of
victims of the September 11, 2001 tragedies October 2001

Webber, Leon
Board of Marital and Family Therapy

LEON T. WEBBER, D.Mn., LMFT

Alaska Licensed Marriage and Family Therapist # 53
Alaska Licensed Approved Supervisor

EDUCATIONAL BACKGROUND

	Public Schools of Portland Maine
1964	B.A. in Psychology, Augusta College, Sioux Falls, S.D.
1968 -1973	D.Mn. (Doctorate of Ministry) Meadville/Lombard Theological School (Affiliated with University of Chicago)
1970 - 1971	Alfred Alder Institute of Chicago
1968 – 1970	2 year Clinical Internship in Marital and Family Therapy Robert MacGregor, Ph.D., Supervisor
1967 – 1973	Graduate Studies, University of Chicago

PROFESSIONAL BACKGROUND

1974–current	Private Practice, Marriage and Family Therapy Training, Consultation, Supervision, Direct Service Licensed Marriage and Family Therapist Licensed Approved Supervisor (Note: LMFT Licensing became law in Alaska in 1993. Prior to 1993, Dr. Webber was a Clinical Member and Approved Supervisor in AAMFT.) Anchorage, Alaska
2007-current	Marriage and Family Therapist in Integrated Care, Providence Hospital Cancer Center

Anchorage, Alaska

1995 –current	Publisher, Intuitive Eye Press, Inc.
2004 –current	Team Coordinator APS/ BP Alaska Critical Incident Stress Management Team
1994 – 2006	Clinical Director, Adult Attention Deficit Disorder Clinic, Anchorage, Alaska.
1992 – current	Co-Director/Senior Trainer International Institute for the Communication Arts
1995 – 2002	Family Therapy Consultant, Kenaitze Indian Tribe, Nakenu Family Therapy Center, Kenai, Alaska
1993 – 2000	Family Therapy Consultant & Supervisor Central Peninsula Mental Health Center, Kenai, Alaska
1989 – 1992	Manager/Clinical Supervisor Family Therapy Department, Charter North Hospital, Anchorage, Alaska
1989 – 1990	Family Therapy Consultant/Supervisor Fahrenkamp Center, Fairbanks, Alaska State of Alaska, Department Health and Social Services Division of Mental Health & Development Disabilities
1974 -1990	Director, Family Institute of Alaska and The Center for Family Studies (A non-profit corporation established in 1974 to provide training, education, consultation and research in marital and family therapy)
1986 – 1987	Director The Diabetic Retinopathy Program (A community based program for diabetic retinopathy

patients and their families.)

1985 – 1990	Faculty Member Hawaii Family Institute Maui, Hawaii
1976 – 1978	Director of Family Therapy The Alaska Clinic Department of Psychiatry and Family Therapy Anchorage, Alaska
1970 – 1974	Founder and Executive Director The Depot: Team Family Method Program Chicago, Illinois
1970 – 1972	Family Therapy Training Consultant Illinois Department of Mental Health MacFarland Zone Center, Springfield, Illinois Chicago State Hospital, Chicago Illinois Elgin State Hospital, Elgin, Illinois
1968 – 1969	Intern/ Principal Assistant to Robert MacGregor, Ph.D. Chief Family Studies Illinois Department of Health Chicago, Illinois
1968 – 1969	Youth Minister First Unitarian Church of Chicago Chicago, Illinois
1966 – 1967	Student Minister Cornish Federated Church Cornish, Maine

1965 – 1966	Director United Presbyterian Camp and Conference Center Wilmont, New Hampshire
1962 – 1963	Assistant Director Camp Norge: Norwegian Community Services Welfare Camp, New City, New York

COLLEGE AND UNIVERSITY LEVEL TEACHING
Past and Current

1976 – 2011	Supervisor, Family Therapy Practicum Graduate School of Psychology, University of Alaska, Anchorage
1974 -	Guest Lecturer, Department of Nursing and Behavioral Science
	Guest Lecturer, Graduate School of Psychology University of Alaska Anchorage
	Guest Lecturer, Graduate School of Psychology, Alaska Pacific University, Anchorage
1985 – 1999	Annual Guest Lecturer Philosophy Department University of Hawaii
1974 – 1975	Visiting lecturer at Alaska Methodist University
1973 – 1974	Adjunct Faculty Member Meadville/Lombard Theological School
1973 – 1974	Visiting lecturer Kennedy King College Malcolm X College University of Illinois College of Nursing

Harper College

1972 – 1974 Family Therapy Field Supervisor
University of Illinois College of Nursing,
Kennedy King College

CONTINUING EDUCATION

Complete list available on request.

CERTIFICATIONS

Certified Emergency Service Specialist and Industry and Workplace Specialist, International Critical Incident Stress Foundation, Inc., 2007

EMDR Training, Level One and Level Two training. Barbara Parrett, R.N., Francine Shapiro, Ph.D., 1997, 1998.

Diplomate and Certified Trauma Specialist. American Academy of Experts in Post-Traumatic Stress, 2006.

CRISIS DEBRIEFING

Dr. Webber coordinates and manages confidential Critical Incident Response services for small and large businesses and agencies in Alaska.

PROFESSIONAL CONSULTANCIES AND TRAINING

United States Court: Ninth Judicial Circuit

Central Peninsula Counseling Services

Kenai Department of Family and Youth Services

Co-Chief Clinical Consultant, Exxon Valdez Plaintiff Team

Anchorage Girl Scout Council: Community Crisis Intervention for Exxon Valdez Oil Spill Response in Valdez, Cordova, 1989

Han Ma Um Center: An Yang City, Republic of Korea

Alaska Men's Support Network

Department of the Air Force, Elmendorf Hospital, Department of Psychiatry

Anchorage Council on Drug Aid, Anchorage, Alaska

Narcotic Drug Treatment Center, Anchorage, Alaska

GAAB Alcoholism Program, Anchorage, Alaska

Atlantic Richfield Company, Contemporary Consumer Issues

Governor's Council on Child Abuse, Anchorage, Alaska

Alaska Youth Advocates, Anchorage, Alaska

Juvenile Probation Office, Anchorage, Alaska

Alaska Conference of Methodist Ministers

Providence Hospital: "Family Intervention in Hospital Settings", nine month training program for hospital staff.

National Education Association (Alaska)/University of Alaska, Rural Education: Consultant and trainer for teachers in Anchorage, Matanuska-Susitna Valley, Pribilof Islands, Copper River, Adak, Kenai, Valdez, and Chugach.

Catholic Diocese of Anchorage

Anchorage Police Department

United States Department of Adult Probation and Parole, Anchorage, Alaska

Alaska Native Hospital Psychiatric Unit, Anchorage, Alaska

Alaska Division of Social Services, Anchorage, Alaska

Alaska Children's Services, Long and Short House, Anchorage, Alaska

State of Hawaii, Maui Community Mental Health Center

Anchorage Community College Conference on Families and Work

Alaska Council on Prevention of Alcohol and Drug Abuse

Anchorage Mental Health Association, Board Member and Secretary

Alaska Mental Health Association, Board Member

Chicago, Illinois 1968-1974

National Training Center on Drug Abuse, Chicago, Illinois

Illinois Board of Education, Chicago, Illinois

Cook County Sheriff's Department, Chicago, Illinois

Chicago Police Department, Chicago, Illinois

Illinois Academy of Criminology

Illinois Department of Corrections, Chicago, Illinois

Illinois Department of Family and Children's Services, Chicago, Illionois

Chicago Board of Health, Chicago, Illinois

Youth-Family Multi-Service Community Center, Chicago, Illinois
Past President and Board Member

CURRENT AND PAST ADVISORY COMMITTEE MEMBERSHIPS

Six States Judges Conference 1980, Chairperson

Statewide Symposium on Family Psychotherapy,
Chairperson 1975, 1980, 1981,1982, 1983

Continuing Education in Mental Health for Alaska, Steering Committee

Chairman, Professional Advisory Board for
Alaska Court Status Offender LEAA Grant.

Youth and Family Multi-Service Community Center, Chicago, Illinois
Past President and Board Member

Anchorage Council on Drug Aid, Past Chairperson of Board

Family Connection Agency

SPD Steering Committee Task Force on Deinstitutionalization, Chairperson

Family Life Committee, YMCA

Anchorage Rotary, Chairperson, Committee for Disabilities and Special Needs, 2003-2004.

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

Past Memberships: Focusing Institute, World Federation for Mental Health, Illinois Group Psychotherapy Society, American Academy of Religion and Science, Illinois Academy of Criminology, American Association for the Advancement of Science

Team Family Methods Association, Past President and Board Member

American Family Therapy Association, Charter Member

American Association of Marriage and Family Therapy, Clinical Member and Approved Supervisor

Alaska Association of Marriage and Family Therapy, Past President. Board Member

International Group Therapy Association, and American Group Psychotherapy Association, Member.

Anchorage Downtown Rotary

General Semantics Institute

International Critical Incident Stress Management Foundation, Inc.

American Academy of Experts In Traumatic Stress

PRESENTATIONS AND WORKSHOPS

(Additional presentations available on request.)

International Focusing Network: Yearly Training Workshops and retreats in Germany and Switzerland, 1983-1989, with Linda Webber, Ph.D., LMFT.

Alaska Methodist Conference: Facilitator of Annual Retreats for Ministers and their spouses, 1987, 1989.

Ninth Circuit Court, Communication Seminar on Interactive Focusing for judges, staff and attorneys, 1992, with Linda Webber, Ph.D., LMFT.

Integral Communication™, Speakeasy®, Focusing and Interactive Focusing. Training Groups for Health Care Professionals. Anchorage, Alaska, 1992-present, with Linda Webber, Ph.D., LMFT.

Interactive Focusing and Integral Communication. Full day communication skills training for entire Family Advocacy Staff of United States Air Forces (South Seas), Anchorage, Alaska, 1992, with Linda Webber, Ph.D., LMFT.

"Interactive Focusing and Multiple Impact Therapy." One day training for staff of Philadelphia Child Guidance Center, Philadelphia, 1993, with Linda Webber, Ph.D., LMFT.

Interactive Focusing Training. Focusing Zentrum, Three day trainings for mental health professionals, Karlsruhe, German, 1995-1998, with Linda Webber, Ph.D., LMFT.

"Communication issues for Couples with Adult Attention Deficit Disorder." Adult Attention Deficit Disorder Conferences, San Diego, California, Ann Arbor, Michigan, 1996-1998, with Linda Webber, Ph.D., LMFT.

"Handling Grief and Loss: Designed for the Clinician – Weekend Intensive", 1997, Friends for Continuing Medical Education, Anchorage, Alaska, with Linda Webber, Ph.D., LMFT.

Institute for Integral Development: Training Institute on Addictions. Integral Communication™ and Speakeasy®. Santa Fe, New Mexico, 1999; Clearwater Beach, Florida, 2000; Colorado Springs, Colorado, 2000, Seattle, Washington, 2001, with Linda Webber, Ph.D., LMFT.

International Focusing Konferenz, Karlsruhe, Germany, 2000. Integral Communication™ and Speakeasy®. Opened conference with Speakeasy® Game, presented two workshops, with Linda Webber, Ph.D., LMFT.

Integral Communication™/Speakeasy® Couples Retreat (5 days), Gresgen, Germany. Annual event, 1990-2000, with Linda Webber, Ph.D., LMFT.

Communication in the Workplace The Libby Group. LLC, Anchorage, Alaska, presentations 1990-2000.

Integral Communication™/Speakeasy® Couples Retreat (5 days), LeHohwald, France. Annual event, 2002, 2003, ongoing, with Linda Webber, Ph.D., LMFT.

"Ethics in Rural Psychology." Homer Community Mental Health Center, Homer, Alaska, 2002. Full day workshop for all staff members, with Linda Webber, Ph.D., LMFT.

"Ethical Issues in Rural and Small Urban Settings." Alaska Association of Marriage and Family Therapy, Anchorage, Alaska, 2002. Full day presentation, with Linda Webber, Ph.D., LMFT.

"Supervision of Marriage and Family Therapists: Models and Ethics." Half day seminar for Alaska Association of Marriage and Family Therapy Approved Supervisors, Anchorage, Alaska, 2002, with Linda Webber, Ph.D., LMFT.

Communication Training, Ethics, Couple and Family Issues. Alaska Pacific University graduate classes, Anchorage, Alaska, yearly presentations. 1998-ongoing.

Stress Management, Critical Incident Management/Debriefing. BP Alaska, Anchorage, Alaska, 2007-ongoing, as requested.

JOINT CONFERENCE PRESENTATION EXPERIENCE:

Summary: 30 years experience presenting individually and with Linda Webber, Ph.D., at state, national and international conferences

Ninth Circuit Court, Communication Seminar on Interactive Focusing for judges, staff and attorneys, Anchorage, Alaska, 1992.

Integral Communication™, Speakeasy®, Focusing and Interactive Focusing. Training Groups for Health Care Professionals. Anchorage, Alaska, 1992-present.

"Interactive Focusing and Multiple Impact Therapy." One day training for staff of Philadelphia Child Guidance Center, Philadelphia, 1993.

Interactive Focusing Training. Focusing Zentrum, Three day trainings for mental health professionals, Karlsruhe, German, 1995-1997.

"Communication issues for couples with Adult Attention Deficit Disorder." Adult Attention Deficit Disorder Conferences, San Diego, California, Ann Arbor, Michigan, 1996-1998.

"Handling Grief and Loss: Designed for the Clinican – Weekend Intensive". Friends for Continuing Medical Education, Anchorage, Alaska, 1997.

Institute for Integral Development: Training Institute on Addictions. Integral Communication™ and Speakeasy®. Two (2) two hour workshops at each confernce. Santa Fe, New Mexico, 1999; Clearwater Beach, Florida, 2000; Colorado Springs, Colorado, 2000, Seattle, Washington, 2001.

International Focusing Konferenz, Karlsruhe, Germany,
Integral Communication™ and Speakeasy®. Opened conference with Speakeasy® Game, presented two workshops, 2000.

Integral Communication™/Speakeasy® Couples Retreat (5 days), Gresgen, Germany. Annual event, 1990-2000.

Integral Communication™/Speakeasy® Couples Retreat (5 days), LeHohwald, France. Annual event, 2002, 2003, ongoing.
"Ethics in Rural Psychology." Full day workshop for all staff members. Homer Community Mental Health Center, Homer, Alaska, 2002.

"Ethics in Rural and Small Urban Settings." Full day presentation for Alaska Association of Marriage and Family Therapy, Anchorage, Alaska, 2002.

"Supervision of Marriage and Family Therapists: Models and Ethics." Half day seminar for Alaska Association of Marriage and Family Therapy Approved Supervisors, Anchorage, Alaska, 2002.

Young, JoAnn
Board of Marital and Family Therapy

JoAnn Young RN CCM

QUALIFICATIONS

Registered Nurse with more than 25 years nursing experience, working med/surgical as floor/charge nurse, and urgent care clinic. Team player dedicated to quality, continuous improvement and bottom line objectives utilizing resourcefulness and problem solving skills with clinical knowledge. Knowledgeable in writing/revising policies and procedures.

CREDENTIALS

RN ALASKA #26688

RN ARIZONA #RN049666

CERTIFICATIONS

CERTIFIED CASE MANAGER

EDUCATION

Associate Degree in Nursing, Iowa Central Community College
Storm Lake, Iowa 1999-1982

PROFESSIONAL EXPERIENCE

Case Manager, Premera Blue Cross Blue Shield, Anchorage, AK 4/2007-Present
Member advocate, assisting member with services within benefit guidelines.

Clinic Nurse, Bagdad Community Health Center, Bagdad, AZ 6/1998-3/2007
Wrote nursing procedures, performed hearing and pulmonary tests, ordered medical supplies.

Staff Nurse, Boswell Hospital Sun City, AZ 1/ 2000-5/2000
Assisted in pre-op and post-op patient, helped train new graduates.

Staff Nurse, Wickenburg Extended Care Unit, Wickenburg, AZ 1/1999-9/1999
Responsible for six to fifteen patients on the Medicare wing
Qualified as a patient advocate in the absence of a social worker.

Staff/charge nurse, Yavapai Regional Medical Center, Prescott, AZ 6/1988-5/1998

Revised nursing policies and procedures as a member of the Policy/Procedure Committee.

Assisted in emergencies as a Trauma or Code Blue team member.

Responsible for glucose monitoring quality control for a medical surgical floor.

Relief Nurse, Nurse's Central Registry, Phoenix, AZ
5/1986-6/1988

Qualified as a staff relief nurse for various hospitals throughout the Phoenix area.

Provided private duty nursing in the hospital, home care for the terminally ill.

Staff/charge nurse, Phoenix General Hospital-
11/1984-5/1986

Organized and facilitated weekly ward conferences to discuss new procedures, policies, and concerns.

Staff/charge nurse, Whiteriver Indian Hospital, White River, AZ
11/1982-11/1984

Organized /prioritized patient care for up to 25 patients.

Staff nurse, St. Joseph's Hospital and Medical Center- **7/1982 - 11/1982**

Assisted in patient care on the oncology floor being responsible for five to six patients.

PROFESSIONAL AFFILIATIONS

Case Management Society of America
AK Chapter Case Management Society of America

Barton, Mike
Alaska Mental Health Trust Authority Board of Trustees

Mike Barton

Relevant Experience

Executive- The Rise Group (08/07- present)
Responsible for developing and maintaining relationships with public and private entities that utilize construction management services. Primary focus is the Alaska Natural Gas Pipeline as well as Federal construction activities. Position became half-time in 2009 because of the national economic situation.

Commissioner of Transportation and Public Facilities - State of Alaska (7/94-12/94; 12/02-12/06)
Provide executive leadership and direction for 3500 employees located throughout Alaska with a $450 million annual operating budget and a capital construction program of a billion dollars per year. Responsible for determining and accomplishing objectives including budgeting and allocation of resources. Activities included construction and/or maintenance of over 6000 miles of state roads; operation of the eleven ships of the Alaska Marine Highway serving 33 ports of call and 3300 miles of routes; operation of Anchorage and Fairbanks International Airports; operation of 259 other airports throughout Alaska; maintenance of over 600 public buildings throughout Alaska. Served on the Boards of the Alaska Railroad, the Alaska Industrial Development and Export Authority, and the Alaska Energy Authority. Extensive dealings with members of the state legislature and staff, members of Congress and staff, federal agency officials, local officials, other state agencies, the public, special interest groups, and the media. Experience in legal matters including litigation and labor relations.

Chairman of the Board- Juneau International Airport (8/95-12/02)
Served as the first Board chairman. Worked with the City Assembly, other Board members, staff, tenants and airport users to coordinate the development of policies for the operation of the airport. Provided direction for the airport manager to ensure policies of the City Assembly and the Board were implemented and that the airport was operated in a safe, secure and cost-effective manner. Extensive dealings with airport tenants including airline representatives, local officials, FAA and the Transportation Security Administration. Non-paid position.

Regional Forester - US Forest Service (8/84-4/94)
Served as one of the nine Regional Foresters in the Forest Service. Provided executive leadership for 1000 employee organization with annual budgets ranging from $70-120 million. Established and accomplished objectives that contributed to hundreds of private sector jobs. Included was the production of commodity outputs from the national forests in Alaska such as timber, fish, subsistence wildlife, and minerals as well as non-commodity outputs such as wilderness, recreation use, and aesthetics. Responsible for all support activities to accomplish objectives including budgeting and allocation of resources, procurement, road construction, wildfire prevention and suppression, aircraft and boat operations, computer operations, labor relations, equal employment opportunity and affirmative action programs, employee safety programs, law enforcement, and other administrative activities. Represented Secretary of Agriculture on the five member federal Subsistence Board. Served as Dept. of Agriculture trustee on the six member Exxon Valdez Oil Spill Trustee Council which oversees the expenditure of the billion dollar Exxon settlement for the restoration of the spill impacted area. Extensive dealings, including Congressional testimony, with national and state legislators and staff, other federal, state, and local officials, the public, special interest groups, the media, users and permittees of the National Forests, and private landowners. Experience in legal matters including litigation. Served as lead negotiator with agency sign-off authority in the negotiation of national union contract for the Forest Service with 20,000 member employee union.

Skills

- executive leadership
- program development and administration
- budgeting and allocation of resources
- dealing with government processes and officials
- dealing with the legal system
- public involvement and public relations including the news media
- negotiations

Awards

- US Dept of Agriculture Superior Service Award, 1969- "Extraordinary action in the preservation of water quality in wilderness"
- US Dept of Agriculture Superior Service Award, 1989- "Efforts to improve the Forest Service national fisheries program"
- Numerous performance bonus awards

Community Service

- Juneau International Airport Board, elected chair 1995-2002
- Gastineau Channel Little League Board; elected Treasurer twice, President twice
- Rotary
- Golden North Salmon Derby Co-chair, 5 years
- Mayor's Task Force on the Diamond Park Aquatic Center 2008-present
- Other individual projects

Education

- Bachelor of Science, University of Michigan, 1961
- Master of Forestry, University of Michigan, 1965

Military

- Officer, US Army, 1961-1963

Webb, Russell
Alaska Mental Health Trust Authority Board of Trustees

Russell E. Webb

EXPERIENCE HIGHLIGHTS

- Thirty-two years experience in government service, 30 in Alaska.

- Twenty-five years experience developing, analyzing and executing state government agency operating and capital budgets providing health and social services to Alaskans.

- Twenty-five years experience representing executive agencies in all aspects of state legislative processes including: policy development and drafting of legislation, analyzing program and fiscal impact of proposed legislation, testifying in legislative hearings, preparing and presenting formal position papers and other informational materials, informal work with legislators and staff.

- Twenty years experience managing and directing state agencies and statewide service systems providing behavioral health, public health, child and adult protection, juvenile justice, developmental disabilities, and senior services.

- Twenty-five years experience managing and implementing statewide and community-specific planning efforts involving state public health, child protection, juvenile justice, behavioral health, developmental disabilities, and senior program services.

- Twenty-five years experience designing, writing, awarding, and managing grant programs and contract services provided by local government agencies, tribes, community non-profit organizations, private citizens, and for-profit organizations.

- Twenty-five years experience managing development and implementation of capital projects.

- Twenty-five years experience managing and performing program and fiscal analysis of statewide health and social service programs - translating service objectives into resource requirements, forecasting outcomes, preparing and presenting analysis.

- Twenty-five years experience developing and implementing quality control processes, analyzing program functioning, measuring outcomes, developing and projecting impacts of alternative action plans and implementing necessary improvements.

- Twenty years experience managing design, development, implementation, and operation of information systems including one of the first microcomputer-based management information systems and one of the first web-based systems in Alaska state government.

- Managed combined program planning efforts and capital project planning for replacement of Alaska Psychiatric Institute (Anchorage) and facilitated new facility providing integrated behavioral health treatment (Fairbanks) involving state and local government agencies, the Trust, non-profit and tribal organizations, and Trust beneficiaries.

- Faculty member National Judicial College teaching mental health system structure and financing to judges from throughout the nation.

Russell E. Webb [redacted]

EDUCATION

B.S. Psychology, 1972 - University of Tulsa
Tulsa, Oklahoma.

EMPLOYMENT HISTORY

Private Consultant	Anchorage, Alaska	Jul 2005 – May 2007
Program Officer	Alaska, Mental Health Trust Authority Anchorage, Alaska	Dec 2002 – Jul 2005
Deputy Commissioner	Department of Health & Social Services Juneau, Alaska	Jan 1997 – Dec 2002
Deputy Director	Division of Public Health, Department of Health and Social Services Juneau, Alaska	Mar 1994 – Jan 1997
Health Planner	Division of Alcoholism & Drug Abuse Department of Health & Social Services Juneau, Alaska	Nov 1991 – Mar 1994
Health Planner	Division of Public Health, Department of Health and Social Services Juneau, Alaska	Mar 1991 – Nov 1991
Director	Division of Family & Youth Services Department of Health & Social Services Juneau, Alaska	Dec 1989 – Mar 1991
Deputy Director	Division of Family & Youth Services Department of Health & Social Services Juneau, Alaska	Aug 1988 – Aug 1989
Social Services Program Coordinator	Division of Family & Youth Services Department of Health & Social Services Juneau, Alaska	Apr 1984 – Aug 1988

Social Worker IV	Division of Family & Youth Services Department of Health & Social Services Juneau, Alaska	Feb 1981 – Apr 1984
Probation Officer II	Division of Corrections Department of Health & Social Services Juneau, Alaska	Mar 1977 – Feb 1981
Social Worker II/III	Division of Social Services Department of Health & Social Services Juneau, Alaska	Nov 1975 – Mar 1977
Juvenile Probation Officer	Department of Institutions, Social, & Rehabilitative Services Tulsa, Oklahoma	Oct 1973 – Jul 1975

REFERENCES
Available on request.

Downing, Peggy
Board of Certified Direct-Entry Midwives

Center for Women's Health Care

Peggy Downing, MD, FACOG

Board-Certified: American Board of Obstetrics and Gynecology

Fellow: American College of Obstetricians and Gynecologists

MD: University of Texas Medical Branch, Galveston, TX

Ellen Faucett, DO, FACOOG

Board-Certified: American Osteopathic Board of Obstetrics and Gynecology

Fellow: American College of Osteopathic Obstetricians and Gynecologists

DO: College of Osteopathic Medicine and Surgery, Des Moines, IA

Complete well-woman care:

- Annual exams & Pap smears
- Colposcopy
- Contraception
- 3D & 4D ultrasound
- Care for heavy bleeding
- [illegible] solutions
- [illegible]opause care
- Diagnosis & treatment of endometriosis

Dedicated obstetric care:

- Prenatal care
- Individualized birthing options
- Birthing at Mat-Su Regional Medical Center
- Low- & high-risk pregnancy care
- Diabetic pregnancy care
- Amniocentesis
- In-office stress testing
- Cesarean section
- Vaginal births after C-section
- Certified midwife care
- Infertility solutions

Surgical solutions:

- Tubal ligation
- Fibroid removal
- Incontinence correction, bladder repair
- Laparoscopy
- Pelvic or uterine prolapse correction
- Hysterectomy – vaginal, abdominal & laparoscopic
- Laser surgery with CO_2 laser

Comforts & conveniences:

- Summer & winter gowns in various sizes
- Warmed instruments
- [illegible]es on stirrups
- [illegible]ed water, candy & snacks
- Immediate appointments
- Insurance accepted & filed
- [illegible]nancing available
- Kids toys in reception
- Educational books & tapes

Peggy A. Downing, M.D.

Education

OB?GYN Residency, University of Texas Medical School, 7-84 to 7-87
Internship, University of Texas Medical School, 7-87 to 7-84
Medical School, University of Texas Medical School, 9-79 to 5-83
BS Chemistry Magna Cum Laude, Southwestern University, 9-75 to 5-79

Employment

1987 – 1988 Employed as Physician, Susan Lemagie, M.D. (private practice)

1988 – Current Physician/Practice Owner, Center For Women's Health Care (private practice)

Licenses

Texas, G4999 1983 – current
Alaska 2234 1987- current

Board Certification

ACOG 12-7-90 to 4-30-2008
FACOG 9-30-91

Current Affiliations

Mat-Su Regional Medical Center/Valley Hospital, Palmer, AK – Active Staff since 1987
Providence Hospital Anchorage, AK – Courtesy Staff since 1988
Alaska Regional Hospital, Anchorage, AK – Courtesy Staff since 1994
University of Washington, Seattle, WA – Clinical Instructor since 1992

Advanced Coursework, Conferences and Seminars

American Board of Gynecology Recertification Exam, Medical Ethics and Professionalism, Neonatal Resuscitation, Clinical Quality Improvement, Maternal Fetal Medicine and Nursing, New Treatment for Type II Diabetics, Special Needs of Women Over 40, Conference on Women's Health Care, Premature Labor and Preeclampsia Management.
Medical Staff Directory 12/03-12/04
Maternal Child Health Section Chair 05/06-9/06

Withdrew

Allen, Jennifer
Board of Nursing

Jennifer "Robin" Allen

WORK EXPERIENCE:

09/2007 to Present — **ALASKA REGIONAL HOSPITAL-HCA, Anchorage, Alaska**
ORTHO TECH/ LPN/ ER TECH responsible for all duties expected Emergency Department team member, including all previous duties, And Orthopedic duties hospital wide.

07/2004 to 9/2007 — ALASKA REGIONAL HOSPITAL - HCA, Anchorage, Alaska.
LPN/EMERGENCY ROOM TECHNICIAN responsible for all duties expected of Emergency Department team member, including phlebotomy, EKGs, triage assistance, and assisting RN's with tasks as requested.

12/2001 to 04/2004 — GULF COAST MEDICAL CENTER - HCA, Panama City, Florida.
LPN - EMERGENCY DEPARTMENT STAFF NURSE responsible for all duties expected of Emergency Department team member, including dispensing of medication, ambulance patient receiving and triage, conscious sedation, and assist physicians with minor surgical procedures, including set-up.
NURSE TECHNICIAN/GRADUATE NURSE - Orthopedic Floor from December 2001 through March 2002.

09/2000 to 05/2001 — CHEMICAL ADDICTIONS AND RECOVERY EFFORT, Panama City, Florida.
MEDICAL SERVICES AID responsible for admitting, orientation, and monitoring of clients in Detox Unit, including taking and recording vital signs, intake & output, conducting group sessions, and assisting nurses as required.

07/1995 to 12/1998 — NORTH POLE OPTICAL, North Pole, Alaska.
OPTICIAN responsible for all facets of Opticianry, including assessment of client eyewear needs, dispensing and fabrication of eyewear, office management, inventory control, purchasing, accounts payable/receivable, insurance billing, and display advertising.

02/1987 to 07/1995 — ROTHMEYER OPTICAL & SUNLAND OPTICAL, Fairbanks, Alaska.
OPTICIAN/REGIONAL MANAGER responsible for management and maintenance of contract optical concessions on four major military installations in the State of Alaska.

EDUCATION:

2003 - 2004 GULF COAST COMMUNITY COLLEGE, Panama City, Florida.
Pre-Requisites for RN Program.

12/2001 TOM P. HANEY TECHNICAL CENTER, Panama City, Florida.
Practical Nurse graduate.

1971 - 1973 UNIVERSITY OF ALASKA, Anchorage, Alaska.
Liberal Arts.

1970 - 1974 STATE OF ALASKA DISPENSING OPTICIAN APPRENTICESHIP PROGRAM, Anchorage, Alaska. Optician graduate.

1968 - 1971 WEST ANCHORAGE HIGH SCHOOL, Anchorage, Alaska.
H.S. graduate.

LICENSES & CERTIFICATES:

- **Licensed Practical Nurse: Alaska No. 5894**
- **Licensed Practical Nurse: Florida No. PN5152810**
- **BLS**
- **ACLS**
- **IV Therapy**
- **Registered Orthopedic Technologist**

VOLUNTEER WORK:

Board Member for State of Alaska Dispensing Opticians Licensing Board, 1980's Executive Board Member of Opticians Association of Alaska.1980's March of Dimes LPN of the year 2010. Member of Alaska Nurses Association.

REFERENCES:

Furnished upon request.

Farnstrom, Beth
Board of Nursing

Beth Gartner Farnstrom, BSN, RN

Objective: A position on the Alaska Board of Nursing.

Employment:

1999 to present	Providence Alaska Medical Center, Anchorage, AK Staff RN and Charge Nurse in Post Anesthesia Care Unit
1985 to 1999	The Ohio State Medical Center, Columbus, OH Staff RN in Post Anesthesia Care Unit
1981 to 1985	The Ohio State Medical Center, Columbus, OH Assistant Head Nurse in Cardiovascular and Thoracic Unit
1980 to 1981	The Ohio State Medical Center, Columbus, OH Staff Nurse in Cardiovascular and Thoracic Unit

Professional Organizations:

1980 to present	American Nurses Association
1986 to present	American Society of Peri-Anesthesia Nurses (ASPAN) Member 1991 National Conference Committee Hostess 1998 National Convention
2000 to present	Northwest Component of ASPAN

Current License: Alaska RN License

Current Certification:
CPR-BLS
PALS
ACLS

Awards and Recognitions:
1991 Recipient of the Ohio State Medical Center Clinical Excellence in Nursing Award
1990-1991 President of Ohio Post Anesthesia Nurses Association

Education:
Bachelor of Science in Nursing
Capital University, Columbus, OH
December 1979

Gillette, Julie
Board of Nursing

Julie A. Gillette

SUMMARY OF QUALIFICATIONS

Health Information Technology Specialist trained in health information functions such as content and format of records, retention and storage requirements, indexes and registries, and forms design. Special interest in quality systems as they apply to information technologies for data search and access. Familiar with laws and regulations addressing release of information and retention of records, as well as the legal and regulatory issues surrounding confidentiality of information. Detail-oriented with technical expertise yielding streamline operations to benefit patient care and regulatory compliance.

HIT SKILL AREAS

Policy & Regulations	• HIPPA	• CPT	• ICD9
Medical Office	• Patient Accounts	• LYTEC	• EHRs

EDUCATION

A.A.S.	**Health Information Technology**	DeVry University	June, 2008
A.A.S.	**Logistics**	Community College of the Air Force	August, 2001
A.A.S.	**Electronic Systems**	Community College of the Air Force	June, 1997

EXPERIENCE

HEALTH INFORMATION TECH (TRAINING AND EXPERIENCE)

- June 2008-February 2010 Medical Records Manager, Valley Neuroscience Center, Jeffrey Sponsler, MD.
- Primary duties: Proofreading reports, coordinating diagnostic testing, referrals to other specialties, and ensuring patient records were received from third parties as requested. Ensuring patients complete pre-diagnostic requirements for new patient visits. Tracking referrals and reports.
- Managed electronic records for over 2,800 patients, maintained continuity & consistency
- Streamlined referring physician program resulted in 25% reduction of pending referrals & overdue reports.
- Chosen by practicum director to compare EHRs to data in LYTEC for monitoring patients on seizure medications. Captured data on 132 patients' last appointments, diagnoses, and lab results.
- Developed an Excel sheet to capture a list of 375 potential Video Electroencephalogram candidates out of 2089 patients using epilepsy diagnostic codes.
- Coordinated contact with 900 doctors statewide in the clinic's first major marketing campaign.

UNITED STATES AIRFORCE — APRIL 1998 – APRIL 2006

• **Superintendent, Contingency Plans**	Minot AFB, ND	2004-2006
• **Chief, Logistics Plans**	Elmendorf AFB, AK	2002-2004
• **Superintendent, 3rd Wing Support Agreements**	Elmendorf AFB, AK	2000-2002
• **Unit Deployment Manager**	Elmendorf AFB, AK	1998-2000

LEADERSHIP/MANAGEMENT

- Innovative support agreement manager, developed a template that slashed reviews by 30 days and converted program from paper to electronic.
- Analyzed monthly deployment taskings and developed a program matching personnel exactly to positions reducing the error rate 80% in 120 days.
- Led, directed, and supervised one Non-Commissioned Officer and two airmen supporting Minot AFB installation logistics planning efforts. Orchestrated installation support and deployment of 3,712 personnel and 2,269 tons of cargo.
- Supervised the development and completion of the Base Support Plans for the Pacific Air Command and NORAD contingency taskings for two main bases, one air station, two forward operating locations, and 18 remote radar sites.

4301 South Well Site Road ♦Wasilla, Alaska 99654
(907) 376-5455♦ loggiemonster@hotmail.com

Julie A. Gillette

- Led two individuals in the management of a $5 million support agreements program consisting of 87 interservice and intraservice support agreements, memorandums of agreement, and memorandums of understanding. Won Logistic Planner of the Year.
- Trained 117 unit deployment managers to meet demands of two major regional conflicts and rotations of ten Air Expeditionary Teams.

COMMUNICATION

- Created user friendly data sheets for operational war plans reducing deployment planning time by 20%.
- Benchmarked as an Air Force instruction and training materials author; wrote local supplements and base training programs adopted command-wide.
- Wrote detailed performance evaluations for five Air Force personnel; leadership earned major command level awards for subordinates.

TEAM BUILDING

- Motivated high-performance teams while cultivating productive relationships
- Led and supervised eleven personnel fostering a positive work environment producing consecutive outstanding quality inspection results

COMMUNITY INVOLVEMENT:

- July 2010-Present Home schooling a second grader enrolled in Raven Correspondence Course
- June 2010-Present-Weekly Church Bulletin Coordinator and Administrator
- August 2008-May 2010 Secretary for the church women's group serving 145 families in need. Performed administrative duties and assisted monthly with various church and community outreach programs.

Pringle, Erin
Board of Nursing

Curriculum Vita

Name: Erin Pringle, RN, MS Assistant Professor, UAA School of Nursing

Education:

2008 Master of Nursing Education, University of Alaska, Anchorage.

2001 Master of Science, Exercise Physiology, University of Nebraska, Omaha, Nebraska
Master's Thesis: The Relationship Between Running Performance and Lung Functions and Capacities

2001 Squadron Officer School, Air University
A 6-week graduate level military course for Captains in the U.S. Air Force. Topics of study include military history, leadership, management, and military affairs

2003 Air Command & Staff College, Air University
A 16-month graduate-level study for officers with the rank of Major in the U.S. military. Students have an option to obtain a Master's of Military Science through this program. Topics of study include advanced military history and leadership, war planning, and combat strategy

1994 Bachelor of Science, Nursing, University of Wyoming, Laramie Wyoming

License:

Registered Nurse - State of Alaska

Certifications:

Basic Life Support, current
Neonatal Resuscitation, current
Advanced Life Support, current
Advanced Life Support in Obstetrics
AWHONN Fetal Heart Monitoring Instructor
Trauma Nurse Care Course

Continuing Education

- InCITE (Interprofessional Collaboration for Integrative Technologies in Education) Annual Faculty Development Workshop, 2009
- Association of Women's Health, Obstetric & Neonatal Nurses Annual Convention, 2009
- Rebuilding Your Nursing Curriculum: Integrating the Evidence into Nursing Education, 2010
- Technology Fellows – Intensive Training, Univ of Alaska, Anchorage
- CAFÉ: Center for Advancing Faculty Excellence, University of Alaska, ongoing
- Neonatal Resuscitation Program
- Trauma Nursing Medical Effects of Ionizing Radiation, Omaha Nebraska
- Maternity Center Skills Day, Providence Hospital
- Executive Team Management Training Conference, Wright-Patterson AFB
- Mass Casualty Incident Management, Lincoln Nebraska
- Being An Effective Preceptor, Providence Hospital
- AWHONN Fetal Heart Monitoring Instructor Course, Elmendorf AFB
- Combat Medicine, Offutt AFB, Nebraska

Professional Experience

Medical/Surgical Nursing, AK Regional Hospital, 2007 - present

Currently working part-time in busy pre-operative unit averaging 40 surgeries/day. Previous med surg experience includes two years full-time floor nursing on medical surgical unit in 30-bed hospital. Provided pre and post-operative care to pediatrics and adults as well as long-term care for a variety of medical conditions. Also completed 6-month Air Force Internship in Medical/Surgical Nursing with rotations through the emergency room, surgery, and inpatient units.

Assistant Professor (UAA School of Nursing) 2004 - present

Courses Taught:

Sem/Year:	Course #:	Course Title:
Fall 04,05,06,07,08,09	NURS 220	Perinatal Nursing Course Coordinator
Fall 04,05,06,07,08,09	NURS 221	Adv. Parenteral Lab Course Coordinator
Fall 04,05,06,07,08,09	NURS 220L	OB Clinicals
Sp 05,06,07,08,09,10	NURS 220	Perinatal Nursing Course Coordinator (web-based course)
Sp 05,06,07,08,09,10	NURS 220L	OB Clinicals
Sp 07,08,09	NURS 295	Advanced Practicum in Nursing

Outreach Coordinator (UAA School of Nursing) 2008-present

Work with the Chair, AAS Nursing Program, to coordinate the twelve site Outreach (distant) delivery of an NLNAC-accredited associate degree nursing program in Alaska. Responsible for mentoring/guiding outreach faculty in teaching & planning for local community student experiences. Duties include traveling to Outreach sites for the purpose of site evaluation, ensuring distant sites are assessed for essential resources used in course delivery, coordinating video/audio conference schedules, intensive clinical rotation schedules & instructional technology and instructional design initiatives for Outreach delivery.

Clinical Nurse, Obstetric/Gynecologic (Inpatient)

Seven Years of full-time inpatient floor nursing in Labor & Delivery, Postpartum, Newborn Nursery, and High-risk Perinatal units. Facilities included small rural hospitals and high risk tertiary maternity centers. Functioned as charge nurse of 8-12 staff members per shift and in-house nursing night supervisor of 50-bed hospital. Have also functioned as a nurse preceptor orienting new nurses to inpatient OB nursing.

Traveling Nurse

Worked three travel nurse assignments at busy Labor and Delivery units with 200+ deliveries per month. Able to function independently with very little orientation.

Obstetric/Gynecologic (Outpatient)

One year full-time in busy OB/GYN clinic, seeing 300 patients per day. Duties included telephone triage for a variety of women's health situations, patient education, and assistance with minor procedures.

Childbirth Educator

Director of Childbirth Education at Offutt Air Force Base Hospital. Duties included coordinating classes for 250 couples per year, education and scheduling childbirth instructors, teaching class, advertising, and ordering of supplies and materials.

Military

Twelve years military service: 5 years active duty, 7 years reserve. Member of Air Force Reserve Nurse Corps, rank of Major, having completed extensive training in combat medicine and readiness, trauma, leadership, and deployment capability. Served as assistant Chief Nurse Executive of 50-member nursing flight. Duties included coordination of training for military medics and yearly performance evaluations for every nurse in the flight. Performed tour of duty at Prince Sultan Air Base, Saudi Arabia, in December of 2000, and Misawa Air Base, Japan in 2002. These were peacetime deployments in forward locations with varied duties including night shift supervisor of the inpatient medical facility.

College of Nursing Committees

2004-current: AAS (Associate of Applied Science) Program Committee
2004-current: AAS Curriculum Committee
2004-current: SON (School of Nursing) Faculty Association
2005-current: SON Scholarship Committee
2008-current: SON Scholarship Committee, **Chair**
2009: SON Dispute Resolution Committee, **Chair**
2007-current: UAA Technology Fellows Selection Committee
2007: UAA Search Committee: Associate Professor of Medical Lab Technology
2007: UAA Advisory Committee for the Chancellor's Awards for Excellence

Professional Organizations/Professional Development

AWHONN: Association for Women's Health, Obstetrical, and Newborn Nursing, current member
UAA MENTORING: Participant in the SON formal mentoring program
CAFÉ: Center for Advancing Faculty Excellence, Best Practices in Teaching & Learning
ROA: Reserve Officer's Association
OCF: Officer's Christian Fellowship
Sigma Theta Tau, Honor Society for Nursing
ANA: Alaska Nurses Association

Publications

Pringle, E.M., Latin, R.W., & Berg, K. (2005). The relationship between 10 Km running performance and pulmonary function. *Journal of Exercise Physiology*, 8(5), 22-28.

Honors, Awards, Grants, Fellowships

2005 University of Alaska Technology Fellowship: One of 12 faculty selected university-wide to participate in the first annual technology fellows training
2009 – current: Alaska delegate to the WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) Nursing Technology Collaborative

Service

School of Nursing Mentorship Program: provides new nursing faculty with mentorship to the University

Air Force ROTC: Mentoring/Career Counseling – serve as a resource for cadets interested in a military nursing career

Health Fair: Member of the Alaska Health Fair Organization, regularly volunteering at local Health fairs

Church: Volunteer as medical officer for busy children's ministry of approximately 1000 kids/week

Barney, Paul
Board of Examiners in Optometry

Paul M. Barney, OD

Curriculum Vitae

Current Position

Specialty	Optometric Physician, Medical Consultation

Education

Optometry School	1980 to 1984	Doctor of Optometry Southern California College of Optometry Fullerton, California
Undergraduate	1976 to 1980	Bachelor of Science Degree North Dakota State University Fargo, North Dakota

Clinical Experience

1990 to Present	Pacific Cataract and Laser Institute Chehalis, Washington and Anchorage, Alaska Staff Optometric Physician
1985 to 1990	Inland Eye Institute Colton, California Director of Contact Lenses and Optometric Services

Professional Organizations

1980 to Present	American Optometric Association
1990 to Present	Washington Association of Optometric Physicians
1991 to Present	Adjunct Professor, Pacific University College of Optometry
1996 to Present	Board of Advisors, Canvasback Missions, Inc.
1999 to Present	Board of Directors, Canvasback Missions, Inc
1999 to Present	Alaska Optometric Association

Professional Licenses

1985	California

1990	Washington
1999	Alaska

Interests

Hiking, backpacking, mountain biking, rock and ice climbing, skiing, and photography.

Personal

Born in McVille, North Dakota

Devito, Lori
Board of Pharmacy

LORI A. DEVITO, RPH

S[redacted]

C[redacted]

OBJECTIVE

To be a leader and positive role model in the Profession of Pharmacy. To organize, direct, own and operate a home infusion pharmacy as well as maintain an ongoing liaison to the governing body, professional advisory committee and staff. To employ qualified skilled personnel and ensure staff is updated on education and evaluations. To implement an effective budgeting and accounting system which will allow for the pharmacy to operate in the most efficient and cost effective manner possible.

QUALIFICATIONS

Registered Pharmacist for 24 years in Soldotna, Alaska
Hospital and Retail Pharmacist -24 years
Long Term Care Facility Pharmacy Consultant- 24 years
Home Infusion Pharmacist Manager, President/CEO/Owner – 19 years
Home Health Care Administrator, President/CEO/Owner-15 years
Trained in I.V. Admixtures, Sterile Compounding, Home Health Care Fittings, Ostomy Supplies, TENS units, Oxygen Usage, Wound Care, Clinical / Retail Pharmacy, DME
Prescription Compounding Certified
In-service Teacher- Diabetic/Pharmacy
In-service Teacher-Ambulatory IV equipment, Enteral Equipment
CPR Certified
Main Speaker at National Home Infusion Association
Attended Several Home Health Care Educational Seminars regarding administration/Cost Reporting/Clinical Care
Preceptor for Students of Pharmacy

EDUCATION

1983-1986	Bachelor of Science in Pharmacy, University of Colorado-Boulder, Colorado
1981-1983	Undergraduate Pharmacy, Colorado State University, Fort Collins, Colorado
1986-1995	Small Business Administration, Kenai Peninsula Community College, Kenai, AK
1981	High School Graduate, Kenai Central High School, Kenai, Ak

AWARDS/OTHER INFORMATION

1993-Present	Member National Home Infusion Association
1996-Present	Member National Association of Home Care
1988-1995	Member National Association Retail Druggist's
1986-Present	Member Alaska Pharmaceutical Association
1992-1993	President Alaska Pharmaceutical Association
1991-1992	America Pharmacy Association Alaskan Delegate (Washington, D.C.)
1997-2003	APHA-Alaska Legislative Affairs Representative
1992	Pharmacy Leadership Award-AKPHA
1993	President's Award in Pharmacy-AKPHA
1995	Distinguished Young Pharmacist Award-AKPHA
1985	Bowden Pharmaceutical Scholarship-Recipient
1986	Member Alaska Home Care Association-Secretary
1988-1995	Member Peninsula Home Health Care-Board
1995-2005	Soroptimist Twin Cities Member
1997-1998	Soroptimist Twin Cities President
1998	Founder-Soroptimist Cancer Fund

WORK HISTORY

1993-Present	Professional Home I.V., Inc. Owner/CEO/Pharmacy Manager
1996-Present	1st Choice Home Health Care, Inc. Owner/CEO
1986-1996	Soldotna Professional Pharmacy-Retail Pharmacist
1991-1995	Central Peninsula General Hospital- Hospital Pharmacist
1984-1986	Soldotna Professional Pharmacy-Pharmacy Intern
1985-1986	Pharmacy Externships: Pharmacy Financial Management—Yuma, Colorado Hospital & Clinical Pharmacy- Shiprock, N.M. Chain/Retail Pharmacy-Denver, Colorado Nursing Home Pharmacy Consultant-Denver, Colorado
1979-1983	DeVito Co-Nook Lure Company-Partner in Manufacturing Business
1975-1984	Soldotna Drug Store-Pharmacy Tech, Inventory, etc.

LICENSES

Pharmacist	Alaska	License #837
Pharmacist	Colorado	License #18657
Pharmacist	South Carolina	License #12854

White, Dirk
Board of Pharmacy

Dirk Thomas White

Professional Experience:

White's Inc. dba White's Pharmacy, Harry Race Pharmacy
Season's Card/Gift Shop
106 Lincoln Street Sitka, Alaska 99835

Pharmacist & Corp. President
1985 to Present

Awards:

Alaskan Young Pharmacist of the Year	1987
Sitka Chamber of Commerce Business of the Year	1999
Willard B. Simmons Independent Pharmacist of the Year	2006
Bowl of Hygeia 2007	
2010 Alumnus of the Year - South Dakota State University Pharmacy School	

Community and Professional Service:

- Phi Delta Chi Professional Fraternity-Theta Chapter
  V.P., Life member
- Rotary International
  Secretary of the Sitka Club
- Alaska Raptor Rehabilitation Center
  1985 to present, Original Board member, Board President-3 years, moved center to current site, conducted a national ED search, budget went from $0 to over $1 million in12 years.
- St. Peter's by the Sea Episcopal Church
  Serving on the Vestry, Deanery, and as Stewardship Director
- KCAW-FM "Raven Radio" Community Public Radio
  On air host, fundraising, and program development
- Junior Achievement -Classroom Presenter
- Alaska Communications System-Local Advisory Board
- Baranof Barracudas Swim Club
  Board of Directors, Past President, USA Swimming Stroke and Turn Judge
- AmerisourceBergen West Region Advisory Board
- Alaska Pharmacists Association-member since 1985
  Board of Directors, Past President, Legislative Committee Co-Chair currently, and Past Committee Chairman
- Alaska State Board of Pharmacy Current Board Secretary
- ALPS Credit Union-Supervisory Committee
- NCPA

Steering Committees (Legislative, 3rd Party Payment and Home Health Care) Nominations Committee, Convention session moderator, Session Panel member/presenter, House of Delegates representing Alaska for the last 15 years or more, NCPA Foundation Fundraising committee.

- Retail Management Solutions
  Advisory Board

Affiliations:

St. Peter's By the Sea Episcopal Church
NCPA Since 1988
PCCA Since 1986
IACP Since inception
APhA Since 1989
AKPhA Since 1985
AADE Since 1989
Photo Marketing Assoc. International (PMA)
National Ice Cream Retailers Assoc. (NICRA)
Natural Products Assoc. (NPA) formerly NNFA
Association of Natural Medicine Pharmacists (ANMP)
American Botanical Council
Phi Delta Chi
Girl Scouts and Boy Scouts
USA Swimming
Ducks Unlimited
NRA
Alaska Tourism Industry Association (ATIA)
Sitka Chamber of Commerce
Sitka Convention and Visitors Bureau
Alaska Diabetes Association

Publications:

Computer Talk
July 2003 pp.16-18
America's Pharmacist
February 2005 pp. 22-25
NCPA-Pfizer Digest
2005

Education:

University of Mississippi		Oxford, MS
APhA Apple Management Program		1990
South Dakota State University		Brookings, SD
Bachelor of Science in Pharmacy		1985
University of Minnesota		Morris, MN
Bachelor of Science in Biology		1979

DeRuyter, John
Board of Psychologist and Psychological Associate Examiners

Curriculum Vitae
John DeRuyter Psy D.

Education

Psy.D. Wheaton College, Graduated 2003 (final GPA 3.82)
(Specialization: Clinical Psychology)
M.A. in Clinical Psychology, Wheaton College, 2000
B.A. in Psychology, University of Alaska Fairbanks, 1998,

Licensing

Psychologist, Alaska license #547, Effective 07/12/2005 Expires 06/30/2006

Research Interests

Effective group interventions for blended families;
Role of peer and parental support in adolescent attachment stability and friend selection;
Factors that limit or enhance couple's participation in marital enrichment programs;

Clinical Experience and Employment History

Clinical Director/Psychologist, Hope Counseling Center, 03/2004 to present
Counselor/Psychologist, Hope Counseling Center, 06/2003 to 03/2004
Onsite Evaluator for the Sitka Tribe of Alaska Safe Start Program 2002 – 2004
Adjunct Professor University of Alaska Fairbanks 08/2002 to 07/2003
Predoctoral internship, Hope Counseling Center, 05/2002 to 05/2003
Clinical Clerkship, Conley Outreach, 09/2001 – 05/2002
Clinical Clerkship, Hope Counseling Center, 05/10/2002 - 08/03/2002
Clinical Externship, Conley Outreach, 09/01/2000 - 05/05/2001
Clinical Externship, American Indian Health Service, Chicago, 09/01/1999 - 07/31/2000
Group coordinator and night monitor, Life Givers residential treatment

program, Fairbanks Alaska, 1997 - 1998
Part time pastoral counselor, Fairhill Community Church, Fairbanks Alaska, 09/15/94 - 07/26/98
Owner, Flower Shop Downtown, Fairbanks Alaska 1995-1998
Pilot and Director of Flight Operations, Alaska Central Express, Fairbanks Alaska, 1988-1995

Professional Memberships

Alaska Psychological Association 2004 - present
National Association for Rural Mental Health 1999- present
American Psychological Association 1998- present

Research Experience

Onsite Evaluator for the Sitka Tribe of Alaska Safe Start Program 2002 – 2004

Efficacy study of blended family educational workshops to increase remarried couples marital satisfaction, Wheaton College, 2001 - 2003

Adolescent stress and peer group friend selection, University of Alaska Fairbanks, 1997-1998

Teaching Experience

Adjunct Professor University of Alaska Fairbanks 08/2002 to 07/2003
Hope Counseling Center, Blended Family Workshop, 2001
Conley Outreach Community Services, Community Care Team training, 2001
Wheaton College, Teaching Assistant, 1999 - present

Administrative Experience

Small business owner and manager of The Flower Shop Downtown, Fairbanks Alaska, 1992 - 1998

Director of Operations for Alaska Central Express, Fairbanks Alaska, 1989 - 1998

Academic/Professional Awards:

1998, selected as "Student of the Year" by University of Alaska Fairbanks psychology faculty

Conference Presentations:

DeRuyter, J. (2000, August). *Training Mental Health Workers for Rural Practice*. Paper presented as part of a training symposium presented at the annual conference of the National Association for Rural Mental Health (NARMH), Portland Oregon.

Participated in a panel discussion concerning innovative training protocols for developing rural mental health professionals, annual conference of the National Association for Rural Mental Health, August 2000, Portland Oregon.

Continuing Education and Training:

Alaska Native Cross Cultural Studies and Substance Abuse Issues, Rural Providers Conference, June 7 -11, 2004 Seward Alaska. Rural Alaska Community Action Program Inc. 40 hours

Behavioral Health Conference, Providence Alaska Learning Institute, October 29, 2004. 7.2 hours

Imagery & Hypnosis, John Carpenter, PESI HealthCare April 8, 2005. 6.25 hours

Counseling Victims of Sexual Trauma, Jean Shinners. Cross Country University, June 6, 2005. 6 hours.

Incorporating Spirituality into Psychological Treatment: Themes, Principles, and Interventions. Co-occurring Disorders Institute, October 14, 2005. 7 hours

Supporting Return: Options for Military and Their Families, Co-occurring Disorders institute. February 27 – 28, 2006, 11 hours.

Supervisory Relationships: Exploring the Human Element, CE-credit.com. June 14, 2006, 7 hours.

Psychopharmacology, PESI HealthCare, August 23, 2006. 6.25 hours

Legal Issues in Behavioral Health, MEDS-PDN, November 3, 2006. 6 hours.

Ethics in Healthcare, National Association of Social Workers, April 3, 2007. 3 hours

References available upon request:

Syzdek, Jennifer
Board of Social Work Examiners

Jennifer N. Syzdek

Objective: To affect positive change in our world, through education, community involvement, and social justice.

Work Experience

Director of Operations	Hearts & Hands Adult Day Care · Anchorage, AK	2009- present
Program and policy development to meet SDS standards. Overseeing program operation and staffing.		
Activity Director and Dispatcher	Hearts & Hands Adult Day Care · Anchorage, AK	2008- 2009
Scheduling and preparing activities for clients. Supervising, training and hiring direct service.		
Activity Facilitator	Hearts & Hands Adult Day Care · Anchorage, AK	summer 2008
Planning and facilitating well-rounded activities for clients who are elderly or experiencing disabilities		
Transporting clients on a daily basis and assisting with personal cares as needed		
AmeriCorps VISTA member	Southeast Alaska Independent Living · Ketchikan, AK	2007- 2008
Developing a fundraising plan, recruiting volunteers, organizing and carrying out a fundraising event		
Assisting with ORCA (Outdoor Recreation and Community Access) as needed		
Live-in Caregiver	Create-Ability, Inc · Madison, WI	2006- 2007
Sought to provide care and recreation for a high quality of life for three men with disabilities		
Oversaw and directed six part-time staff		
Youth and Education Director	St. Agnes Church · Walker, MN	2003- 2005
Lead, instructed, and coordinated religious education and youth programs		
Took the initiative to develop an adult education program and create a working web of active volunteers		
Reformatted programs to meet the needs of students and to provide enjoyable learning environments		
Developed a weekly education program for grades one through adult		
Substitute Paraprofessional	Walker-Hackensack-Akeley Elementary School · MN	2005
Environmental Educator	Deep Portage Conservation Reserve · Hackensack, MN	2002- 2003
Provided outdoor instruction in a variety of environmental sciences and outdoor activities		

Volunteer Positions

Theology and Brew Coordinator	Diocese of Anchorage · Anchorage, AK	2010- present
Project Homeless Connect Volunteer	Coalition on Homelessness · Anchorage, AK	2009- present
High School Retreat Volunteer	Holy Family and St. Benedict's · Anchorage, AK	2009- present
Young Adult Activity Coordinator	Holy Family Cathedral · Anchorage, AK	2009- present
Just Faith Facilitator	Diocese of Anchorage · Anchorage, AK	2009- 2010
Soup Kitchen Cook/ Coordinator	Holy Name/ Salvation Army · Ketchikan, AK	2007- 2008
Adult Faith Formation Director	Holy Name Church · Ketchikan, AK	2007- 2008
Activities Volunteer	Pioneer Home · Ketchikan, AK	Summer 2007
Cabin Maintenance Volunteer	Forest Service · Ketchikan, AK	Summer 2007
English as a Second Language Teacher	Catholic Multi-Cultural Center · Madison, WI	2006- 2007
Principal's Assistant	St. Ambrose Academy · Madison, WI	2006- 2007

Education

Juniata College	Huntingdon, PA	1998- 2002
Bachelor of Science · Environmental Science, emphasizing Mathematics		
Leeds University · school year abroad	Leeds, England	2000- 2001

William J. Streur

Streur, William
Commissioner - Department of Health and Social Services

PERSONAL

A highly motivated and confident manager, a strong communicator, a quick thinker, and excellent strategist, with strengths in startup, acquisitions, fundraising, contract negotiation and turnaround and change. Perceived as charismatic, an articulate speaker with a thorough knowledge of managed care strategies, the health insurance market, claims systems, the Medicaid market, indigent and uninsured needs issues and all health delivery operations.

WORK HISTORY

State of Alaska
Anchorage/Juneau, Alaska
Deputy Commissioner, Medicaid and Health Care Policy. **2007-Present**

Responsible for all aspects of the $1.2B Medicaid, SCHIP and CAMA programs for the State including all policy development and implementation, claims benefit packages and payment for services and oversight of the fiscal agent contract. Responsible to coordinate the five year plan for the Legislature, interface with the legislature on budget, policy and regulation development, benefit coverage and provider/enrollee satisfaction. Implements all federally mandated changes to programs, promulgate regulations and develops state plan amendments to satisfy requirements. The position coordinates all activities of the Deputy position including interfaces with other divisions, departments of stat e government and the legislature. Oversee the development of the new MMIS development (DDI) and all other IT improvements for the Medicaid and SCHIP programs. Directly manage the Department health planning and systems development, rate review and facility survey sections. Analyze and review all financial performance to coordinate budget, spending and project needs throughout the fiscal year. Serve as primary liaison for the department with Center for Medicare and Medicaid Services (CMS).

First Health Services Corporation
Anchorage Alaska
Senior Director, Alaska Operations **2003-2007**

Lead position administering over 90 employees in the fulfillment of the State of Alaska MMIS Medicaid contract for all operations including MMIS, SURS, claims/correspondence scanning and OCR, claims adjudication, Pharmacy (POS, PDL, Profiling and Reporting, etc.), and mental health inpatient/residential utilization review and care coordination. Directed and oversaw the operations and beginning of the transition to a new MMIS system for the State, the State's first since 1987.

- Maintained an open communicative relationship regarding the fiscal agent services with the State while facing significant legal and contractual challenges regarding the new MMIS development.
- Redesigned the contract with the State for Claims review and SURS functions and preserved its continuation into 2010.

Upper Peninsula Health Plan **1998-2003**
Marquette, Michigan
President and Chief Executive Officer

Founding officer for the Plan and its first employee. Plan's ownership consists of 13 of the Upper Peninsula's 14 hospitals and nearly 200 physician investors with over 800 total providers serving Medicaid and CHIP populations. Plan is recognized as a leader in innovative involvement with the provider community. State Medicaid leadership points to the Plan as a model of quality and customer satisfaction for others to follow. Led the plan to successful NCQA accreditation in 2003.

- Guided the concept development, raised funds from investors, employed staff and prepared the Plan for its initial service population and brought the Plan to profitability in 26 months with an enrollment of approximately 20,000 Medicaid members.

- Led the Plan to a rating as one of the top five health plans in Michigan (Benchmark Plan) for quality and customer satisfaction (member and provider) in its second full year of operation. This achievement was repeated in the third and fourth years of operation. Awarded quality bonus each year.

Consultant-Self Employed **1997-1998**
Marquette, Michigan
Medicaid and Managed Care Strategy
Consultant and trainer to a variety of organizations and corporations on managed care issues including strategic planning, business process management, alliances, acquisitions and mergers, implementation strategies, benefit design systems development, network development and contracting, administrative structures, gate keeping approaches, and training. Trained over 1000 persons on managed healthcare strategies, transition issues, structure acceptance and courtesies. Contracts include state government, universities, mental health organizations, hospital systems, county government and private health plans. Consistently rated as outstanding instructor and presenter.

PeaceHealth **1987 - 1997**
Eugene, Oregon
Corporate Director (Vice President) of Behavioral Health
Responsible for overseeing the development of a nonprofit coordinated and comprehensive behavioral health system supporting the corporation's overall strategic plan. The position objectives were to develop and ensure consistent standards throughout the PeaceHealth system and to ensure the long-term viability of a behavioral health service line fully integrated with other health care services corporately and in each region. One member of a four person team addressing the strategy of the corporation.

- Acquired a large, privately owned, and freestanding behavioral health case management and delivery system. Recovered acquisition costs in first five months of operation. Realized over a 17% net corporate gain per annum for first three years of operation. Emerged as the largest behavioral health provider in the state of Washington, Oregon and Alaska.

Recovery Northwest (PeaceHealth) **1984 - 1987**
Vancouver, Washington
CEO
Hired as a turnaround CEO. Brought the company to profitability and sold to PeaceHealth, which expanded and grew the business line with me as the product line manager.

Northern Michigan Substance Abuse Services **1978 – 1984**
Gaylord, Michigan
Executive Director, building the agency from one representing 12 counties in Northern Michigan to one representing 23 counties. Seen as one of the premier agencies in the state system and operating continuously through 2009.

United States Air Force **1970 - 1976**
United States Air Force Reserve **1980 - 1995**
Served in a variety of officer duties including aircrew, maintenance officer, race relations, equal opportunity and drug and alcohol control and rehabilitation. Opened first formal chemical dependency treatment unit for Armed Forces in Europe. Vietnam and Desert Storm (Kuwait liberation) veteran. Numerous deployments representing the United States. Bronze Star and Meritorious Service Medal recipient. Highest decorated officer in the unit upon retirement in November 1995.

PROFESSIONAL AFFILIATIONS AND APPOINTMENTS

- Managed Care Consultant to design team of Oregon Health Plan, the state's Medicaid Managed Care effort.

- Board member and volunteer to numerous human services organizations, active in my church.

- Seventeen year Rotarian, Paul Harris Fellow (x3), Club President 2000-2001.

EDUCATION

Graduate study toward concurrent Master's degrees in Business and Sociology
Ball State University and Troy State University

Bachelor of Arts, (Pre Medicine/Liberal Arts)
Northern Michigan University, Marquette, Michigan

Celeste Hodge

From: Alida Bus
Sent: Monday, March 21, 2011 9:02 AM
To: Celeste Hodge
Subject: RE: Confirmation of Governor's Appointments

Hi Celeste,

I apologize for not getting back to you earlier. Sen. Egan doesn't have any issues with any of the recommended appointments.

Thanks,
Alida

From: Celeste Hodge
Sent: Monday, March 21, 2011 8:59 AM
To: Alida Bus
Subject: FW: Confirmation of Governor's Appointments

Alida,
Your senator is the only one I'm still waiting on a response from regarding the governor's recommended appointees. Does he have any issues with any of those recommended for appointment? Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

From: Christine Marasigan
Sent: Thursday, March 17, 2011 4:42 PM
To: Celeste Hodge
Subject: RE: Confirmation of Governor's Appointments

Celeste,

Our office has no issues at this time with the appointments.

Christine

From: Celeste Hodge
Sent: Thursday, March 17, 2011 1:21 PM
To: Alida Bus; Amory Lelake; Christine Marasigan; Gayle Keller; Katherine Ellis; Sen. Bettye Davis; Sen. Dennis Egan; Sen. Fred Dyson; Sen. Johnny Ellis; Sen. Kevin Meyer
Subject: Confirmation of Governor's Appointments
Importance: High

Senate HSS Members,
The governor's appointment packets were delivered to members months ago. Since that time, I've asked several times if senator's had any concerns with any of the names the governor recommended for legislative confirmation. So far, no one has mentioned any concerns to me. If there are no concerns with any of the individuals recommended, we will simply process the report at the Senate HSS meeting on Monday. If there are concerns, please let me know no-later-than 5:00 PM today so I can invite that individual or those individuals to this Monday's meeting. I'm attaching a copy of the report for your review. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Amory Lelake
Sent: Thursday, March 17, 2011 2:00 PM
To: Celeste Hodge
Cc: Sen. Johnny Ellis
Subject: RE: Confirmation of Governor's Appointments

Senator Ellis has no concerns.

From: Celeste Hodge
Sent: Thursday, March 17, 2011 1:21 PM
To: Alida Bus; Amory Lelake; Christine Marasigan; Gayle Keller; Katherine Ellis; Sen. Bettye Davis; Sen. Dennis Egan; Sen. Fred Dyson; Sen. Johnny Ellis; Sen. Kevin Meyer
Subject: Confirmation of Governor's Appointments
Importance: High

Senate HSS Members,
The governor's appointment packets were delivered to members months ago. Since that time, I've asked several times if senator's had any concerns with any of the names the governor recommended for legislative confirmation. So far, no one has mentioned any concerns to me. If there are no concerns with any of the individuals recommended, we will simply process the report at the Senate HSS meeting on Monday. If there are concerns, please let me know no-later-than 5:00 PM today so I can invite that individual or those individuals to this Monday's meeting. I'm attaching a copy of the report for your review. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Christine Marasigan
Sent: Thursday, March 17, 2011 4:42 PM
To: Celeste Hodge
Subject: RE: Confirmation of Governor's Appointments

Sen Meyer

Hi Celeste,

Our office has no issues at this time with the appointments.

Christine

From: Celeste Hodge
Sent: Thursday, March 17, 2011 1:21 PM
To: Alida Bus; Amory Lelake; Christine Marasigan; Gayle Keller; Katherine Ellis; Sen. Bettye Davis; Sen. Dennis Egan; Sen. Fred Dyson; Sen. Johnny Ellis; Sen. Kevin Meyer
Subject: Confirmation of Governor's Appointments
Importance: High

Senate HSS Members,
The governor's appointment packets were delivered to members months ago. Since that time, I've asked several times if senator's had any concerns with any of the names the governor recommended for legislative confirmation. So far, no one has mentioned any concerns to me. If there are no concerns with any of the individuals recommended, we will simply process the report at the Senate HSS meeting on Monday. If there are concerns, please let me know no-later-than 5:00 PM today so I can invite that individual or those individuals to this Monday's meeting. I'm attaching a copy of the report for your review. Please let me know if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Gayle Keller
Sent: Monday, March 21, 2011 8:18 AM
To: Celeste Hodge
Subject: RE: Confirmation of Governor's Appointments

Good morning Celeste, thank you for doing a good job of keeping the appointees before us. Sen. Dyson had no comments (I would of told you Friday as requested if he had). As a reminder, the senator had an excused absence for today.
Gayle

From: Celeste Hodge
Sent: Sunday, March 20, 2011 8:59 PM
To: Alida Bus; Amory Lelake; Christine Marasigan; Gayle Keller; Katherine Ellis; Sen. Bettye Davis; Sen. Dennis Egan; Sen. Fred Dyson; Sen. Johnny Ellis; Sen. Kevin Meyer
Subject: RE: Confirmation of Governor's Appointments

Senate HSS Members,
As shared last week, we will process the report of the governor's recommended appointees during Monday's Senate HSS meeting. Resumes of those recommended were delivered months ago to you. Please feel free to bring your copies with you to the meeting. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Physical Therapy & Occupational Therapy

Celeste Hodge

From: Valerie Phelps [Valerie@Aptak.com]
Sent: Friday, March 18, 2011 8:59 AM
To: Celeste Hodge
Subject: RE: CONFIRMATION HEARINGS FOR BOARD APPOINTMENTS AND COMMISSIONER OF DHSS

Dear Celeste,
I will be boarding a plane at about 2pm Alaska time on Monday the 21st, but will call in at 1:30 and stay on as long as I am able to. Would it be possible to move my name toward the beginning of the list in case anyone has questions for me?
I was selected to be on the PT/OT Board.
I hope you are having a great day!
valerie

Valerie Phelps, PT, OCS, FAAOMPT
practice director
advanced physical therapy
main: (907) 279-4266
direct: (907) 743-8226
http://www.aptak.com
creating an environment for wellness and healing

This communication may contain privileged and/or confidential information. It is intended solely for the use of the addressee. If you are not the intended recipient, you are strictly prohibited from disclosing, copying, distribution or using any of this information. If you received this communication in error, please contact the sender immediately and destroy the material in its entirety, whether electronic or hard copy. This communication may contain nonpublic personal information about patients subject to the restrictions of the HIPPA standards. You may not directly or indirectly reuse or redisclose such information for any purpose other than to provide the services for which you are receiving the information.

Note to Patients regarding e-mail transmissions:
There are a number of risks you should consider before using email to communicate with us: email can be circulated, forwarded and stored in numerous paper and electronic files; email can be intercepted, altered, forwarded or used without authorization or detection; email senders can easily misaddress an email; backup copies of email may exist even after the sender deletes the email; employers and online services have the right to inspect email transmitted through their systems; email is easier to falsify than handwritten or signed documents; and email can be used to introduce viruses into computer systems. Confidentiality of Internet communications cannot be guaranteed by Advanced Physical Therapy. Use of the Internet is solely at your own risk.

From: Celeste Hodge [mailto:Celeste_Hodge@legis.state.ak.us]
Sent: Friday, March 18, 2011 6:04 AM
To: tkovaleski@scf.cc; drpaul@cvinternet.net; drbob@alaska.net; ltw@alaska.net; joAnn.Young@PREMERA.com; mikebarton@gci.net; russwebb@acsalaska.net; epringle@gci.net; bkfarnstrom@gci.net; dave_robin1@yahoo.com; loggiemonster@hotmail.com; paul.barney@pcli.com; dirkrph@ptialaska.net; homeiv1@alaska.net; Valerie Phelps; jderuyter@hopecounselingcenter.org; ntaboutu@yahoo.com; selina.kokotovich@alaska.gov; Laughlin, Wilda J (HSS)
Subject: CONFIRMATION HEARINGS FOR BOARD APPOINTMENTS AND COMMISSIONER OF DHSS

In accordance with AS39.05.080, the Health and Social Services Committee will be considering your recommendation from the governor for an appointed position on Monday, March 21, 2011 at 1:30 PM in the Butrovich Room #205 of the Capitol in Juneau, Alaska. Please feel free to attend or teleconference into the meeting in case members have questions by calling the toll free conference number at 1-855-463-5009. If you have questions, please contact me. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee

Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: robin allen [dave_robin1@yahoo.com]
Sent: Friday, March 18, 2011 10:20 AM
To: Celeste Hodge
Subject: Re: CONFIRMATION HEARINGS FOR BOARD APPOINTMENTS AND COMMISSIONER OF DHSS

I, Jennifer Robin Allen, resigned my appointment to the Board of Nursing, Friday March 11, 2011. I will forward the email to you. Thanks you for your time.

--- On **Fri, 3/18/11, Celeste Hodge <*Celeste_Hodge@legis.state.ak.us*>** wrote:

From: Celeste Hodge <Celeste_Hodge@legis.state.ak.us>
Subject: CONFIRMATION HEARINGS FOR BOARD APPOINTMENTS AND COMMISSIONER OF DHSS
To: "tkovaleski@scf.cc" <tkovaleski@scf.cc>, "drpaul@cvinternet.net" <drpaul@cvinternet.net>, "drbob@alaska.net" <drbob@alaska.net>, "ltw@alaska.net" <ltw@alaska.net>, "joAnn.Young@PREMERA.com" <joAnn.Young@PREMERA.com>, "mikebarton@gci.net" <mikebarton@gci.net>, "russwebb@acsalaska.net" <russwebb@acsalaska.net>, "epringle@gci.net" <epringle@gci.net>, "bkfarnstrom@gci.net" <bkfarnstrom@gci.net>, "dave_robin1@yahoo.com" <dave_robin1@yahoo.com>, "loggiemonster@hotmail.com" <loggiemonster@hotmail.com>, "paul.barney@pcli.com" <paul.barney@pcli.com>, "dirkrph@ptialaska.net" <dirkrph@ptialaska.net>, "homeiv1@alaska.net" <homeiv1@alaska.net>, "valerie@aptak.com" <valerie@aptak.com>, "jderuyter@hopecounselingcenter.org" <jderuyter@hopecounselingcenter.org>, "ntaboutu@yahoo.com" <ntaboutu@yahoo.com>, "selina.kokotovich@alaska.gov" <selina.kokotovich@alaska.gov>, "Laughlin, Wilda J (HSS)" <wilda.laughlin@alaska.gov>
Date: Friday, March 18, 2011, 6:03 AM

In accordance with AS39.05.080, the Health and Social Services Committee will be considering your recommendation from the governor for an appointed position on Monday, March 21, 2011 at 1:30 PM in the Butrovich Room #205 of the Capitol in Juneau, Alaska. Please feel free to attend or teleconference into the meeting in case members have questions by calling the toll free conference number at 1-855-463-5009. If you have questions, please contact me. Thanks.

Celeste Graham-Hodge, Committee Aide

Senate Health & Social Services Committee

Office of Senator Bettye Davis

716 W. 4th Avenue #400

Anchorage, Alaska 99501

(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)

State Capitol

Juneau, Alaska 99801

(907) 465-4906; (907) 465-3756 (Fax)

Toll Free: 1-800-770-3822

Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Sanders, Nancy L (CED) [nancy.sanders@alaska.gov]
Sent: Monday, March 21, 2011 9:07 AM
To: Celeste Hodge
Subject: FW: Resignation by Board of Nursing appointee

Importance: High

Good morning. I understand that the confirmation hearing for Board appointees is scheduled for this afternoon at 1:30 p.m. I am forwarding a copy of a resignation letter for a new appointee to the Board of Nursing so that you have the up to date information. Can she be withdrawn from consideration?

Thank you, Nancy Sanders

Nancy Sanders, PhD, RN
Executive Administrator
Alaska Board of Nursing
nancy.sanders@alaska.gov
550 W. 7th Ave, Suite 1500
Anchorage, AK 99501
907.269.8161 fax: 907.269.8196
www.nursing.alaska.gov
"choose respect"

From: robin allen [mailto:dave_robin1@yahoo.com]
Sent: Friday, March 11, 2011 10:16 AM
To: Maitlen, Brandon R (GOV); Sanders, Nancy L (CED)
Subject: Resignation

To All Concerned,

I would like to thank-you for the honor and opportunity to serve on the Board of Nursing. However, due to family and financial hardships that serving on the Board will create for me, I feel that it is best for me to resign my appointment effective immediately, Friday March 11, 2011.

I hope that you will appreciate that this has been a difficult decision. I do feel that I would bring a value to the Board and hope that perhaps the future will bring this opportunity around again. My first responsibility is to my family. I feel that it would be a dis-service to all involved for me to try to continue to serve and that its best to resign now, rather than later.

I will return all the materials given to me at orientation last week.

Respectfully,
J Robin Allen LPN.

Celeste Hodge

From: beth gartner [b_gartner@yahoo.com]
Sent: Sunday, March 20, 2011 3:23 PM
To: Celeste Hodge
Subject: Confirmation Hearing for Board of Nursing

Dear Celeste,

Thank you for the information about the confirmation hearings scheduled for the Board of Nursing on Monday, March 21st. I am in the East Coast time zone for the week and am scheduled for an event that co insides with the hearing time. I sincerely apologize for not being available.

I am truly interested to be reappointed for my second 4 year term. I have served this past term as secretary, vice chair and as chair. I continue to work as an RN in a Post Anesthesia Care Unit and am able to balance my work schedule with the commitment to the Board of Nursing.

Thank you for conveying my willingness to serve. I look forward to hearing from you.

Sincerely,
Beth Farnstrom, RN

Not available
But very interested in being Reappointed for 2nd 4th term.

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 2, 2011

SUBJECT: Confirmation of Governor's Appointment

Pursuant to AS 39.05.080, the President has referred the following name for legislative confirmation to your committee for a hearing, recommendation and report:

Commissioner – Department of Health and Social Services

√ William Streur
Appointed: 2/1/2011

Resume(s) will be transmitted electronically.

KW:jcs
gl #2

Alaska State Legislature

Senate

Office of the Secretary

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Official Business

RECEIVED
FEB 03 2011

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 2, 2011

SUBJECT: Confirmation of Governor's Appointment

Pursuant to AS 39.05.080, the President has referred the following name for legislative confirmation to your committee for a hearing, recommendation and report:

Commissioner – Department of Health and Social Services
William Streur
Appointed: 2/1/2011

Resume(s) will be transmitted electronically.

KW:jcs
gl #2

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 2, 2011

SUBJECT: Confirmation of Governor's Appointments

Pursuant to AS 39.05.080, the President has referred the following names for legislative confirmation to your committee for a hearing, recommendation and report:

Board of Dental Examiners
Cheryl Fellenberg – Wasilla
Appointed: 3/1/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Dr. Thomas Kovaleski – Chugiak
Appointed: 3/1/2011 Term Expires: 3/1/2015

Dr. Paul Silveira – Valdez
Appointed: 3/1/2011 Term Expires: 3/1/2015

Dr. Robert Warren – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

Board of Marital and Family Therapy
Leon Webber – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

JoAnn Young – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2014

Alaska Mental Health Trust Authority Board of Trustees
Mike Barton – Douglas
Appointed: 12/9/2010 Term Expires: 3/1/2014

Russell Webb – Anchorage
Appointed: 12/9/2010 Term Expires: 3/1/2013

Board of Certified Direct-Entry Midwives
Dr. Peggy Downing – Wasilla
Appointed: 5/31/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Board of Nursing
Jennifer "Robin" Allen – Palmer
Appointed: 3/1/2011 Term Expires: 3/1/2015

Beth Farnstrom – Anchorage
Appointed: 3/1/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Julie Gillette – Wasilla
Appointed: 3/1/2011 Term Expires: 3/1/2015

Erin Pringle – Anchorage
Appointed: 8/26/2010 Term Expires: 3/1/2014

Board of Examiners in Optometry
Dr. Paul Barney – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

Board of Pharmacy
Lori DeVito – Soldotna
Appointed: 3/1/2011 Term Expires: 3/1/2012

Dirk White – Sitka
Appointed: 3/1/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

State Physical Therapy and Occupational Therapy Board
Valerie Phelps – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2013

Board of Psychologist and Psychological Associate Examiners
Dr. John DeRuyter – Fairbanks
Appointed: 6/6/2007
Reappointed: 3/1/2011 Term Expires: 3/1/2015

Board of Social Work Examiners
Jen Syzdek – Anchorage
Appointed: 3/1/2011 Term Expires: 3/1/2015

Resume(s) will be transmitted electronically.

KW:jcs
gl #2

Celeste Hodge

From: Ben Robinson
Sent: Monday, February 07, 2011 9:15 AM
To: Celeste Hodge
Cc: Julianna Singh
Subject: Governor's Appointments - Legislative Confirmation Reports & Resumes Attached
Attachments: hss commissioner 2.2.11 #2.doc; hss.2.2.11.#2.doc; hss #2.doc; Commissioner, HSS - Streur#2.pdf; Dental Examiners - Fellenberg#2.pdf; Dental Examiners - Kovaleski#2.docx; Dental Examiners - Silveira#2.doc; Dental Examiners - Warren#2.pdf; Marital and Family Therapy - Webber#2.doc; Marital and Family Therapy - Young#2.rtf; Mental Health Trust - Barton#2.pdf; Mental Health Trust - Webb#2.pdf; Midwives - Downing#2.pdf; Nursing - Allen# 2.doc; Nursing - Farnstrom#2.pdf; Nursing - Gillette#2.doc; Nursing - Pringle#2.docx

Pursuant to AS 39.05.080, Governor's Appointment(s) were referred to your committee for a committee hearing, recommendation and report. You should have received a memo listing the appointees referred to your committee. For your convenience, a copy of the memo is attached.

Also, attached are:

1) Senate Confirmation Committee Report - If you have more than one appointee, use this Report document as a template. Cut and paste appointees into the Report to correlate with your hearings.

2) Appointee Resume(s) - If your committee received an abundance of referrals, you may receive more than one email containing resumes (the file size may be too large to send all resumes in one email attachment).

Contact Julianna or Ben in the Senate Secretary's Office at 465-3701 if you have questions about the attachments.

Good luck with your hearings.
-Ben

SENATE
CONFIRMATION COMMITTEE REPORT

Date: 3/21/11

In accordance with AS 39.05.080, the Health and Social Services Committee reviewed the following and recommends the appointments be forwarded to a joint session for consideration:

Commissioner – Department of Health and Social Services
William Streur

Board of Dental Examiners
Cheryl Fellenberg – Wasilla
Dr. Thomas Kovaleski – Chugiak
Dr. Paul Silveira – Valdez
Dr. Robert Warren – Anchorage

Board of Marital and Family Therapy
Leon Webber – Anchorage
JoAnn Young – Anchorage

Alaska Mental Health Trust Authority Board of Trustees
✓ Mike Barton – Douglas ~~3yr~~ In Person
✓ Russell Webb – Anchorage → 3 5
~~3 yrs~~ In Person

Board of Certified Direct-Entry Midwives
Dr. Peggy Downing – Wasilla

Board of Nursing
~~Jennifer "Robin" Allen – Palmer~~ Resigned
Beth Farnstrom – Anchorage
Julie Gillette – Wasilla
Erin Pringle – Anchorage

Board of Examiners in Optometry
Dr. Paul Barney – Anchorage

Board of Pharmacy
Lori DeVito – Soldotna
Dirk White – Sitka

Senior Master Planning

State Physical Therapy and Occupational Therapy Board
Valerie Phelps – Anchorage

Board of Psychologist and Psychological Associate Examiners
Dr. John DeRuyter – Fairbanks

Board of Social Work Examiners
Jen Syzdek – Anchorage

This does not reflect an intent by any of the members to vote for or against the confirmation of the individuals during any further sessions.

Signature:	**Printed Last Name**
Chair:	

Please return to the Senate Secretary's Office (Room 211).

CONFIR-MATIONS 2012

<TARGET><BILL></BILL><SUBJECT>CONFIRMATIONS 2012</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE
CONFIRMATION COMMITTEE REPORT

Date: 3/14/12

In accordance with AS 39.05.080, the Health and Social Services Committee reviewed the following and recommends the appointment(s) be forwarded to a joint session for consideration:

Board of Marital and Family Therapy
Reverend John Downing – Eagle River
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

State Medical Board
Camille Carlson – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. Elizabeth Kohnen – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Miller – Juneau
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Powers – Dillingham
Appointed: 12/2/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Alaska Mental Health Trust Authority Board of Trustees
Larry Norene – Eagle River
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2017

Board of Certified Direct-Entry Midwives
Cheryl Corrick – Fairbanks
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Nursing
Rochelle Lehrer – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Denise Valentine – Anchorage
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Occupational Safety and Health Review Board
James Montgomery, Jr. – Kenai
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Timothy Sharp – Fairbanks
Appointed: 10/12/1995
Reappointed: 6/23/1999
Reappointed: 1/23/2006
Reappointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Examiners in Optometry
Dr. Forrest Messerschmidt – Juneau
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Pharmacy
John Cotter – Fairbanks
Appointed: 9/1/2011 Term Expires: 3/1/2013

Lori DeVito – Soldotna
Appointed: 3/1/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Christopher Kim – Anchorage
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Theodore Mala, Jr. – Anchorage
Appointed: 5/11/2011 Term Expires: 3/1/2015

State Physical Therapy and Occupational Therapy Board
David Carey – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Kathleen Lind – Anchorage
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

James Parietti – Chugiak
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Professional Counselors
Lillian Mitchell – Anchorage
Appointed: 8/8/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Psychologist and Psychological Associate Examiners
Al Levy – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Christian Muntean – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Joel Wieman – Anchorage
Appointed: 2/1/2012 Term Expires: 3/1/2016

Board of Social Work Examiners
Marilyn Kerr – Anchorage
Appointed: 6/13/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

This does not reflect an intent by any of the members to vote for or against the confirmation of the individual(s) during any further sessions.

Signature:	**Printed Last Name**
	Dyson
	Mayer
Chair:	DAVIS

Please return to the Senate Secretary's Office (Room 211).

Downing, John
Board of Marital & Family Therapy

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Marriage & Family, Public Seat
(For example, Board of Agriculture, Public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
None

Name: The Very Rev. John W. Downing

Mailing Address:

Residence Address:

City, State and Zip Code: Eagle River, AK 99577

Home or Message Telephone: ss Telephone:

Fax Number: Cell Phone:

Email address:

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional):

Social Security Number (Optional, required if appointed for travel reimbursement etc

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ If "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

See resume

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

See resume

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time served.

See Resume

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

See Resume

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you

DATE OF BIRTH: SEX: FEMALE ___ MALE ___

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): ___

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): John W Downing Date: 1/28/08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Fr. John W Downing Date: 1/28/08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
#1	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological Assoc
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Fr. John Downing, (Age)____ of (Hometown): Eagle River
is (Job title/Place of employment): Assist. Pastor, St. John Orthodox Cathedral
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): Fr Downing holds a B.A. from U. of Maryland & a Masters of Divinity from Church Divinity School of the Pacific, Berkeley CA.
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.
Fr. Downing's service at St. John Orthodox Cathedral, Eagle River and St. Herman, Wasilla

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Resume

The Very Rev. John W. Downing. M.Div., MFT

Eagle River, Alaska 99577

APPLICATION: FOR THE PUBLIC SEAT ON THE STATE BOARD OF MARRIAGE AND FAMILY THERAPIST

EDUCATION: Graduated University of Maryland, Bachelor of Arts degree, 1955.

Attended Virginia Theological Seminary, Alexandria, Virginia, 1955-1956.

Graduated Church Divinity School of the Pacific (Episcopal); Masters of Divinity degree, Berkeley, California, 1956-1958

Leadership Skills Training, sponsored by the National Episcopal Training Institute, 1963 –1968.

Certified Reality Therapist, Los Angeles, CA 1979-81.

TEACHING EXPERIENCE: Life Credentialed Adult Education instructor, Santa Barbara, CA Adult School; (part-time); courses on Interpersonal Communication, Couples Communication, Self-Awareness, Communication Skills, Children of Divorce. 1968 – 1975.

University of California, Santa Barbara Campus Extension Program Courses taught: Theories of Communication Counseling, Human Sexuality, Communication in the Family and Marriage, Interpersonal Communication, Self-Awareness, Marriage for '70's, Crisis in Religion, Children of Divorce and Survival of the Family. 1970 –74.

Learning Tree University (adult school) Chatsworth, California. Taught classes on Communication Skills, Creative Communication, Interpersonal Relationships. Couples Communication and Self-Awareness (part-time), 1988 – 1993.

Seminars and workshops at least monthly with patients in private practice, 1970 –83.

Antiochian Christian Orthodox Church, Southern California Deanery Committee on Marriage and Family, chair and lecturer, weekend seminars. Topics taught: Orthodox understanding of marriage, Enhancing Marital Relationships, Communication in Marriage, Marital Relationship Skills, 1998–2003. (approximately 30 presentations.)

Assistant Pastor St. John Orthodox Cathedral, Eagle River, 2003 to present pastoral counseling specialist.

CONSELING-THERAPY EXPERIENCE: California Licensed Marriage, Family and Child Therapist # 27066.

In private practice 1968 to 2003..

Total Counseling experience 40 years.

Staff therapist Family Service Agency of the Monterey Peninsula 1983-85.

Director and therapist of Family Service Agency of Burbank, California 1995-2000.

PASTORAL EXPERIENCE: Converted to Orthodoxy 1991. Ordained to the sacred priesthood December 5, 1993. Attached to St. Michael Orthodox Church (Western Rite) Whittier, CA 1991.- 2003. Assistant pastor St. John Orthodox Cathedral, Eagle River, Alaska, 2003 to present.

As Episcopal priest: ordained 1958, served parishes in Nevada, Northern California, Washington, D.C., Central California, Wisconsin, and Los Angeles, CA.

Dean, Semper Virens Deanery, Humbolt and Del Norte Counties, Northern California, 1965 -68.

Canon Missioner and Dean, Diocese of Milwaukee and Cadle Deanery, 1985 – 88.

PERSONAL: Born Baltimore MD Married 30 years to Kh. Nancy Lee Downing (d. 10/19/02) Five grown children.

Resume

The Very Rev. John W. Downing. M.Div., MFT

Eagle River, Alaska 99577

APPLICATION: FOR THE PUBLIC SEAT ON THE STATE BOARD OF MARRIAGE AND FAMILY THERAPIST

EDUCATION: Graduated University of Maryland, Bachelor of Arts degree, 1955.

Attended Virginia Theological Seminary, Alexandria, Virginia, 1955-1956.

Graduated Church Divinity School of the Pacific (Episcopal); Masters of Divinity degree, Berkeley, California, 1956-1958

Leadership Skills Training, sponsored by the National Episcopal Training Institute, 1963 –1968.

Certified Reality Therapist, Los Angeles, CA 1979-81.

TEACHING EXPERIENCE: Life Credentialed Adult Education instructor, Santa Barbara, CA Adult School; (part-time); courses on Interpersonal Communication, Couples Communication, Self-Awareness, Communication Skills, Children of Divorce, 1968 – 1975.

University of California, Santa Barbara Campus Extension Program Courses taught: Theories of Communication Counseling, Human Sexuality, Communication in the Family and Marriage, Interpersonal Communication, Self-Awareness, Marriage for '70's, Crisis in Religion, Children of Divorce and Survival of the Family. 1970 –74.

Learning Tree University (adult school) Chatsworth, California. Taught classes on Communication Skills, Creative Communication, Interpersonal Relationships. Couples Communication and Self-Awareness (part-time), 1988 – 1993.

Seminars and workshops at least monthly with patients in private practice, 1970 –83.

Antiochian Christian Orthodox Church, Southern California Deanery Committee on Marriage and Family, chair and lecturer, weekend seminars. Topics taught: Orthodox understanding of marriage, Enhancing Marital Relationships, Communication in Marriage, Marital Relationship Skills, 1998–2003. (approximately 30 presentations.)

Assistant Pastor St. John Orthodox Cathedral, Eagle River, 2003 to present pastoral counseling specialist.

CONSELING-THERAPY EXPERIENCE: California Licensed Marriage, Family and Child Therapist # 27[illegible].

In private practice 1968 to 2003..

Total Counseling experience 40 years.

Staff therapist Family Service Agency of the Monterey Peninsula 1983-85.

Director and therapist of Family Service Agency of Burbank, California 1995-2000.

PASTORAL EXPERIENCE: Converted to Orthodoxy 1991. Ordained to the sacred priesthood December 5, 1993. Attached to St. Michael Orthodox Church (Western Rite) Whittier, CA 1991.- 2003. Assistant pastor St. John Orthodox Cathedral, Eagle River, Alaska, 2003 to present.

As Episcopal priest: ordained 1958, served parishes in Nevada, Northern California, Washington, D.C., Central California, Wisconsin, and Los Angeles, CA.

Dean, Semper Virens Deanery, Humbolt and Del Norte Counties, Northern California, 1965 --68.

Canon Missioner and Dean, Diocese of Milwaukee and Cadle Deanery, 1985 -- 88.

PERSONAL: Born Baltimore MD Married 30 years to Kh. Nancy Lee Downing (d. 10/19/02) Five grown children.

Downing, John
Board of Marital & Family Therapy

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Marriage & Family, Public Seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
None.

Name: The Very Rev. John W. Downing

Mailing Address: _____

Residence Address: _____

City, State and Zip Code: Eagle River, AK 99577

Home or Message Telephone: _____ ss Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel reimbursement etc) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

See resume

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

See resume

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time served.

See Resume

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

See Resume.

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: SEX: FEMALE _____ MALE ___ ___

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): John W Downing _____ Date: 1/28/08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Fr. John W Downing Date: 1/28/08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/ Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
#1	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological Assoc
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/ Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

Fr. John Downing (Name): Downing, (Age), ___ of (Hometown): Eagle River
is (Job title/Place of employment): ~~Assist Pastor~~ St John Orthodox Cathedral
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): Fr Downing holds a BA from U. of Maryland & a Masters of Divinity from Church Divinity School of the Pacific, Berkeley CA.
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.
Fr. Downing serves at St. John Orthodox Cathedral, Eagle River and St Herman, Wasilla

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Powers, David
State Medical Board

JUN 0 6 2008

Office of the Governor
Anchorage

OFFICE OF THE GOVERNOR
ANCHORAGE
JUN 16 2008

Honorable Sarah Palin
Governor, State of Alaska
550 W. 7th Ave Ste. 1700
Anchorage, Alaska 99501

Governor Palin,

Recently Frank Bailey contacted me regarding the possibility of serving on the Alaska State Medical Board, and I am writing to let you know that if appointed, I will gladly accept the position.

I came to Alaska in 1984 as a Commissioned Officer in the United States Indian Health Service. Since then, I have practiced in various sites throughout the State, including Anchorage, Juneau, Nome, Barrow, St Paul Island, and for the past 15 years in Dillingham.

Long distance medicine is part of our daily routine, as we work with Community Health Aides and Mid-Level practitioners in approximately 30 outlying villages.

If appointed, I will endeavor to contribute from this rural prospective while working with other members of the Board on pertinent issues.

Thank you for your consideration,
Sincerely,

D Powers MD

David J. Powers, M.D.
Bristol Bay Area Health Corporation

Dillingham, Alaska 99576

CURRICULUM VITAE

DAVID J. POWERS, M.D.

DILLINGHAM, AK 99576

EDUCATION:

College:	1974-1978, Northwest Nazarene College, Nampa, Idaho
Degree:	BA Biology, Minor in Chemistry
Honors:	Freshman Chemistry Student Award Senior Biology Student Award Salutatorian of 1978 graduating class Received academic scholarship Sophomore, Junior, Senior years
Medical School:	1979-1983, Oral Roberts University School of Medicine
Degree:	M.D.
Honors:	Graduated upper 1/3 of 1983 graduating class
PGY I :	July 1983 – July 1984, Family Practice Internship at A.H. Gould, Family Practice Residency Program, University of Colorado Affiliated, Grand Junction, Colorado
PCY II & III:	July 1987 – July 1989, Family Practice Residency of Idaho, Boise, Idaho
Certification:	Board Certified, American Board of Family Practice 2003-2010

OCCUPATIONAL EXPERIENCE:

1994- Present	Kanakanak Hospital, P.O. Box 130 Dillingham, AK 99576, Staff Physician. Currently Clinical Director
1992 – 1994	Emergency Room Physician, Boise, Idaho
1990 – 1992	Kanakanak Hospital, P.O. Box 130, Dillingham, AK 99576, Staff Physician.
1989 – 1990	Locum Tenens and Emergency Room work
1987 – 1989	Completed Residency Training, Family Practice Residency of Idaho, Inc., Boise, ID
1986 – 1987	Indian Health Service, Juneau, AK, General Practice
1984 – 1986	Alaska Native Medical Center, Anchorage, AK, General Medical Officer, Orthopaedics

Miller, David
State Medical Board

CURRICULUM VITAE

DAVID A. MILLER, MD, FACS

OFFICE ADDRESS: Alaska Minimally Invasive Surgery Center

Juneau, AK 99801

PERSONAL:

EDUCATION:	Leavenworth High School Leavenworth, Kansas	1981
	B.S. Chemistry University of Kansas Lawrence, KS	1985
	M.D. Allopathic Medicine University of Kansas School of Medicine Kansas City, KS	1989
POST-GRADUATE	Internship – General Surgery Keesler Medical Center Keesler AFB Biloxi, MS	1989-1990
	Residency – General Surgery Keesler Medical Center Keesler AFB Bilox, MS	1990-1994
BOARD QUALIFICATIONS:	Board Certified and Diplomate of The American Board of Surgery	1995-present
LICENSURE:	State of Alaska #4283	Exp. 12/31/08
PROFESSIONAL AFFILIATIONS:	American College of Surgeons	1996-present
	Society of Laparoendoscopic Surgeons	2000-present
	Society of Air Force Clinical Surgeons	1994-2001
	38th Parallel Medical Society	1994-2001
PUBLICATIONS:	H-Type Tracheoesophageal Fistula Repair, 41st Annual Symposium, Society of Air Force Clinical Surgeons, San Antonio, TX	1994

TEACHING APPOINTMENTS:	Instructor, Advanced Laparoscopic Workshop 38th Parallel Medical Society Seoul, Korea	1994
	Instructor, Advanced Laparoscopic Procedures National Hospital Columbo, Sri Lanka	1999
MILITARY SERVICE:	Air Force ROTC Scholarship University of Kansas, Lawrence, KS	1981
	Air Force Health Profession Scholarship University of Kansas, Kansas City, KS	1985
	Surgical Resident Keesler AFB, Biloxi, MS	1989-1994
	General Surgeon 51st Medical Group, Osan, Korea	1994-1995
	General Surgeon 3rd Medical Group, Elmendorf AFB Anchorage, AK	1995-2001
HONORS AND AWARDS:	Eagle Scout	1976
	National Honor Society	1980
	Kansas Honor Student	1981
	Vocal Scholarship, University of Kansas	1981
	Tuba Scholarship, University of Kansas	1981
	Air Force ROTC/Health Profession Scholarship	1981-1989
	Dean's Honor Roll	1981
	Sons of the American Revolution Award	1982
	Vice Commandant's Award	1983
	General Dynamics Award	1984
	Honors Research in Chemistry	1985
COMMUNITY SERVICE:	Assistant Scout Master, Boy Scouts of America	1981-1988
	Surgical Orderly, Cushing Memorial Hospital Leavenworth, KS	1980-1983
	Host Family Special Olympics World Winter Games	2001

PERFORMING ARTS:

Bass Soloist with Symphony Orchestra and Chorus:	Leavenworth, KS	1981-1987
	Lawrence, KS	1981-1985
	Biloxi, MS	1989-1994
	Anchorage, AK	1996-2000
	Juneau, AK	2008
Operatic Roles:	Figaro, *The Barber of Seville*	2005
	Leporello, *Don Giovanni*	2006
	Papageno, *The Magic Flute*	2007
	Gaston, *Beauty and the Beast*	2007
	Scarpia and Angelotti, *Tosca*	2007
	Morales, *Carmen*	2008
	Talpa, *Il Tabarro*	2008
	Simone, *Gianni Schicchi*	2008

147392

Medical Board, State — **Elizabeth Ann Kohnen**

General Information

Board/Commission and seat you are seeking:
Medical Board, State, physician member

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
none

First	*Middlename*	*Last Name*
Elizabeth	**Ann**	**Kohnen**
Mailing Address	*City* **Fairbanks**	*State & ZIP*
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?* **Yes**	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
David S. Grauman, MD, PC - paid, 1993-present
physician unpaid volunteer Breast Cancer Detection Center in past - 1 year (weekly visits)
physician unpaid volunteer Red Cross in Cambodia - 1993 or 94 - 2 months

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
BA - Colgate University 1980
MD - University of Pennsylvania 1987
Internship and Residency, Strong Memorial Hospital, Rochester NY 1987-1990
MPH - Medical College of Wisconsin
Private primary care Internal Medicine practice in Fairbanks 1992 - present

obtained that may be used as qualifying criteria:
State of Alaska Physician License #2889
DEA # BK3209233
Board Certified in Internal Medicine
Fellow of the American College of Physicians

List any community service, municipal government, and state positions held, and any awards received.
Commisioned Corps of Public Health Service - Physician, acting 04, Bethel AK 1990-1992
Phi Beta Kappa 1980
High Honors in Religion 1980, Colgate University

Fellow of the American College of Physicians
Community Advisory Board for KUAC (public radio)
Previous physician volunteer Breast Cancer Detection Center

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

{Your Name}, {age} of {hometown}, is {job title/place of employment} holds {education level, school, or relevant experiences}.
Elizabeth Kohnen, MD, MPH has been in private primary care internal medicine practice in Fairbanks since 1992 .

Submitted: 01/10/12 at 12:45 pm from 66.230.107.60

Carlson, Camille
State Medical Board

Bar, Board of Governors of the Alaska — **Cam Olson Carlson**

General Information

Board/Commission and seat you are seeking:
Bar, Board of Governors of the Alaska, Public Seat

Additional Boards/Commissions of interest:
1) Judicial Conduct, Commission on
2) Judicial Council, Alaska

State Boards/Commissions on which you have served
Board of Psychologists and Psychological Associates Examiners

First	*Middlename*	*Last Name*
Cam	**Olson**	**Carlson**
Mailing Address	*City* **Fairbanks**	*State & ZIP* **AK 99708**
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?* **Yes**	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
-Legal liaison (paralegal) for St. Paul Church during extensive court action (Bd. of Trustees, AK Missionary Conference of the United Methodist Church vs St. Paul United Methodist Church et al), Superior Court and Alaska Supreme Court; conducted legal document search, prepared materials for distribution, maintained contact with 6 attorneys in Fairbanks, Anchorage and Fresno,CA; unpaid voluntary; 2002-2006.
-Coordinated and did actual construction on St. Paul United Methodist Church (unpaid, voluntary).
-Coordinated and did some labor on building of St. Paul Church's new building (unpaid, voluntary).
-Volunteer office manager for state-wide election campaigns- Tom Fink, Governor (twice), David

Cuddy, U.S. Senate (twice), Sean Parnell, Governor;(all unpaid).
-Election Board precinct chair for Fairbanks North Star Borough and State of Alaska; 25+ years (paid).
-More available if needed.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
-B.S. Degree, Education - University of Wisconsin - Madison
-12 credits in Criminal Justice - University of Alaska - Fairbanks
-Paralegal Certification from Denver Paralegal Institute
-Pro-bono paralegal work in St. Paul Church court case

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Paralegal Certification - Denver Paralegal Institute 1990-1991

List any community service, municipal government, and state positions held, and any awards received.
-Alaska Board of Psychologists and Psychological Associates Examiners: Public Member, 2005 to present.
-Ice Alaska: Visa assistance; marketing.
-Alaska International Senior Games: Board member ? 3 ? years.
-St. Paul Church, Fairbanks: Co-Founder; lay-leader; church council chair and secretary; chair - construction committee for building of two churches (hands on for first one!);legal liaison for court case with United Methodists; Sunday School teacher; etc; 27 years.
-Fairbanks North Star Borough School Board: Member (elected position), 1975-1978
-University of Alaska Cooperative Extension Service Statewide Advisory Council: Member.
-4-H: Local club leader, organized 15-20 project leaders, 25-30 youth members; numerous awards; 10+ years.
-UAF Women's Association: community service activities; initiated and chaired community wide Recycle Sale, 10 years; revised bylaws; 40+ years.
-Alaska Republican Party: Republican of the Year - 1998, Interior Republicans; delegate to district, state and national conventions; District Chair, District 29/7 2000-2002; State Central Committee 2000-2010; 30+ years
-Alaska Crippled Children and Adults (ACCA) Board: Board President and Secretary; organized 1st March of Dimes Telethon in Fairbanks; revised bylaws; 10 years.
-Youth Basketball Board: Secretary; revised bylaws; 1 year.
-USA Track and Field: Association level certified track and field official; official at numerous district and state track events; organized 1988 state track and field meet; also officiated at cross country and x-c ski meets; 20+ years.
-Fairbanks United Way allocation board; 1 year.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this

application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

Cam Carlson, of Fairbanks, is retired and holds a B.S. degree from the University of Wisconsin-Madison and Paralegal Certification from Denver Paralegal Institute.

Submitted: 12/15/10 at 12:37 pm from 65.74.119.44

Norene, Larry
Alaska Mental Health Trust
Authority Board of Trustees

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Mental Health Trust Authority
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Larry G. Norene

Mailing Address:

Residence Address:

City, State and Zip Code:

Home or Message Telephone:

Business Telephone:

Fax Number:

Cell Phone:

Email address:

AS 39.05.100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO Voter Registration Number (Optional)

Social Security Number (Optional, required if appointed for travel, reimbursement etc.):

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

License #2178 State of Alaska R.E. Broker

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

Bachelor of Economics, U. of Oregon, 1964
Numerous MAI appraisal courses
Numerous CCIM investment courses

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Three time Pres. Alaska MLS
Anchorage Platting Board, 4 yrs, Pres.
Anchorage Board of Equalization, 5 yrs, Pres. 3 yrs
various mayoral task force.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

Anchorage Assessing office 1964-1970 - Supervisor
Commercial & Land appraisal, Wakeland & Malone - 1970-1978
Broker, Norene Realty, 1970 - Present
Developed subdivisions, Anch. & Mat-Su 1975-1985

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): [signature] Date: 11/12/07

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Larry Norene Date: 11/12/07

(Indicate top three boards/commissions of interest by number with #1 as your preference)

- Accounting Board
- Aerospace Development Corporation
- Aging Commission
- Agriculture & Conservation
- Alaska Juvenile Justice Advisory Committee
- Alaska Retirement Management Board
- Alaska Statehood Celebration Commission
- Alaska-Alberta Bilateral Council
- Alcohol/Drug Abuse
- Alcoholic Beverage Control
- Architectural Registration
- Arts Council
- (3) Assessment Review Board
- Aviation Advisory Board
- Bald Eagle Preserve
- Bar Association
- Barbers & Hairdressers
- Behavioral Health Advisory Board
- Bering Sea Fishermen's Services
- Boating Safety Council
- Boundary Commission
- Children's Trust Board
- Chiropractic Examiners
- Coastal Policy Committee
- Commercial Fisheries Entry
- Commercial Fisheries/Agriculture Bank
- Community Service Commission
- Corrections Advisory
- Committee
- Dental Examiners
- Developmental Disabilities Special Education
- Domestic Violence/Sexual Assault
- Education Early Development
- Education Professional Practices
- Emergency Medical Services
- Emergency Response Commission
- Employment of People with Disabilities
- Exxon Valdez Oil Spill Trustee
- Faith-Based & Community Initiatives Council
- Fire Standards Council
- Fisheries

- Fisherman's Fund Advisory Appeals
- Forestry
- Game
- Health Council
- Historical Commission
- Historical Records Advisory
- Homeless Council
- Housing Finance Corporation
- Human Rights
- Immunization Forum
- Independent Living Council
- Industrial Development Export Authority
- Interstate Compact
- Law Enforcement Assistance Council
- Legislative Council
- Marine Exchange
- Marine Navigation Advisory Council
- Marine Pilots
- Marine Transportation Advisory Board
- Massage Therapy
- Medical Board
- Mental Health Trust Authority
- Museums
- Natural Resources Commission
- Navigable Waters Board Bank
- Oil Spill Prevention Authority
- Oil & Gas Development Corporation
- Outdoor Recreation Advisory Board
- Pacific Northwest Fish
- Pacific Salmon Fisheries Management Council
- Parole Board
- Permanent Fund
- Nursing
- Petroleum Refinery Safety Commission
- Petroleum Systems Integrity Commission
- Commissioners
- Physical Therapy Examining Panel

- Pacific Salmon Commission Transboundary Panel
- Parole Board
- Permanent Fund
- Pharmacy Board
- Physical/Occupational Therapy
- Pioneers Home Advisory
- Police Standards Council
- Postsecondary Education
- Professional Counselors
- Professional Teaching Practices
- Psychologist/Psychological Associate Examiners
- Public Offices Commission
- Real Estate Recovery Institute
- Railroad Corporation
- Real Estate Appraisers
- Real Estate Commission
- Regents
- Regulatory Commission (RCA)
- Research & Gas Development
- Safety Advisory Council
- Seafood Marketing Institute
- Social Work Examiners
- Student Loan Corporation
- Substance Abuse Commissions
- Surface Transportation Council
- Telecommunications
- Uniform State Laws
- Veterans Advisory Council
- Veterinary Examiners
- Workers' Compensation
- Water and Wastewater Works
- Western Interstate Nuclear Higher Education
- Wood-Tikchik State Park
- Workers' Compensation
- Workers' Compensation Appeals Commission
- Workforce Investment Board
- Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following, information that will be included in the press release.

(Name): Larry Norene (Age):
is (Job title/Place of employment): Broker, Norene Realty
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): Bachelors - economics
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Corrick, Cheryl
Certified Direct-Entry Midwives

OFFICE OF THE GOVERNOR
MAILROOM

JAN 11 2008

Cheryl Corrick

January 8, 2008

State of Alaska
Office of Governor Sarah Palin
Attention: Frank Bailey, Director of Boards & Commissions
P.O. Box 110001
Juneau, AK 99811-0001

January 8, 2008

Dear Governor Palin,

I am a Certified Direct-entry Midwife (CDM) in the State of Alaska. I am also a Certified Professional Midwife (CPM), which is a national certification. I have resided in Fairbanks for the past 35 years. I received my midwifery certification in April 1996 and have been privileged to attend the births of over 600 Alaskan babies. I have served on the Midwives Association of Alaska's peer review committee for the past 8 years. I understand that I have been recommended for a position on the State of Alaska's Board of Certified Direct-entry Midwives. If I am offered this appointment I will gladly accept this position and serve with integrity and reliability. Thank you for your consideration.

Sincerely,

Cheryl Corrick, CDM, CPM

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Certified Direct-entry Midwives
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Cheryl Cornick

Mailing Address: _____

Residence Address: _____, Fairbanks, AK 99709

City, State and Zip Code: Fairbanks, AK 99701

Home or Message Telephone: _____ Business Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria: Certified Direct-entry Midwife, 4-22-96
Certified Professional Midwife (National Assoc. of Registered Midwives) 1998

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
1992-1996 Via Vita Health Project, Inc. Midwifery Education Program and apprenticeship

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced. N/A

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).
Via Vita Health Project Inc. dba Alaska Family Health + Birth Center

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE ___ _____ MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Cheryl Cornish Date: 1-8-08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Cheryl Corrick Date: 1-8-08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
1	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Cheryl Correct, (Age): ___ of (Hometown): Fairbanks
is (Job title/Place of employment): Director of Administration of Alaska Family Health + Birth Cente
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): Certified Direct-entry Midwife and Certified Professional midwife certificate
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Nursing, Board of — **Rochelle Ann Lehrer**

General Information

Board/Commission and seat you are seeking:
Nursing, Board of, LPN

Additional Boards/Commissions of interest:
1) Nursing, Board of

State Boards/Commissions on which you have served
none

First	*Middlename*	*Last Name*
Rochelle	**Ann**	**Lehrer**

Mailing Address	*City*	*State & ZIP*
	Fairbanks	**AK 99712**

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
Denali Center, January, 1999-Present Licensed Practical Nurse, 2004 to Present Denali Center Education Council Member, 2008 to Present Certified Nursing Assistant, State of Alaska

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
University of Alaska Anchorage, Anchorage, Alaska Undergraduate, Practical Nursing, and Current Nursing Program Excelsior College, New York, New York Current Nursing Classes

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Certified Nursing Assistant, 1999 to 2004 Certified Eden Associate Certified in Wound Vac Care

CPR, American Health Association, 2009 Licensed Practical Nurse, State of Alaska, 2004 to Present

List any community service, municipal government, and state positions held, and any awards received.
PTA Member, Joy Elementary, since 2003 Relay For Life, since 2003 Hospice of the Tanana Valley Plant Sale Fundraiser, since 2003

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
Rochelle Lehrer
773 Foxtail Drive, Fairbanks, AK 99712, 907-455-0201, rochelle.lehrer@bannerhealth.com
Summary of Skills
 Wide knowledge of wound care.
 Broad experience and education in bariatric care.
 Solid knowledge and experience in geriatrics and dementia care.
 Extensive experience in diabetes management and education.
Education
University of Alaska Anchorage, Anchorage, Alaska
Undergraduate, Practical Nursing, and Current Nursing Program
Excelsior College, New York, New York
Current Nursing Classes
Professional Experience
Denali Center, January, 1999 - Present
 Licensed Practical Nurse, 2004 to Present.
 Denali Center Education Council Member, 2008 to Present
 Certified Nursing Assistant, 1999 to 2004
Licenses and Certifications
 Licensed Practice Nurse, State of Alaska, 2004 to Present
 CPR, American Heart Association, 2009
 Certified in Advanced Wound Care
 Certified Eden Associate
 Certified Nursing Assistant, State of Alaska, 1999 to 2004
Professional Associations
 Licensed Practice Nurse, State of Alaska, 2004 to Present
 CPR, American Heart Association, 2009
 Certified Nursing Assistant, State of Alaska, 1999 to 2004

Community Involvement

 Hospice of Tanana Valley, since 2003
 Relay for Life, since 2002
 PTA Member , Joy Elementary, since 2009

Press Release Wording

{Rochelle Ann Lehrer}, of {Fairbanks}, is {an LPN at Fairbanks Memorial Hospital/ Denali Center} holds {LPN State of Alaska and currently taking prerequsite classes toward her RN}.

Submitted: 01/20/11 at 4:03 pm from 206.174.59.85

Valentine, Denise
Board of Nursing

OFFICE OF THE GO
MAILROOM
OCT 17 2011

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: RN, nursing
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
RN - Board of Nursing

Name: Denise Valentine

Mailing Address: _____

Residence Address: _____

City, State and Zip Code: Anchorage, AK 99507

Home or Message Telephone: _____ Business Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Denise Valentine Date: 10/14/11

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Kruk Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
✓	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

Denise Valentine, MSN, FNP

Education	**1984**	Bachelor's of Science, Nursing. University of Northern Colorado.
	2005	Master's of Science, Nursing Science. Option: Family Nurse Practitioner tract, University of Alaska, Anchorage. Course work included nursing research, biostatistics, nursing theory, curriculum development, teaching and learning in nursing, and clinical hours spent in urban and rural health care settings. Completed a quantitative thesis on a women's health issue. Family Nurse Practitioner certification obtained in June 2005 through American Academy of Nurse Practitioners.
Professional Credentials And Memberships		Current licensure as an RN and ANP in Alaska DEA number assigned. Member, American Academy of Nurse Practitioners. Member 2008 through present, Alaska Board of Nursing Secretary for the Alaska Board of Nursing January 2009 - January 2011. Vice Chair for the Alaska Board of Nursing January 2011 through present.
Volunteer:	**2007 to 2008**	Congregational Care Ministry at Changepoint Church,
	2009 and 2011	Precepted two students in the Family Nurse Practitioner Program at the University of Alaska, Anchorage.
	June 2011-Present	Brother Francis Caring Clinic - Providing medical care to the homeless 2-3 hours/month.
Professional Employment	**1984-85**	LDS hospital (500-600 beds), Salt Lake City, Utah. Full time employment. Nurse on the orthopedic wing.

1. Community home health agency, Salt Lake City, Utah.
   Responsibilities included home health nursing care throughout Salt Lake County.

2. Salt Lake County Health Department, Salt Lake City, Utah.
   Full time employment. Administered immunizations, WIC education and certification. Managed a county health care clinic staffed by a family nurse practitioner and registered nurse.

1. Primary Children's Hospital, Salt Lake City, Utah.
   Part time employment. Discharge Planner for the rehabilitation team. Set up rehabilitation therapies for patient home care, arranged for proper durable medical equipment and managed the pediatric arthritis clinic.

1. Raised my three children in rural Alaska.

2000 to Oct 2005 Reinstated RN License in Alaska. Whitestone Training Center, Delta Junction, Alaska. General school nursing for a private Christian school in a remote rural enviornment. Provide general nursing and immunizations and documenting student's status.

Whitestone Care Services, Delta Junction, Alaska. Co-owner. Manage respite care and care coordination services. Provide nursing care and evaluation in the community of Whitestone, AK.

Covenant Life College Whitestone, AK. Taught general health and nursing courses. Physiology and Health sciences. Taught medical terminology and Certified Nursing Assistant classes.

2002 to June 2005 Family Medical Center, Delta Junction, Alaska. Part time employment. A rural family practice clinic serving 6,000 residents. Office RN. Responsibilities included obtaining vital signs, managing patient flow, assisting DO and PA-C's with patient care and treatment as needed.

July 2005 To Oct 2005 Family Medical Center, Delta Junction, Alaska
Family Nurse Practitioner. Part time employment. Take medical histories and perform physical examinations. Order and interpret laboratory tests and x-rays. Diagnose, treat, and monitor acute and chronic illnesses. Prescribe medications and other treatments. Provide patient and

	family education. Provide appropriate referral to other health care providers.
2003 to Oct 2005	Whitestone Community Association, Whitestone, Alaska. Vice-President, Community Health. Volunteer work providing nursing evaluation and patient care to 180 residents. Responsible for providing strategic planning and long-term health care assessment and analysis for the association in preparing for health care funding.
Nov 2005 To Aug 2006	Family Nurse Practitioner at Dayspring Medical Center Pain Management Clinic, Mocksville, NC. Part time employment. Evaluate effectiveness of treatment of patients receiving care for chronic pain and multiple sclerosis. Duties include administering IV medications, writing prescriptions, assessments, education.
Oct 2006 to Present	Anchorage Medical and Surgical Clinic. Full time employment. Provide medical care for adults ages 16-90+. Evaluate, diagnose and treat long term illnesses such as diabetes, heart diseases. Other responsibilities include managing Coumadin levels, ordering and interpreting x-rays and laboratory tests. Clinic uses electronic medical records for documentation.

Montgomery, James
Occupational Safety & Health Review Bd

Occupational Safety and Health Review Board — **James Everett Montgomery**

General Information

Board/Commission and seat you are seeking:
Occupational Safety and Health Review Board, Industry Seat

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
Occupational Safety and Health Review Board

First	*Middlename*	*Last Name*
James	**Everett**	**Montgomery**

Mailing Address	*City*	*State & ZIP*
	Kenai	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
1973-75 US Army Viet Nam Era Veteran.
1977-86 US Oil and Refining Co.
1986-Present BP Ltd (Operations,Health Safety,Environmental and Safety, Operations and Risk Auditor)

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
34 years in the Oil, Gas and Refining industry.
Process Safety Management training.
PSM auditor
AD Little Auditor,
HAZOP tarining.

obtained that may be used as qualifying criteria:
Occupational Health Safety Technologist-(Board of Certified Safety Professionals)
Incident Safety Officer- National Fire Academy
Fire Dept. Safety Officer (FDSOA)

List any community service, municipal government, and state positions held, and any awards received.
Executive Board of Boys and Girls Club of the Kenai Pennisula.
First Lady's Volunteer award Mrs. Murkowski
Phi Beta Kappa non-educator volunteer award Kenaio Pennisula.
High School Football Coach -22 years both Varsity and Junior Varsity Levels
High School Soccer Coach – Women's JV Coach
Community Liaison Member- BP External Affairs

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resume Addendum
James E. Montgomery Jr.
Safety and Operations Auditor
BP International

OBJECTIVE

Throughout my career, I have received extensive knowledge and training in production and safety, first as a Control Room Operator and Supervisor at US Oil & Refining Company, Control Room/Facility Operator(Operations Dept) BP Alaska and then in the HSE dept, as a HSE Advisor. I'm presently in an International Safety and Operations Audit Group working for the BP Board of Directors, which has expanded my ability, knowledge for personal growth and contribute to the success and performance of the B P as a company.

PROFESSIONAL SKILLS

April 2010-Present Site Safety Lead MC 252 Response Jefferson Branch.
Assigned to Venice originally then Grand Isle on 5/5, responsibilities initially included oversight of Cocodrie and Pt. Fourchon. When Grand Isle work team went to 3000 plus employees, Cocodrie and Pt. Fourchon were assigned to the new developed Regional Safety Manager. HSE team consisted of Safety, Medical, Coast Guard, National Guard and the Jefferson Parish Sheriffs Dept. 200 plus employees at its peak.
• Site safety plans.
• Emergency response plans

• Hazcom (developed a GI site plan)
• Developed a Safe Practice manual for New Orleans to review.
• Developed training for site, RTV, Supervisor training on Hazard recognition.
• Managed staffing at GI to meet the operation needs and was consistently lower ratio of Safety staff to workers than other sites.

2006-April 2010 S&O Auditor
Assigned tasks included auditing of gHSEr, OMS and PSM standards. Individual areas of auditing were HSE, Operations, Leadership, Emergency Response, Incident Investigation, Assurance, Maintenance and Security.

• International Program auditing
• Detailed deficiency reports
• Mitigating actions to address deficiencies
• International travel with different teams, Singapore, China, Trinidad, Egypt, Great Britain
• US based sites, Gulf of Mexico, Durango Colorado, Whiting Refinery (Indiana), East Coast Pipelines, NAG, Mid-Con Greater Prudhoe Bay and Alaska Consolidated Team (Endicott, Milne Point and North Star)
HSE Safety Advisor, Greater Prudhoe Bay Business Unit

Previous Duties GPB Facilities group included:
• Assist all facility and field personnel to ensure adequate safety, health and loss prevention measures are being followed.
• Assist all facility and field personnel in identifying and mitigating hazards and risks. Assist in the development and application of standards, policies and procedures.
• Conduct formal and informal audits, investigations and inspections of facilities and work in progress.
• Core job specific activities include permitting, confine space entry, training, pre-job and weekly safety meetings, operating procedures, hazards analysis, emergency response and providing information on injury and illness trends.

1995 -1997 Safety Specialist, Prudhoe Bay Western Operating

1986 - 1995 Production Operator, Gathering Center II Prudhoe Bay Western Operating
DCS control room (Lead Console Operator), alarm management, plant operations, permitting, safe outs, commissioning PWH project, Water flood and gas management.

1984 – 1986 Operations Shift Relief (TRX) Supervisor, US Oil and Refining Co.
Covered for vacation and vacancies in operations responsible for the following units: Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating, Sulfur Recovery, Gasoline blending and Marine shipping and receiving.

1984-1986 Supervisor Asphalt Plant, US Oil and Refining Co
Responsible for blending, quality control, inventory, scheduling of product loading and personnel.

1977-1984 Production Operator, US Oil and Refining Co
B-Operator for Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating and Sulfur Recovery Units. Blender responsible for blending operations and QC of asphalt products. Worked on research/development and commissioning of the emulsion asphalt blending systems.

1975-1977 Utility Helper, US Oil and Refining Co
Part-time employment

1973-1975 US Army- Combat Medic
Stationed in Germany during the Viet Nam Conflict.

EDUCATION & TRAINING

• Occupational Health Safety Technologist- Certification from the American Industrial Hygienist and Board of Certified Safety Professionals

• Advanced Safety Certificate- National Safety Council (Principles of Occupational Safety and Health, Safety Management Techniques, Fundamentals Industrial Hygiene)

• Incident Safety Officer- National Fire Academy

• Incident Safety Officer- Fire Dept. Safety Officers Association

• Fall Protection Competent Person- Gavitec

• Hazmat Technician- 40 Hour

• Trainer Decision Point- Hazard Recognition Plus System

• Fire Dept Certifications-High Angle Rescue, Confined Space Rescue, Tactics and Strategy, Flammable Liquids Fire Fighting- Univ. Reno

• Powered Industrial Truck- Trained and Competent to certify BP employees

• Continuing development- Advanced Safety Audit, Fundamentals of Industrial Hygiene Monitoring, Scaffold Competent Person, OSHA Classes (Trenching, Painting Booths and Machine Guarding), First Aid, CPR, Media Training (External Affairs) and Time Management.

• Pursuing a BS in Occupational Health and Safety – Columbia Southern University

• Coaching Certificate State of Alaska- University Alaska Anchorage

Hobbies and Interest:
• High School Football Coach -18 years both Varsity and Junior Varsity Levels

• High School Soccer Coach – Women's JV Coach

• Community Liaison Member- BP External Affairs

• Board of Directors Kenai Boys and Girls Club- Kenai Peninsula

• First Lady's Volunteer award Mrs. Murkowski

PROFESSIONAL & PERSONAL REFERENCES FURNISHED UPON REQUEST

James E. Montgomery Jr.
Safety and Operations Auditor
BP International

OBJECTIVE

Throughout my career, I have received extensive knowledge and training in production and safety, first as a Control Room Operator and Supervisor at US Oil & Refining Company, Control Room/Facility Operator(Operations Dept) BP Alaska and then in the HSE dept, as a HSE Advisor. I'm presently in an International Safety and Operations Audit Group working for the BP

Board of Directors, which has expanded my ability, knowledge for personal growth and contribute to the success and performance of the B P as a company.

PROFESSIONAL SKILLS

April 2010-Present Site Safety Lead MC 252 Response Jefferson Branch.
Assigned to Venice originally then Grand Isle on 5/5, responsibilities initially included oversight of Cocodrie and Pt. Fourchon. When Grand Isle work team went to 3000 plus employees, Cocodrie and Pt. Fourchon were assigned to the new developed Regional Safety Manager. HSE team consisted of Safety, Medical, Coast Guard, National Guard and the Jefferson Parish Sheriffs Dept. 200 plus employees at its peak.
• Site safety plans.
• Emergency response plans
• Hazcom (developed a GI site plan)
• Developed a Safe Practice manual for New Orleans to review.
• Developed training for site, RTV, Supervisor training on Hazard recognition.
• Managed staffing at GI to meet the operation needs and was consistently lower ratio of Safety staff to workers than other sites.

2006-April 2010 S&O Auditor
Assigned tasks included auditing of gHSEr, OMS and PSM standards. Individual areas of auditing were HSE, Operations, Leadership, Emergency Response, Incident Investigation, Assurance, Maintenance and Security.

• International Program auditing
• Detailed deficiency reports
• Mitigating actions to address deficiencies
• International travel with different teams, Singapore, China, Trinidad, Egypt, Great Britain
• US based sites, Gulf of Mexico, Durango Colorado, Whiting Refinery (Indiana), East Coast Pipelines, NAG, Mid-Con Greater Prudhoe Bay and Alaska Consolidated Team (Endicott, Milne Point and North Star)
HSE Safety Advisor, Greater Prudhoe Bay Business Unit

Previous Duties GPB Facilities group included:
• Assist all facility and field personnel to ensure adequate safety, health and loss prevention measures are being followed.
• Assist all facility and field personnel in identifying and mitigating hazards and risks. Assist in the development and application of standards, policies and procedures.
• Conduct formal and informal audits, investigations and inspections of facilities and work in progress.
• Core job specific activities include permitting, confine space entry, training, pre-job and weekly safety meetings, operating procedures, hazards analysis, emergency response and providing information on injury and illness trends.

1995 -1997 Safety Specialist, Prudhoe Bay Western Operating

1986 - 1995 Production Operator, Gathering Center II Prudhoe Bay Western Operating
DCS control room (Lead Console Operator), alarm management, plant operations, permitting, safe outs, commissioning PWH project, Water flood and gas management.

1984 – 1986 Operations Shift Relief (TRX) Supervisor, US Oil and Refining Co.
Covered for vacation and vacancies in operations responsible for the following units: Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating, Sulfur Recovery, Gasoline blending and Marine shipping and receiving.

1984-1986 Supervisor Asphalt Plant, US Oil and Refining Co
Responsible for blending, quality control, inventory, scheduling of product loading and

personnel.

1977-1984 Production Operator, US Oil and Refining Co
B-Operator for Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating and Sulfur Recovery Units. Blender responsible for blending operations and QC of asphalt products. Worked on research/development and commissioning of the emulsion asphalt blending systems.

1975-1977 Utility Helper, US Oil and Refining Co
Part-time employment

1973-1975 US Army- Combat Medic
Stationed in Germany during the Viet Nam Conflict.

EDUCATION & TRAINING

• Occupational Health Safety Technologist- Certification from the American Industrial Hygienist and Board of Certified Safety Professionals

• Advanced Safety Certificate- National Safety Council (Principles of Occupational Safety and Health, Safety Management Techniques, Fundamentals Industrial Hygiene)

• Incident Safety Officer- National Fire Academy

• Incident Safety Officer- Fire Dept. Safety Officers Association

• Fall Protection Competent Person- Gavitec

• Hazmat Technician- 40 Hour

• Trainer Decision Point- Hazard Recognition Plus System

• Fire Dept Certifications-High Angle Rescue, Confined Space Rescue, Tactics and Strategy, Flammable Liquids Fire Fighting- Univ. Reno

• Powered Industrial Truck- Trained and Competent to certify BP employees

• Continuing development- Advanced Safety Audit, Fundamentals of Industrial Hygiene Monitoring, Scaffold Competent Person, OSHA Classes (Trenching, Painting Booths and Machine Guarding), First Aid, CPR, Media Training (External Affairs) and Time Management.

• Coaching Certificate State of Alaska- University Alaska Anchorage

Hobbies and Interest:
• High School Football Coach -18 years both Varsity and Junior Varsity Levels

• High School Soccer Coach – Women's JV Coach

• Community Liaison Member- BP External Affairs

• Board of Directors Kenai Boys and Girls Club- Kenai Peninsula

• First Lady's Volunteer award Mrs. Murkowski

Press Release Wording

years in the Oil and Gas Industry and holds OHST/ISO and FDSOA.

Submitted: 01/05/12 at 6:14 am from 216.67.10.16

Fairbanks, AK. 99712

Sharp, Timothy
Occupational Safety and Health Review Bd

Curriculum Vitae
of
TIMOTHY O. SHARP

OBJECTIVE: To serve in the Knowles Administration on the Occupational Safety Board

QUALIFICATIONS:

*Twenty years of commitment to LIUNA and organized labor.
*Resourceful, aggressive, creative, loyal, dependable, responsible.
*Well developed personal and professional labor contacts around the world.

EDUCATION:

Undergraduate Work - Boise State University- Communications Major 1972-1974 Alaska Laborers Training School - Foreman's Training Course - 1978, Steward's Training Course - 1983, Hazardous Waste Training Course 80 hours - 1989, Alaska Health Project/UAF, Industrial Hazards in Work place - 1985, Labor Law / Wage & Hour Seminar-1992, Harvard Trade Union Program-1993 (Elected commencement speaker), AFL-CIO Organizing Institute Internship-1993, Presently in pursuit of Labor Studies Degree at Antioch/George Meany School for Labor Studies, Computer literate (Macintosh)

WORK HISTORY & EXPERIENCE:

*Worked as journeyman, shop steward, foreman and general foreman directly with, and in support of all, building trade and pipeline craft on some of the largest projects in Prudhoe Bay and on the North Slope of Alaska.
*Responsible for placement and production of up to seventy Laborers at a time.
*Ten years working exclusively as shop steward on large and small projects dealing daily with wage/hour questions, jurisdiction,safety issues and basic contract interpretation.
*Created and presented a monthly series of union education classes over a six month period dealing with union history, labor law, pension plan and other miscellaneous topics for local union.
*Assisted in strategy and implementation of several large organizing drives with the Amalgamated Clothing and Textile Workers and the International Brotherhood of Teamsters in the midwest and southern United States.
*Twice elected as delegate to Alaskan Democratic Party Convention. Proposed at precinct level, carried to State convention and was responsible for adoption of party planks concerning striker replacement and labor law reform.
*Coordinated letter writing campaign lobbying State House and Senate on issues impacting labor during the 1988 legislative session.
*Elected to and presently serving fourth term as Executive Board member of Laborer's Local #942.
*Lectured at area high schools on U.S. labor history.
*Elected and served as delegate to State AFL-CIO Conventions and Laborer's International Convention.
*Selected to serve on AFL-CIO observer team and fact finding mission to South Africa to compile a report on potential problems that might impact the recent elections.
*Currently developing labor contacts and exchanges for future LIUNA health and safety programs in Yakutia-Sakha region of Russia
* Presently employed as full-time organizer/representative for LIUNA Local #942.

Messerschmidt, Forrest
Board of Examiners in Optometry

Optometry, Board of Examiners in **Forrest Bates Messerschmidt**

General Information

Board/Commission and seat you are seeking:
Optometry, Board of Examiners in, Optometrist

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
None

First	*Middlename*	*Last Name*
Forrest	**Bates**	**Messerschmidt**
Mailing Address	*City*	*State & ZIP*
	Juneau	**AK 99801**
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?*	
	Yes	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
Self employed since 1989
Private practice Optometry Juneau, Alaska
Participating Doctor Vision USA, American Optometric Assn. - provides free examination for eligible low income families

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
Graduate Pacific University Bachelors of Science 1986
Graduate Pacific University Doctor of Optometry 1988

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Licensed Optometrist Alaska 22 years
Full Licensure with TPA endorsement
Member Alaska Optometric Assn. 22 years
Member American Optometric Assn. 27 years

List any community service, municipal government, and state positions held, and any awards received.
Vision USA Participating Doctor
Volunteer in past with Juneau Youth Sailing, Juneau Tennis Assn.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

Forrest Messerschmidt,O.D., of Juneau, is a Optometrist/Optometric Physician in private practice in Juneau, Alaska. He holds a bachelors degree in Visual Science and a Doctorate in Optometry from Pacific University in Forest Grove, Oregon.

Submitted: 01/24/12 at 4:01 pm from 69.178.68.53

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Christopher J Kim Date: 1/22/2009

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers / Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/ Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
X	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

2009-01-22 09:07 907-339-1319 Huffman Carrs 1813 p 3/4

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): CJ Kim (Age): of (Hometown): Anchorage
is (Job title/Place of employment): Pharmacist / Safeway.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): B S Pharmacy

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

2009-01-22 09:07 907-339-1319 Huffman Carrs 1813 p 4/4

Mala, Theodore Jr.
Board of Pharmacy

TED MALA, JR.

Professional Account Management Experience:

- Identifying and closing the highest revenue new business deal.
- Multicultural awareness resulting in higher sales volume.
- Exceptional rapport building skills resulting in longer partnerships.

Business Development Manager, NANA Management Services Nov. 2010- Present

Work with some of the most visible and prominent businesses in Alaska to develop and maintain relationships statewide.

Senior Media Consultant, The Alaska Journal of Commerce June 2010-Sept. 2010

Establish relationships with key accounts such as Southcentral Foundation, CH2M Hill, Alaska Native Heritage Center, and Bristol Bay Native Corporation.

- Develop targeted sales strategies, proposals, and contracts.
- Independently maintain quota of 25 cold calls and five new business appointments per week
- Sold $80,000 in new business revenue in the 10 weeks I consulted for AJOC.

Major Account Manager, Los Angeles Times 2007-2009

Develop and maintain key accounts such as Twentieth Century Fox, Charles Drew University, Los Angeles Country Club, and Century City Doctor's Hospital.

- Closed first quarter 258% to goal.
- Develop targeted sales strategies to close record-breaking business deals.
- Independently maintain quota of 100 cold calls and five new business appointments per week.
- Develop targeted sales strategies, proposals, and contracts.
- Selected as member of the inaugural Los Angeles Times sales strategy council.

Luxury Real Estate Agent, Surterre Properties 2007-2011

Represent Newport Beach's premier luxury real estate office in prestigious Crystal Cove, Newport Coast.

- Strong rapport building, extensive product knowledge, and tactful negotiating yielded sale of home just under five million dollars in Newport Coast.
- Design targeted marketing materials distinguishing team brand.
- Develop rapport and maintain relationships with clients resulting in repeat business and referrals.

Advertising Consultant, Yellow Book USA 2003-2007

Designed comprehensive advertising programs representing multicultural clients from varying industries.

- Secured business through cold calling, appointment setting, studying industry trends, in-depth needs analysis, calculating ROI, and negotiating contracts.
- Personally designed effective ad copy.
- Supervised territory growth and development.
- Created Spanish/English advertising programs.
- Independently maintained quota of 200 cold calls and eight new business appointments per week.
- Grew all territory assignments on average 20%.

Corporate Account Representative, The Alaska Club 2002-2003

Managed the development and maintenance of corporate accounts for Alaska's premier health club network.

- Prospected major corporate clients.
- Designed and pitched corporate presentations and proposals.
- Secured corporate partnerships.
- Current record holder for most new members signed up in one day (29).
- Ranked as number one salesperson in the history of The Alaska Club.

Project Coordinator, Southcentral Foundation 2001-2002

Instrumental in developing the Family Wellness Warrior Initiative (FWWI) at Southcentral Foundation/Alaska Native Medical Center.

- Represented the President/CEO and Board of Directors in public speaking engagements aimed at spreading awareness of the initiative's purpose which is to combat domestic violence, abuse, and neglect in Alaska.
- Gave a speech to 500 people which was broadcast live statewide.
- Built relationships with leaders in the community to garner support including Alaska Native Leaders, Judges, the head of the DOC, the head of DHSS, CEO's, legislators, and many others.
- Presented to the boards of directors of all the major Native Health Corporations in Alaska seeking the passing of a resolution supporting the initiative.
- Every board of directors passed a unanimous resolution of support.

EDUCATION/RECENT PROFESSIONAL DEVELOPMENT

- Current State of California Real Estate License
- Power Messaging - Corporate Visions, Inc.

- Spin Selling – Strategic Sales Solutions

COMPUTER SKILLS

- Microsoft Office Suite (Outlook, Excel, Word, PowerPoint)
- Salesforce.com

REFERENCES AVAILABLE UPON REQUEST

Cotter, John
Board of Pharmacy

John E. Cotter

Address

Experience

2008 to present Fairbanks Memorial Hospital, Fairbanks AK

Associate Administrator for Professional Services

- Radiology, Laboratory and Pharmacy
- Responsible for oversight of all routine operations of the ancillary service departments. Develops programs, goals and objectives consistent with those of the organizations overall strategic plan and initiatives. Develops operational and capital budgets, manages operating expenses and key indicators within the budget.

1997 to 2008 Fairbanks Memorial Hospital, Fairbanks, AK

Director of Pharmacy

- Responsible for leading, developing and coordinating the operation of Pharmacy Services. Develops services that provide and enhance quality patient care while promoting fiscal responsibility in the utilization of resources. Directs the activities that provide for the purchasing, receiving, storage, delivery and distribution of medications from the pharmacy. Plans, directs, monitors, and evaluates the provision of distributive and clinical pharmacy services to all patient care areas.
- 166 bed acute care community Hospital
- 88 bed long term care facility
- Home health care
- Retail pharmacy

1985 to 1997 Fairbanks Memorial Hospital, Fairbanks, AK

Pharmacy Assistant Manager & Staff

- as above

1989 to 2002 1984th US Army Hospital, Fort Wainwright, AK

Pharmacy Officer

- 1984th US Army Reserve Hospital

1982 to 1985 US Army, Bassett USA Hospital, Fort Wainwright, AK

Assistant Pharmacy Manager

- Active Duty
- Inpatient & Outpatient Care

1979 to 1982 US Army, Womack USA Hospital, Ft Bragg, NC

Officer in Charge, Inpatient Pharmacy

- Active Duty
- Inpatient care

1977 to 1979 Wrentham State School, Wrentham, MA
Staff Pharmacist

Education

1977 Massachusetts College of Pharmacy, Boston, MA
B.S. Pharmacy

1985 University of Laverne, Fort Wainwright, AK
M.A. Organizational Management

Pharmacy Licensure

Alaska Pharmacy #766, First Issue 10/1983, Expires 6/30/2012

Massachusetts PH16823, First Issue 6/1977 Expires 12/31/2012

Professional Association

- American Society of Health-System Pharmacists
- Alaska Pharmacists Association
- American College of Healthcare Executives

DeVito, Lori
Board of Pharmacy

LORI A. DEVITO, RPH

OBJECTIVE

To be a leader and positive role model in the Profession of Pharmacy. To organize, direct, own and operate a home infusion pharmacy as well as maintain an ongoing liaison to the governing body, professional advisory committee and staff. To employ qualified skilled personnel and ensure staff is updated on education and evaluations. To implement an effective budgeting and accounting system which will allow for the pharmacy to operate in the most efficient and cost effective manner possible.

QUALIFICATIONS

Registered Pharmacist for 24 years in Soldotna, Alaska
Hospital and Retail Pharmacist -24 years
Long Term Care Facility Pharmacy Consultant- 24 years
Home Infusion Pharmacist Manager, President/CEO/Owner – 19 years
Home Health Care Administrator, President/CEO/Owner-15 years
Trained in I.V. Admixtures, Sterile Compounding, Home Health Care Fittings, Ostomy Supplies, TENS units, Oxygen Usage, Wound Care, Clinical / Retail Pharmacy, DME
Prescription Compounding Certified
In-service Teacher- Diabetic/Pharmacy
In-service Teacher-Ambulatory IV equipment, Enteral Equipment
CPR Certified
Main Speaker at National Home Infusion Association
Attended Several Home Health Care Educational Seminars regarding administration/Cost Reporting/Clinical Care
Preceptor for Students of Pharmacy

EDUCATION

1983-1986	Bachelor of Science in Pharmacy, University of Colorado-Boulder, Colorado
1981-1983	Undergraduate Pharmacy, Colorado State University, Fort Collins, Colorado
1986-1995	Small Business Administration, Kenai Peninsula Community College, Kenai, AK
1981	High School Graduate, Kenai Central High School, Kenai, Ak

AWARDS/OTHER INFORMATION

1993-Present	Member National Home Infusion Association
1996-Present	Member National Association of Home Care
1988-1995	Member National Association Retail Druggist's
1986-Present	Member Alaska Pharmaceutical Association
1992-1993	President Alaska Pharmaceutical Association
1991-1992	America Pharmacy Association Alaskan Delegate (Washington, D.C.)
1997-2003	APHA-Alaska Legislative Affairs Representative
1992	Pharmacy Leadership Award-AKPHA
1993	President's Award in Pharmacy-AKPHA
1995	Distinguished Young Pharmacist Award-AKPHA
1985	Bowden Pharmaceutical Scholarship-Recipient
1986	Member Alaska Home Care Association-Secretary
1988-1995	Member Peninsula Home Health Care-Board
1995-2005	Soroptimist Twin Cities Member
1997-1998	Soroptimist Twin Cities President
1998	Founder-Soroptimist Cancer Fund

WORK HISTORY

1993-Present	Professional Home I.V., Inc. Owner/CEO/Pharmacy Manager
1996-Present	1st Choice Home Health Care, Inc. Owner/CEO
1986-1996	Soldotna Professional Pharmacy-Retail Pharmacist
1991-1995	Central Peninsula General Hospital- Hospital Pharmacist
1984-1986	Soldotna Professional Pharmacy-Pharmacy Intern
1985-1986	Pharmacy Externships: Pharmacy Financial Management—Yuma, Colorado Hospital & Clinical Pharmacy- Shiprock, N.M. Chain/Retail Pharmacy-Denver, Colorado Nursing Home Pharmacy Consultant-Denver, Colorado
1979-1983	DeVito Co-Nook Lure Company-Partner in Manufacturing Business
1975-1984	Soldotna Drug Store-Pharmacy Tech, Inventory, etc.

LICENSES

Pharmacist	Alaska	License #837
Pharmacist	Colorado	License #18657
Pharmacist	South Carolina	License #12854

Kim, Christopher
Board of Pharmacy

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Pharmacy, Pharmacist
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served: none

Name: Christopher J Kim (CJ)

Mailing Address: ___

Residence Address: Same

City, State and Zip Code: ___

Home or Message Telephone: ___ Business Telephone: ___

Fax Number: ___ Cell Phone: ___

Email address: ___

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO ___ Voter Registration Number (Optional): ___

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): ___

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES ___ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO ___

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES ___ NO X

If "YES", explain:

Fax Received
JAN 22 2009
Office of the Governor

2009-01-22 09:06 907-339-1319 Huffman Carrs 1813 P 1/4

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Pharmacist License 1999 - Present

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

BS. of Pharmacy, Oregon State University

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

Carrs/Safeway Corp. RPh 1999 - Present

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: 0 SEX: FEMALE _____ MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Christopher G. Kim Date: 1/22/2007

Please attach a current resume with your application.

2009-01-22 09:06 907-339-1319 Huffman Carrs 1813 P 2/4

Carey, David
State Physical Therapy &
Occupational Therapy Board

Physical Therapy and Occupational Therapy Board, State — **David A Carey**

General Information

Board/Commission and seat you are seeking:
Physical Therapy and Occupational Therapy Board, State, Public

Additional Boards/Commissions of interest:
1) Juvenile Justice Advisory Committee, Alaska
2) Alcoholism and Drug Abuse, Advisory Board on
3) Emergency Medical Services, Alaska Council on

State Boards/Commissions on which you have served
None

First	*Middlename*	*Last Name*
David	**A**	**Carey**
Mailing Address	*City* **Anchorage**	*State & ZIP*
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?*	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
-Assets,Inc - 5 years employed as a "Life Skills Coach" for a non-profit organization that provided services for people with mental disabilities.

- Volunteers of America- 2 years employed as a Drug and Alcohol prevention Instructor for the Anchorage School District.

- 2008 Olympic Boxing Team Member and volunteer boxing coach

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
- John F. Kennedy High School class of 1999
- University of Anchorage Alaska

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
- Certified Drug and Alcohol prevention instructor, January 2009.

List any community service, municipal government, and state positions held, and any awards received.
None

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

{Your Name}, {age} of {hometown}, is {job title/place of employment} holds {education level, school, or relevant experiences}.

Submitted: 12/27/11 at 4:50 pm from 24.237.108.58

Parietti, James
State Physical Therapy and Occupational Therapy Bd

Physical Therapy and Occupational Therapy Board, State — **James Kenneth Parietti**

General Information

Board/Commission and seat you are seeking:
Physical Therapy and Occupational Therapy Board, State, physical therapist seat

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
none

First	*Middlename*	*Last Name*
James	**Kenneth**	**Parietti**

Mailing Address	*City*	*State & ZIP*
	Chugiak	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
EMPLOYMENT HISTORY

Physical Therapist - Mat-Su Regional Medical Center Palmer, Alaska 11/10 - present
I am a pool physical therapist who covers weekends and holidays for the inpatient hospital population. Duties include performing initial evaluations, providing care/treatment, attending rounds as required/needed, communicating with various other medical staff and family members, evaluating and requesting equipment for patient needs upon discharge and performing hospital/corporate based continuing education as required.

Physical Therapist - Eagle Center Physical Therapy
Eagle River, Alaska 06/10 - present
I am a staff physical therapist involved in all aspects of patient care including initial evaluations,

progress notes and discharge summaries. I also assist with marketing of the facility to local referral sources and attending events where I promote health topics and our services to potential clients/patients.

Clinic Director/Physical Therapist - Denali Physical Therapy Anchorage Alaska 06/08 – 03/10
I helped open and was a limited partner of an outpatient orthopaedic clinic. Duties included doing due diligence with referral sources, researching a location for the practice, assisting with buildout design, marketing the facility and services to referral sources, identifying new revenue sources, ordering supplies/equipment and being responsible for the facility income statement. I also provided all aspects of patient care including evaluations, re-evaluations/progress notes, daily treatment and discharge summaries.

Business Development/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 10/06 – 5/08
The first part of my job duties included marketing the facility and staff to referral sources, identifying new revenue sources, diversifying and expanding facility operations, communicating to local staff the needs/preferences of referral sources and being a communication channel between staff and referral sources. I assisted in coordinating in services, surgery observations and educational opportunities for local staff. I also addressed patient questions/concerns and acted as a liaison between the patient, the referral source and the clinic.
As a therapist I was responsible for patient care, including performing initial evaluations, treatment, re-evaluations/progress notes and discharge summaries.

Site Coordinator/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 08/05 – 10/06
I was hired to turn the integrated medical facility clinic around. Duties included supervision of clinical and non-clinical staff, compliance with Medicare regulations, marketing facility and staff to referral sources, obtaining new revenue streams, diversifying and expanding facility operations, delegating various job tasks to staff (pool maintenance, supplies/equipment ordering, Medicare review, staff education), maintaining compliance with HealthSouth policies, reporting to my chain of command, being responsible for the facility income statement, review of the facility general ledger, performing monthly staff meetings, conducting employee performance appraisals and hiring/firing of staff. I also provided all aspects of patient care including evaluations, re-evaluations/progress notes and discharge summaries.

Owner/Operator Personal Touch Physical Therapy
Hilton Head Island, South Carolina 1998 – 2005
I incorporated and opened an orthopaedic private practice. Duties included marketing the facility and services to physicians, designing and building out the practice, negotiating and contracting billing services as well as lease arrangements. I provided all aspects of patient care including initial evaluations, progress notes/re-evaluations and discharge summaries. I performed all equipment acquisition, obtained insurance and Medicare provider numbers and performed all other aspects of operating a private practice.

Physical Therapist Jasper County School System
Ridgeland, South Carolina 1996 – 2005
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist Beaufort County School System 1997 – 2004
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist Beaufort-Jasper Home Health Services 1995 – 1998
Evaluate and provide services to Medicaid home bound individuals, maintain open

communication with staff/family and provide progress notes to physicians and ancillary services

Physical Therapist Care One 1994 – 1995
Provide services in an outpatient orthopaedic clinic including evaluations, treatment plans, progress notes and communication with other medical personnel.

Owner/Operator Health Quest One Fitness Center 1993 – 2003
Perform daily business functions including interaction with members, facility maintenance, equipment repair, marketing, billing and supervision of employees. Duties also included designing the fitness center, equipment acquisition, lease negotiations, subcontractor negotiations, contract development in compliance with state law as well as all other duties associated with owning/operating a business.

Physical Therapist ABC Home Health Agency 1993 – 1993
Evaluate and provide services to home bound individuals, maintain open communication with staff and provide progress notes to physicians and ancillary services.

Physical Therapist
HealthSouth Rehabilitation Corp., Merritt Island, FL 1992 – 1993
Provide physical therapy services in an outpatient orthopaedic clinic. Duties included performing evaluations, developing treatment plans, writing progress notes, discharge summaries and communicating with physicians, peers, patients and family members.

Physical Therapist South Miami Hospital 1991 - 1992
Evaluate and provide services to post-op orthopaedic, neurological, wound and general de-conditioned patients in an acute rehabilitation setting. Communicate with physicians, other staff, peers, patients and family members. I also filled in for other therapists in the rehab center and worked in the insensitive limb clinic with patients with chronic circulatory problems.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
FORMAL EDUCATION

1990 Master of Science in Physical Therapy (M.S.P.T.)
University of Miami, Coral Gables Florida

1989 Licensed Massage Therapist
Educating Hands School of Massage, Miami, Florida

1989 Certified Strength & Conditioning Specialist
National Strength & Conditioning Association

1988 Master of Science in Athletic Training & Sport Sciences
Long Island University, Brooklyn, New York

1987 B.S., School & Community Health Education
East Carolina University, Greenville, North Carolina

1985 Certified Massage Therapist
Community Wholistic Health Center, Carrboro, NC

1984 A.A. Brevard College, Brevard, North Carolina

CONTINUING EDUCATION

2011 Kinesio Taping - Advanced Whole Body (KT3)
Kinesio Taping Association International, Eagle River, Alaska

2011 Kinesio Taping - Fundamentals and Advanced (KT1 & KT2)
Kinesio Taping Association International, Eagle River, Alaska

2011 Strain Counterstrain II for the Extremities
Jones Institute, Anchorage, Alaska

2009 Total Motion Release
Total Motion Release, Charleston, South Carolina

2008 The Shoulder Girdle Complex:
Medical Screening and Orthopaedic Fundamentals
Empiridence Seminars, Anchorage, Alaska

2007 Diagnosis & Treatment of Movement System Impairment Syndromes of the Low Back and Hip
Alaska Physical Therapy Association, Girdwood, AK

2006 Evaluation & Treatment of the Cervicothoracic Spine
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Shoulder Update 2006
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Certified Pool/Spa Operator
National Swimming Pool Foundation, Anchorage, AK

2006 Pelvic Girdle and Hip
HealthSouth Rehabilitation Corporation, Seattle, WA

2005 Strength and Conditioning
HealthSouth Rehabilitation Corporation, Anchorage, AK

2005 Vestibular Rehabilitation
Great Lake Seminars, Charleston, South Carolina

2003 Pilates
International Weightlifting Association, Charleston, SC

2001 Mulligan Concepts
Brian Mulligan, Augusta, Georgia

2001 Special Needs Child
South Carolina/Georgia Dept. of Social Services, Augusta, GA

2000 Myofascial Release
John Barnes, University of West Virginia, West Virginia

1998 Adaptive Golf
Roper Hospital, Charleston, South Carolina

1997 Concepts of Electrical Stimulation
Memorial Hospital, Charleston, South Carolina

1997 Treatment of the Lumbar Complex
Great Lakes Seminars, Charleston, South Carolina

1995 Work Conditioning, Work Hardening and Work Simulation
Roy Matheson and Associates, Toronto, Canada

1995 Job Task Analysis
Roy Matheson and Associates, Toronto, Canada

1995 Functional Capacity Evaluation
Keith Blankenship, Nashville, Tennessee

1992 Foot and Ankle Clinical Specialization Course – Level 1
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Basic Skills Enhancement Course
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Shoulder and Upper Extremity: Current Concepts & Treatment
The Miami Sports Medicine Seminar, Miami, Florida

1992 Knee Rehabilitation
Knee Works & The Florida Knee Center, Clearwater Beach, FL

1991 Clinical Applications of the Feldenkrais Method – Level 1
The Institute for Movement Studies and South Miami Hospital, Miami, Florida

1990 The Treatment of the Diabetic Foot
South Miami Hospital Medical Ed. Committee, Miami, Florida

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Physical Therapist - Alaska License No. 1703

List any community service, municipal government, and state positions held, and any awards received.
When I was a limited partner of Denali PT I would treat patient patients who could not afford our services and who were usually uninsured at a discounted rate. This is one of the ways I assisted the community. We also sponsored local groups/events.
No prior government positions held but I am eager to begin this journey now.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"

"I certify"

Resumé Addendum
James K. Parietti M.S., M.S.P.T.

EMPLOYMENT HISTORY

Physical Therapist
Mat-Su Regional Medical Center, Palmer Alaska 11/10 - present
I am a pool physical therapist who covers weekends and holidays for the inpatient hospital population. Duties include performing initial evaluations, providing care/treatment, attending rounds as required/needed, communicating with various other medical staff and family members, evaluating and requesting equipment for patient needs upon discharge and performing hospital/corporate based continuing education as required.

Physical Therapist
Eagle Center Physical Therapy, Eagle River Alaska 06/10 - present
I am a staff physical therapist involved in all aspects of patient care including initial evaluations, progress notes and discharge summaries. I also assist with marketing of the facility to local referral sources and attending events where I promote health topics and our services to potential clients/patients.

Clinic Director/Physical Therapist
Denali Physical Therapy, Anchorage Alaska 03/10 - 03/10
I helped open and was a limited partner of an outpatient orthopaedic clinic. Duties included doing due diligence with referral sources, researching a location for the practice, assisting with buildout design, marketing the facility and services to referral sources, identifying new revenue sources, ordering supplies/equipment and being responsible for the facility income statement. I also provided all aspects of patient care including evaluations, re-evaluations/progress notes, daily treatment and discharge summaries.

Business Development/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 10/06 – 5/08
The first part of my job duties included marketing the facility and staff to referral sources, identifying new revenue sources, diversifying and expanding facility operations, communicating to local staff the needs/preferences of referral sources and being a communication channel between staff and referral sources. I assisted in coordinating in services, surgery observations and educational opportunities for local staff. I also addressed patient questions/concerns and acted as a liaison between the patient, the referral source and the clinic.
As a therapist I was responsible for patient care, including performing initial evaluations, treatment, re-evaluations/progress notes and discharge summaries.

Site Coordinator/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 08/05 – 10/06
I was hired to turn the integrated medical facility clinic around. Duties included supervision of clinical and non-clinical staff, compliance with Medicare regulations, marketing facility and staff to referral sources, obtaining new revenue streams, diversifying and expanding facility operations, delegating various job tasks to staff (pool maintenance, supplies/equipment ordering, Medicare review, staff education), maintaining compliance with HealthSouth policies, reporting to my chain of command, being responsible for the facility income statement, review of the facility general ledger, performing monthly staff meetings, conducting employee performance appraisals and hiring/firing of staff. I also provided all aspects of
EMPLOYMENT HISTORY (Cont.)

patient care including evaluations, re-evaluations/progress notes and discharge summaries.

Owner/Operator
Personal Touch Physical Therapy, Hilton Head Island SC 1998 – 2005
I incorporated and opened an orthopaedic private practice. Duties included marketing the facility and services to physicians, designing and building out the practice, negotiating and contracting billing services as well as lease arrangements. I provided all aspects of patient care including initial evaluations, progress notes/re-evaluations and discharge summaries. I performed all equipment acquisition, obtained insurance and Medicare provider numbers and performed all other aspects of operating a private practice.

Physical Therapist Jasper County School System 1996 – 2005
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist Beaufort County School System 1997 – 2004
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist
Beaufort-Jasper Home Health Services, Ridgeland SC 1995 – 1998
Evaluate and provide services to Medicaid home bound individuals, maintain open communication with staff/family and provide progress notes to physicians and ancillary services

Physical Therapist
Care One, Hilton Head Island South Carolina 1994 – 1995
Provide services in an outpatient orthopaedic clinic including evaluations, treatment plans, progress notes and communication with other medical personnel.

Owner/Operator
Health Quest One Fitness Center, Hilton Head Island SC 1993 – 2003
Perform daily business functions including interaction with members, facility maintenance, equipment repair, marketing, billing and supervision of employees. Duties also included designing the fitness center, equipment acquisition, lease negotiations, subcontractor negotiations, contract development in compliance with state law as well as all other duties associated with owning/operating a business.

Physical Therapist
ABC Home Health Agency, Merritt Island, FL 1993 – 1993
Evaluate and provide services to home bound individuals, maintain open communication with staff and provide progress notes to physicians and ancillary services.

Physical Therapist
HealthSouth Rehabilitation Corp., Merritt Island, FL 1992 – 1993
Provide physical therapy services in an outpatient orthopaedic clinic. Duties included performing evaluations, developing treatment plans, writing progress

EMPLOYMENT HISTORY (Cont.)

notes, discharge summaries and communicating with physicians, peers, patients and family members.

Physical Therapist
South Miami Hospital, Miami Florida 1991 - 1992
Evaluate and provide services to post-op orthopaedic, neurological, wound and general de-

conditioned patients in an acute rehabilitation setting. Communicate with physicians, other staff, peers, patients and family members. I also filled in for other therapists in the rehab center and worked in the insensitive limb clinic with patients with chronic circulatory problems.

FORMAL EDUCATION

1990 Master of Science in Physical Therapy (M.S.P.T.)
University of Miami, Coral Gables Florida

1989 Licensed Massage Therapist
Educating Hands School of Massage, Miami, Florida

1989 Certified Strength & Conditioning Specialist
National Strength & Conditioning Association

1988 Master of Science in Athletic Training & Sport Sciences
Long Island University, Brooklyn, New York

1987 B.S., School & Community Health Education
East Carolina University, Greenville, North Carolina

1985 Certified Massage Therapist
Community Wholistic Health Center, Carrboro, NC

1984 A.A. Brevard College, Brevard, North Carolina

CONTINUING EDUCATION

2011 Kinesio Taping - Advanced Whole Body (KT3)
Kinesio Taping Association International, Eagle River, Alaska

2011 Kinesio Taping - Fundamentals and Advanced (KT1 & KT2)
Kinesio Taping Association International, Eagle River, Alaska

2011 Strain Counterstrain II for the Extremities
Jones Institute, Anchorage, Alaska

2009 Total Motion Release
Total Motion Release, Charleston, South Carolina

2008 The Shoulder Girdle Complex:
Medical Screening and Orthopaedic Fundamentals
Empiridence Seminars, Anchorage, Alaska

CONTINUING EDUCATION (Cont.)

2007 Diagnosis & Treatment of Movement System Impairment Syndromes of the Low Back and Hip
Alaska Physical Therapy Association, Girdwood, AK

2006 Evaluation & Treatment of the Cervicothoracic Spine
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Shoulder Update 2006
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Certified Pool/Spa Operator

National Swimming Pool Foundation, Anchorage, AK

2006 Pelvic Girdle and Hip
HealthSouth Rehabilitation Corporation, Seattle, WA

2005 Strength and Conditioning
HealthSouth Rehabilitation Corporation, Anchorage, AK

2005 Vestibular Rehabilitation
Great Lake Seminars, Charleston, South Carolina

2003 Pilates
International Weightlifting Association, Charleston, SC

2001 Mulligan Concepts
Brian Mulligan, Augusta, Georgia

2001 Special Needs Child
South Carolina/Georgia Dept. of Social Services, Augusta, GA

2000 Myofascial Release
John Barnes, University of West Virginia, West Virginia

1998 Adaptive Golf
Roper Hospital, Charleston, South Carolina

1997 Concepts of Electrical Stimulation
Memorial Hospital, Charleston, South Carolina

1997 Treatment of the Lumbar Complex
Great Lakes Seminars, Charleston, South Carolina

1995 Work Conditioning, Work Hardening and Work Simulation
Roy Matheson and Associates, Toronto, Canada

1995 Job Task Analysis
Roy Matheson and Associates, Toronto, Canada

1995 Functional Capacity Evaluation
Keith Blankenship, Nashville, Tennessee

CONTINUING EDUCATION (Cont.)

1992 Foot and Ankle Clinical Specialization Course – Level 1
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Basic Skills Enhancement Course
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Shoulder and Upper Extremity: Current Concepts & Treatment
The Miami Sports Medicine Seminar, Miami, Florida

1992 Knee Rehabilitation
Knee Works & The Florida Knee Center, Clearwater Beach, FL

1991 Clinical Applications of the Feldendkrais Method – Level 1
The Institute for Movement Studies and South Miami Hospital, Miami, Florida

1990 The Treatment of the Diabetic Foot
South Miami Hospital Medical Ed. Committee, Miami, Florida

Press Release Wording

{Your Name}, {age} of {hometown}, is {job title/place of employment} holds {education level, school, or relevant experiences}. James K Parietti, of Chugiak is a staff physical therapist of Eagle Center Physical Therapy. James holds a Masters degree in Physical Therapy from the University of Miami and has been working in the field for 21 years

Submitted: 01/27/12 at 11:18 am from 72.35.101.4

Psychologist and Psychological Assoc. Examiners, Board of

General Information

Board/Commission and seat you are seeking:
Psychologist and Psychological Assoc. Examiners, Board of, LPA

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
None

First	*Middlename*	*Last Name*
Allen	**Lee**	**Levy**
Mailing Address	*City*	*State & ZIP*
	Anchorage	
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?*	
	Yes	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
Yes

Please explain the potential financial benefit
I am a Licensed Psychological Associate. It is possible that proposed changes in regulations could affect my practice.

Employment History

Employment work history including paid, unpaid or voluntary.
Therapist in private practice. November 2005 to present. Provided individual and family therapy to adults, children, and adolescents in private mental health practice. Occasionally do forensic work in connection with divorce and custody cases.

Therapist and Medicaid Auditor, UHS Good Samaritan LLC, December 2001 to November 2005. Provided individual, family, and group therapy to adults, children, and adolescents in outpatient mental health clinic. Audited all provider charts for compliance with Medicaid regulations and documentation standards. Revised and designed progress notes, treatment plans and other forms to be more Medicaid compliant and easier to complete.

Adjunct Faculty University of Alaska Anchorage, 2005- present. Proposed, planned, and taught

one credit course: Coordinating Child and Family Therapy with Other Service Providers and Agencies. Also taught Lifespan Development, Personality Psychology, Abnormal Psychology and General Psychology.

Presenter and trainer, UAA ISER sponsored international conference on problems associated with alcoholism, Anadyr Russia, July 9 – 22, 2004 and October 22 – 27, 2004. Presented lectures, workshops, and demonstrations on individual and group therapy as applied in residential settings, play therapy, and Fetal Alcohol Spectrum Disorders at the regional mental health hospital and the regional children's home.

Presenter and trainer, University of Alaska Anchorage Raven's Quest Summer Internship Program, Summer 2003, 2004, and 2005. Presented workshops on group challenge activities, lectured on practicing individual, family, and group therapy in private practice, lectured on challenges in human services and the field of mental health.

Clinician, South Central Foundation The Pathway Home, August – October 2001. Trained staff in Therapeutic Community, Positive Peer Culture, and Mandt Basic and Intermediate levels. Wrote policy and procedures. Created forms. Supervised staff. Developed program and staff schedules.

Relief Clinical Associate, South Central Counseling Center, Spring 2001. Provided individual and group therapy to chronically mentally ill clients in the Institutional Discharge Program. Planned and carried out special therapeutic activities (e.g., art, music, computers) for clients.

Youth Counselor, McLaughlin Youth Center, Anchorage Alaska, 1990- 2000. Acted as primary counselor for three to five residents. Developed individual treatment programs for counselees. Facilitated group therapy sessions. Wrote and kept up to date all necessary documentation (e.g., weekly cumulative entries, monthly progress reports, annual reviews, special court reports, Institutional Review Board memos, incident reports). Conducted individual, family, and group counseling sessions. Intervened in crisis situations. Planned and supervised outings, community service projects, and group challenge activities.

Case Manager, McLaughlin Aftercare Project, 1997-1998. Provided individual and family counseling, support, crisis intervention, assessment, drug testing, vocational assistance, and other services to adolescents released from treatment at McLaughlin Youth Center. Planned and carried out special group challenge activities for groups of residents on pre-release status from McLaughlin Youth Center. Supervised case load of three to five former residents. Contacted each former resident twice each week for face to face meetings and at least once per week by telephone. Wrote and kept current all necessary documentation.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
80+ hours of continuing education in topics related to ethical practice and psychology
Master of Science Clinical Psychology, University of Alaska Anchorage, 2001.

Bachelor of Arts, Liberal Arts, The Evergreen State College, Olympia, Washington, 1981.

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Licensed Psychological Associate license #548 current license valid from 06/15/2011 - 06/30/2013

List any community service, municipal government, and state positions held, and any awards received.
Served on Executive Board of Alaska Psychological Association in various capacities (Member at Large, Treasurer) from 2006 -2009. Recently rejoined as co-chair of Continuing Education

Committee.

I have ten years of service as a Youth Counselor at McLaughlin Youth Center from 1990 to 2000. Was twice awarded employee of the month.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
Allen L. Levy LPA

Anchorage, Alaska
Anchorage Ak,

Treatment Experience

Therapist in private practice. November 2005 to present. Provided individual and family therapy to adults, children, and adolescents in private mental health practice. Occasionally do forensic work in connection with divorce and custody cases.

Therapist and Medicaid Auditor, UHS Good Samaritan LLC, December 2001 to November 2005. Provided individual, family, and group therapy to adults, children, and adolescents in outpatient mental health clinic. Audited all provider charts for compliance with Medicaid regulations and documentation standards. Revised and designed progress notes, treatment plans and other forms to be more Medicaid compliant and easier to complete.

Youth Counselor, McLaughlin Youth Center, Anchorage Alaska, 1990- 2000. Acted as primary counselor for three to five residents. Developed individual treatment programs for counselees. Facilitated group therapy sessions. Wrote and kept up to date all necessary documentation (e.g., weekly cumulative entries, monthly progress reports, annual reviews, special court reports, Institutional Review Board memos, incident reports). Conducted individual, family, and group counseling sessions. Intervened in crisis situations. Planned and supervised outings, community service projects, and group challenge activities.

Case Manager, McLaughlin Aftercare Project, 1997-1998. Provided individual and family counseling, support, crisis intervention, assessment, drug testing, vocational assistance, and other services to adolescents released from treatment at McLaughlin Youth Center. Planned and carried out special group challenge activities for groups of residents on pre-release status from McLaughlin Youth Center. Supervised case load of three to five former residents. Contacted each former resident twice each week for face to face meetings and at least once per week by

telephone. Wrote and kept current all necessary documentation.

Relief Clinical Associate, South Central Counseling Center, Spring 2001. Provided individual and group therapy to chronically mentally ill clients in the Institutional Discharge Program. Planned and carried out special therapeutic activities (e.g., art, music, computers) for clients.

Teaching/training and Service Experience

Adjunct Faculty University of Alaska Anchorage, 2005- present. Proposed, planned, and taught one credit course: Coordinating Child and Family Therapy with Other Service Providers and Agencies. Also taught Lifespan Development, Personality Psychology, Abnormal Psychology and General Psychology.

Presenter and trainer, UAA ISER sponsored international conference on problems associated with alcoholism, Anadyr Russia, July 9 – 22, 2004 and October 22 – 27, 2004. Presented lectures, workshops, and demonstrations on individual and group therapy as applied in residential settings, play therapy, and Fetal Alcohol Spectrum Disorders at the regional mental health hospital and the regional children's home.

Presenter and trainer, University of Alaska Anchorage Raven's Quest Summer Internship Program, Summer 2003, 2004, and 2005. Presented workshops on group challenge activities, lectured on practicing individual, family, and group therapy in private practice, lectured on challenges in human services and the field of mental health.

Management Experience

Clinician, South Central Foundation The Pathway Home, August – October 2001. Trained staff in Therapeutic Community, Positive Peer Culture, and Mandt Basic and Intermediate levels. Wrote policy and procedures. Created forms. Supervised staff. Developed program and staff schedules.

Education, License, and Awards

Licensed Psychological Associate, State of Alaska license number 548. Passed Examination for Professional Practice in Psychology (EPPP) with an 80%.

Best Oral Presentation 2001 Behavioral Sciences Conference of the North: GOOD BEHAVIOR IN THE CAFETERIA: TEACHER AND STAFF ATTITUDES AND PERCEPTIONS ON APPLYING THE GOOD BEHAVIOR GAME IN A SCHOOL CAFETERIA.

Master of Science Clinical Psychology, University of Alaska Anchorage, 2001.

Bachelor of Arts, Liberal Arts, The Evergreen State College, Olympia, Washington, 1981.

Languages Spoken

Russian – nearly fluent
Hebrew – rusty

Press Release Wording

Allen L. Levy, ! President of Generations A Family Place Inc. holds a Bachelor of Arts in Liberal Arts from the Evergreen State College and a Master of Science in Clinical Psychology from the University of Alaska Anchorage.

Submitted: 11/29/11 at 3:41 pm from 24.237.46.171

Muntean, Christian
Board of Psychologist &
Psychological Assoc Examiners

CHRISTIAN MUNTEAN

FUNCTIONAL SUMMARY

- Executive Director of Beyond Borders since 2004.
- Principle consultant, mediator & trainer.
- Develops and oversees programs, staff, trainers and mediator panel.
- Extensive international and cross-cultural experience within non-governmental & governmental organizations.
- Provides state-wide services to regional and tribal organizations, commercial, non-profit & faith-based organizations.
- Facilitates planning, community conversations and collaborations.
- Creative and resourceful community developer and problem solver.
- Effective at supporting clients to navigate challenging conversations.

Selected Clients: Institute of the North; Cook Inlet Tribal Council; Southcentral Foundation; Tanana Chiefs Conference; RurAL CAP; Nome Eskimo Community; Region X Head Start, , Amundsen Educational Center; Northern Adjusters Inc.; Leadership for Africa (Swaziland); Medair South Sudan (Switzerland/South Sudan); JUCUM Panama (Panama), Faith Christian Community/ Turang Nusa (Indonesia); Anchorage Youth Development Coalition; Covenant Youth of Alaska, Evangelical Covenant Church of Alaska

RELEVANT EXPERIENCE

- Facilitation consultant for organizations, dialogues and community conversations.
- Highly experienced in multi-cultural, multi-disciplinary environments.
- Successful mediator with 80%+ settlement rate.
- Facilitated strategic planning for numerous non-profit, business and faith-based organizations.
- Founded the Center for Conflict Resolution.
- Collaborated with faith community, non-profit and state government to build trust and create relationships for collaborative projects.
- Conducted field research and made recommendations regarding the sustainability and potential peace-building impact of medical programs in Southern Sudan.
- Coordinated with local and regional community leaders to rehabilitate a public utility work / economic rejuvenation project impacting 12 communities. (Kosovo)
- Founded two therapeutic preschools in coordination with refugee camp and minority population leaders. (Kosovo)
- Co-chair of the UNHCR Regional Mental Health Committee in Kosovo

- Responsible for the assessment of need, beneficiary selection and monitoring of reconstruction of homes for 15 communities in Kosovo.
- Oversaw the housing selection and reconstruction process and developed ethics policy as a member of the Municipal Housing Committee under Decan Municipality and the United Nations Mission in Kosovo.

EDUCATION

2005-2007 **Eastern University/World Vision & Habitat for Humanity – Pathways to Leadership** Africa Cohort
MA Organizational Leadership – Emphasis on NGO Management

1996-2000 **University of Alaska, Anchorage** Anchorage, Alaska
BA Sociology – Applied Emphasis on Communities and Change

1993-1995 **University of the Nations** Jerusalem, Israel; Tyler, Texas
Ministry Certificates

RELATED TRAINING/EXPERIENCE

M.J. Murdock Charitable Trust
The Mentoring Experience, 2008; Sr. Mentor, 2009, 2010

United States Institute of Peace
Conflict Analysis Course – Certificate 2008; *Interfaith Conflict Resolution* – Certificate 2009

Peacemaker Ministries
Personal Peacemaking, 2007; Fundamentals of Conflict Coaching & Mediation 2009; Mediation & Arbitration Certification Course 2009; Conflict Coaching & Mediation Instructor Course 2010

Gwen Kennedy & Associates
Facilitator's Study Group 2008-2009; Triple Impact Leadership 2010 (With Edith Seashore)

Institute for Life Coach Training
Foundational Coaching 2008-2009

Southcentral Foundation/Family Wellness Warriors Initiative:
Trained Trainer 2007

Critical Incident Stress Management: *Basic, Advanced, Peer, Child, Suicide, Mass Disaster, Pastoral* // International Critical Incident Stress Foundation 2002 – 2003

AFFILIATIONS/ MEMBERSHIPS

Alaska Bar Association: Alternative Dispute Resolution Section
Member (2009 – Current)

Alaska Native Professional Association
Member (2008-Current)

Alaskan Leadership Development Network
Member (2008-Current)

Commonwealth North
Member (2010 – Current)

Medair Association: Medair (Emergency Relief and Rehabilitation) Ecublens, Switzerland. www.medair.org (2003-2010)

Humanitarian Accountability Partnership International:
Reference Group Member Geneva, Switzerland
http://www.hapinternational.org/en/(2005-2006)

Municipal Housing Committee: Decan Municipality/United Nations Mission in Kosovo (2001)
Member

Peje / Decan Regional Mental Health Committee (convened by the United Nations High Commissioner for Refugees) (2001)
Co-Chair

Wieman, Joel
Board of Psychologist & Psychological Assoc. Examiners

Psychologist and Psychological Assoc. Examiners, Board of **Joel Barry Wieman**

General Information

Board/Commission and seat you are seeking:
Psychologist and Psychological Assoc. Examiners, Board of, Psychologist Seat

Additional Boards/Commissions of interest:
1) Fisheries, Board of
2) Game, Board of

State Boards/Commissions on which you have served

First	*Middlename*	*Last Name*
Joel	**Barry**	**Wieman**

Mailing Address	*City*	*State & ZIP*
	Anchorage	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
Self employed in Private Practice from 1985 to the present.

Prior to that I worked with the South Central Counseling Center from 1979 to 1985.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
I received my BA in Psychology from UAA in 1973, my MS in 1977 from the California School of Professional Psychology, and my Ph.D. from the same institution in 1979. I have done hundreds of hours of continuing education since that time, a minimum of 20 hours per year.

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
I am licensed as a Psychologist in Alaska. License number AA-227, 1983

List any community service, municipal government, and state positions held, and any awards received.
I served for six years on the Councel of Representatives of the American Psychological Association; Have been the Secretary of the Alaska Psychological Association and the President of the Alsaka Psychological Association.
I have most recently served on the Minicipal Health and Social Services Comission, stepping down this fall after six years. I was also CO-President of the Alaska Biathlon Association.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
I will mail my resume.

Press Release Wording

Dr. Joel Wieman, is Psychologist in private practice, holds {Ph.D. in Psychology from The California School of Professional Psychology.

Submitted: 11/23/11 at 4:36 pm from 66.58.128.224

Kerr, Marilyn
Board of Social Work Examiners

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Social Work Examiners
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Marilyn B. Kerr L.C.S.W.

Mailing Address: ____

Residence Address: _____

City, State and Zip Code: Anchorage AK 99507

Home or Message Telephone: _____ Business Telephone: ____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria: L.C.S.W - State of Alaska 1989 through present #AA00143

B. List both formal and informal education and training experiences: (Use additional paper if necessary). Resume attached

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Served as chair of National Girls/Womens Hockey Tournament (2000-2002); 1st in our state

Serve as liturgy committee member at Holy Cross Parish, Anchorage Ak.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

See attached chronological resume

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: SEX: FEMALE _____ MALE _____

ETHNICITY:
Alaska Native ____ American Indian ____ Asian or Pacific Islander ____ Black ____ Hispanic ____ White

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Marilyn K Kerr LCSW Date: 4/21/2011

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Marilyn B. Kerr L.C.S.W. Date: 4/21/2011

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
1	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Marilyn S. Kerr, (Age): ___ of (Hometown): ___
is (Job title/Place of employment): Providence Behavioral Medicine Grp
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): M.S.W.; B.B. LCSW # AA00143 (AK).
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

RESUME

Marilyn B. Kerr L.C.S.W.

Residence:

Education:

Master of Social Work 1972
University of Denver (CO)

Bachelor of Arts
College of St. Catherine (MN)

Licensure: LCSW, ALASKIA, 1989 through current
Professional Accreditation: ACSW – granted 1995 per NASW, current

Employment Experience:

1997-present: Mental Health Therapist - Providence Behavioral Medicine Group AK), 1997 – present; provide outpatient individual, family and group therapy services served as chair of Customer Service Committee 2004-2007.

1995-1997: Mental Health Therapist - Alaska Guidance and Diagnostic Clinic (AK), 1995-1997 – provided outpatient individual, family and group therapy services to adolescents; coordinated with Providence Discovery Adolescent inpatient services to provide family group programs.

1992-1995: Mental Health Therapist – Providence Discovery Adolescent Mental Health (AK) program; provided primarily outpatient services to adolescents and families; provided in/outpatient group services to adolescents and parents. Coordinated with Breakthrough chemical dependency program to provide services to adolescent children of adults in substance abuse program.

1987-1992 Employee Assistance Clinician - Human Affairs of Alaska, Inc. (AK); provided assessment and referral services; served as contract liaison to federal agencies; provided crisis services including CISD; developed programs for supervisors; managed return to work services for temporarily impaired employees.

1986-1990 Contract Social Worker - Medicaid certified facilities including Hope Cottages, Inc., (AK) and Cordova Community Hospital (AK); provided social work services to long term residents with focus on cultural and family inclusion; coordinated with medical staff and interdisciplinary teams.

1985 Contract Social Worker - Army National Guard (AK) stress management training (single event).

1982-1984 Social Worker – Home Health Care, Inc., (AK); contracted to begin social work component for Medicare/Medicaid certified agency. Provided direct services to home-based patients and families; coordinated with health care team to deal with terminal diagnoses, life-space crises, and utilization of resources and alternatives to institutionalization.

1980-1987 Assistant Adjunct Professor, School of Social Work, University of Alaska Anchorage: provided supervision to social work students; liaison to Anchorage Foster Parents Association.

1979-1981 Social Worker, Aleutian Pribilof Islands Association (AK). Developed social work program transitioning from BIA services; served nine villages, educated re: Indian Child Welfare Act, coordinated with state child welfare personnel; tTrained Community Health Aides re: family violence, community support, mental health and child welfare issues.

1978-1980 Clinician, Family Resource Center (AK); contracted to provide clinical services to individuals and families with focus on recovery issues related to alcohol and drug abuse.

1977-1978 Staff Supervisor, Mary Johnson House, Alaska Children's Services (AK). Provided staff supervision and direct services to adolescents in short term residential care.

1976-1977 Social Work Supervisor Ketchikan Children's Home, Ketchikan (AK). Supervised full-time staff of group home and shelter homes; coordinated with DFYS and State court system; direct services to children and families; served on State of Alaska residential care committee under Governor Jay Hammond.

1974-1976 Social Worker III, Division of Social Services, Ketchikan District (State of AK). Provided child protection services, day care licensing, foster care services, coordination with courts and local resources.

1973-1974 Supervisor, Specialized Services Unit, Children's Services Division, State of Oregon (Bend, OR). Supervised child protection unit, foster care licensing, responsible for Deschutes County CSD budget; participated in multiple impact assessment training, coordinating local agencies to focus and streamline child/teen placements.

1972-1973 Social Worker, Protective and Maternity Services, Denver Dept. of Welfare, (CO). Served problem pregnancy clients, liaison to adoption unit; provided life-space crisis intervention, foster placement, coordinated with University of Colorado Medical Center.

Additional field experience and personal or employer references available upon request

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 2, 2012

SUBJECT: Confirmation of Governor's Appointment(s)

Pursuant to AS 39.05.080, the President has referred the following name(s) for legislative confirmation to your committee for a hearing, recommendation and report:

Board of Marital and Family Therapy
Reverend John Downing – Eagle River
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

State Medical Board
Camille Carlson – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. Elizabeth Kohnen – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Miller – Juneau
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Powers – Dillingham
Appointed: 12/2/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Alaska Mental Health Trust Authority Board of Trustees
Larry Norene – Eagle River
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2017

Board of Certified Direct-Entry Midwives
Cheryl Corrick – Fairbanks
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Nursing
Rochelle Lehrer – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Denise Valentine – Anchorage
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Occupational Safety and Health Review Board
James Montgomery, Jr. – Kenai
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Timothy Sharp – Fairbanks
Appointed: 10/12/1995
Reappointed: 6/23/1999
Reappointed: 1/23/2006
Reappointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Examiners in Optometry
Dr. Forrest Messerschmidt – Juneau
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Pharmacy
John Cotter – Fairbanks
Appointed: 9/1/2011 Term Expires: 3/1/2013

Lori DeVito – Soldotna
Appointed: 3/1/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Christopher Kim – Anchorage
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Theodore Mala, Jr. – Anchorage
Appointed: 5/11/2011 Term Expires: 3/1/2015

State Physical Therapy and Occupational Therapy Board
David Carey – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Kathleen Lind – Anchorage
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

James Parietti – Chugiak
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Professional Counselors
Lillian Mitchell – Anchorage
Appointed: 8/8/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Psychologist and Psychological Associate Examiners
Al Levy – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Christian Muntean – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Joel Wieman – Anchorage
Appointed: 2/1/2012 Term Expires: 3/1/2016

Board of Social Work Examiners
Marilyn Kerr – Anchorage
Appointed: 6/13/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Resume(s) are available electronically by using the following link and your LAA user login: http://intranet/docs/confirmation_resumes/

Note that some resumes contain personal contact information for references. Please respect the personal nature of all contact information.

KW:jcs
gl #1

SENATE
CONFIRMATION COMMITTEE REPORT

Date: _____

In accordance with AS 39.05.080, the Health and Social Services Committee reviewed the following and recommends the appointment(s) be forwarded to a joint session for consideration:

Board of Marital and Family Therapy
Reverend John Downing – Eagle River
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

State Medical Board
Camille Carlson – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. Elizabeth Kohnen – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Miller – Juneau
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Powers – Dillingham
Appointed: 12/2/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Alaska Mental Health Trust Authority Board of Trustees
Larry Norene – Eagle River
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2017

Board of Certified Direct-Entry Midwives
Cheryl Corrick – Fairbanks
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Nursing
Rochelle Lehrer – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Denise Valentine – Anchorage
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Occupational Safety and Health Review Board
James Montgomery, Jr. – Kenai
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Timothy Sharp – Fairbanks
Appointed: 10/12/1995
Reappointed: 6/23/1999
Reappointed: 1/23/2006
Reappointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Examiners in Optometry
Dr. Forrest Messerschmidt – Juneau
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Pharmacy
John Cotter – Fairbanks
Appointed: 9/1/2011 Term Expires: 3/1/2013

Lori DeVito – Soldotna
Appointed: 3/1/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Christopher Kim – Anchorage
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Theodore Mala, Jr. – Anchorage
Appointed: 5/11/2011 Term Expires: 3/1/2015

State Physical Therapy and Occupational Therapy Board
David Carey – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Kathleen Lind – Anchorage
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

James Parietti – Chugiak
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Professional Counselors
Lillian Mitchell – Anchorage
Appointed: 8/8/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Psychologist and Psychological Associate Examiners
Al Levy – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Christian Muntean – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Joel Wieman – Anchorage
Appointed: 2/1/2012 Term Expires: 3/1/2016

Board of Social Work Examiners
Marilyn Kerr – Anchorage
Appointed: 6/13/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

This does not reflect an intent by any of the members to vote for or against the confirmation of the individual(s) during any further sessions.

Signature:	**Printed Last Name**
Chair:	

Please return to the Senate Secretary's Office (Room 211).

Celeste Hodge

From: Mary Pagenkopf
Sent: Wednesday, March 14, 2012 10:51 AM
To: Committee Aides
Subject: Committee Bill Files

This is a reminder that at the end of the Twenty-Seventh Legislature (April 2012) your committee bill files must be sent to the Legislative Reference Library.

Please ... make sure these files contain the original, or best copy, of all important information on each bill or subject considered by your committee during the two-year legislature, and include all committee documents you have put online. (Please read the section in the *House* or *Senate Guide for Committee Aides* concerning transfer of these files to the library.)

If you have any questions, please contact us.

Thank you,

Mary Pagenkopf, Librarian
Legislative Reference Library
State Capitol
Juneau, AK 99801
907 465-3808
907 465-4844 fax
legislative_library@legis.state.ak.us

North to the Future
Business & Professional Women Club
Celeste Graham-Hodge, President
P. O. Box 202803
Anchorage, AK 99520
Phone: 229-4228

February, 2012

"WOMAN OF THE YEAR"

Guidelines

The recipient:

- **Must be a paid North to the Future (NTTF) member.**
- **Provide a brief overview of club involvement, community service, education level, youth involvement, and career advancement.**
- **Summarize, in 100 words or less, why you think you or your nominee should be chosen as NTTF's Woman of the Year.**

The Selection committee:

- **Must be comprised of 3 paid members of NTTF**
- **The Selection Committee is appointed by the Women's History Committee.**

Some helpful hints:

For community service and career advancement, consider attaching copies of any certificates, letters and anything else you can think of that may help the selection committee.

Answer all areas on the application in full detail even if in list format. Show your education in your responses.

Indicate volunteer work for five years. The nominee still could be recognized for long-term services. Community service is still important whether done today or yesterday.

Consider nominating yourself! Remember the saying: "If it's to be, it's up to me!"

North to the Future BPW/AK
2012 WOMAN OF THE YEAR

Nomination Form

Name: _____

Street Address: _____

City / State / Zip Code: _____

Name of Employer: _____

Position / Title: _____

Contact Numbers: Home: _____ **Office:** _____ **E-mail:** _____

Education: **High School:** _____ **College:** _____

Degree Obtained: _____

Honors / Awards: _____

BPW Involvement: _____

_____

Community Involvement: _____

_____

Professional Organizations: _____

_____

North to the Future BPW/AK/USA Member: **/ / Yes** **/ / No** **/ / How many Years?**

Summary: 100 Words or less, why this nominee should be North to the Future Woman of the Year?
(Use a separate sheet of paper, if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

APPLICATIONS MUST BE RECEIVED ON OR BEFORE March 12, 2012

Return Application to: North to the Future/BPW, P. O. Box 202803, Anchorage, AK 99520
Attention: Hattie Gardner or call 694-6426/748-0542Cell or email: capri0186@aol.com for information

Alaska State Legislature

Senate

Office of the Secretary

Official Business

State Capitol, Room 211
Juneau, Alaska 99801-1182
Phone: (907) 465-3701
Fax: (907) 465-2832
Email:senate_secretary@legis.state.ak.us

Memorandum

TO: Senator Davis, Chair
Health and Social Services Committee

FROM: Kirsten Waid
Secretary of the Senate

DATE: February 2, 2012

SUBJECT: Confirmation of Governor's Appointment(s)

Pursuant to AS 39.05.080, the President has referred the following name(s) for legislative confirmation to your committee for a hearing, recommendation and report:

Board of Marital and Family Therapy
Reverend John Downing – Eagle River
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

State Medical Board
Camille Carlson – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. Elizabeth Kohnen – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Miller – Juneau
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Dr. David Powers – Dillingham
Appointed: 12/2/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Alaska Mental Health Trust Authority Board of Trustees
Larry Norene – Eagle River
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2017

Board of Certified Direct-Entry Midwives
Cheryl Corrick – Fairbanks
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Nursing
Rochelle Lehrer – Fairbanks
Appointed: 3/1/2012 Term Expires: 3/1/2016

Denise Valentine – Anchorage
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Occupational Safety and Health Review Board
James Montgomery, Jr. – Kenai
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Timothy Sharp – Fairbanks
Appointed: 10/12/1995
Reappointed: 6/23/1999
Reappointed: 1/23/2006
Reappointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Examiners in Optometry
Dr. Forrest Messerschmidt – Juneau
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Pharmacy
John Cotter – Fairbanks
Appointed: 9/1/2011 Term Expires: 3/1/2013

Lori DeVito – Soldotna
Appointed: 3/1/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Christopher Kim – Anchorage
Appointed: 3/1/2009
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Theodore Mala, Jr. – Anchorage
Appointed: 5/11/2011 Term Expires: 3/1/2015

State Physical Therapy and Occupational Therapy Board
David Carey – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Kathleen Lind – Anchorage
Appointed: 1/29/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

James Parietti – Chugiak
Appointed: 3/1/2012 Term Expires: 3/1/2016

Board of Professional Counselors
Lillian Mitchell – Anchorage
Appointed: 8/8/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Board of Psychologist and Psychological Associate Examiners
Al Levy – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Christian Muntean – Anchorage
Appointed: 3/1/2012 Term Expires: 3/1/2016

Joel Wieman – Anchorage
Appointed: 2/1/2012 Term Expires: 3/1/2016

Board of Social Work Examiners
Marilyn Kerr – Anchorage
Appointed: 6/13/2011
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Resume(s) are available electronically by using the following link and your LAA user login: http://intranet/docs/confirmation_resumes/

Note that some resumes contain personal contact information for references. Please respect the personal nature of all contact information.

KW:jcs
gl #1

Note that some resumes contain personal contact information for references. Please respect the personal nature of all contact information.

Board of Marital and Family Therapy
Reverend John Downing
18735 Monastery Drive
Eagle River, AK 99577
Cell: 622-0822
Appointed: 1/28/2008
Reappointed: 3/1/2012 Term Expires: 3/1/2016

Downing, John
Board of Marital & Family Therapy

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Marriage & Family, Public Seat
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
none

Name: The Very Rev. John W. Downing

Mailing Address: _____

Residence Address _____

City, State and Zip Code: Eagle River, AK 99577

Home or Message Telephone: _____ ss Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel reimbursement etc) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

See resume

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

See resume

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

See Resume

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

See Resume.

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: SEX: FEMALE _____ MALE ___ __

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White __ .

MILITARY SERVICE (if applicable, give dates): _____ _____ __

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): John W Downing _____ Date: 1/28/08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Fr. John W Downing Date: 1/28/08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fishermen's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
#1	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological Assoc
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

Fr. John Downing (Age).___of (Hometown): Eagle River
(Name):
is (Job title/Place of employment): ~~Assist Pastor~~ St John Orthodox Cathedral
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): Fr Downing holds a BA from U of Maryland & a Masters of Divinity from Church Divinity School of the Pacific, Berkeley CA.
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.
Fr. Downing's service at St. John Orthodox Cathedral, Eagle River and St Herman, Wasilla

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Resume

The Very Rev. John W. Downing. M.Div., MFT

Eagle River, Alaska 99577

APPLICATION: FOR THE PUBLIC SEAT ON THE STATE BOARD OF MARRIAGE AND FAMILY THERAPIST

EDUCATION: Graduated University of Maryland, Bachelor of Arts degree, 1955.

Attended Virginia Theological Seminary, Alexandria, Virginia, 1955-1956.

Graduated Church Divinity School of the Pacific (Episcopal); Masters of Divinity degree, Berkeley, California. 1956-1958

Leadership Skills Training, sponsored by the National Episcopal Training Institute, 1963 –1968.

Certified Reality Therapist, Los Angeles, CA 1979-81.

TEACHING EXPERIENCE: Life Credentialed Adult Education instructor, Santa Barbara, CA Adult School; (part-time); courses on Interpersonal Communication, Couples Communication, Self-Awareness, Communication Skills, Children of Divorce, 1968 – 1975.

University of California, Santa Barbara Campus Extension Program Courses taught: Theories of Communication Counseling, Human Sexuality, Communication in the Family and Marriage, Interpersonal Communication, Self-Awareness, Marriage for '70's, Crisis in Religion, Children of Divorce and Survival of the Family. 1970 –74.

Learning Tree University (adult school) Chatsworth, California. Taught classes on Communication Skills, Creative Communication, Interpersonal Relationships. Couples Communication and Self-Awareness (part-time), 1988 – 1993.

Seminars and workshops at least monthly with patients in private practice, 1970 –83.

Antiochian Christian Orthodox Church, Southern California Deanery Committee on Marriage and Family, chair and lecturer, weekend seminars. Topics taught: Orthodox understanding of marriage, Enhancing Marital Relationships, Communication in Marriage, Marital Relationship Skills, 1998–2003. (approximately 30 presentations.)

Assistant Pastor St. John Orthodox Cathedral, Eagle River, 2003 to present pastoral counseling specialist.

CONSELING-THERAPY EXPERIENCE: California Licensed Marriage, Family and Child Therapist ע"פ 2706.

In private practice 1968 to 2003..

Total Counseling experience 40 years.

Staff therapist Family Service Agency of the Monterey Peninsula 1983-85.

Director and therapist of Family Service Agency of Burbank, California 1995-2000.

PASTORAL EXPERIENCE: Converted to Orthodoxy 1991. Ordained to the sacred priesthood December 5, 1993. Attached to St. Michael Orthodox Church (Western Rite) Whittier, CA 1991.- 2003. Assistant pastor St. John Orthodox Cathedral, Eagle River, Alaska, 2003 to present.

As Episcopal priest: ordained 1958, served parishes in Nevada, Northern California, Washington, D.C., Central California, Wisconsin, and Los Angeles, CA.

Dean, Semper Virens Deanery, Humbolt and Del Norte Counties, Northern California, 1965 –68.

Canon Missioner and Dean, Diocese of Milwaukee and Cadle Deanery, 1985 -- 88.

PERSONAL: Born Baltimore MD Married 30 years to Kh. Nancy Lee Downing (d. 10/19/02) Five grown children.

Carlson, Camille
State Medical Board

Bar, Board of Governors of the Alaska — **Cam Olson Carlson**

General Information

Board/Commission and seat you are seeking:
Bar, Board of Governors of the Alaska, Public Seat

Additional Boards/Commissions of interest:
1) Judicial Conduct, Commission on
2) Judicial Council, Alaska

State Boards/Commissions on which you have served
Board of Psychologists and Psychological Associates Examiners

First	*Middlename*	*Last Name*
Cam	**Olson**	**Carlson**
Mailing Address	*City*	*State & ZIP*
	Fairbanks	**AK 99708**
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?*	
	Yes	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
-Legal liaison (paralegal) for St. Paul Church during extensive court action (Bd. of Trustees, AK Missionary Conference of the United Methodist Church vs St. Paul United Methodist Church et al), Superior Court and Alaska Supreme Court; conducted legal document search, prepared materials for distribution, maintained contact with 6 attorneys in Fairbanks, Anchorage and Fresno,CA; unpaid voluntary; 2002-2006.
-Coordinated and did actual construction on St. Paul United Methodist Church (unpaid, voluntary).
-Coordinated and did some labor on building of St. Paul Church's new building (unpaid, voluntary).
-Volunteer office manager for state-wide election campaigns- Tom Fink, Governor (twice), David

Cuddy, U.S. Senate (twice), Sean Parnell, Governor;(all unpaid).
-Election Board precinct chair for Fairbanks North Star Borough and State of Alaska; 25+ years (paid).
-More available if needed.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
-B.S. Degree, Education - University of Wisconsin - Madison
-12 credits in Criminal Justice - University of Alaska - Fairbanks
-Paralegal Certification from Denver Paralegal Institute
-Pro-bono paralegal work in St. Paul Church court case

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Paralegal Certification - Denver Paralegal Institute 1990-1991

List any community service, municipal government, and state positions held, and any awards received.
-Alaska Board of Psychologists and Psychological Associates Examiners: Public Member, 2005 to present.
-Ice Alaska: Visa assistance; marketing.
-Alaska International Senior Games: Board member ? 3 ? years.
-St. Paul Church, Fairbanks: Co-Founder; lay-leader; church council chair and secretary; chair - construction committee for building of two churches (hands on for first one!);legal liaison for court case with United Methodists; Sunday School teacher; etc; 27 years.
-Fairbanks North Star Borough School Board: Member (elected position), 1975-1978
-University of Alaska Cooperative Extension Service Statewide Advisory Council: Member.
-4-H: Local club leader, organized 15-20 project leaders, 25-30 youth members; numerous awards; 10+ years.
-UAF Women's Association: community service activities; initiated and chaired community wide Recycle Sale, 10 years; revised bylaws; 40+ years.
-Alaska Republican Party: Republican of the Year - 1998, Interior Republicans; delegate to district, state and national conventions; District Chair, District 29/7 2000-2002; State Central Committee 2000-2010; 30+ years
-Alaska Crippled Children and Adults (ACCA) Board: Board President and Secretary; organized 1st March of Dimes Telethon in Fairbanks; revised bylaws; 10 years.
-Youth Basketball Board: Secretary; revised bylaws; 1 year.
-USA Track and Field: Association level certified track and field official; official at numerous district and state track events; organized 1988 state track and field meet; also officiated at cross country and x-c ski meets; 20+ years.
-Fairbanks United Way allocation board; 1 year.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this

application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

Cam Carlson, of Fairbanks, is retired and holds a B.S. degree from the University of Wisconsin-Madison and Paralegal Certification from Denver Paralegal Institute.

Submitted: 12/15/10 at 12:37 pm from 65.74.119.44

Medical Board, State — **Elizabeth Ann Kohnen**

General Information

Board/Commission and seat you are seeking:
Medical Board, State, physician member

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
none

First	*Middlename*	*Last Name*
Elizabeth	**Ann**	**Kohnen**
Mailing Address	*City* **Fairbanks**	*State & ZIP*
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?* **Yes**	

Date of Birth

Gender

Military Service

Ethnicity

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
David S. Grauman, MD, PC - paid, 1993-present
physician unpaid volunteer Breast Cancer Detection Center in past - 1 year (weekly visits)
physician unpaid volunteer Red Cross in Cambodia - 1993 or 94 - 2 months

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
BA - Colgate University 1980
MD - University of Pennsylvania 1987
Internship and Residency, Strong Memorial Hospital, Rochester NY 1987-1990
MPH - Medical College of Wisconsin
Private primary care Internal Medicine practice in Fairbanks 1992 - present

obtained that may be used as qualifying criteria:
State of Alaska Physician License #2889
DEA # BK3209233
Board Certified in Internal Medicine
Fellow of the American College of Physicians

List any community service, municipal government, and state positions held. and any awards received.
Commisioned Corps of Public Health Service - Physician, acting 04, Bethel AK 1990-1992
Phi Beta Kappa 1980
High Honors in Religion 1980, Colgate University

Fellow of the American College of Physicians
Community Advisory Board for KUAC (public radio)
Previous physician volunteer Breast Cancer Detection Center

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

{Your Name}, {age} of {hometown}, is {job title/place of employment} holds {education level, school, or relevant experiences}.
Elizabeth Kohnen, MD, MPH has been in private primary care internal medicine practice in Fairbanks since 1992 .

Submitted: 01/10/12 at 12:45 pm from 66.230.107.60

Miller, David
State Medical Board

CURRICULUM VITAE

DAVID A. MILLER, MD, FACS

OFFICE ADDRESS: Alaska Minimally Invasive Surgery Center

Juneau, AK 99801

PERSONAL:

EDUCATION:	Leavenworth High School Leavenworth, Kansas	1981
	B.S. Chemistry University of Kansas Lawrence, KS	1985
	M.D. Allopathic Medicine University of Kansas School of Medicine Kansas City, KS	1989
POST-GRADUATE	Internship – General Surgery Keesler Medical Center Keesler AFB Biloxi, MS	1989-1990
	Residency – General Surgery Keesler Medical Center Keesler AFB Bilox, MS	1990-1994
BOARD QUALIFICATIONS:	Board Certified and Diplomate of The American Board of Surgery	1995-present
LICENSURE:	State of Alaska #4283	Exp. 12/31/08
PROFESSIONAL AFFILIATIONS:	American College of Surgeons Society of Laparoendoscopic Surgeons Society of Air Force Clinical Surgeons 38th Parallel Medical Society	1996-present 2000-present 1994-2001 1994-2001
PUBLICATIONS:	H-Type Tracheoesophageal Fistula Repair, 41st Annual Symposium, Society of Air Force Clinical Surgeons, San Antonio, TX	1994

TEACHING APPOINTMENTS:	Instructor, Advanced Laparoscopic Workshop 38th Parallel Medical Society Seoul, Korea	1994
	Instructor, Advanced Laparoscopic Procedures National Hospital Columbo, Sri Lanka	1999
MILITARY SERVICE:	Air Force ROTC Scholarship University of Kansas, Lawrence, KS	1981
	Air Force Health Profession Scholarship University of Kansas, Kansas City, KS	1985
	Surgical Resident Keesler AFB, Biloxi, MS	1989-1994
	General Surgeon 51st Medical Group, Osan, Korea	1994-1995
	General Surgeon 3rd Medical Group, Elmendorf AFB Anchorage, AK	1995-2001
HONORS AND AWARDS:	Eagle Scout	1976
	National Honor Society	1980
	Kansas Honor Student	1981
	Vocal Scholarship, University of Kansas	1981
	Tuba Scholarship, University of Kansas	1981
	Air Force ROTC/Health Profession Scholarship	1981-1989
	Dean's Honor Roll	1981
	Sons of the American Revolution Award	1982
	Vice Commandant's Award	1983
	General Dynamics Award	1984
	Honors Research in Chemistry	1985
COMMUNITY SERVICE:	Assistant Scout Master, Boy Scouts of America	1981-1988
	Surgical Orderly, Cushing Memorial Hospital Leavenworth, KS	1980-1983
	Host Family Special Olympics World Winter Games	2001

PERFORMING ARTS:

Bass Soloist with Symphony Orchestra and Chorus:	Leavenworth, KS	1981-1987
	Lawrence, KS	1981-1985
	Biloxi, MS	1989-1994
	Anchorage, AK	1996-2000
	Juneau, AK	2008
Operatic Roles:	Figaro, *The Barber of Seville*	2005
	Leporello, *Don Giovanni*	2006
	Papageno, *The Magic Flute*	2007
	Gaston, *Beauty and the Beast*	2007
	Scarpia and Angelotti, *Tosca*	2007
	Morales, *Carmen*	2008
	Talpa, *Il Tabarro*	2008
	Simone, *Gianni Schicchi*	2008

147392

Powers, David
State Medical Board

JUN 0 6 2008

Office of the Governor
Anchorage

OFFICE OF THE GOVERNOR
FAIRBANKS
JUN 16 2008

Honorable Sarah Palin
Governor, State of Alaska
550 W. 7th Ave Ste. 1700
Anchorage, Alaska 99501

Governor Palin,

Recently Frank Bailey contacted me regarding the possibility of serving on the Alaska State Medical Board, and I am writing to let you know that if appointed, I will gladly accept the position.

I came to Alaska in 1984 as a Commissioned Officer in the United States Indian Health Service. Since then, I have practiced in various sites throughout the State, including Anchorage, Juneau, Nome, Barrow, St Paul Island, and for the past 15 years in Dillingham.

Long distance medicine is part of our daily routine, as we work with Community Health Aides and Mid-Level practitioners in approximately 30 outlying villages.

If appointed, I will endeavor to contribute from this rural prospective while working with other members of the Board on pertinent issues.

Thank you for your consideration,
Sincerely,

D Powers MD

David J. Powers, M.D.
Bristol Bay Area Health Corporation

Dillingham, Alaska 99576

CURRICULUM VITAE

DAVID J. POWERS, M.D.

DILLINGHAM, AK 99576

EDUCATION:

College:	1974-1978, Northwest Nazarene College, Nampa, Idaho
Degree:	BA Biology, Minor in Chemistry
Honors:	Freshman Chemistry Student Award Senior Biology Student Award Salutatorian of 1978 graduating class Received academic scholarship Sophomore, Junior, Senior years
Medical School:	1979-1983, Oral Roberts University School of Medicine
Degree:	M.D.
Honors:	Graduated upper 1/3 of 1983 graduating class
PGY I :	July 1983 – July 1984, Family Practice Internship at A.H. Gould, Family Practice Residency Program, University of Colorado Affiliated, Grand Junction, Colorado
PCY II & III:	July 1987 – July 1989, Family Practice Residency of Idaho, Boise, Idaho
Certification:	Board Certified, American Board of Family Practice 2003-2010

OCCUPATIONAL EXPERIENCE:

1994- Present	Kanakanak Hospital, P.O. Box 130 Dillingham, AK 99576, Staff Physician. Currently Clinical Director
1992 – 1994	Emergency Room Physician, Boise, Idaho
1990 – 1992	Kanakanak Hospital, P.O. Box 130, Dillingham, AK 99576, Staff Physician.
1989 – 1990	Locum Tenens and Emergency Room work
1987 – 1989	Completed Residency Training, Family Practice Residency of Idaho, Inc., Boise, ID
1986 – 1987	Indian Health Service, Juneau, AK, General Practice
1984 – 1986	Alaska Native Medical Center, Anchorage, AK, General Medical Officer, Orthopaedics

Norene, Larry
Alaska Mental Health Trust
Authority Board of Trustees

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Mental Health Trust Authority
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Larry G. Norene

Mailing Address:

Residence Address:

City, State and Zip Code:

Home or Message Telephone: Business Telephone:

Fax Number: Cell Phone:

Email address:

AS 39.05.100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO Voter Registration Number (Optional)

Social Security Number (Optional, required if appointed for travel, reimbursement etc.):

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES NO ✓ If "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

License #2178 State of Alaska R.E. Broker

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

Bachelor of Economics, U. of Oregon, 1964
Numerous MAI appraisal courses
Numerous CCIM investment courses

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

Three time Pres. Alaska MLS
Anchorage Platting Board, 4 yrs, Pres.
Anchorage Board of Equalization, 5 yrs, Pres. 3 yrs
various mayoral task forces.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

Anchorage Assessing office 1964-1970 - Supervisor
Commercial & Land appraisal, Wakeland & Nomone - 1970-1978
Broker, Norene Realty, 1970 - Present
Developed subdivisions, Anch. & Mat-Su 1975-1985

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employers or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): [signature] Date: 11/12/07

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Larry Norene Date: 11/12/07

(Indicate top three boards/commissions of interest by number with #1 as your preference)

- Accounting Board
- Aerospace Development Corporation
- Aging Commission
- Agriculture & Conservation
- Alaska Juvenile Justice Advisory Committee
- Alaska Retirement Management Board
- Alaska Statehood Celebration Commission
- Alaska-Alberta Bilateral Council
- Alcohol/Drug Abuse
- Alcoholic Beverage Control
- Architectural Registration Board
- Arts Council
- 3 Assessment Review Board
- Aviation Advisory Board
- Bald Eagle Preserve
- Bar Association
- Barbers & Hairdressers
- Battered Women's Advisory Board
- Bicentennial Commission Services
- Building Safety Council
- Broadcasting Commission
- Childcare Facility Board
- Chiropractic Examiners
- Coastal Policy Advisory Committee
- Commercial Fisheries Entry
- Commercial Fisheries Agriculture Bank
- Commercial Fisheries Commission
- Commercial Fisheries Advisory Committee
- Dental Examiners
- Developmental Education
- Domestic Violence/Sexual Assault
- Education/Early Development
- Education Commission of the States
- Emergency Medical Services
- Emergency Response Commission
- Employment of People with Disabilities
- Enoch Valley Municipal Trustee
- Faith-Based & Community Initiatives Council
- Fire Standards Council
- Fisheries

- Fishermen's Fund Advisory & Appeals
- Forestry
- Game
- Health Council
- Historical Commission
- Historical Records Advisory
- Homeless Council
- Housing Finance Corporation
- Human Rights
- Immigration Forum
- Independent Living Council
- Industrial Development Export Authority
- Interstate Compact
- Judicial Conduct
- Judicial Council
- Knik Arm Bridge
- Labor Relations Agency
- Land Use Advisory
- Law Revision Commission
- Marine Pilots
- Marine Transportation Advisory Board
- Marriage & Family Therapy
- Medical Board
- Mental Health Board
- Mental Health Trust Authority
- Motor Vehicles
- Museums Commission
- Municipal Bond Bank
- Natural Gas Authority
- Natural Resource Corporation
- Oil Spill Regional Advisory Council
- Pacific Northern Fish
- Pacific Northern Fisheries Management Council
- Parks Trust Historical Fund
- Planning
- Professional Teaching Practices
- Psychologist/Psychological Associate
- Public Offices Commission
- Public Safety Commission
- Optometry
- Pacific Marine Fisheries Commission
- Pacific Salmon Commission-Commissioners
- Pacific Salmon Commission-Transboundary Panel

- Parole Board
- Permanent Fund
- Pharmacy Board
- Physical & Occupational Therapy
- Pioneers Home Advisory
- Police Standards Council
- Postsecondary Education
- Professional Counselors
- Professional Teaching Practices
- Psychologist/Psychological Associate
- Public Offices Commission
- PWSRCAC Oil Spill Recovery Institute
- Railroad Corporation
- Real Estate Appraisers
- Real Estate Commission
- Regents
- Regulatory Commission (RCA)
- Renewable & Gas Development
- Reserve Advisory Council
- Seafood Marketing Institute
- Seismic Hazards Safety Commission
- Social Work Examiners
- Southeast Conference
- Southeast Regional Commissions
- Spruce Beetle Council
- Telecommunications
- Uniform State Laws
- Veterans Advisory Council
- Veterinary Examiners
- Violent Crimes Compensation
- Water and Wastewater Works
- Western Interstate Energy Higher Educ
- Wild & Scenic Rivers Park
- Workers' Compensation
- Workers' Compensation Appeals Commission
- Workforce Investment Board
- Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Larry Narone (Age):
is (Job title/Place of employment): Broker, Narone Realty
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): Bachelors - economics
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

[redacted]

Schneider, Deborah
Bd of Certified Direct Entry Midwives

Deborah Schneider
[redacted]
Wasilla, Alaksa 99687
[redacted]

Employment:

2005-present	**Owner of Windsong Midwifery, LLC and the Birth Place** **Provide complete antenatal care to low risk women in an out of hospital setting. (Birth Center and Home)**
1990-2010	**Anchorage Fire Department - Muni. of Anchorage** **Mobile Intensive Care Paramedic/FireFighter-III** **Provide advanced emergency medical care in the Municipality of Anchorage, population approx. 350,000.**
2001-2004	**Mat-Su Midwifery, Inc** **Contract Certified Direct Entry Midwife.** **Provided prenatal care, labor and delivery services to low risk women.**
1986-1990	**Co-owner MedTech International** **Provided Emergency Medical training throughout the State of Alaska, both basic and advanced life support. State of Alaska certified EMT-I, II, and III instructor. State of Alaska EMT Certifying officer.**
1989	**Assistant Medical Coordinator for VECO during the Exxon oil spill**
1985-1990	**Chugiak Volunteer Fire Department** **EMT-III provider for volunteer fire department** **Provided training for EMT I, II, and III to members**
1985-1986	**Arctic Medical Transports** **Mobile Intensive Care Paramedic** **Ground ambulance transport attendant**

[redacted]

Professional Associations:

1985-present Member, Midwife Association of Alaska
2005-present Midwife Association of Alaska - continuing education committee member
2006-present Midwife Association of Alaska - Peer Review member

References:

Pam Weaver, CDM
[redacted]

Steve Alexander, MICP
[redacted]

Michael Levy, MD
Alaska Regional Hospital, Emergency Room
[redacted]

Corrick, Cheryl
Certified Direct-Entry Midwives

OFFICE OF THE GOVERNOR
MAILROOM

JAN 11 2008

Cheryl Corrick

January 8, 2008

State of Alaska
Office of Governor Sarah Palin
Attention: Frank Bailey, Director of Boards & Commissions
P.O. Box 110001
Juneau, AK 99811-0001

January 8, 2008

Dear Governor Palin,

I am a Certified Direct-entry Midwife (CDM) in the State of Alaska. I am also a Certified Professional Midwife (CPM), which is a national certification. I have resided in Fairbanks for the past 35 years. I received my midwifery certification in April 1996 and have been privileged to attend the births of over 600 Alaskan babies. I have served on the Midwives Association of Alaska's peer review committee for the past 8 years. I understand that I have been recommended for a position on the State of Alaska's Board of Certified Direct-entry Midwives. If I am offered this appointment I will gladly accept this position and serve with integrity and reliability. Thank you for your consideration.

Sincerely,

Cheryl Corrick, CDM, CPM

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Certified Direct-entry Midwives
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Cheryl Cornick

Mailing Address: _____

Residence Address: Fairbanks, AK 99709

City, State and Zip Code: Fairbanks, AK 99701

Home or Message Telephone: _____ Business Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria: Certified Direct-entry Midwife, 4-22-96
Certified Professional Midwife (National Assoc. of Registered Midwives) 1998

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
1992-1996 Via Vita Health Project, Inc. Midwifery Education Program and apprenticeship

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced. N/A

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).
Via Vita Health Project Inc. dba Alaska Family Health + Birth Center

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: _____ SEX: FEMALE ___ _____ MALE _____

ETHNICITY:
Alaska Native ____ American Indian ____ Asian or Pacific Islander ____ Black ____ Hispanic ____ White ____

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Cheryl Cornish Date: 1-8-08

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Cheryl Connick Date: 1-8-08

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
1	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Cheryl Correct, (Age): ___ of (Hometown): Fairbanks
is (Job title/Place of employment): Director of Administration of Alaska Family Health + Birth Cente
(Name) holds (Listing of earned degrees like bachelor's, master's,
ect.): Certified Direct-entry Midwife and Certified Professional Midwife certificate
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

Nursing, Board of — **Rochelle Ann Lehrer**

General Information

Board/Commission and seat you are seeking:
Nursing, Board of, LPN

Additional Boards/Commissions of interest:
1) Nursing, Board of

State Boards/Commissions on which you have served
none

First	*Middlename*	*Last Name*
Rochelle	**Ann**	**Lehrer**

Mailing Address	*City*	*State & ZIP*
	Fairbanks	**AK 99712**

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
Denali Center, January, 1999-Present Licensed Practical Nurse, 2004 to Present Denali Center Education Council Member, 2008 to Present Certified Nursing Assistant, State of Alaska

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
University of Alaska Anchorage, Anchorage, Alaska Undergraduate, Practical Nursing, and Current Nursing Program Excelsior College, New York, New York Current Nursing Classes

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Certified Nursing Assistant, 1999 to 2004 Certified Eden Associate Certified in Wound Vac Care

CPR, American Health Association, 2009 Licensed Practical Nurse, State of Alaska, 2004 to Present

List any community service, municipal government, and state positions held, and any awards received.
PTA Member, Joy Elementary, since 2003 Relay For Life, since 2003 Hospice of the Tanana Valley Plant Sale Fundraiser, since 2003

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
Rochelle Lehrer
773 Foxtail Drive, Fairbanks, AK 99712, 907-455-0201, rochelle.lehrer@bannerhealth.com
Summary of Skills
 Wide knowledge of wound care.
 Broad experience and education in bariatric care.
 Solid knowledge and experience in geriatrics and dementia care.
 Extensive experience in diabetes management and education.
Education
University of Alaska Anchorage, Anchorage, Alaska
Undergraduate, Practical Nursing, and Current Nursing Program
Excelsior College, New York, New York
Current Nursing Classes
Professional Experience
Denali Center, January, 1999 - Present
 Licensed Practical Nurse, 2004 to Present.
 Denali Center Education Council Member, 2008 to Present
 Certified Nursing Assistant, 1999 to 2004
Licenses and Certifications
 Licensed Practice Nurse, State of Alaska, 2004 to Present
 CPR, American Heart Association, 2009
 Certified in Advanced Wound Care
 Certified Eden Associate
 Certified Nursing Assistant, State of Alaska, 1999 to 2004
Professional Associations
 Licensed Practice Nurse, State of Alaska, 2004 to Present
 CPR, American Heart Association, 2009
 Certified Nursing Assistant, State of Alaska, 1999 to 2004

Community Involvement

 Hospice of Tanana Valley, since 2003
 Relay for Life, since 2002
 PTA Member , Joy Elementary, since 2009

Press Release Wording

{Rochelle Ann Lehrer}, of {Fairbanks}, is {an LPN at Fairbanks Memorial Hospital/ Denali Center} holds {LPN State of Alaska and currently taking prerequsite classes toward her RN}.

Submitted: 01/20/11 at 4:03 pm from 206.174.59.85

Valentine, Denise
Board of Nursing

OFFICE OF THE GO
MAILROOM
OCT 17 2011

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: RN - nursing
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:
RN - Board of Nursing

Name: Denise Valentine

Mailing Address: _____

Residence Address: _____

City, State and Zip Code: Anchorage, AK 99507

Home or Message Telephone: _____ Business Telephone: _____

Fax Number: _____ Cell Phone: _____

Email address: _____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES ✓ NO _____ Voter Registration Number (Optional): _____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.) _____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES _____ NO ✓ if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES ✓ NO _____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES _____ NO ✓

If "YES", explain:

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Rose Valentine Date: 10/14/11

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers/ Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
✓	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

Denise Valentine, MSN, FNP

Education	**1984**	Bachelor's of Science, Nursing. University of Northern Colorado.
	2005	Master's of Science, Nursing Science. Option: Family Nurse Practitioner tract, University of Alaska, Anchorage. Course work included nursing research, biostatistics, nursing theory, curriculum development, teaching and learning in nursing, and clinical hours spent in urban and rural health care settings. Completed a quantitative thesis on a women's health issue. Family Nurse Practitioner certification obtained in June 2005 through American Academy of Nurse Practitioners.
Professional Credentials And Memberships		Current licensure as an RN and ANP in Alaska DEA number assigned. Member, American Academy of Nurse Practitioners. Member 2008 through present, Alaska Board of Nursing Secretary for the Alaska Board of Nursing January 2009 - January 2011. Vice Chair for the Alaska Board of Nursing January 2011 through present.
Volunteer:	**2007 to 2008**	Congregational Care Ministry at Changepoint Church,
	2009 and 2011	Precepted two students in the Family Nurse Practitioner Program at the University of Alaska, Anchorage.
	June 2011-Present	Brother Francis Caring Clinic - Providing medical care to the homeless 2-3 hours/month.
Professional Employment	**1984-85**	LDS hospital (500-600 beds), Salt Lake City, Utah. Full time employment. Nurse on the orthopedic wing.

1. Community home health agency, Salt Lake City, Utah.
   Responsibilities included home health nursing care throughout Salt Lake County.

2. Salt Lake County Health Department, Salt Lake City, Utah.
   Full time employment. Administered immunizations, WIC education and certification. Managed a county health care clinic staffed by a family nurse practitioner and registered nurse.

1. Primary Children's Hospital, Salt Lake City, Utah.
   Part time employment. Discharge Planner for the rehabilitation team. Set up rehabilitation therapies for patient home care, arranged for proper durable medical equipment and managed the pediatric arthritis clinic.

1. Raised my three children in rural Alaska.

2000 to Oct 2005 Reinstated RN License in Alaska. Whitestone Training Center, Delta Junction, Alaska. General school nursing for a private Christian school in a remote rural enviornment. Provide general nursing and immunizations and documenting student's status.

Whitestone Care Services, Delta Junction, Alaska. Co-owner. Manage respite care and care coordination services. Provide nursing care and evaluation in the community of Whitestone, AK.

Covenant Life College Whitestone, AK. Taught general health and nursing courses. Physiology and Health sciences. Taught medical terminology and Certified Nursing Assistant classes.

2002 to June 2005 Family Medical Center, Delta Junction, Alaska. Part time employment. A rural family practice clinic serving 6,000 residents. Office RN. Responsibilities included obtaining vital signs, managing patient flow, assisting DO and PA-C's with patient care and treatment as needed.

July 2005 To Oct 2005 Family Medical Center, Delta Junction, Alaska Family Nurse Practitioner. Part time employment. Take medical histories and perform physical examinations. Order and interpret laboratory tests and x-rays. Diagnose, treat, and monitor acute and chronic illnesses. Prescribe medications and other treatments. Provide patient and

	family education. Provide appropriate referral to other health care providers.
2003 to Oct 2005	Whitestone Community Association, Whitestone, Alaska. Vice-President, Community Health. Volunteer work providing nursing evaluation and patient care to 180 residents. Responsible for providing strategic planning and long-term health care assessment and analysis for the association in preparing for health care funding.
Nov 2005 To Aug 2006	Family Nurse Practitioner at Dayspring Medical Center Pain Management Clinic, Mocksville, NC. Part time employment. Evaluate effectiveness of treatment of patients receiving care for chronic pain and multiple sclerosis. Duties include administering IV medications, writing prescriptions, assessments, education.
Oct 2006 to Present	Anchorage Medical and Surgical Clinic. Full time employment. Provide medical care for adults ages 16-90+. Evaluate, diagnose and treat long term illnesses such as diabetes, heart diseases. Other responsibilities include managing Coumadin levels, ordering and interpreting x-rays and laboratory tests. Clinic uses electronic medical records for documentation.

Montgomery, James
Occupational Safety & Health Review Bd

Occupational Safety and Health Review Board — **James Everett Montgomery**

General Information

Board/Commission and seat you are seeking:
Occupational Safety and Health Review Board, Industry Seat

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
Occupational Safety and Health Review Board

First	*Middlename*	*Last Name*
James	**Everett**	**Montgomery**

Mailing Address	*City*	*State & ZIP*
	Kenai	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
1973-75 US Army Viet Nam Era Veteran.
1977-86 US Oil and Refining Co.
1986-Present BP Ltd (Operations,Health Safety,Environmental and Safety, Operations and Risk Auditor)

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
34 years in the Oil, Gas and Refining industry.
Process Safety Management training.
PSM auditor
AD Little Auditor,
HAZOP tarining.

obtained that may be used as qualifying criteria:
Occupational Health Safety Technologist-(Board of Certified Safety Professionals)
Incident Safety Officer- National Fire Academy
Fire Dept. Safety Officer (FDSOA)

List any community service, municipal government, and state positions held, and any awards received.
Executive Board of Boys and Girls Club of the Kenai Pennisula.
First Lady's Volunteer award Mrs. Murkowski
Phi Beta Kappa non-educator volunteer award Kenaio Pennisula.
High School Football Coach -22 years both Varsity and Junior Varsity Levels
High School Soccer Coach – Women's JV Coach
Community Liaison Member- BP External Affairs

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
James E. Montgomery Jr.
Safety and Operations Auditor
BP International

OBJECTIVE

Throughout my career, I have received extensive knowledge and training in production and safety, first as a Control Room Operator and Supervisor at US Oil & Refining Company, Control Room/Facility Operator(Operations Dept) BP Alaska and then in the HSE dept, as a HSE Advisor. I'm presently in an International Safety and Operations Audit Group working for the BP Board of Directors, which has expanded my ability, knowledge for personal growth and contribute to the success and performance of the B P as a company.

PROFESSIONAL SKILLS

April 2010-Present Site Safety Lead MC 252 Response Jefferson Branch.
Assigned to Venice originally then Grand Isle on 5/5, responsibilities initially included oversight of Cocodrie and Pt. Fourchon. When Grand Isle work team went to 3000 plus employees, Cocodrie and Pt. Fourchon were assigned to the new developed Regional Safety Manager. HSE team consisted of Safety, Medical, Coast Guard, National Guard and the Jefferson Parish Sheriffs Dept. 200 plus employees at its peak.
- **Site safety plans.**
- **Emergency response plans**

• Hazcom (developed a GI site plan)
• Developed a Safe Practice manual for New Orleans to review.
• Developed training for site, RTV, Supervisor training on Hazard recognition.
• Managed staffing at GI to meet the operation needs and was consistently lower ratio of Safety staff to workers than other sites.

2006-April 2010 S&O Auditor
Assigned tasks included auditing of gHSEr, OMS and PSM standards. Individual areas of auditing were HSE, Operations, Leadership, Emergency Response, Incident Investigation, Assurance, Maintenance and Security.

• International Program auditing
• Detailed deficiency reports
• Mitigating actions to address deficiencies
• International travel with different teams, Singapore, China, Trinidad, Egypt, Great Britain
• US based sites, Gulf of Mexico, Durango Colorado, Whiting Refinery (Indiana), East Coast Pipelines, NAG, Mid-Con Greater Prudhoe Bay and Alaska Consolidated Team (Endicott, Milne Point and North Star)
HSE Safety Advisor, Greater Prudhoe Bay Business Unit

Previous Duties GPB Facilities group included:
• Assist all facility and field personnel to ensure adequate safety, health and loss prevention measures are being followed.
• Assist all facility and field personnel in identifying and mitigating hazards and risks. Assist in the development and application of standards, policies and procedures.
• Conduct formal and informal audits, investigations and inspections of facilities and work in progress.
• Core job specific activities include permitting, confine space entry, training, pre-job and weekly safety meetings, operating procedures, hazards analysis, emergency response and providing information on injury and illness trends.

1995 -1997 Safety Specialist, Prudhoe Bay Western Operating

1986 - 1995 Production Operator, Gathering Center II Prudhoe Bay Western Operating
DCS control room (Lead Console Operator), alarm management, plant operations, permitting, safe outs, commissioning PWH project, Water flood and gas management.

1984 – 1986 Operations Shift Relief (TRX) Supervisor, US Oil and Refining Co.
Covered for vacation and vacancies in operations responsible for the following units: Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating, Sulfur Recovery, Gasoline blending and Marine shipping and receiving.

1984-1986 Supervisor Asphalt Plant, US Oil and Refining Co
Responsible for blending, quality control, inventory, scheduling of product loading and personnel.

1977-1984 Production Operator, US Oil and Refining Co
B-Operator for Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating and Sulfur Recovery Units. Blender responsible for blending operations and QC of asphalt products. Worked on research/development and commissioning of the emulsion asphalt blending systems.

1975-1977 Utility Helper, US Oil and Refining Co
Part-time employment

1973-1975 US Army- Combat Medic
Stationed in Germany during the Viet Nam Conflict.

EDUCATION & TRAINING

• Occupational Health Safety Technologist- Certification from the American Industrial Hygienist and Board of Certified Safety Professionals

• Advanced Safety Certificate- National Safety Council (Principles of Occupational Safety and Health, Safety Management Techniques, Fundamentals Industrial Hygiene)

• Incident Safety Officer- National Fire Academy

• Incident Safety Officer- Fire Dept. Safety Officers Association

• Fall Protection Competent Person- Gavitec

• Hazmat Technician- 40 Hour

• Trainer Decision Point- Hazard Recognition Plus System

• Fire Dept Certifications-High Angle Rescue, Confined Space Rescue, Tactics and Strategy, Flammable Liquids Fire Fighting- Univ. Reno

• Powered Industrial Truck- Trained and Competent to certify BP employees

• Continuing development- Advanced Safety Audit, Fundamentals of Industrial Hygiene Monitoring, Scaffold Competent Person, OSHA Classes (Trenching, Painting Booths and Machine Guarding), First Aid, CPR, Media Training (External Affairs) and Time Management.

• Pursuing a BS in Occupational Health and Safety – Columbia Southern University

• Coaching Certificate State of Alaska- University Alaska Anchorage

Hobbies and Interest:
• High School Football Coach -18 years both Varsity and Junior Varsity Levels

• High School Soccer Coach – Women's JV Coach

• Community Liaison Member- BP External Affairs

• Board of Directors Kenai Boys and Girls Club- Kenai Peninsula

• First Lady's Volunteer award Mrs. Murkowski

PROFESSIONAL & PERSONAL REFERENCES FURNISHED UPON REQUEST

James E. Montgomery Jr.
Safety and Operations Auditor
BP International

OBJECTIVE

Throughout my career, I have received extensive knowledge and training in production and safety, first as a Control Room Operator and Supervisor at US Oil & Refining Company, Control Room/Facility Operator(Operations Dept) BP Alaska and then in the HSE dept, as a HSE Advisor. I'm presently in an International Safety and Operations Audit Group working for the BP

Board of Directors, which has expanded my ability, knowledge for personal growth and contribute to the success and performance of the B P as a company.

PROFESSIONAL SKILLS

April 2010-Present Site Safety Lead MC 252 Response Jefferson Branch.
Assigned to Venice originally then Grand Isle on 5/5, responsibilities initially included oversight of Cocodrie and Pt. Fourchon. When Grand Isle work team went to 3000 plus employees, Cocodrie and Pt. Fourchon were assigned to the new developed Regional Safety Manager. HSE team consisted of Safety, Medical, Coast Guard, National Guard and the Jefferson Parish Sheriffs Dept. 200 plus employees at its peak.
• Site safety plans.
• Emergency response plans
• Hazcom (developed a GI site plan)
• Developed a Safe Practice manual for New Orleans to review.
• Developed training for site, RTV, Supervisor training on Hazard recognition.
• Managed staffing at GI to meet the operation needs and was consistently lower ratio of Safety staff to workers than other sites.

2006-April 2010 S&O Auditor
Assigned tasks included auditing of gHSEr, OMS and PSM standards. Individual areas of auditing were HSE, Operations, Leadership, Emergency Response, Incident Investigation, Assurance, Maintenance and Security.

• International Program auditing
• Detailed deficiency reports
• Mitigating actions to address deficiencies
• International travel with different teams, Singapore, China, Trinidad, Egypt, Great Britain
• US based sites, Gulf of Mexico, Durango Colorado, Whiting Refinery (Indiana), East Coast Pipelines, NAG, Mid-Con Greater Prudhoe Bay and Alaska Consolidated Team (Endicott, Milne Point and North Star)
HSE Safety Advisor, Greater Prudhoe Bay Business Unit

Previous Duties GPB Facilities group included:
• Assist all facility and field personnel to ensure adequate safety, health and loss prevention measures are being followed.
• Assist all facility and field personnel in identifying and mitigating hazards and risks. Assist in the development and application of standards, policies and procedures.
• Conduct formal and informal audits, investigations and inspections of facilities and work in progress.
• Core job specific activities include permitting, confine space entry, training, pre-job and weekly safety meetings, operating procedures, hazards analysis, emergency response and providing information on injury and illness trends.

1995 -1997 Safety Specialist, Prudhoe Bay Western Operating

1986 - 1995 Production Operator, Gathering Center II Prudhoe Bay Western Operating
DCS control room (Lead Console Operator), alarm management, plant operations, permitting, safe outs, commissioning PWH project, Water flood and gas management.

1984 – 1986 Operations Shift Relief (TRX) Supervisor, US Oil and Refining Co.
Covered for vacation and vacancies in operations responsible for the following units: Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating, Sulfur Recovery, Gasoline blending and Marine shipping and receiving.

1984-1986 Supervisor Asphalt Plant, US Oil and Refining Co
Responsible for blending, quality control, inventory, scheduling of product loading and

personnel.

1977-1984 Production Operator, US Oil and Refining Co
B-Operator for Light Crude, Heavy Crude, Catalytic Reformer, Fuel Oil Hydro Treating and Sulfur Recovery Units. Blender responsible for blending operations and QC of asphalt products. Worked on research/development and commissioning of the emulsion asphalt blending systems.

1975-1977 Utility Helper, US Oil and Refining Co
Part-time employment

1973-1975 US Army- Combat Medic
Stationed in Germany during the Viet Nam Conflict.

EDUCATION & TRAINING

• Occupational Health Safety Technologist- Certification from the American Industrial Hygienist and Board of Certified Safety Professionals

• Advanced Safety Certificate- National Safety Council (Principles of Occupational Safety and Health, Safety Management Techniques, Fundamentals Industrial Hygiene)

• Incident Safety Officer- National Fire Academy

• Incident Safety Officer- Fire Dept. Safety Officers Association

• Fall Protection Competent Person- Gavitec

• Hazmat Technician- 40 Hour

• Trainer Decision Point- Hazard Recognition Plus System

• Fire Dept Certifications-High Angle Rescue, Confined Space Rescue, Tactics and Strategy, Flammable Liquids Fire Fighting- Univ. Reno

• Powered Industrial Truck- Trained and Competent to certify BP employees

• Continuing development- Advanced Safety Audit, Fundamentals of Industrial Hygiene Monitoring, Scaffold Competent Person, OSHA Classes (Trenching, Painting Booths and Machine Guarding), First Aid, CPR, Media Training (External Affairs) and Time Management.

• Coaching Certificate State of Alaska- University Alaska Anchorage

Hobbies and Interest:
• High School Football Coach -18 years both Varsity and Junior Varsity Levels

• High School Soccer Coach – Women's JV Coach

• Community Liaison Member- BP External Affairs

• Board of Directors Kenai Boys and Girls Club- Kenai Peninsula

• First Lady's Volunteer award Mrs. Murkowski

Press Release Wording

years in the Oil and Gas Industry and holds OHST/ISO and FDSOA.

Submitted: 01/05/12 at 6:14 am from 216.67.10.16

Fairbanks, AK. 99712

Sharp, Timothy
Occupational Safety and Health Review Bd

Curriculum Vitae
of
TIMOTHY O. SHARP

OBJECTIVE: To serve in the Knowles Administration on the Occupational Safety Board

QUALIFICATIONS:
*Twenty years of commitment to LIUNA and organized labor.
*Resourceful, aggressive, creative, loyal, dependable, responsible.
*Well developed personal and professional labor contacts around the world.

EDUCATION: Undergraduate Work - Boise State University- Communications Major 1972-1974 Alaska Laborers Training School - Foreman's Training Course - 1978, Steward's Training Course - 1983, Hazardous Waste Training Course 80 hours - 1989, Alaska Health Project/UAF, Industrial Hazards in Work place - 1985, Labor Law / Wage & Hour Seminar-1992, Harvard Trade Union Program-1993 (Elected commencement speaker), AFL-CIO Organizing Institute Internship-1993, Presently in pursuit of Labor Studies Degree at Antioch/George Meany School for Labor Studies, Computer literate (Macintosh)

WORK HISTORY & EXPERIENCE:
*Worked as journeyman, shop steward, foreman and general foreman directly with, and in support of all, building trade and pipeline craft on some of the largest projects in Prudhoe Bay and on the North Slope of Alaska.
*Responsible for placement and production of up to seventy Laborers at a time.
*Ten years working exclusively as shop steward on large and small projects dealing daily with wage/hour questions, jurisdiction,safety issues and basic contract interpretation.
*Created and presented a monthly series of union education classes over a six month period dealing with union history, labor law, pension plan and other miscellaneous topics for local union.
*Assisted in strategy and implementation of several large organizing drives with the Amalgamated Clothing and Textile Workers and the International Brotherhood of Teamsters in the midwest and southern United States.
*Twice elected as delegate to Alaskan Democratic Party Convention. Proposed at precinct level, carried to State convention and was responsible for adoption of party planks concerning striker replacement and labor law reform.
*Coordinated letter writing campaign lobbying State House and Senate on issues impacting labor during the 1988 legislative session.
*Elected to and presently serving fourth term as Executive Board member of Laborer's Local #942.
*Lectured at area high schools on U.S. labor history.
*Elected and served as delegate to State AFL-CIO Conventions and Laborer's International Convention.
*Selected to serve on AFL-CIO observer team and fact finding mission to South Africa to compile a report on potential problems that might impact the recent elections.
*Currently developing labor contacts and exchanges for future LIUNA health and safety programs in Yakutia-Sakha region of Russia
* Presently employed as full-time organizer/representative for LIUNA Local #942

Messerschmidt, Forrest
Board of Examiners in Optometry

Optometry, Board of Examiners in **Forrest Bates Messerschmidt**

General Information

Board/Commission and seat you are seeking:
Optometry, Board of Examiners in, Optometrist

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
None

First	*Middlename*	*Last Name*
Forrest	**Bates**	**Messerschmidt**
Mailing Address	*City*	*State & ZIP*
	Juneau	**AK 99801**
Home/Message Phone	*Business Phone*	*Cell Phone*
Email Address	*Are you a registered voter?*	
	Yes	

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
Self employed since 1989
Private practice Optometry Juneau, Alaska
Participating Doctor Vision USA, American Optometric Assn. - provides free examination for eligible low income families

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
Graduate Pacific University Bachelors of Science 1986
Graduate Pacific University Doctor of Optometry 1988

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Licensed Optometrist Alaska 22 years
Full Licensure with TPA endorsement
Member Alaska Optometric Assn. 22 years
Member American Optometric Assn. 27 years

List any community service, municipal government, and state positions held, and any awards received.
Vision USA Participating Doctor
Volunteer in past with Juneau Youth Sailing, Juneau Tennis Assn.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

Forrest Messerschmidt,O.D., of Juneau, is a Optometrist/Optometric Physician in private practice in Juneau, Alaska. He holds a bachelors degree in Visual Science and a Doctorate in Optometry from Pacific University in Forest Grove, Oregon.

Submitted: 01/24/12 at 4:01 pm from 69.178.68.53

Cotter, John
Board of Pharmacy

John E. Cotter

Address

Experience

2008 to present Fairbanks Memorial Hospital, Fairbanks AK

Associate Administrator for Professional Services

- Radiology, Laboratory and Pharmacy
- Responsible for oversight of all routine operations of the ancillary service departments. Develops programs, goals and objectives consistent with those of the organizations overall strategic plan and initiatives. Develops operational and capital budgets, manages operating expenses and key indicators within the budget.

1997 to 2008 Fairbanks Memorial Hospital, Fairbanks, AK

Director of Pharmacy

- Responsible for leading, developing and coordinating the operation of Pharmacy Services. Develops services that provide and enhance quality patient care while promoting fiscal responsibility in the utilization of resources. Directs the activities that provide for the purchasing, receiving, storage, delivery and distribution of medications from the pharmacy. Plans, directs, monitors, and evaluates the provision of distributive and clinical pharmacy services to all patient care areas.
- 166 bed acute care community Hospital
- 88 bed long term care facility
- Home health care
- Retail pharmacy

1985 to 1997 Fairbanks Memorial Hospital, Fairbanks, AK

Pharmacy Assistant Manager & Staff

- as above

1989 to 2002 1984th US Army Hospital, Fort Wainwright, AK

Pharmacy Officer

- 1984th US Army Reserve Hospital

1982 to 1985 US Army, Bassett USA Hospital, Fort Wainwright, AK

Assistant Pharmacy Manager

- Active Duty
- Inpatient & Outpatient Care

1979 to 1982 US Army, Womack USA Hospital, Ft Bragg, NC

Officer In Charge, Inpatient Pharmacy

- Active Duty
- Inpatient care

1977 to 1979 Wrentham State School, Wrentham, MA
Staff Pharmacist

Education

1977 Massachusetts College of Pharmacy, Boston, MA
B.S. Pharmacy

1985 University of Laverne, Fort Wainwright, AK
M.A. Organizational Management

Pharmacy Licensure

Alaska Pharmacy #766, First Issue 10/1983, Expires 6/30/2012

Massachusetts PH16823, First Issue 6/1977 Expires 12/31/2012

Professional Association

- American Society of Health-System Pharmacists
- Alaska Pharmacists Association
- American College of Healthcare Executives

DeVito, Lori
Board of Pharmacy

LORI A. DEVITO, RPH

OBJECTIVE

To be a leader and positive role model in the Profession of Pharmacy. To organize, direct, own and operate a home infusion pharmacy as well as maintain an ongoing liaison to the governing body, professional advisory committee and staff. To employ qualified skilled personnel and ensure staff is updated on education and evaluations. To implement an effective budgeting and accounting system which will allow for the pharmacy to operate in the most efficient and cost effective manner possible.

QUALIFICATIONS

Registered Pharmacist for 24 years in Soldotna, Alaska
Hospital and Retail Pharmacist -24 years
Long Term Care Facility Pharmacy Consultant- 24 years
Home Infusion Pharmacist Manager, President/CEO/Owner – 19 years
Home Health Care Administrator, President/CEO/Owner-15 years
Trained in I.V. Admixtures, Sterile Compounding, Home Health Care Fittings, Ostomy Supplies, TENS units, Oxygen Usage, Wound Care, Clinical / Retail Pharmacy, DME
Prescription Compounding Certified
In-service Teacher- Diabetic/Pharmacy
In-service Teacher-Ambulatory IV equipment, Enteral Equipment
CPR Certified
Main Speaker at National Home Infusion Association
Attended Several Home Health Care Educational Seminars regarding administration/Cost Reporting/Clinical Care
Preceptor for Students of Pharmacy

EDUCATION

1983-1986	Bachelor of Science in Pharmacy, University of Colorado-Boulder, Colorado
1981-1983	Undergraduate Pharmacy, Colorado State University, Fort Collins, Colorado
1986-1995	Small Business Administration, Kenai Peninsula Community College, Kenai, AK
1981	High School Graduate, Kenai Central High School, Kenai, Ak

AWARDS/OTHER INFORMATION

1993-Present	Member National Home Infusion Association
1996-Present	Member National Association of Home Care
1988-1995	Member National Association Retail Druggist's
1986-Present	Member Alaska Pharmaceutical Association
1992-1993	President Alaska Pharmaceutical Association
1991-1992	America Pharmacy Association Alaskan Delegate (Washington, D.C.)
1997-2003	APHA-Alaska Legislative Affairs Representative
1992	Pharmacy Leadership Award-AKPHA
1993	President's Award in Pharmacy-AKPHA
1995	Distinguished Young Pharmacist Award-AKPHA
1985	Bowden Pharmaceutical Scholarship-Recipient
1986	Member Alaska Home Care Association-Secretary
1988-1995	Member Peninsula Home Health Care-Board
1995-2005	Soroptimist Twin Cities Member
1997-1998	Soroptimist Twin Cities President
1998	Founder-Soroptimist Cancer Fund

WORK HISTORY

1993-Present	Professional Home I.V., Inc. Owner/CEO/Pharmacy Manager
1996-Present	1st Choice Home Health Care, Inc. Owner/CEO
1986-1996	Soldotna Professional Pharmacy-Retail Pharmacist
1991-1995	Central Peninsula General Hospital- Hospital Pharmacist
1984-1986	Soldotna Professional Pharmacy-Pharmacy Intern
1985-1986	Pharmacy Externships: Pharmacy Financial Management—Yuma, Colorado Hospital & Clinical Pharmacy- Shiprock, N.M. Chain/Retail Pharmacy-Denver, Colorado Nursing Home Pharmacy Consultant-Denver, Colorado
1979-1983	DeVito Co-Nook Lure Company-Partner in Manufacturing Business
1975-1984	Soldotna Drug Store-Pharmacy Tech, Inventory, etc.

LICENSES

Pharmacist	Alaska	License #837
Pharmacist	Colorado	License #18657
Pharmacist	South Carolina	License #12854

Kim, Christopher
Board of Pharmacy

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Pharmacy, Pharmacist
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served: None

Name: Christopher J. Kim (CJ.)

Mailing Address: ___

Residence Address: Same

City, State and Zip Code: ___

Home or Message Telephone: ___ Business Telephone: ___

Fax Number: ___ Cell Phone: ___

Email address: ___

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO ___ Voter Registration Number (Optional): ___

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): ___

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES ___ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO ___

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES ___ NO X

If "YES", explain:

Fax Received
JAN 2 2 2009
Office of the Governor

2009-01-22 09:09 907-339-1319 Huffman Carrs 1813 P 1/4

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:

Pharmacist License 1999 - Present

B. List both formal and informal education and training experiences: (Use additional paper if necessary).

BS of Pharmacy, Oregon State University

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).

CARR/Safeway Corp. RPh 1999 - Present

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: 0 SEX: FEMALE _____ MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander Black ___ Hispanic ___ White ___

MILITARY SERVICE (if applicable, give dates): _____ _____ _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Christopher J. Kim Date: 1/22/2009

Please attach a current resume with your application.

2009-01-22 09:06 907-339-1319 Huffman Carrs 1813 P 2/4

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Christopher J Kim Date: 1/22/2009

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/ Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers / Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/ Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/ Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
X	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

2009-01-22 09:07 907-339-1319 Huffman Carrs 1813 P 3/4

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): C J Kim (Age): of (Hometown): Anchorage
is (Job title/Place of employment): Pharmacist / Safeway.
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): B S Pharmacy.
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

2009-01-22 09:07 907-339-1319 Huffman Carrs 1813 p 4/4

Mala, Theodore Jr.
Board of Pharmacy

TED MALA, JR.

Professional Account Management Experience:

- Identifying and closing the highest revenue new business deal.
- Multicultural awareness resulting in higher sales volume.
- Exceptional rapport building skills resulting in longer partnerships.

Business Development Manager, NANA Management Services Nov. 2010- Present

Work with some of the most visible and prominent businesses in Alaska to develop and maintain relationships statewide.

Senior Media Consultant, The Alaska Journal of Commerce June 2010-Sept. 2010

Establish relationships with key accounts such as Southcentral Foundation, CH2M Hill, Alaska Native Heritage Center, and Bristol Bay Native Corporation.

- Develop targeted sales strategies, proposals, and contracts.
- Independently maintain quota of 25 cold calls and five new business appointments per week
- Sold $80,000 in new business revenue in the 10 weeks I consulted for AJOC.

Major Account Manager, Los Angeles Times 2007-2009

Develop and maintain key accounts such as Twentieth Century Fox, Charles Drew University, Los Angeles Country Club, and Century City Doctor's Hospital.

- Closed first quarter 258% to goal.
- Develop targeted sales strategies to close record-breaking business deals.
- Independently maintain quota of 100 cold calls and five new business appointments per week.
- Develop targeted sales strategies, proposals, and contracts.
- Selected as member of the inaugural Los Angeles Times sales strategy council.

Luxury Real Estate Agent, Surterre Properties 2007-2011

Represent Newport Beach's premier luxury real estate office in prestigious Crystal Cove, Newport Coast.

- Strong rapport building, extensive product knowledge, and tactful negotiating yielded sale of home just under five million dollars in Newport Coast.
- Design targeted marketing materials distinguishing team brand.
- Develop rapport and maintain relationships with clients resulting in repeat business and referrals.

Advertising Consultant, Yellow Book USA 2003-2007

Designed comprehensive advertising programs representing multicultural clients from varying industries.

- Secured business through cold calling, appointment setting, studying industry trends, in-depth needs analysis, calculating ROI, and negotiating contracts.
- Personally designed effective ad copy.
- Supervised territory growth and development.
- Created Spanish/English advertising programs.
- Independently maintained quota of 200 cold calls and eight new business appointments per week.
- Grew all territory assignments on average 20%.

Corporate Account Representative, The Alaska Club 2002-2003

Managed the development and maintenance of corporate accounts for Alaska's premier health club network.

- Prospected major corporate clients.
- Designed and pitched corporate presentations and proposals.
- Secured corporate partnerships.
- Current record holder for most new members signed up in one day (29).
- Ranked as number one salesperson in the history of The Alaska Club.

Project Coordinator, Southcentral Foundation 2001-2002

Instrumental in developing the Family Wellness Warrior Initiative (FWWI) at Southcentral Foundation/Alaska Native Medical Center.

- Represented the President/CEO and Board of Directors in public speaking engagements aimed at spreading awareness of the initiative's purpose which is to combat domestic violence, abuse, and neglect in Alaska.
- Gave a speech to 500 people which was broadcast live statewide.
- Built relationships with leaders in the community to garner support including Alaska Native Leaders, Judges, the head of the DOC, the head of DHSS, CEO's, legislators, and many others.
- Presented to the boards of directors of all the major Native Health Corporations in Alaska seeking the passing of a resolution supporting the initiative.
- Every board of directors passed a unanimous resolution of support.

EDUCATION/RECENT PROFESSIONAL DEVELOPMENT

- Current State of California Real Estate License
- Power Messaging - Corporate Visions, Inc.

- Spin Selling – Strategic Sales Solutions

COMPUTER SKILLS

- Microsoft Office Suite (Outlook, Excel, Word, PowerPoint)
- Salesforce.com

REFERENCES AVAILABLE UPON REQUEST

Carey, David
State Physical Therapy &
Occupational Therapy Board

Physical Therapy and Occupational Therapy Board, State — **David A Carey**

General Information

Board/Commission and seat you are seeking:
Physical Therapy and Occupational Therapy Board, State, Public

Additional Boards/Commissions of interest:
1) Juvenile Justice Advisory Committee, Alaska
2) Alcoholism and Drug Abuse, Advisory Board on
3) Emergency Medical Services, Alaska Council on

State Boards/Commissions on which you have served
None

First	*Middlename*	*Last Name*
David	**A**	**Carey**

Mailing Address	*City*	*State & ZIP*
	Anchorage	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
-Assets,Inc - 5 years employed as a "Life Skills Coach" for a non-profit organization that provided services for people with mental disabilities.

- Volunteers of America- 2 years employed as a Drug and Alcohol prevention Instructor for the Anchorage School District.

- 2008 Olympic Boxing Team Member and volunteer boxing coach

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
- John F. Kennedy High School class of 1999
- University of Anchorage Alaska

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
- Certified Drug and Alcohol prevention instructor, January 2009.

List any community service, municipal government, and state positions held. and any awards received.
None

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum

Press Release Wording

{Your Name}, {age} of {hometown}, is {job title/place of employment} holds {education level, school, or relevant experiences}.

Submitted: 12/27/11 at 4:50 pm from 24.237.108.58

Lind, Kathleen
State Physical Therapy & Occupational Therapy Bd

Physical/Occupational Therapy

Occupational Therapist seat – Kathleen Lind, of Anchorage – 13 years as OT with Anchorage School District; 15 years part-time OT at Alaska Regional Hospital; prior to Alaska worked as senior therapist, clinical educator at some top Chicago therapy centers and hospitals. B.A. in OT from Indiana/Purdue Univ. 1975, M.A. in health admin from Governor's State Univ. in Illinois, 1988. Licensed Alaska OT since 1992; longtime member, continuing education chair for Alaska Occupational Therapy Assoc., which endorses her. The OT for Dan's son endorses her strongly as widely informed and involved, and good advocate for practice of OT in Alaska, hard worker, fair.

Parietti, James
State Physical Therapy and Occupational Therapy Bd

Physical Therapy and Occupational Therapy Board, State — **James Kenneth Parietti**

General Information

Board/Commission and seat you are seeking:
Physical Therapy and Occupational Therapy Board, State, physical therapist seat

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
none

First	*Middlename*	*Last Name*
James	**Kenneth**	**Parietti**

Mailing Address	*City*	*State & ZIP*
	Chugiak	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
EMPLOYMENT HISTORY

Physical Therapist - Mat-Su Regional Medical Center Palmer, Alaska 11/10 - present
I am a pool physical therapist who covers weekends and holidays for the inpatient hospital population. Duties include performing initial evaluations, providing care/treatment, attending rounds as required/needed, communicating with various other medical staff and family members, evaluating and requesting equipment for patient needs upon discharge and performing hospital/corporate based continuing education as required.

Physical Therapist - Eagle Center Physical Therapy
Eagle River, Alaska 06/10 - present
I am a staff physical therapist involved in all aspects of patient care including initial evaluations,

progress notes and discharge summaries. I also assist with marketing of the facility to local referral sources and attending events where I promote health topics and our services to potential clients/patients.

Clinic Director/Physical Therapist - Denali Physical Therapy Anchorage Alaska 06/08 – 03/10
I helped open and was a limited partner of an outpatient orthopaedic clinic. Duties included doing due diligence with referral sources, researching a location for the practice, assisting with buildout design, marketing the facility and services to referral sources, identifying new revenue sources, ordering supplies/equipment and being responsible for the facility income statement. I also provided all aspects of patient care including evaluations, re-evaluations/progress notes, daily treatment and discharge summaries.

Business Development/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 10/06 – 6/08
The first part of my job duties included marketing the facility and staff to referral sources, identifying new revenue sources, diversifying and expanding facility operations, communicating to local staff the needs/preferences of referral sources and being a communication channel between staff and referral sources. I assisted in coordinating in services, surgery observations and educational opportunities for local staff. I also addressed patient questions/concerns and acted as a liaison between the patient, the referral source and the clinic.
As a therapist I was responsible for patient care, including performing initial evaluations, treatment, re-evaluations/progress notes and discharge summaries.

Site Coordinator/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 08/05 – 10/06
I was hired to turn the integrated medical facility clinic around. Duties included supervision of clinical and non-clinical staff, compliance with Medicare regulations, marketing facility and staff to referral sources, obtaining new revenue streams, diversifying and expanding facility operations, delegating various job tasks to staff (pool maintenance, supplies/equipment ordering, Medicare review, staff education), maintaining compliance with HealthSouth policies, reporting to my chain of command, being responsible for the facility income statement, review of the facility general ledger, performing monthly staff meetings, conducting employee performance appraisals and hiring/firing of staff. I also provided all aspects of patient care including evaluations, re-evaluations/progress notes and discharge summaries.

Owner/Operator Personal Touch Physical Therapy
Hilton Head Island, South Carolina 1998 – 2005
I incorporated and opened an orthopaedic private practice. Duties included marketing the facility and services to physicians, designing and building out the practice, negotiating and contracting billing services as well as lease arrangements. I provided all aspects of patient care including initial evaluations, progress notes/re-evaluations and discharge summaries. I performed all equipment acquisition, obtained insurance and Medicare provider numbers and performed all other aspects of operating a private practice.

Physical Therapist Jasper County School System
Ridgeland, South Carolina 1996 – 2005
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist Beaufort County School System 1997 – 2004
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist Beaufort-Jasper Home Health Services 1995 – 1998
Evaluate and provide services to Medicaid home bound individuals, maintain open

communication with staff/family and provide progress notes to physicians and ancillary services

Physical Therapist Care One 1994 – 1995
Provide services in an outpatient orthopaedic clinic including evaluations, treatment plans, progress notes and communication with other medical personnel.

Owner/Operator Health Quest One Fitness Center 1993 – 2003
Perform daily business functions including interaction with members, facility maintenance, equipment repair, marketing, billing and supervision of employees. Duties also included designing the fitness center, equipment acquisition, lease negotiations, subcontractor negotiations, contract development in compliance with state law as well as all other duties associated with owning/operating a business.

Physical Therapist ABC Home Health Agency 1993 – 1993
Evaluate and provide services to home bound individuals, maintain open communication with staff and provide progress notes to physicians and ancillary services.

Physical Therapist
HealthSouth Rehabilitation Corp., Merritt Island, FL 1992 – 1993
Provide physical therapy services in an outpatient orthopaedic clinic. Duties included performing evaluations, developing treatment plans, writing progress notes, discharge summaries and communicating with physicians, peers, patients and family members.

Physical Therapist South Miami Hospital 1991 - 1992
Evaluate and provide services to post-op orthopaedic, neurological, wound and general de-conditioned patients in an acute rehabilitation setting. Communicate with physicians, other staff, peers, patients and family members. I also filled in for other therapists in the rehab center and worked in the insensitive limb clinic with patients with chronic circulatory problems.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
FORMAL EDUCATION

1990 Master of Science in Physical Therapy (M.S.P.T.)
University of Miami, Coral Gables Florida

1989 Licensed Massage Therapist
Educating Hands School of Massage, Miami, Florida

1989 Certified Strength & Conditioning Specialist
National Strength & Conditioning Association

1988 Master of Science in Athletic Training & Sport Sciences
Long Island University, Brooklyn, New York

1987 B.S., School & Community Health Education
East Carolina University, Greenville, North Carolina

1985 Certified Massage Therapist
Community Wholistic Health Center, Carrboro, NC

1984 A.A. Brevard College, Brevard, North Carolina

CONTINUING EDUCATION

2011 Kinesio Taping - Advanced Whole Body (KT3)
Kinesio Taping Association International, Eagle River, Alaska

2011 Kinesio Taping - Fundamentals and Advanced (KT1 & KT2)
Kinesio Taping Association International, Eagle River, Alaska

2011 Strain Counterstrain II for the Extremities
Jones Institute, Anchorage, Alaska

2009 Total Motion Release
Total Motion Release, Charleston, South Carolina

2008 The Shoulder Girdle Complex:
Medical Screening and Orthopaedic Fundamentals
Empiridence Seminars, Anchorage, Alaska

2007 Diagnosis & Treatment of Movement System Impairment Syndromes of the Low Back and Hip
Alaska Physical Therapy Association, Girdwood, AK

2006 Evaluation & Treatment of the Cervicothoracic Spine
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Shoulder Update 2006
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Certified Pool/Spa Operator
National Swimming Pool Foundation, Anchorage, AK

2006 Pelvic Girdle and Hip
HealthSouth Rehabilitation Corporation, Seattle, WA

2005 Strength and Conditioning
HealthSouth Rehabilitation Corporation, Anchorage, AK

2005 Vestibular Rehabilitation
Great Lake Seminars, Charleston, South Carolina

2003 Pilates
International Weightlifting Association, Charleston, SC

2001 Mulligan Concepts
Brian Mulligan, Augusta, Georgia

2001 Special Needs Child
South Carolina/Georgia Dept. of Social Services, Augusta, GA

2000 Myofascial Release
John Barnes, University of West Virginia, West Virginia

1998 Adaptive Golf
Roper Hospital, Charleston, South Carolina

1997 Concepts of Electrical Stimulation
Memorial Hospital, Charleston, South Carolina

1997 Treatment of the Lumbar Complex
Great Lakes Seminars, Charleston, South Carolina

1995 Work Conditioning, Work Hardening and Work Simulation
Roy Matheson and Associates, Toronto, Canada

1995 Job Task Analysis
Roy Matheson and Associates, Toronto, Canada

1995 Functional Capacity Evaluation
Keith Blankenship, Nashville, Tennessee

1992 Foot and Ankle Clinical Specialization Course – Level 1
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Basic Skills Enhancement Course
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Shoulder and Upper Extremity: Current Concepts & Treatment
The Miami Sports Medicine Seminar, Miami, Florida

1992 Knee Rehabilitation
Knee Works & The Florida Knee Center, Clearwater Beach, FL

1991 Clinical Applications of the Feldenkrais Method – Level 1
The Institute for Movement Studies and South Miami Hospital, Miami, Florida

1990 The Treatment of the Diabetic Foot
South Miami Hospital Medical Ed. Committee, Miami, Florida

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Physical Therapist - Alaska License No. 1703

List any community service, municipal government, and state positions held, and any awards received.
When I was a limited partner of Denali PT I would treat patient patients who could not afford our services and who were usually uninsured at a discounted rate. This is one of the ways I assisted the community. We also sponsored local groups/events.
No prior government positions held but I am eager to begin this journey now.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"

"I certify"

Resume Addendum
James K. Parietti M.S., M.S.P.T.

EMPLOYMENT HISTORY

Physical Therapist
Mat-Su Regional Medical Center, Palmer Alaska 11/10 - present
I am a pool physical therapist who covers weekends and holidays for the inpatient hospital population. Duties include performing initial evaluations, providing care/treatment, attending rounds as required/needed, communicating with various other medical staff and family members, evaluating and requesting equipment for patient needs upon discharge and performing hospital/corporate based continuing education as required.

Physical Therapist
Eagle Center Physical Therapy, Eagle River Alaska 06/10 - present
I am a staff physical therapist involved in all aspects of patient care including initial evaluations, progress notes and discharge summaries. I also assist with marketing of the facility to local referral sources and attending events where I promote health topics and our services to potential clients/patients.

Clinic Director/Physical Therapist
Denali Physical Therapy, Anchorage Alaska 03/10 - 03/10
I helped open and was a limited partner of an outpatient orthopaedic clinic. Duties included doing due diligence with referral sources, researching a location for the practice, assisting with buildout design, marketing the facility and services to referral sources, identifying new revenue sources, ordering supplies/equipment and being responsible for the facility income statement. I also provided all aspects of patient care including evaluations, re-evaluations/progress notes, daily treatment and discharge summaries.

Business Development/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 10/06 – 5/08
The first part of my job duties included marketing the facility and staff to referral sources, identifying new revenue sources, diversifying and expanding facility operations, communicating to local staff the needs/preferences of referral sources and being a communication channel between staff and referral sources. I assisted in coordinating in services, surgery observations and educational opportunities for local staff. I also addressed patient questions/concerns and acted as a liaison between the patient, the referral source and the clinic.
As a therapist I was responsible for patient care, including performing initial evaluations, treatment, re-evaluations/progress notes and discharge summaries.

Site Coordinator/Physical Therapist
HealthSouth Rehabilitation Corp., Anchorage Alaska 08/05 – 10/06
I was hired to turn the integrated medical facility clinic around. Duties included supervision of clinical and non-clinical staff, compliance with Medicare regulations, marketing facility and staff to referral sources, obtaining new revenue streams, diversifying and expanding facility operations, delegating various job tasks to staff (pool maintenance, supplies/equipment ordering, Medicare review, staff education), maintaining compliance with HealthSouth policies, reporting to my chain of command, being responsible for the facility income statement, review of the facility general ledger, performing monthly staff meetings, conducting employee performance appraisals and hiring/firing of staff. I also provided all aspects of
EMPLOYMENT HISTORY (Cont.)

patient care including evaluations, re-evaluations/progress notes and discharge summaries.

Owner/Operator
Personal Touch Physical Therapy, Hilton Head Island SC 1998 – 2005
I incorporated and opened an orthopaedic private practice. Duties included marketing the facility and services to physicians, designing and building out the practice, negotiating and contracting billing services as well as lease arrangements. I provided all aspects of patient care including initial evaluations, progress notes/re-evaluations and discharge summaries. I performed all equipment acquisition, obtained insurance and Medicare provider numbers and performed all other aspects of operating a private practice.

Physical Therapist Jasper County School System 1996 – 2005
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist Beaufort County School System 1997 – 2004
Evaluate and provide services to physically (and usually mentally) challenged children, participate in IEP/staff meetings, communicate with facility and parents, provide progress notes of student progress and order equipment.

Physical Therapist
Beaufort-Jasper Home Health Services, Ridgeland SC 1995 – 1998
Evaluate and provide services to Medicaid home bound individuals, maintain open communication with staff/family and provide progress notes to physicians and ancillary services

Physical Therapist
Care One, Hilton Head Island South Carolina 1994 – 1995
Provide services in an outpatient orthopaedic clinic including evaluations, treatment plans, progress notes and communication with other medical personnel.

Owner/Operator
Health Quest One Fitness Center, Hilton Head Island SC 1993 – 2003
Perform daily business functions including interaction with members, facility maintenance, equipment repair, marketing, billing and supervision of employees. Duties also included designing the fitness center, equipment acquisition, lease negotiations, subcontractor negotiations, contract development in compliance with state law as well as all other duties associated with owning/operating a business.

Physical Therapist
ABC Home Health Agency, Merritt Island, FL 1993 – 1993
Evaluate and provide services to home bound individuals, maintain open communication with staff and provide progress notes to physicians and ancillary services.

Physical Therapist
HealthSouth Rehabilitation Corp., Merritt Island, FL 1992 – 1993
Provide physical therapy services in an outpatient orthopaedic clinic. Duties included performing evaluations, developing treatment plans, writing progress

EMPLOYMENT HISTORY (Cont.)

notes, discharge summaries and communicating with physicians, peers, patients and family members.

Physical Therapist
South Miami Hospital, Miami Florida 1991 - 1992
Evaluate and provide services to post-op orthopaedic, neurological, wound and general de-

conditioned patients in an acute rehabilitation setting. Communicate with physicians, other staff, peers, patients and family members. I also filled in for other therapists in the rehab center and worked in the insensitive limb clinic with patients with chronic circulatory problems.

FORMAL EDUCATION

1990 Master of Science in Physical Therapy (M.S.P.T.)
University of Miami, Coral Gables Florida

1989 Licensed Massage Therapist
Educating Hands School of Massage, Miami, Florida

1989 Certified Strength & Conditioning Specialist
National Strength & Conditioning Association

1988 Master of Science in Athletic Training & Sport Sciences
Long Island University, Brooklyn, New York

1987 B.S., School & Community Health Education
East Carolina University, Greenville, North Carolina

1985 Certified Massage Therapist
Community Wholistic Health Center, Carrboro, NC

1984 A.A. Brevard College, Brevard, North Carolina

CONTINUING EDUCATION

2011 Kinesio Taping - Advanced Whole Body (KT3)
Kinesio Taping Association International, Eagle River, Alaska

2011 Kinesio Taping - Fundamentals and Advanced (KT1 & KT2)
Kinesio Taping Association International, Eagle River, Alaska

2011 Strain Counterstrain II for the Extremities
Jones Institute, Anchorage, Alaska

2009 Total Motion Release
Total Motion Release, Charleston, South Carolina

2008 The Shoulder Girdle Complex:
Medical Screening and Orthopaedic Fundamentals
Empiridence Seminars, Anchorage, Alaska

CONTINUING EDUCATION (Cont.)

2007 Diagnosis & Treatment of Movement System Impairment Syndromes of the Low Back and Hip
Alaska Physical Therapy Association, Girdwood, AK

2006 Evaluation & Treatment of the Cervicothoracic Spine
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Shoulder Update 2006
HealthSouth Rehabilitation Corporation, Anchorage, AK

2006 Certified Pool/Spa Operator

National Swimming Pool Foundation, Anchorage, AK

2006 Pelvic Girdle and Hip
HealthSouth Rehabilitation Corporation, Seattle, WA

2005 Strength and Conditioning
HealthSouth Rehabilitation Corporation, Anchorage, AK

2005 Vestibular Rehabilitation
Great Lake Seminars, Charleston, South Carolina

2003 Pilates
International Weightlifting Association, Charleston, SC

2001 Mulligan Concepts
Brian Mulligan, Augusta, Georgia

2001 Special Needs Child
South Carolina/Georgia Dept. of Social Services, Augusta, GA

2000 Myofascial Release
John Barnes, University of West Virginia, West Virginia

1998 Adaptive Golf
Roper Hospital, Charleston, South Carolina

1997 Concepts of Electrical Stimulation
Memorial Hospital, Charleston, South Carolina

1997 Treatment of the Lumbar Complex
Great Lakes Seminars, Charleston, South Carolina

1995 Work Conditioning, Work Hardening and Work Simulation
Roy Matheson and Associates, Toronto, Canada

1995 Job Task Analysis
Roy Matheson and Associates, Toronto, Canada

1995 Functional Capacity Evaluation
Keith Blankenship, Nashville, Tennessee

CONTINUING EDUCATION (Cont.)

1992 Foot and Ankle Clinical Specialization Course – Level 1
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Basic Skills Enhancement Course
HealthSouth Rehabilitation Corporation, Orlando, Florida

1992 Shoulder and Upper Extremity: Current Concepts & Treatment
The Miami Sports Medicine Seminar, Miami, Florida

1992 Knee Rehabilitation
Knee Works & The Florida Knee Center, Clearwater Beach, FL

1991 Clinical Applications of the Feldendkrais Method – Level 1
The Institute for Movement Studies and South Miami Hospital, Miami, Florida

1990 The Treatment of the Diabetic Foot
South Miami Hospital Medical Ed. Committee, Miami, Florida

Press Release Wording

{Your Name}, {age} of {hometown}, is {job title/place of employment} holds {education level, school, or relevant experiences}. James K Parietti, of Chugiak is a staff physical therapist of Eagle Center Physical Therapy. James holds a Masters degree in Physical Therapy from the University of Miami and has been working in the field for 21 years

Submitted: 01/27/12 at 11:18 am from 72.35.101.4

Mitchell, Lillian
Board of Professional Counselors

Hi Ivy. My name is Lillian Mitchell, a RN that retired from Providence Alaska Medical Center in 2005 after working there over 27 years. I had worked for Providence several years before in the late 60's and early 70's. I have a BA degree in human resources and a MAT. I am currently involved in volunteer work with the Alaska state fair and I am involved in the Parish nurse ministry with my church. I served on the board of directors for the Blood Bank of Alaska for several years. I have lived in Anchorage over 34 years, arriving in Alaska the first time in 1968 when my husband was assigned here with the Air Force. If you need additional information, please e-mail me. I would like information regarding the medical emergency Board, the duties, purpose, location and expectations etc. Thanks, Lillian Mitchell.

Psychologist and Psychological Assoc. Examiners, Board of

General Information

Board/Commission and seat you are seeking:
Psychologist and Psychological Assoc. Examiners, Board of, LPA

Additional Boards/Commissions of interest:

State Boards/Commissions on which you have served
None

First	*Middlename*	*Last Name*
Allen	**Lee**	**Levy**

Mailing Address	*City*	*State & ZIP*
	Anchorage	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
Yes

Please explain the potential financial benefit
I am a Licensed Psychological Associate. It is possible that proposed changes in regulations could affect my practice.

Employment History

Employment work history including paid, unpaid or voluntary.
Therapist in private practice. November 2005 to present. Provided individual and family therapy to adults, children, and adolescents in private mental health practice. Occasionally do forensic work in connection with divorce and custody cases.

Therapist and Medicaid Auditor, UHS Good Samaritan LLC, December 2001 to November 2005. Provided individual, family, and group therapy to adults, children, and adolescents in outpatient mental health clinic. Audited all provider charts for compliance with Medicaid regulations and documentation standards. Revised and designed progress notes, treatment plans and other forms to be more Medicaid compliant and easier to complete.

Adjunct Faculty University of Alaska Anchorage, 2005- present. Proposed, planned, and taught

one credit course: Coordinating Child and Family Therapy with Other Service Providers and Agencies. Also taught Lifespan Development, Personality Psychology, Abnormal Psychology and General Psychology.

Presenter and trainer, UAA ISER sponsored international conference on problems associated with alcoholism, Anadyr Russia, July 9 – 22, 2004 and October 22 – 27, 2004. Presented lectures, workshops, and demonstrations on individual and group therapy as applied in residential settings, play therapy, and Fetal Alcohol Spectrum Disorders at the regional mental health hospital and the regional children's home.

Presenter and trainer, University of Alaska Anchorage Raven's Quest Summer Internship Program, Summer 2003, 2004, and 2005. Presented workshops on group challenge activities, lectured on practicing individual, family, and group therapy in private practice, lectured on challenges in human services and the field of mental health.

Clinician, South Central Foundation The Pathway Home, August – October 2001. Trained staff in Therapeutic Community, Positive Peer Culture, and Mandt Basic and Intermediate levels. Wrote policy and procedures. Created forms. Supervised staff. Developed program and staff schedules.

Relief Clinical Associate, South Central Counseling Center, Spring 2001. Provided individual and group therapy to chronically mentally ill clients in the Institutional Discharge Program. Planned and carried out special therapeutic activities (e.g., art, music, computers) for clients.

Youth Counselor, McLaughlin Youth Center, Anchorage Alaska, 1990- 2000. Acted as primary counselor for three to five residents. Developed individual treatment programs for counselees. Facilitated group therapy sessions. Wrote and kept up to date all necessary documentation (e.g., weekly cumulative entries, monthly progress reports, annual reviews, special court reports, Institutional Review Board memos, incident reports). Conducted individual, family, and group counseling sessions. Intervened in crisis situations. Planned and supervised outings, community service projects, and group challenge activities.

Case Manager, McLaughlin Aftercare Project, 1997-1998. Provided individual and family counseling, support, crisis intervention, assessment, drug testing, vocational assistance, and other services to adolescents released from treatment at McLaughlin Youth Center. Planned and carried out special group challenge activities for groups of residents on pre-release status from McLaughlin Youth Center. Supervised case load of three to five former residents. Contacted each former resident twice each week for face to face meetings and at least once per week by telephone. Wrote and kept current all necessary documentation.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
80+ hours of continuing education in topics related to ethical practice and psychology
Master of Science Clinical Psychology, University of Alaska Anchorage, 2001.

Bachelor of Arts, Liberal Arts, The Evergreen State College, Olympia, Washington, 1981.

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
Licensed Psychological Associate license #548 current license valid from 06/15/2011 - 06/30/2013

List any community service, municipal government, and state positions held, and any awards received.
Served on Executive Board of Alaska Psychological Association in various capacities (Member at Large, Treasurer) from 2006 -2009. Recently rejoined as co-chair of Continuing Education

Committee.

I have ten years of service as a Youth Counselor at McLaughlin Youth Center from 1990 to 2000. Was twice awarded employee of the month.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
Allen L. Levy LPA

Anchorage, Alaska
Anchorage Ak,

Treatment Experience

Therapist in private practice. November 2005 to present. Provided individual and family therapy to adults, children, and adolescents in private mental health practice. Occasionally do forensic work in connection with divorce and custody cases.

Therapist and Medicaid Auditor, UHS Good Samaritan LLC, December 2001 to November 2005. Provided individual, family, and group therapy to adults, children, and adolescents in outpatient mental health clinic. Audited all provider charts for compliance with Medicaid regulations and documentation standards. Revised and designed progress notes, treatment plans and other forms to be more Medicaid compliant and easier to complete.

Youth Counselor, McLaughlin Youth Center, Anchorage Alaska, 1990- 2000. Acted as primary counselor for three to five residents. Developed individual treatment programs for counselees. Facilitated group therapy sessions. Wrote and kept up to date all necessary documentation (e.g., weekly cumulative entries, monthly progress reports, annual reviews, special court reports, Institutional Review Board memos, incident reports). Conducted individual, family, and group counseling sessions. Intervened in crisis situations. Planned and supervised outings, community service projects, and group challenge activities.

Case Manager, McLaughlin Aftercare Project, 1997-1998. Provided individual and family counseling, support, crisis intervention, assessment, drug testing, vocational assistance, and other services to adolescents released from treatment at McLaughlin Youth Center. Planned and carried out special group challenge activities for groups of residents on pre-release status from McLaughlin Youth Center. Supervised case load of three to five former residents. Contacted each former resident twice each week for face to face meetings and at least once per week by

telephone. Wrote and kept current all necessary documentation.

Relief Clinical Associate, South Central Counseling Center, Spring 2001. Provided individual and group therapy to chronically mentally ill clients in the Institutional Discharge Program. Planned and carried out special therapeutic activities (e.g., art, music, computers) for clients.

Teaching/training and Service Experience

Adjunct Faculty University of Alaska Anchorage, 2005- present. Proposed, planned, and taught one credit course: Coordinating Child and Family Therapy with Other Service Providers and Agencies. Also taught Lifespan Development, Personality Psychology, Abnormal Psychology and General Psychology.

Presenter and trainer, UAA ISER sponsored international conference on problems associated with alcoholism, Anadyr Russia, July 9 – 22, 2004 and October 22 – 27, 2004. Presented lectures, workshops, and demonstrations on individual and group therapy as applied in residential settings, play therapy, and Fetal Alcohol Spectrum Disorders at the regional mental health hospital and the regional children's home.

Presenter and trainer, University of Alaska Anchorage Raven's Quest Summer Internship Program, Summer 2003, 2004, and 2005. Presented workshops on group challenge activities, lectured on practicing individual, family, and group therapy in private practice, lectured on challenges in human services and the field of mental health.

Management Experience

Clinician, South Central Foundation The Pathway Home, August – October 2001. Trained staff in Therapeutic Community, Positive Peer Culture, and Mandt Basic and Intermediate levels. Wrote policy and procedures. Created forms. Supervised staff. Developed program and staff schedules.

Education, License, and Awards

Licensed Psychological Associate, State of Alaska license number 548. Passed Examination for Professional Practice in Psychology (EPPP) with an 80%.

Best Oral Presentation 2001 Behavioral Sciences Conference of the North: GOOD BEHAVIOR IN THE CAFETERIA: TEACHER AND STAFF ATTITUDES AND PERCEPTIONS ON APPLYING THE GOOD BEHAVIOR GAME IN A SCHOOL CAFETERIA.

Master of Science Clinical Psychology, University of Alaska Anchorage, 2001.

Bachelor of Arts, Liberal Arts, The Evergreen State College, Olympia, Washington, 1981.

Languages Spoken

Russian – nearly fluent
Hebrew – rusty

Press Release Wording

Allen L. Levy, ! President of Generations A Family Place Inc. holds a Bachelor of Arts in Liberal Arts from the Evergreen State College and a Master of Science in Clinical Psychology from the University of Alaska Anchorage.

Submitted: 11/29/11 at 3:41 pm from 24.237.46.171

Muntean, Christian
Board of Psychologist &
Psychological Assoc Examiners

CHRISTIAN MUNTEAN

FUNCTIONAL SUMMARY

- Executive Director of Beyond Borders since 2004.
- Principle consultant, mediator & trainer.
- Develops and oversees programs, staff, trainers and mediator panel.
- Extensive international and cross-cultural experience within non-governmental & governmental organizations.
- Provides state-wide services to regional and tribal organizations, commercial, non-profit & faith-based organizations.
- Facilitates planning, community conversations and collaborations.
- Creative and resourceful community developer and problem solver.
- Effective at supporting clients to navigate challenging conversations.

Selected Clients: Institute of the North; Cook Inlet Tribal Council; Southcentral Foundation; Tanana Chiefs Conference; RurAL CAP; Nome Eskimo Community; Region X Head Start, , Amundsen Educational Center; Northern Adjusters Inc.; Leadership for Africa (Swaziland); Medair South Sudan (Switzerland/South Sudan); JUCUM Panama (Panama), Faith Christian Community/ Turang Nusa (Indonesia); Anchorage Youth Development Coalition; Covenant Youth of Alaska, Evangelical Covenant Church of Alaska

RELEVANT EXPERIENCE

- Facilitation consultant for organizations, dialogues and community conversations.
- Highly experienced in multi-cultural, multi-disciplinary environments.
- Successful mediator with 80%+ settlement rate.
- Facilitated strategic planning for numerous non-profit, business and faith-based organizations.
- Founded the Center for Conflict Resolution.
- Collaborated with faith community, non-profit and state government to build trust and create relationships for collaborative projects.
- Conducted field research and made recommendations regarding the sustainability and potential peace-building impact of medical programs in Southern Sudan.
- Coordinated with local and regional community leaders to rehabilitate a public utility work / economic rejuvenation project impacting 12 communities. (Kosovo)
- Founded two therapeutic preschools in coordination with refugee camp and minority population leaders. (Kosovo)
- Co-chair of the UNHCR Regional Mental Health Committee in Kosovo

- Responsible for the assessment of need, beneficiary selection and monitoring of reconstruction of homes for 15 communities in Kosovo.
- Oversaw the housing selection and reconstruction process and developed ethics policy as a member of the Municipal Housing Committee under Decan Municipality and the United Nations Mission in Kosovo.

EDUCATION

2005-2007 **Eastern University/World Vision & Habitat for Humanity – Pathways to Leadership** Africa Cohort
MA Organizational Leadership – Emphasis on NGO Management

1996-2000 **University of Alaska, Anchorage** Anchorage, Alaska
BA Sociology – Applied Emphasis on Communities and Change

1993-1995 **University of the Nations** Jerusalem, Israel; Tyler, Texas
Ministry Certificates

RELATED TRAINING/EXPERIENCE

M.J. Murdock Charitable Trust
The Mentoring Experience, 2008; Sr. Mentor, 2009, 2010

United States Institute of Peace
Conflict Analysis Course – Certificate 2008; *Interfaith Conflict Resolution* – Certificate 2009

Peacemaker Ministries
Personal Peacemaking, 2007; Fundamentals of Conflict Coaching & Mediation 2009; Mediation & Arbitration Certification Course 2009; Conflict Coaching & Mediation Instructor Course 2010

Gwen Kennedy & Associates
Facilitator's Study Group 2008-2009; Triple Impact Leadership 2010 (With Edith Seashore)

Institute for Life Coach Training
Foundational Coaching 2008-2009

Southcentral Foundation/Family Wellness Warriors Initiative:
Trained Trainer 2007

Critical Incident Stress Management: *Basic, Advanced, Peer, Child, Suicide, Mass Disaster, Pastoral* // International Critical Incident Stress Foundation 2002 – 2003

AFFILIATIONS/ MEMBERSHIPS

Alaska Bar Association: Alternative Dispute Resolution Section
Member (2009 – Current)

Alaska Native Professional Association
Member (2008-Current)

Alaskan Leadership Development Network
Member (2008-Current)

Commonwealth North
Member (2010 – Current)

Medair Association: Medair (Emergency Relief and Rehabilitation) Ecublens, Switzerland. www.medair.org (2003-2010)

Humanitarian Accountability Partnership International:
Reference Group Member Geneva, Switzerland
http://www.hapinternational.org/en/(2005-2006)

Municipal Housing Committee: Decan Municipality/United Nations Mission in Kosovo (2001)
Member

Peje / Decan Regional Mental Health Committee (convened by the United Nations High Commissioner for Refugees) (2001)
Co-Chair

Wieman, Joel
Board of Psychologist & Psychological Assoc. Examiners

Psychologist and Psychological Assoc. Examiners, Board of **Joel Barry Wieman**

General Information

Board/Commission and seat you are seeking:
Psychologist and Psychological Assoc. Examiners, Board of, Psychologist Seat

Additional Boards/Commissions of interest:
1) Fisheries, Board of
2) Game, Board of

State Boards/Commissions on which you have served

First	*Middlename*	*Last Name*
Joel	**Barry**	**Wieman**

Mailing Address	*City*	*State & ZIP*
	Anchorage	

Home/Message Phone	*Business Phone*	*Cell Phone*

Email Address	*Are you a registered voter?*
	Yes

Date of Birth	*Ethnicity*
Gender	
Military Service	

Conflict of Interest

Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
Yes

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you are applying?
No

Please explain the potential financial benefit

Employment History

Employment work history including paid, unpaid or voluntary.
Self employed in Private Practice from 1985 to the present.

Prior to that I worked with the South Central Counseling Center from 1979 to 1985.

Education, Training, Experience & Qualifications

List both formal and informal education and training experiences:
I received my BA in Psychology from UAA in 1973, my MS in 1977 from the California School of Professional Psychology, and my Ph.D. from the same institution in 1979. I have done hundreds of hours of continuing education since that time, a minimum of 20 hours per year.

List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria:
I am licensed as a Psychologist in Alaska. License number AA-227, 1983

List any community service, municipal government, and state positions held, and any awards received.
I served for six years on the Councel of Representatives of the American Psychological Association; Have been the Secretary of the Alaska Psychological Association and the President of the Alsaka Psychological Association.
I have most recently served on the Minicipal Health and Social Services Comission, stepping down this fall after six years. I was also CO-President of the Alaska Biathlon Association.

Conviction Record

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?
No

Conviction Circumstances

Certification of Accuracy & Completeness

By submitting this online application, I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Type "I certify"
"I certify"

Resumé Addendum
I will mail my resume.

Press Release Wording

Dr. Joel Wieman, is Psychologist in private practice, holds {Ph.D. in Psychology from The California School of Professional Psychology.

Submitted: 11/23/11 at 4:36 pm from 66.58.128.224

Kerr, Marilyn
Board of Social Work Examiners

STATE OF ALASKA
OFFICE OF THE GOVERNOR
P.O. Box 110001, Juneau, AK 99811-0001
Phone: (907) 465-3500 Fax: (907) 465-3532

BOARDS AND COMMISSIONS APPLICATION FORM

INSTRUCTIONS

A separate application is required for each position for which you apply. Complete and specific answers will aid in rapid and accurate processing of your resume. Please type or print legibly in ink. Forward to the above address. Be sure your answers are true. A willfully false answer may result in your disqualification or removal from office if you are appointed.

Board or Commission and seat for which I am applying: Board of Social Work Examiners
(For example, Board of Agriculture, public seat)

Please list any other State Boards or Commissions on which you currently or previously have served:

Name: Marilyn B. Kerr L.C.S.W.

Mailing Address: ____

Residence Address: ____

City, State and Zip Code: Anchorage AK 99507

Home or Message Telephone: ____ Business Telephone: ____

Fax Number: ____ Cell Phone: ____

Email address: ____

AS 39-05-100 requires that a person appointed to a state board or commission be a registered voter prior to the last general election:

Are you a registered voter: YES X NO ____ Voter Registration Number (Optional): ____

Social Security Number (Optional, required if appointed for travel, reimbursement etc.): ____

Have you ever been convicted of a misdemeanor within the past five years or a felony within the past ten years?

YES ____ NO X if "YES", explain the circumstances on a separate sheet of paper and attach it to this application. A conviction is not necessarily grounds for disqualification. The number of convictions, nature, recentness, and relationship to the board position applied for, will be evaluated and a determination will be made after a review of all relevant facts.

CONFLICTS OF INTEREST: Certain boards and commissions require full disclosure of personal financial data under AS 39.50.010. If required for the board or commission for which you are applying, are you willing to do so?
YES X NO ____

Could you or any member of your family be affected financially by decisions to be made by the board or commission for which you have applied? YES ____ NO X

If "YES", explain:

TRAINING AND EXPERIENCE: (If resume attached, it is not necessary to complete items A-D)

A. List any professional licenses, certifications, or registrations and dates obtained that may be used as qualifying criteria: L.C.S.W - State of Alaska 1989 through present
#AA00143

B. List both formal and informal education and training experiences: (Use additional paper if necessary).
Resume attached

C. List any community service, municipal government, and state positions held, and any awards received. Include both compensated and uncompensated positions (such as president of a service organization or a mayor). Include length of time serviced.
Served as chair of National Girls/Womens Hockey Tournament (2000-2002); 1st in the state
Serve as liturgy committee member at Holy Cross Parish, Anchorage Ak.

D. Employment work history – paid, unpaid or voluntary: (Use additional paper of necessary).
See attached chronological resume

The Office of the Governor and the State of Alaska have an Affirmative Action Equal Employment Opportunity Program. To assist in the program, you are asked to voluntarily answer the following questions to provide the information necessary for reporting purposes. Under State and Federal law, the information you provide will not be used to illegally discriminate against you.

DATE OF BIRTH: SEX: FEMALE _____ MALE _____

ETHNICITY:
Alaska Native ___ American Indian ___ Asian or Pacific Islander ___ Black ___ Hispanic ___ White

MILITARY SERVICE (if applicable, give dates): _____

CERTIFICATION: I swear the information I have entered on this form is true to the best of my knowledge. I understand that if I deliberately conceal or enter false information on the form my application may be rejected, I may be removed from the list of eligible candidates, or I may be removed from the position. I agree that the Office of the Governor may contact present or former employees or other persons who know me to obtain an additional information about my skills and abilities. I understand that the information on this application is public information and may be released through a legal request for such information.

Signature (in ink): Marilyn K Kerr LCSW Date: 4/21/2011

Please attach a current resume with your application.

STATE OF ALASKA
OFFICE OF THE GOVERNOR

BOARDS AND COMMISSIONS

Name: Marilyn B. Kerr L.C.S.W. Date: 4/21/2011

(Indicate top three boards/commissions of interest by number with #1 as your preference)

	Accounting Board
	Aerospace Development Corporation
	Aging Commission
	Agriculture & Conservation
	Alaska Juvenile Justice Advisory Committee
	Alaska Retirement Management Board
	Alaska Statehood Celebration Commission
	Alaska-Alberta Bilateral Council
	Alcohol/Drug Abuse
	Alcoholic Beverage Control
	Architects/Engineers / Land Surveyors
	Arts Council
	Assessment Review Board
	Aviation Advisory Board
	Bald Eagle Preserve
	Bar Association
	Barbers & Hairdressers
	Bering Sea Fishery Advisory Board
	Big Game Commercial Services
	Boating Safety Council
	Broadcasting Commission
	Children's Trust Board
	Chiropractic Examiners
	Clemency Advisory Committee
	Commemorative Coin Commission
	Commercial Fisheries Entry
	Commercial Fishing/Agriculture Bank
	Community Service Commission
	Denali Access System Advisory Committee
	Dental Examiners
	Disabilities/Special Education
	Domestic Violence/Sexual Assault
	Education & Early Development
	Education Commission/States
	Emergency Medical Services
	Emergency Response Commission
	Employment of People with Disabilities
	Exxon Valdez Oil Spill Trustee
	Faith-Based & Community Initiatives Council
	Fire Standards Council
	Fisheries

	Fisherman's Fund Advisory & Appeals
	Forestry
	Game
	Health Council
	Historical Commission
	Historical Records Advisory
	Homeless Council
	Housing Finance Corporation
	Human Rights
	Humanities Forum
	Independent Living Council
	Industrial Development/Export Authority
	Interstate Oil & Gas Compact
	Judicial Conduct
	Judicial Council
	Knik Arm Bridge
	Labor Relations Agency
	Libraries Advisory
	Local Boundary Commission
	Marine Pilots
	Marine Transportation Advisory Board
	Marital & Family Therapy
	Medical Board
	Mental Health Board
	Mental Health Trust Authority
	Midwives
	Minerals Commission
	Municipal Bond Bank
	Natural Gas Authority
	Natural Gas Pipeline Corporation
	Natural Resources Conservation Dev
	North Pacific Anadromous Fish
	North Pacific Fisheries Management Council
	North Pacific Research Board
	Nursing
	Occupational Safety
	Oil & Gas Conservation Commission
	Optometry
	Pacific Marine Fisheries Commission
	Pacific Salmon Commission-Commissioners
	Pacific Salmon Commission- Northern Panel

	Pacific Salmon Commission-Transboundary Panel
	Parole Board
	Permanent Fund
	Pharmacy Board
	Physical/Occupational Therapy
	Pioneer's Home Advisory
	Police Standards Council
	Postsecondary Education
	Professional Counselors
	Professional Teaching Practices
	Psychologist/ Psychological assoc.
	Public Offices Commission
	PWS Oil Spill Recovery Institute
	Railroad Corporation
	Real Estate Appraisers
	Real Estate Commission
	Regents
	Regulatory Commission (RCA)
	Royalty Oil & Gas Development
	Safety Advisory Council
	Seafood Marketing Institute
	Seismic Hazards Safety Commission
1	Social Work Examiners
	Student Loan Corporation
	Subsistence Resource Commissions
	Suicide Prevention Council
	Telecommunications
	Uniform State Laws
	Veterans Advisory Council
	Veterinary Examiners
	Violent Crimes Compensation
	Water and Wastewater Works
	Western Interstate Comm/Higher Educ
	Wood-Tikchik State Park
	Worker's compensation
	Worker's Compensation Appeals Commission
	Workforce Investment Board
	Yukon River Panel

If appointed, a press release will be issued announcing your appointment pending the completion of the appointment process with the Governor's office. Please supply our office with the following information that will be included in the press release.

(Name): Marilyn B. Kerr, (Age): ___ of (Hometown): ___
is (Job title/Place of employment): Providence Behavioral Medicine Grp
(Name) holds (Listing of earned degrees like bachelor's, master's, ect.): M.S.W; B.A LCSW # AA00143 (AK).
(Or list relevant experience to the position you are being appointed to)

Examples:

John A. Doe, 38 of Soldotna, is Director of T-Shirts & Co. Doe holds a bachelor's degree in business administration from X University and a master's degree in communications from X University.

John A. Doe, 38 of Palmer, is the owner and operator of Doe and Associates, Inc. Doe previously served as division manager at X, Inc. Doe is a certified personnel consultant.

RESUME

Marilyn B. Kerr L.C.S.W.

Residence:

Education:

Master of Social Work 1972
University of Denver (CO)

Bachelor of Arts
College of St. Catherine (MN)

Licensure: LCSW, ALASKIA, 1989 through current
Professional Accreditation: ACSW – granted 1995 per NASW, current

Employment Experience:

1997-present: Mental Health Therapist - Providence Behavioral Medicine Group AK), 1997 – present; provide outpatient individual, family and group therapy services served as chair of Customer Service Committee 2004-2007.

1995-1997: Mental Health Therapist - Alaska Guidance and Diagnostic Clinic (AK), 1995-1997 – provided outpatient individual, family and group therapy services to adolescents; coordinated with Providence Discovery Adolescent inpatient services to provide family group programs.

1992-1995: Mental Health Therapist – Providence Discovery Adolescent Mental Health (AK) program; provided primarily outpatient services to adolescents and families; provided in/outpatient group services to adolescents and parents. Coordinated with Breakthrough chemical dependency program to provide services to adolescent children of adults in substance abuse program.

1987-1992 Employee Assistance Clinician - Human Affairs of Alaska, Inc. (AK); provided assessment and referral services; served as contract liaison to federal agencies; provided crisis services including CISD; developed programs for supervisors; managed return to work services for temporarily impaired employees.

1986-1990 Contract Social Worker - Medicaid certified facilities including Hope Cottages, Inc., (AK) and Cordova Community Hospital (AK); provided social work services to long term residents with focus on cultural and family inclusion; coordinated with medical staff and interdisciplinary teams.

1985 Contract Social Worker - Army National Guard (AK) stress management training (single event).

1982-1984 Social Worker – Home Health Care, Inc., (AK); contracted to begin social work component for Medicare/Medicaid certified agency. Provided direct services to home-based patients and families; coordinated with health care team to deal with terminal diagnoses, life-space crises, and utilization of resources and alternatives to institutionalization.

1980-1987 Assistant Adjunct Professor, School of Social Work, University of Alaska Anchorage: provided supervision to social work students; liaison to Anchorage Foster Parents Association.

1979-1981 Social Worker, Aleutian Pribilof Islands Association (AK). Developed social work program transitioning from BIA services; served nine villages, educated re: Indian Child Welfare Act, coordinated with state child welfare personnel; tTrained Community Health Aides re: family violence, community support, mental health and child welfare issues.

1978-1980 Clinician, Family Resource Center (AK); contracted to provide clinical services to individuals and families with focus on recovery issues related to alcohol and drug abuse.

1977-1978 Staff Supervisor, Mary Johnson House, Alaska Children's Services (AK). Provided staff supervision and direct services to adolescents in short term residential care.

1976-1977 Social Work Supervisor Ketchikan Children's Home, Ketchikan (AK). Supervised full-time staff of group home and shelter homes; coordinated with DFYS and State court system; direct services to children and families; served on State of Alaska residential care committee under Governor Jay Hammond.

1974-1976 Social Worker III, Division of Social Services, Ketchikan District (State of AK). Provided child protection services, day care licensing, foster care services, coordination with courts and local resources.

1973-1974 Supervisor, Specialized Services Unit, Children's Services Division, State of Oregon (Bend, OR). Supervised child protection unit, foster care licensing, responsible for Deschutes County CSD budget; participated in multiple impact assessment training, coordinating local agencies to focus and streamline child/teen placements.

1972-1973 Social Worker, Protective and Maternity Services, Denver Dept. of Welfare, (CO). Served problem pregnancy clients, liaison to adoption unit; provided life-space crisis intervention, foster placement, coordinated with University of Colorado Medical Center.

Additional field experience and personal or employer references available upon request

[redacted]

Schneider, Deborah
Bd of Certified Direct Entry Midwives

Deborah Schneider
[redacted]
Wasilla, Alaksa 99687
[redacted]

Employment:

2005-present	Owner of Windsong Midwifery, LLC and the Birth Place Provide complete antenatal care to low risk women in an out of hospital setting. (Birth Center and Home)
1990-2010	Anchorage Fire Department - Muni. of Anchorage Mobile Intensive Care Paramedic/FireFighter-III Provide advanced emergency medical care in the Municipality of Anchorage, population approx. 350,000.
2001-2004	Mat-Su Midwifery, Inc Contract Certified Direct Entry Midwife. Provided prenatal care, labor and delivery services to low risk women.
1986-1990	Co-owner MedTech International Provided Emergency Medical training throughout the State of Alaska, both basic and advanced life support. State of Alaska certified EMT-I, II, and III instructor. State of Alaska EMT Certifying officer.
1989	Assistant Medical Coordinator for VECO during the Exxon oil spill
1985-1990	Chugiak Volunteer Fire Department EMT-III provider for volunteer fire department Provided training for EMT I, II, and III to members
1985-1986	Arctic Medical Transports Mobile Intensive Care Paramedic Ground ambulance transport attendant

1983-1984	Arctic Medical Transport EMT-II Ground ambulance transport attendant
1983-1984	Chugiak Volunteer Fire Department EMT I and EMT II provider for volunteer fire department

Education:

1984-1985	Central Washington University Paramedic Program, National Registry of Paramedic certificate CPR-Instructor
1982-1983	Anchorage Community College General Studies and Emergency Medical Technician certificate
1985-1997	State of Alaska Emergency Medical Technician Instructor for EMT-I, EMT-II, and EMT-III. State of Alaska Certifying Officer
1991-present	Advanced Cardiac Life Support Provider; 2004 Advanced Cardiac Life Support Instructor. Pediatric Life Support Provider; 2003 Pediatric Life Support Instructor.
1997-2001	Midwifery Eduction Foundiation At distance education program for midwifery. Student midwife at Bearing in Mind Birth Center with J. Adamson, CNM and Z. Collette-Paule, CNM and at Mat-Su Midwifery with P. Weaver, CDM and J. Davidson, CDM. Licensed Certified Direct-Entry Midwife State of Alaska March 2001. License number 31.
1997-present	Neonatal Resuscitation Provider
2006-2008	Re-Licensed as State of Alaska EMT-I, EMT-II and EMT-III Instructor

[redacted]

Professional Associations:

1985-present Member, Midwife Association of Alaska
2005-present Midwife Association of Alaska - continuing education committee member
2006-present Midwife Association of Alaska - Peer Review member

References:

Pam Weaver, CDM
[redacted]

Steve Alexander, MICP
[redacted]

Michael Levy, MD
Alaska Regional Hospital, Emergency Room
[redacted]

CONGEN-
ITAL
CMV
INFORMA
TION

<TARGET><BILL></BILL><SUBJECT>CONGENITAL CMV
INFORMATION</SUBJECT><COMM>SHSS27</COMM></TARGET>

Every year, 1 in 150 children is born with congenital CMV.

Congenital CMV (cytomegalovirus) causes deafness, blindness, cerebral palsy, mental and physical disabilities, seizures, and death.

WHY IS CMV AWARENESS IMPORTANT?

In the United States, about 50 to 60% of women are at risk for contracting CMV infection during pregnancy.
In a recent survey of women in the United States, only 14% had heard of CMV, compared with 97% who had heard of Down Syndrome and 98% who had heard of HIV/AIDS. With CMV prevention measures rarely communicated to women, Stop CMV wants to increase the public profile of congenital CMV to save tens of thousands of babies each year from death and disability.

ABOUT STOP CMV & THE CMV ACTION NETWORK

The mission of Stop CMV and The CMV Action Network is to prevent and eliminate congenital CMV and to improve the lives of all people affected by congenital CMV.
Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

HOW YOU CAN HELP

There are many ways to make a difference, whether it be online or volunteering locally--there is always a way to participate in CMV awareness, outreach, and advocacy. Your service, caring and contribution can help change lives and prevent congenital CMV.
Visit Stop CMV at www.StopCMV.org for more information about CMV and how you can get involved.

If you are pregnant or planning a pregnancy, learn how you can prevent congenital CMV:

- DO wash your hands after handling babies or small children.
- DON'T share food or drinks with babies or small children.
- DON'T kiss babies or small children on the mouth.

Learn the facts about CMV

- Most common virus transmitted from mother to unborn baby
- More common than Down Syndrome, Spina Bifida and Fetal Alcohol Syndrome
- Spread through saliva, urine, tears, blood, mucus, and other bodily fluids
- Found mostly in healthy babies, toddlers, and young children
- Poses a major risk to pregnant women, especially mothers, daycare workers, preschool teachers, therapists, and nurses

Prevent birth defects. Stop CMV.

For more information, visit Stop CMV at www.StopCMV.org or the Centers for Disease Control and Prevention (CDC) at www.cdc.gov/cmv.

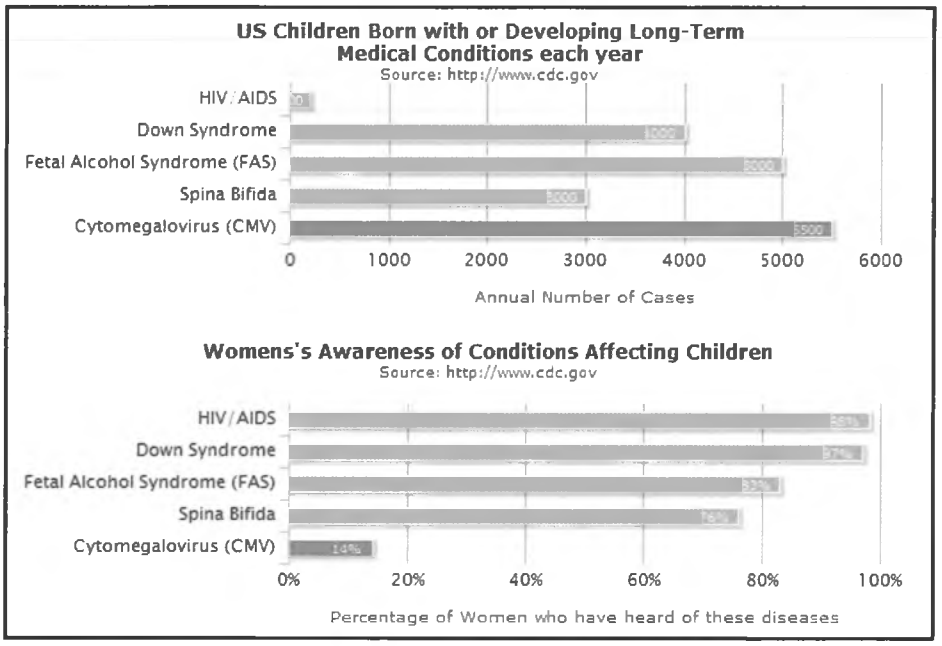
AWARENESS . OUTREACH . ADVOCACY
STOP CMV AND THE CMV ACTION NETWORK INC.

CMV
STOP CMV
The CMV Action Network

CMV Awareness

More children have disabilities due to congenital CMV (cytomegalovirus) than other well-known infections and syndromes, including Down Syndrome, Fetal Alcohol Syndrome, Spina Bifida, and Pediatric HIV/AIDS.

- A 2008 study, funded by the Center for Disease Control (CDC) found that **only 14% of women in the United Stated had heard of Cytomegalovirus (CMV).** *Ross DS, Victor M, Sumartojo E, Cannon MJ: Women's Knowledge of Congenital Cytomegalovirus: Results from the 2005 HealthStyles survey, J Women's Health, Vol. 17, 849-858 (2008).*
- The American College of Obstetricians and Gynecologists (ACOG) and the CDC recommend that OB/GYNs counsel women on basic prevention measures to guard against CMV infection.
- Only 44% of OB/GYNs reported counseling their patients about preventing CMV, according to a 2007 survey. *Knowledge and practices of obstetricians and gynecologists regarding cytomegalovirus infection during pregnancy-United States, 2007, MMWR, Vol. 57, 65-68 (January 25, 2008).*



Preventing CMV among pregnant women

- Women are not routinely screened for CMV during pregnancy.
- Infants are not routinely tested for CMV after birth.
- Behavioral intervention programs need to be developed, implemented, and evaluated
  - A study in France showed that women who were educated about preventing CMV transmission were able to significantly reduce their rates of infection during pregnancy; a similar intervention needs to be tested in the U.S.

CMV has never received dedicated funding

- It is time to fund public education and awareness campaigns to help prevent this common virus.

About Stop CMV and The CMV Action Network

Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

Stop CMV - The CMV Action Network

P.O. Box 62214
Sunnyvale, CA
94088-2214

www.stopcmv.org
info@stopcmv.org

A non-profit 501(c)(3) organization

STOP CMV
The CMV Action Network
www.stopcmv.org

CMV Facts

Incidence

- Congenital CMV is the most common congenital (meaning present at birth) infection in the U.S.
  - 1 in 150 children is born with congenital CMV (approx. 35,000 each year)
- Congenital CMV is the most common cause of birth defects and childhood disabilities in the U.S.
  - 1 in 750 children develops permanent disabilities due to congenital CMV (approx. 5,500-8,000 each year)
- Congenital CMV causes more disabilities than Down Syndrome, Fetal Alcohol Syndrome, and Neural Tube Defects (Spina Bifida, Anacepahly, etc.).
- Congenital CMV is a leading cause of Cerebral Palsy, hearing loss, mental disability, and ADHD/Autism.
- Congenital CMV also causes vision loss, feeding issues/Failure to Thrive (FTT), sleeping issues, sensory issues, small head/small brain (Microcephaly), intercranial calcifications, seizures, and death

- There are approximately 400 fatal cases of congenital CMV each year; this number doesn't include miscarriages.
- CMV can cause symptoms when the baby is born or later in the baby's life; in some infants, symptoms and problems can arise months or years after birth.

Congenital CMV can be diagnosed if the virus is found in an infant's urine, saliva, blood, or other body tissues during the first week after birth.

Congenital CMV cannot be diagnosed if the infant is tested more than one week after birth.

- Anyone can become infected with CMV, which is common and usually harmless.
- Most people don't realize that they have been infected with CMV.
- One of the highest risk groups are pregnant women who have not yet contracted CMV prior to pregnancy, as they will possibly pass the virus to their developing child, causing potential birth defects.

Transmission

- CMV is found in body fluids, including urine, saliva, blood, mucus, and tears.
- CMV is very common in home and daycare settings, especially among healthy children 1 to 3 years of age who are at high risk for contracting CMV from their peers.

(over)

About Stop CMV and The CMV Action Network

Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

Stop CMV - The CMV Action Network

P.O. Box 62214
Sunnyvale, CA
94088-2214

www.stopcmv.org
info@stopcmv.org

A non-profit 501(c)(3) organization

STOP CMV
The CMV Action Network
www.stopcmv.org

- Mothers and women who work with infants and young children should be educated about the risks of CMV and the precautions they can take to prevent infection.

Prevention

- Simple steps to avoid exposure to saliva and urine that might contain CMV:
  - Wash your hands often with soap and water for 15-20 seconds, especially after changing diapers, feeding a young child, wiping a young child's nose or drool, and handling children's toys.
  - Do not share food, drinks, or eating utensils used by young children.
  - Do not put a child's pacifier in your mouth.
  - Do not share a toothbrush with a young child.
  - Avoid contact with saliva when kissing a child.
  - Clean toys, countertops, and other surfaces that come into contact with children's urine or saliva.

All statistics and information cited from the Center for Disease Control and Prevention (CDC) - www.cdc.gov/cmv

The State of CMV

Background

Promising strategies for preventing and treating congenital CMV are available. They include raising awareness, developing behavioral interventions to prevent infection in pregnant women, and improving outcomes in congenitally infected children through early detection and intervention. To be successful, these approaches require adequate surveillance and laboratory capacity. However, prevention and treatment strategies have never been implemented on a wide scale.

Current efforts

Congenital CMV does not receive dedicated federal funding. Fortunately, people have realized a need to address this issue. By using CDC general funds and external grants, small research activities have been funded, including:

- Study of the natural history of CMV infection among women
- Surveys of women's knowledge, attitudes, and behaviors related to congenital CMV
- Laboratory assessments of CMV persistence in the environment and the efficacy of hand washing for removing CMV from hands
- Study of long-term outcomes in a cohort of children born with congenital CMV

Issues needing immediate attention

Awareness – Awareness campaigns are needed to explain the dangers posed by CMV and how they can be prevented

- Only 14-22% of women have ever heard of CMV.
- Most obstetricians do not discuss CMV or CMV prevention with their patients.

Preventing CMV infection among pregnant women – Behavioral intervention programs need to be developed, implemented, and evaluated

- A licensed CMV vaccine is unlikely to be available for many years.
- A large intervention study in France showed that women who were educated about preventing CMV transmission were able to significantly reduce their rates of infection during pregnancy; a similar intervention needs to be tested in the U.S.

Evaluating newborn CMV screening – Research and pilot screening programs are needed to determine whether benefits of screening outweigh costs and potential harms

- Congenital CMV infections are more common than the combined metabolic or endocrine disorders currently in the U.S. core newborn screening panel.

(over)

About Stop CMV and The CMV Action Network

Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

Stop CMV - The CMV Action Network

P.O. Box 62214
Sunnyvale, CA
94088-2214

www.stopcmv.org
info@stopcmv.org

A non-profit 501(c)(3) organization

STOP CMV
The CMV Action Network
www.stopcmv.org

- Newborn CMV screening has significant potential for improving children's functional outcomes (e.g., language and educational development) through early detection and intervention.

Surveillance – Ongoing surveillance is needed to assess the burden of congenital CMV and to make it possible to monitor the effectiveness of future prevention programs.

- There is no ongoing assessment of the occurrence of CMV infection among pregnant women, rates of congenital infection among newborns, or rates of disability among infected newborns.

Laboratory capacity – Diagnostic methods are not yet sufficient for universal CMV screening programs.

- Standards and controls need to be developed for quality control of newborn CMV screening.
- Improved diagnostic tools are needed for prenatal maternal screening and diagnosis.

Stop CMV and The CMV Action Network

Who we are

Since 2003, Stop CMV has been working to foster congenital CMV awareness via internet and public awareness campaigns. The CMV Action Network is comprised of families, friends and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus. We realize that the incidence of children born with congenital CMV can be greatly reduced with grassroots public education and awareness. Additionally, we hope that women, families and friends will become familiar with CMV and will take vigilant steps to prevent infection. We believe that it is better for women and their families to learn about CMV prior to pregnancy in order to be well informed and take preventative actions.

Mission

The mission of Stop CMV and The CMV Action Network is to prevent and eliminate congenital CMV and to improve the lives of all people affected by congenital CMV.

Strategic Goals

Organization – Develop and maintain an efficient organization to cost-effectively fulfill the mission and increase the quality, consistency and scope of The CMV Action Network

Funding – Develop and maintain annual revenue sources sufficient to fulfill the mission and support an appropriate capital reserve

Awareness – Support media and education programs to improve awareness and help decrease the incidence of congenital CMV affected pregnancies

Outreach – Facilitate open communication and gatherings among active Stop CMV members and provide support and resources to all CMV families in need

Advocacy – Serve as a key congenital CMV advocacy group, the unified voice of CMV familes, and increase funding for congenital CMV related research and awareness projects

June is National CMV Awareness Month

Through the efforts of Stop CMV, June was listed as National Congenital Cytomegalovirus Awareness Month, a National Health Observance (NHO) with the U.S. Department of Health and Human Services.

Your support is urgently needed to stop the spread of congenital Cytomegalovirus (CMV) and specifically to assist Stop CMV and The CMV Action Network with legislation to raise awareness of congenital CMV.

STOP CMV
The CMV Action Network
www.stopcmv.org

About Stop CMV and The CMV Action Network

Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

Stop CMV - The CMV Action Network

P.O. Box 62214
Sunnyvale, CA
94088-2214

www.stopcmv.org
info@stopcmv.org

A non-profit 501(c)(3) organization

CMV Vaccine

Vaccines for preventing CMV infection are still in the research and development stage.

Vaccine Progress

- CMV vaccines are still in the research and development stage
- Phase I trials can be done (with a small number of subjects) and can cost under $1 million.
- Phase II trial costs can vary. A recent trial took 10 years and cost $7.5 million.
- Phase III trials can cost anywhere from $10 million-$100 million depending on FDA subject requirements.

Economic Burden/Cost Impact

- The annual cost for caring for CMV children is estimated at $1billion-$2 billion for the U.S. alone. *Institute of Medicine Committee to Study Priorities for Vaccine Development. Vaccines for the 21st Century: A Tool for Decision Making. Washington, D.C.: National Academy Press; 2000*
- The cost of vaccine development is dwarfed by the economic burden of caring for CMV children.

Timing

- In 2000, the Institute of Medicine (IOM) ranked the development of a CMV vaccine as a highest priority because of the lives it would save and the disabilities it would prevent.
- It may be a number of years before there is a Food and Drug Administration-approved CMV vaccine.

About Stop CMV and The CMV Action Network

Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

Stop CMV -
The CMV Action Network

P.O. Box 62214
Sunnyvale, CA
94088-2214

www.stopcmv.org
info@stopcmv.org

A non-profit 501(c)(3) organization

STOP CMV
The CMV Action Network
www.stopcmv.org

CMV Stories

Every year in the United States alone, thousands more children are born with congenital CMV. Their parents experience an unspeakable fear and pain as they learn more about CMV and its effects as they piece together what life will look like for their children and their families.

"The first time I see my daughter, we are baptizing her because she may not live. She is dying. There is no moment where they hand her to me. The moment when I take her face in and I know that she is mine. There is, instead, a moment when I look at her and I don't understand what went wrong. Why it is that I expected a healthy baby girl and instead I am looking at a dying neonate. Her skin is covered in red blotches, she has a wealth of black hair. She seems to have my nose. I cannot see her mouth because a tube is down her throat and tape covers the better portion of her chin, mouth and upper lip. I make myself take pictures of that moment, of us as a family. Because I still hope that someday this moment will just be ancient history." – Lauren Grace's Story, Iowa

"He was a very bright boy early on, teaching himself how to read at age two, but not learning how to walk until age 2-1/2. At age 5, he was diagnosed with ADHD and takes medication to help him at school. At age 7, Jeb was diagnosed with an autism spectrum disorder, pervasive developmental disorder (PDD-NOS)." – Jeb's Story, Wisconsin

"I remember sitting in the doctor's office at 22 weeks. They told me if I wanted to terminate, they would set me up with a doctor in another state, since it was no longer legal in my state. I was a single 19-year old sitting in a doctor's office in tears. It was the most important decision of my life. I had no one to talk to. I wish I had known about Stop CMV." – Logan's Story, Connecticut

"When I looked at him I noticed he was covered in red dots...I asked the nurse why he was covered in dots and she said some babies are born like that…When she came back she had the pediatrician with her. He told us that Dalen would have to stay in the NICU because he had an enlarged spleen and liver also that he didn't know what was wrong with him. My heart sank. I felt like I was in a show on Discovery Health Channel." – Dalen's Story, Mississippi

"I am only 16 and it's hard to process things in my mind when the doctors were telling me that she might come out like this or like that, so I just shut them all out and hoped for the best… She is 1 year old now. I don't think she can see because she doesn't follow or look at me. She laughs a lot, can't sit up yet or walk but I'm working on it." – Angelina's Story, Rhode Island

"I received two IV infusions of CMV immunoglobulin and went for another ultrasound at the end of the week. Two perinatologists came in to complete the ultrasound. As they looked at the monitors in silence, I began to cry. The ascites in our baby boy's belly had gotten so much worse. It had also spread to his chest, arms and legs. His liver was enlarged and damaged. I had barely any amniotic fluid left. I was 23 weeks pregnant. I was induced that night. We sat outside of the hospital and cried for most of the day before finally going to labor and delivery. We understood that our baby would die during the labor and delivery process." – Milan's Story, Illinois

(over)

About Stop CMV and The CMV Action Network

Since 2003, Stop CMV has been working to foster awareness of congenital CMV through internet and public awareness campaigns. The CMV Action Network is comprised of families, friends, and medical professionals personally affected by CMV and committed to public education efforts to prevent future cases of the virus.

Stop CMV - The CMV Action Network

P.O. Box 62214
Sunnyvale, CA
94088-2214

www.stopcmv.org
info@stopcmv.org

A non-profit 501(c)(3) organization

STOP CMV
The CMV Action Network
www.stopcmv.org

"I was depressed and confused. I didn't know what to think anymore. I was shaking the entire morning and thinking where did I get this virus, what I did wrong. I couldn't believe what was happening. All the care I had, I never drink or smoke. I was very careful with my food, with my environment, taking all the precautions and I got CMV." – Zachary's Story, Texas

"While in the NICU he stopped eating and a NG tube was placed through his nose. It was a rough month for all of us. Kaden was such a strong baby. He hardly ever cried and just seemed to take everything that was thrown his way. It was very clear he was going to be a fighter." – Kaden's Story, Washington

Read any of the over 100 CMV parent stories from around the United States and the world at www.stopcmv.org/stories.

Raelyn - Missouri
born September 4, 2010

Ashley - Michigan
born August 9, 1989

Carson - North Carolina
born August 22, 2007

Chelsea - Louisiana
born April 15, 1996 - passed away April 13, 2000

Rachel - Ireland
born February 26, 2009

Alan - Ohio
born August 9, 1994

Ashley - South Africa
born May 14, 2001

Cameron - Arizona
born November 21, 2004

Scarlett - Idaho
born October 28, 2006 - passed away November 14, 2006

Gabriel - Florida
born October 26, 2009

Reese - North Carolina
born August 4, 2010

Aedan - South Africa
born October 24, 2006 - passed away July 7, 2010

Lowee - Arizona
born June 15, 2007

Jack - Georgia
born January 7, 2005

Precious - United Kingdom
born May 18, 2007 - passed away June 14, 2007

Carmine and Giulliana - Connecticut
born May 3, 2009

Abby - Georgia
born April 1, 2004

Melissa - Mexico
born January 21, 2002

Angelina - Rhode Island
born August 6, 2009

Evie - Iowa
born October 31, 2007

Maria - Portugal
born December 12, 2007

Milan - Illinois
born and passed away July 17, 2010

Amber - Texas
born September 12, 2000

Kaitlyn - North Carolina
born July 23, 2009

James - Canada
born October 22, 2007

Jenna - Arizona
born June 23, 2009 - stillborn

Mia - Australia
born March 30, 2007

Noah - New York
born October 11, 2004

Kaileigh - Canada
born June 20, 1998 - passed away September 12, 2009

Musa - Australia
born October 15, 2007

Lauren Grace - Iowa
born February 12, 2010

Giuliano - New York
born April 2, 1996

Caiti - Arizona
born August 25, 2001

Zach - Florida
born September 8, 2001

Madison - Texas
born August 1, 2000

Emma - Michigan
born August 14, 2007

Logan - Connecticut
born August 17, 2009

Cruz - Australia
born May 5, 2005

Elijah - Texas
born November 28, 2006

Alexis - Florida
born August 3, 2008

Jayden - Colorado
born January 17, 2008

Kylee - Oklahoma
born May 24, 1999

Jakob - Georgia
born November 19, 2000

Starlitt - Connecticut
born January 30, 2010

Ryan - New Jersey
born August 1, 2001

Riley - Florida
born and passed away November 27, 2009

Daniel - Georgia
born July 2, 1983

Gracie - Connecticut
born March 2, 2009

Liam - Virginia
born February 6, 2007

Chloe - Michigan
born December 16, 1998

Zachary - Texas
born May 9, 2009

Krystal - Utah
born July 9, 1995

Michael - Texas
born December 17, 2003

Bailey - Alaska
born September 30, 1995

David - Florida
born March 3, 1997

Trenton - Missouri
born July 26, 2006

Portia - Michigan
born August 17, 2007

Joshua - New York
born March 28, 2008

Jeb - Wisconsin
born December 24, 1999

Addison - Georgia
born March 27, 2009

Katie - Indiana
born August 30, 2006

Isaiah - Nebraska
born December 28, 2001

Kristen - New York
born April 5, 1982

Danny - Missouri
born March 11, 2008

Samantha - Colorado
born April 1, 2010

Avery - Minnesota
born June 5, 2008

Amari - California
born September 12, 2007

George - Virginia
born July 30, 2005 -
passed away April 17,
2007

Amilia - Connecticut
born September 27, 2006

Leah - Tennessee
born July 17, 2008

Dalen - Mississippi
born May 25, 2009

Landon Joe - North
Carolina
born August 11, 2007

Rachael - Tennessee
born September 4, 1995

Andrew - Missouri
born March 19, 2009

Miranda -
Florida
born 2008

Aydon -
Alabama
born July 2,
2008

Riley Jean -
Florida
born October 30, 2008

Tanner - Alabama
born December 13, 2008

Laney - Texas
born April 20, 2008

Jamie - United Kingdom
born January 9, 2007

Austin - Florida
born October 21, 1992

Kyra - Kentucky
born March 27, 2002

Cassie - Wisconsin
born September 20, 1988

Matthew - Michigan
born August 30, 2008

Ruth Elyse - Illinois
born August 28, 2008 -
stillborn

Elias David - Arizona
born October 30, 2008 -
stillborn

Savanah - Utah
born March 25, 2004

Jeremiah - Virginia
born June 22, 2005

Kaiden - Australia
born July 4, 2007

Audrey - North Carolina
born July 26, 2006

Kaden - Washington
born January 1, 2006

Leah - Washington
born January 15, 2008

Colby - Georgia
born September 14, 2006

Jaxon - Alabama
born November 25, 1998

Riley and Rachel -
California
born August 9, 2003

Brayden - Pennsylvania
born July 12, 2006

Jacob - Virginia
born September 2, 2006

Katelyn Marie - Arizona
born November 6, 2003

Joshua Daniel - Nevada
born February 8, 2007

Elizabeth - New York
born December 18, 1989
- passed away February
9, 2006

Tobias - Florida
born January 12, 2008

Bryson - Texas
born February 25, 2009

Gabriela - California
born July 14, 2005

Maeve - New York
born November 30, 2008

Audrey - Poland
born July 30, 2007

Nolan - Oregon
born November 27, 2002

NEIGHBOR WORKS ANCHORAGE, FUNDING REQUEST 2012

<TARGET><BILL></BILL><SUBJECT>NEIGHBOR WORKS ANCHORAGE, FUNDING REQUEST
2012</SUBJECT><COMM>SHSS27</COMM></TARGET>

NeighborWorks®
ANCHORAGE

February 3, 2012

The Honorable Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801

Dear Senator Davis:

NeighborWorks® Anchorage respectfully submits for your consideration a request for funding to support our work in the critical areas of affordable housing, strengthening neighborhoods, and community engagement. Formerly known as Anchorage Neighborhood Housing Services, Inc. we have been improving the quality of life for Anchorage families and individuals for 30 years.

We are requesting funding from the State of Alaska to help us repair the historic Loussac-Sogn Single Resident Occupancy building, located in downtown Anchorage. This property provides safe, stable housing for many of our community's most vulnerable individuals. A number of repairs are needed to maintain the property on behalf of our residents. Last year we initiated the first of the repairs by replacing the elevator and adding chair lifts. For your convenience, our revitalization request has been categorized by building specialty.

We greatly appreciate the opportunity to be considered for this important funding, and thank you for taking the time to review our request.

Sincerely,

Debe Mahoney
Executive Director

480 West Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage Legislative Request 2012

NeighborWorks® Anchorage Loussac-Sogn Revitalization Project

Anchorage Neighborhood Housing Services, Inc. dba NeighborWorks® Anchorage (NWA) was founded in 1981 and is dedicated to improving the quality of life for families and individuals by strengthening neighborhoods and creating and preserving housing opportunities. As a member of the NeighborWorks® America network of excellence, NWA provides affordable rental opportunities to nearly 3,000 individuals through its 950 units, housed in nine properties throughout Anchorage. Two of our properties are located in the downtown area. One of which, the Loussac-Sogn is in the heart of downtown and provides affordable rental housing for Anchorage's very low income seniors, individuals with disabilities, and other individuals earning less than 50% of the area median income (currently less than $29,850). The ground floor provides retail rental space for three minority-owned businesses, two not-for-profit organizations, The International Gallery of Contemporary Art, which has been located in our building for a number of years, and Urban Prints, a new social enterprise targeting disadvantaged young adults that opened for business this winter. As a business under the Anchorage Urban League, the goal is to provide job training for young adults facing individual challenges including homelessness and disabilities.

In addition to rental housing, NWA offers products and services through its homeownership line of business, supporting new homeowners through education and lending products and providing supportive services to existing homeowners. Services include minor repair grants and loans and accessibility modifications for seniors and the disabled. Through our community-wide Paint the Town program, we assist homeowners with minor exterior repair and painting. This program brings together local vendors, volunteer paint teams, and homeowners.

NeighborWorks® Anchorage is committed to housing our community's hard to house families and individuals, thereby reducing homelessness and contributing to long-term, stable housing. We are members of many local coalitions and working groups on affordable housing and other community issues. We are a member of the Anchorage Continuum of Care and a founding partner of the Anchorage Project Homeless Connect. We work closely with many providers of supportive services to permanently house their clients and consumers, including providing housing for individuals and families coming out of emergency shelter. We work with local, non-profit recipients of federal homeless assistance programs to provide permanent housing solutions for our community's most vulnerable populations. Using the "Beyond Shelter" model, we provide the housing while our partners provide services such as mobile case management, self-sufficiency training, and other life skills development.

NeighborWorks® Anchorage goes beyond providing safe, clean and affordable housing; we offer opportunities for residents to have more than just a place to call home. NWA's community engagement programs and resident services offer continuous, self-renewing efforts aimed at relationship building, problem solving and building a stronger community. They are based on the belief that people have the ability to name their problems and identify the additional information and resources they need to solve them. This is a people-focused process that improves the quality of life for individuals and the greater community.

We provide information and referrals for a vast array of community services through our partner agencies. Over the past two years we also held six Community Resource Fairs at our properties. Participants were able to receive free credit reports and flu vaccines, sign their

children up for Denali Kid Care, apply for library cards and access more than 17 additional services and resources.

In support of long-term, systemic change, we provide activities such as participation in NeighborWorks® America's Community Leadership Institute, Leadership Training and Coaching, and Resident Council support. We also encourage resident involvement through volunteer opportunities such as Project Homeless Connect.

Four of our properties currently have resident councils and our two downtown properties have floor leader programs. Resident councils serve as a means for residents to successfully integrate into their surroundings and become involved in leadership development. Resident council members learn how to conduct effective meetings and how to develop community organizing skills and techniques. Councils usually meet monthly to discuss property issues as well as resident programs and services. These councils plan social activities and events to encourage resident involvement and to promote relationship and community building efforts.

Throughout the year, we offer Community Leadership Training free of charge to residents and community members. Based on national practices, the workshops include topics such as team building, advocacy, civic engagement and diversity. Workshops include active participation, detailed workbooks and often guest speakers. Focused on the issues that the participants identify as the most critical challenges they face, we develop a curriculum based on national leadership training models. These workshops have led participants to attend assembly meetings, volunteer in the community and become award winning leaders in their neighborhoods.

Through our programs and projects, we have also discovered that by mentoring someone who faces overwhelming challenges, their life can be transformed long term. Therefore, we initiated a pilot mentoring project called Stepping Stones to work with at-risk adults. The team includes over ten community leaders who are fully committed to the project. At the announcement of this new pilot program, we received applications from 14 potential mentees. We have no doubt that lives will change for all of us based on our past successes and the commitment of so many community leaders who have worked on the project for the last year. Our intent is to build on those successes, resulting in a model that can be duplicated in other communities.

NeighborWorks® Anchorage recognizes that we must do more than provide "bricks and mortar" in order to create stable permanent housing, especially for those in our community that are the most vulnerable. As our community focuses on finding solutions to increase permanent, stable housing, NWA is taking a leading role by focusing expanded efforts on resident services and community engagement.

Our ultimate goal is to increase the likelihood of individuals and families retaining stable, permanent housing. We believe this is a foundation to a better quality of life. Families and individuals who can successfully retain housing can focus on other areas of life like health and well being, education, financial stability, and planning for the future. Stable families benefit all our neighborhoods, communities and our future. Educational attainment and success is higher when children are not moving from school to school. Access to stable permanent housing can reduce the number of people in emergency shelter or those living in substandard conditions.

Need Statement/Project Description

NeighborWorks® Anchorage provides housing for some of our community's most vulnerable residents in two properties located in the downtown area. One property, The Loussac-Sogn is a historic building we purchased, remodeled and placed in service in 1994. Built in 1947, the Loussac-Sogn originally provided office and medical clinic space. Since 1994, this three-story historic building has provided single room occupancy residential apartments in the center of downtown Anchorage. The structure has 50 efficiency units and 2 one-bedroom units on the top two floors, and 6 commercial units on the first floor. The residential portion of the building features congregate kitchens, bathrooms, and laundry facilities on each floor. There are lounges with cable television so the residents can choose to gather in a "family-like" setting. The Loussac-Sogn program targets rental applicants at or below 50% of the area median income, or slightly less than $30,000 annually. The standard single room rent is $500 per month at this time.

As previously stated, residents of the Loussac-Sogn represent some of our community's most vulnerable individuals. The following provides a snap-shot of our current residents:

Youngest:	Age 20	Lowest Income:	$ 4,901
Oldest:	Age 79	Highest Income:	$18,214
Average:	Age 49	Average Income:	$16,558*

*Currently 71% of our residents are below 30% of the area median income.

Female:	20	Disabled:	15
Male:	26	Seniors:	26

A sampling of employed residents work in the following industries: AmeriCorp Volunteer, retail sales, music and entertainment, hotel and tourism, food service/restaurant, plumbing apprentice, grocery.

- We currently house 14 senior women with disabilities living on fixed incomes; three are over 70 years old.
- Three young women found housing here after gaining mental stability from an institution; one is currently going to college part-time.
- Two middle-aged women gained stable housing after being homeless; one woman was nearly beaten to death while she was homeless and was in a coma for months, she is now stable and enjoys working during the summer at a nearby fish camp.
- Eight previously homeless men are currently housed at the Loussac-Sogn having been referred by local shelters; six have held down jobs in the neighborhood. One has gained a management position at JC Penney and hopes to buy a home in Anchorage this summer.
- We have fourteen male residents that are disabled and living on fixed incomes.
- Eleven of our residents are gainfully employed.
- One young woman moved here from Hawaii, participated in the Nine Star Program and has joined the Air Force.

Successfully retaining housing can be a challenge, especially for those families and individuals that have special needs, have past histories that make accessing mainstream housing difficult, or who have experienced homelessness, trauma, or other life altering events and are attempting to reintegrate into their community. Success means one must be able to pay the rent on time

and abide by the lease terms, tend to housekeeping and hygiene, and be a respectful neighbor, amongst others. Without extra help, many people with special needs and difficult histories can find these requirements impossible to meet, and therefore continue cycling through substandard housing nonstop. Many landlords will deny housing if past histories and references are poor, often limiting housing options. Lacking permanent housing, or being frequently transient is not just a negative social problem, it also has negative consequences for the individual. We all need to feel that we contribute to something, that we are part of something, and that we are accepted and valued by others. Lacking a stable community, those in a condition of transiency will often not be able to meet this need to belong.

Providing a place to call home plus supporting vulnerable residents takes time and money. The Loussac-Sogn was originally constructed in 1947 and while the building was rehabbed in 1994 and continually receives improvement, some of the important mechanisms and the cosmetic factors need additional attention.

The Loussac-Sogn operates without government subsidy, and contributes to the tax base of Anchorage. Operating on highly affordable, below market rents limits the ability of the property to be refinanced or be otherwise recapitalized using debt. In the past year NeighborWorks® Anchorage has invested over $150,000 into the property, including replacing the elevator and adding a stair lift to increase accessibility. We leveraged a $50,000 capital grant from NeighborWorks® America, and used a large portion of the buildings reserves to fund these critical improvements.

We have identified three categories of physical improvements needed to preserve the building and retain our ability to house vulnerable residents. The first priority is to rehab the roof and preserve the exterior of the building. The roof is the original roof from 1947 and while it has been repaired and re-layered over the years, a comprehensive re-roofing is now needed to extend the life of the property. The exterior of the building needs to be repainted and the awnings over the commercial storefronts need to be replaced. This will help protect the structure from the elements and restore the building's historic look. The exterior wainscot at street level is deteriorated and needs to be rehabilitated; restoring this element will preserve key historic façade in downtown Anchorage. As the Loussac is a Registered Historic Property, all exterior rehabilitation work will be done in conformance with the applicable standards for historic preservation. The look of the building will not be changed, but rather renewed and the historical features preserved and highlighted. Request: $1,328,050

The second priority is to replace and upgrade the boilers and water heaters that provide heat and hot water, as well as the rooftop air handling unit (RTU) that provides for ventilation and indoor air quality. While functional, the boilers are old and inefficient and we seek to replace them with new energy efficient systems (at least 95% AFUE/ASHRAE rating). The water heaters will be upgraded as well. The RTU has reached the end of its economic and useful life, and is deteriorated; replacement is necessary. Improving the air circulation and ventilation will improve indoor air quality, which results in a healthier home for the residents. Increasing the efficiency will help reduce the operating cost of the building, resulting in a more sustainable building and ensuring long term and stable housing that remains affordable. Request $178,250

The third priority area is to modernize the building interiors, included new flooring, paint, and upgrades to the plumbing and lighting systems. We believe that our residents should have a "home-like" environment in which to live, as this instills a pride of place and improves the quality of life. We seek to increase the quality and amount of lighting in each of the units to help address issues such as Seasonal Affective Disorder (SAD) and combat the long, dark, and cold months we experience in the north. Replacing the flooring in the common areas will reduce trip

hazards and help preserve the entire building by reducing water infiltration and damage to the subfloor and other building systems. The new flooring and carpet products available are durable, resilient and easy to clean and maintain, which will help reduce ongoing maintenance and replacement costs. Request $192,010

Recent improvements for fire and life safety requirements have depleted the reserves for this building. Offering affordable rents without government subsidy means that the Loussac-Sogn operates on a break even basis without additional capacity of debt financing for capital improvements. The aging facility demands greater effort and expense for annual repairs and maintenance, which more often are short term fixes for the serious building needs. Also, increased costs of utilities and property taxes paid to the Municipality of Anchorage add to the strain on the annual operating budget.

This investment of state capital funds into the Loussac-Sogn will preserve a historic building and piece of Alaska history, continue to support our small business tenants with an attractive and visible building, and enhance our ability to achieve the ultimate goal of ensuring stable long-term, affordable housing for the vulnerable people that we serve.

Fund Request/Budget

NeighborWorks® Anchorage respectfully requests funding from the State of Alaska for the repair of the historic Loussac-Sogn Single Resident Occupancy building.

State support for the repair of the building will not only benefit the residents but it will also benefit the downtown business district and the community at large. We will continue to serve our community's most vulnerable citizens with safe and desirable housing, ensuring the continuance of our part in answering the need to provide affordable housing to those individuals with very low incomes and special needs.

As indicated above, the capital needs of the building exceed what can be leverage from debt sources and revenue from operations. Capital funds for the preservation and revitalization of the building are vital to maintaining the near and long term capacity to house vulnerable individuals.

Our requested budget is presented below. A detailed budget is attached.

CATEGORY 1 – Building Envelope Preservation	$1,328,050
CATEGORY 2 – HVAC Energy Efficiency Upgrades	$ 178,250
CATEGORY 3 – Interior Preservation	$ 192,010
TOTAL REQUEST	$1,698,310

NeighborWorks® Anchorage is committed to changing lives, changing community and changing futures. Suffering trauma, dealing with physical or mental illness, and having no place to call home are burdens many of us will never face. The Loussac-Sogn provides vulnerable members of our community with a place they can call home, a connection to the wider community and foundation for a better future.

Loussac-Sogn Building Capital Renovation Budget

Category/Item		Cost Estimate
Category 1 - Building Envelope Preservation		
Re-Roof Building	$	1,250,625
Exterior Repaint	$	35,565
Replacement of Awnings	$	41,860
Category Subtotal	***$***	***1,328,050***
Category 2 - HVAC Energy Efficiency Upgrades		
Energy Efficiency Upgrade of Boilers and Water Heaters	$	132,250
Replacement of Roof Top Air Handlers	$	46,000
Category Subtotal	***$***	***178,250***
Category 3 - Interior Preservation		
Replacement of Flooring in Common Areas	$	92,860
Repainting of Common Areas	$	22,000
Unit Lighting	$	26,000
Structural and Water Damage Repairs	$	51,150
Category Subtotal	$	192,010

BUDGET SUMMARY		
Category 1 (Building Envelope) Subtotal	**$**	**1,328,050**
Category 2 (HVAC Efficiency) Subtotal	**$**	**178,250**
Category 3 (Interior Modernization) Subtotal	**$**	**192,010**
Total Project Cost	**$**	**1,698,310**

Anchorage Housing Market Analysis

Prepared for:
Municipality of Anchorage

Prepared by:

McDowell GROUP

Juneau • Anchorage

with

ECONorthwest
ECONOMICS • FINANCE • PLANNING

March 2012

Acknowledgements

The study team would like to express its appreciation to each of the Anchorage Housing Market Analysis Technical Advisory Committee members who provided their time and professional opinion and expertise throughout the entire study period. We thank:

- Pita Benz, Cook Inlet Tribal Council
- Mark Butler, Federation of Community Councils
- Tamás Deak, kpb Architects
- Daniel Delfino, Alaska Housing Finance Corporation
- Jim Fredrick, NeighborWorks Anchorage
- Ernie Hall, Anchorage Assembly
- Jeff Judd, Cook Inlet Housing Authority
- Mark Korting, RE/MAX Properties, Inc.
- Bill Popp, Anchorage Economic Development Corporation
- Andre Spinelli, Spinell Homes, Inc.
- Connie Yoshimura, CY Investments, LLC

Municipality of Anchorage Planning Division:

- Lisa Ameen
- Tom Davis, AICP
- Karen Iverson, AICP

This project was funded by the Energy Efficiency and Conservation Block Grant, a program of the American Recovery and Reinvestment Act.

Executive Summary

The Municipality of Anchorage (MOA) contracted with McDowell Group and ECONorthwest to conduct a technical analysis of housing demand and preferences in the Anchorage Bowl and Chugiak-Eagle River. The purpose of the study was to evaluate overall housing demand over the 2010 to 2030 period and evaluate the financial feasibility of compact housing types. The study was designed to answer questions such as:

- *What is future housing demand and which mix of housing options is preferred?*
- *Is there enough available land to construct new housing to meet this future demand?*
- *What role does compact housing development play in meeting this expected growth?*
- *Are there policy, financial, market, or physical barriers that need to be addressed to accommodate expected demand for housing and make development of new compact housing financially feasible, given the cost of building new compact housing and achievable rents in Anchorage?*
- *If no action is taken to accommodate housing demand, what may happen to Anchorage's housing market and rate of population growth?*

The study's key finding is that there is not enough buildable land to accommodate future housing demand under historical development patterns, current land-use policies and development options. Building mid-rise residential and mid-rise mixed-use rental developments is not financially feasible in current market conditions. Without changes in the existing construction environment, Anchorage will not be able to accommodate the forecast for population growth, which could have adverse effects on the area's growth and economic health.

The mismatch between future housing demand and land supply is serious and needs attention. If not properly addressed, the housing gap could affect population growth in Anchorage as well as decrease affordability for both renters and homeowners. Both impacts would affect the health of the local economy. Policies that can help Anchorage accommodate expected growth are those that will increase land use efficiency; increase residential densities; increase the buildable land supply, especially through redevelopment; and ensure housing affordability.

Demand Analysis Results

- Demand for approximately 18,200 new dwellings in the Anchorage Bowl and 3,300 new dwellings in Chugiak-Eagle River over the next 20 years is expected.[1]

[1] Based on the Institute of Social and Economic Research at the University of Alaska Anchorage forecast for population growth (December 2009) for the entire Municipality of Anchorage and Municipal staff's analysis for how this breaks out by Municipal sub-areas.

- The demand for attached and compact housing types will increase over time; attached housing is projected to make up 65 percent of housing demand preference in the Anchorage Bowl by 2030 (up from 58 percent currently). An aging population, decreases in housing affordability, and changes in lifestyle will drive this shift in housing preference toward attached housing, particularly in the Anchorage Bowl.

- A survey of over 800 households in the Anchorage Bowl and Chugiak-Eagle River found that 18 percent of respondents were "highly likely" candidates to choose compact housing based on their stated housing preference.

Land Supply and Housing Capacity

- As of 2010, there were 5,800 acres of buildable residential land in the Anchorage Bowl, including 5,200 acres of vacant (undeveloped) land and 600 acres of partially vacant land that has space to be further subdivided or developed.

- The inventory shows a 30 to 40 percent decline in the amount of buildable residential land in the Anchorage Bowl since 1998.

- Without increasing the current level of housing density and increasing the rate of redevelopment, the Anchorage Bowl will lack land for about 8,900 of the projected new housing units, or about half of expected demand.

Projected Residential Land Sufficiency, Anchorage Bowl, 2010 to 2030

Structure Type	Land Capacity	Projected Housing Demand	Sufficiency (capacity minus demand)
Large Lot Single Family	2,030	362	1,668
Single Family	3,614	6,003	(2,389)
Two Family / Duplex	1,272	3,455	(2,183)
Townhouse	768	1,455	(687)
Multifamily / Other	3,315	6,909	(3,594)
Total	**11,000**	**18,184**	
Total "surplus units"	--	--	**1,668**
Total "deficit units"	--	--	(8,852)

Source: ECONorthwest

- Chugiak-Eagle River has enough land to meet its own projected demand for all housing types. The surplus land capacity in Chugiak-Eagle River could accommodate some of the Bowl's single-family detached housing demand; however, it is not the ideal location to address the Bowl's need for dense urban multifamily development and cannot accommodate all of the projected demand.

Projected Residential Land Sufficiency, Chugiak-Eagle River, 2010 to 2030

Structure Type	Land Capacity	Projected Housing Demand	Sufficiency (capacity minus demand)
Large Lot Single Family	1,700	665	1,035
Single Family	2,587	1,663	924
Two Family / Duplex	914	499	415
Townhouse	707	132	575
Multifamily / Other	629	365	264
Total "surplus units"	**6,537**	**3,324**	**3,213**

Source: ECONorthwest.

Financial Feasibility of Compact Housing

- Pro forma financial feasibility analysis for four housing prototypes, including 1) small-lot single-family detached units, 2) infill townhomes, 3) mid-rise residential development, and 4), mid-rise mixed-use development, concludes:
    - Of the four prototypes, small-lot single-family detached units (on a 3,000 square foot lot) are the most financially feasible compact housing and can be built profitably. However, the current minimum lots size (6,000 sq. ft.) and width (50 feet) would need to be amended.
    - The townhome prototype is close to feasible but sensitive to changes in the assumptions including increasing costs or decreases in sale price. This sensitivity explains the tendency for developers to choose a condominium approach which allows the developer to lower development costs slightly and reduce the amount of land needed.
    - Pro forma analyses of mid-rise (four-story) residential and mid-rise mixed-use rental prototypes demonstrate that these types of developments are not financially feasible. The financial gap can range from 20 to 55 percent of total development costs. Rents 25 to 60 percent higher than current norms would be required to make most of these projects financially feasible without a subsidy.
- Key factors that affect the financial feasibility of compact housing development in the Anchorage Bowl and Chugiak-Eagle River are:
    - Local costs for compact and other forms of housing are high. Anchorage construction costs are 37 percent higher than the nation's average. Contributing cost factors include: a short construction season, lack of contiguous utility, street and sidewalk grids, presence of unexpected contamination on sites, presence of peat that must be removed for structural integrity, higher transport costs for materials, smaller and less flexible labor pool resulting in higher labor costs, and less than ideal building sites, among other factors.

- Parking is expensive (but necessary) to provide. Reducing parking requirements or other creative approaches to addressing parking needs could bring housing projects closer to feasibility.

- The limited access to equity and the conservative lending environment is a barrier to developing mid-rise residential and mixed-use structures. Many banks require 30 percent of the project costs to be in the form of equity. Some equity lenders charge up to 20 percent interest. For condominium projects, lenders have high pre-sale requirements. The current conservative lending environment is not unique to Anchorage

- The Anchorage Bowl and Chugiak-Eagle River lack neighborhoods with a traditional "main street" architectural form where higher density development typically locates. Compact housing is easier to finance and sell when it is located near retail and other types of amenities (such as grocery stores, coffee shops, transit access, etc.).

- Public investment and other creative solutions will be necessary to make mid-rise multifamily and mixed-use development feasible in Anchorage in the near future.

Implications for Housing Policy in Anchorage

The key conclusions of the analysis are:

- Given the historic density of development and rate of redevelopment, the Anchorage Bowl does not have sufficient vacant buildable residential land to accommodate the demand for housing units forecasted over the next 20 years.
- Building mid-rise residential and mid-rise mixed-use rental developments is not financially feasible in the current market.

Those conclusions lead to an obvious, broad policy question: *What can the Municipality do to accommodate the expected demand for housing?* This question is not new to the Municipality—the preferred growth alternative in *Anchorage 2020* was the Urban Transition Scenario, whose policies included developing more intensive urban centers in Downtown and Midtown and encouraging infill and redevelopment where appropriate.

Housing Policy Options for Further Consideration

Assuming that *Anchorage 2020*, still represents the vision for the community, the following are the study team's suggestions for housing policies that merit further consideration by policy makers, city planners, housing advocacy groups, neighborhood community councils, developers, and financial institutions. The Municipality is already considering some of these options through the Title 21 rewrite process, the *Anchorage 2020 Comprehensive Plan*, and other initiatives.

Increase Efficient Land Use

- Update the Land-Use Map to increase land use efficiency and implement *Anchorage 2020* and the Title 21 Rewrite.
- Reduce parking requirements for multifamily housing to reduce development costs.

Increase Residential Densities

- Allow small-lot single-family housing on smaller lots (less than 6,000 square feet) and narrower lots (less than 50 feet) where appropriate and with design standards.
- Provide opportunity areas for building denser housing, such as the centers identified in *Anchorage 2020.*
- Develop funding solutions to provide infrastructure to support residential densities and more efficient use of land.
- Implement design standards to ensure development of desirable communities and protection of land values.

Increase the Supply of Buildable Land

- Phase infrastructure expansion into large land holdings in Chugiak-Eagle River.
- Conserve the residential land supply by limiting rezoning of residential land for other uses.
- Identify publicly owned lands that are suitable and make them available for residential development.

Facilitate Redevelopment

- Create and implement a redevelopment strategy to encourage infill and more compact residential development.
- Identify key redevelopment stakeholders, tools, and opportunity areas or sites to implement a redevelopment strategy.
- Target and clarify the existing tax-abatement and fee-waiver ordinance to increase effectiveness as a redevelopment tool.

Ensure Affordable Housing

- Expand affordable and workforce housing opportunities by identifying appropriate tools or financial incentives to create or rehabilitate affordable housing.

Improve the Regulatory Process

- Seek ways to further streamline development regulations and the permit process.

Next Steps

This technical report offers a detailed analysis of the housing demand challenges facing the Anchorage Bowl and Chugiak-Eagle River, and provides a basis for continued work on housing issues. The Municipality's next steps are to complete work on the Title 21 Revisions and develop a strategic plan to implement the preferred recommendations from this report. Some policy options will create more community or developer resistance, and policy makers and Municipal staff will need to prioritize housing policies to be adopted based on the outcomes they are most concerned about, as part of a strategic planning process.

AFFORDABLE RENTAL HOUSING A.C.T.I.O.N.
A Call To Invest in Our Neighborhoods

Alaska Fact Sheet

History of the LIHTC Program's Success in **Alaska**

2,734 affordable rental homes
4,156 jobs created
$200 million in local income
$23 million in state and local revenue
$100 million in federal revenue

The Low Income Housing Tax Credit (LIHTC) program is the most successful affordable housing production and preservation program in the nation's history. The program is designed to support the development and rehabilitation of affordable rental housing through private capital investment, and has received broad bipartisan support throughout its 25-year history.

As a provision of the Tax Reform Act of 1986, the LIHTC program has provided critical financing for the development of **2,734 affordable rental homes** in **Alaska**. Since 1987, over $75 billion of capital has been invested in the LIHTC program, financing the development of over **2.4 million affordable rental homes** throughout the nation. Widely considered the nation's most successful housing production program, the LIHTC finances approximately 90 percent of all affordable rental housing development. In 2010, 50 percent of all multifamily housing starts were financed by the LIHTC program.

The LIHTC program has a direct impact on job creation through both the construction and development of an affordable housing community and the residual benefits of that investment. Prior to the 2007-2009 recession, approximately **140,000 jobs** were created annually. It is estimated that 122 direct jobs and 30 permanent jobs are created per 100 affordable rental homes built; most of which are in the small business sector. Direct jobs are generated during the development and construction of an affordable housing community, while permanent jobs are created in the retail and business service industries due to the ongoing operation and occupancy of those affordable rental homes. Since 1987, over **2.8 million direct jobs** and almost **700,000 permanent jobs** have been created due to the economic impact of the LIHTC program; including over **3,000 direct jobs** and **800 permanent jobs** in **Alaska**.

As the fundamental housing resource used to transform communities, the LIHTC program creates affordable housing for working families and people with special needs (such as the elderly, the disabled, and the homeless) in urban, suburban, and rural communities throughout the country. In addition to successfully achieving a public policy goal, the LIHTC program has generated over **$57 billion** in tax revenue for the Federal government through increased investment.

The LIHTC program has a direct economic impact within the community through both the development of infrastructure and job creation. The impact of construction and the expansion of the tax base from the ongoing operations of the affordable apartment communities attracts investment and generates tax revenue for states and municipalities. Over the past 25 years, this increased investment has led to a return of **$200 million** in local income for **Alaska** communties, and over **$23 million** in state and local tax revenue for **Alaska**

In 2008, **149 affordable rental homes** received LIHTC financing in **Alaska**, creating approximately **182 direct jobs** and **45 permanent jobs** for the state. Through this investment, **Alaska** benefited from over **$1 million** in additional state and local tax revenue. During that year, increased investment also led to an additional **$13 million** in income for **Alaska** localities.

The LIHTC program is a premier example of a public-private partnership as it is designed to attract private investment by large corporations for a public good. The public-private nature of the LIHTC program has brought a private-sector discipline to the industry, as the ability for investors to claim tax credits and maintain a strong rate of return on their investment is determined by the project's success. Such a "pay-for-performance" model has led to the very effective management of LIHTC properties. Average vacancy rates for the overall rental market are double that of LIHTC-financed properties, and LIHTC properties have an extraordinarily low foreclosure rate of only 0.1 percent annually.

Currently there is an unmet national demand for over 2 million affordable rental homes. Although substantial vacancy rates are present in many markets, rental units that remain empty are typically high-end and are not affordable for the majority of Americans. The unmet demand for affordable housing will continue to grow over the next decade, presenting a shortfall of up to 5 million rental units by the year 2020.

NeighborWorks®

ANCHORAGE

Building Community Through Neighborhoods

NeighborWorks®
ANCHORAGE

Presents:

A Community Leadership Workshop Series

Participate in an opportunity to shape Anchorage's future in this exciting project

Attend all 4 workshops and receive a ***Community Leadership Award***

You can sign up today for one or all of these workshops:

- March 24, 2012 - Community Issues
- April 21, 2012 - Community Engagement
- August 18, 2012 - Community Vision
- October 20, 2012 - Community Action

- **Location: NeighborWorks® Anchorage, 480 West Tudor Road, Anchorage, 99503**
- All workshops are free of charge, materials and meals provided
- Open to all residents and community members
- All workshops are scheduled for a Saturday from 9:30 – 3:30
- Sign up today as space is limited to the first **25** participants

To register or for additional information:

Call Vickie Dodge-Pamplin at 677-8409 or Hazel Blackmore at 677-8412

Or go to our website at: www.nwanchorage.org for more information

NeighborWorks®
CHARTERED MEMBER

Leadership Workshop Series 2012

A path to becoming involved in shaping the future of our community.

1. Community Issues – *March 24*
    a. Identify and Investigate
2. Community Engagement - *April 21*
    a. Education and Collaboration
3. Community Vision– *August 18*
    a. Sustainable Solutions
4. Community Action – *October 20*
    a. Service and Impact

NeighborWorks® Anchorage is dedicated to improving the quality of life for families and individuals by preserving homes, creating new housing opportunities and strengthening neighborhoods. We continue to work to address the needs of low and moderate income families and neighborhoods, and look forward to the day when everyone is successfully housed in a thriving community. **Our 2011 highlights include:**

Providing Quality Affordable Apartments:

- Over 1,800 Anchorage residents have a safe and stable home at one of our 9 rental communities. We are the largest non-profit provider of affordable housing in Anchorage. Our portfolio continues to see very high demand for our rental units and had an average occupancy rate of 97% in 2011.
- Through a partnership with RurAL CAP, we completed weatherizing the Spruce View Apartments and the Hampstead Heath Apartments, and began weatherizing the Stephen's Park Apartments. As a result, these properties will be more energy efficient, with lower utility costs for both NeighborWorks® Anchorage and the residents.
- In collaboration with community partners such as Catholic Social Services and Beyond Shelter, we housed 32 "hard-to-house" families and individuals, with 78% of those families staying successfully housed.
- We purchased the Hampstead Heath Apartments from the Low-Income Housing Tax Credit development partnership, securing the affordability of these 88 units for the long term.
- $498,000 was invested in our affordable housing portfolio in 2011 to update building systems and extend the economic life of our properties, increasing comfort and safety for over 1,800 residents.

Developing and Preserving Affordable Housing:

- We constructed an additional three 'for sale' condominium units at our Hollybrook Terrace project in Independence Park (South Anchorage). In 2010, the project won the "Golden Hammer" award at the annual Anchorage Homebuilders Association "Parade of Homes" for their price range.
- We commenced construction of a HUD funded rental housing project for low-income persons who experience a disability. The project, named The Roosevelt, will feature 10 accessible one-bedroom units, and is being built in Spenard. As a Section 811 project, all rents will be income-based allowing residents to pay no more than 30% of their income towards rent. The complex will be ready for occupancy in the summer of 2012. This project represents a $2.3 million dollar investment into the affordable housing needs of Anchorage.
- Construction of a HUD funded rental housing project for low-income seniors is also underway. The project, called Connolly Square in honor of the founder of NeighborWorks® Anchorage, will feature 20 accessible one-bedroom units, and is being built in the Airport Heights neighborhood. As a Section 202 project, all rents will be income based allowing residents to pay no more than 30% of their income towards rent. The complex will be ready for occupancy in the summer of 2012. This project represents a $5.3 million dollar investment into the affordable housing needs of Anchorage.
- We completed a $1.8 million dollar sprinkler system replacement and unit modernization project at the Spruce View Apartments, preserving 82 units of affordable housing in Anchorage.

Creating, Educating, and Supporting Homeowners:

- We assisted 31 households in becoming homeowners through our innovative lending programs for low-to-moderate income borrowers.
- 97 individuals received our one-on-one pre-purchase counseling providing them with the tools to become successful homeowners.
- We provided home maintenance education for 148 homeowners, helping them maintain their homes.
- 27 of our new homeowners in Anchorage participated in our post-purchase education workshops where they learned common home maintenance and ways to protect their investment.
- We have held our mortgage loan delinquency rate to less than 4% through the diligent work of our lending staff, both in pre- and post-purchase education and through working one-on-one with "at-risk" borrowers.

Repairing, Rehabbing and Restoring Pride of Homeownership:

- We acquired, rehabbed, and resold 4 homes into affordable homeownership, creating 4 new homeowners. Two of these units were foreclosures. Three of these units were completed under the HARP program.
- We assisted 54 homeowners by preserving their asset and retaining their ability to live independently through the completion of 71 accessibility and minor repair projects.
- We created 12 new homeowners by originating second mortgage or down payment assistance loans.
- We organized over 200 volunteers and raised $30,000 in community contributions to repaint 18 homes for our annual Paint the Town community beatification project held in June 2011. Since 2006, our community teams have painted 92 homes for deserving neighbors in neighborhoods across the city.

Community Engagement, Creative Partnerships, and Empowering Residents:

- We helped train and empower over 50 new community leaders through our quarterly leadership training workshops and the NeighborWorks® America Community Leadership Institute trainings.
- Over 900 residents participated in resident councils and resident-driven activities like community volunteer service projects and social events.
- We are a key partner in the Project Homeless Connect program. Two events were held, serving more than 1,400 households with 150 agencies providing services to the homeless.
- We hosted and provided volunteers for the Adelaide Mobile Food Pantry distributing more than 30,000 pounds of food to over 3,000 residents. Over 300 people volunteered to help at this bi-monthly event.
- Grant funding and donations totaled over $50,000 which is 28% of the total expenditures for three Community Engagement Program projects including environmental justice, mentorship, and community building through our holiday meals program.
- We have three mentor/mentee matches for our Stepping Stones Mentorship Program for adults who have experienced homelessness. Community volunteers and leaders serve as mentors and work side by side with mentees to assist them in developing their individual success plan. We plan to expand the Stepping Stones Mentorship Program with a goal of 10 mentor/mentee matches.

NeighborWorks® Anchorage – Home, Community, and the Future

NeighborWorks® CHARTERED MEMBER

QUALITY AFFORDABLE HOUSING | A SANCTUARY | a stepping stone | EMPOWERING | compassionate

480 West Tudor Road • Anchorage, Alaska 99507 • 907-677-8490

NeighborWorks® Anchorage Property Team

Debe Mahoney, Executive Director

Mike Courtney, Deputy Director

Michaela Sisson, Property Manager

April Graham, Resident Manager

Tim Fahey, Facility Manager

Sonny Fungchenpen, Maintenance Mechanic

NeighborWorks® ANCHORAGE

480 West Tudor Road
Anchoage, Alaska 99503
Phone: (907) 677-8490
Fax: (907) 677-8450
www.nwanchorage.org

NeighborWorks® Anchorage is dedicated to improving the quality of life for families and individuals by preserving homes, creating new housing opportunities and strengthening neighborhoods.

NeighborWorks® CHARTERED MEMBER

EQUAL HOUSING OPPORTUNITY

Loussac Sogn

Single Room Occupancy Apartments

429 D Street
Anchorage, Alaska 99501
(907) 272-4446

Project Information

Historic building built in 1947 in the heart of downtown Anchorage

50 single room occupancy units and 2 one-bedroom units on top 2 floors

6 commercial units on ground floor

Amenities include lounges with cable television and congregate kitchens, bathrooms and laundry facilities

Resident eligibility

50% Area Median Income or less ($29,850)

Renovated in 1994, the Loussac-Sogn provides affordable housing to some of our community's most vulnerable residents—seniors, the disabled, and those on fixed incomes. It also provides space for small locally owned businesses and non-profits, giving them a place in the core of downtown Anchorage.

We are forging new partnerships with our commercial space users, and have recently welcomed UrbanPrints to the building. A screen printing social enterprise, UrbanPrints offers job training and employment skills to disadvantaged young adults.

NeighborWorks® Anchorage is working to ensure that the Loussac-Sogn can remain a part of Anchorage history, continue to provide affordable housing to those who need it most, and be a vital part of a thriving downtown neighborhood.

Housing our community's most vulnerable residents

Resident demographics

Male	26	Female	20
Disabled	15	Seniors	26

Youngest	Age 20
Oldest	Age 79
Average	Age 49

Lowest income	$ 4,901 annually
Highest income	$18,214 annually
Average income	$16,558 annually

Currently 71% of our residents are below 30% of the Area Median Income ($17,900)

Development Team

Architect:
Gary Peterson and Associates

General Contractor:
Cornerstone Construction

Developer/Sponsor:
NeighborWorks® Anchorage

Owner:
The Roosevelt, Inc.

Property Manager:
NeighborWorks® Anchorage

NeighborWorks® ANCHORAGE

480 West Tudor Road
Anchoage, Alaska 99503
Phone: (907) 677-8490
Fax: (907) 677-8450
www.nwanchorage.org

NeighborWorks® Anchorage is dedicated to improving the quality of life for families and individuals by preserving homes, creating new housing opportunities and strengthening neighborhoods.

NeighborWorks® CHARTERED MEMBER

EQUAL HOUSING OPPORTUNITY

The Roosevelt

Supportive Housing for People with Disabilities

HUD Section 811 Project

1403 West 32nd Ave.
Anchorage, Alaska 99503

Project Information

10 accessible 1-bedroom units

Amenities include lounges, community space, on-site laundry, business center, and storage

Rental assistance provided by the United States Department of Housing and Urban Development (HUD)

Resident eligibility

18+ years old

50% Area Median Income or less ($29,850)

Experience a qualified disability

The Roosevelt will provide permanent, independent living rental units and help meet the shortage of affordable housing designed for those who experience a disability. The building will receive rental assistance from HUD, ensuring that the residents will pay no more than 30% of their income to rent.

Designed to accommodate the needs of those who experience a disability, the building features accessible units and fixtures, as well as spaces for community and social activities.

Conveniently located in Spenard, with easy access to public transportation and other services, The Roosevelt is made possible by funding from the Alaska Housing Finance Corporation's Neighborhood Stabilization Program, NeighborWorks® America, and the HUD Section 811 Supportive Housing for the Disabled Program.

Source of Funds

HUD Section 811 Program	$ 2,085,900
Neighborhood Stabilization Program	$ 178,400
Alaska Housing Finance Corporation	$ 14,000
NeighborWorks® America	$ 50,000
NeighborWorks® Anchorage	$ 10,000
Total development cost	**$ 2,338,300**

Development Team

Architect:
Gary Peterson and Associates

General Contractor:
Cornerstone Construction

Developer/Sponsor:
NeighborWorks® Anchorage

Owner:
Connolly Square, Inc.

Property Manager:
NeighborWorks® Anchorage

NeighborWorks® ANCHORAGE

480 West Tudor Road
Anchoage, Alaska 99503
Phone: (907) 677-8490
Fax: (907) 677-8450
www.nwanchorage.org

NeighborWorks® Anchorage is dedicated to improving the quality of life for families and individuals by preserving homes, creating new housing opportunities and strengthening neighborhoods.

NeighborWorks® CHARTERED MEMBER

EQUAL HOUSING OPPORTUNITY

Connolly Square

Supportive Housing for the Elderly

HUD Section 202 Project

1540 Charter Circle
Anchorage, Alaska 99508

Project Information

20 accessible 1-bedroom units

Amenities include lounges, community space, on-site laundry, business center, and storage

Rental assistance provided by the United States Department of Housing and Urban Development (HUD)

Resident eligibility

62+ years old

50% Area Median Income or less ($29,850)

Named in honor of the founder of NeighborWorks® Anchorage, Faye Connolly, Connolly Square will provide permanent, independent living rental units and help meet the shortage of affordable housing designed for seniors. The building will receive rental assistance from HUD, ensuring that the residents will pay no more than 30% of their income to rent.

Designed to accommodate the needs of seniors, the building features accessible units and fixtures, as well as spaces for community and social activities.

Located in the Airport Heights neighborhood of Anchorage, close to Alaska Regional Hospital, Connolly Square is made possible by funding from the Alaska Housing Finance Corporation's Neighborhood Stabilization Program, and the HUD Section 202 Supportive Housing for the Elderly Program.

Source of Funds

HUD Section 202 Program	$ 4,362,900
Neighborhood Stabilization Program	$ 493,640
HUD Section 202 Demonstration Project Grant	$ 400,000
NeighborWorks® Anchorage	$ 25,000
Total development cost	**$ 5,281,540**

NeighborWorks®
ANCHORAGE

Campbell View

3560 W. Dimond Blvd. • 907-677-1191

South Anchorage near Blackberry & Dimond

Quiet Luxury near Campbell Lake with views of the Chugach Mountains. Washers & Dryers. Fireplaces. Balconies. Sorry, No Pets!

Floor Plans

1 BR's Starting at $ 875+E | 2 BR's Starting at $ 985+E
3 BR's Starting at $1095+E | Security Deposit $750
Prices & Availability Subject to Change.

Office Hours
Call to Schedule Appointment.

Schools
Kincaid Elementary, Mears Middle School, Dimond High School.

Hampstead Heath

6641 Hampstead Drive • 907-349-3323

South Anchorage near Old Seward & Dowling

Quiet community living with the look and feel of a single family neighborhood awaits you - our spacious 2 & 3 bedrooms are located on 19 acres of beautifully landscaped grounds featuring a playground, basketball court, and a sledding hill. We offer a clubhouse (with F/P), which can be rented out for special occasions. On-site management. Small Pets on Approval.

Floor Plans
2 BR's (800 sq. ft.) Starting at $1050+E
3 BR's (1012 sq. ft.) Starting at $1225+E
Security Deposit $700-800.
Income Limits Apply.
Call Manager for Details.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Features/Amenities
- Garage Space (for 1-Car)
- W/D Hook-ups
- Private Storage
- Heat Included
- Cable Available at a Reduced Rate

Schools
Taku Elementary, Romig Middle School, West High School.

Think you don't make enough to live the good life? Think again.

If your yearly income is less than the following maximum incomes you may qualify to live at Hampstead Heath.

- 1 Person $35,160
- 2 People $40,140
- 3 People $45,180
- 4 People $50,160
- 5 People $54,180
- 6 People $58,200
- 7 People $62,220
- 8 People $66,240

Spruce View

10605 Spruce View Loop • 907-349-5055

South Anchorage near Lake Otis & O'Malley

Spacious townhouse style units w/ W/D Hookups, 2-car heated garage, storage. Beautiful landscaping, including a playground and clubhouse. Sorry, No Pets!

Floor Plans
2 BR's Starting at $980+Util | 3 BR's Starting at $1125+Util | Security *Deposit $800. Income Limits Apply - See Hampstead Heath above.*
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Schools
Spring Hill Elementary, Hanshew Middle School, Service High School

NeighborWorks®
ANCHORAGE

Our Apartments

Building Community through Neighborhoods

DOWNTOWN/GOV'T HILL

The Adelaide SRO
Efficiency Units
201 E. 9th Avenue **258-9017**

Loussac Sogn SRO
Efficiency Units
429 D Street **272-4446**

Merrill Crossing
Efficiency, 1 & 2 Bedrooms
1275 E. 9th Avenue **279-8957**

Panoramic View
Efficiency, 1, 2 & 3 Bedrooms
787 Elm Street **272-2536**

MIDTOWN

Hampstead Heath
2 & 3 Bedrooms
6641 Hampstead Drive **349-3323**

MIDTOWN - Continued

The Mallary
1 & 2 Bedrooms
660 W. 34th Avenue **563-3574**

Stephen's Park
1, 2 & 3 Bedrooms
3200 LaTouche Street **279-1224**

SOUTHSIDE

Campbell View
1, 2 & 3 Bedrooms
3560 W. Dimond Blvd. **677-1191**

Spruce View
2 & 3 Bedrooms
10605 Spruce View Loop **349-5055**

Formerly Known As Anchorage Neighborhood Housing Services, Inc.
www.nwanchorage.org

NeighborWorks®
ANCHORAGE

NeighborWorks® ANCHORAGE

Panoramic View

787 Elm Street • 907-272-2536

Next door to Elmendorf Air Force Base

Our community is located in the historic Government Hill neighborhood and offers quality, affordable rental housing great for families or individuals. Many units feature spectacular views of Anchorage and the surrounding Chugach Mountains. We are two minutes from Anchorage's most popular salmon fishing stream, Ship Creek. Sorry, No Pets!

Floor Plans
Eff's (390+ sq. ft.) Starting at $615+E
1 BR's (522+ sq. ft.) Starting at $715+E
2 BR's (665+ sq. ft.) Starting at $815+E
3 BR's (1030 sq. ft.) Starting at $950+E
Security Deposit $500-650
Prices & Availability Subject to Change.

Features/Amenities
- Keyed Access
- Garages Available
- Playground
- Close to Bus Routes

Office Hours
Monday - Friday 9:00 - 6:00

Directions
Take "A" Street north through downtown, cross over the Ship Creek Bridge, drive up the hill (E. Loop Rd.) and turn right at the stop light on Hollywood Dr. Our leasing office is on the corner of Hollywood & Elm. Welcome Home to Panoramic View!

Schools
Government Hill, Central Middle School, West High School

Loussac Sogn SRO

429 "D" Street • 907-272-4446

Rooms for Rent, Standard, Single or Deluxe

Furnished unit w/kitchenette in a historic 3 story building with keyed entrance, elevator, community kitchen facilities, lounge areas with cable TV, computer lab and washer/dryer on each floor. On-Site management. Sorry, No Pets!

Floor Plans
Standard Single Rm $500. Deluxe Single Rm $540. 1 BR's $750. Heat & Electric included. Security Deposit $300 & $450. Units are restricted to persons whose annual income does not exceed $29,650.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

The Adelaide

201 East 9th Avenue • 907-258-9017

Single Room Occupancy

Furnished unit with small kitchenette in a keyed access building with an elevator, community kitchen facilities, lounge areas w/cable TV, computer lab and W/D on each floor. Resident council. On-site management. Sorry, No Pets!

Floor Plans
Single Room $669 | 1 BR's $775 | Heat & Electric included. Security Deposit $50-$150 & $350. Section 8 Based Assistance: rent = to 30% of resident's gross monthly income ($50 Min.) To qualify, applicant must be homeless.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

NeighborWorks® ANCHORAGE

Merrill Crossing

1275 East 9th Avenue • 907-279-8957

Near Downtown

Clean & conveniently located near downtown, shopping & bus routes. On-site laundry. Garages available for an add'l monthly cost. Sorry, No Pets!

Floor Plans
Eff's Starting at $650 | 1 BR's Starting at $745 | 2 BR's Starting at $845
Security Deposit $550-600. Income limits on some units.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Schools
Airport Heights, Central Middle School, West High School.

Stephen's Park

3200 LaTouche Street • 907-279-1224

Midtown off 36th Avenue and LaTouche

Our extra large units are nestled in the heart of midtown, minutes from UAA, APU, the medical district, shopping and schools on beautifully landscaped grounds with a playground and a clubhouse. Balconies face inner courtyards. Our large clubhouse is available to rent out for special occasions. On-site management. Sorry, No Pets!

Floor Plans
1 BR's (778 sq. ft.) Starting at $ 825
2 BR's (980 sq. ft.) Starting at $1000
3 BR's (1195 sq. ft.) Starting at $1250
Security Deposit $600-800.
Income Limits Apply.
Call Manager for details.
Prices & Availability Subject to Change.

Features/Amenities
- Covered Parking
- Private Balconies
- On-site Laundry
- Some units have F/P's
- All Utilities Included
- Cable Available at a Reduced Rate

Directions
East on 36th Avenue to the LaTouche Street stop light. Turn onto LaTouche and follow to Stephen's Park entry on your left. Turn in and Stephen's Park leasing office is on your right. Welcome home to Stephen's Park!

Office Hours
Monday - Friday 9:00 - 6:00

Schools
Rogers Park Elementary, Wendler Middle School, East High School.

The Mallary

660 West 34th Avenue • 907-563-3574

Midtown off 36th Avenue and C Street

Clean, conveniently located in midtown. Playground & picnic area, BBQ grills. Laundry Facilities. On-site management. Small Pets on Approval.

Floor Plans
1 BR's Starting at $795+E | 2 BR's Starting at $910+E
Security Deposit $650. Income limits on some units.
Prices & Availability Subject to Change.

Office Hours
Monday - Friday 9:00 - 6:00

Schools
North Star, Central Middle School, West High School.

COMMUNITY COLLABORATION

NeighborWorks®
ANCHORAGE

Community Collaboration

NeighborWorks® Anchorage ardently believes that collaboration is the most powerful way to achieve our goal to build community through neighborhoods. By working together, sharing skills and knowledge, and pooling our resources, we can meet the needs of our community. We share a common vision with many partners of a strong, vibrant and sustainable community where everyone has a place to call home.

We are dedicated to a philosophy of teamwork, sharing ideas, and are focused on the people we serve. Our teamwork is part and parcel of everything we do, and our staff work collaboratively with one another and with our partners. Working together as a team, we can accomplish great things.

NeighborWorks® Anchorage works to develop, sustain, and further our community partnerships and collaborations. We cultivate strong bonds with the public, private and non-profit sectors to make a positive and lasting impact on the communities we serve.

Our community partners and supporters are wide and varied, ranging from service providers such as the ARC of Anchorage, Anchorage Community Mental Health Services, Catholic Social Services, other housing providers like Cook Inlet Housing Authority, Habitat for Humanity and Anchorage Housing Initiatives, to public agencies including Alaska Housing Finance Corporation, HUD, and Department of Neighborhoods at the Municipality of Anchorage.

Our work is made possible through the support of the private sector where we count many lenders, businesses and suppliers as our friends and colleagues.

NeighborWorks® Anchorage is COMPASSIONATE.

Please contact our office if you would like further information. We can be reached at 907-677-8490.

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

COMMUNITY BUILDING

NeighborWorks®
ANCHORAGE

Community Building

NeighborWorks® Anchorage believes that all residents should have opportunities for civic engagement, leadership development and connections to the wider community. We empower people to make a positive difference in our neighborhoods and our city. We bring people together and focus on what makes a community a positive place to live. We teach people how to work with a diversity of opinions and backgrounds, and build strong, vibrant, and sustainable neighborhoods.

We offer unique opportunities for community building and engagement:

LEADERSHIP DEVELOPMENT

We are a member of NeighborWorks® America's Community Leadership Institute program, and our training workshops teach skills needed for successful community based leaders and advocates. Skills learned are then applied to a neighborhood project. Members are empowered to address issues by finding positive solutions that build and strengthen their neighborhoods.

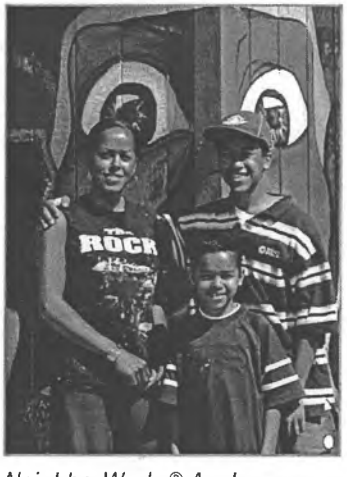
RESIDENT SERVICES AND CONNECTIONS

We work to develop relationships through resident councils, social activities and community events. These services are available to all residents at any NeighborWorks® Anchorage apartment community.

We can also facilitate access to vital services that enhance quality of life.

COMMUNITY OUTREACH

We collaborate with businesses, schools, community groups, and partner agencies to provide volunteer opportunities, workshops, and seminars to all members of the community. We support activities that encourage and foster a brighter future for everyone.



NeighborWorks® Anchorage is EMPOWERING.

We invite you and/or you organization to get involved in our community building activities. Please contact our office if you would like further information about our programs. We can be reached at 907-677-8490.

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

HOME REHAB

NeighborWorks®
ANCHORAGE

Home Rehab and Accessibility

Even the best built home will, at some point, need to undergo repairs or major replacements. Often the cost of replacing a roof or heating system will be a major expense. NeighborWorks® Anchorage can support current homeowners by maintaining the health, safety, and value of their homes through our repair and rehabilitation programs.

NeighborWorks® Anchorage manages grant programs on behalf of the U.S. Department of Housing and Urban Development, the Municipality of Anchorage, and the Alaska Housing Finance Corporation. Our knowledgeable and caring staff are experienced in guiding our customers through this often complicated process of outlining the work, hiring the contractor, and managing the project.

GRANTS

- **Minor Repair Program:** This program assists income eligible families who own and occupy a single family residence or mobile home in need of minor repair. Typical repairs may include roof repair/replacement, replacement of heating systems, or other health and safety improvements. Accessibility repairs can also be performed with Minor Repair Program funds.
- **Senior Access Program:** This program provides home accessibility modifications for qualified seniors, which allow them to continue to live independently in their own homes. Available to persons over 55 years of age, this grant can provide for accessibility improvements such as bathroom modifications, ramps, handrails, or stair lifts. Small assisted living homes of five bedrooms or less may be eligible for smaller grants to make improvements for eligible senior residents.

HOME IMPROVEMENT LOANS

NeighborWorks® Anchorage may be able to finance home improvement projects. These loans are made on a case-by-case basis. We welcome your questions, so please feel free to call our staff if you are interested in a home improvement loan.

NeighborWorks® Anchorage provides a SANCTUARY.

PAINT THE TOWN

Originally introduced in 1988, NeighborWorks® Anchorage re-launched Paint the Town in 2007 as part of the NeighborWorks® America nationwide NeighborWorks® Week. In the last two years we have assisted nearly 30 families with their exterior painting. Each year we hope to grow the program in order to help more families maintain the curb appeal of their homes. We invite you and/or your organization to get involved in this great community project.

Please contact our office if you would like further information about any of our home improvement programs. We can be reached at 907-677-8490.

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

HOMEOWNERSHIP

NeighborWorks®
ANCHORAGE

Counseling ✶ Education ✶ Lending

Home ownership remains at the heart of most Americans and that dream is alive and well in Anchorage. NeighborWorks® Anchorage offers homebuyer education and an array of affordable loan programs designed to assist home buyers with purchasing a home. Experienced staff assist potential new homeowners with the lending process and help determine how our loan products may best fit their needs. We offer down payment and closing cost assistance loans, first mortgages, and partner with a number of local lenders. All loan programs are subject to income limits and other borrower eligibility requirements.

COUNSELING AND EDUCATION

- **Pre-and Post-Purchase Counseling and Education:** Staff are HUD certified counselors and well versed in working with individuals and families in preparing them for homeownership. Pre-purchase counseling helps prospective homebuyers determine affordability based on their individual financial situation. Post-purchase classes help integrate new homeowners into their community and make them stronger, more self-reliant and more comfortable in their roles as new homeowners.
- **Foreclosure Prevention:** NeighborWorks® Anchorage has joined the Homeownership Preservation Foundation in a national campaign to help homeowners who are facing foreclosure. Borrowers can call: 1-888-995-HOPE or visit www.995hope.org/.
- **Financial Literacy:** The ABCs of Money program, designed for both adults and children, offers an opportunity to learn the basics of saving and money management, credit building, and lending practices.
- **Predatory Lending Prevention:** NeighborWorks® Anchorage is a key member of the statewide Don't Borrow Trouble® Alaska campaign. Victims of predatory lending or loan scams can call the hotline at 1-800-478-6501 or visit www.muni.org/dontborrowtroublealaska.

LENDING PROGRAMS

- **AnCHOR (Anchorage Communities Home Ownership Resource) Loan:** Through our partnership with the Municipality of Anchorage, the program provides a second or third mortgage to low- to moderate-income homebuyers to help pay for down payment and/or closing costs.
- **Revolving Loan Fund:** The "gap" loan fund provides the difference between a homebuyer's first mortgage and the sales price. This results in a lower monthly payment and increases the homebuyer's purchasing power.
- **NeighborHomes Loan:** In concert with Alaska Housing Finance Corporation, we provide down payment assistance loans to make homeownership available to households that may otherwise not be able to afford a conventional loan.
- **First Mortgage Loans:** First mortgage loans are offered on a case by case basis. These loans provide funding for borrowers who might not meet traditional lending requirements.

NeighborWorks® Anchorage is a STEPPING STONE.

Please contact our office if you would like further information about any of our home ownership programs. We can be reached at 907-677-8490.

NeighborWorks®
CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

NeighborWorks® ANCHORAGE

Affordable Rental Housing

HOME SWEET HOME

NeighborWorks® Anchorage is dedicated to providing quality, safe, and clean affordable apartment homes in convenient locations all over Anchorage. From well appointed three-bedroom units to practical efficiencies, we have an apartment that is ideal for any lifestyle. All our apartment communities are professionally managed and are located near schools, bus lines, and shopping. Many of our properties are also located close to major employment centers, including the downtown, midtown, and southeast business districts. Our Single Room Occupancy communities offer a less expensive alternative to the traditional studio apartment, allowing residents more freedom to pursue other interests without devoting most of their income to housing. We offer housing opportunities to people of all income levels, and some of our units feature rental assistance to qualified applicants.

Each of our employees embodies our values of integrity, professionalism, and customer first service. Our hard-working staff is focused on delivering the highest level of service and treating each resident first and foremost as a valued customer. Maintenance is available 24 hours a day to ensure the utmost comfort for our residents. We believe that everyone deserves a place to call home.

YOUR HOME IS OUR PASSION

At NeighborWorks® Anchorage, we value our partnership with those who serve in the armed forces. We participate in the Military Rental Partnership Program with both Elmendorf Air Force Base and Fort Richardson Army Post. Garden Villa, Boniface Plaza, and Stephens Park Apartments are properties approved for this program, and we encourage our military personnel to apply.

We believe a home is more than just a roof over your head. Residents can join programs and activities at many of our properties and become part of their greater community. Community building is a resident driven process in which people from all walks of life work effectively and collaboratively to create more livable and inclusive communities. Resident councils and leadership development activities are just two examples of volunteer opportunities available to our residents. Our goal is to create an environment that enhances every resident's quality of life in a safe, positive, family setting.

NeighborWorks® Anchorage is QUALITY.

LIVE ✶ WORK ✶ PLAY

Our mission is to provide clean, affordable and inclusive rental communities where our residents can enjoy a great quality of life, children can play safely, and families can enjoy their homes in peaceful settings. We are building community through neighborhoods!

Please contact our office if you would like further information on our apartment communities or our affordable rental housing programs. We can be reached at 907-677-8490. Our knowledgeable staff will be happy to answer your questions.

NeighborWorks® CHARTERED MEMBER

NeighborWorks® Anchorage 480 W. Tudor Road, Anchorage, AK 99503 p 907.677.8490 f 907.677.8450 www.nwanchorage.org

Debe Mahoney
Executive Director

dmahoney@nwanchorage.org

480 West Tudor Road, Anchorage, AK 99503
p 907.677.8415 f 907.677.8452 c 907.360.0896

NeighborWorks®
CHARTERED MEMBER

OVERVIEW ALASKA'S CITIZEN REVIEW PANEL

<TARGET><BILL></BILL><SUBJECT>OVERVIEW ALASKA'S CITIZEN REVIEW PANEL</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska's Citizen Review Panel

Citizen Review Panel

Citizen Review Panel: Who

- The CRP is composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect.
- Susan Heuer, Anchorage (Chair)
- Bonnie Edmondson, North Pole
- Jeanne Evans, Bethel
- Dana Hallett, Haines
- Pat Hefley, Juneau
- Kristin Hull, Wasilla
- Steve McComb, Palmer
- Stella Schuchardt, Fairbanks

Citizen Review Panel

Citizen Review Panel: What

To provide oversight to the Office of Children's Services and gather public input on how well child protection is being delivered statewide. The Panel does this primarily by visiting different regions of the state and talking to OCS staff and partner agencies about how well the system is working. The Panel produces an annual report for OCS which is also distributed to all members of Legislature.

Citizen Review Panel: Where

Statewide! Since 2008 we've been to the following communities.

- Anchorage
- Aniak
- Barrow
- Bethel
- Cantwell
- Chitina
- Copper Center
- Delta Junction
- Dillingham
- Fairbanks
- Gakona
- Glennallen
- Healy
- Hooper Bay
- Juneau
- Kenai
- Kenny Lake
- Ketchikan
- King Salmon
- Kodiak
- Kwigillingok
- Naknek
- Northway
- Nuquisut
- Palmer
- Petersburg
- Point Hope
- Saint Mary's
- Sitka
- Soldotna
- Tok
- Unalaska
- Valdez
- Wainwright
- Wasilla
- Wrangell

Citizen Review Panel: When

The Panel has been active in Alaska since 2002.

Citizen Review Panel: Why

The Citizen Review Panel is mandated by state and federal law. The Panel was created through the federal Child Abuse Prevention & Treatment Act (CAPTA); Keeping Children & Families Safe Act of 2003 and through Alaska statute Sec. 47.14.205.

Benefits of CRP

- Eight volunteer members all contributing a minimum of 250 active hours annually
- We're the eyes and ears of the public for the Legislature and OCS
- Unique function of identifying and advocating for ancillary services that OCS cannot request
- Jointly we can achieve a vastly improved child protection system for the children of Alaska

Issues CRP is monitoring

- Wasilla: Director Lawton is closely monitoring, Judges see improvement
- Bethel: Nearly fully staffed, we are returning next month
- In-home safety: struggling to acquire data to determine safety of children in-home

2012 CRP Recommendations to OCS

1. That OCS use the data they are collecting as a management tool.

2012 CRP Recommendations to OCS

2. When a report of harm is screened in for safety issues and a decision is made to work with the family and keep the child at home, OCS should evaluate the timeliness and effectiveness of referrals and services to ensure the safety of children receiving "in-home" services.

2012 CRP Recommendations to OCS

3. That OCS address licensing issues.

CRP Recommendations to the Legislature

- That options be explored to obtain housing for OCS rural workers.
- That there be support for more licensing workers and support staff, pending the upcoming workload study.
- That there be support for an additional OPA CINA attorney in the Palmer office to continue recent court improvements.

Alaska's Citizen Review Panel

For more information, please visit our website
www.crpalaska.org

Citizen Review Panel

Alaska Children's Alliance Membership List

ANCHORAGE
Cory Bryant, MSW, Manager
Alaska C.A.R.E.S.
907-212-2492 or 877-561-8301 | corinne.bryant@providence.org

BETHEL
Elena Aluskak, Program Manager
Irniamta Ikayurviat, TWC
907-543-3144 | elena_aluskak@twcpeace.org

COPPER RIVER BASIN
Gina Hoke, Executive Director
Copper River Basin CAC
907-822-3733 | director@crbcac.com

DILLINGHAM
Kyle Belleque, CAC Manager
Nitaput Child Advocacy Center
907-842-1230 | kbelleque@bbahc.org
www.bbahc.org/child_advocacy

FAIRBANKS
Lori Markkanen, Program Manager
RCPC Stevie's Place
907-374-2850 | lmarkkanen@rcpcfairbanks.org

JUNEAU
Brian Messing, Program Manager
S.A.F.E. CAC
907-463-6157 | brian.messing@ccsjuneau.org

KENAI PENINSULA
Jessica Lawmaster, Program Manager
907-235-7712 | jessica@havenhousealaska.org

Homer:
South Peninsula Haven House
907-235-7712 | jessica@havenhousealaska.org

Kenai:
Central Peninsula Child Advocacy Center
907-690-2113 | kenaifa@havenhousealaska.org

Seward:
Seward Child Advocacy Center
907-769-1010 | sewardcac@havenhousealaska.org

KODIAK
Cindy Harrington, Director of Child Services
Kodiak CAC
Kodiak Area Native Association
907-486-9878 | cindy.harrington@kanaweb.org

MAT-SU
Jennifer Burkmire, Executive Director
The Children's Place
907-357-5157 | jburkmire@thechildrens-place.org
www.thechildrens-place.org

NOME/BERING STRAIT
Ryan Larson, Program Director
Kawerak CAC
907-443-4379 | cac.dir@kawerak.org

FRIENDS OF CACS

Cathy Baldwin-Johnson, MD
Medical Consultant
907-561-8301 | Cathy.BaldwinJohnson@providence.org

Colleen James, SART/SANE
Clinical Forensic Services Coordinator
Kenai Peninsula Borough
907-714-4547 | cjames@cpgh.org

Diane Payne
Director, Justice for Native Children Project
Alaska Summit Enterprise, Inc.
907-694-5709 | dpayne@aksummit.com

Brochure designed by Diane Karalunas

For more information contact:
Pam Karalunas,
Chapter Coordinator
907-688-0163
pkaralunas@gci.net

www.akchildrensalliance.com

The Alaska Children's Alliance

"Let us pray and work diligently,
and not take our ease,
until every Alaskan child
is safe, loved, and nurtured
every day of his or her life."

~ Senator Fred Dyson

A Chapter of the National Children's Alliance

What is the Alaska Children's Alliance?

The Alaska Children's Alliance (ACA) is a non-profit coalition of established and developing children's advocacy centers (CAC's), multi-disciplinary teams (MDT's), and child protection teams (CPT's) dedicated to improving community responses to child maltreatment.

ACA is a state chapter of the National Children's Alliance (NCA). NCA is a non-profit accrediting organization that was developed to support and sustain the continued evolution of the CAC model. NCA provided Chapter Grant funding for the development of ACA and its publications, such as this brochure.

The Mission of the Alaska Children's Alliance

The mission of the Alaska Children's Alliance is to promote a culturally appropriate multidisciplinary response to child maltreatment throughout Alaska.

What is a Children's Advocacy Center?

A Children's Advocacy Center (CAC) provides a child-friendly environment that allows law enforcement, child protection workers, prosecutors, medical providers, victim/family advocacy, tribal representatives, and mental health providers to work together when there are allegations of child abuse. Referrals are accepted from the Office of Children's Services, law enforcement agencies (Alaska State Troopers, local police departments) and medical providers.

Why does Alaska need Children's Advocacy Centers?

- Alaska continues to have very high rates of child abuse and neglect, particularly child sexual abuse
- Child maltreatment is strongly linked to juvenile and adult crime, teen pregnancy, alcohol & drug abuse, suicide, and future family violence
- Child maltreatment has also been shown to be major contributors to poor adult medical and mental health
- Studies show that the annual economic impact of child abuse is $182,000 per maltreated child.
- Children are less fearful when investigations are conducted using CACs
- Parents & caregivers are more satisfied with the investigations when CACs are used

What happens at a Children's Advocacy Center?

- Comprehensive, multidisciplinary evaluation for child abuse concerns
- Specialized forensic interview in a child-oriented interview room which is video-taped and monitored by other members of the team
- Thorough, non-invasive medical exam by specially trained medical professionals
- Support, referrals, and follow up for children and families

Goals of CAC's, MDT's, & CPT's

- Assure that children are not further victimized by the systems designed to protect them
- Assure the child is safe
- Reduce the long term affects associated with trauma for the child and family
- Enhance and coordinate the investigation so that the accuracy of the concern is quickly and reliably determined
- Promote successful prosecution of criminal child abuse
- Encourage support and treatment for abused children and their families

TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE INFORMA-TION

<TARGET><BILL></BILL><SUBJECT>TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE INFORMATION</SUBJECT><COMM>SHSS27</COMM></TARGET>

TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE

JUNEAU HILL DAY ROSTER

FEBRUARY 15-17, 2012

Attending Juneau Hill Day	Tribal Health Organization	Representative	City	Senate	House
Yes	Aleutian Pribilof Islands Association	Aubrey Wegeleben	St. Paul	S	37
Yes	Arctic Slope Native Association	Angela Cox	Barrow	T	40
Yes	Copper River Native Association	Michael Horton	Copper Center	C	6
Yes	Council of Athabascan Tribal Gov'ts	Joyce Hughes	Fort Yukon	C	6
Yes	Eastern Aleutian Tribes	Gary Williams	King Cove	S	37
Yes	Kenaitze Indian Tribe, IRA	Tim Gillis	Kenai	Q	33
Yes	Kodiak Area Native Association	Margene Andrus	Kodiak	R	36
Yes	Maniilaq Association	Vivian Fleming	Kotzebue	T	40
Yes	Metlakatla Indian Community	Eula Marie Crippen, PhD	Metlakatla	A	2
Yes	Norton Sound Health Corporation	Jay David	Nome	T	39
Yes	SE Alaska Regional Health Consortium	Melody Price-Yonts*	Sitka	A	2
Yes	Southcentral Foundation	Chanda Aloysius	Anchorage	J-P & OTHER	19-32 & OTHER
Yes	Yukon Kuskokwim Health Corporation	Jennifer "Jay" Bierley	Bethel	S	38
Yes	Alaska Native Tribal Health Consortium	Laura Báez	Anchorage	? & OTHER	? & OTHER
Yes	Alaska Native Tribal Health Consortium	Lakota Murray Holman	Anchorage	I & OTHER	18 & OTHER
Yes	Ketchikan Indian Community	Stephanie Johnson	Ketchikan	A	2
Yes	Maniilaq Association	Bree Swanson	Kotzebue	T	40
Yes	Alaska Native Tribal Health Consortium	Dabney Van Liere	Anchorage	N	27

TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE

JUNEAU HILL DAY ROSTER

FEBRUARY 15-17, 2012

Attending Juneau Hill Day	Tribal Health Organization	Representative	City	Senate	House
Yes	Aleutian Pribilof Islands Association	Aubrey Wegeleben	St. Paul	S	37
Yes	Arctic Slope Native Association	Angela Cox	Barrow	T	40
Yes	Copper River Native Association	Michael Horton	Copper Center	C	6
Yes	Council of Athabascan Tribal Gov'ts	Joyce Hughes	Fort Yukon	C	6
Yes	Eastern Aleutian Tribes	Gary Williams	King Cove	S	37
Yes	Kenaitze Indian Tribe, IRA	Tim Gillis	Kenai	Q	33
Yes	Kodiak Area Native Association	Margene Andrus	Kodiak	R	36
Yes	Maniilaq Association	Vivian Fleming	Kotzebue	T	40
Yes	Metlakatla Indian Community	Eula Marie Crippen, PhD	Metlakatla	A	2
Yes	Norton Sound Health Corporation	Jay David	Nome	T	39
Yes	SE Alaska Regional Health Consortium	Melody Price-Yonts*	Sitka	A	2
Yes	Southcentral Foundation	Chanda Aloysius	Anchorage	J-P & OTHER	19-32 & OTHER
Yes	Yukon Kuskokwim Health Corporation	Jennifer "Jay" Bierley	Bethel	S	38
Yes	Alaska Native Tribal Health Consortium	Laura Báez	Anchorage	? & OTHER	? & OTHER
Yes	Alaska Native Tribal Health Consortium	Lakota Murray Holman	Anchorage	I & OTHER	18 & OTHER
Yes	Ketchikan Indian Community	Stephanie Johnson	Ketchikan	A	2
Yes	Maniilaq Association	Bree Swanson	Kotzebue	T	40
Yes	Alaska Native Tribal Health Consortium	Dabney Van Liere	Anchorage	N	27

Behavioral remaining Salaries

125 aides
125 SBAES
RHS Program

Shared funding
RHS
Masters Program

TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE

A SUBCOMMITTEE OF THE ALASKA TRIBAL HEALTH DIRECTORS, ALASKA TRIBAL HEALTH SYSTEM

WHO WE ARE

The Tribal Behavioral Health Directors (TBHD) Committee was created in 2005 as a subcommittee of the Alaska Tribal Health Directors. The Alaska Tribal Health Directors formalized and the Alaska Native Health Board approved the committee in 2008. The TBHD Committee reports directly to the Alaska Tribal Health Directors.

The TBHD Committee performs several functions:

- Statewide behavioral health planning and advocacy
- Consulting with the State of Alaska on funding, and service delivery for tribal behavioral health, including Medicaid and grant programs;
- Providing mutual support in addressing funding, workforce, and service delivery issues that all are addressing in their organizations and communities.

CHALLENGES IN OUR COMMUNITIES

The second leading cause of outpatient visits for the Alaska Tribal Health System during FY2007 was for mental health disorders (7.0%).

During 2003-2005, second and third leading causes of injury hospitalization were suicide attempts (18.9%) and assaults (12.0%), respectively.

DISPROPORTIONALITY

Statistics about behavioral health generally point to harm to self, harm to others, and death. Alaska Native and American Indian (AI/AN) people are disproportionately affected by behavioral health issues. The reasons vary, but most point to a huge cultural shift over the last few generations.

The TBHD Committee relies on the Alaska Native Epidemiology Center for comprehensive data on the disproportionate effects of behavioral health issues for AI/AN peoples.

SUICIDE

AI/AN people in Alaska complete suicide at twice the rate as other Americans. In Western Alaska rates are seven times higher than the national average. Suicide is linked to historical trauma, substance abuse, sexual abuse and family violence. Friends, families and communities are the first line of defense.

Behavioral Health Aides (BHA) work in tribal behavioral health and wellness programs to support individuals in their healing processes and prevent suicide. When suicides occur, BHAs work with the survivors listening, and supporting them.

SUBSTANCE USE

Alaska's alcohol issues are well documented, yet our statewide substance abuse treatment capacity is very low. The Alaska State Trauma Registry shows that 73% of all assaults on AI/AN people in Alaska are alcohol related, as are 67% of hypothermia and 60% of suicide attempts. Tribal behavioral health programs offer a range of services, some funded by the State. Tribes are beginning to use sobering centers (Fairbanks, Bethel) to deal with immediate effects and Screening, Brief Intervention, and Referral to Treatment (SBIRT) to address alcohol-related emergencies.

Contact the Tribal Behavioral Health Directors Committee via
Alaska Native Tribal Health Consortium, Division of Community Health Services, Behavioral Health & Rural Services
Department: Phone: 907-729-2431.

DOMESTIC VIOLENCE & SEXUAL ASSAULT

With limited domestic violence/sexual assault response capacity at the public safety and victim advocate levels, communities have difficulty conveying baseline information about interpersonal violence. Behavioral health providers are developing community teams through an Indian Health Service (IHS) initiative, in coordination with the Network on Domestic Violence & Sexual Assault and Alaska Tribal Health Consortium (ANTHC).

HOW WE PARTNER WITH THE STATE OF ALASKA AND MENTAL HEALTH TRUST

TRIBAL CONSULTATION

The federal government recognizes that it is vital and essential for the State of Alaska to consult with tribes about a number of issues. The TBHD Committee is the entity with which state agencies consults regarding programs affecting tribal behavioral health services.

MEDICAID FUNDING

The Committee works with DHSS and DBH staff to optimize Medicaid income for tribal behavioral health, reducing costs to the state. Medicaid is the second largest state budget item in Alaska, after public school funding. Nearly 40% of Medicaid clients are AI/AN people, and an equal amount of program expenditures are made on their behalf. AI/AN people are more likely to use services provided by the Alaska Tribal Health System (ATHS) if available. However, two-thirds of the funds spent on the health care of AI/AN clients in Alaska are paid to private sector providers.

BRING THE KIDS HOME

AI/AN children from Alaska are over-represented in the population of children in custody and represent 49% of the children sent to out of state placements and 22% of the non custody children sent to out of state placements.

A subcommittee has been working with state DBH staff to bolster services and streamline the business practices of tribal organizations to bring kids home from out-of-state behavioral health placements and to serve them in their home communities.

WORKFORCE DEVELOPMENT: THE BEHAVIORAL HEALTH AIDE

The ATHS has invested in the development of the BHA model so that local people can be trained to provide a full range of behavioral health services. The ATHS has developed standards and procedures for BHAs, a certification process, and assessment processes for ongoing training needs of BHAs. The BHA program has gained national interest since the Community Health Aide Program Certification Board approved the certification process.

BHAs receive training through the University of Alaska, tribal health organizations, conferences, and field experience.

BENEFITS OF WORKING WITH US

CULTURALLY RELEVANT SERVICES

Tribal behavioral health programs are located within tribal health organizations. Tribal

Contact the Tribal Behavioral Health Directors Committee via
Alaska Native Tribal Health Consortium, Division of Community Health Services, Behavioral Health & Rural Services
Department: Phone: 907-729-2431.

behavioral health services are delivered in coordination with other health services.

INDIAN HEALTH SERVICE FUNDS

IHS provides approximately 40% of the funding to tribal health organizations in Alaska to deliver services to IHS beneficiaries.

MEDICAID REIMBURSEMENT AT 100%

Medicaid services delivered to AI/AN people by tribal programs are reimbursed by the federal government at 100 percent.

WE NEED TO COLLABORATE TO BE EFFECTIVE AND EFFICIENT

BILLING

Since cost of health care exceeds the IHS funding, tribal health organizations have gradually been developing billing processes for health services.

Through the tribal consultation process, the State and the tribes identified program improvements that will lead to better Medicaid billing processes.

DATA

The IHS RPMS data system and the State of Alaska's AKAIMS do not interface. AKAIMS has 276 data elements in its minimum data set. Of these, only 74 items overlap with the RPMS medical module.

Tribal behavioral health programs that are DBH grantees must report through AKAIMS. Tribal health organizations must use RPMS or another data system to report to IHS. Since half the State's behavioral health programs are tribal, the Committee would like the State DBH to assist in the development of a work plan that resolves the inefficiencies of data collection and allow agencies to interface directly with the AKAIMS database.

Contact the Tribal Behavioral Health Directors Committee via
Alaska Native Tribal Health Consortium, Division of Community Health Services, Behavioral Health & Rural Services Department: Phone: 907-729-2431.

Tribal Behavioral Health Directors Committee

February 17, 2011
Presented on behalf of the TBHDC by
Michael Horton, LPC &
Melody Price-Yonts, MS, CDC I

Level 3
Level 4
State Plan Amend

Tribal Behavioral Health Directors Committee

A Subcommittee of the Alaska Tribal Health Directors

- Created in 2005
- Alaska Native Health Board approved in 2008
- 24 members from 26 tribal health entities
- Meet and report quarterly
- Over 800 employees in the tribal BH system
- 6.5 million in tribal grant funding for BHAs

HHS -
Mental Health Services

Tribal Behavioral Health Directors Committee

Current Priorities Include:

- Suicide Prevention
- Domestic Violence & Sexual Assault
- Substance Abuse Prevention & Treatment
- Training & Credentialing for Behavioral Health Aides
- Development of the Behavioral Health Aide Manual (BHAM)

Growing Our Own

The Behavioral Health Aide Model

- Model is federally recognized through the Community Health Aide Program & Certification.
- 125 BHA providers working within tribal behavioral health
- Trained and certified to provide a broad range of behavioral health services.
- Focus on prevention, intervention, treatment, case management and aftercare for those who are affected by substance use and mental health disorders.
- The BHA Certification is equivalent to that of the State of Alaska BH Commission.

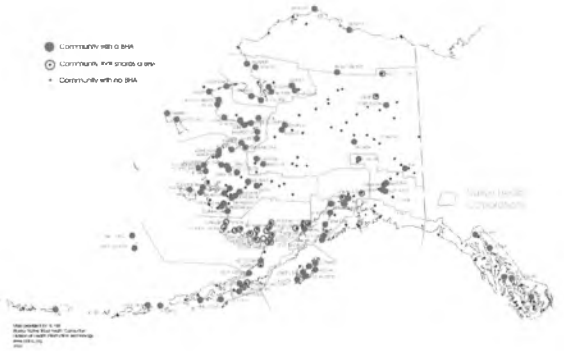
What do standards and certification mean to BHAs?

~Emma Mathias, Former BHA I, YKHC

"I think the BHA standards are what we need as a BHA to better serve our clients. It's important for me because out there our clients are struggling and with us BHAs in the village the clients will get the help they need to sobriety and support. I feel that I know with this standard I'm helping our people and others to overcome their addictions and struggle."

THE ALASKA TRIBAL HEALTH SYSTEM

Behavioral Health Aide Locations



Behavioral Health Aide Digital Story

Title: *Opening Wounds of Silence*

By Karen Mitchell, BHA III, Maniilaq Association

Karen is from and works in Noatak, Alaska –

- Population about 500,
- Located 55 air miles north of Kotzebue and 70
- Miles north of the Arctic Circle

Behavioral Health Aide- The Story Beyond the Digital Story

"Thank you for listening at my story." ~ Karen

What do standards and certification mean to BHAs?

"To me it means to show that I am capable of doing the work that is required of my level. Any agency within the state can recognize my capabilities of accomplishing the tasks that required of me in the work field."

~ Simeon John, BHA I, YKHC

BHA Training Opportunities

Experience

Conferences

University of Alaska System

Tribal Health Organizations

How does the State benefit from working with Tribal Behavioral Health?

- Eligibility for 100% FMAP
- Delivery of effective culturally relevant services
- Sole provider of health services in most rural areas – serves all community members (native and non-native)

State Plan Amendment (SPA)

Partnership between the Alaska Tribal Health System & the State of Alaska

After years of negotiation and building communication and understanding among the tribal providers and the State, a state plan amendment was drafted and submitted to the Alaska Native Health Board (ANHB) for endorsement.

The SPA was endorsed by ANHB and has been submitted to the State for action!

State Plan Amendment (SPA)

Partnership between Tribal Health & State of Alaska

This recommendation was ratified by ANHB on 12/2/2011.

"... *BHA Certification requires that BHAs of all levels have a high level of training and experience. An extensive amount of work was completed to match training with skills and competencies on all levels. The Tribal Behavioral Health Directors support the resubmission of the State Plan Amendment and request the inclusion of levels III and Practitioner in the reimbursement plan with consideration for BHA I and II in the future.*"

Opportunities to Improve within the Tribal Behavioral Health System

Reporting mandates that currently reduce efficiency due to lack of interface:

- Federal government reporting requirements
- State of Alaska – AKAIMS
- Other Electronic Health Records (EHR)

Inefficiencies

* Staff resources
* Training
* Labor expenses
* Limited web connectivity
* Data entry in multiple systems
* Data errors

Removing Reggie Jones

Alphabet Soup

merger

Goal:

Develop a work plan with the SOA that resolves the inefficiencies of data collection. ✓

Allow agencies to interface directly with the AKAIMS database. ✓

Thank You

To connect with the Tribal Behavioral Health Directors Committee, please contact the ANTHC Behavioral Health & Rural Services Department at: 907-729-2431.

SB

5

<TARGET><BILL>SB 5</BILL><SUBJECT>SB 5</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 5 - "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Sponsor Statement

Senate Bill 5 increases and restores to original levels established 14 years ago the qualifying income eligibility standard to 200% of the Federal Poverty Level (FPL) for the State Children's Health Insurance Program (SCHIP) called Denali KidCare (DKC) in Alaska. Alaska as one of the nation's wealthiest states is only one of four states which funds its SCHIP program below 200% FPL. This bill makes health insurance accessible to an estimated 1277 more uninsured children and 225 pregnant women in Alaska. Denali KidCare is an enhanced Medicaid reimbursement program receiving up to 70% federal matching funds.

Denali KidCare serves an estimated 7900 Alaska children and remains one of the least costly medical assistance programs in the state at about $1,700 per child with full coverage, including dental care, which is about 20% of the cost of adult senior coverage. Early intervention and preventative care will greatly increase Alaska children's health and yield substantial savings to the state and public and private sector hospital emergency rooms which must admit indigent and uninsured patients for non-emergency treatment. It is estimated per the Kaiser Foundation that the 24,000 uninsured children in Alaska with a medical need are five times as likely not to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost.

A similar bill was overwhelmingly passed with bipartisan support by the Legislature in 2010. Governor Parnell subsequently vetoed the bill over concern that increased eligibility to Denali KidCare would require an increase in state-funded induced terminations of pregnancies. Medicaid funds 51% of all births in Alaska. In order to continue to receive federal funding for the state Medicaid program of which Denali KidCare is part, and in order to comply with state law, constitutional provisions, and Alaska Supreme Court rulings, the state must provide medical services for pregnant women including medically necessary terminations, as well as prenatal and postpartum care.

The Alaska Department of Health and Social Services (DHSS) estimated that no more than 10% or 22 more induced terminations would result with minimal expense from the increase in eligibility for Denali KidCare to 200% FPL. Induced terminations under Denali KidCare cost about $384,000 annually or less than 0.18% or 1/5 of 1% of the $217 million of the DKC budget.

While the Governor understandably is concerned about the mushrooming cost of the state Medicaid program, Denali KidCare which is about 18% of the $1.2 billion total state Medicaid budget should not be among his first cuts at the expense of Alaska's most vulnerable children and pregnant women. Increasing eligibility for DKC to 200% FPL under Senate Bill 5 is uncomplicated, manageable, and could take effect immediately with prompt implementation by DHSS.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 24, 2011

SUBJECT: Sectional Summary (SB 5; Work Order No. 27-LS0057\B)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Amends the medical assistance eligibility provisions for persons under 19 years of age and for pregnant women by increasing the household income limit from 175 to 200 percent of the federal poverty line.

Section 2. Increases the household income limit from 175 to 200 percent of the federal poverty line for requiring premiums and cost-sharing contributions from medical assistance recipients who are under 19 years of age.

Section 3. Provides for an immediate effective date.

JMM:ljw
11-034.ljw

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB005**
() Publish Date:

Identifier (file name): SB005-DHSS-PAFS-02-17-11
Title: Medical Assistance Eligibility
Sponsor: Sen. Bettye Davis, Sen. Dennis Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Public Assistance Field Services
OMB Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	187.0		187.0	187.0	187.0	187.0	187.0
Travel							
Services	19.4		19.4	19.4	19.4	19.4	19.4
Commodities	1.0		1.0	1.0	1.0	1.0	1.0
Capital Outlay	14.4						
Grants							
Miscellaneous							
TOTAL OPERATING	**221.8**	**0.0**	**207.4**	**207.4**	**207.4**	**207.4**	**207.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	144.2		134.8	134.8	134.8	134.8	134.8
1003 GF Match	77.6		72.6	72.6	72.6	72.6	72.6
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**221.8**	**0.0**	**207.4**	**207.4**	**207.4**	**207.4**	**207.4**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time	**2.0**		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared by: Ron Kreher, Acting Director — Phone (907) 465-2680
Division: Public Assistance — Date/Time 2/17/11 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/17/2011
DHSS Finance & Management Services

(Revised 12/29/2010 OMB)

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB005
2011 LEGISLATIVE SESSION SB005

Analysis:

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare(DKC) program was originally created.

This fiscal note represents the additional administrative costs needed to support the increased eligibility determination workload resulting from more pregnant women and children applying for medical assistance, using the assumptions from the companion fiscal notes for the Division of Health Care Services and the Division of Behavioral Health.

The eligibility decision includes verifying information and determining whether a pregnant woman or child qualifies for DKC when they apply, acting on changes, and periodically re-examining a household's eligibility.

We assume that 218 pregnant women and 1,277 children will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and that implementation will begin July 1, 2011. We estimate two additional Eligibility Technician II (Range 14) positions will be needed to manage this additional work in FY2012.

Total Administrative Costs for Two ET II Positions:

Personal Services: Two Eligibility Technician II Range 14 at a cost of $187.0, including benefits, for 12 months.
Contractual: Annual cost for office space, phones, etc. will be $19.4.
Commodities: Annual cost for the office supplies will be $1.0.

Additional Cost of FY2012:
Equipment/Supply: A one-time cost of $14.4 for desktop computer, software, printer, and work stations will be needed for the new positions.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB005**
() Publish Date:

Identifier (file name): SB005-DHSS-BHMS-02-17-11
Title: Medical Assistance Eligibility
Sponsor: Sen. Bettye Davis, Sen. Dennis Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants	567.0		615.7	668.7	726.2	788.6	856.4
Miscellaneous							
TOTAL OPERATING	**567.0**	**0.0**	**615.7**	**668.7**	**726.2**	**788.6**	**856.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	383.6		416.5	452.3	491.2	533.4	579.3
1003 GF Match	183.4		199.2	216.4	235.0	255.2	277.1
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**567.0**	**0.0**	**615.7**	**668.7**	**726.2**	**788.6**	**856.4**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version

Prepared by: Kimberly Poppe-Smart, Director — Phone 907-334-2520
Division: Health Care Services — Date/Time 2/17/11 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/17/2011
DHSS Finance & Management Services

(Revised 12/29/2010 OMB)

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB005
SB005

Analysis:

Denali KidCare is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually. In 2003, DKC eligibility limits were reduced from 200% of poverty to 175% and frozen at 2003 levels. In 2007, the income limits were unfrozen, but remained at 175% of poverty. This bill would restore Denali KidCare to its original level.

Children age 18 and under at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2012, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid. Pregnant women under this income level are eligible only for regular Medicaid (50% match).

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated at 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY 2012 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2010. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Costs projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XIX, or Title XXI rates during 2010 and our best estimates for federal medical assistance percentages (FMAPs) between 2012 and 2017. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2012 and 2017.

Expenditures for the Behavioral Health Medicaid Services component were determined based on the component's share of expenses for the affected eligibility subtypes in 2010. Behavioral Health paid about 15% of the costs for affected DKC children in 2010. No charges for services for DKC pregnant women were paid by this component in 2010.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB005**
() Publish Date:

Identifier (file name): SB005-DHSS-HCMS-02-17-11
Title: Medical Assistance Eligibility
Sponsor: Sen. Bettye Davis, Sen. Dennis Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants	2,718.2		2,952.0	3,205.8	3,481.5	3,781.0	4,106.1
Miscellaneous							
TOTAL OPERATING	**2,718.2**	**0.0**	**2,952.0**	**3,205.8**	**3,481.5**	**3,781.0**	**4,106.1**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	1,897.8		2,061.1	2,238.3	2,430.8	2,639.9	2,866.9
1003 GF Match	820.4		890.9	967.5	1,050.7	1,141.1	1,239.2
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**2,718.2**	**0.0**	**2,952.0**	**3,205.8**	**3,481.5**	**3,781.0**	**4,106.1**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Kimberly Poppe-Smart, Director — Phone 907-269-7827
Division: Health Care Services — Date/Time 2/17/11 12:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/17/2011
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB005
2011 LEGISLATIVE SESSION

Analysis:

Denali KidCare is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually. In 2003, DKC eligibility limits were reduced from 200% of poverty to 175% and frozen at 2003 levels. In 2007, the income limits were unfrozen, but remained at 175% of poverty. This bill would restore Denali KidCare to its original level.

Children age 18 and under at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2012, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid. Pregnant women under this income level are eligible only for regular Medicaid (50% match).

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY2012 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2010. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Cost projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XXI rates , Title XIX, or State General Fund only (for abortions) during 2010 and our best estimates for federal medical assistance percentages (FMAPs) between 2012 and 2017. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2012 and 2017.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2010. Health Care Services Medicaid paid 100% of the costs for DKC pregnant women and about 85% of the costs for affected DKC children in 2010.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

Fact Sheet on Denali KidCare as it Relates to Abortion Funding

Thank you for your questions regarding the Denali KidCare program and how it relates to abortion funding in Alaska. Because the department has received numerous questions that are similar, but worded slightly differently, we have paraphrased the questions and compiled the responses in a Fact Sheet for consistency.

We hope this addresses the intent of the questions you posed. If not, please contact Wilda Laughlin at 465-1613.

- **How many more abortions do you project would be covered if income eligibility for Denali KidCare were increased from 175% to 200%?**

  - Past history in Medicaid services shows that approximately 10% of pregnant enrollees have sought abortion related services. Applying that number to the anticipated growth in enrollment of pregnant enrollees as a result of the expansion (218), we expect approximately 22 will seek these services.

- **How much federal money will the state lose over the next 10 years as a result of the Governor's intended veto of SB 13, assuming that funding levels remain stable?**

  - The fiscal note for SB13 estimates that the state would have spent $1,592,700 in federal funds in FY 2011. The fiscal note also assumes 8.6% growth in total costs per year. If we assume the federal percentage of spending remains the same (69.7%) and grows at 8.6% per year, then over 10 years (through 2020) this totals $23,740,650 in federal funds.

- **Is the program affected by an Alaska Supreme Court decision that says certain abortions must be paid for?**

  - Yes. The Alaska Supreme Court ruled in *DHSS v. Planned Parenthood*, 28 P.3d 904 (Alaska 2001) that the State must fund medically necessary abortions for pregnant women if it funds other medically necessary services for other financially needy persons.

- **How is "medically necessary" defined?**

  - "Medically necessary" as it applies to abortions paid for under Denali KidCare is not defined in statute or regulation, or by Court decision.

- **Is there anything unique to abortions that are paid for under DKC as opposed to regular Medicaid?**

  - No.

- **How much is Denali KidCare's annual budget?**

  - Spending in Calendar Year 2009:
    - Title XXI kids: $30,246,349
    - DKC Pregnant Women: $60,578,841
    - DKC Title XIX kids: $125,761,129
    - **Total DKC: $216,586,319**

- **How much money is spent on abortions?**
  - In Calendar Year 2009:
    - Of total DKC spending: $384,000 was spent on abortion-related services
    - Of total Medicaid Spending: $616,000 was spent on abortion-related services

- **How many additional women and children would have been eligible for Denali KidCare if the eligibility had been expanded from 175 percent to 200 percent of the federal poverty level?**

  - The fiscal note for SB13 estimates 218 pregnant women and 1,277 children would have been covered by the expansion of Denali KidCare.

- **What other services do children have access to under DKC?**

  - See Department website: http://www.hss.state.ak.us/dhcs/DenaliKidCare/gen_info_dkc.htm

Georgetown University Health Policy Institute
Center for Children and Families

To: Interested Parties
From: Tricia Brooks, Georgetown Center for Children and Families
Re: Alaskan Options for Expanding Coverage for Pregnant Women
Date: November 4, 2010

During a recent trip to Alaska to participate in the Kids First Alaska meeting on October 19, 2010 at the invitation of the All Alaska Pediatric Partnership and the Mat Su Health Care Foundation, I was asked to provide clarifying information on opportunities to expand federally supported medical coverage to pregnant women in Alaska. This memo outlines current coverage in Alaska and provides an overview of federal options and requirements for expanding coverage.

Current Coverage for Pregnant Women and Children in Alaska

Currently, Alaska provides traditional Medicaid coverage to pregnant women with income up to 175% of the Federal Poverty Level (FPL) who are citizens or immigrants lawfully residing in the U.S. for at least five years. Additionally, the state provides, as federally required, emergency medical coverage for labor and delivery services to any uninsured pregnant woman who meets the Medicaid guidelines, regardless of citizenship or immigration status.

While the purpose of this memo is to identify options for expanding coverage to pregnant women, certain options are related to coverage for children. Alaska uses its Medicaid program for covering both children and pregnant women. Currently, the State provides Medicaid coverage for children up to 150% FPL and coverage between 150% and 175% FPL for children through a Medicaid expansion funded through the Children's Health Insurance Program (CHIP) called Denali Kid Care. The CHIP-funded Medicaid expansion for children qualifies for a higher financial participation rate. In Alaska the federal participation rate for Medicaid is 50%[1] and for CHIP is 65%.

Options for Expanding Coverage for Pregnant Women with Federal Financial Participation

- *Expand Medicaid Coverage*

  Federal Requirements and Options - States with Medicaid programs are required to cover pregnant women who are citizens with income up to 133% of the federal poverty level (FPL). States may expand income eligibility through Medicaid to pregnant women who are citizens and, at the state option, lawfully-residing immigrants up to an income level approved by the federal government. States are

also required to cover labor and delivery cost of all uninsured women under emergency Medicaid services if they otherwise meet Medicaid income and asset requirements.

Alaska Options – Alaska may expand Medicaid coverage for pregnant women with incomes higher than the current limit of 175% FPL. Under this option, the state may also elect to provide coverage for lawfully residing immigrant pregnant women. An expansion of eligibility requires a Medicaid State Plan Amendment (SPA). Federal financial participation under this option is 50%.

- *Expand CHIP Coverage to Pregnant Women*

Federal Requirements and Options – The 2009 federal reauthorization of the CHIP program (CHIPRA) expanded options for states to cover pregnant women. Under CHIPRA, states may provide coverage to pregnant women who are citizens and, at the state option, lawfully residing immigrant pregnant women, through CHIP up to 300% FPL, if certain conditions are met. Among those conditions, the state must cover children under Medicaid/CHIP up to at least 200% FPL and cover pregnant women through Medicaid up to 185% FPL. Pregnant women cannot be covered at a higher income level than children.

Alaska Options – To expand coverage to pregnant women under CHIPRA, the state would first have to expand Denali Kid Care coverage to children from the current income level of 175% FPL up to at least 200% FPL or higher, depending on the proposed income limit for pregnant women. Additionally, the state would have to expand Medicaid coverage to pregnant women between 175% and 185% FPL. With those coverage levels, the state may expand coverage for pregnant women above 185% FPL drawing down the higher 65% CHIP federal match.

This option would require a Medicaid SPA to raise the income eligibility level for pregnant women to 185% FPL. Additionally, Alaska must submit a CHIP SPA to expand income eligibility for children up to 200% FPL (or higher depending on the proposed income limit for pregnant women) and to provide CHIP coverage to pregnant women above 185% FPL.

The SPA establishes what is technically a separate CHIP program for low-income pregnant women rather than a CHIP-funded Medicaid expansion program as is Denali Kid Care. However, it can be operated as a "Medicaid look-alike" program using the existing Medicaid administrative structure and health care delivery system. The expansion to pregnant women between 175% and 185% FPL would qualify for the 50% federal Medicaid match, while expanded coverage for children above 175% FPL and for pregnant women above 185% would qualify for the higher federal CHIP match of 65%.

- *Expand Coverage Under the CHIP Unborn Child Option*

  Federal Requirements and Options - States may provide prenatal care, labor, and delivery services to pregnant women through the unborn child option in CHIP. Sixty days of postpartum care can also be funded if services are provided under a global capitation arrangement, which bundles payment for all prenatal, labor, delivery, and postpartum care. Through this option, coverage is provided without regard to the pregnant woman's immigration status. While it is the unborn child who is eligible, services are directed to the pregnant woman to ensure the delivery of a healthy newborn, including medical and dental services for the mother deemed necessary to promote the health of the unborn child.

  Alaska Options - The state may expand coverage under the CHIP unborn child option for the unborn child of pregnant women who do not otherwise qualify for Medicaid, as well as pregnant women above the current income limit of 175% FPL. Like the previous option, this would require a CHIP State Plan Amendment to create a separate CHIP program to establish coverage for the unborn child.

  Currently eligible children, ages 0 - 18 would continue to be covered under Denali Kid Care while the pregnant women receiving services based on the eligibility of their unborn child would be covered under the separate CHIP program. In this case, Alaska may also wish to design its CHIP unborn child coverage as a "Medicaid look-alike" program as described above. Services provided to pregnant women under the unborn child option qualify for a 65% federal financial participation in Alaska.

Summary

Several options exist for Alaska to expand coverage to pregnant women directly through Medicaid and/or CHIP. Financial participation depends on the option(s) chosen. This overview of provisions in CHIPRA to cover pregnant women may be helpful. Stakeholders may wish to review additional information provided to states by the Centers for Medicaid and Medicare (CMS) in these relevant State Health Official (SHO) letters of guidance and Q & A memos:

State Health Official Letter on the Unborn Child Option

State Health Official Letter on Lawfully Residing Children and Pregnant Women

State Health Official Letter on Covering Pregnant Women through CHIP

State Health Official Letter on Frequently Asked Questions about Covering Pregnant Women

[1] The 50% federal participation is the traditional matching rate for Alaska. During the period July 2008 through June 2011, the American Recovery and Reinvestment Act (ARRA) provides a higher match to help states deal with the increased need for services during the economic downturn.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM November 18, 2010

SUBJECT: Medicaid funding of "medically necessary" abortions
(Work Order No. 27-LS0175)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have asked about the meaning of "medical necessity" as it relates to medical assistance (Medicaid) funding of abortions. State and federal statutes fail to define the phrase, although the concept forms the basis for coverage of all services under the jointly funded Medicaid program and is defined for purposes other than abortion services in regulation.

Despite a federal exclusion for most abortion services known as the "Hyde Amendment," upheld by the United States Supreme Court, the Alaska Supreme Court in 2001 specifically held that the equal protection guarantee under our state constitution requires the state to cover medically necessary abortion services, as it does for all other medical services covered under state Medicaid funding. The standard for "medical necessity" in Alaska appears to be similar for all Medicaid services and includes services that are broader than life saving services but less than elective services, as discussed below.

FEDERAL LAW DRAWS A DISTINCTION BETWEEN ABORTION SERVICES FUNDING AND OTHER TYPES OF COVERED SERVICES

The federal purpose of the Medicaid program established the medical necessity standard under 42 U.S.C.S. § 1396-1 as follows:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of *necessary medical services*, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Emphasis added.) Since 1976, Congress has prohibited, either by an amendment to the annual appropriations bill for the United States Department of Health and Human Services, or by joint resolution, the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances. The "Hyde Amendment" provides that:

> [N]one of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service.

Pub. L. 96-123.

After the passage of the Hyde Amendment, federal courts wrestled with questions about whether state and federal governments are required to pay for an indigent woman's exercise of a fundamental constitutional right when a "medically necessary" abortion is involved. In several close decisions, the U.S. Supreme Court determined that the federal constitution does not require public financial support of the right to choose an abortion in cases that do not involve rape or incest or a threat to the mother's life. Beal v. Doe, 432 U.S. 438 (1977); Maher v. Roe, 432 U.S. 464 (1977); Harris v. McRae, 448 U.S. 297 (1980); Webster v. Reproductive Health Services, 492 U.S. 490 (1989). It is instructive to note the trial court definition in the McRae case of the phrase "medically necessary" for purposes of abortion funding was "a professional judgment for the physician that may be exercised in the light of all factors--physical, emotional, psychological, familial and the woman's age--relevant to the well-being of the patient."

The federal courts ruled in these cases that governments are not required to provide money to assist in the exercise of constitutional rights; governments are only prohibited from placing obstacles in the way of exercising those rights. Withholding funding, said the federal courts, is not an obstacle to the indigent woman who seeks an abortion. Her poverty may be an obstacle, but the government did not create the poverty. She is still free to have an abortion, but not with public money. The federal courts suggested other private money might be available. In light of these federal decisions, it is clear that public funding for abortions, even when "medically necessary," is not required under the federal constitution.

ALASKA LAW REQUIRES A MORE UNIFORM BUT INEXACT STANDARD FOR STATE MEDICAID FUNDING OF ALL TYPES OF SERVICES COVERED, INCLUDING ABORTION SERVICES

In the early 1990's, the state attempted to adopt the federal distinction for funding of abortion services and disregarded the general medical necessity definition adopted in regulation for other types of services. In a direct challenge to the state regulation that provided only for public funding of abortion services to preserve the life of the mother or

in cases of rape or incest, the Alaska Supreme Court held that the state must pay for medically necessary abortions for participants in the Medicaid program as it does for other types of services. State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001). The Alaska Supreme Court determined then that the "rape, incest, and to prevent the death of the mother" restrictions of the Hyde Amendment are too narrow to satisfy the requirements of the Alaska state constitution.

The Alaska constitution has been consistently interpreted to provide broader protections than the federal constitution. For instance, in Valley Hospital Ass'n v. Mat-Su Coalition for Choice, 948 P.2d 963, 969 (Alaska 1997), the Alaska Supreme Court held that "reproductive rights are fundamental . . . [and] include the right to an abortion." Later, in State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001), the Alaska Supreme Court, although basing its decision on due process considerations rather than the privacy clause used by the lower court, came to the same conclusion the lower court had. The conclusion was that if the state Department of Health and Social Services (DHSS) restricted abortion coverage for Medicaid-eligible women to only those covered by the exceptions in the Hyde Amendment, it would result in unconstitutional implementation of Medicaid in Alaska.

There is language in the Planned Parenthood of Alaska, Inc. case (cited above; see 28 P.3d at 913) strongly suggesting that the Alaska Supreme Court considers women who carry their pregnancy to term to be similarly situated with women who have an abortion (in that they are both exercising their constitutional freedom of reproductive choice). If the court continues to hold that position when faced with a renewed public abortion funding challenge, there is a possibility that the court will find that the state may not be able to burden the right to abortion services under the state Medicaid program unless a similar burden is placed on medical services to continue a pregnancy, and in the absence of comparable burdens on continuation of a pregnancy the state cannot burden the right to abortion services.

The consequence of having a more broadly interpreted right to public funding of abortions for Medicaid recipients in Alaska than what is allowed under federal law is that DHSS must cover some Medicaid abortions with 100% state money (no federal match).[1] The federal government does not prohibit states from using their own funds.

Over the years, language has appeared in Alaska budget acts that purport to prohibit DHSS from using any of its appropriated money for abortions outside the scope of the

---

[1] Alaska is reportedly not alone in using purely state funds for some Medicaid abortions that the federal government will not fund. I do not have an up-to-date list and I have not double-checked the cases cited, but the ACLU says that 17 states fund abortions outside the Hyde Amendment restrictions, 4 voluntarily and 13 under court order. I have attached the relevant information, as reported by the ACLU, excerpted from http://www.aclu.org. I cannot vouch for the accuracy of the ACLU website, but if you require further information about public funding of abortions in other states, please let the office know.

Hyde Amendment. However, DHSS has been under court order to continue to pay for medically necessary abortions and has complied with the state attorney general's advice to do so.[2]

---

[2] For instance, with regard to the 2007 fiscal year operating budget, the attorney general wrote the following:

> This year's budget, as did the prior four years' budgets, contains the following language regarding abortion funding:
>
> > No money appropriated in this appropriation may be expended for an abortion that is not a mandatory service required under AS 47.07.030(a). The money appropriated for Health and Social Services may be expended only for mandatory services required under Title XIX of the Social Security Act and for optional services offered by the state under the state plan for medical assistance that has been approved by the United States Department of Health and Human Services . . . .
>
> [citation omitted]. As we opined before, this language is intended to prevent expenditures from these appropriations for therapeutic or medically necessary abortions. DHSS, however, is under a superior court order to operate its Medicaid program in a constitutional manner by providing payment for them. That superior court order has been upheld by the Alaska Supreme Court, which specifically rejected an argument that the separation-of-powers doctrine precluded the superior court from ordering the state to pay. State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, 28 P.3d 904 (Alaska 2001). Thus, the DHSS is faced with a ruling from the state's highest court that the limit on payment for abortion services results in the operation of the Medicaid program in an unconstitutional manner, while DHSS is ostensibly without the money available to pay for services to operate the program legally. . . . Five years ago, the plaintiffs in the Planned Parenthood case asked the superior court to clarify how similar budget restrictions impacted its judgment. The superior court, three days after the supreme court affirmed the judgment, issued an opinion ordering the DHSS not to comply with the restrictions. To date, therefore, DHSS has obeyed the superior court's order and we must advise DHSS to continue to obey it; i.e., to continue to pay for these medically necessary abortions, until such time as a court reverses the order that is now in effect.

2007 Alas. AG LEXIS 21, 7 - 8.

According to DHSS, the money used for Medicaid abortions not covered by the Hyde Amendment (i.e., abortions for which the federal government will not contribute federal money), comes from the appropriation made by the legislature to DHSS for Medicaid.[3]

Other attempts to narrow the definition of "medical necessity" for purposes of abortion services funding have similarly failed. In 2002, for example, the Alaska Legislature passed and the governor vetoed a bill (SB 364, 22nd Legislature) that added a new section to AS 47.07 to provide that the state Medicaid program may only pay for medically necessary abortions and for abortions to terminate pregnancies resulting from rape or incest. The bill prescribed what is a medically necessary abortion and established requirements for submitting claims for payment for abortions. (See SB 364, attached). That bill provided as follows:

> (b) A claim for payment for a medically necessary abortion that is submitted to the department must be accompanied by a written certification by the treating physician that the abortion is medically necessary to treat a serious
>
> (1) adverse physical condition of a pregnant woman that
>
> (A) either is caused by the pregnancy or would be significantly aggravated by continuation of the pregnancy; and
>
> (B) would seriously endanger the physical health of the woman if the pregnancy were not terminated by an abortion; or
>
> (2) psychological illness of a pregnant woman who requires medication for treatment of the illness if
>
> (A) the medication required to treat the illness would be highly dangerous to the fetus; and
>
> (B) the health of the woman would be endangered if the mediation was not taken during pregnancy.

Since the bill was vetoed and the definition of "medical necessity" for purposes of abortion services funding contained in former 7 AAC 43.140(a) was held to be unconstitutional in 2001 and has recently been repealed but not reenacted, the state currently lacks a clear definition of the phrase as it applies to abortion services. The repealed regulatory definition provided that:

> (a) Payment for an abortion will, in the department's discretion, be covered under Medicaid if the physician services invoice is accompanied by certification that the (1) life of the mother would be endangered if the pregnancy were carried to term; or (2) pregnancy is the result of an act of rape or incest.

---

[3] If the physician submitting the Medicaid claim for costs associated with an abortion does not provide the information that would allow DHSS to document to the federal government that a particular abortion falls within the Hyde Amendment exceptions, then DHSS does not seek a federal match for the costs associated with that abortion.

What remains in the regulations for abortion services funding are the terms "elective" and "therapeutic" (a term that appears to be used as a substitute in the regulations for "medical necessity"), defined in 7 AAC 47.290, along with the general concept of "medically necessary" for all covered services under 7 AAC 105.100.

For general relief funding,[4] 7 AAC 47.290 provides as follows:

> . . .
>
> (7) "elective abortion" means a procedure, other than a therapeutic abortion, to terminate a pregnancy;
>
> (8) "therapeutic abortion" means the termination of a pregnancy;
>
> (A) certified by a physician as medically necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health; or
>
> (B) that resulted from actions that would constitute a crime of sexual assault under AS 11.41.410 - 11.41.425, a crime of sexual abuse of a minor under AS 11.41.434 - 11.41.440, or the crime of incest under AS 11.41.450.

For state funding under Medicaid, 7 AAC 105.100 describes "covered services" to include the general concept of "medically necessary" with cross-references to specified types of services as follows:

> The department will pay for a service only if that service
>
> (1) is identified as a covered service in accordance with AS 47.07, 7 AAC 43, and 7 AAC 105 - 7 AAC 160;
>
> (2) is provided to an individual who is eligible for Medicaid under 7 AAC 100 on the date of service;
>
> (3) is ordered or prescribed by a provider authorized to order or prescribe that service under applicable law;
>
> (4) is provided by a person who is enrolled as a Medicaid provider or rendering provider under 7 AAC 105.210, or otherwise eligible to receive payment for services under 7 AAC 43 and 7 AAC 105 - 7 AAC 160;
>
> *(5) is medically necessary as determined by criteria established under 7 AAC 43 and 7 AAC 105 - 7 AAC 160 or by the standards of practice applicable to the provider;*
>
> (6) has received prior authorization from the department, if prior authorization is required under 7 AAC 43 or 7 AAC 105 - 7 AAC 160; and

---

[4] Like the Medicaid program, the general relief program is designed to meet "medical needs." While some abortions are termed "elective" by some observers, they still meet a medical need, as determined by the physician who performs the abortion procedure. Distinguishing among types of abortions in the general relief program would infringe the same privacy and equal protection interests as courts have determined are infringed when abortion funding restrictions are imposed under the Medicaid program.

(7) is not specifically excluded as a noncovered service under 7 AAC 43 or 7 AAC 105 - 7 AAC 160.

(Emphasis added.) The phrase "medically necessary" is defined for purposes of mental health services and other purposes such as vision, hearing, and dental screening funding under Medicaid as follows:

7 AAC 43.486. Medical necessity determinations for mental health rehabilitation services
(a) The division will, in its discretion, periodically review the recipient's clinical record to determine whether the services requested are medically necessary. A medically necessary mental health rehabilitation service is a service designed to

(1) screen recipients for the presence of a mental or emotional disorder;

(2) assess the nature and extent of the mental or emotional disorder and its impact upon the recipient's ability to meet the demands of daily living, social, occupational, or educational functioning;

(3) diagnose the mental or emotional disorder;

(4) treat the mental or emotional disorder;

(5) provide rehabilitation for the mental or emotional disorder;

(6) prevent the relapse or deterioration of the recipient's condition due to the mental or emotional disorder.

(b) In making its determination as to whether the proposed services are medically necessary, the division will consider the following:

(1) the recommendations of the referring physician, mental health professional clinician, or interdisciplinary team organized under 7 AAC 43.470 that prescribed, ordered, recommended, or approved the service;

(2) the recipient's diagnosis and level of functioning;

(3) the risk of danger from the recipient to self or other individuals;

(4) the appropriateness of the level of care and the need for inpatient or residential care;

(5) whether the intervention targets specific symptoms and behavioral and social dysfunction, and logically derives from the assessments and diagnosis;

(6) whether the proposed services in the individualized treatment plan are consistent with generally accepted community-based treatments and practices for the treatment of the specific symptoms and behavioral and social dysfunction;

(7) whether the recipient agrees with the referring physician, mental health professional clinician, or interdisciplinary team under (1) of this subsection that the focus of the treatment will be the symptoms and behavioral and social dysfunction targeted for intervention;

(8) the extent to which past and current treatment has been successful in treating the symptoms and behavioral and social dysfunction;

(9) if the recipient is under 21 years of age, whether the recipient has, as indicated by the American Psychiatric Association's Diagnostic

and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, dated 2000, an Axis V Global Assessment of Functioning (GAF) rating at admission of 50 or less, or the recipient has an Axis V Global Assessment of Functioning (GAF) rating at admission of more than 50, but exhibits specific mental, behavioral, or emotional disorders that place the recipient at imminent risk for out-of-home supervision or protective custody of state or local authorities; the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, dated 2000, is adopted by reference;

(10) the extent to which a less restrictive or intrusive alternative treatment is not available;

(11) the extent to which a less expensive alternative is not available;

(12) the extent to which the units of service requested are no more than are necessary to meet the treatment or rehabilitation needs of the recipient;

(13) the extent to which the duration of services requested are no more than are necessary to reach the recipient-approved goals outlined in the individualized treatment plan;

(14) if the requested services are intended to prevent the relapse or deterioration of a mental disorder, the extent to which social functioning is improved through interventions provided as active treatment, targeted in specific therapeutic goals, and included in the individualized treatment plan;

(15) the likelihood that the recipient will benefit from any therapy provided on the same day as the recipient has received crisis intervention services.

(c) Payment for services determined not to be medically necessary under this section is subject to recovery under 7 AAC 105.260.

The limitation on abortion services funding is, as for other Medicaid covered services "medical necessity," a phrase that is not clearly defined in Alaska. The regulations that pertain to other types of covered services provide some guidance. Because the right to state funding for medically necessary abortions under the current state Medicaid program is protected by the Alaska constitution, the term "medically necessary abortion" has acquired a constitutional component of unknown scope. The relatively few Alaska cases involving abortion rights do not provide guidance as to how broadly the term "medically necessary abortion" is to be construed. There is a possibility that the Alaska courts may find that there are additional situations other than those described in the vetoed bill that fall within the scope of a medically necessary abortion and thus must be covered under the state Medicaid program.

What follows is a brief overview of how other states have handled the issue after the federal exception was rejected under those state's constitutional protections.

CASE LAW FROM STATES OTHER THAN ALASKA

Other states have dealt with the issue of state funding of abortion services in various ways. After the federal decisions of the 1970's that upheld restrictions on public abortion funding, courts in a number of states were required to analyze the issue under their own laws and constitutions to see if they supported the same conclusion. In contrast with the federal decisions, several state decisions determined that funding for abortions could not be singled out under public assistance programs. See Moe v. Sec'y of Admin. and Fin., 417 N.E.2d 387 (Mass. 1981); Comm. to Defend Reproductive Rights v. Myers, 625 P.2d 779 (Cal. 1981); Right to Choose v. Byrne, 450 A.2d 925 (N.J. 1982); Planned Parenthood Ass'n v. Dep't of Human Res., 663 P.2d 1247 (Or. App. 1983), affirmed at 687 P.2d 785 (Or. 1984); and Doe v. Maher, 515 A.2d 134 (Conn. Super. 1986); contra, Fischer v. Dep't of Pub. Welfare, 502 A.2d 114 (Pa. 1985).

Except for the Pennsylvania case, these state courts weighed the private and state interests involved with abortions and struck a different balance than the federal courts. They considered the state's desire to save money, state policies to promote childbirth, state claims that poor women can still choose to find private money to fund their abortions, state interests in protecting unborn life, and state arguments that they are not required to provide money for the exercise of constitutional rights. Most of these arguments had been successful in federal courts. Not so in the state courts of Massachusetts, California, New Jersey, Oregon, and Connecticut.

In Moe v. Secretary of Administration and Finance, supra, the highest state court in Massachusetts determined that the Massachusetts constitution afforded a greater degree of protection for the right to choose an abortion than the federal constitution.[5] In upholding the right of Medicaid recipients to have their abortions paid for, the court observed:

> [T]he Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weigh the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to "achieve with carrots what [it] is forbidden to achieve with sticks." (citation omitted). We are therefore in agreement with the views expressed by Justice Brennan, writing in dissent to Harris v. McRae, [when he wrote] "In every pregnancy, [either medical procedures for its termination, or medical procedures to bring the pregnancy to term are] medically necessary, and the poverty-stricken woman depends on the Medicaid Act to pay for the expenses associated with [those] procedure[s]. But under [this restriction], the Government will fund only those procedures incidental to childbirth. By thus injecting coercive financial incentives favoring childbirth into a decision that is constitutionally

[5] Moe, 417 N.E.2d at 400.

> guaranteed to be free from governmental intrusion, [this restriction] deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in Roe v. Wade."[6]

In Committee to Defend Reproductive Rights v. Myers, supra, the highest court in California made a determination similar to Massachusetts'. The court noted that the state had no constitutional obligation to provide medical care to the poor or to fund the exercise of all constitutional rights, but held:

> Once the state furnishes medical care to poor women in general, it cannot withdraw part of that care solely because a woman exercises her constitutional right to choose to have an abortion.[7]

In Right to Choose v. Byrne, supra, the highest court in New Jersey also came to a similar conclusion, using an equal protection analysis. The court struck down a restrictive abortion funding statute, stating:

> [T]he Legislature need not fund any of the costs of medically necessary procedures pertaining to pregnancy. . . . Once it undertakes to fund medically necessary care attendant upon pregnancy, however, government must proceed in a neutral manner. Given the high priority accorded in this State to the rights of privacy and health, it is not neutral to fund services medically necessary for childbirth while refusing to fund medically necessary abortions. . . . The statute affects the right of poor pregnant women to choose between alternative necessary medical services. No compelling state interest justifies that discrimination, and the statute denies equal protection to those exercising their constitutional right to choose a medically necessary abortion.[8]

In Planned Parenthood Ass'n v. Department of Human Resources, supra, the court struck down an Oregon Medicaid regulation that would have restricted funding of abortions, saying:

> [I]t is difficult to understand the rational basis for denying one medically necessary surgical procedure to a pregnant woman solely because it involves an abortion while, at the same time, funding all other medically necessary services relating to pregnancy.[9]

---

[6] Id. at 402.

[7] Myers, 625 P.2d at 798 and footnote 31 accompanying the text.

[8] Byrne, 450 A.2d at 935 - 936.

[9] Planned Parenthood, 663 P.2d at 1255.

In Doe v. Maher, supra, a Connecticut court struck down a state Medicaid regulation that prohibited funding for medically necessary abortions, saying:

> This court is unable to reconcile the mandate and logic of the United States Supreme Court in Roe v. Wade . . . with the McRae . . . decision. Medicaid reimbursement funds are made available for all the health care costs of women, including the medical costs necessary to carry the fetus to term, but not for the medically necessary abortion. Surely, this constitutes infringement on the right to an abortion. . . . In adopting the regulation, . . . the state has ceased to preserve its neutrality at least under our state constitution. . . . And since that one exception also is a subject of a woman's constitutional rights, the regulation impinges upon those constitutional rights to the same practical extent as if the state were to affirmatively rule that poor women were prohibited from obtaining an abortion.[10]

In each of the state cases quoted in this section, the state court struck down an abortion funding restriction that would have been upheld by a federal court. These cases clearly demonstrate that state courts can find independent state grounds to strike down an abortion restriction that might be upheld in federal court. Unfortunately, the cases do not provide a standard definition of "medical necessity" for purposes of all covered services.

CONCLUSION

The concept of "medical necessity" provides the baseline for Medicaid and other types of public funding of covered health care services. Under the federal law, the United States Supreme Court upheld an exemption for coverage of abortions services that was narrower than the standard for all other types of covered services. Many states, including Alaska, found an equal protection and liberty interest violation in drawing a distinction among various types of service coverage.

Current Alaska legislation and regulations defer to the treating physician to determine whether a service is medically necessary for the physician's patient under the applicable standard of practice for most covered services, including abortion services.

If I may be of further assistance, please advise.

JMM:ljw
10-418.ljw

Attachements

---

[10] Doe, 515 A.2d at 151 and 152.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 5 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Background of SCHIP/Denali Kid Care

- State Children's Health Insurance Program (SCHIP), which is administered in Alaska through the Denali KidCare Program was created in 1997 to reduce the number of uninsured children by providing subsidized insurance to children of those parents who are too poor to afford insurance but make too much to receive Medicaid coverage. About 1/3 of all children in America get health services through Medicaid or the SCHIP program.
- The Denali KidCare Program is 70% funded by the federal government up to the state's allocated funding level. After that, the reimbursement rate declines to slightly over 50%.
- Denali KidCare provides health insurance for children up to age 18 and pregnant women who meet income guidelines. There is no cost to eligible children, teens and pregnant women. However, youth who are 18 may be required to contribute a limited amount for some services.
- Roughly 7,900 children were covered by Denali KidCare in 2009.
- The cost per child of Denali KidCare is about $1,700 annually, compared to over $12,000 for an elderly person who qualifies for federal aid.
- By comparison, private health insurance for a family of three, *e.g.,* a pregnant woman with two children, is estimated at $8,000-$17,000 annually. Unlike Denali KidCare, this insurance may require a substantial deductible, 20% co-pay, and no vision, dental or hearing benefits.

Why Coverage for Pregnant Women is Important In Alaska

- Alaska has one of the nation's highest documented pregnancy-associated mortality ratios – 58 per 100,000 live births during 1990-1999 (DHSS). National data indicate that women who receive no prenatal care are at increased risk of pregnancy-related death.

- Only 58% of women in Alaska receive adequate prenatal care, compared with 75% nationally.
- Mothers having late or no prenatal care are more likely to have low birth weight or pre-term infants and are at increased risk fro pregnancy-related mortality and complications of childbirth (DHSS).
- The average cost of hospital care for a premature baby was $75,000 in 2001, compared with $1,300 for a healthy, full-term infant. The March of Dimes Prenatal Data Center reports that premature babies cost about $13.1 billion annually.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 5 "An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

Repercussions of the Unmet Health Care Needs of Alaska's Uninsured Children

- The number of uninsured children in Alaska is estimated to be about 24,100 or 19% of the uninsured population (Kaiser Family Foundation, 2008-2009).
- Over the last 10 years Alaska has seen a 31% decline in the number of children covered by private health insurance (Robert Wood Johnson Foundation).
- Nationally, more than 80% of uninsured children are from working families (Kaiser Commission on Medicaid and the Uninsured).
- Uninsured children have much higher health risks than do covered children. They receive less preventative care and are diagnosed at more advanced stages of illness (Kaiser, *supra*).
- Uninsured children are more likely to develop throat, eye, and ear infections, serious dental problems, and chronic conditions such as asthma and diabetes. They are more than five times as likely as insured children to have an unmet need for medical care and nine times more likely not to be examined by a regular doctor. They are also four times more likely to use emergency rooms which are much more costly than care in physicians' offices (*Pediatrics* 105, 113; "Care for Children," *New England Journal of Medicine*, 330).
- Almost 1/3 of uninsured children received no medical treatment during a 1-year period between 2002 and 2003 (*Health Affairs* 23, no. 5, September-October 2004).
- Uninsured children are 25% more likely to miss school than insured children (Children's Defense Fund, Minnesota). Continued illness affects school performance and, in the long run, workforce participation (Southern Institute on Children and Families). A National Institute of Medicine study indicates that lack of insurance results in lost national economic productivity of $65-$130 billion annually.

kff.org kaiserhealthnews.org kaiseredu.org healthreform.kff.org globalhealth.kff.org

state facts.org
Your source for state health data

AK • US • GO PRINT PDF SHARE SAVE AS PDF

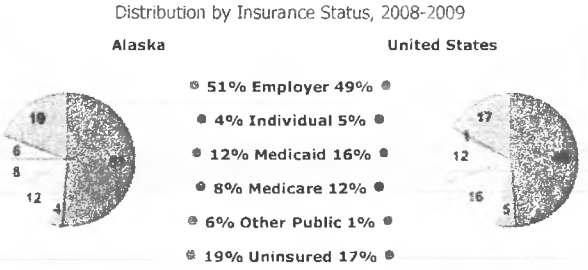
Alaska & United States

State Medicaid Fact Sheets

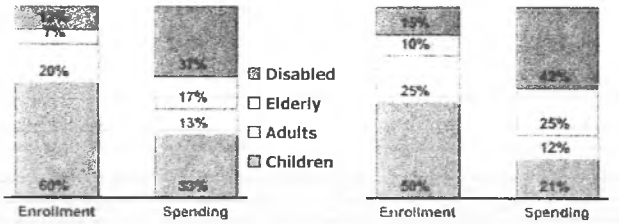
Total Residents, 2008-2009

AK: 666,900 **US:** 303,343,300

Distribution by Insurance Status, 2008-2009



Medicaid Enrollment and Spending by Group, FY2007



120,800 $944M 58,106,000 $300,001M

Alaska United States

	Number		Percent		Notes
	AK	US	AK	US	
Demographic Profile, 2008-2009					
Total Residents	666,900	303,343,300	-	-	
Income					
Poor Residents (below 100% FPL)	117,700	60,939,000	18	20	% of total residents
Residents (100-138% FPL)	48,000	22,851,100	7	8	% of total residents
Median Annual Income	$63,505	$49,945	-	-	
Age					
Children (0-18)	194,300	79,305,700	29	26	% of total residents
Poor Children	43,900	21,472,200	23	27	% of total children
Adults (19-64)	416,100	185,424,200	62	61	% of total residents
Poor Adults	66,100	34,149,200	16	18	% of total adults
Elderly (65+)	56,400	38,613,300	8	13	% of total residents
Poor Elderly	7,700	5,317,700	14	14	% of total elderly
Distribution by Race/Ethnicity					
White	472,600	196,769,100	71	65	% of total residents
Black	24,400	36,795,300	4	12	% of total residents
Hispanic	27,800	48,828,900	4	16	% of total residents
Other	142,200	20,949,900	21	7	% of total residents
Non-Citizen	24,800	21,578,800	4	7	% of total residents
Population Living in Non-Metropolitan Areas	205,300	48,866,200	31	16	% of total residents
Health Insurance Coverage of Nonelderly, 2008-2009					
Medicaid	76,700	44,144,600	13	17	% of nonelderly
Children	46,500	26,325,400	61	60	% of Medicaid
Adults	30,100	17,819,200	39	40	% of Medicaid
Uninsured	125,800	49,997,900	21	19	% of nonelderly
Children	24,100	8,284,500	19	17	% of uninsured
Adults	101,700	41,713,400	81	83	% of uninsured
Nonelderly (below 100% FPL)	47,200	19,831,900	37	40	% of uninsured
Nonelderly (100-138% FPL)	10,800	6,060,700	9	12	% of uninsured
Nonelderly (139-250% FPL)	35,800	12,877,100	28	26	% uninsured
Nonelderly (251-399% FPL)	19,400	6,476,400	15	13	% of uninsured
Nonelderly (400%+ FPL)	12,600	4,751,900	10	10	% of uninsured
Employer Sponsored Insurance	341,700	149,690,000	56	57	% of nonelderly

Individual Insurance	23,300	13,767,100	4	5	% of nonelderly
Other Public	43,000	7,130,200	7	3	% of nonelderly
Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2008-2009					
Uninsured	-	-	-2.4	1.5	% point change
Medicaid	-	-	1.0	1.7	% point change
Employer-Sponsored	-	-	2.4	-3.2	% point change
Individually Purchased	-	-	-2.0	-0.1	% point change
Medicaid Enrollment					
Total Enrollment, FY2007	120,800	58,106,000	-	-	% of total residents
Children	72,900	28,754,500	60.3	49.5	% of Medicaid enrollees
Adults	24,500	14,627,000	20.3	25.2	% of Medicaid enrollees
Elderly	8,500	5,934,900	7.0	10.2	% of Medicaid enrollees
Disabled	14,900	8,789,500	12.3	15.1	% of Medicaid enrollees
% Enrolled in Managed Care, 2009	-	-	0.0	71.7	% of Medicaid enrollees
Medicaid Expenditures					
Total Medicaid Spending, FY2008	$890,169,313	$338,791,482,443	-	-	Including DSH
Disproportionate Share Hospital Payments (DSH)	$15,580,779	$17,738,530,492	1.8	5.2	% of total spending
Acute Care	$532,601,181	$206,255,691,313	59.8	60.9	% of total spending
Rx Drugs	$50,424,021	$15,274,195,878	9.5	7.4	% of acute care spending
Long Term Care (LTC)	$341,987,353	$114,797,260,638	38.4	33.9	% of total spending
Nursing Home	$74,009,055	$49,639,456,902	21.6	43.2	% of LTC spending
Home/Personal Care	$212,808,098	$47,762,519,611	62.2	41.6	% of LTC spending
Per Enrollee Medicaid Spending, FY2007					
Total	$7,815	$5,163	-	-	
Children	$4,261	$2,135	32.4	18.6	% of total spending
Adults	$5,108	$2,541	13.3	11.9	% of total spending
Elderly	$19,143	$12,499	17.4	24.3	% of total spending
Disabled	$23,194	$14,481	35.7	40.9	% of total spending
Other Medicaid Spending Measures					
Federal Contribution per State Dollar, FY2010	1.66	1.28	62.46	56.20	
General Fund Spending on Medicaid, SFY2008	$408	$111,711	7.9	16.3	% of general fund spending
Medicaid Eligibility Levels by Annual Income and FPL, 2011					
Pregnant Women	-	-	175	-	% of federal poverty level
Infants	-	-	150	-	% of federal poverty level
Children 1-5	-	-	150	-	% of federal poverty level
Children 6-19	-	-	150	-	% of federal poverty level
Working Parents	-	-	81	-	
Medicaid and Medicare Dual Eligibles					
Total Dual Eligible Enrollment, 2007	13,020	8,896,020	100	100	
Total Dual Eligible Spending in Millions, 2007	$255	$120,520	100	100	
Total Medicare Enrollment, 2010	64,797	46,589,141	9	15	% of total residents
Estimated Annual "Clawback" Payment, 2006	$17,202,153	$6,605,675,559	-	-	
CHIP					
Eligibility Income Level for Family of 3, 2011	-	-	-	-	% of federal poverty level
Change in CHIP Enrollment, June 2008-09	-	-	-0.3	2.7	% growth, 2008-2009
Total CHIP Spending, FY2007	$21,611,463	$10,046,523,960	-	-	

PRINTABLE PDF SAVE AS PDF

Other Options

Compare AK to US 60

- View **Sources and Notes**
- Download Fact Sheets for all **50 states and D.C.** (104 page PDF/3.6MB)
- View **states with the lowest and highest values**.
- Click on any topic above to jump directly to **Statehealthfacts.org**.
- Return to the Medicaid Fact Sheets **home page**.

- View **Children's Health Fact Sheets**.

kff.org kaiserhealthnews.org kaiseredu.org Search GO Contact Us Email Subscriptions Privacy Statement

ASPE.hhs.gov U.S. Department of Health & Human Services

The 2011 HHS Poverty Guidelines

The following figures are the 2011 HHS poverty guidelines that are scheduled to be published in the *Federal Register* on January 20, 2011. (Additional information will be posted after the guidelines are published.)

2011 HHS Poverty Guidelines

Persons in Family	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,890	$13,600	$12,540
2	14,710	18,380	16,930
3	18,530	23,160	21,320
4	22,350	27,940	25,710
5	26,170	32,720	30,100
6	29,990	37,500	34,490
7	33,810	42,280	38,880
8	37,630	47,060	43,270
For each additional person, add	3,820	4,780	4,390

Go to Further Resources on Poverty Measurement, Poverty Lines, and Their History

Go to Frequently Asked Questions (FAQs)

Return to the main Poverty Guidelines, Research, and Measurement page.

Last Revised: 01/18/11

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SHO # 09-006
CHIPRA #2

May 11, 2009

Dear State Health Official:

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, ensures that States are able to provide necessary health coverage for low-income uninsured children eligible under the Children's Health Insurance Program (CHIP). Section 111 of CHIPRA adds a new section 2112 to the Social Security Act (the Act) which gives States the option to provide necessary prenatal, delivery, and postpartum care to low-income uninsured pregnant women through an amendment to its State child health plan (CHIP plan) (as described in section 2112). This letter provides general information concerning the new option and guidance on amending your CHIP plan to reflect the coverage of pregnant women, should your State wish to take advantage of this option.

Background

Prior to CHIPRA, States could provide services to pregnant women either through a Section 1115 demonstration program or under the CHIP State plan by covering unborn children. CHIPRA allows States to continue providing coverage through these two options or through a new option of covering pregnant women under the CHIP plan. This letter outlines the differences between options to assist States in adopting coverage for pregnant women.

Continuation of Existing Section 1115 Pregnant Women Demonstrations

The CHIPRA allows States to continue existing section 1115 demonstrations that provide coverage for pregnant women with title XXI funds. These States may continue demonstrations or modify their CHIP plans to include pregnant women as described below.

Continuation of Coverage for Unborn Children Under the CHIP Plan

States will continue to have the option of considering an unborn child to be a targeted low-income child and therefore eligible for coverage under CHIP, if other applicable eligibility criteria are met. This permits States to provide health care services to promote healthy pregnancies, regardless of the mother's eligibility status. States may continue to pay for pregnancy and delivery services through a bundled payment or global fee method, under which a single payment is made for prenatal care, labor, delivery, and postpartum care.

New Option to Cover Targeted Low-Income Pregnant Women Under the CHIP Plan

The CHIPRA also allows States the option of providing health care coverage for uninsured, low-income pregnant women under the CHIP plan. Under this option, the pregnant woman is eligible for coverage, rather than the unborn child.

States that choose to cover pregnant women under the CHIP plan are eligible to receive enhanced Federal Medical Assistance Payments (FMAP) for such expenditures and have the option of providing presumptive eligibility to pregnant women.

As established in CHIPRA (Section 111), in order to cover pregnant women through the State plan option under CHIP, States must meet the following criteria:

- States may only provide coverage under the CHIP plan for pregnant women who were not eligible under the Medicaid State plan as of July 1, 2008;
- States must cover pregnant women under Medicaid up to the minimum income level of 185 percent of the Federal poverty level (FPL). Any State that currently does not provide Medicaid coverage for pregnant women up to this income level, can only claim regular FMAP for pregnant women covered under a Medicaid expansion whose family income is at or below 185 percent of the FPL;
- States may not establish a higher income eligibility level for pregnant women than the State's eligibility level for targeted low-income children;
- States must cover children under 19 years of age under Medicaid or CHIP, up to a minimum income level of 200 percent of the FPL;
- States must not apply an effective income level for pregnant women under CHIP that is lower than the Medicaid effective income level and cannot cover higher income pregnant women without covering lower income pregnant women;
- States must not apply any preexisting condition exclusion or waiting period for CHIP coverage of pregnant women;
- States must not impose any cap or limitation on the enrollment of targeted low-income children, and must not have any waiting list or any procedures designed to delay applications for enrollment; and
- States may not require enrollee cost sharing for preventive or pregnancy-related services.

Benefits

States have the flexibility to offer coverage that meets the requirements of section 2103 of the CHIP statute under the new CHIP option for pregnant women, including in most cases, benefits during a 60-day postpartum period.

Coverage of Both the Unborn Child and Pregnant Women

States may opt to cover both the unborn child and pregnant women under the CHIP plan. If States elect both options, we want to emphasize that States will need to uniquely identify

enrollees so that there is no duplication of payment for services. Eligibility under either category is subject to screening for Medicaid eligibility, and payment is not available under CHIP for services that would be covered under Medicaid.

Submitting a CHIP Plan Amendment

States wishing to adopt any of the options described above and be eligible for funds under title XXI, must submit a CHIP plan amendment, which must be approved by the Secretary. States adopting such an expansion will be able to amend their CHIP plan by submitting the enclosed addendum to the CHIP plan and budget form. The addendum sections correspond to the relevant sections in your current State Child Health Plan Template.

States that have implemented CHIP through a Medicaid expansion program, but wish to extend coverage to unborn children and/or pregnant women under a separate child health program, may do so by submitting the same CHIP plan amendment above. Such States would then continue to cover children from birth through age 18 under Medicaid expansion programs, and would operate separate CHIP programs only for pregnant women and/or unborn children.

To incorporate either of these provisions into the CHIP plan, the State, through the appropriate State official, should submit these pages electronically to both the Centers for Medicare & Medicaid Services (CMS) Central and Regional Offices. Once approved, these pages will be added to the current State Child Health Plan as an addendum describing coverage for pregnant women. Before submitting such an amendment, please review the current approved CHIP plan to determine if it is necessary to amend additional sections simultaneously (e.g., if a new benefit package is being adopted, if cost sharing is being modified just for this eligibility group, if different service delivery type is being used, if different enrollee protections apply, or if the State has not previously implemented a separate child health program). Note that if a State does not choose to use the same benefit type and package of services for pregnant women or unborn children, the State needs to submit a revised section 6 of the State plan with its amendment. Questions or assistance may be provided by your Central Office or Regional Office project officer.

In addition to offering the option of covering targeted low-income pregnant women under the CHIP plan, CHIPRA requires that children born to a woman receiving pregnancy-related assistance shall be deemed on the date of the child's birth to have applied for coverage under CHIP or Medicaid, and shall be found eligible for the appropriate program, and until the child reaches age one (as described in section 2112(e) of the Act). During this deemed eligibility period, the new law stipulates that the child health or medical assistance eligibility identification number of the mother shall also serve as the identification of the child. Additionally, during this period, all claims shall be submitted and paid for the child under the mother's identification number (unless the State issues a separate identification number for the child before the child reaches age one).

Draft State plan template pages to implement these options are enclosed. CMS is in the process of obtaining the required Office of Management and Budget (OMB) clearance under the Paperwork Reduction Act for the State plan amendment (SPA) templates. Given that States may need considerable time to complete these templates, CMS is sharing in draft the SPA template at

this time. Until such time when this SPA template is assigned an OMB clearance number, States are not obligated to respond.

It is well established that access to prenatal services and care throughout a mother's pregnancy improves health outcomes for both the mother and child. Therefore, we encourage States to consider these options to establish eligibility for this vulnerable population.

Sincerely,

/s/

Jackie Garner
Acting Director
Center for Medicaid and State Operations

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Barbara Levine
Director of Policy and Programs
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Addendum to State Child Health Plan Describing Coverage of Pregnant Women

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements. (Section 2101)

1.1 The State will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); or

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); or

1.1.3. ☐ A combination of both of the above.

1.2 ☐ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☐ Please provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR Part 80, Part 84, and Part 91, and 28 CFR Part 35. (42 CFR 457.130)

1.4 ☐ Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date:

Implementation date:

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination. (Section 2102 (a)(1)-(3) and Section 2105)(c)(7)(A)-(B))

2.2. Describe the current State efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102(a)(2) and 42 CFR 457.80(b))

2.2.1. The steps the State is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and State-only child health insurance):

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102(b)(1)(A), 42 CFR 457.305(a), and 457.320(a))

4.1.1. ☐ Geographic area served by the Plan:

4.1.2. ☐ Age:

4.1.3. ☐ Income:

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☐ Residency (as long as residency requirement is not based on length of time in State) :

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☐ Access to or coverage under other health coverage:

4.1.8. ☐ Duration of eligibility:

4.1.9. ☐ Other standards (identify and describe):

4.1-P. ☐ The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. ***Please describe the population of pregnant women that the State proposes to cover in this section. Please include any criteria, such as the above categories (e.g., income and resources) that will be applied to this population. Please use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction).***

4.2. The State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. ***Please confirm that this applies to pregnant women as well as targeted low-income children.***

4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition. ***Please confirm that this applies to pregnant women as well as targeted low-income children.***

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102(b)(2) and 42 CFR 457.350)

4.3.1 Describe the State's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7) and 42 CFR 457.305(b))

☐ Check here if this section does not apply to your State.

Please note that this box should be checked as related to children because States may not have an enrollment cap or waiting list for children and cover pregnant women.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a State health benefits plan) are furnished child health assistance under the State child health plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B), 42 CFR 457.310(b), 42 CFR 457.350(a)(1), and 457.80(c)(3))

Please confirm that the State does not apply a waiting period for pregnant women.

Section 8. Cost Sharing and Payment. (Section 2103(e))

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) ***Please indicate if this applies for pregnant women also.***

8.1.1. ☐ YES

8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge, and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A), 42 CFR 457.505(a), 457.510(b) and (c), and 457.515(a) and (c))

8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

Please include a statement that no cost sharing will be charged for pregnancy-related services.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c) and 42 CFR 457.120(a) and (b))

9.9.1 Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required at 42 CFR section 457.125. (Section 2107(c) and 42 CFR 457.120(c))

States should provide notice and consultation with Tribes on proposed pregnant women expansions.

9.10. Provide a 1-year projected budget. (Section 2107(d) and 42 CFR 457.140)

The budget must describe:

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Please include a separate budget line to indicate the cost of providing coverage to pregnant women.

kaiser commission on medicaid and the uninsured

HOLDING STEADY, LOOKING AHEAD: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY RULES, ENROLLMENT AND RENEWAL PROCEDURES, AND COST SHARING PRACTICES IN MEDICAID AND CHIP, 2010-2011

EXECUTIVE SUMMARY

Prepared by:

Martha Heberlein, Tricia Brooks, and Jocelyn Guyer
Georgetown University Center for Children and Families

and

Samantha Artiga and Jessica Stephens
Kaiser Commission on Medicaid and the Uninsured
The Henry J. Kaiser Family Foundation

January 2011

THE HENRY J. KAISER FAMILY FOUNDATION

Executive Summary

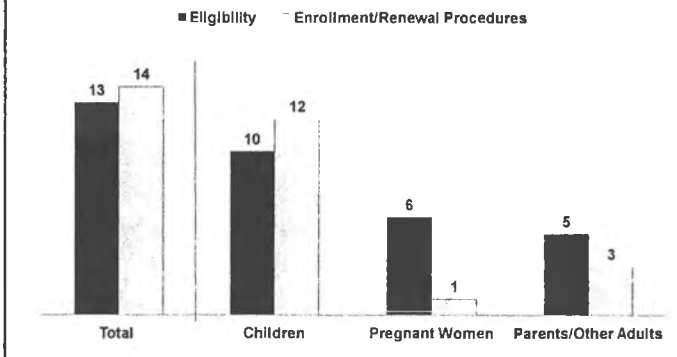
Introduction

Over the past year, as the nation's attention was focused on the country's continuing economic problems and the debate over the passage of broader health care reform, Medicaid and the Children's Health Insurance Program (CHIP) continued to play their central role of providing coverage to millions of people who otherwise lack affordable coverage options. In 2010, this role was more pronounced than ever as families losing their jobs and access to employer-based coverage turned to public programs in growing numbers. Without Medicaid and CHIP, many more individuals would have become uninsured, adding to the 50 million currently without coverage. Based on a survey of state officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, this tenth annual report provides an overview of state actions on eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP during 2010, as well as the status of coverage as of January 1, 2011, for children, parents, pregnant women, and other non-disabled adults.

As the survey findings illustrate, families could turn to Medicaid and CHIP because nearly all states "held steady" or made targeted improvements in their eligibility and enrollment rules in 2010, with a total of 13 states expanding eligibility and 14 states making improvements in enrollment and renewal procedures (Figure 1). This striking stability in public programs can be directly attributed to the federal government's decision both to provide temporary Medicaid fiscal relief to states through June 2011, and to require states to maintain their Medicaid and CHIP eligibility rules and enrollment procedures until broader health reform goes into effect.

Figure 1

Number of States Improving Access to Health Care Coverage, January 2010 – January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

During 2010, states also were starting to look ahead to implementation of the Affordable Care Act (ACA) and, in some instances, to take advantage of early options to improve Medicaid coverage. Health reform provides a broad expansion in coverage that will take effect in 2014, including extending Medicaid to a new national eligibility floor of 133 percent of the federal poverty level ($24,352 for a family of three and $14,404 for an individual in 2010). However, it is important for states to begin taking steps now to address the technological changes necessary to develop the online, consumer-friendly enrollment process envisioned under the ACA. Although there has been some progress in 2010, the survey highlights that states still have a significant amount of work to be prepared in 2014. Looking ahead, it will be important for state policymakers to continue moving forward on implementation while sustaining the gains and progress made in coverage to date.

Key Findings on Eligibility and Enrollment Procedures

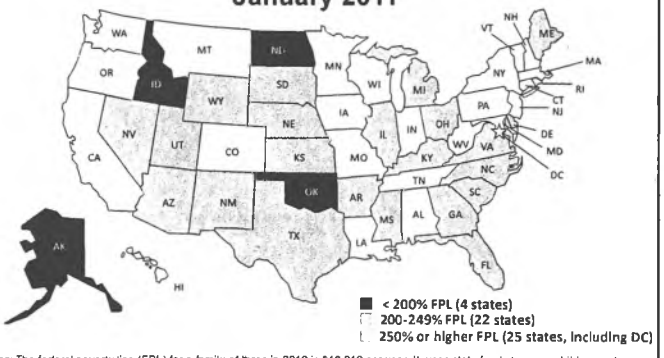
Nearly all states (49, including DC) held steady or made targeted improvements in their Medicaid and CHIP eligibility rules and enrollment procedures in 2010. By doing so, they maintained the central role of Medicaid and CHIP in providing affordable coverage to children and, to a lesser extent, their parents and other adults, many of whom lost jobs and their access to employer-based coverage in the ongoing economic downturn. This stability can be directly attributed to provisions in the American Recovery and Reinvestment Act (ARRA) adopted in February 2009, that required states to maintain their Medicaid eligibility rules and enrollment procedures as a condition of receiving a significant, temporary increase in the federal Medicaid matching rate. The ACA also included a maintenance-of-effort (MOE) requirement designed to keep Medicaid coverage steady for adults until broader reform goes into effect in 2014 and for children until 2019, as well as to extend these protections to children covered by CHIP. Without the MOE requirements and enhanced federal funding, many states almost certainly would have needed to turn to cutbacks in coverage in 2010 as a result of continuing budget pressures. Two states (AZ and NJ) did make coverage reductions that were not subject to the MOE. States also made other changes such as cuts to provider reimbursement rates and benefits to reduce Medicaid spending growth in 2010.

Despite significant budget challenges, 13 states went beyond maintaining coverage to implement targeted eligibility expansions for children, pregnant women, and adults in 2010. These expansions varied in size and scope. Most of the expansions focused on providing increased coverage to uninsured children, and in a many cases, also produced some state savings by allowing the state to draw down federal matching funds for previously fully state-funded coverage.

Building on progress made over the past decade, 3 states (CO, KS, and OR) increased income eligibility in Medicaid/CHIP for children in 2010. As such, as of January 1, 2011, 25 states, including DC, cover children in families with income at least up to 250 percent of the federal poverty level ($45,775 for a family of three in 2010), although enrollment remains heavily concentrated among the lowest-income children (Figure 2). Oregon also added a buy-in program in 2010 that enables families with incomes above Medicaid and CHIP thresholds to buy into coverage.

Figure 2

Children's Eligibility for Medicaid/CHIP by Income, January 2011



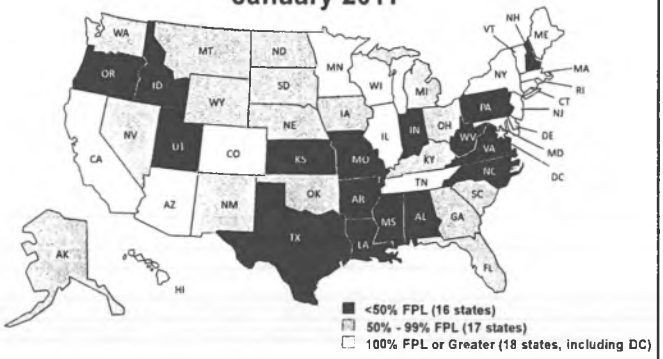
Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. IL uses state funds to cover children up to 300% of the FPL; OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

In 2010, states continued to take advantage of the option to cover lawfully-residing immigrant children and pregnant women during their first five years residing in the country. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allowed states to draw down federal funding to cover these populations without imposing a 5-year waiting period. Six (6) states (DE, MN, MT, NE, NC, and WI) adopted the option for lawfully-residing immigrant children in 2010, resulting in a total of 21 states having eliminated this barrier for children as of January 1, 2011. In 15 of these states, coverage had previously been provided to these children with state-only dollars. In addition, in 2010, 5 states (DE, MN, NE, NC, and WI) adopted this option for lawfully-residing pregnant women, bringing the total number eliminating the "five-year bar" for pregnant women to 17. In 9 of these states, coverage had previously been provided with state-only dollars.

While states have made significant progress in expanding coverage for children, eligibility for their parents continues to lag far behind. In 2010, only one state (CO) expanded Medicaid coverage for parents. As of January 1, 2011, 33 states do not cover parents up to 100 percent of the federal poverty level ($18,310 for a family of three in 2010). The median eligibility threshold for parents remains at 64 percent of the federal poverty level and 16 states limit eligibility to below 50 percent of the federal poverty level ($9,155 for a family of three in 2010). In the absence of further expansions, these restrictive eligibility levels will leave most uninsured, low-income parents without an affordable coverage option until the health reform expansion goes into effect in 2014 (Figure 3).

Figure 3

Medicaid Eligibility for Working Parents by Income, January 2011



Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid at higher income levels.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

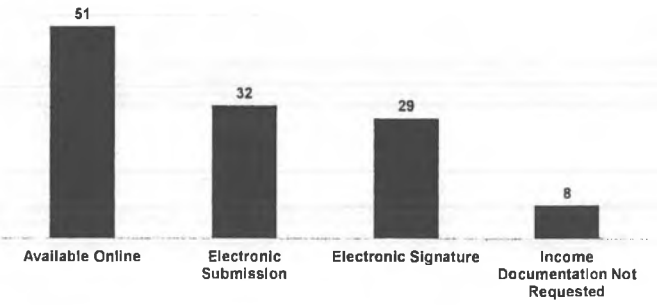
Low-income adults without dependent children remain ineligible for Medicaid in the vast majority of states. Under the ACA, Medicaid eligibility will be expanded to a minimum of 133 percent of the federal poverty level, ending the historic exclusion of non-disabled, non-pregnant adults without dependent children from the program. While this change is not required to be in effect until January 1, 2014, states have the option of moving early to cover these adults. In 2010, Connecticut and the District of Columbia took advantage of this option and moved low-income adults they had previously served through state-funded programs to Medicaid. Further, California received approval in 2010 for a waiver to continue and expand county coverage initiatives serving low-income adults. However, even with these expansions, as of January 1, 2011, only seven states (AZ, CT, DE, DC, HI, NY, and VT) provide Medicaid or Medicaid-equivalent benefits to adults without dependent children. Additional states offer more limited coverage to these adults, but in most states, low-income adults without children do not have access to public coverage regardless of their income.

States adopted improvements in their enrollment and renewal procedures in 2010 that helped to reduce burdens on families, streamline administrative processes, and achieve program efficiencies. In making these improvements, states often turned to options provided by CHIPRA. Specifically, 29 states took advantage of the CHIPRA option to more efficiently and accurately verify citizenship status by relying on an electronic data match with the Social Security Administration (SSA). A smaller, but still notable number of states, moved ahead with other simplification measures including the CHIPRA "Express Lane Eligibility" option, as well as long-standing strategies such as presumptive eligibility and continuous eligibility for children. Many appear to have done so at least in part to qualify for the Medicaid performance bonuses included in CHIPRA. These bonuses provide a financial reward and recognition to states that have implemented at least 5 of 8 simplification policies and that have reached specific enrollment targets for children in Medicaid. The Administration encouraged states in their efforts by launching the *Connecting Kids to Coverage Challenge*, a partnership of national and state organizations committed to enrolling all five million uninsured but eligible children in public programs.

States continued work to modernize their programs and begin preparing for health reform implementation by focusing on technological improvements. A number of states made program improvements such as offering applications that can be submitted online. Despite this early work, the survey findings highlight that states have a long way to go to develop the integrated, technology-driven, web-based eligibility systems for Medicaid, CHIP, and subsidized Exchange coverage that are envisioned and required under reform. For example, all states, including DC, post their Medicaid applications online, but only 32 accept the electronic submission of those applications. Among the 32 that accept electronic submission, 29 allow for the use of an electronic signature, but only 8 do not routinely ask families to submit paper documentation of information via mail or fax before checking other data sources to verify eligibility (Figure 4). In light of a rule proposed by the Administration at the end of 2010 to provide states with a 90 percent matching rate to prepare their Medicaid eligibility systems for health reform and the likelihood of additional guidance and funding opportunities in the months ahead, it can be expected that next year's survey will show more developments in this area.

Figure 4

Status of Online Applications for State Medicaid Programs, January 2011



Notes: In some states the online application is only available for children applying for coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Conclusion

As implementation of broader health reform moves forward, the findings of this survey describe the foundation for coverage of low-income families and individuals through Medicaid and CHIP. These programs will play an even more substantial role in the years to come, particularly with the expansion in coverage for low-income adults. Valuable lessons can be learned from how states have streamlined and simplified their enrollment and renewal procedures in these programs, and while additional improvements will be necessary to further transform Medicaid and CHIP in order to fulfill the promise of reform, they provide a sound platform on which to begin.

Looking ahead, states face the challenge of implementing reform while at the same time dealing with significant budget pressures due to the nation's continuing economic problems and the corresponding increased need for Medicaid and CHIP. To continue forward progress on reform and keep the foundation solid, it will be important to focus on sustaining the coverage gains and progress made to date even in the face of these challenges. Health reform has the potential to markedly reduce the number of uninsured and provides states new opportunities to modernize, streamline, and continue to improve their Medicaid programs. While some of the most significant changes in health reform do not go into effect until 2014, it is important for states to lay the groundwork now. In 2010, there were initial signs of state Medicaid agencies preparing for health reform implementation, but more activity can be expected in 2011.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347 5274
Website: www.kff.org/kcmu

This publication (#8130-ES) is available on the Kaiser Family Foundation's website at www.kff.org.

FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

NOVEMBER 2010

Access to Abortion Coverage and Health Reform

The Patient Protection and Affordable Care Act (ACA) will make significant changes to health coverage for women, expanding their access to coverage and broadening the health benefits that many will receive. Coverage for abortion services, however, was addressed separately under health reform. As result, the extent of abortion coverage that women will receive once ACA is fully implemented in 2014 will depend largely on policies enacted at the state level as well as choices that plans and consumers will make in terms of coverage of abortion services. This brief summarizes the major insurance coverage provisions of the ACA that are relevant for women of reproductive age, reviews current federal and state policies on abortion coverage and how they may be modified under health reform, and discusses the potential impact of the federal legislation on women's access to abortion coverage.

How does the Patient Protection and Affordable Care Act affect overall coverage for women of reproductive age?

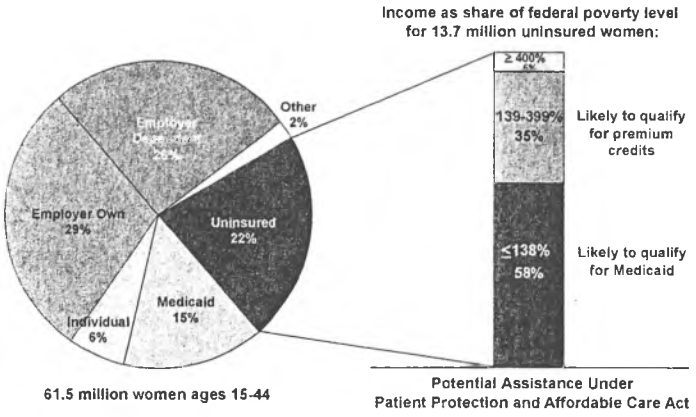
Signed into law on March 23, 2010, the ACA is a federal law aimed at ensuring that almost all U.S. citizens and legal residents have health insurance by requiring that most individuals obtain a minimum level of insurance coverage by 2014. This is to be achieved through a combination of public and private insurance expansions. By 2014, Medicaid will be available to cover many more of the nation's poorest uninsured, employers will be more likely to offer affordable coverage to their employees, and small businesses and other uninsured individuals will have access to state-based exchanges that will offer a variety of plans from which they can purchase insurance. The scope of benefits, including abortion, covered under these different avenues will vary.

The ACA will expand health care coverage to many of the nation's uninsured by extending Medicaid eligibility to all qualifying individuals with incomes up to 138% of the federal poverty level (FPL).[1] Uninsured individuals with incomes above 138% FPL will be able to purchase coverage in new state-based insurance exchanges that will act as marketplaces, open to all qualifying, uninsured individuals and small businesses with up to 100 employees. These state-based exchanges are to offer multiple insurance plans that uninsured individuals can choose from to purchase coverage. To help with the costs of insurance, the federal government will provide subsidies (in the form of premium credits) to eligible individuals and families with incomes from 139% to 399% FPL or if their share of premiums exceeds 9.5% of their income.[2]

It is estimated that 13.7 million women ages 15 to 44 are uninsured currently, 93% of whom would qualify for federal assistance under the health reform law, based on their income. The act would potentially extend Medicaid to 58% or 8 million women, and an estimated 4.8 million women (35%) would qualify for federal premium credits[3] to purchase coverage as shown in Figure 1.

Figure 1

Health Insurance Coverage and Poverty Levels of Uninsured Women Ages 15 to 44, 2009



Other includes programs such as Medicare and military-related coverage.
The federal poverty level for a family of four in 2009 was $22,050.
SOURCE: KFF/Urban Institute analysis of 2010 ASEC Supplement to the Current Population Survey, U.S. Census Bureau.

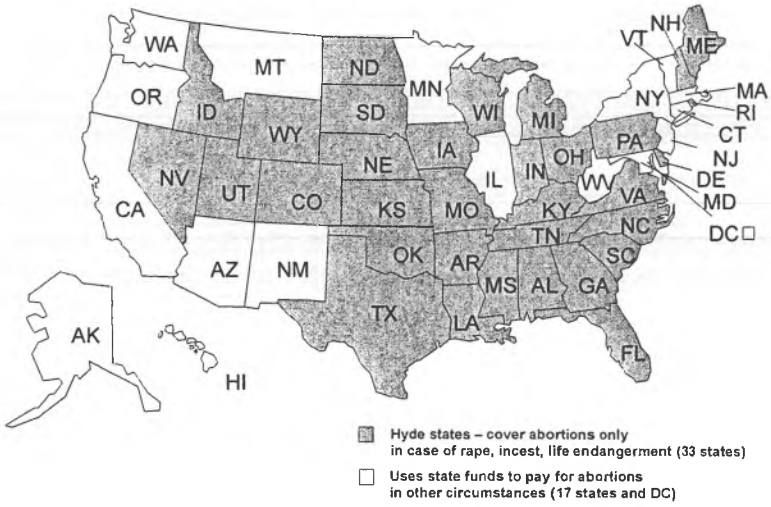
What are current federal and state laws regarding abortion coverage and financing?

Federal law bans the use of any federal funds for abortion, except when the pregnancy is a result of rape, incest, or if it is determined to endanger the woman's life. In effect since 1977, this rule known as the Hyde Amendment is not a permanent law; rather it has been attached annually to Congressional appropriations bills, and has been approved every year by the Congress. The Hyde Amendment initially affected only funding for abortions under Medicaid, but over the years, its reach broadened to limit federal funds for abortion for federal employees, women in the Indian Health Service, and in the military.

State level policies also have a large impact on abortion coverage, particularly since states are responsible for operation of Medicaid programs. The Medicaid program serves millions of low-income women and is a major payor of reproductive health services. It is estimated that two-thirds of adult women on Medicaid are in their reproductive years.[4] As discussed earlier, the federal Hyde Amendment restricts state Medicaid programs from using federal funds to cover abortions beyond the cases of life endangerment, rape, or incest. However, if a state chooses to, it can use its own funds to cover abortions in certain other circumstances, and states will continue to have this option under health reform. Currently, 17 states and the District of Columbia use state-only funds to cover abortions beyond the federal limitations for women on Medicaid.[5] In the other 33 states, Medicaid programs do not pay for any abortions beyond the Hyde restrictions (Figure 2). Currently, in these 33 states, an estimated 4.6 million women ages 15 to 44 are uninsured and have incomes less than 138% FPL, and would meet the income eligibility criteria to qualify for Medicaid under health reform (Table 2).[6]

Figure 2

Abortion Financing Under Medicaid, 2010



Source: Guttmacher Institute, State Policies in Brief, "State Funding of Abortion Under Medicaid," November 2010.

States also have authority over the scope of benefits for public employees. Currently, 13 states restrict abortion coverage in insurance plans for public employees. These restrictions range from states that provide coverage only under the Hyde limits to states that prohibit coverage for all abortions, regardless of circumstances.[7] States also regulate benefits covered by private insurance plans. Currently, at least four states (Idaho, Kentucky, Missouri, and North Dakota) prohibit private insurance coverage for abortions except in the case of rape, incest, or to save the woman's life. These states allow insurers to sell riders for abortion coverage, but there is little evidence about their availability and no documentation of their cost or impact on access.

How will abortion coverage be handled by Medicaid and plans in the exchanges under health reform?

Medicaid: The ACA reinforces current federal restrictions, limiting federal funds to be spent on abortions only to cases when the pregnancy endangers the life of the woman or results from rape or incest. This will not change for Medicaid under health reform; state Medicaid programs will continue to have the option to cover other medically necessary abortions using only state funds and no federal funds. President Obama issued an executive order as part of health reform that restated the federal limits specifically for Medicaid and community health centers.[8]

Plans in the Exchange: Plans participating in state-based exchanges will be required to cover a minimum set of services, defined as "essential health benefits, and the ACA explicitly prohibits states from including abortion in any essential benefits package. Therefore, no state or insurer offering a plan in an exchange will be required to offer abortion coverage, and each exchange must include at least one plan that does not cover abortions beyond those permitted by current federal law. Furthermore, states can bar all plans participating in the state exchanges from covering abortions, which at least five states (Arizona, Louisiana, Mississippi, Missouri, and Tennessee) have already elected to do since the health reform law's passage.[9]

If the state does not bar coverage of abortions, private insurers can offer a plan that covers abortions beyond the federal limitations within an exchange. The ACA outlines a methodology for states to follow to ensure that no federal funds are used towards coverage for abortions beyond Hyde. Any plan that covers abortions beyond Hyde limitations must estimate the actuarial value of such coverage by taking into account the cost of the abortion benefit (valued at least $1 per enrollee per month). This estimate cannot take into account any savings that might be achieved as a result of the abortions. Furthermore, plans that receive federal subsidies (it is believed that all plans in the exchanges will receive at least some federal subsidies) would have to collect two premium payments from all enrollees, including men and women of all ages. One payment would be for the value of the abortion benefit and the other payment would be for all other services. The funds would be deposited in separate allocation accounts, overseen and managed by state health insurance commissioners. Both the federal Office of Management and Budget and the Department of Health and Human Services are expected to publish guidelines in 2010 that states must follow to ensure that exchanges are adhering to these requirements.[10] The health reform law prohibits plans in the exchanges from discriminating against any provider because of "unwillingness" to provide abortions. It does not preempt other current state policies regarding abortion, such as parental notification and waiting period laws.

Currently, most (55%) women of reproductive age are covered through employer-sponsored plans from their own job or their husbands. Many of these plans do cover abortion currently and will be allowed to continue once health reform is fully implemented. Table 1 summarizes the ACA's major provisions on abortion coverage.

Table 1: Summary of Abortion Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)

Benefit Design	Prohibits abortion coverage from being required as part of the federally established essential benefits package; States can prohibit coverage for any abortions by all plans in their state-based exchange; At least one plan within a state exchange must not cover abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest); Private Plans: Can provide a plan in the exchanges that covers abortions beyond those permitted by federal law as long as they comply with requirement to segregate federal funds; All states' Pre-existing Condition Insurance Plans cannot cover abortions beyond those permitted by federal law.
Financing	Prohibit federal subsidies (for premiums or cost sharing) from being used to purchase a health plan in the exchanges that includes coverage for abortions beyond those permitted by federal law; In order to segregate funds, plans that choose to offer coverage for abortions beyond Hyde limitations must estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at least $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Any exchange plan that covers abortions and includes enrollees that receive federal subsidies must collect two separate premium payments from all enrollees — one payment for value of abortion benefit and one payment for all other covered services.
State Role	Law will have no effect on state laws regarding coverage, funding or procedural requirements on abortions, such as parental notification/consent laws; States can use state-only funds to pay for "medically necessary" abortions beyond federal requirements under Medicaid or to pay for abortion coverage in plans offered in an exchange; States can prohibit plans in new exchanges from covering any abortions; State-level health insurance commissioners will monitor and oversee payment segregation requirements for the purchase of plans within their respective exchanges.
Discrimination/ Protection	Prohibit plans participating in the exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

How much does an abortion cost?

The ACA's complex combination of restrictions means that under health reform, many currently uninsured women will obtain coverage either through Medicaid or an exchange; however, many of these women will not be covered for abortions and will have to pay out-of-pocket if they seek one. The cost of an abortion varies depending on factors such as location, facility, timing, and type of procedure. A clinic-based abortion at 10 weeks' gestation is estimated to cost between $400 and $550, whereas an abortion at 20-21 weeks' gestation is estimated to cost $1,250-$1,800 or more.[11] Though the vast majority (~90%) of abortions are performed early in pregnancy, the costs could still be economically challenging for many low-income women.[12]

What is the impact of the federal abortion provisions on women in high-risk pools?

The new health insurance exchanges will become operational in 2014. Prior to that time, some uninsured individuals will be able to buy coverage in new state-based, federally subsidized high-risk pools. Separate from states' currently operating high-risk pools, these new federally funded, Pre-existing Condition Insurance Plans (PCIP) will be open to individuals who have been uninsured for at least six months with existing health conditions, and will provide temporary coverage until exchanges become fully operational in 2014. States can operate the PCIPs or request the federal government to operate them, but all are financed with federal funds.

In July 2010, the Department of Health and Human Services issued a federal directive prohibiting all of these new PCIPs from covering abortions, effectively extending the Hyde Amendment to these plans as well.[13] Women who enroll in these temporary high-risk pools will not be able to use their own private dollars to purchase abortion coverage. Since many women eligible for PCIPs have more health problems than average, they could be more likely to encounter medical complications should they become pregnant. It is estimated that an additional 200,000 to 400,000 individuals are expected to enroll in the temporary PCIPs.[14] This order does not preempt states' policies on abortion coverage in their existing high-risk pools, nor does it prohibit women from paying a provider directly should they seek an abortion.

* * * * *

As a result of health reform, many more women will gain health insurance coverage. The decisions that the federal government, states, insurance companies, and policymakers will make over the next few years will determine the extent of abortion coverage that will be available to women across the nation once health reform is fully implemented in 2014.

Table 2: State Level Estimates of Percent of Uninsured Women Ages 15-44 Likely to Qualify for Federal Assistance under the Patient Protection and Affordable Care Act

		Uninsured Women, 2008-2009		Percent of Currently Uninsured Women Ages 15-44 Potentially Eligible for Federal Assistance in 2014	
	Total Number of Women Ages 15-44 in State	Number	Percent of Total Women in State	Likely to Qualify for Medicaid **	Likely to Qualify for Premium Credits in the Exchanges ***
Alabama*	941,940	193,965	21%	63%	32%
Alaska	138,624	34,647	25%	49%	43%
Arizona	1,290,755	302,354	23%	58%	34%
Arkansas*	556,616	161,324	29%	57%	39%
California	7,712,611	1,909,644	25%	58%	36%
Colorado*	1,020,305	213,345	21%	57%	37%
Connecticut	683,718	91,238	13%	48%	41%
Delaware	174,875	28,325	16%	50%	40%
District of Columbia	149,583	17,640	12%	58%	32%
Florida*	3,439,595	1,000,591	29%	54%	38%
Georgia*	2,060,710	516,501	25%	64%	31%
Hawaii	243,668	25,898	11%	60%	28%
Idaho*	300,011	67,734	23%	59%	36%
Illinois	2,652,361	469,469	18%	54%	39%
Indiana*	1,263,857	253,215	20%	60%	36%
Iowa*	572,244	94,251	16%	52%	40%
Kansas*	546,268	97,788	18%	69%	26%
Kentucky*	859,623	208,348	24%	65%	32%
Louisiana*	923,220	232,129	25%	63%	31%
Maine*	244,584	29,488	12%	45%	44%
Maryland	1,172,744	196,542	17%	53%	41%
Massachusetts	1,353,253	90,192	7%	--	--
Michigan*	1,956,538	355,014	18%	58%	34%
Minnesota	1,030,700	125,338	12%	46%	47%
Mississippi*	593,878	138,132	23%	64%	31%
Missouri*	1,173,596	218,902	19%	53%	40%
Montana	181,434	38,227	21%	51%	39%
Nebraska*	351,675	52,110	15%	58%	38%
Nevada*	520,000	133,246	26%	50%	42%
New Hampshire*	256,892	37,572	15%	40%	48%
New Jersey	1,726,605	329,250	19%	53%	36%
New Mexico	396,222	122,328	31%	66%	28%
New York	4,035,744	708,705	18%	50%	40%
North Carolina*	1,893,856	425,668	22%	64%	31%
North Dakota*	124,975	16,977	14%	52%	46%
Ohio*	2,248,979	350,501	16%	58%	37%
Oklahoma*	722,740	167,708	23%	53%	42%
Oregon	751,120	160,498	21%	58%	36%
Pennsylvania*	2,393,581	327,877	14%	55%	37%
Rhode Island*	214,038	34,393	16%	59%	35%
South Carolina*	902,532	199,945	22%	60%	32%
South Dakota*	151,360	27,366	18%	59%	36%
Tennessee*	1,257,375	246,435	20%	56%	41%
Texas*	5,133,199	1,781,564	35%	58%	37%
Utah*	599,794	106,561	18%	53%	37%
Vermont	118,214	14,618	12%	39%	47%
Virginia*	1,593,387	273,285	17%	47%	45%
Washington	1,335,218	220,188	16%	53%	42%
West Virginia	342,321	80,517	24%	56%	37%
Wisconsin*	1,092,394	120,614	11%	56%	39%
Wyoming*	104,779	20,313	19%	45%	47%

Notes: The federal poverty level (FPL) for a family of four in 2009 was $22,050.
* State does not provide funds for abortions beyond restrictions in federal Hyde Amendment.
** Percent of women ages 15-44 who are currently uninsured with incomes <138% of the federal poverty level.
*** Percent of women ages 15-44 who are currently uninsured with incomes 139-399% of the federal poverty level.
-- Sample size insufficient to make reliable estimate.
Source: Kaiser Family Foundation/Urban Institute estimates of ASEC supplement to March 2009 and March 2010 Current Population Surveys, U.S. Census Bureau.

ENDNOTES

[1] Legislation extends Medicaid coverage to all individuals with incomes up to 133% of the poverty level (FPL) and includes a provision to disregard first 5% of income, effectively extending Medicaid to all individuals with incomes up to 138% FPL.

[2] Congressional Budget Office, *Letter to Congressman John Dingell Regarding H.R. 3962*, November 6, 2009.

[3] Note that undocumented individuals will not have access to coverage through Medicaid or exchanges, regardless of ability to pay for coverage.

[4] Kaiser Family Foundation, *Medicaid's Role for Women*, 2007.

[5] Guttmacher Institute, State Policies in Brief, November 1, 2010.

[6] Kaiser Family Foundation/Urban Institute analysis of 2009, 2010 ASEC supplements to Current Population Survey, Bureau of the Census.

[7] Guttmacher Institute, *State Policies in Brief*, September 1, 2010.

[8] The White House Office of the Press Secretary, *Executive Order – Patient Protection and Affordable Care Act's Consistency with Longstanding Restrictions o the Use of Federal Funds for Abortion*, March 24, 2010. Available at www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst.

[9] Cohen, S. Insurance Coverage of Abortion: The Battle to Date and the Battle to Come, *Guttmacher Policy Review*, Fall 2010.

[10] Kaiser Health News, *Text: The President's Executive Order on Abortion Funding and The Health Bill*, Kaiser Family Foundation, March 25, 2010. Available at: www.kaiserhealthnews.org/Stories/2010/March/24/text-Obama-abortion-executive-order.aspx.

[11] Personal communication with Stephanie Poggi, National Network of Abortion Funds, November 13, 2009.

[12] Guttmacher Institute. *An Overview of Abortion in the United States*, January 2008.

[13] U.S. Health and Human Services, *Statement of HHS Spokeswoman Jenny Backus on the Pre-Existing Condition Insurance Plan Policy*, July 14, 2010.

[14] U.S. Health and Human Services, *HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan*, July 1, 2010. Available at: www.hhs.gov/news/press/2010pres/07/20100701a.html.

This brief was prepared by Usha Ranji, Alina Salganicoff, and Tina Park of the Kaiser Family Foundation.

This publication (#8021) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION **www.kff.org**

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

adn.com
Anchorage Daily News

Print Page | Close Window

Parnell cites abortion in KidCare funds veto

CUTS: Governor axes over $300 million in state spending.

By SEAN COCKERHAM
scockerham@adn.com

(06/04/10 14:34:15)

Gov. Sean Parnell vetoed more than $300 million in state spending Thursday, including money for renewable energy and to expand Denali KidCare for low-income children and pregnant women.

Parnell vetoed nearly $3 million aimed at letting more Alaskans have health care costs covered under Denali KidCare. It's an increase he supported when it overwhelmingly passed the Legislature. But the governor said he reversed his position after recently finding out some Denali Kid Care money goes to fund abortions.

"My intention here today is to make sure we don't expand state government funding of abortions here in Alaska," Parnell said in announcing the veto.

His administration could not say how much Denali KidCare money is going to fund abortions, and critics of the decision say he's denying help to more than 1,000 children.

The Denali KidCare veto was the only significant cut Parnell made to the $8 billion budget that funds state agencies and services. But the governor axed $300 million from the separate $3.1 billion state budget for construction and maintenance projects, which is among the largest capital budgets the state has seen. The Legislature approved the budgets before adjourning for the year in April.

Parnell vetoed money for about 150 projects throughout the state, from roads to sewers to a new house for polar bears Ahpun and Louie at the Alaska Zoo. In many cases the governor reduced funding for projects instead of zeroing them out. He halved the $50 million intended for renewable energy grants, saying most of the money appropriated in the past for such projects still hasn't been spent. He cut $250,000 of the $1 million for deferred maintenance at the governor's mansion.

His veto of Denali KidCare money drew by far the strongest reaction, with Democrats saying it was outrageous. Anchorage Democratic Sen. Bettye Davis, who sponsored the Denali Kid Care money, said it would have allowed 1,300 children and 225 pregnant women to receive care.

Ethan Berkowitz, one of Parnell's Democratic opponents for governor, called the decision cold-hearted. "If you want to be tough, you don't be tough by slapping kids around," he said.

Hollis French, a Democratic state senator who is also running against Parnell, said the decision was depriving hundreds of children of coverage "because you're afraid a few women might make a choice you don't agree with." The courts made it clear the state has to pay for "medically necessary" abortions for poor women and the program doesn't fund elective abortions, he said.

Officials with AARP Alaska and the Central Council of Tlingit and Haida Head Start program said the governor's veto will hurt people struggling to raise children.

Parnell said he wanted to offer the health care to more women and children. But he said he couldn't bring himself to do it after recently discovering Denali Kid Care also funded abortions. Parnell said he couldn't believe it when he found out.

"I want to be able to provide those services. But if your governor doesn't stand for life and liberty, as he understands it in his conscience, then you don't have a governor," Parnell said.

Parnell said there are "hundreds of abortions being paid for by these funds." But state Sen. Davis said that's not true and only a "very small number" of abortions are funded. She said that's what the Alaska Department of Health and Social Services, which administers the program, told her when she inquired last year.

The Department of Health and Social Services was not answering any questions about it Thursday, even after Parnell referred reporters to the agency when he was asked how much Denali KidCare money is going for abortions. The agency said it could not answer that question, nor could it say how many abortions were funded or how it made the decisions on which abortions it should pay for.

Agency spokeswoman Cathy Stadem said the answers had to be run past the governor's office and she hoped to give them the next day. "Everything is having to be vetted through (the Alaska Department of Law) and through the governor's office," she said.

The $2.9 million Parnell vetoed would have expanded eligibility of the Denali KidCare program to cover households with income up to 200 percent of the federal poverty level, a threshold that's about $55,150 for a family of four. Proponents said most states fund at that level while Alaska is currently at about 175 percent.

BUILDING PROJECTS AXED

Sitka Republican Sen. Bert Stedman said he didn't realize Denali Kid Care money went to abortions and understands Parnell's reasoning on the veto. But Stedman said there was no financial reason for Parnell to chop hundreds of millions of dollars from the state budget for construction and maintenance projects.

"It's a political decision, not a financial one," said Stedman, who helped craft the budget.

The state has $12 billion in cash reserves on top of the Alaska Permanent Fund, Stedman said, and if the projects aren't funded now, they might never happen.

Parnell said the state has a surplus from high oil prices but it's not going to last forever. He said the amount of spending he approved will create jobs but not break the bank.

"These vetoes for the most part don't represent projects I do not like. They represent projects I think should be deferred to another time because of the fiscal situation," the governor said.

Ralph Samuels, a Republican running for governor, criticized Parnell for not cutting more. He said Parnell didn't do nearly enough at a time when oil production is declining.

There were about $70 million in road and drainage money vetoes in Anchorage. The mayor's office said nearly $10 million more was axed from the budget in planned upgrades for the Loussac Library, Sullivan Arena, the Ben Boeke and Dempsey Anderson ice arenas, and recreation centers in Spenard and Fairview.

But Anchorage Mayor Dan Sullivan said "a healthy list of road, public safety and other priority

projects remains, and will lead to a robust level of economic activity for Anchorage."

Parnell cut the biggest project in the budget for the Mat-Su Borough. He vetoed $22 million of the $57 million that the Legislature appropriated for work toward an extension of the Alaska Railroad from north of Willow to Port MacKenzie. Mat-Su Economic Development Director David Hanson said the remaining money will go to design and engineer the route, buy right of way and begin construction.

Mat-Su borough officials said they were mostly happy with the $137 million in projects they kept.

Find Sean Cockerham online at adn.com/contact/scockerham or call 257-4344. Daily News reporter Rindi White contributed to this story.

Print Page | Close Window

Copyright © Fri Jan 21 10:59:35 UTC-0900 20111900 The Anchorage Daily News (www.adn.com)

adn.com
Anchorage Daily News

Print Page Close Window

KidCare funded 664 'medically necessary' abortions in '09

DENALI KIDCARE: Physicians determine what is "medically necessary."

By SEAN COCKERHAM
scockerham@adn.com

(06/18/10 11:47:08)

The Alaska Department of Health and Social Services says 664 abortions were funded last year through Denali KidCare, the state health care program for low-income children and pregnant women.

Gov. Sean Parnell this month vetoed money to expand Denali KidCare to serve more Alaskans, saying he did it because some of the money pays for abortions.

Parnell said at the time that Denali KidCare funded "hundreds" of abortions. Anchorage Democratic Sen. Bettye Davis had disputed that, saying she'd previously spoken to the state health department and that a "very small number" of abortions are funded through Denali KidCare.

The health department couldn't answer for nearly two weeks exactly how many abortions were actually funded through the program. But a department spokeswoman sent out the figures Thursday showing Denali KidCare had paid for between 636 and 689 abortions every year for the past five years.

Last year's 664 is a substantial portion of the total abortions received by Alaskans. The Bureau of Vital Statistics reports 1,875 abortions in Alaska as a whole last year, although that doesn't count Alaskans who had the procedure performed out of state.

Davis didn't return a phone call Thursday seeking comment. But others were not ready to accept the state's numbers at face value.

"I am waiting for clarification about those numbers, but the bottom line is this -- Denali KidCare only pays for medically necessary abortions," said Hollis French, a Democratic state senator who is running against Parnell for governor. "Standing between a woman and her doctor is irresponsible, particularly when the stance also includes denying 1,200 children access to affordable medical care."

Denali KidCare is required to fund "medically necessary" abortions because of a 2001 Alaska Supreme Court ruling. The court ruled that "if the state undertakes to fund medically necessary services for poor Alaskans, it may not exclude from that program women who medically require abortions."

The state does not define what is "medically necessary," leaving that to the treating physician.

"I've been doing this for thirty-some years, not just abortions but health care. And early on I learned that only a physician can determine medical necessity," Bill Streur, deputy commissioner of the state health department, said earlier this month.

Jim Minnery, president of the anti-abortion group Alaska Family Council, said on Thursday that the

definition of "medically necessary" needs to be tightened.

He questioned how many abortions funded by Denali KidCare are related to the health of the mother, saying doctors are free to determine it's "medically necessary" to have an abortion if the birth would interfere with the mother's work or education.

Clover Simon, vice president of Planned Parenthood of Alaska, which provides abortions, said there was a court order during the 2001 case over state-funded abortions that set out what "medically necessary" is about. She said the term refers to "abortions certified by a physician to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services, in his or her professional judgment."

The state health department said $384,000 out of Denali KidCare's $217 million budget went to pay for "abortion related services." That's 0.18 percent of the total.

It adds up to about $580 for each abortion. The state and Planned Parenthood said that figure sounds about right, noting that the reimbursement to physicians through Denali KidCare is less than it would be with private insurance.

There were 55,754 Alaskans enrolled in Denali KidCare last year to receive help from the state with their health care costs, including 7,947 pregnant women.

The $3 million that Parnell vetoed would have allowed 1,300 more children and 218 more pregnant women on Denali KidCare, according to state estimates.

The money would have expanded eligibility of the program to cover households with income up to 200 percent of the federal poverty level, a threshold that's about $55,150 for a family of four. Proponents of the expansion said most states fund at that level while Alaska is currently at about 175 percent.

Ethan Berkowitz, another Democrat running against Parnell for governor, has said the issue is about health care and not abortion. If the issue for Parnell was really abortion he would have opposed all the Denali KidCare money, Berkowitz said, instead of just saying people can get health services if they are up to 175 percent of the poverty line but not between 175 and 200 percent.

Parnell spokeswoman Sharon Leighow said the governor had nothing to add Thursday to what he said when he vetoed the money. Parnell said he was acting to "make sure we don't expand state government funding of abortions here in Alaska."

Find Sean Cockerham online at adn.com/contact/scockerham or call him at 257-4344.

Print Page | Close Window

Copyright © Fri Jan 21 10:59:03 UTC-0900 20111900 The Anchorage Daily News (www.adn.com)

adn.com
Anchorage Daily News

Print Page Close Window

Scenarios show emergency room visit is no cure-all for many children

COMPASS: ***Other points of view***

By SEN. BETTYE DAVIS

(07/23/10 21:23:29)

While stories of the governor's veto of Senate Bill 13 and the funding for the expansion of the state's Denali KidCare program fade from the media, just under 1,300 children and over 200 pregnant women will be faced with the daily reality of not having basic insurance coverage. That is why I sponsored this legislation, and that is where my interest in this remains.

Some may argue that they still have the ability to seek treatment at an emergency room. While that is true, let's look at some scenarios that Denali KidCare would cover with a less costly visit to a doctor's office.

Try taking your 6-month-old to an emergency room for checkups that include hearing or vision tests, immunizations and other various well-baby screenings instead of a pediatrician's office. They can't help you with that at the emergency room.

Perhaps while talking to your 2-year-old child, you notice he can only imitate speech or actions but doesn't produce words or phrases spontaneously. Without speech language therapy, his speech could fall further behind his peers' as he grows older. You can't get speech therapy in an emergency room.

We all know smart children who seem to lose interest or can't follow things in class, who we later learn couldn't see the visuals the teacher used because they didn't know they needed glasses. You can't get glasses in an emergency room.

How about not being able to eat or concentrate during school or at home because of a toothache? The emergency room doesn't offer dental checkups, cleanings and fillings.

Your 14-year-old breaks her leg while engaged in sports and goes to the emergency room for treatment. In this instance she will no doubt receive outstanding care, but what about follow-up physical therapy? You can't get that in an emergency room.

There are many other great services offered through Denali KidCare, such as mental health therapy, substance abuse treatment, chiropractic services, foot doctor's services and the fundamentally important but many times forgotten medical transportation services. I haven't even touched upon the prenatal services available to pregnant women that are critical to the wellbeing of the mother and birth of a healthy child.

Let me make it clear that I believe that we have some of the most highly trained, caring and compassionate professionals staffing our emergency rooms statewide and I am highly supportive of them. But an emergency room is designed for just what it pronounces itself to be: a place to treat people during emergencies. While either a doctor or an emergency room visit for your child can provide you with laboratory tests, prescription drugs or, in a worst-case scenario, hospitalization for a major traumatic event, the costs for these services could easily be a financial nightmare for any family. If the family cannot pay most or any of the bills, those costs are spread throughout the health care system to

those with insurance, whose premiums go up accordingly. And if those services are done exclusively at an emergency room, the costs are even higher.

while some individuals want to take this valuable program and use it as a touchstone for their opinions on government spending or philosophical battles, I remain focused on helping to bring health care to those who have no real interest in politics but just need assistance to see a doctor. For those women and children, the fact that the veto of SB 13 is no longer headline news doesn't change their needs.

Sen. Bettye Davis, an Anchorage Democrat, has represented District K in the state Senate since 2001.

Print Page Close Window

Copyright © Sat Jul 24 2010 10:34:50 GMT-0800 (AKDT)1900 The Anchorage Daily News (www.adn.com)

Georgetown University Health Policy Institute
Center for Children and Families

To: Interested Parties
From: Tricia Brooks, Georgetown Center for Children and Families
Re: Alaskan Options for Expanding Coverage for Pregnant Women
Date: November 4, 2010

During a recent trip to Alaska to participate in the Kids First Alaska meeting on October 19, 2010 at the invitation of the All Alaska Pediatric Partnership and the Mat Su Health Care Foundation, I was asked to provide clarifying information on opportunities to expand federally supported medical coverage to pregnant women in Alaska. This memo outlines current coverage in Alaska and provides an overview of federal options and requirements for expanding coverage.

Current Coverage for Pregnant Women and Children in Alaska

Currently, Alaska provides traditional Medicaid coverage to pregnant women with income up to 175% of the Federal Poverty Level (FPL) who are citizens or immigrants lawfully residing in the U.S. for at least five years. Additionally, the state provides, as federally required, emergency medical coverage for labor and delivery services to any uninsured pregnant woman who meets the Medicaid guidelines, regardless of citizenship or immigration status.

While the purpose of this memo is to identify options for expanding coverage to pregnant women, certain options are related to coverage for children. Alaska uses its Medicaid program for covering both children and pregnant women. Currently, the State provides Medicaid coverage for children up to 150% FPL and coverage between 150% and 175% FPL for children through a Medicaid expansion funded through the Children's Health Insurance Program (CHIP) called Denali Kid Care. The CHIP-funded Medicaid expansion for children qualifies for a higher financial participation rate. In Alaska the federal participation rate for Medicaid is 50%[1] and for CHIP is 65%.

Options for Expanding Coverage for Pregnant Women with Federal Financial Participation

- *Expand Medicaid Coverage*

  Federal Requirements and Options - States with Medicaid programs are required to cover pregnant women who are citizens with income up to 133% of the federal poverty level (FPL). States may expand income eligibility through Medicaid to pregnant women who are citizens and, at the state option, lawfully-residing immigrants up to an income level approved by the federal government. States are

also required to cover labor and delivery cost of all uninsured women under emergency Medicaid services if they otherwise meet Medicaid income and asset requirements.

Alaska Options – Alaska may expand Medicaid coverage for pregnant women with incomes higher than the current limit of 175% FPL. Under this option, the state may also elect to provide coverage for lawfully residing immigrant pregnant women. An expansion of eligibility requires a Medicaid State Plan Amendment (SPA). Federal financial participation under this option is 50%.

- *Expand CHIP Coverage to Pregnant Women*

Federal Requirements and Options – The 2009 federal reauthorization of the CHIP program (CHIPRA) expanded options for states to cover pregnant women. Under CHIPRA, states may provide coverage to pregnant women who are citizens and, at the state option, lawfully residing immigrant pregnant women, through CHIP up to 300% FPL, if certain conditions are met. Among those conditions, the state must cover children under Medicaid/CHIP up to at least 200% FPL and cover pregnant women through Medicaid up to 185% FPL. Pregnant women cannot be covered at a higher income level than children.

Alaska Options – To expand coverage to pregnant women under CHIPRA, the state would first have to expand Denali Kid Care coverage to children from the current income level of 175% FPL up to at least 200% FPL or higher, depending on the proposed income limit for pregnant women. Additionally, the state would have to expand Medicaid coverage to pregnant women between 175% and 185% FPL. With those coverage levels, the state may expand coverage for pregnant women above 185% FPL drawing down the higher 65% CHIP federal match.

This option would require a Medicaid SPA to raise the income eligibility level for pregnant women to 185% FPL. Additionally, Alaska must submit a CHIP SPA to expand income eligibility for children up to 200% FPL (or higher depending on the proposed income limit for pregnant women) and to provide CHIP coverage to pregnant women above 185% FPL.

The SPA establishes what is technically a separate CHIP program for low-income pregnant women rather than a CHIP-funded Medicaid expansion program as is Denali Kid Care. However, it can be operated as a "Medicaid look-alike" program using the existing Medicaid administrative structure and health care delivery system. The expansion to pregnant women between 175% and 185% FPL would qualify for the 50% federal Medicaid match, while expanded coverage for children above 175% FPL and for pregnant women above 185% would qualify for the higher federal CHIP match of 65%.

- *Expand Coverage Under the CHIP Unborn Child Option*

  Federal Requirements and Options - States may provide prenatal care, labor, and delivery services to pregnant women through the unborn child option in CHIP. Sixty days of postpartum care can also be funded if services are provided under a global capitation arrangement, which bundles payment for all prenatal, labor, delivery, and postpartum care. Through this option, coverage is provided without regard to the pregnant woman's immigration status. While it is the unborn child who is eligible, services are directed to the pregnant woman to ensure the delivery of a healthy newborn, including medical and dental services for the mother deemed necessary to promote the health of the unborn child.

  Alaska Options - The state may expand coverage under the CHIP unborn child option for the unborn child of pregnant women who do not otherwise qualify for Medicaid, as well as pregnant women above the current income limit of 175% FPL. Like the previous option, this would require a CHIP State Plan Amendment to create a separate CHIP program to establish coverage for the unborn child.

  Currently eligible children, ages 0 - 18 would continue to be covered under Denali Kid Care while the pregnant women receiving services based on the eligibility of their unborn child would be covered under the separate CHIP program. In this case, Alaska may also wish to design its CHIP unborn child coverage as a "Medicaid look-alike" program as described above. Services provided to pregnant women under the unborn child option qualify for a 65% federal financial participation in Alaska.

Summary

Several options exist for Alaska to expand coverage to pregnant women directly through Medicaid and/or CHIP. Financial participation depends on the option(s) chosen. This overview of provisions in CHIPRA to cover pregnant women may be helpful. Stakeholders may wish to review additional information provided to states by the Centers for Medicaid and Medicare (CMS) in these relevant State Health Official (SHO) letters of guidance and Q & A memos:

State Health Official Letter on the Unborn Child Option

State Health Official Letter on Lawfully Residing Children and Pregnant Women

State Health Official Letter on Covering Pregnant Women through CHIP

State Health Official Letter on Frequently Asked Questions about Covering Pregnant Women

[1] The 50% federal participation is the traditional matching rate for Alaska. During the period July 2008 through June 2011, the American Recovery and Reinvestment Act (ARRA) provides a higher match to help states deal with the increased need for services during the economic downturn.

Bill Hogan
Commissioner
P.O. Box 110601
Juneau, AK 99811-0601
www.hss.state.ak.us

STATE OF ALASKA
DEPARTMENT OF
HEALTH AND SOCIAL SERVICES

Fact Sheet

COMMISSIONER'S OFFICE

Denali KidCare Fact Sheet (as relates to the topic of abortion)

1. **How big is Denali KidCare's annual budget?**
   - Spending in CY 2009:
     - Title XXI kids: $30,246,349
     - DKC Pregnant Women: $60,578,841
     - DKC Title XIX kids: $125,761,129
     - **Total DKC: $216,586,319**

2. **What fraction, estimated, is spent on abortions or on programs that include public money for abortions?**

   In CY 2009 in comparison to the above:
   - Of total DKC spending: $384,000 was spent on abortion-related services.

3. **How many abortions are performed each year (on average) with funding from Denali Kid Care?**
   - The department has data on abortion-'related' services. This does not necessarily equal the number of abortions. It indicates services provided that are related to abortion. From Jan 1, 2009 through Dec. 31, 2009, 664 individuals on Denali KidCare received abortion-related services. In Alaska as a whole, the Bureau of Vital Statistics reports that in calendar year 2009 there were 1,875 total abortions

4. **How many additional women and children would have been eligible for Denali KidCare if the eligibility had been expanded from 175 percent to 200 percent of the federal poverty level?**
   - The fiscal note for SB13 estimates 218 pregnant women and 1,277 children would have been covered by the expansion of Denali KidCare.

5. **How many abortions are conducted in Alaska each year and how many of those do you estimate receive state subsidies?**

    - The Bureau of Vital Statistics reports that in calendar year 2009 there were 1,875 abortions in Alaska as a whole. See #9 for additional information.

6. **How much is the state giving up in Federal matching funds with this veto? Is it a 50/50 match?**
    - The fiscal note for SB13 estimates that the state would have spent $1,592,700 in federal funds in FY 2011. For 2011, the estimated funding was estimated to be 69.7% federal when the regular Medicaid, CHIP, and tribal health federal match rates are factored together.

7. **Under what conditions may a woman have an abortion paid for? What is medically necessary?**
    - "Medically necessary" as it applies to abortions paid for under Denali KidCare is not defined in statute or regulation, or by Court decision.

8. **Is the program affected by an Alaska Supreme Court decision that says certain abortions must be paid for?**
    - Yes. The Alaska Supreme Court ruled in *DHSS v. Planned Parenthood*, 28 P.3d 904 (Alaska 2001) that the State must fund medically necessary abortions for pregnant women if it funds other medically necessary services for other financially needy persons.

9. **What is the average number of abortions per year paid for by Denali KidCare?**
    - From CY 2005 – CY 2009, an average of 664 individuals per year on Denali KidCare received abortion-related services. The number of abortion-related services provided each year remained relatively steady during this period.
    - The following is the number of abortions funded through the Denali Kid Care program in the last five years.(We are aware that the number of abortions listed for 2009 (664) is the same number we listed for individuals on Denali KidCare who received "abortion-related services" in the Fact Sheet sent out June 7, 2010 (question #3).)

        - 2005: 680
        - 2006: 689
        - 2007: 636
        - 2008: 653
        - 2009: 664
        - **Five year average: 664**

10. Does the state have any choice in funding abortions through Denali Kid Care?

- No. The Alaska Supreme Court held in 2001 that if "the State undertakes to fund medically necessary services for poor Alaskans, it may not selectively exclude from that program women who medically require abortions." The 2001 decision is State v. Planned Parenthood, 28 P.3d 904 (Alaska 2001). In other words, any benefits program for financially eligible Alaskans enacted by the State must include funding for medically necessary abortions if it includes funding for other medically necessary services.

11. Is that because the courts have ruled that the state cannot restrict funding for "medically necessary" abortions?

- Yes

12. What is the definition being used for "medically necessary" abortions? Is it still to "prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health."?

- "Medically necessary" as it applies to abortions paid for under Denali KidCare is not defined in statute or regulation, or by Court decision.

13. Is there a specific amount of money allocated for abortion procedures and how is that amount decided upon?

- No specific amount of funding is allocated for abortion-related services in the Department budget.

14. Does Planned Parenthood accept Denali KidCare aid?

- Planned Parenthood is an enrolled Medicaid provider and therefore can bill the Department for services provided to people on Denali KidCare.

15. Has the state awarded any grants to Planned Parenthood?

- No grant awards have been issued to Planned Parenthood of Alaska or Planned Parenthood of the Great Northwest in FY2010.

16. How many women and children were enrolled in Denali KidCare in CY2009

- Title XIX DKC kids (< 19 yrs) 39,138
- Title XXI CHIP kids (< 19 yrs) 14,914
- DKC Pregnant women any age 7,947

Total <u>unduplicated</u> enrollment: 55,754*

*: NOTE: The 3 bulleted numbers do not add up to the total shown above because some clients change categories throughout the year and are counted more than once.

###

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

MEMORANDUM

DATE: March 28, 2011

TO: Senator Bettye Davis, Chair, Senate HSS Committee

FROM: Jon Sherwood, DHSS Medical Assistance Administrator

SUBJECT: Denali KidCare

Senator Davis, below is the Department's response to two issues that came up in the hearing on SB 5 on March 23, 2011.

First, we believe there may have been some confusion regarding regulations defining medical necessity as it related to abortion and the definition of therapeutic abortion. There are regulations defining therapeutic abortion at 7 AAC 47.290; however, these regulations only apply to the General Relief Medical program. This program was defunded by the Alaska Legislature in 1998. Prior to that time, abortions for Medicaid eligible women were covered under the General Relief Medical program. This defunding of the program that covered abortions for Medicaid eligible women is what triggered the court cases that currently govern state-funded abortions. Nothing in those court decisions applies the definition at 7 AAC 47.290 to the current requirement to pay for abortions nor provides a separate definition of medical necessity.

There is no specific definition of medical necessity for abortions in 7 AAC 105.100 or elsewhere in 7 AAC 105, the regulations that govern Medicaid services. Under 7 AAC 105.100(5), the general criteria for medical necessity if there is no specific definition for a service is "by the standards of practice applicable to the provider".

Given these facts, the Department believes its previous statement that there is no statute, regulation, or court decision that defines medical necessity as it applies to abortions paid for under Denali KidCare is accurate.

Second, questions arose about how the Department uses coding to determine that services are abortion-related, and if services for miscarriages or stillbirths might be included.

The Division of Health Care Services determines whether a claim is for an abortion related service based on a combination of procedure codes and diagnosis codes as follows:

If a claim comes in with one of several ICD-9 diagnosis codes related to pregnancy, the claim is pended for review. The reviewer then identifies the procedure code and determines if the procedure code - diagnosis code combination is an abortion-related service. If so, the claim is assigned a collocation code that will be charged against state funds only. In some cases, the reviewer may request medical case notes to make the final determination of whether or not the claim is for an abortion-related service.

While a multitude of procedure codes may be included in abortion-related services, use of diagnosis codes directs the reviewer to correctly exclude services related to miscarriage, stillbirths, or other circumstances not related to abortions when we identify abortion-related services.

Cc: William Streur, DHSS Commissioner

RECEIVED
MAR 27 2011

Sen. Bettye Davis

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Sunday, March 27, 2011 10:54 AM
To: Thomas Obermeyer
Cc: Sen. Bettye Davis; Celeste Hodge; Streur, William J (HSS); Sherwood, Jon (HSS)
Subject: FW: SB 5 - Coding of Abortions - Separating the facts

Senator Davis, below is the Department's response to two issues that came up in the hearing on SB 5 on Wednesday.

First, we believe there may have been some confusion regarding regulations defining medical necessity as it related to abortion and the definition of therapeutic abortion. There are regulations defining therapeutic abortion at 7 AAC 47.290; however, these regulations only apply to the General Relief Medical program. This program was defunded by the Alaska Legislature in 1998. Prior to that time, abortions for Medicaid eligible women were covered under the General Relief Medical program. This defunding of the program that covered abortions for Medicaid eligible women is what triggered the court cases that currently govern state-funded abortions. Nothing in those court decisions applies the definition at 7 AAC 47.290 to the current requirement to pay for abortions nor provides a separate definition of medical necessity.

There is no specific definition of medical necessity for abortions in 7 AAC 105.100 or elsewhere in 7 AAC 105, the regulations that govern Medicaid services. Under 7 AAC 105.100(5), the general criteria for medical necessity if there is no specific definition for a service is "by the standards of practice applicable to the provider".

Given these facts, the Department believes its previous statement that there is no statute, regulation, or court decision that defines medical necessity as it applies to abortions paid for under Denali KidCare is accurate.

Second, questions arose about how the Department uses coding to determine that services are abortion-related, and if services for miscarriages or stillbirths might be included.

The Division of Health Care Services determines whether a claim is for an abortion related service based on a combination of procedure codes and diagnosis codes as follows:

If a claim comes in with one of several ICD-9 diagnosis codes related to pregnancy, the claim is pended for review. The reviewer then identifies the procedure code and determines if the procedure code - diagnosis code combination is an abortion-related service. If so, the claim is assigned a collocation code that will be charged against state funds only. In some cases, the reviewer may request medical case notes to make the final determination of whether or not the claim is for an abortion-related service.

While a multitude of procedure codes may be included in abortion-related services, use of diagnosis codes directs the reviewer to correctly exclude services related to miscarriage, stillbirths, or other circumstances not related to abortions when we identify abortion-related services.

Tom--I will put this on department letterhead and send first thing Monday morning.
w.

From: Thomas Obermeyer [mailto:Thomas_Obermeyer@legis.state.ak.us]

Sent: Thursday, March 24, 2011 12:42 PM
To: Sherwood, Jon (HSS)
Cc: Laughlin, Wilda J (HSS); Hodge, Celeste (LAA); Davis, Bettye J (LAA)
Subject: SB 5 - Coding of Abortions - Separating the facts

March 24, 2011

Jon,

SB 5 will be continued Monday, March 28, 2011 in Senate HSS at 1:30 p.m. Could you be there?

Senator Davis asks if you could provide the information requested yesterday before the hearing on SB 5 is continued Monday, March 28 in (S)HSS at 1:30. Her question, as I recall, concerned the coding of abortions.

This question is two-pronged as I see it:

1. It goes to funding "abortion-related services" including counseling, ultrasounds and other services that don't necessarily end in an abortion. Does the coding have bearing on the finances as well as the medical procedure? And are they distinguishable by costs or procedure alone?

2. It brings up the question whether the estimated increase of 22 abortions resulting from increasing DKC eligibility to 200% are coded differently if they are induced surgically or chemically, or other methods; whether some coded abortions ultimately result only in counseling and ultrasounds but not termination; whether abortions which are spontaneous or still born or other are distinguished from voluntary/elective but "medically necessary" abortions for the health of the mother under current law and regulations - the AAC definition per Memo provided by email to Wilda yesterday. Whether coding might distinguish the type of abortion posited by Senator Meyer: Could a woman get an abortion merely because she was depressed (recognizing "medically necessary" prerequisite) and is it coded differently so that we have a better breakdown of the 22 anticipated terminations.

Jon, feel free to rephrase my questions, as you are the expert, but I think you know what I am driving at. Is the number 22 of increased abortions a realistic figure, or is it unavoidably inflated due to a variety of procedures, costs and services which typically are not considered abortions but abortion-related services?

Tom

Thomas S. Obermeyer, MO Atty, M.B.A.

Office of Senator Bettye Davis, Chair

Alaska State Senate Health & Social Services Committee

State Capitol Rm 30

Anchorage, Alaska 99501

907-465-3762Direct

907-465-3822 Office

907-465-3756 Fax

800-770-3822 Toll Free

Thomas_Obermeyer@legis.state.ak.us

CONFIDENTIALITY STATEMENT

This message including any attachments is for the sole use of the intended recipient(s) above and may contain confidential or privileged information. Any unauthorized review, disclosure, copying, distribution, or use of the contents is strictly prohibited. If you are not the intended recipient or have received this message in error, please notify the sender by email, destroy all copies, and delete this email.

Thomas Obermeyer

From: Thomas Obermeyer
Sent: Wednesday, March 23, 2011 5:03 PM
To: Celeste Hodge
Cc: 'wilda.laughlin@alaska.gov'; 'Kraly, Stacie L (LAW)'; 'mike.barnhill@alaska.gov'; 'john.cramer@alaska.gov'; Sen. Bettye Davis; LAA Legal
Subject: SB 5 Denali KidCare Legislative Legal Services Memorandum 11/18/2010 regarding Medicaid Funding of "medically necessary" abortions
Attachments: Docs - Leg.Legl.Memo Med. Nec. 11-18-2010.pdf; SB5 Docs -DHSS Fact Sheet DKC abortion funding-undated.pdf

March 23, 2011
Celeste Hodge, Committee Aide
Senate Health & Social Services Committee

Celeste,

Per request by members of the Senate Health & Social Services Committee today regarding SB 5, attached is the 11-page Legislative Legal Services Memorandum and work-product of Legislative Counsel Jean Mischel dated November 18, 2010 to which I cited in quoting the definition of "medically necessary" abortions in federal US Supreme Court case law and a similar definition in the Alaska Administrative Code regarding "medically necessary" abortions and other covered services. Please distribute this memorandum to (S)HSS Committee members as soon as possible.

The Memorandum indicates that the issue in federal courts revolved around interpretation of the Hyde Amendment of 1973, with subsequent instructional interpretation of the definition of "medically necessary" in U.S. Supreme Court case *Harris v. McRae*, 448 U.S. 297 (1980) (see page 2 of the memorandum). Page 6 of the Memorandum provides definitions of "medically necessary" from the Alaska Administrative Code 7 AAC 47.290 along with the general concept of "medically necessary" for all covered services under 7 AAC 105.100. The memorandum provides other references to Alaska Statutes and Alaska Administrative Code concerning the same subject. I assume this memorandum will help Assistant Attorney General Stacie Kraly who promised, as I recall, a nationwide review of the same and a response within three months in Senator Davis's August 3, 2010 Senate HSS meeting, *i.e.*, almost 8 months ago. Jean Mischel produced this lengthy and substantive legal Memorandum within a week after request on November 9, 2010.

I note for the record, that the attached document from DHSS, Office of the Commissioner, to which Senator Dyson referred from the hearing package and titled "Fact Sheet on Denali KidCare as it Relates to Abortion Funding" was both undated and unsigned. He indicated it contradicted the legal memorandum attached, *i.e.,* that, in quoting, "'medically necessary' as it applies to abortions paid for under Denali KidCare is not defined in statute or regulation, or by Court Decision." In asking for clarification of the date from Wilda Laughlin after the hearing on SB 5 today, I understood it was subsequently dated upon request and republished although we never received a copy. I believe Senator Davis's office received the attached sometime last fall between September and November.

Tom Obermeyer
Legislative Assistant
Office of Senator Bettye Davis
465-3762

Cc: LAA Legal Services: Attn: Jean Mischel

Thomas S. Obermeyer, MO Atty, M.B.A.
Office of Senator Bettye Davis, Chair

Alaska State Senate Health & Social Services Committee
State Capitol Rm 30
Anchorage, Alaska 99501
907-465-3762Direct
907-465-3822 Office
907-465-3756 Fax
800-770-3822 Toll Free
Thomas_Obermeyer@legis.state.ak.us

CONFIDENTIALITY STATEMENT
This message including any attachments is for the sole use of the intended recipient(s) above and may contain confidential or privileged information. Any unauthorized review, disclosure, copying, distribution, or use of the contents is strictly prohibited. If you are not the intended recipient or have received this message in error, please notify the sender by email, destroy all copies, and delete this email.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM November 18, 2010

SUBJECT: Medicaid funding of "medically necessary" abortions
(Work Order No. 27-LS0175)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have asked about the meaning of "medical necessity" as it relates to medical assistance (Medicaid) funding of abortions. State and federal statutes fail to define the phrase, although the concept forms the basis for coverage of all services under the jointly funded Medicaid program and is defined for purposes other than abortion services in regulation.

Despite a federal exclusion for most abortion services known as the "Hyde Amendment," upheld by the United States Supreme Court, the Alaska Supreme Court in 2001 specifically held that the equal protection guarantee under our state constitution requires the state to cover medically necessary abortion services, as it does for all other medical services covered under state Medicaid funding. The standard for "medical necessity" in Alaska appears to be similar for all Medicaid services and includes services that are broader than life saving services but less than elective services, as discussed below.

FEDERAL LAW DRAWS A DISTINCTION BETWEEN ABORTION SERVICES FUNDING AND OTHER TYPES OF COVERED SERVICES

The federal purpose of the Medicaid program established the medical necessity standard under 42 U.S.C.S. § 1396-1 as follows:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of *necessary medical services*, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Emphasis added.) Since 1976, Congress has prohibited, either by an amendment to the annual appropriations bill for the United States Department of Health and Human Services, or by joint resolution, the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances. The "Hyde Amendment" provides that:

> [N]one of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service.

Pub. L. 96-123.

After the passage of the Hyde Amendment, federal courts wrestled with questions about whether state and federal governments are required to pay for an indigent woman's exercise of a fundamental constitutional right when a "medically necessary" abortion is involved. In several close decisions, the U.S. Supreme Court determined that the federal constitution does not require public financial support of the right to choose an abortion in cases that do not involve rape or incest or a threat to the mother's life. Beal v. Doe, 432 U.S. 438 (1977); Maher v. Roe, 432 U.S. 464 (1977); Harris v. McRae, 448 U.S. 297 (1980); Webster v. Reproductive Health Services, 492 U.S. 490 (1989). It is instructive to note the trial court definition in the McRae case of the phrase "medically necessary" for purposes of abortion funding was "a professional judgment for the physician that may be exercised in the light of all factors--physical, emotional, psychological, familial and the woman's age--relevant to the well-being of the patient."

The federal courts ruled in these cases that governments are not required to provide money to assist in the exercise of constitutional rights; governments are only prohibited from placing obstacles in the way of exercising those rights. Withholding funding, said the federal courts, is not an obstacle to the indigent woman who seeks an abortion. Her poverty may be an obstacle, but the government did not create the poverty. She is still free to have an abortion, but not with public money. The federal courts suggested other private money might be available. In light of these federal decisions, it is clear that public funding for abortions, even when "medically necessary," is not required under the federal constitution.

ALASKA LAW REQUIRES A MORE UNIFORM BUT INEXACT STANDARD FOR STATE MEDICAID FUNDING OF ALL TYPES OF SERVICES COVERED, INCLUDING ABORTION SERVICES

In the early 1990's, the state attempted to adopt the federal distinction for funding of abortion services and disregarded the general medical necessity definition adopted in regulation for other types of services. In a direct challenge to the state regulation that provided only for public funding of abortion services to preserve the life of the mother or

in cases of rape or incest, the Alaska Supreme Court held that the state must pay for medically necessary abortions for participants in the Medicaid program as it does for other types of services. State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001). The Alaska Supreme Court determined then that the "rape, incest, and to prevent the death of the mother" restrictions of the Hyde Amendment are too narrow to satisfy the requirements of the Alaska state constitution.

The Alaska constitution has been consistently interpreted to provide broader protections than the federal constitution. For instance, in Valley Hospital Ass'n v. Mat-Su Coalition for Choice, 948 P.2d 963, 969 (Alaska 1997), the Alaska Supreme Court held that "reproductive rights are fundamental . . . [and] include the right to an abortion." Later, in State v. Planned Parenthood of Alaska, Inc., 28 P.3d 904 (Alaska 2001), the Alaska Supreme Court, although basing its decision on due process considerations rather than the privacy clause used by the lower court, came to the same conclusion the lower court had. The conclusion was that if the state Department of Health and Social Services (DHSS) restricted abortion coverage for Medicaid-eligible women to only those covered by the exceptions in the Hyde Amendment, it would result in unconstitutional implementation of Medicaid in Alaska.

There is language in the Planned Parenthood of Alaska, Inc. case (cited above; see 28 P.3d at 913) strongly suggesting that the Alaska Supreme Court considers women who carry their pregnancy to term to be similarly situated with women who have an abortion (in that they are both exercising their constitutional freedom of reproductive choice). If the court continues to hold that position when faced with a renewed public abortion funding challenge, there is a possibility that the court will find that the state may not be able to burden the right to abortion services under the state Medicaid program unless a similar burden is placed on medical services to continue a pregnancy, and in the absence of comparable burdens on continuation of a pregnancy the state cannot burden the right to abortion services.

The consequence of having a more broadly interpreted right to public funding of abortions for Medicaid recipients in Alaska than what is allowed under federal law is that DHSS must cover some Medicaid abortions with 100% state money (no federal match).[1] The federal government does not prohibit states from using their own funds.

Over the years, language has appeared in Alaska budget acts that purport to prohibit DHSS from using any of its appropriated money for abortions outside the scope of the

---

[1] Alaska is reportedly not alone in using purely state funds for some Medicaid abortions that the federal government will not fund. I do not have an up-to-date list and I have not double-checked the cases cited, but the ACLU says that 17 states fund abortions outside the Hyde Amendment restrictions, 4 voluntarily and 13 under court order. I have attached the relevant information, as reported by the ACLU, excerpted from http://www.aclu.org. I cannot vouch for the accuracy of the ACLU website, but if you require further information about public funding of abortions in other states, please let the office know.

Hyde Amendment. However, DHSS has been under court order to continue to pay for medically necessary abortions and has complied with the state attorney general's advice to do so.[2]

---

[2] For instance, with regard to the 2007 fiscal year operating budget, the attorney general wrote the following:

> This year's budget, as did the prior four years' budgets, contains the following language regarding abortion funding:
>
> > No money appropriated in this appropriation may be expended for an abortion that is not a mandatory service required under AS 47.07.030(a). The money appropriated for Health and Social Services may be expended only for mandatory services required under Title XIX of the Social Security Act and for optional services offered by the state under the state plan for medical assistance that has been approved by the United States Department of Health and Human Services . . . .
>
> [citation omitted]. As we opined before, this language is intended to prevent expenditures from these appropriations for therapeutic or medically necessary abortions. DHSS, however, is under a superior court order to operate its Medicaid program in a constitutional manner by providing payment for them. That superior court order has been upheld by the Alaska Supreme Court, which specifically rejected an argument that the separation-of-powers doctrine precluded the superior court from ordering the state to pay. State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, 28 P.3d 904 (Alaska 2001). Thus, the DHSS is faced with a ruling from the state's highest court that the limit on payment for abortion services results in the operation of the Medicaid program in an unconstitutional manner, while DHSS is ostensibly without the money available to pay for services to operate the program legally. . . . Five years ago, the plaintiffs in the Planned Parenthood case asked the superior court to clarify how similar budget restrictions impacted its judgment. The superior court, three days after the supreme court affirmed the judgment, issued an opinion ordering the DHSS not to comply with the restrictions. To date, therefore, DHSS has obeyed the superior court's order and we must advise DHSS to continue to obey it; i.e., to continue to pay for these medically necessary abortions, until such time as a court reverses the order that is now in effect.

2007 Alas. AG LEXIS 21, 7 - 8.

According to DHSS, the money used for Medicaid abortions not covered by the Hyde Amendment (i.e., abortions for which the federal government will not contribute federal money), comes from the appropriation made by the legislature to DHSS for Medicaid.[3]

Other attempts to narrow the definition of "medical necessity" for purposes of abortion services funding have similarly failed. In 2002, for example, the Alaska Legislature passed and the governor vetoed a bill (SB 364, 22nd Legislature) that added a new section to AS 47.07 to provide that the state Medicaid program may only pay for medically necessary abortions and for abortions to terminate pregnancies resulting from rape or incest. The bill prescribed what is a medically necessary abortion and established requirements for submitting claims for payment for abortions. (See SB 364, attached). That bill provided as follows:

> (b) A claim for payment for a medically necessary abortion that is submitted to the department must be accompanied by a written certification by the treating physician that the abortion is medically necessary to treat a serious
>
> (1) adverse physical condition of a pregnant woman that
>
> (A) either is caused by the pregnancy or would be significantly aggravated by continuation of the pregnancy; and
>
> (B) would seriously endanger the physical health of the woman if the pregnancy were not terminated by an abortion; or
>
> (2) psychological illness of a pregnant woman who requires medication for treatment of the illness if
>
> (A) the medication required to treat the illness would be highly dangerous to the fetus; and
>
> (B) the health of the woman would be endangered if the mediation was not taken during pregnancy.

Since the bill was vetoed and the definition of "medical necessity" for purposes of abortion services funding contained in former 7 AAC 43.140(a) was held to be unconstitutional in 2001 and has recently been repealed but not reenacted, the state currently lacks a clear definition of the phrase as it applies to abortion services. The repealed regulatory definition provided that:

> (a) Payment for an abortion will, in the department's discretion, be covered under Medicaid if the physician services invoice is accompanied by certification that the (1) life of the mother would be endangered if the pregnancy were carried to term; or (2) pregnancy is the result of an act of rape or incest.

---

[3] If the physician submitting the Medicaid claim for costs associated with an abortion does not provide the information that would allow DHSS to document to the federal government that a particular abortion falls within the Hyde Amendment exceptions, then DHSS does not seek a federal match for the costs associated with that abortion.

What remains in the regulations for abortion services funding are the terms "elective" and "therapeutic" (a term that appears to be used as a substitute in the regulations for "medical necessity"), defined in 7 AAC 47.290, along with the general concept of "medically necessary" for all covered services under 7 AAC 105.100.

For general relief funding,[4] 7 AAC 47.290 provides as follows:

> . . .
> (7) "elective abortion" means a procedure, other than a therapeutic abortion, to terminate a pregnancy;
> (8) "therapeutic abortion" means the termination of a pregnancy;
> (A) certified by a physician as medically necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health; or
> (B) that resulted from actions that would constitute a crime of sexual assault under AS 11.41.410 - 11.41.425, a crime of sexual abuse of a minor under AS 11.41.434 - 11.41.440, or the crime of incest under AS 11.41.450.

For state funding under Medicaid, 7 AAC 105.100 describes "covered services" to include the general concept of "medically necessary" with cross-references to specified types of services as follows:

> The department will pay for a service only if that service
> (1) is identified as a covered service in accordance with AS 47.07, 7 AAC 43, and 7 AAC 105 - 7 AAC 160;
> (2) is provided to an individual who is eligible for Medicaid under 7 AAC 100 on the date of service;
> (3) is ordered or prescribed by a provider authorized to order or prescribe that service under applicable law;
> (4) is provided by a person who is enrolled as a Medicaid provider or rendering provider under 7 AAC 105.210, or otherwise eligible to receive payment for services under 7 AAC 43 and 7 AAC 105 - 7 AAC 160;
> *(5) is medically necessary as determined by criteria established under 7 AAC 43 and 7 AAC 105 - 7 AAC 160 or by the standards of practice applicable to the provider;*
> (6) has received prior authorization from the department, if prior authorization is required under 7 AAC 43 or 7 AAC 105 - 7 AAC 160; and

---

[4] Like the Medicaid program, the general relief program is designed to meet "medical needs." While some abortions are termed "elective" by some observers, they still meet a medical need, as determined by the physician who performs the abortion procedure. Distinguishing among types of abortions in the general relief program would infringe the same privacy and equal protection interests as courts have determined are infringed when abortion funding restrictions are imposed under the Medicaid program.

(7) is not specifically excluded as a noncovered service under 7 AAC 43 or 7 AAC 105 - 7 AAC 160.

(Emphasis added.) The phrase "medically necessary" is defined for purposes of mental health services and other purposes such as vision, hearing, and dental screening funding under Medicaid as follows:

7 AAC 43.486. Medical necessity determinations for mental health rehabilitation services

(a) The division will, in its discretion, periodically review the recipient's clinical record to determine whether the services requested are medically necessary. A medically necessary mental health rehabilitation service is a service designed to

(1) screen recipients for the presence of a mental or emotional disorder;

(2) assess the nature and extent of the mental or emotional disorder and its impact upon the recipient's ability to meet the demands of daily living, social, occupational, or educational functioning;

(3) diagnose the mental or emotional disorder;

(4) treat the mental or emotional disorder;

(5) provide rehabilitation for the mental or emotional disorder;

(6) prevent the relapse or deterioration of the recipient's condition due to the mental or emotional disorder.

(b) In making its determination as to whether the proposed services are medically necessary, the division will consider the following:

(1) the recommendations of the referring physician, mental health professional clinician, or interdisciplinary team organized under 7 AAC 43.470 that prescribed, ordered, recommended, or approved the service;

(2) the recipient's diagnosis and level of functioning;

(3) the risk of danger from the recipient to self or other individuals;

(4) the appropriateness of the level of care and the need for inpatient or residential care;

(5) whether the intervention targets specific symptoms and behavioral and social dysfunction, and logically derives from the assessments and diagnosis;

(6) whether the proposed services in the individualized treatment plan are consistent with generally accepted community-based treatments and practices for the treatment of the specific symptoms and behavioral and social dysfunction;

(7) whether the recipient agrees with the referring physician, mental health professional clinician, or interdisciplinary team under (1) of this subsection that the focus of the treatment will be the symptoms and behavioral and social dysfunction targeted for intervention;

(8) the extent to which past and current treatment has been successful in treating the symptoms and behavioral and social dysfunction;

(9) if the recipient is under 21 years of age, whether the recipient has, as indicated by the American Psychiatric Association's Diagnostic

and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, dated 2000, an Axis V Global Assessment of Functioning (GAF) rating at admission of 50 or less, or the recipient has an Axis V Global Assessment of Functioning (GAF) rating at admission of more than 50, but exhibits specific mental, behavioral, or emotional disorders that place the recipient at imminent risk for out-of-home supervision or protective custody of state or local authorities; the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, dated 2000, is adopted by reference;

(10) the extent to which a less restrictive or intrusive alternative treatment is not available;

(11) the extent to which a less expensive alternative is not available;

(12) the extent to which the units of service requested are no more than are necessary to meet the treatment or rehabilitation needs of the recipient;

(13) the extent to which the duration of services requested are no more than are necessary to reach the recipient-approved goals outlined in the individualized treatment plan;

(14) if the requested services are intended to prevent the relapse or deterioration of a mental disorder, the extent to which social functioning is improved through interventions provided as active treatment, targeted in specific therapeutic goals, and included in the individualized treatment plan;

(15) the likelihood that the recipient will benefit from any therapy provided on the same day as the recipient has received crisis intervention services.

(c) Payment for services determined not to be medically necessary under this section is subject to recovery under 7 AAC 105.260.

The limitation on abortion services funding is, as for other Medicaid covered services "medical necessity," a phrase that is not clearly defined in Alaska. The regulations that pertain to other types of covered services provide some guidance. Because the right to state funding for medically necessary abortions under the current state Medicaid program is protected by the Alaska constitution, the term "medically necessary abortion" has acquired a constitutional component of unknown scope. The relatively few Alaska cases involving abortion rights do not provide guidance as to how broadly the term "medically necessary abortion" is to be construed. There is a possibility that the Alaska courts may find that there are additional situations other than those described in the vetoed bill that fall within the scope of a medically necessary abortion and thus must be covered under the state Medicaid program.

What follows is a brief overview of how other states have handled the issue after the federal exception was rejected under those state's constitutional protections.

CASE LAW FROM STATES OTHER THAN ALASKA

Other states have dealt with the issue of state funding of abortion services in various ways. After the federal decisions of the 1970's that upheld restrictions on public abortion funding, courts in a number of states were required to analyze the issue under their own laws and constitutions to see if they supported the same conclusion. In contrast with the federal decisions, several state decisions determined that funding for abortions could not be singled out under public assistance programs. See Moe v. Sec'y of Admin. and Fin., 417 N.E.2d 387 (Mass. 1981); Comm. to Defend Reproductive Rights v. Myers, 625 P.2d 779 (Cal. 1981); Right to Choose v. Byrne, 450 A.2d 925 (N.J. 1982); Planned Parenthood Ass'n v. Dep't of Human Res., 663 P.2d 1247 (Or. App. 1983), affirmed at 687 P.2d 785 (Or. 1984); and Doe v. Maher, 515 A.2d 134 (Conn. Super. 1986); contra, Fischer v. Dep't of Pub. Welfare, 502 A.2d 114 (Pa. 1985).

Except for the Pennsylvania case, these state courts weighed the private and state interests involved with abortions and struck a different balance than the federal courts. They considered the state's desire to save money, state policies to promote childbirth, state claims that poor women can still choose to find private money to fund their abortions, state interests in protecting unborn life, and state arguments that they are not required to provide money for the exercise of constitutional rights. Most of these arguments had been successful in federal courts. Not so in the state courts of Massachusetts, California, New Jersey, Oregon, and Connecticut.

In Moe v. Secretary of Administration and Finance, supra, the highest state court in Massachusetts determined that the Massachusetts constitution afforded a greater degree of protection for the right to choose an abortion than the federal constitution.[5] In upholding the right of Medicaid recipients to have their abortions paid for, the court observed:

> [T]he Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weigh the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to "achieve with carrots what [it] is forbidden to achieve with sticks." (citation omitted). We are therefore in agreement with the views expressed by Justice Brennan, writing in dissent to Harris v. McRae, [when he wrote] "In every pregnancy, [either medical procedures for its termination, or medical procedures to bring the pregnancy to term are] medically necessary, and the poverty-stricken woman depends on the Medicaid Act to pay for the expenses associated with [those] procedure[s]. But under [this restriction], the Government will fund only those procedures incidental to childbirth. By thus injecting coercive financial incentives favoring childbirth into a decision that is constitutionally

[5] Moe, 417 N.E.2d at 400.

> guaranteed to be free from governmental intrusion, [this restriction] deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in Roe v. Wade."[6]

In Committee to Defend Reproductive Rights v. Myers, supra, the highest court in California made a determination similar to Massachusetts'. The court noted that the state had no constitutional obligation to provide medical care to the poor or to fund the exercise of all constitutional rights, but held:

> Once the state furnishes medical care to poor women in general, it cannot withdraw part of that care solely because a woman exercises her constitutional right to choose to have an abortion.[7]

In Right to Choose v. Byrne, supra, the highest court in New Jersey also came to a similar conclusion, using an equal protection analysis. The court struck down a restrictive abortion funding statute, stating:

> [T]he Legislature need not fund any of the costs of medically necessary procedures pertaining to pregnancy. . . . Once it undertakes to fund medically necessary care attendant upon pregnancy, however, government must proceed in a neutral manner. Given the high priority accorded in this State to the rights of privacy and health, it is not neutral to fund services medically necessary for childbirth while refusing to fund medically necessary abortions. . . . The statute affects the right of poor pregnant women to choose between alternative necessary medical services. No compelling state interest justifies that discrimination, and the statute denies equal protection to those exercising their constitutional right to choose a medically necessary abortion.[8]

In Planned Parenthood Ass'n v. Department of Human Resources, supra, the court struck down an Oregon Medicaid regulation that would have restricted funding of abortions, saying:

> [I]t is difficult to understand the rational basis for denying one medically necessary surgical procedure to a pregnant woman solely because it involves an abortion while, at the same time, funding all other medically necessary services relating to pregnancy.[9]

---

[6] Id. at 402.

[7] Myers, 625 P.2d at 798 and footnote 31 accompanying the text.

[8] Byrne, 450 A.2d at 935 - 936.

[9] Planned Parenthood, 663 P.2d at 1255.

In Doe v. Maher, supra, a Connecticut court struck down a state Medicaid regulation that prohibited funding for medically necessary abortions, saying:

> This court is unable to reconcile the mandate and logic of the United States Supreme Court in Roe v. Wade . . . with the McRae . . . decision. Medicaid reimbursement funds are made available for all the health care costs of women, including the medical costs necessary to carry the fetus to term, but not for the medically necessary abortion. Surely, this constitutes infringement on the right to an abortion. . . . In adopting the regulation, . . . the state has ceased to preserve its neutrality at least under our state constitution. . . . And since that one exception also is a subject of a woman's constitutional rights, the regulation impinges upon those constitutional rights to the same practical extent as if the state were to affirmatively rule that poor women were prohibited from obtaining an abortion.[10]

In each of the state cases quoted in this section, the state court struck down an abortion funding restriction that would have been upheld by a federal court. These cases clearly demonstrate that state courts can find independent state grounds to strike down an abortion restriction that might be upheld in federal court. Unfortunately, the cases do not provide a standard definition of "medical necessity" for purposes of all covered services.

CONCLUSION

The concept of "medical necessity" provides the baseline for Medicaid and other types of public funding of covered health care services. Under the federal law, the United States Supreme Court upheld an exemption for coverage of abortions services that was narrower than the standard for all other types of covered services. Many states, including Alaska, found an equal protection and liberty interest violation in drawing a distinction among various types of service coverage.

Current Alaska legislation and regulations defer to the treating physician to determine whether a service is medically necessary for the physician's patient under the applicable standard of practice for most covered services, including abortion services.

If I may be of further assistance, please advise.

JMM:ljw
10-418.ljw

Attachements

---

[10] Doe, 515 A.2d at 151 and 152.

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

Fact Sheet on Denali KidCare as it Relates to Abortion Funding

Thank you for your questions regarding the Denali KidCare program and how it relates to abortion funding in Alaska. Because the department has received numerous questions that are similar, but worded slightly differently, we have paraphrased the questions and compiled the responses in a Fact Sheet for consistency.

We hope this addresses the intent of the questions you posed. If not, please contact Wilda Laughlin at 465-1613.

- **How many more abortions do you project would be covered if income eligibility for Denali KidCare were increased from 175% to 200%?**

  - Past history in Medicaid services shows that approximately 10% of pregnant enrollees have sought abortion related services. Applying that number to the anticipated growth in enrollment of pregnant enrollees as a result of the expansion (218), we expect approximately 22 will seek these services.

- **How much federal money will the state lose over the next 10 years as a result of the Governor's intended veto of SB 13, assuming that funding levels remain stable?**

  - The fiscal note for SB13 estimates that the state would have spent $1,592,700 in federal funds in FY 2011. The fiscal note also assumes 8.6% growth in total costs per year. If we assume the federal percentage of spending remains the same (69.7%) and grows at 8.6% per year, then over 10 years (through 2020) this totals $23,740,650 in federal funds.

- **Is the program affected by an Alaska Supreme Court decision that says certain abortions must be paid for?**

  - Yes. The Alaska Supreme Court ruled in *DHSS v. Planned Parenthood*, 28 P.3d 904 (Alaska 2001) that the State must fund medically necessary abortions for pregnant women if it funds other medically necessary services for other financially needy persons.

- **How is "medically necessary" defined?**

  - "Medically necessary" as it applies to abortions paid for under Denali KidCare is not defined in statute or regulation, or by Court decision.

- **Is there anything unique to abortions that are paid for under DKC as opposed to regular Medicaid?**

  - No.

- **How much is Denali KidCare's annual budget?**

  - Spending in Calendar Year 2009:
    - Title XXI kids: $30,246,349
    - DKC Pregnant Women: $60,578,841
    - DKC Title XIX kids: $125,761,129
    - **Total DKC: $216,586,319**

- **How much money is spent on abortions?**
  - In Calendar Year 2009:
    - Of total DKC spending: $384,000 was spent on abortion-related services
    - Of total Medicaid Spending: $616,000 was spent on abortion-related services

- **How many additional women and children would have been eligible for Denali KidCare if the eligibility had been expanded from 175 percent to 200 percent of the federal poverty level?**

  - The fiscal note for SB13 estimates 218 pregnant women and 1,277 children would have been covered by the expansion of Denali KidCare.

- **What other services do children have access to under DKC?**

  - See Department website: http://www.hss.state.ak.us/dhcs/DenaliKidCare/gen_info_dkc.htm

ALASKA STATE LEGISLATURE

SESSION ADDRESS
Alaska State Capitol,
Room 30
Juneau, AK 99801
(907) 465-3822
Fax: (907) 465-3756

INTERIM ADDRESS
716 W. 4th Avenue,
Suite 400
Anchorage, AK 99501
(907) 269-0144
Fax: (907) 269-0148

Senator Bettye Davis

Press Release

For Immediate Release: March 22nd, 2011

Denali KidCare Bill Would Provide Health Care to Nearly 1300 Alaskan Kids

Senate Bill 5 sets income eligibility requirements at 200% of the Federal Poverty Level

JUNEAU-The Senate Health and Social Services committee is meeting this week to consider Senate Bill 5, which would increase and restore income eligibility levels for the Denali KidCare program to 200-percent of the Federal Poverty Level which was the level originally set 14-years ago.

Denali KidCare serves almost 8,000 Alaska children and remains one of the least costly medical assistance programs in the state. Senate Bill 5 would help place an additional 1300 kids and 225 pregnant women in the program.

The Kaiser Foundation estimates the 24,000 uninsured children with medical needs in Alaska are five times less likely to have a regular doctor as insured children and four times more likely to use emergency rooms at a much higher cost.

SUGGESTED QUOTE: "The numbers are heartbreaking," said Sen. Bettye Davis, the primary sponsor of Senate Bill 5. "Alaska is one of the wealthiest states in the nation. Yet, Alaska is one of only four states that fund children's insurance programs with eligibility levels set below 200-percent of the Federal Poverty Level."

The Legislature overwhelmingly passed a similar bill last year, but Governor Parnell vetoed it over concerns that increased eligibility for the program would require the state to pay for more medically necessary induced terminations of pregnancies. However, the Alaska Department of Health and Social Services estimated the additional funding for Denali KidCare would result in no more than 22 more induced terminations.

Who: Senate Health and Social Services Committee
What: Hearing to set Denali KidCare income eligibility levels at 200% of Federal Poverty Level
Where: Alaska State Capitol, Butrovich Room
When: Wednesday, March 23rd, 1:30p.m.

###

For more information, please contact Celeste Hodge in Senator Davis' Office at (907) 465-3822.

###

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/11

Date of 5-Day Notice: 3/24/11
(in accordance with Uniform Rule 23)

FURTHER: Finance

DATE TURNED IN TO OFFICE: 3/28/11

Health and Social Services Committee considered SENATE BILL NO. 5

SB 5-MEDICAL ASSISTANCE ELIGIBILITY

"An Act relating to eligibility requirements for medical assistance for certain children and pregnant women; and providing for an effective date."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS	✓			1
DHS	✓			2
DHS	✓			3

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Meyer				X
	ELLIS	X			
	[illegible]	X			
	Dyson		X		
CHAIR:	PAVIS	X			

SB5 - SUPPORT LETTERS FROM:

1. AARP
2. Alaska Association of Homes for Children, which includes: Alaska Baptist Family Services; Alaska Children's Svcs; Alaska Family Services; Covenant House of Alaska; Family Centered Services of Alaska; Juneau Youth Services; Kenai Peninsula Community Care; Maniilaq Association; Nome Children's Home; North Slope Borough Children's Services; North Star Behavioral Health; Presbyterian Hospitality House; Providence Behavioral Health Systems; Residential Youth Care; Searhc; The Boys and Girls Home of Alaska; The Salvation Army Booth Memorial; Youth Advocates of Sitka;
3. Alaska Chapter of the American Academy of Pediatrics
4. Alaska Primary Care Association
5. Alaska Women's Lobby
6. American Academy of Pediatrics
7. Anchorage Senior Citizen Advisory Committee, Dept. of H&SS, Municipality of Anchorage
8. Doris Robbins, Individual
9. Dr. Monica Gross
10. George Brown, Pediatric colleagues throughout Alaska
11. Juneau Youth Services
12. March of Dimes Foundation, Alaska Chapter
13. Mary Sweeney, Individual
14. Nicki Shelton, National and Alaska Trainer, Parents as Teachers
15. Planned Parenthood

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 4, 2011

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 5 (Davis)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we strongly encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 5, which you authored with your Committee colleagues Senators Egan and Ellis, Senators French, and Wielechowski and co-sponsored by Senator Thomas.

AARP is the world's largest organization of grandparents. Our 91,000 AARP members in Alaska are concerned about the health of their grandchildren as well as everyone else's grandkids.

Many of our members enjoy the security of health insurance from Medicare and understand how important good coverage is to their wellness and pocketbooks.

AARP stands in strong support of this effort to take Denali KidCare to a higher eligibility level and allow more children and pregnant women to secure health coverage.

Ensuring that children have affordable health care coverage is a priority for all of us who care about our children, grandchildren, and our country's future.

Denali KidCare is an essential building block in efforts to reform our health care system. AARP believes that every American should have access to high quality, affordable health coverage no matter where they live. We need to strengthen Denali KidCare now.

Thousands of children who would otherwise be uninsured are receiving needed health care because of this program. In fact, since Congress first authorized the states to begin the program, the percentage of uninsured children has fallen by a third over the past decade, while at the same time the number of uninsured adult Americans continued to grow.

Together, Denali KidCare and Medicaid have been an essential buffer as fewer

employers offer coverage that families can afford.

Covering children's health care needs is a cost-effective use of taxpayer dollars, given the substantial long-term benefits that relatively low-cost children's health care coverage can provide. After all, productive working years and healthy aging both require an early start.

The success of Denali KidCare is far from complete, however. Many children remain uninsured – many lost coverage because of changes to Denali KidCare when the income eligibility level was lowered and, because of the flat eligibility level, more children are dropped from the program every year.

We can no longer allow so many children and pregnant women to go without access to proper health care. Alaska has a duty to give all children the best possible start in life. Failure to address children's health needs unwisely raises the risk of increasing health care costs and developing future generations who will be less healthy as they age.

By working together to improve Denali KidCare through adequate funding, effective enrollment, and appropriate pediatric preventive care, we can strengthen the bonds between generations and build a healthier future for all of us of every age.

AARP recommends an "AYE" vote on SB 5.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Dennis Egan
Senator Johnny Ellis
Senator Kevin Meyer
Senator Fred Dyson

aahc
ALASKA ASSOCIATION OF
Homes for Children

Alaska Baptist Family Services
Anchorage, AK

Alaska Children's Services
Anchorage, AK

Alaska Family Services
Palmer, AK

Covenant House of Alaska
Anchorage, AK

Family Centered Services of Alaska
Fairbanks, AK

Juneau Youth Services
Juneau, AK

Kenai Peninsula Community Care Center
Kenai, AK

Maniilaq Association
Kotzebue, AK

Nome Children's Home
Nome, AK

North Slope Borough Children's Services
Barrow, AK

North Star Behavioral Health
Anchorage & Palmer, AK

Presbyterian Hospitality House
Fairbanks, AK

Providence Behavioral Health Systems
Anchorage, AK

Residential Youth Care
Ketchikan, AK

Searhc
Sitka, AK

The Boys and Girls Home of Alaska
Fairbanks, AK

The Salvation Army Booth Memorial Home
Anchorage, AK

Youth Advocates of Sitka
Sitka, AK

March 7, 2011

Senator Bettye Davis, Chair
Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

RE: Support for Senate Bill 5 from AAHC.

Dear Senator Davis:

Alaska Association of Homes for Children (AAHC) thanks you again for introducing legislation to raise the Medical Assistance Eligibility this session. Moving the guidelines for Denali KidCare eligibility from 175 to 200% of the Federal Poverty Level (FPL) is essential.

Our association supports the restoration of Denali KidCare eligibility to a minimum level of 200% of the FPL. We believe this is a sound fiscal policy as the federal government covers a large portion of the cost. In addition, children without health care get less preventative care, have much higher health risks and are four times more likely to use expensive emergency room care.

You've seen the statistics - Alaska is one of the last states with income eligibility standards less that 200% FPL. Alaska should be one of the leaders in ensuring our children's well-being, not one of the last states!

Raising the threshold for Denali KidCare is a wise investment in the health and wellbeing of Alaska's children. Thank you for your continued support of on this critical issue.

Thank you,

Brad Ohs
AAHC President

cc: Senator Dennis Egan
Senator Johnny Ellis
Senator Kevin Meyer
Senator Fred Dyson

Senate Bill 5 and Denali Kid Care Expansion

March 21, 2011

The Alaska Chapter of the American Academy of Pediatrics is in support of SB 5 and expansion of Denali Kid Care to 200% FPL.

Every child has medical needs that cannot be ignored. Denying coverage to a family in poverty does not change this fact. Alaska's huge size and minimally developed wilderness present a challenge in medically caring for its children. Denali KidCare (DKC) is the only means for many of these children to have access to local primary care, and when needed, the ability to reach specialty care in Anchorage. The federal government pays 64% of the cost of the State Children's Health Insurance Program (SCHIP/DKC) for non-Alaska Native children and 100% for Alaska Native children. Alaska has some of the most stringent eligibility requirements in the United States, 175% Federal Poverty Limit, placing us at 48th out of the 50 states in covering our poorest children. Senate Bill 13 was overwhelmingly passed with bipartisan support during the last legislative session. It expands DKC back to 200% of the Federal Poverty Line, its original level when instituted in 1998, and more in line with the rest of the United States. The cost of this expansion is estimated to add less than $1M to the annual State budget. Many legislators from both parties, including Governor Parnell, publically pledged support for this bill and claimed to recognize the importance of taking care of the basic health needs of our children. Suddenly, the Governor, who is a former finance committee chairman, reversed his support claiming he did not understand DKC funding and the potential for covering selective abortion services. The Alaska Department of Health and Social Services reports that 0.18% of DKC funding went to abortion related services last year. The service is permissible if deemed a medical necessity.

Prior to last year, expansion of children's healthcare was never once an abortion issue until Governor Parnell faced re-election and the republican primary. The Governor vetoed DKC expansion arguing that it was morally wrong to spend state funds on a medical plan with an abortion benefit. The Governor and his family are covered under the state workers plan called AlaskaCare (Wells Fargo Insurance Services). A call to the AlaskaCare benefits line reveals "abortion services are a covered benefit for employees and their dependents when deemed medically indicated." It appears the Governor is unconcerned with state funds paying for a healthcare plan with an abortion benefit, if the plan is for himself, his family, administration and staff. For Governor Parnell to claim that DKC expansion is an abortion bill simply does not ring true. Nearly every healthcare plan in the state has an allowance for some sort of abortion service, including the Governor's own. If the Governor truly believes that state funding should not be used towards a plan with abortion services, then he has the opportunity to take a stand with himself, his own family, his staff and administration. Not with the poor and vulnerable.

Alaska ranks at the bottom of the country in regards to domestic violence, rape and once again, children's healthcare coverage. This is not an abortion issue. It is an issue of social justice, of doing what is right. As a State, we cab do better.

M. David Bomalaski, MD, FAAP
Legislative Representative
Alaska Chapter of the American Academy of Pediatrics

Jody L. Butto, MD, FAAP
President
Alaska Chapter of the American Academy of Pediatrics

Sen. Bettye Davis

From: Shelley Hughes [ShelleyH@alaskapca.org]
Sent: Sunday, March 06, 2011 7:33 PM
To: Sen. Bettye Davis
Cc: Thomas Obermeyer; Celeste Hodge
Subject: SB 5 Support
Attachments: APCA Resolution Denali KidCare 2011-01.pdf

Dear Senator Davis:

Please find our resolution in support of the expansion of Denali KidCare attached to this message. We wanted to make sure you had it for the bill packets for SB 5 for Senate HSS!

Shelley

Shelley S. Hughes
Government Affairs Director
Alaska Primary Care Association
903 West Northern Lights Blvd Ste 200
Anchorage AK 99503
907.841.1634 mobile
907.929.2734 fax
shelleyv@alaskapca.org
Promoting primary care access for all Alaskans
****
www.alaskapca.org
Browse APCA's helpful advocacy information and resources.

ALASKA PRIMARY CARE ASSOCIATION

RESOLUTION 2011-01
Denali KidCare Expansion

WHEREAS the Alaska Primary Care Association (APCA) strives toward the goal of a statewide healthy population with its mission to promote primary care access for all Alaskans, and because health insurance coverage is a key component related to health care access; and

WHEREAS Community Health Centers (CHCs) and the Children's Health Insurance Program (CHIP), which is the Denali KidCare Program in Alaska, together provide access to health care for medically vulnerable populations;[1] and

WHEREAS 25,600 children 18 years and younger in 2009 were uninsured in Alaska,[2] and many children from low income families do not have appropriate health care access due to lack of coverage and the cost of premiums in relation to family budgets; and

WHEREAS the provision of health coverage to low income children in Alaska would help ensure access for these children and provider choice by the parents, as well as provide reimbursements to help cover the cost of care to private sector providers, including individual physicians, group practices, and CHCs; and

WHEREAS approximately 17,800 Alaskan children 18 years or younger living below 300% of the Federal Poverty Level (FPL) were uninsured in 2008,[3] and

WHEREAS even though the Denali KidCare upper income eligibility guideline was increased in 2007 to 175% of the FPL, the fact that 46% of Alaska's children live at or below 200% FPL as compared to 40.6% nationwide and 39% in HRSA Region X indicates that Alaska has more children in the 175% to 200% FPL range per capita than most other states; [4] and

WHEREAS Alaska has seen a 31% decline in the number of children covered by private health insurance in the past decade[5] and the cost of caring for uninsured children is passed on to other Alaskans and to businesses, raising premiums and out-of-pocket expenses for everyone;[6] and

WHEREAS uninsured children are 9 times less likely to have a regular doctor, 4 times more likely to be taken to emergency rooms, and 25% more likely to miss school than insured children;[7] and

WHEREAS increasing Denali KidCare income eligibility levels to a minimum of 200% above the FPL will increase health care access for children in families that meet this criteria and result in improved public health and overall health outcomes throughout the state for Alaskan children; and

WHEREAS increasing the income eligibility guidelines for Denali KidCare to 200% of Alaska's federal poverty level would make 1,300 more children and 225 more pregnant women eligible for health coverage under Denali KidCare; [8] and

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 fax: 907.929.2734 www.alaskapca.org

ALASKA
PRIMARY CARE ASSOCIATION

WHEREAS the Federal Medical Assistance Percentage (FMAP) in Alaska in FY 2010 is 66% for non-Natives,[9] and 100% for Alaskan Natives and American Indians treated in tribal facilities,[10] the cost to the state for insuring children through Denali KidCare is relatively low, with an estimated annual total premium in 2009 per child at $1700,[11] which includes the state's 34% portion, or an estimated $600, for full coverage, including dental;

THEREFORE BE IT RESOLVED that the Alaska Primary Care Association supports the increase of the Denali KidCare income eligibility levels to a minimum of 200% above the FPL.

DONE AND DATED THE 16th DAY OF September IN THE YEAR 2010

SIGNED BY

Sonia Handforth-Kome
Board President, Alaska Primary Care Association

[1] NACHC, http://www.nachc.com/advocacy/Files/SCHIP_Fact_Sheet.pdf.
[2] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).
[3] Ibid..
[4] Legislative Health Care Initiatives Presentation to the Anchorage Chamber of Commerce, August 27, 2007.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Sponsor Statement, Senate Bill 13, Senator Bettye Davis, http://aksenate.org/index.php?bill=SB13 accessed July 22, 2010.
[9] The Henry J Kaiser Foundation State Health Facts; http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=61&rgn=3 accessed July 22, 2010.
[10] Alaska Tribal Health System Sustainability Issues (PowerPoint), by Valerie Davidson, Alaska Native Tribal Health Consortium, February, 2009.
[11] Sponsor Statement, Senate Bill 13, Senator Bettye Davis, http://aksenate.org/index.php?bill=SB13 accessed July 22, 2010.

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 fax: 907.929.2734 www.alaskapca.org

ALASKA WOMEN'S LOBBY
AWL Mission: To defend and advance the rights and needs of Women, Children and Families in Alaska

P.O. Box 20891
Juneau, Alaska 99802-0891
www.akwomenslobby.org

2011 AWL Steering Committee Members

Caren Robinson
Lobbyist

Jorden Nigro
Chair

Jayne Andreen

Elizabeth Belknap

Nancy Courtney

Kathy Dietrich

Torie Foote

LaRae Jones

Rebecca Madison

Taber Rehbaum

Kari Robinson

Nancy Scheetz-Freymilier

Libby Silberling

Geran Tarr

Letter of Support-March 2011

SB 5: Medical Assistance Eligibility

The Alaska Women's Lobby, a statewide group with steering committees in Fairbanks, Anchorage and Juneau, whose mission is to defend and advance the rights and needs of women, children and families in Alaska, supports the expansion of eligibility for Denali Kid Care. When the State Child Health Insurance Program started in Alaska eligibility was set at 200% of the federal poverty line. The legislature reduced eligibility requirements in 2003, dropping children and pregnant women from the program and keeping others from being able to participate. It is past time to take the state back to where we were seven years ago and in fact we should join the 24 states that have set income eligibility above the 200% poverty level.

According to the 2010 Children's Health Insurance Program Reauthorization Act (CHIPRA) Annual Report **13 states implemented eligibility expansions in 2010 and many others simplified their enrollment and renewal procedures.** Forty-six states and the District of Columbia now cover children with incomes up to 200% of the Federal Poverty Level (FPL) in Medicaid and CHIP, with 24 of those states and the District of Columbia covering children with incomes up to 250 percent of the FPL. Twenty-two states now offer coverage to lawfully residing immigrant children and/or pregnant women, enabling states to receive federal funding for this coverage. (Fifteen states previously provided this coverage with state-only funds, so this option has resulted in new coverage for children and/or pregnant women in 7 states.)

Denali Kid Care extends a vital safety net for hard-working parents who either aren't offered insurance for their children through their jobs, or can't afford the coverage that is offered. It is a critical step in our state's journey to ensure that all Alaskans have access to stable, high quality health insurance coverage.

We extend our thanks to Senator Davis for her constant effort to provide health care for Alaskan children; reintroducing this critical piece of legislation in the 27th Legislature. Thanks also to early co-sponsors Senators Egan, Ellis, French, Wielechowski and Thomas. Everyone should feel good about signing on to this bill. Increasing the number of children eligible for Denali Kid Care is a wise investment in their lives and our future as a State.

Sen. Bettye Davis

Subject: FW: Letter of Support for SB 5

From: Muntean, Marta M. [mailto:MunteanMM@ci.anchorage.ak.us]
Sent: Thursday, March 24, 2011 11:14 AM
To: Sen. Bettye Davis
Subject: Letter of Support for SB 5

Senator Davis,

I am writing on behalf of the Municipality of Anchorage Senior Citizen Advisory Committee. The Committee would like to send a letter of support for your efforts and the efforts of your colleagues in regards to SB 5.

We have the letter read to be faxed today; the Committee would like to know if there any others that should be cc'ed and receive a copy of this letter.

Kind regards,

Marta Muntean

MSW Intern, Senior Services
Depart. of Health & Social Services
Municipality of Anchorage
907.343.7775

Sen. Bettye Davis

From: D. Robbins [drobbins.r@gmail.com]
Sent: Wednesday, March 23, 2011 12:11 PM
To: Sen. Bettye Davis; Sen. Dennis Egan; Sen. Johnny Ellis; Sen. Kevin Meyer; Sen. Fred Dyson
Subject: Support for SB 5 Restore Denali KidCare to 200% of Poverty Level

(S) H&SS
Chair: Senator Davis
Members:
Senator Egan
Senator Ellis
Senator Meyer
Senator Dyson

I fully support a return to the original income eligibility levels for the Denali KidCare program. Please return to the 200-percent of the Federal Poverty Level which was the level originally set 14-years ago.

The savings in prevention is worth twice the money paid for this! This assistance is needed more than ever these days with other options fading.

Please pass this legislation.

Sincerely,

Doris Robbins

1281 Overhill Dr.
Fairbanks AK 99709-6753
(907) 374-0597
drobbins@gci.net

--
Doris Robbins

(907) 374-0597
Fairbanks AK 99709-6753
drobbins.r@gmail.com

Natural Soaps Soothing to the Skin
www.alaskasoaps.com

Celeste Hodge

From: Sen. Bettye Davis
Sent: Monday, March 07, 2011 7:52 AM
To: Celeste Hodge
Subject: FW: Support for SB 5

From: Monica Gross [mailto:ameeaa@ak.net]
Sent: Sunday, March 06, 2011 6:04 PM
To: Sen. Bettye Davis
Subject: Support for SB 5

Testimony in Support of Senate Bill 5 to Senate Health and Social Services Committee

March 7, 2011

Dear Chairwoman Davis and Senators Egan, Ellis, Meyer and Dyson,

My name is Dr. Monica Gross. I am a board certified pediatrician who has practiced in Alaska since 1993. I support Senate Bill 5. This bill will strengthen Alaskan families and save healthcare dollars by increasing Denali Kid Care coverage.

When children have medical insurance the entire health care emphasis changes to one that strengthens the family and saves overall health care costs. Medical care is shifted from crisis-oriented care to well child and preventative care. This shift has ramifications not only for children's health, but also for family and community health.

When families don't have medical insurance kids are brought to the doctor or emergency room when they are very sick and parents are really scared. Doctors respond in crisis mode- expensive tests are ordered, drugs are prescribed and parents admonished for "waiting too long". The role of parents as the primary caregiver for their child is undermined.

When kids have medical insurance they are brought in for well child checkups and preventative care. The whole medical model shifts. Parents and doctors are a team working together to keep children healthy and prevent disease. Parents are empowered, and the important job they are doing is validated. Time is available to

answer questions and counsel about age appropriate health promotion and illness prevention. This exchange sets the stage for families where children can develop and grow and become productive and healthy members of their community. Expensive emergency room health care costs are avoided.

Please support Senate Bill 5.

Monica Gross, M.D.

Fellow, American Academy Pediatrics

524 Main Street

Juneau, Alaska

907-586-6789

Celeste Hodge

From: Sen. Bettye Davis
Sent: Wednesday, March 23, 2011 7:41 AM
To: Celeste Hodge
Subject: Fwd: Sen. Davis' E-mail

Sent from my iPhone

Begin forwarded message:

> **From:** George Brown <gwbrown1776@yahoo.com>
> **Date:** March 23, 2011 7:31:26 AM AKDT
> **To:** "Sen. Bettye Davis" <Senator_Bettye_Davis@legis.state.ak.us>
> **Cc:** Joy Lyon <jlyon@aeyc-sea.org>, "Jessie_Kiehl@legis.state.ak.us" <Jessie_Kiehl@legis.state.ak.us>
> **Subject: Fw: Sen. Davis' E-mail**
>
> Senator Davis:
>
> I will not be able to give direct testimony in favor of your new DKC bill. I speak with and for my pediatric colleagues throughout Alaska in support of providing more preventive and medical home based care for Alaska's children.
>
> When T. R. Reed spoke here in Juneau early this year, he stressed our real need is to achieve a national majority consensus that helath care is a basic right, as have all other modern democratic societies. It is, at hea a fairness and moral issue, and certianly fairness for health care for all children is essential for our human futures.
>
> Thank you for your persistent leadership. George
>
> --- On **Tue, 3/22/11, Jesse Kiehl <*Jesse_Kiehl@legis.state.ak.us*>** wrote:
>
> From: Jesse Kiehl <Jesse_Kiehl@legis.state.ak.us>
> Subject: Sen. Davis' E-mail
> To: "M. D. George Brown (Gwbrown1776@yahoo.com)" <Gwbrown1776@yahoo.com>
> Date: Tuesday, March 22, 2011, 9:50 PM
>
> Senator_bettye_davis@legis.state.ak.us

Juneau Youth Services, Inc.

907.789.7610
907.789.2106 Fax

P.O. Box 32839
Juneau, AK 99803

March 7, 2011

Senator Bettye Davis, Chair
Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

Re: Support for SB 5

Dear Senator Davis,

I am writing on behalf of both Juneau Youth Services and the Alaska Association of Homes for Children. Thank you for once again introducing legislation (SB 5) to raise the eligibility threshold for Denali KidCare from 175% to 200% of the Federal Poverty Level (FPL).

As you know, Alaska is one of the strictest states in the country when it comes to eligibility for Children's Medicaid (Denali KidCare). The estimate last year was that raising the eligibility criteria to 200% of the FPL would result in an additional 1,200 children and 200 pregnant women being covered under Denali KidCare. With a high rate of federal matching funds, this increase could take place with a minimal increment in state operating funds.

It is important to recognize that Denali KidCare is a major funding source for children's behavioral health and residential services in Alaska. Approximately 75% of the children and youth served by Juneau Youth Services access these services through Medicaid/Denali KidCare. Denali KidCare is also a major factor in ensuring that Alaska's children and youth receive services as close to their home communities as possible.

Raising the threshold for Denali KidCare is a wise investment in the health and wellbeing of Alaska's children. Thank you for your leadership on this critical issue.

Sincerely,

Walter Majoros

Walter Majoros
Executive Director

RECEIVED
MAR 14 ...

March of Dimes Foundation
Alaska Chapter
3209 Denali Street, Suite 200
Anchorage, AK 99503
Telephone (907) 276-4111
Fax (907) 276-3375

March 9, 2011

The Honorable Bettye Davis
State Capitol, Room 30
Juneau, AK 99801

RE: Support for Senate Bill 5 pending in the House Health and Social Services Committee

Dear Senator Davis:

I am writing to you to express the support of March of Dimes for **Senate Bill 5.** The mission of March of Dimes to improve maternal and child health by preventing birth defects, premature birth and infant mortality can best be achieved if all women of childbearing age, infants and children have access to comprehensive health coverage.

Senate Bill 5 reinstates Medicaid and Denali KidCare (DKC) for children and pregnant women in Alaska up to 200% of Federal Poverty Level (FPL). This was the original eligibility level when DKC was established in 1997. The eligibility threshold was reduced and frozen at 175% FPL by the Legislature in 2003. This bill will help reinstate eligibility to many of Alaska's 24,000 uninsured children as well as provide maternity coverage for several of Alaska's 34,000 women of childbearing age who have no health insurance.

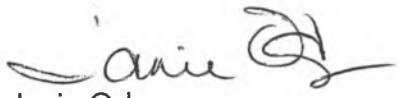
The Institute of Medicine has found that health coverage is the single most important factor in determining whether or not a child receives needed health services. Coverage also plays a key role in access to maternity care services for pregnant women.

Women who receive maternity care are more likely to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance use and poor nutrition. Such care may thus help improve the health of both mothers and infants. For example, singleton infants born to mothers who received late or no prenatal care in 2004 were nearly twice as likely to be low birth weight (less than 5 1/2 pounds) as infants born to mothers who received early prenatal care —9.9 percent compared with 5.9 percent.

In addition to pregnant women, health insurance status is the single most important influence in determining whether health care is accessible to children when they need it, according to another Institute of Medicine study. Though uninsured newborns are more likely than insured babies to be sick, they receive fewer hospital services.

Uninsured children are the most likely to have no usual source of medical care - 28.8 percent, compared with only 2.3 percent of privately insured youngsters and 4.6 percent of children in public insurance programs.
March of Dimes is a leading nonprofit organization for maternal, infant and child health. With chapters nationwide and its premier event, March for Babies, March of Dimes works to improve the health of women, infants and children. **I urge you bring Senate Bill 5 before the House Health and Social Services Committee for a vote and ensure passage of this important piece of legislation.**

Sincerely,



Janie Odgers
State Director

Celeste Hodge

From: Sen. Bettye Davis
Sent: Wednesday, March 23, 2011 10:44 AM
To: Celeste Hodge; Thomas Obermeyer
Subject: FW: SB5 Denali Kid Care

From: Mary Sweeney [mailto:marysweeney333@gmail.com]
Sent: Wednesday, March 23, 2011 10:35 AM
To: Sen. Bettye Davis
Subject: SB5 Denali Kid Care

Dear Senator Davis,

I am writing in strong support of SB5 expanding eligibility for Denali Kid Care. I am a preschool teacher. I like my job and I'm good at it but it doesn't provide health care benefits. I raised my two children here in Juneau. They have aged out of Denali Kid Care but it provided their health care as they were growing up. My oldest daughter has cystic fibrosis and there is no way I could have afforded to buy health care for her given her condition, even if I'd been able to afford it for my younger daughter which I could not. Denali Kid Care was essential for our family. Because the income guidelines to qualify are so low, I had to reject offers of more hours and other jobs that may have paid a little more but not enough to purchase health insurance.

Alexander Sadighi ,writing in the Alaska Law Review, Vol.27:1, cogently argues that it would be in the best financial interest of the state to pass this bill. More importantly, it is also in the best interest of children and families.

Sincerely,
Mary Sweeney
520 3rd. Street
Juneau, AK 99801

(907) 586-1792

Celeste Hodge

From: Sen. Bettye Davis
Sent: Tuesday, March 22, 2011 3:49 PM
To: Celeste Hodge
Subject: FW: Denali KidCare

From: Nicshelt9 [mailto:nicshelt9@aol.com]
Sent: Tuesday, March 22, 2011 2:53 PM
To: Sen. Bettye Davis
Subject: Denali KidCare

Dear Senator Davis,
Thank you for your actions to improve the health and development of Alaska's young children.

Denali KidCare is vital for many families to access health care for their children. I have been in education for 39 years; 16 years have been with Parents as Teachers. In Hoonah, we do screenings with young children. Since we don't have a doctor or hospital, many parents need to fly to Juneau for prenatal visits or to follow up with doctors' appointments.

The expense of flying, ground transportation, lodging, and meals are a huge obstacle which prevents many families from following up with needed care. Since children's brains develop faster in the first 3 years of life than at any other time of their lives, detecting and treating any condition which may interfere with learning is most crucial.

Denali KidCare is the vital link for families to access health care. 200% of the poverty level is not extravagant for families with young children. It can frequently make the difference between receiving medical care and children entering school with conditions which could have been resolved much earlier.

Thank you for your sponsorship of SB5, the Denali KidCare bill.

Sincerely,

Nicki Shelton, National and Alaska Trainer
Parents as Teachers
PO Box 101
Hoonah, AK 99829

(907) 945-3380

Planned Parenthood VOTES! ALASKA

March 7, 2011

Dear Senate Health and Social Services Committee Chair and Members:

Planned Parenthood Votes! Alaska, a member organization representing over 1800 Alaskans, supports the increase in Denali Kid Care eligibility to 200% of the Federal Poverty Level as outlined in SB 5.

1. Even in these hard economic times, a Denali Kid Care income eligibility increase is good policy for the health and economics of our state –

   An increase in Denali Kid Care eligibility to 200% of the federal poverty level reflects sound fiscal policy as research shows that preventive care, such as that received through Denali Kid Care, has a positive return on investment. For example, children and pregnant women without access to health care are four times more likely to use expensive emergency room care for medical treatment. Since the federal government covers almost 65% of the entire cost of Denali Kid Care the additional financial exposure associated with a return to 200% of federal poverty level is nominal compared to the long term expenses the State of Alaska will most likely incur if these vulnerable children and pregnant women continue to be denied access to health care.

2. Increasing Denali Kid Care to 200% of Alaska's federal poverty level simply brings it back up to its original level approved by the legislature in 1999
3. Alaska continues to be one of the few states that does not prioritize health care for low income children and pregnant women.

Denali Kid Care and Abortion Coverage

Abortion coverage through Denali Kid Care is less than .18% of the total budget for DKC.

Unintended pregnancy ending in abortion disproportionately affects low income women, because Alaska does not offer subsidized family planning services these rates continue to be high.

80% of private insurance plans cover abortion services as part of their regular coverage, providing coverage to low income women who qualify for Denali Kid Care is not an extreme position, and it is required under the 2001 Supreme Court Ruling.

Clover Simon, MSW
Director Planned Parenthood Votes! Alaska
4050 Lake Otis Pkwy STE 205
Anchorage AK 99508
907.770.9705

CS FOR SENATE BILL NO. 5(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, EGAN, ELLIS, FRENCH, AND WIELECHOWSKI, Thomas

A BILL

FOR AN ACT ENTITLED

"An Act relating to eligibility requirements for medical assistance for certain children; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical

assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is

not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)**;**

(16) persons under 13 years of age who are not covered under (a) of this section and whose household income does not exceed 200 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2).

*** Sec. 2.** AS 47.07.042(d) is amended to read:

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) **or (16)** and whose household income is between 150 and **200** [175] percent of the federal poverty line. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

27-LS0057\I
Mischel
2/23/12

CS FOR SENATE BILL NO. 5( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, EGAN, ELLIS, FRENCH, AND WIELECHOWSKI, Thomas

A BILL

FOR AN ACT ENTITLED

"An Act relating to eligibility requirements for medical assistance for certain children; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section who the department has determined cannot be placed for adoption without medical

assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is

not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed 175 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)**;**

(16) persons under 13 years of age who are not covered under (a) of this section and whose household income does not exceed 200 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2).

*** Sec. 2.** AS 47.07.042(d) is amended to read:

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) **or (16)** and whose household income is between 150 and **200** [175] percent of the federal poverty line. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 20, 2012

SUBJECT: Equal Protection Considerations (CSSB 5( ))
(Work Order No. 27-LS0057\I)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested an analysis of the equal protection considerations presented by the above referenced bill draft that accomplishes the purpose of SB 5, to expand medical assistance eligibility for children without a commensurate increase in services for teens and pregnant women funded under the medical assistance program. You understand that the equal protection clause of the Alaska Constitution has been interpreted to prohibit a preference in coverage for women who choose not to terminate a pregnancy over those who do. As you know, the federal and state Medicaid programs currently provide for mandatory minimum coverage based on age and income limits. For example, under 42 U.S.C. § 1396, a state must provide mandatory coverage for children under 6 years of age and pregnant women with incomes up to 133 percent of the federal poverty guideline. You now ask whether the expanded income eligibility in the bill that excludes persons 13 years of age and older is constitutional.

Equal Protection Considerations.

Article I, sec. 1 of the Alaska Constitution declares "that all persons are equal and entitled to equal rights, opportunities, and protection under the law." The law mandates equal treatment for those who are "similarly situated" and evaluates equal protection claims using a three-step sliding scale test that "places a progressively greater or lesser burden on the state, depending on the importance of the individual right affected by the disputed classification and the nature of the governmental interests at stake." *Malabed v. North Slope Borough*, 70 P.3d 416, 421 (Alaska 2003). The court determines the weight of the individual interest impaired by the classification, examines the importance of the purposes underlying the government's action, and evaluates the means employed to further those goals to determine the closeness of the means-to-end fit. *Id.* The greater the weight of the individual interest, the greater showing that must be made demonstrating that the classification achieves a legitimate governmental objective.

A more recent Alaska Supreme Court decision described the test for analyzing whether a law violates the constitutional right to equal protection as follows:

> Under the Alaska Constitution, the "legitimate reason test" is "the standard level of scrutiny . . . in equal protection cases," and we apply it to laws that do not employ classifications based on suspect factors or infringe on fundamental rights. Under this test, a law "will survive as long as a 'legitimate reason for the disparate treatment exists' and the law creating the classification 'bears a fair and substantial relationship to that reason.'"

Griswold v. City of Homer, 252 P.2d 1020 (Alaska 2011), 2011 Alas. LEXIS 43, 25-26 (Alaska June 10, 2011) (internal cites omitted).

A challenge of CSSB 5( ), draft version "I," based on the exclusion of teenage boys and girls for the expanded medical assistance coverage under equal protection principles would likely be analyzed using the least restrictive rational basis test, which requires the state to show a legitimate reason for the law, and that the law is sufficiently related to the reason. With respect to the proposed bill, the legislature must articulate a legitimate state objective in excluding teenagers from the expanded coverage. It is my understanding that the objective is to provide expanded coverage for the youngest, and arguably most vulnerable population, without providing for expanded abortion or other family planning services for fertile teenagers. By drawing a distinction based upon age and not gender or type of medical care, a challenger on equal protection grounds must first convince the court that all persons under age 19 are similarly situated and therefore all deserve expanded medical assistance coverage.

In *Valley Hosp. Ass'n v. Mat-Su Coalition for Choice*, 948 P.2d 963, 969 (Alaska 1997), the Alaska Supreme Court held that "reproductive rights are fundamental . . . [and] include the right to an abortion." In *Alaska Department of Health and Social Services v. Planned Parenthood*, 28 P.3d 904 (Alaska 2001), the Alaska Supreme Court, basing its decision on equal protection considerations rather than the privacy clause, concluded that if the state restricted abortion coverage for Medicaid-eligible women to only those covered by the exceptions in the Hyde Amendment (for life saving measures and for rape and incest), it would result in the unconstitutional implementation of Medicaid in Alaska.

Under a higher level of scrutiny for effect on a fundamental right, a court may view the age limitations as narrowly tailored to serve a compelling governmental interest in providing children's health coverage while discouraging teen pregnancy and abortion for the higher income limit recipient. By maintaining the status quo for all other income limit categories and by excluding all types of medical services, the type of discriminatory and burdensome past attempts to discourage abortions is avoided. However, the Alaska Supreme Court may find that the failure to cover medical services for people over the age of 13 whose household income is between 175 and 200 percent of the federal poverty guideline and the availability of those same services for children under 13 years of age results in unconstitutionally discriminatory treatment of teens who may be considered to

be similarly situated to younger children. Obviously, the lower the age limit the less likely reproductive rights would be affected.

A court may be less concerned about differential treatment in the context of expanded coverage than for existing minimum income eligible categories because of the choices states must make with limited resources. In providing the rationale for the differential coverage, the legislature could describe the economic and policy reasons behind its decision and that the amendment is narrowly or at least reasonably tailored to satisfy those concerns.

In this instance you have made clear that you wish to provide expanded eligibility for children but not to expand abortion or any other reproductive service for pregnant teens. I do not know how a court would come out on that issue but similar distinctions made for other types of services may be persuasive. For example, Alaska has elected to fund persons up to age 21 for specified services such as rehabilitative and psychiatric services, and others to age 19, under its Denali KidCare program for all covered services. Indeed, most of the mandatory categories under federal Medicaid law rely on age distinctions.

In *Beal v. Doe*, 432 U.S. 438 (1977), the United States Supreme Court held that while the Social Security Act (which includes Medicaid) does not require a participating state to fund every medical procedure falling within delineated categories of medical need and that it is not inconsistent with the Act's goals to refuse to fund unnecessary, though perhaps desirable, medical services, "serious questions" might be presented if state Medicaid plans did not cover necessary medical treatment. Prenatal care at any reproductive age may be found to be a necessary medical treatment.

The Alaska Supreme Court in the 2001 Planned Parenthood decision cited above was not persuaded by the state's economic interest argument for prohibiting Medicaid coverage of abortions. Noting that the savings on abortions were speculative, the court held that a government agency is constitutionally bound to apply neutral criteria in allocating health care benefits to poor Alaskans, even if considerations of expense, medical feasibility, or the necessity of particular services otherwise limit the health care it provides.

While age categories on its face appear to be neutral and common, some courts have found otherwise. For example, in *Samantha A v. Department of Social and Health Services*, 256 P.3d 1138 (Wash. 2011), the Washington State Supreme Court held that denial of Medicaid benefits solely based on the age of a child and whether the child was living with her parents was arbitrary and unenforceable. That case is not of precedential value here but provides some insight into how a court may analyze the issue of age for prenatal care or other types of services.

At the same time, Congress has excluded pregnant adults under 65 year of age from its own expansion of Medicaid under the Patient Protection and Affordable Care Act, effective in 2014, under 42 U.S.C. § 1396a(10)(i)(VIII), as follows:

> . . . beginning January 1, 2014, who are **under 65 years of age, not pregnant**, not entitled to, or enrolled for, benefits under part A of title XVIII [42 U.S.C.S. §§ 1395c et seq.], or enrolled for benefits under part B of title XVIII [42 U.S.C.S. §§ 1395j et seq.], and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5) [42 U.S.C.S. § 1397jj(c)(5)]) applicable to a family of the size involved, subject to subsection (k);

Summary.
I have been unable to find a case or advisory opinion of precedential value that is related to the issue of establishing a higher than minimum income limit for medical assistance services that excludes teens. The nature of the medical assistance program provides for the "categorically needy" in a way that often discriminates on the basis of the age of the recipient. A court may find that a teenager is not similarly situated to a younger child for medical assistance purposes. If a court finds them to be similarly situated, an equal protection challenge may be overcome by a legitimate state objective that is fairly and substantially related to the age distinction drawn in CSSB 5( ), version "I." If, however, a court found CSSB 5( ) affects the fundamental right of reproduction, the legislature must articulate a compelling governmental interest for the age limits and a court must find the law to be narrowly tailored to serve that purpose.

If I may be of further assistance, please advise.

JMM:ljw
12-216.ljw

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill No. 5 – Denali Kid Care

****

Explanation of Committee Substitute Version "I"

CSSB 5( ) 27-LS0057\I – Version "I"

- **Increases income eligibility coverage to 200% FPL only for children under age 13 who are not otherwise covered under subsection (a).**
- **Pregnant women are not included in the increase in income eligibility to 200% FPL. Eligibility for pregnant women and children ages 13-19 remains the same at 175% FPL.**
- **Premiums & cost sharing provisions are left in, increasing premium and cost sharing household income levels from between 150% FPL and 175% FPL to between 150% FPL and 200% FPL.**

968

27-LS0057\~~B~~I
Mischel
~~1/4/11~~

2/23/12

CS FOR SENATE BILL NO. 5( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - ~~FIRST~~SECOND SESSION

~~BY SENATORS DAVIS, EGAN, ELLIS, FRENCH, AND WIELECHOWSKI~~

~~Introduced~~BY

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, EGAN, ELLIS, FRENCH, AND WIELECHOWSKI, Thomas

A BILL

FOR AN ACT ENTITLED

"An Act relating to eligibility requirements for medical assistance for certain children ~~and pregnant women~~; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.07.020(b) is amended to read:

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance

under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under 21 years of age who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(8) persons under 21 years of age and not covered under (a) of this section[,], who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program[,] except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under 21 years of age not covered under (a) of this section

who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

(D) home and community-based services under a waiver approved by the federal government are either not available to them under this chapter or would be inappropriate for them;

(12) disabled persons, as described in 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under applicable federal regulations or guidelines, is less than 250 percent of the official poverty line applicable to a family of that size according to the United States Department of Health and Human Services, and who, but for earnings in excess of the limit established under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect to whom a supplemental security income is being paid under

42 U.S.C. 1381 - 1383c; a person eligible for assistance under this paragraph who is not eligible under another provision of this section shall pay a premium or other cost-sharing charges according to a sliding fee scale that is based on income as established by the department in regulations;

(13) persons under 19 years of age who are not covered under (a) of this section and whose household income does not exceed ~~200~~ [175] percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(14) pregnant women who are not covered under (a) of this section and whose household income does not exceed ~~200~~ [175] percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(15) persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)~~.~~**;**

(16) persons under 13 years of age who are not covered under (a) of this section and whose household income does not exceed 200 percent of the federal poverty line as defined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2).

*** Sec. 2.** AS 47.07.042(d) is amended to read:

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) **or (16)** and whose household income is between 150 and **200** [175] percent of the federal poverty line. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version: **SB005**
Fiscal Note Number:
Publish Date:

Identifier (file name): SB005-DHSS-PAFS-03-16-12
Title: Medical Assistance Eligibility
Sponsor: Sen. Davis, Sen. Egan
Requester: Senate Health and Social Services Committee

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Public Assistance Field Services
OMB Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services	207.9		207.9	207.9	207.9	207.9	207.9
Travel							
Services	21.3		21.3	21.3	21.3	21.3	21.3
Commodities	1.1		1.1	1.1	1.1	1.1	1.1
Capital Outlay	19.8						
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**250.1**	**0.0**	**230.3**	**230.3**	**230.3**	**230.3**	**230.3**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	162.6		149.7	149.7	149.7	149.7	149.7
1003	GF Match	87.5		80.6	80.6	80.6	80.6	80.6
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**250.1**	**0.0**	**230.3**	**230.3**	**230.3**	**230.3**	**230.3**

POSITIONS							
Full-time	**2.0**		**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Updated fiscal note to reflect current fiscal year. Updates administrative costs, including personnel and equipment.

Prepared by: Ron Kreher, Director — Phone: (907) 465-2680
Division: Public Assistance — Date/Time: 3/16/12 4:00 PM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date: 3/16/2012
DHSS Finance & Management Services

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB005
2012 LEGISLATIVE SESSION

Analysis

This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from 175%. It restores eligibility levels to the levels used when the Denali KidCare (DKC) program was originally created.

This fiscal note represents the additional administrative costs needed to support the increased eligibility determination workload resulting from more pregnant women and children applying for medical assistance, using the assumptions from the companion fiscal notes for the Division of Health Care Services and the Division of Behavioral Health.

The eligibility decision includes verifying information and determining whether a pregnant woman or child qualifies for DKC when they apply, acting on changes, and periodically re-examining a household's eligibility.

We assume that 218 pregnant women and 1,277 children will enroll in Medicaid if the qualifying income limit is revised to 200% FPG, and that implementation will begin July 1, 2012. We esitmate two additional Eligibility Technician II (Range 14) positions will be needed to manage this additional work in FY2013.

Total Administrative Costs for Two ET II Positions:

Personal Services: Two Eligibility Technician II (Range 14) at a cost of $207.9, including benefits, for 12 months.
Contractual: Annual cost for office space, phones, etc will be $21.3
Commodities: Annual cost for the office supplies will be $1.1

Additional Cost of FY2013:
Equipment/Supply: A one time cost of $19.8 for a desktop computer, software, printer, and work stations will be needed for the new positions.

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version **SB005**
Fiscal Note Number
Publish Date

Identifier (file name) SB005-DHSS-BHMS-03-16-12
Title Medical Assistance Eligibility
Sponsor Sen. Davis, Sen. Egan
Requester Senate Health and Social Services Committee

Dept. Affected Health and Social Services
Appropriation Medicaid Services
Allocation Behavioral Health Medicaid Services
OMB Component Number 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits	615.7		668.7	726.2	788.6	856.4	930.0
Miscellaneous							
TOTAL OPERATING	**615.7**	**0.0**	**668.7**	**726.2**	**788.6**	**856.4**	**930.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	416.5		452.3	491.2	533.4	579.3	628.7
1003	GF Match	199.2		216.4	235.0	255.2	277.1	301.3
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**615.7**	**0.0**	**668.7**	**726.2**	**788.6**	**856.4**	**930.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Updated fiscal note to reflect current fiscal year.

Prepared by Kimberli Poppe-Smart, deputy Commisioner — Phone 907-334-2530
Division Health Care Services — Date/Time 3/16/12 4:00 PM
Approved by Nancy Rolfzen, Assistant Commissioner — Date 3/16/2012
DHSS Finance and Management Services

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB005

Analysis

Denali KidCare is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually. In 2003, DKC eligibility limits were reduced from 200% of poverty to 175% and frozen at 2003 levels. In 2007, the income limits were unfrozen, but remained at 175% of poverty. This bill would restore Denali KidCare to its original level.

Children age 18 and under at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2013, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid. Pregnant women under this income level are eligible only for regular Medicaid (50% match). Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY2013 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2010. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Cost projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS or Title XXI during 2010 and our best estimates for federal medical assistance percentages (FMAPs) between 2013 and 2018. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2013 and 2018.

Expenditures for the Behavioral Health Medicaid Services component were determined based on the component's share of expenses for the affected eligibility subtypes in 2010. Behavioral Health paid 15% of the costs for affected DKC children in 2010. No charges for services for DKC pregnant women were paid by this component in 2010.

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version **SB005**
Fiscal Note Number
Publish Date

Identifier (file name) SB005-DHSS-HCMS-03-16-12
Title Medical Assistance Eligibility
Sponsor Sen. Davis, Sen. Egan
Requester Senate Health and Social Services Committee

Dept. Affected Health and Social Services
Appropriation Medicaid Services
Allocation Health Care Medicaid Services
OMB Component Number 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits	2,952.0		3,205.8	3,481.5	3,781.0	4,106.1	4,459.2
Miscellaneous							
TOTAL OPERATING	**2,952.0**	**0.0**	**3,205.8**	**3,481.5**	**3,781.0**	**4,106.1**	**4,459.2**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	2,061.1		2,238.3	2,430.8	2,639.9	2,866.9	3,072.4
1003	GF Match	890.9		967.5	1,050.7	1,141.1	1,239.2	1,386.8
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**2,952.0**	**0.0**	**3,205.8**	**3,481.5**	**3,781.0**	**4,106.1**	**4,459.2**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Updated fiscal note to reflect current fiscal year.

Prepared by Kimberli Poppe-Smart, Deputy Commissioner
Division Health Care Services
Approved by Nancy Rolfzen, Assistant Commissioner
DHSS Finance and Management Services

Phone 907-334-2520
Date/Time 3/16/12 4:00 PM
Date 3/16/2012

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB005

Analysis

Denali KidCare is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children and pregnant women under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually. In 2003, DKC eligibility limits were reduced from 200% of poverty to 175% and frozen at 2003 levels. In 2007, the income limits were unfrozen, but remained at 175% of poverty. This bill would restore Denali KidCare to its original level.

Children age 18 and under at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2013, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid. Pregnant women under this income level are eligible only for regular Medicaid (50% match).

Between 2003 and 2006, the number of enrolled children with household incomes between 151% and 200% FPG dropped by 2,553 and the number of enrolled pregnant women with incomes between 134% and 200% dropped by 436. This fiscal analysis assumes that the additional enrollment due to this bill will be equal to about half that number of people (estimated as 218 pregnant women and 1,277 children). The assumption is that most people affected by this bill will enroll by the end of SFY2013 and that enrollment will resume normal growth (about 2% per year) thereafter.

Further assumptions are that participation, i.e. the proportion of enrollees that obtain services during the year, will not change with implementation of this bill and will remain the same throughout the projection period. First year costs are based on an estimate for the number of new enrollees times the average cost per enrollee for the affected eligibility subtypes in 2010. Medicaid children in the income range addressed by this bill tend to have lower Medicaid costs than those from families with lower incomes, and those lower costs are reflected in our estimates.

Cost projections incorporate 8.6% annual growth (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XXI rates , Title XIX, or State General Fund only (for abortions) during 2010 and our best estimates for federal medical assistance percentages (FMAPs) between 2013 and 2018. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2013 and 2018.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2010. Health Care Services Medicaid paid 100% of the costs for DKC pregnant women and about 85% of the costs for affected DKC children in 2010.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **CSSB005(HSS)**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB005CS(HSS)-DHSS-PAFS-04-02-12
Title: Medical Assistance Eligibility
Sponsor: Senator Davis
Requester: Senate Rules Committee

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Public Assistance Field Services
OMB Component Number: 236

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services	93.5		93.5	93.5	93.5	93.5	93.5
Travel							
Services	9.7		9.7	9.7	9.7	9.7	9.7
Commodities	0.5		0.5	0.5	0.5	0.5	0.5
Capital Outlay	57.2						
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**160.9**	**0.0**	**103.7**	**103.7**	**103.7**	**103.7**	**103.7**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	104.6		67.4	67.4	67.4	67.4	67.4
1003	GF Match	56.3		36.3	36.3	36.3	36.3	36.3
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**160.9**	**0.0**	**103.7**	**103.7**	**103.7**	**103.7**	**103.7**

POSITIONS							
Full-time	**1**		1	1	1	1	1
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial legislation expanded DKC ocverage to 200% of federal poverty guidelines for a larger service population (i.e., pregnant women and children up to 19 years of age.)

Prepared by: Ron Kreher, Director — Phone (907) 465-2680
Division: Public Assistance — Date/Time 4/2/12 9:00 AM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date 4/2/2012
DHSS Finance & Management Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. CSSB005(HSS)

Analysis

This legislation increases the income level for Denali KidCare to 200% of federal poverty guidelines and limits the expanded coverage to children 12 years of age and younger. This fiscal note represents the additional adminstrative costs needed to support the increased eligibility determination workload resulting from more children qualifying for medical assistance. The eligiblity determination includes verifying information and determining whether a child qualifies for DKC when they apply, acting on changes, and periodically re-examining the child's eligibilty.

It is assumed that an additional 968 children will be enrolled in Medicaid if the qualifying income limit is revised to 200% and restricted to children 12 years of age and younger, and that implementation will begin July 1, 2012. It is estimated that 1 Eligibiity Technician II (R14) position is needed to manage this additional work in FY13.

Total Administrative Costs of One ET II Position
Personal Services: One Eligibility Technician II, Range 14 at a cost of $93.5, including benefits for 12 months.
Contractual: Annual costs for office space, phones, etc. will be $9.7
Commodities: Annual cost for office supplies will be $0.5

Additional costs for FY13
Equipment: A onetime cost of $7.2 for desktop computer, software, printer, and work stations is needed for the new position. An additional onetime cost of $50.0 is associated with the programming and testing of the Eligibility Information System for implementation of this bill.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **CSSB005(HSS)**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB005CS(HSS)-DHSS-BHMS-04-02-12
Title: Medical Assistance Eligibility
Sponsor: Senator Davis
Requester: Senate Rules Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits	171.0		185.7	201.7	219.1	237.9	258.4
Miscellaneous							
TOTAL OPERATING	**171.0**	**0.0**	**185.7**	**201.7**	**219.1**	**237.9**	**258.4**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	123.4		134.0	145.6	158.1	171.7	186.5
1003	GF Match	47.6		51.7	56.1	61.0	66.2	71.9
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**171.0**	**0.0**	**185.7**	**201.7**	**219.1**	**237.9**	**258.4**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial legislation expanded DKC coverage from 175% to 200% of the federal poverty guideline (FPG) for a larger service population, specifically for pregnant women and children up to 19 years of age. This version maintains coverage for pregnant women and children ages 13 to 19 years of age at 175% of the FPG, but expands DKC coverage to 200% of the FPG for persons 12 years of age and younger.

Prepared by: Kimberli Poppe-Smart — Phone: 907-269-7827
Division: Health Care Services — Date/Time: 4/2/12 12:00 PM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date: 4/2/2012
DHSS Finance & Management Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA **BILL NO.** CSSB005(HSS)
2012 LEGISLATIVE SESSION

Analysis

Denali KidCare (DKC) is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children ages 0-12 under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually.

Children at ages 12 years and younger at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2013, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid.

First-year costs are based on an estimate for the number of new enrollees (968) times the average cost per enrollee ages 0-12 for the most close related eligibility category in 2011.

Out-year cost projections incorporate an 8.6% annual growth factor (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XXI rates, Title XIX during 2011, and our best estimates for federal medical assistance percentages (FMAPs) between 2013 and 2018. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP), so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2013 and 2018.

Expenditures for the Behavioral Health Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2010. Behavioral Health Medicaid paid approximately 10.2% of the costs for the most closely related category of DKC children age 0-12 in 2011.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **CSSB005(HSS)**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB005CS(HSS)-DHSS-HCMS-04-02-12
Title: Medical Assistance Eligibility
Sponsor: Senator Davis
Requester: Senate Rules Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Serivces
OMB Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits	1,505.8		1,635.3	1,775.9	1,928.7	2,094.5	2,274.6
Miscellaneous							
TOTAL OPERATING	**1,505.8**	**0.0**	**1,635.3**	**1,775.9**	**1,928.7**	**2,094.5**	**2,274.6**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	1,086.7		1,180.2	1,281.7	1,391.9	1,511.6	1,641.6
1003	GF Match	419.1		455.1	494.2	536.8	582.9	633.0
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
	TOTAL	**1,505.8**	**0.0**	**1,635.3**	**1,775.9**	**1,928.7**	**2,094.5**	**2,274.6**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial legislation expanded DKC coverage from 175% to 200% of the federal poverty guideline (FPG) for a larger service population, specifically for pregnant women and children up to 19 years of age. This version maintains coverage for pregnant women and children ages 13 to 19 years of age at 175% of the FPG, but expands DKC coverage to 200% of the FPG for persons 12 years of age and younger.

Prepared by: Kimberli Poppe-Smart, Deputy Commissioner — Phone: 907-269-7827
Division: Health Care Services — Date/Time: 4/2/12 9:00 AM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date: 4/2/2012
DHSS Finance & Management Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. CSSB005(HSS)

Analysis

Denali KidCare (DKC) is part of Alaska's Medicaid program, covering low income children and pregnant women. This legislation increases the income level for covering children ages 0-12 under Denali KidCare to 200% of the federal poverty guidelines, up from the current level of 175% of the federal poverty guidelines, which are adjusted annually.

Children at the age of 12 years and younger at this income level are part of Alaska's Medicaid CHIP expansion and are eligible for enhanced federal matching funds. For FY2013, the federal CHIP match is projected at 65%, compared to an estimated 50% for regular Medicaid.

First-year costs are based on an estimate for the number of new enrollees (968) times the average cost per enrollee ages 0-12 for the most closely related eligibility category in 2011.

Out-year cost projections incorporate an 8.6% annual growth factor (Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025, DHSS, updated for 2006). That growth rate includes changes in population, enrollment, utilization, and medical-price inflation.

Fund source calculations are based on the relative proportion of costs for these eligibility types that were reimbursed at IHS, Title XXI rates,Title XIX rates during 2011, and our best estimates for federal medical assistance percentages (FMAPs) between 2013 and 2018. Children affected by this legislation are included in the State Children's Health Insurance Program (SCHIP) so most of their Medicaid costs would normally be matched at the enhanced rate for Title XXI services. Fund projections assume sufficient SCHIP allocation to fully fund the additional children between 2013 and 2018.

Expenditures for the Health Care Services Medicaid component were determined based on that component's share of expenses for the affected eligibility subtypes in 2010. Health Care Services Medicaid paid approximately 89.8% of the costs for the most closely related category of DKC children age 0-12 in 2011.

SB

8

<TARGET><BILL>SB 8</BILL><SUBJECT>SB 8</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT

DATE: 2/28/11

FURTHER:

DATE TURNED IN TO OFFICE: 3/17/11

Health and Social Services Committee considered SENATE BILL NO. 8

SB 8-STUDENT QUESTIONNAIRES AND SURVEYS

"An Act relating to questionnaires and surveys administered in the public schools."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
K. Meyer	Meyer			X	
	LEAR	X			
Fred Dyson	Dyson		X		
CHAIR: Bettye Davis	DAVIS	X			

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/11

FURTHER: Health and Social Services

Date of 5-Day Notice: 2/10/11
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/28/11

Education Committee considered SENATE BILL NO. 8

SB 8-STUDENT QUESTIONNAIRES AND SURVEYS

"An Act relating to questionnaires and surveys administered in the public schools."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS			✓	1

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	STEVENS			X	
	DAVIS	X			
	French	X			
CO-CHAIR:	Meyer			X	
CO-CHAIR:	Thomas	✓			

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 8 - "An Act relating to questionnaires and surveys administered in the public schools."

Sponsor Statement

The purpose of this bill is to increase participation in the national biennial Youth Risk Behavior Survey (YRBS) in order to meet the minimum 60% participation required by the Centers for Disease Control (CDC) for the survey to be validated for assessment, recording and reporting of reliable results. Alaska has periodically failed to meet minimum participation levels. This anonymous survey will next be administered in Alaska School Districts in Spring 2011 and 2013. This survey is enormously valuable to all aspects of society dealing with our youth. Failure to obtain usable information adversely affects education and funding of many services.

To help achieve this objective this bill will change the parental consent requirement for the YRBS from active to passive, that is, from written to implied consent if the parent does not object or deny permission in writing for the student to participate in the survey. To alleviate increased concerns about protecting the right to privacy the bill provides lengthy and detailed new notice requirements which will be sent to parents at least two weeks in advance of the survey. There will be ample time and opportunity for parents to review the survey with instructions on how to opt out. Students may also independently decline to participate or to answer specific questions in this completely voluntary and anonymous survey. Absolute privacy and anonymity are maintained by strict administrative procedures and return of surveys to CDC. Written permission is still required to be obtained from the student's parent or legal guardian for all other surveys, anonymous or not that inquire into personal or private family affairs of the student and not a matter of public record or subject to public observation.

Although research and experience suggest that the vast majority of parents would consent to their students participating in this survey, failure of parents to return written consent forms has been found more often to be the result of lack of interest or attention, rather than refusal. Consequently, results from whole schools periodically must be disregarded when not enough parental consent forms are returned.

Without facts and population-based information on youth risk behavior parents, students, educators, planners, and policy makers cannot understand and address the important health and social issues that affect students' happiness and success in the future. The Youth Risk Behavior Survey helps guide and evaluate important health and prevention programs in both the public and private sectors. Local, state and federal officials, schools, state and federal agencies, public and private grant programs and nonprofit health organizations rely on these surveys to educate, allocate resources, and compare trends concerning safety behaviors, injury prevention, tobacco prevention and control, obesity prevention, diabetes, heart disease and stroke, safe and drug free schools, substance abuse prevention, violence and suicide prevention, HIV, STD prevention, and connectedness to teachers, parents and other adults. SB 8 simply makes it easier to obtain information on youth risk behaviors, while increasing procedures to assure privacy, parental notice, and supervision.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 27, 2011

SUBJECT: Sectional Summary (SB 8; Work Order No. 27-LS0084\A)

TO: Senator Bettye Davis
Chair of the Senate Education Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds an exception for the Youth Risk Behavior Survey (YRBS) to the written permission requirement for student surveys.

Section 2. Provides detailed written notice requirements for all student surveys, including YRBS.

Section 3. Adds specific questions and process for a student and parent to refuse to participate in a student survey by submitting a written denial of permission.

Section 4. Provides an exception to written permission for YRBS and a minimum two week notice provision that is consistent with the requirements in sec. 2.

JMM:ljw
11-049.ljw

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB008**
() Publish Date:

Identifier (file name): SB008-DHSS-DPH-CDPHP
Title: Student Questionnaires and Surveys
Sponsor: Sen. Bettye Davis
Requester: Senate EDC Committee

Dept. Affected: Health and Social Services
Appropriation: Public Health
Allocation: Chronic Disease Prevention and Health Promotion
OMB Component Number: 2818

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Ward B. Hurlburt, MD, MPH - Chief Medical Officer/Director — Phone 269-6680
Division: Public Health — Date/Time 2/2/11 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/11/2011
Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB008
2011 LEGISLATIVE SESSION

Analysis:

This legislation removes the requirement that a student's parent or legal guardian must provide written permission before a student can participate in the Youth Risk Behavior Survey. It requires the school district to provide notice of the survey and give the parent or legal guardian the opportunity to deny permission.

There is no fiscal impact on the Department of Health and Social Services.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version **SB8**
() Publish Date

Identifier (file name) SB8-EED-TLS-2-4-2011
Title "An Act relating to questionnaires and surveys administered in public schools."
Sponsor Senator Davis
Requester Senate Education Committee

Dept. Affected Education & Early Development
Appropriation Teaching & Learning Support
Allocation Student & School Achievement
OMB Component Number 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost _____

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Prepared by Cynthia Curran, Director
Division Teaching & Learning Support
Approved by Michael Hanley
Commissioner

Phone 465-2857
Date/Time 2/4/11 12:00 AM
Date 2/4/2011

(Revised 1/27/2011 OMB)

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB8

Analysis

This legislation has no fiscal impact on the Department of Education and Early Development.

(c) Nothing in this section limits the ability of a peace officer, chief administrative officer, or other appropriate person, acting in compliance with local, state, or federal laws, to search a locker or other container provided in a public or private school by the school district. (§ 5 ch 33 SLA 1995)

Sec. 14.03.110. Questionnaires and surveys administered in public schools. (a) A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into personal or private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or legal guardian.

(b) For an anonymous questionnaire or survey, written permission required under (a) of this section may be obtained annually and is valid until the commencement of the subsequent school year or until the parent or legal guardian who gave permission submits a written withdrawal of permission to the school principal. The school shall provide each student's parent or legal guardian at least two weeks' notice before administering a questionnaire or survey described under this subsection.

(c) If a school administers to a student a questionnaire or survey that is not anonymous, the school shall obtain the written permission required under (a) of this section from the student's parent or legal guardian at least two weeks before the questionnaire or survey is administered.

(d) The school shall give a student's parent or guardian an opportunity to review the questionnaire or survey described under (b) or (c) of this section and shall give the parent or guardian written notice regarding

(1) how the questionnaire or survey will be administered to the student;

(2) how the results of the survey or questionnaire will be used; and

(3) who will have access to the questionnaire or survey.

(e) A student may refuse to participate in a questionnaire or survey administered in a public school. A student's parent or legal guardian may refuse to allow the student to participate in a specified questionnaire or survey.

(f) In this section, "questionnaire or survey" means a list of questions to, or information collected from, a class or group of students. (§ 1 ch 23 SLA 1979; am §§ 1, 2 ch 63 SLA 1999)

Opinions of attorney general. — AS 14.03.110 — As long as survey questions are limited to the student's own activities and the survey does not ask the student questions about parents or other activities occurring within a student's home, the 1997 Youth Behavior Risk Survey does not impermissibly invade the domain of the student's private *'family'* affairs. September 28, 1998 Op. Att'y Gen. (Issued before 1999 amendment to this section.)

Sec. 14.03.115. Access to school records by parent, foster parent, or guardian. Upon request of a parent, foster parent, or guardian of a child under 18 years of age who is currently or was previously enrolled in a municipal school district or a school district that is a regional educational attendance area, the school district shall provide a copy of the child's record. This section does not apply to

(1) a record of a child who is an emancipated minor; or

(2) record information that consists of the child's address if the school district determines that the release of the child's address poses a threat to the health or safety of the child. (§ 1 ch 36 SLA 1999)

Sec. 14.03.120. Education planning; reports. (a) A district shall annually file with the department, and make available to the public, a report that

(1) establishes district goals and priorities for improving education in the district;

(2) includes a plan for achieving district goals and priorities; and

Healthy Alaska

December 2009/January 2010

Inside This Issue:

Page 1
- 2009 Alaska Youth Risk Behavior Survey
- Traditional High School YRBS Key Findings

Page 2
- Traditional High School YRBS Key Findings Continued
- Alternative High School YRBS Key Findings

Page 3
- Alternative High School YRBS Key Findings Continued
- Healthy Reading Kits Available
- Readiness and Emergency Management for Schools Grant

Page 4
- National Drunk and Drugged Driving Prevention Month
- Youth Alliance for a Healthier Alaska Art

Brain Booster:

What phrase is hidden here?

Bid becomes biRd
Ran becomes raIn
Bug becomes buNg
Sin becomes siGn
Pan becomes paIn
Dug becomes duNg
Doe becomes doGe

2009 Alaska Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is part of a national surveillance system developed by the Centers for Disease Control (CDC). Administered every other year by the Department of Education & Early Development and the Department of Health and Social Services in conjunction with Alaska's public high schools, the YRBS is used to evaluate and address the prevalence of health risk behaviors among Alaska's youth that contribute to the leading causes of death and disease.

Due to the hard work of teachers and the high participation level of high school students, enough surveys were collected for the state to be able to draw conclusions about the level of youth risk behavior in Alaska.

Alaska 2009 results compared to 2007: In general the 2009 results were very similar to those of 2007, which is not surprising since changes are usually gradual.

Alaska trends over time: In general the prevalence of many risk behaviors have decreased over the last 14 years. The prevalence of smoking cigarettes, drinking alcohol, using marijuana, physical fightng , and contemplating suicide seem to be going down. The percent of students who have ever had sexual intercourse or reported having sexual intercourse in the past three months has stayed about the same. The percent of students reporting they did not go to school one or more days in the past month because they felt unsafe at school seems to be increasing.

Alaska compared to the US: The 2009 Alaska YRBS results are very similar to the national YRBS data from 2007 (which is the last available data — 2009 national survey results will be released this summer). Fewer students in Alaska reported being in a physical fight in the past 12 months compared to the national results (27.8 percent vs. 35.5 percent), but more students in Alaska reported being hit, slapped, or physically on purpose by their boyfriend or girlfriend in the past 12 months (13.3 percent vs. 9.9 percent). The percent of high school students attending daily PE is less than the national. Only 17.7 percent of high school students attend daily PE in Alaska compared to 30.3 percent of those in the national YRBS survey (2007).

Other Points:

Suicide is the leading cause of death of Alaska youth age 15-19

- 11.7% have made a plan about how they would attempt suicide and 8.5% actually attempted suicide one or more times in the past 12 months.

Motor vehicle crashes are the second leading cause of death among Alaska youth

- 21.3% report having driven in a car driven by someone who had been drinking and 8.9% reported driving a car when they had been drinking.

The obesity epidemic in Alaska and the nation contributes to the risk of heart disease, stroke, diabetes, and other chronic diseases. Health habits such as good nutrition and being physically active are the key to maintaining a health weight.

- 81.8% of high school students do not eat the recommended daily servings of fruits and vegetables.
- 57.6% did not get the recommended 60 minutes of physical activity per day for most days of the week.
- 82.3% did not attend daily PE classes.

Traditional High School YRBS Key Findings

The following key findings compare the 2009 traditional high school survey results to the 2007 results.

Weight Issues:

- 14.4% of students are overweight, compared to 16.2% in 2007.
- 11.8% of students are obese, compared to 11.1% in 2007.

Results continue on next page...

Brain Booster—Answer:

Ringing in the Changes!

Anchorage Association for the Education of Young Children (Anchorage AEYC) Conference

February 4-6, 2010
Downtown Hilton Anchorage Hotel
Anchorage, Alaska

For more information, contact 907-696-5884

Or visit: http://www.anchorageaeyc.org

Alaska Statewide Special Education Conference (ASSEC)

February 6-12, 2010
Downtown Sheraton
Anchorage, Alaska

For more information, contact 907-465-2972

Or visit: http://www.assec.org

Traditional High School Key Findings Continued...

Alcohol, Tobacco and Drug Usage:

- 15.7% of students smoked cigarettes one or more of the past 30 days, compared to 17.8% in 2007.
- 21.7% of students had five or more drinks of alcohol in a row on one or more of the past 30 days, compared to 25.8% in 2007.
- 22.7% of students used marijuana one or more times during the past 30 days, compared to 20.5% in 2007.
- 24.8% of students were offered, sold, or given an illegal drug by someone on school property during the past 12 months, compared to 25.1% in 2007.

Safety Behaviors:

- 12.1% of students never or rarely wear a seat belt when riding as a passenger, compared to 7% in 2007.
- 21.3% of students have rode one or more times within the past 30 days with a driver who had been drinking, compared to 23.5% in 2007.
- 8.9% of students drove drunk within the past 30 days, compared to 9.7% in 2007.

Violence and Suicide:

- 27.8% of students were involved in a physical fight one or more times during the past 12 months, compared to 29.2% in 2007.
- 13.3% of students reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months, compared to 12.4% in 2007.
- 13.9% of students seriously considered attempting suicide in the past 12 months, compared to 16.5% in 2007.

Sexual Behaviors:

- 43.5% of students have ever had sexual intercourse, compared to 45.1% in 2007.
- 30.4% of students had sexual intercourse with one or more people during the past three months, compared with 30.9% in 2007.
- 17.1% of students who had sexual intercourse during the past three months drank alcohol or used drugs before last sexual intercourse, compared to 22.1% in 2007.

Connectedness:

- 59.4% of students agree or strongly agree that their teachers really care about them and give them a lot of encouragement, compared to 56.1% in 2007.
- 83.3% of students feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life, compared 87% in 2007.

Alternative High School YRBS Key Findings

Alternative High Schools were selected to participate in a statewide YRBS for the first time in 2009. EED determined that capturing risk-behavior data on Alternative Schools was essential for 2 reasons: 1) Alternative Schools are intentionally excluded from the Traditional Schools YRBS and therefore no data on their levels of risk behavior was being captured 2) several of the programs the Department manages require it to dedicate resources to Alaska's greatest at-risk youth so data confirming Alternative Schools serve this population was needed.

The data to follow is quite compelling, and indicates significantly higher levels of reported risk behavior in Alternative Schools students than is reported by their Traditional Schools peers for almost every measure. The following data represent key findings from the Alternative High School YRBS only. To view a side-by-side comparison of the Traditional high school responses and the Alternative high school responses, visit: http://www.hss.state.ak.us/dph/chronic/school/pubs/COMPARISON_TRAD_ALT_2009.pdf

Weight Issues:

- 18.3% of students are overweight.
- 18.9% of students are obese.

Results continue on next page...

Fetal Alcohol Spectrum Disorder (FASD) Southeast Alaska Regional Conference

February 18-20, 2010
Centennial Hall
Juneau, Alaska

For more information, contact Donna James at 907-463-7169

Or visit: http://www.ccthita.org/2010fasdconference.html

Alternative High School YRBS Key Findings Continued...

Alcohol, Tobacco and Drug Usage:

- 58% of students smoked cigarettes one or more of the past 30 days.
- 42.7% of students had five or more drinks of alcohol in a row on one or more of the past 30 days.
- 50.5% of students used marijuana one or more times during the past 30 days.
- 32.4% of students were offered, sold, or given an illegal drug by someone on school property during the past 12 months.

Safety Behaviors:

- 13.6% of students never or rarely wear a seat belt when riding as a passenger.
- 29.9% of students have rode one or more times within the past 30 days with a driver who had been drinking.
- 12.3% of students drove drunk within the past 30 days.

Violence and Suicide:

- 9.1% of students were involved in a physical fight one or more times during the past 12 months.
- 21.3% of students reported being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months.
- 18.1% of students seriously considered attempting suicide in the past 12 months.

Sexual Behaviors:

- 82.2% of students have ever had sexual intercourse.
- 65.5% of students had sexual intercourse with one or more people during the past three months.
- 27.7% of students who had sexual intercourse during the past three months drank alcohol or used drugs before last sexual intercourse.

Connectedness:

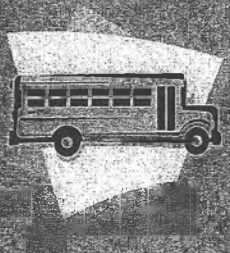
- 72.4% of students agree or strongly agree that their teachers really care about them and give them a lot of encouragement.
- 84.2% of students feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life.

Healthy Reading Kits Available

Healthy Reading is an initiative that seeks to promote K-12 health education sponsored by the Department of Education & Early Development (EED). Healthy Reading offers teachers the ability to teach about important health issues while simultaneously supporting reading practices.

Healthy Reading is comprised of a collection of age appropriate books that are selected and field tested by Alaskan teachers. Each kit contains 9 pieces of children's literature. These books cover an array of health issues that emerge naturally as children grow and develop and allow students to connect reading and writing skills to relevant life thinking skills. Ultimately, Healthy Reading is meant to empower and inform students about health issues, leaving them better able to obtain information, set goals, and develop skills that will promote their individual health.

Currently, the Department of Education & Early Development has three Healthy Reading kits available, Grades 2-4, Grades 4-8, and Grades 9-12. These kits are available to teachers, **FREE** of charge. For more information or to request a kit, please contact Kiara Alexander (907) 465-2304 or kiara.alexander@alaska.gov



Readiness and Emergency Management For Schools Grant (USDOE)

The US Department of Education recently announced the opening of the FY 2010 Readiness and Emergency Management for Schools Grant (REMS). Grants are available to local education agencies. For information regarding the REMS grant, view the USDOE REMS website at http://www.ed.gov/

Did You Know?

According to research by the NHTSA, teens are involved in 5 times as many fatal accidents as adults.

SUBSCRIBE

To subscribe directly to our newsletter, visit us at: www.eed.state.ak.us/tls/schoolhealth/subscribe.htm

FEEDBACK

We are looking for feedback! If there are any changes you would like to see made and/or suggestions for content of the newsletter, please send them to Meghan Nelson at meghan.nelson@alaska.gov

School Health Partners:

www.eed.state.ak.us/tls/schoolhealth/

www.hss.state.ak.us/dph/chronic/school/default.htm

National Drunk and Drugged Driving Prevention (3D) Month

Alcohol-related car crashes rise in frequency during the holiday season, making this season the deadliest season of the year. Due to the increase in events involving alcohol, more people are more likely to find themselves driving while impaired. Unlike other types of accidents, drunk and drugged driving is one of the most preventable tragedies on the road.

Because of this, December has been designated, by presidential proclamation, as the National Drunk and Drugged Driving Prevention Month (or 3D Month). 3D month strives to bring public awareness to and prevention of alcohol and drug related crashes by campaigning for tighter laws and for alcohol checkpoints and by educating youth and adults about the perils of driving under the influence.

In 2008, 45% of all vehicular fatalities in Alaska resulted from alcohol-related incidents. Of all the fatalities and major injuries that occur on Alaska's roads and highways, teen drivers account for approximately 20% of incidents, most caused either by not wearing a seatbelt or by driving under the influence.

Traffic accidents are the leading cause of death among the United States teenage population and, according to the National Highway Traffic Safety Administration (NHTSA), more than one-third are alcohol related. Furthermore, drunk driving often results in the injury or loss of life among passengers and individuals outside the vehicle.

A recent study by the Alaska Department of Transportation & Public Facilities found a link between minor consuming and future DUIs (Driving Under the Influence). This study compared 1995-1999 minor consuming cases in Alaska to 1995-2006 DUI cases and found that 24% of youth charged with minor consuming will go onto have a DUI charge before their 31st birthday (Evaluation of Risk Factors for Repeat DUI Offenses, Preliminary Draft Report, November 2008).

The State of Alaska has developed a plan to reduce and prevent underage drinking, based on the national strategy put forth by the National Research Council, the Institute of Medicine of the National Academics of Science, and Congress. This plan highlights the national strategies as well as strategies that state and local agencies can employ.

To view state's plan, visit: http://www.dot.state.ak.us/stwdplng/hwysafety/assets/pdf/2009_underagedrinkplan.pdf

Youth Alliance for a Healthier Alaska Art Contest

The Youth Alliance for a Healthier Alaska presents: *Make Art. Not Babies. An art contest to promote healthy teen relationships and sexual responsibility.*

Rules and Regulations:

Winning entries for each category will receive: $150 VISA gift card for first place, $50 VISA gift card for second place, $25 VISA gift card for third place

Categories: 1. Video/radio 2. photography/graphic art

There will be a total of 6 winning entries.

Guidelines:

-The competition will be open to teenagers 14 through 19 years of age.

-Participants may enter one entry per category. Participants can only win in one category.

-Entry deadline is **February 19, 2010**. Entries received after this date will not be evaluated.

-Email submission to Sophie Wenzel: Sophie.wenzel@alaska.gov OR Mail to: YAHA, 4701 Business Park Blvd, Suite 20, Bldg J, Anchorage, AK 99503

-By entering the contest the entrant is giving YAHA and the State of Alaska the right to: (1.) publicly display his or her artwork. (2.) The right to photograph or otherwise reproduce the artwork for the use in connection with promotional or advertising activities by YAHA.

-All artwork must be original. All photographs must have been taken by the contestant. All videos and radio announcements must have been produced by contestant

-All entries must be "PG-13"- entries that are not appropriate will not be considered.

Regulations:

Video: Must be 2 minutes or less, Must be on a decrypted disc

Audio: Must be 30 seconds or less, Must be in MP3, WIM, or MPEG4 format

Photograph/Graphic art: Must be no less than 4" x 6" and no bigger than 11"x 17" in JPEG or Adobe format, Must have caption/name on entry

Criteria to Judge: Must have reality, originality and creative pizzazz, and relevancy to the issue.

For questions, please write Sophie.wenzel@alaska.gov

DIVISION OF ADOLESCENT AND SCHOOL HEALTH (DASH)

Summary of Surveillance Activities

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC

Division of Adolescent and School Health

DASH

WHERE CAN I GET MORE INFORMATION?
VISIT WWW.CDC.GOV/HEALTHYYOUTH
OR CALL 800-CDC-INFO (800-232-4636).

CS121301

Summary of Surveillance* Activities

Division of Adolescent and School Health

	Youth Risk Behavior Surveillance System (YRBSS)			School Health Policies and Programs Study (SHPPS)	
	National	State/Territorial/ Tribal/District	Other		
Purpose	■ To determine the prevalence of health-risk behaviors among students ■ To assess trends in these behaviors ■ To examine the co-occurrence of health-risk behaviors			To provide national data on eight components of a school health program at the state, school district, school, and classroom levels	To provide data on school health policies and practices at schools among states, territories, tribal governments, and large urban school districts
Content	■ Unintentional injuries and violence ■ Tobacco use ■ Alcohol and other drug use ■ Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection ■ Unhealthy dietary behaviors ■ Physical inactivity			■ Health education ■ Physical education and activity ■ Health services ■ Mental health and social services ■ Nutrition services ■ Healthy and safe school environment ■ Faculty and staff health promotion ■ Family and community involvement	■ School health education requirements and content ■ Physical education requirements ■ Health services ■ Nutrition-related policies and practices ■ Family and community involvement in school health programs ■ School health policies on HIV and AIDS prevention, tobacco-use prevention, and physical activity ■ Professional preparation and staff development for lead health education teachers
Sample	Nationally representative sample of public and private high school students	Representative sample of public high school students in each jurisdiction	Representative sample of students in: ■ Middle schools ■ Alternative schools ■ Juvenile justice facilities	■ All states ■ Nationally representative sample of school districts ■ Nationally representative sample of public and private elementary schools, middle schools and high schools	Representative sample of public middle schools and high schools in a state, territory, tribal government, or school district
Methods	Self-administered paper-and-pencil questionnaire, conducted in classrooms			Computer-assisted telephone and personal interviews and self-adminstered, mailed questionnaires	Self-administered, mailed questionnaires
Timing	Biennially, since 1991		Varied	Every 6 years, since 1994	Biennially, since 1994
Example Statements	In 2007, 57.3% of Hispanic female high school students in the U.S. attended physical education classes on 1 or more days in an average week when they were in school.	In 2007, 24.4% of female high school students in Kentucky attended physical education classes on 1 or more days in an average week when they were in school.	In 2007, 87.4% of middle school students in Wyoming attended physical education classes on 1 or more days in an average week when they were in school.	**State:** In 2006, 70.5% of states required districts or schools to follow national or state physical education standards or guidelines. **District:** In 2006, 68.9% of districts had someone oversee or coordinate physical education. **School:** In 2006, 78.3% of schools required students to take some physical education.	In 2006, 60.1% of secondary schools in Alabama required students to take 2 or more physical education courses.
Ownership of Data	CDC	States, territories, tribal governments, and districts	Varied	CDC	States, territories, tribal governments, and districts
Contractor	ORC Macro	Westat, Inc., plus companies hired by states, territories, tribal governments, and districts	Varied	ORC Macro	Westat, Inc., plus companies hired by states, territories, tribal governments, and districts
Web Site		www.cdc.gov/yrbs		www.cdc.gov/shpps	www.cdc.gov/healthyyouth/profiles

*Surveillance is the ongoing collection, analysis, and interpretation of data from generalizable samples.

Alaska 2009 Youth Risk Behavior Survey (YRBS) Results

These risk behaviors among high school students[1] ...

Unintentional Injuries and Violence

12% Rarely or never wore a seat belt
21% Rode with a driver who had been drinking alcohol, during the past month
20% Carried a weapon during the past month
28% Were in a physical fight during the past year
9% Attempted suicide during the past year

Alcohol and Other Drug Use

33% Drank alcohol during the past month
22% Reported episodic heavy drinking during the past month[2]
23% Used marijuana during the past month
7% Ever used cocaine
10% Ever used inhalants
21% Ever used prescription drugs without prescription

Sexual Behaviors

44% Ever had sexual intercourse
11% Had sexual intercourse with ≥ 4 people
30% Had sexual intercourse during the past three months
% Did not use a condom during last sexual intercourse[3]

Tobacco Use

48% Ever tried cigarette smoking
16% Smoked cigarettes during the past month
5% Smoked cigarettes on ≥ 20 days during the past month
14% Used smokeless tobacco during the past month
10% Smoked cigars during the past month

Dietary Behaviors

83% Ate fruits and vegetables < 5 times/day during the past 7 days
20% Drank soda or pop one or more times a day during the past 7 days (not including diet soda or pop)

Physical Activity

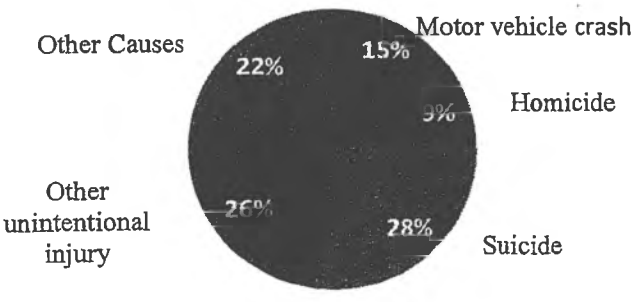
58% Did not meet currently recommended levels of physical activity[4]
54% Did not attend physical education class
82% Did not attend physical education class daily

Overweight

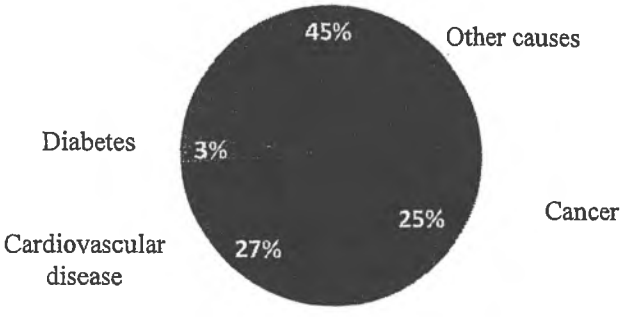
14% Were overweight[5]
12% Were obese[6]

... contribute to these leading causes of death[7]

Youth Aged 10-24 Years



Adults Aged 25 Years and Older



[1] High school students grades 9-12 in Alaska excluding alternative schools and boarding schools, weighted data.

[2] Students who had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the past 30 days

[3] Among students who had sexual intercourse during the past 3 months.

[4] Students who were not physically active for a total of at least 60 minutes per day on 5 or more days of the past 7 days.

[5] Students who were at or above the 85th percentile but below the 95th percentile for body mass index by age and sex.

[6] Students who were at or above the 95th percentile for body mass index by age and sex.

[7] 2004-2006 Alaska mortality data, Centers for Disease Control and Prevention.

For more information visit www.hss.state.ak.us/dph/chronic
Or call 1-888-465-3140

The Alaska Youth Risk Behavior Survey is a joint project between the Department of Health and Social Services and the Department of Education & Early Development in cooperation with the Centers for Disease Control and Prevention

Main Office
130 Seward St #209
Juneau, Alaska 99801
Phone: (907) 586-3650
Fax: (907) 463-4493
www.andvsa.org

ANDVSA
Alaska Network on Domestic Violence & Sexual Assault

Pro Bono Office
PO Box 6631
Sitka, Alaska 99835
Phone: (907) 747-7545
Fax: (907)747-7547

February 4, 2011

Senator Bettye Davis
State Capitol, Room 30
Juneau, AK 99801

Re: Letter of Support for SB 8

Dear Senator Davis:

Thank you for introducing SB 8: *An Act Relating to Questionnaires and Surveys Administered in the Public Schools*. The Alaska Network on Domestic Violence & Sexual Assault is committed to prevention efforts and serving victims of violence. This bill can help. SB 8 will provide a valuable tool in our efforts to understand the prevalence and shared risks of youth experiencing violence, while retaining a family's rights to remove their child from participating in the survey and allow a key segment of the student population, often the most vulnerable students, to participate in the survey.

The Centers for Disease Control and Prevention (CDC) Youth Risk Behavioral Survey (YRBS) is used nationally, and within Alaska, to determine risk behaviors among the Alaska high school student population. CDC developed YRBS data is a credible data source that can be compared to national data. This survey covers a broad range of risk behaviors and streamlines information gathering and administering surveys in the schools. However, currently with our opt-in YRBS policies, many communities, and sometimes our state, have struggled to have enough responses to consider the data valid.

This information and data is essential to help educators, health workers, social service agencies, victim service programs, and other allied professionals to better serve our communities. This data helps teachers working on prevention education to determine the best age to teach various skills and health topics in their classrooms. This data also helps organizations seeking resources to advocate for real needs in their communities as well as assisting health practitioners and others to determine how to best approach students with co-occurring risk behaviors.

Within the field of domestic and sexual violence prevention, current YRBS data indicates that in traditional high schools, more than 17% of 12th grade students have experience physical violence in a dating relationship and more than 11.5% have been forced to have sexual intercourse. We also know that in alternative schools, these numbers are 22.6% and 21.9%. While these numbers are staggering, they are incomplete, due to the current opt-out YRBS policies, with many of the most vulnerable students failing to return permission forms.

This bill is also very timely and in line with Governor Parnell's initiative to end domestic and sexual violence in our state in the next 10 years. One of the key strategies to ending the violence is by focusing on primary prevention efforts that employs various strategies to stop perpetration of violence, *before it ever occurs*. To achieve this, the Governor has brought together a multi-disciplinary group of allied professionals from communities throughout Alaska to look at the current gaps in the data needed to reach our primary prevention goals. SB 8 will help to fill ones of those gaps.

Thank you for bringing forth a bill that will provide a low cost way to better understand the scope of teen dating and sexual violence in Alaska and will assist in strengthening our violence prevention efforts.

Sincerely,

Peggy Brown
Executive Director

cc: Lisa Mariotti, Policy Director
Lori Grassgreen, Director of Prevention Projects

February 24, 2011

Senator Bettye Davis
Alaska Senate Education Committee
Alaska State Senate
State Capitol Room 30
Juneau, Alaska 99801

Dear Senator Davis and Members of the Senate Education Committee:

The Leadership Team of Anchorage United for Youth requests your support for Senate Bill 8, "*An Act relating to questionnaires and surveys administered in the public schools.*"

Anchorage United for Youth has been making real headway at addressing the issues that impact Anchorage youth through a coordinated community effort with over 40 non-profit, public and private partners committed to increasing graduation rates, decreasing youth substance use and reducing juvenile crime rates. Current success with the Anchorage United for Youth plan and its implementation has led to interest from around the state in replicating this effort. Reliable and valid data like that obtained through the Youth Risk Behavior Survey (YRBS) is integral to the success and sustainability of this effort.

Reliable and statistically valid community data is critical to our mission of supporting Anchorage youth. Routine standardized surveys such as the YRBS allow us to track trends over time and help guide and evaluate the important youth programs we implement to keep our youth on track to graduate from high school, avoid delinquency and reject substance use. The YRBS must have a response rate of 60% to make it statistically valid, yet current legislation requires active parental consent which presents significant obstacles and costs to achieving this response rate. Approximately $90,000 is spent for just one survey cycle in order to provide the incentives necessary to simply get permission slips returned. However, failure to return permission slips is primarily linked to apathy, oversight, and student error, not parental refusal of permission, which averages around 10%.

Senate Bill 8 protects previously legislated parental rights to consent, parental rights to notification, and children's rights to refuse participation. We support Senate Bill 8 because it continues to provide these protections and respects the privacy of families, while removing the obstacles to obtaining this vital data that allows us to track and improve conditions for our youth.

We thank you for your commitment to youth in the state of Alaska and ask for your support of Senate Bill 8.

Sincerely,

Greg Razo, Cook Inlet Region, Inc.
Chair, Anchorage United for Youth Leadership Team

Anchorage United for Youth Leadership Team

Contact: Sarah Sledge ssledge@ak.org (907) 263-3803

From: Becky Judd [mailto:bjudd-h@ak.net]
Sent: Thursday, February 24, 2011 11:03 PM
To: Sen. Kevin Meyer
Subject: Support for SB 8

Dear Senator Meyer,

I am writing **in support of SB 8,** an act related to surveys and questionnaires in public sc
believe there will be public testimony on Friday 2/24 at 8am. Please accept this email as public tes

I have worked in the prevention of teen pregnancy, substance use, tobacco and suicide with school
communities statewide for over 20 years. Local schools and agencies need the YRBS data to: 1) e
for services in their community; 2) determine the effectiveness of their efforts in preventing the be
measured. Many state and national grants require this data to get funding.

The active consent law puts an undue burden on the schools to obtain positive parent permissions.
becoming increasingly cumbersome and expensive. In the past, I volunteered assistance to a distric
conducting follow-up calls and letters to parents who forgot to send back the permission slips. My
talking to hundreds of parents, only a few objected to their children's participation in the anonymo

Parents opposed to participation, are already actively involved in their children's lives. Th
when the surveys are taking place and are very proactive in voicing their objections in pa
the active consent is not needed for them. The growing burden on the schools to obtain these
taking time away from instruction. Yet, we need this data, to determine the success of our effort

Please support SB8.

Sincerely,

Becky Judd

6401 Italy Circle

Anchorage, AK 99516

907 345-3619

From: Jeans, Eddy (EED) [mailto:eddy.jeans@alaska.gov]
Sent: Wednesday, March 11, 2009 11:49 AM
To: Thomas Obermeyer
Cc: Herman, Marcy J (EED)
Subject: FW: SB 101

Prior Bill - Same Issues

Here are the responses to the questions at the hearing.

Statistics on parental consent for YRBS:

Data from the statewide survey from the last time the YRBS was administered (2007) showed that (after intense efforts to collect forms), in general 69-70% of parents provided written permission, 10-11% of parents declined permission, the remaining 20% of parents did not respond. (It is the non-responders that affect the survey the most). These rates vary by school and district – contact individual school districts for more information on their local YRBS survey experience.

How is the student identity protected?

The YRBS survey is an anonymous and voluntary survey. The survey has been designed to protect each student's privacy. Students do not put their name or any other identifier, or the name of their class or school on the survey. The teacher or proctor is given special instructions and a script to follow and are also required to sign an *Assurance of Confidentiality Form* which is returned to the Department of Health and Social Services. When students finish the survey, they place their answer sheet in a privacy envelope and seal it shut. The envelopes are then placed in a big box or envelope for returning to the state.

Just another FYI:

The Protection of Pupil Rights Amendment only applies to "required" surveys. (See CDC Parental Permission and the YRBS, 2006)

Let me know if you need any more information.

Patty Owen
School Health/YRBS Coordinator

Response to questions during HHSS hearing 2/11/10 on SB 101 – Questionnaires and Surveys in Public Schools.

1. **Copy of 1995 YRBS Survey** (See attached)

2. **Cost to School Districts to reach the minimum of 60% validity threshold for representative data.**

There is no direct cost to school districts to reach the validity threshold, other than contribution of staff time and often copying and postage. School districts receive incentive funding, depending on their size, between $800 and $30,000 per district. The total state expenditure in 2009 was approximately $90,000 (which included the special Alternative School Survey). In addition, some districts receive supplemental money from their community coalitions. The $90,000 was made up of a combination of federal funding from the YRBS grant and a special contribution of $20,000 from the Division of Behavioral Health and $50,000 as a one-time contribution from the Alaska Mental Health Trust.

3. **Impact on grants of failure to meet the minimum of 60% statistical validity.**

We do not have evidence of loss of federal funding for inadequate response rate to YRBS. What we can provide is examples of the program and grant dollar amounts used at the state level that rely on YRBS data.

- DHSS/Division of Public Health/CDC Tobacco Program funding : approximately $1.6 million per year
- Dept. of Education& Early Development (DEED)/CDC HIV Prevention funding: $275,000 per year
- DEED/Federal funding: Up until recently, the Title IV Safe and Drug-Free Schools and Community Program funds (formerly $1.7 million) relied on YRBS – however, this program has been eliminated. It is anticipated that it will be replaced with a new program (focusing on Positive School Climate) which will likely be competitive and it would be difficult to compete with other states without YRBS data with the majority of states that do have YRBS data.
- DHSS/Division of Behavioral Health Programs/Federal Funding:
    - Federal Substance Abuse Prevention and Treatment Block Grant ($4.8 million approx. per year) has required national outcome measures using YRBS
    - Alaska Youth Suicide Prevention Project, US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). $500,000 per year x 3 years (1.5 million)
    - SAMHSA's Strategic Prevention Framework State Incentive Grant, five-year, $11.5 million grant
- Comprehensive Mental Health Plan: $106,000 from the Alaska Mental Health Trust

Other programs/efforts that rely on the YRBS data:

- Overall tracking progress on State Health Plan (Healthy Alaskans 2010) – approximately 16 measures.
- DEED/No Child Left Behind (NCLB) requirements to collect data captured in the YRBS remain in place and DEED has no other established mechanism to gather this data. Building a new instrument would be costly and labor intensive, and DEED presently lacks the infrastructure to accomplish this and would no doubt run in to the same challenges as YRBS faces.
- Alaska's Plan to Reduce and Prevent Underage Drinking - without the YRBS data we will lose our baseline data to show we are making change.
- DHSS State Epidemiological Outcomes Workgroup contract deliverables relies heavily on YRBS data.
- Alaska Obesity Prevention Plan

Other large community grants:

- 7 SAMSHA grants directly to community coalitions

District level grants:

- One of the eligibility requirements for school districts to apply for state Tobacco Prevention Grants ($800,000) is to collect local YRBS data.

- A query is in process to determine how else school districts have used the data to leverage additional funding. Responses so far have mentioned being able to get grant funding for school counselors to address the needs identified by YRBS.

February 23, 2010

Prior Bill-Same Issues

Representative Bob Herron, Co-Chair
Representative Wes Keller, Co-Chair
House Health, Education and Social Services Committee
Alaska State Capitol
Juneau, AK 99801-1182
Fax: 907-465-4589 (Rep. Herron)
Fax: 907-465-3818 (Rep. Keller)

RE: SB 101 (Davis)--Support

Dear Co-Chairs Herron and Keller:

On behalf of the American Heart Association, we strongly encourage you and your colleagues on the House Health, Education and Social Services Committee to support SB 101, a bill that would change the requirements of parental consent for students to participate in anonymous questionnaires and surveys. Currently, parents must actively consent in order for their child to participate in anonymous surveys about student health and behavior. If SB 101 were to become law, parents and students could still opt out of participation, but if they declined to opt out, their consent to participate would be implied.

The American Heart Association is a national voluntary health agency whose mission is "Building healthier lives, free of cardiovascular diseases and stroke." The American Heart Association supports SB 101 because it would make it feasible to reliably collect weighted, statistically significant data to accomplish important public health tasks like tracking childhood physical activity levels, and ensuring that tobacco prevention programs directed at our youth are on-target and actually effective in reducing tobacco use.

By allowing the state to more reliably track the health of our children, SB 101 will result in better, more effective programs directed at Alaska's children, and ultimately reduce preventable threats to cardiovascular health like tobacco use and chronic obesity.

Should you have any questions about our position, please feel free to contact me at 720-280-3097. Thank you for your consideration.

Sincerely,

Chris Sherwin
Vice-President, Advocacy
American Heart Association/ Pacific Mountain Affiliate

CC: Sen. Bettye Davis
Fax: 907-465-3756

Sen. Bettye Davis

From: Corinne McVee [cmcvee@gmail.com]
t: Monday, February 22, 2010 10:18 PM
Sen. Bettye Davis
Subject: SB 101/HB 130: Student Questionnaires and Surveys

Prior Bill
Same Issues

Dear Senator Davis,

Thank you for supporting SB101/HB 130 "Student Questionnaires and Surveys." The data gathered from the Youth Risk Behavior Survey is of critical importance to Alaska's school districts and other youth-serving organizations. The bill will remove barriers to administering the Youth Risk Behavior Survey (YRBS), an anonymous survey that parents already overwhelmingly grant permission to administer. By eliminating the requirement to gather parental permission forms, the bill will save precious dollars and instructional time in our schools.

As a professional grant writer, I can attest that it is impossible to develop competitive grant applications without YRBS data that is complete, accurate, and timely. The higher the survey participation rate, the better the quality of the data.

I understand that some of the bills' opponents think that students will be encouraged to engage in risky behavior simply by taking the survey. I believe that the opposite is true. If anything, the act of responding to the YRBS may discourage these behaviors by reminding kids that adults are interested in finding out what they are doing. My nine nieces and nephews, most of whom are current or recent high school students, assure me that they did not learn of risky behaviors when taking the YRBS. They were well aware of everything the survey addresses!

By supporting this important bill, you are helping Alaska's youth-serving organizations to get accurate data in order to better address the needs of our young people.

Thank you for considering this matter that is so critical for the welfare of Alaska's youth.

Sincerely,

Corinne McVee

Grant Writer, Anchorage School District

[redacted]0 Habicht Court

Anchorage, AK 99504

907-338-0289

1998 Alaska Statute

Sec. 14.03.110. Questionnaires and surveys administered in public schools.

A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or guardian.

1999 Alaska Statute

Sec. 14.03.110. Questionnaires and surveys administered in public schools.

(a) A school district, principal or other person in charge of a public school, or teacher in a public school may not administer or permit to be administered in a school a questionnaire or survey, whether anonymous or not, that inquires into personal or private family affairs of the student not a matter of public record or subject to public observation unless written permission is obtained from the student's parent or legal guardian.

(b) For an anonymous questionnaire or survey, written permission required under (a) of this section may be obtained annually and is valid until the commencement of the subsequent school year or until the parent or legal guardian who gave permission submits a written withdrawal of permission to the school principal. The school shall provide each student's parent or legal guardian at least two weeks' notice before administering a questionnaire or survey described under this subsection.

(c) If a school administers to a student a questionnaire or survey that is not anonymous, the school shall obtain the written permission required under (a) of this section from the student's parent or legal guardian at least two weeks before the questionnaire or survey is administered.

(d) The school shall give a student's parent or guardian an opportunity to review the questionnaire or survey described under (b) or (c) of this section and shall give the parent or guardian written notice regarding

(1) how the questionnaire or survey will be administered to the student;

(2) how the results of the survey or questionnaire will be used; and

(3) who will have access to the questionnaire or survey.

(e) A student may refuse to participate in a questionnaire or survey administered in a public school. A student's parent or legal guardian may refuse to allow the student to participate in a specified questionnaire or survey.

(f) In this section, "questionnaire or survey" means a list of questions to, or information collected from, a class or group of students.

Youth Risk Behavior Survey
SB 8

Youth Risk Behavior Survey

Senate Bill 8, Student Questionnaires and Surveys, strengthens parental notification and allows for passive parental consent for students taking the Youth Risk Behavior Survey (YRBS.)

Background Information

What the bill does:

SB 8 maintains and strengthens current parent notification provisions. It ensures that parents are informed that the survey will be given, provides for the opportunity to review survey content, and allows parents to choose not to allow their children to participate.

What the YRBS is:

The YRBS is a voluntary, anonymous school-based survey of high school students (grades 9-12). There is also a shorter version for middle school students (grades 7 - 8). It is a nationally recognized and administered survey instrument developed by the Centers for Disease Control and Prevention (CDC) in 1991. The high school survey is conducted every two years on both the national and state level. It is completely anonymous. No identifying information is given and students immediately put their answer sheet into a sealed envelope to be turned in to the state. The survey is administered through cooperation between Alaska's Department of Education & Early Development, Department of Health and Social Services, local school districts and the CDC.

Why we need the law changed:

The current law, requiring signed permission slips for any student to participate, unnecessarily hinders data collection needed to design and evaluate risk prevention programs and services to protect our youth. The state spent about $90,000 in 2009 on incentives to support getting permission slips returned (whether positive or negative). This is in addition to extra staff time and costs incurred by local school districts.

Over the last decade, the survey has had years of not meeting the necessary response rate to have valid data or has barely made the minimum response rate cut off for valid data, resulting in an adequate but less than desirable degree of confidence in the results compared to achieving a higher response rate.

Parental Engagement & Support for Alaska's Youth

SB8 recognizes the need to keep parents informed and given opportunities for engagement. It balances this with the need to keep administrative burden to a minimum, resulting in a bill that supports both parental involvement and the ability to better serve our youth.

American Cancer Society Cancer Action Network / 3851 Piper Street, Suite U240, Anchorage, AK 99508

Alaska Director of Government Relations, Emily Nenon / Emily.Nenon@cancer.org

www.acscan.org/alaska

SB

12

<TARGET><BILL>SB 12</BILL><SUBJECT>SB
12</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 12, 26-LS0089 – "An Act extending the termination date of the Board of Nursing; and providing for an effective date."

SPONSOR STATEMENT

This bill extends the termination date of the Board of Nursing eight years to June 30, 2019. The board was recommended to be extended by the Legislative Budget and Audit Committee in December, 2010.

THE MISSION OF THE ALASKA BOARD OF NURSING IS TO ACTIVELY PROMOTE AND PROTECT THE HEALTH OF THE CITIZENS OF ALASKA THROUGH THE SAFE AND EFFECTIVE PRACTICE OF NURSING AS DEFINED BY LAW.

The board adopts regulations to carry out the laws governing the practice of nursing and the work of nurse aides in Alaska. It makes final licensing decisions and takes disciplinary action against people who violate the licensing laws.

The board meets at least four times a year (AS 08.68.080) and consists of seven members appointed by the governor. One member shall be a licensed practical nurse currently involved in institutional nursing service, one member shall be a registered nurse engages in baccalaureate nursing education, three members shall be registered nurses at large, and two members shall be persons who have no direct financial interest in the health care industry (AS 08.68.010).

The five members of the board who are nurses shall be licensed in the state, and shall have been actively engaged in nursing for not less than four years before appointment, three years of which were within the five years immediately preceding appointment (AS 08.68.060). The board shall annually elect a chairman and secretary from among its members.(AS 08.68.070).

Duties and power of the board are found under AS 08.68.100(a): The board shall

(1) adopt regulations necessary to implement this chapter, including regulations pertaining to practice as an advanced nurse practitioner and a nurse anesthetist and regulations necessary to implement AS 08.68.331–08.68.336 relating to certified nurse aides in order to protect the health, safety, and welfare of clients served by nurse aides;

(2) approve curricula and adopt standards for basic education programs that prepare persons for licensing under AS 08.68.190;

(3) provide for surveys of the basic nursing education programs in the state at the times it considers necessary;

(4) approve education programs that meet the requirements of this chapter and of the board, and deny, revoke, or suspend approval of education programs for failure to meet the requirements;

(5) examine, license, and renew the licenses of qualified applicants;

(6) prescribe requirements for competence before a former nurse may resume the practice of nursing under this chapter;

(7) define by regulation the qualifications and duties of the executive secretary and delegate authority to the executive secretary that is necessary to conduct board business;

(8) develop reasonable and uniform standards for nursing practice;

(9) publish advisory opinions regarding whether nursing practice procedures or policies comply with acceptable standards of nursing practice as defined under this chapter;

(10) require applicants under this chapter to submit fingerprints and the fees required by the Department of Public Safety under AS 12.62.160 for criminal justice information and a national criminal history record check; the department shall submit the fingerprints and fees to the Department of Public Safety for a report of criminal justice information under AS 12.62 and a national criminal history record check under AS 12.62.400.

(b) The board may

(1) conduct hearings upon charges of alleged violations of this chapter or regulations adopted under it;

(2) invoke, or request the department to invoke, disciplinary action against a licensee;

(3) prescribe requirements for competence to continue practice.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version
() Publish Date

Identifier (file name) SB012-CCED-CBPL-01-28-11
Title: Extending Board of Nursing
Sponsor: Senator Davis
Requester: Senate HSS

Dept. Affected: DCCED
Appropriation: CBPL
Allocation: Board of Nursing
OMB Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services		637.3	637.3	637.3	637.3	637.3	637.3
Travel		21.3	21.3	21.3	21.3	21.3	21.3
Services		298.5	298.5	298.5	298.5	298.5	298.5
Commodities		6.3	6.3	6.3	6.3	6.3	6.3
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**963.4**	**963.4**	**963.4**	**963.4**	**963.4**	**963.4**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
1156 Receipt Support Services		963.4	963.4	963.4	963.4	963.4	963.4
TOTAL	**0.0**	**963.4**	**963.4**	**963.4**	**963.4**	**963.4**	**963.4**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial version

Prepared by: Don Habeger, Division Director — Phone: 465-2536
Division: Corporations, Business and Professional Licensing — Date/Time: 1/29/11 2:30 PM
Approved by: Susan K. Bell, Commissioner — Date: 1/29/2011
Commerce, Community & Economic Development

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. _____

Analysis

SB 12 extends the Board of Nursing to June 30, 2019. In accordance with AS 08.03.020 funding extends one year following the termination date allowing the Board to conclude its affairs. The FY2012 funding is included in the Operating Budget request and costs shown are an average of direct costs for a biennial license period.

Travel expenses represent transportation and per diem for the 7 member board and 1 staff to meet at least 4 times each year in accordance with AS 08.68.080.

The program is required to cover costs with licensing fees under AS 08.01.065, and revenue generated by board fees are anticipated to cover its full operating costs. New funds are not required to implement this bill.

Division of Legislative Audit

Report Digest #08-20070-10

Audit Report PDF Format *

* Requires Acrobat Reader Get Acrobat Reader

SUMMARY OF: A Sunset Review of the Department of Commerce, Community and Economic Development, Board of Nursing (BON), September 30, 2010

PURPOSE AND SCOPE OF THE REPORT

In accordance with Title 24 and Title 44 of the Alaska Statutes (sunset legislation), we have reviewed the activities of BON to determine if there is a demonstrated public need for its continued existence and if it has been operating in an effective manner. As required by AS 44.66.050(a), this report shall be considered by the committee of reference during the legislative oversight process in determining whether BON should be reestablished. Currently, under AS 08.03.010 (c)(13), BON will terminate on June 30, 2011, and will have one year from that date to conclude its administrative operations.

REPORT CONCLUSIONS

BON is operating in an efficient and effective manner and should continue to regulate the professions it governs. We believe the board is safeguarding the public interest by ensuring the competence and integrity of those who present themselves to the public for the professions regulated by BON: licensed registered nurses, licensed practical nurses (LPN), advanced nurse practitioners (ANP), certified registered nurse anesthetists, certified nurse aides, and nurse and nurse aide training programs.

BON has conducted its business in a satisfactory manner. It continues to propose changes to regulations to improve the board's effectiveness and to ensure that professionals are properly licensed.

Under AS 08.03.010(c)(13), BON will terminate on June 30, 2011. If not extended by the legislature, under AS 08.03.020, BON will have a one-year period to administratively conclude its affairs. We recommend that the legislature extend the board's termination date to June 30, 2019.

FINDINGS AND RECOMMENDATIONS

1. BON should take steps to ensure all appropriate entities are notified when an ANP's authority to write prescriptions has been revoked or suspended.
2. The BON chairman should take steps to ensure that the required training program reviews are being conducted.
3. The Division of Corporations, Business, and Professional Licensing's chief investigator should take steps to ensure that complaints and cases are investigated timely.
4. The director of Boards and Commissions, Office of the Governor, should fill the LPN position with an LPN currently involved in institutional nursing services.

Audit Report PDF Format *

* Requires Acrobat Reader Get Acrobat Reader

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit

P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@legis.state.ak.us

October 26, 2010

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 and Title 44 of the Alaska Statutes (sunset legislation), we have reviewed the activities of the Board of Nursing (BON), and the attached report is submitted for your review.

DEPARTMENT OF COMMERCE, COMMUNITY,
AND ECONOMIC DEVELOPMENT
BOARD OF NURSING

September 30, 2010

Audit Control Number
08-20070-10

This audit was conducted as required by AS 44.66.050 and under the authority of AS 24.20.271(1). Under AS 08.03.010(c)(13), BON will terminate on June 30, 2011. If the legislature does not extend the termination date, BON will have one year to conclude its administrative operations. In our opinion, BON's termination date should be extended until June 30, 2019. The board has generally displayed an ability to conduct its business in a professional, competent, and efficient manner – with the exception of the areas noted in the recommendations. BON is serving the public interest by promoting the competence and integrity of those who provide services to the public as licensed nurses and nurse aides.

The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Fieldwork procedures utilized in the course of developing the findings and recommendations presented in this report are discussed in the Objectives, Scope, and Methodology.

Pat Davidson, CPA
Legislative Auditor

TABLE OF CONTENTS

	Page
Objectives, Scope, and Methodology	1
Organization and Function	3
Report Conclusions	5
Findings and Recommendations	7
Analysis of Public Need	11
Agency Response	
Office of the Governor	17
Department of Commerce, Community, and Economic Development	19
Board of Nursing	21

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Board of Nursing (BON) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner.

As required by AS 44.66.050(a), this report shall be considered by the committee of reference during the legislative oversight process in determining whether BON should be reestablished. Currently, under AS 08.03.010(c)(13), BON will terminate on June 30, 2011, and will have one year from that date to conclude its administrative operations.

Objectives

The three central, interrelated objectives of our report are:

1. To determine if the termination date of the board should be extended.

2. To determine if the board is operating in the public interest.

3. To determine if the board has exercised appropriate regulatory oversight of licensed registered nurses, licensed practical nurses, advanced nurse practitioners, certified registered nurse anesthetists, certified nurse aides, and nurse and nurse aide training programs.

The assessment of the operations and performance of BON was based on criteria set out in AS 44.66.050(c). Criteria set out in this statute relates to the determination of a demonstrated public need for BON.

Scope and Methodology

The major areas of our review were board proceedings, licensing, complaint investigation, and resolution functions for fiscal years ending June 30, 2006, through June 30, 2010. During the course of our examination, we reviewed and evaluated the following:

- Applicable statutes and regulations related to the licensing and certification of registered nurses, licensed practical nurses, advanced nurse anesthetists, certified nurse aides, and nurse and nurse aide training programs.

- Minutes of meetings of BON.

- Annual Reports issued by BON and the investigative unit of the Division of Corporations, Business and Professional Licensing (DCBPL).
- Complaints filed with DCBPL, Office of the Ombudsman, and the Alaska Human Rights Commission.

- Financial records related to the revenues generated and the operating costs incurred by BON.

- Complaints and related investigative case files maintained by the investigative unit of DCBPL.

- Files related to applicants for, and holders of, licenses issued by BON.

- Files related to applicants for board member seats maintained by the Division of Boards and Commissions with the Office of the Governor.

Additionally we interviewed employees of DCBPL and members of BON.

ORGANIZATION AND FUNCTION

The Board of Nursing (BON) was established for the purpose of controlling and regulating the practice of nursing in the State. Alaska Statute 08.68.100 identifies BON's responsibilities and authority to provide effective control and regulation of the practice of nursing as well as the standards for training necessary to promote, preserve, and protect the public's health, safety and welfare.

Board Membership

BON is composed of seven members. State law requires that one member be a licensed practical nurse (LPN) currently involved in institutional nursing services, one member be a registered nurse (RN) engaged in baccalaureate nursing education, three members be RNs at large, and two members be persons who have no direct financial interest in the health care industry. For current board members, see Exhibit 1.

Exhibit 1

Board of Nursing
As of September 30, 2010

Beth Farnstrom, RN
Chairperson

Agnes Jack, LPN

Janine McCready, Public Member

Denise Ekstrom, RN, ANP

Thomas Hendrix, PhD, RN
Baccalaureate Nursing Education

Kevin Dougherty, Public Member

Erin Pringle, RN Position

Board Duties

In general BON regulates admission into the practice of nursing; establishes and enforces competency by ensuring compliance with professional standards and adopting regulations; and ensures that training programs are performing up to both statewide and national standards.

Most licensing requirements are established by statute. Nurses are either licensed by examination or endorsement.

Examinations for RNs and LPNs are nationally administered exams; the National Council Licensure Examination is administered through a contract with the private sector. Certified nurse aides are tested using the National Nurse Aide Assessment Program (NNAAP) exam. The NNAAP was formulated by the National Council of State Nursing Boards and is administered locally in conjunction with the training centers that have been approved by BON.

Licenses by endorsement, including certifications of nurse aides by endorsement, are issued to nurses licensed in other states that have licensing requirements acceptable to BON.

BON regulates nursing practices in part by:

1. Establishing and amending policy and regulations necessary and desirable to enforce state statutes.

2. Approving curricula for nursing and nurse aide programs; along with adopting standards for basic and continuing competency programs designed to prepare persons for licensure and ensure the maintenance of competency.

3. Issuing licenses on the basis of examination or endorsement to qualified applicants.

4. Holding hearings to resolve investigations that may lead to revocation, suspension, or other disciplinary action against an individual holding a license issued by the board.

5. Periodically reviewing and approving the facility training programs for individuals employed and certified as nursing aides.

6. Keeping the public informed of pertinent information through the use of BON's website which includes disciplinary databases, advisory opinion databases, board meetings and agenda's, meeting minutes, licensure information, regulations and other public notices.

Division of Corporations, Business and Professional Licensing (DCBPL)

DCBPL staff provide administrative support, including budgetary services and functions such as: collecting fees, maintaining files, receiving and issuing application forms, and posting public notices.

The DCBPL investigative unit is empowered with the authority to act on its own initiative or in response to a complaint. They may:

1. Conduct an investigation if it appears a person is engaged in, or is about to engage in a practice over which the Department of Commerce, Community and Economic Development has authority.

2. Issue an order for a licensed individual to stop the practice.

3. Bring an action in superior court to enjoin the act.

4. Examine the books and records of an individual.

5. Issue subpoenas for the attendance of witnesses and records.

REPORT CONCLUSIONS

The Board of Nursing (BON) is operating in an efficient and effective manner and should continue to regulate the professions it governs. We believe the board is safeguarding the public's interest by ensuring the competence and integrity of those who present themselves to the public as licensed registered nurses, licensed practical nurses, advanced nurse practitioners, certified registered nurse anesthetists, certified nurse aides, and nurse and nurse aide training programs.

BON has conducted its business in a satisfactory manner. It continues to propose changes to regulations to improve the board's effectiveness and to ensure that professionals are properly licensed.

Under AS 08.03.010(c)(13), BON is scheduled to be terminated on June 30, 2011. If not extended by the legislature, under AS 08.03.020, the board will have a one-year period to administratively conclude its affairs. We recommend that the legislature extend the board's termination date to June 30, 2019.

(Intentionally left blank)

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Board of Nursing (BON) should take steps to ensure all appropriate entities are notified when an advanced nurse practitioner's (ANP) authority to write prescriptions has been revoked or suspended.

During the prior sunset review, we recommended that BON develop procedures to notify the Board of Pharmacy when there is a termination or change to a nurse's prescriptive authority as required by regulation. After our review in FY 02, BON repealed these regulations and developed a disciplinary database accessible on their website.

During the period from July 1, 2002, to March 31, 2010, there were two incidents where a nurse's authorization to write prescriptions was revoked by BON. One involved an ANP whose license to practice was revoked along with prescriptive authority. In January 2010, another ANP lost prescriptive authority for a period of one year.

The ANP, whose nursing license and authority to write prescriptions was revoked, continued to write prescriptions after the revocation, putting the public at risk. The other ANP whose authority to write prescriptions was revoked for a time frame of one year, has the opportunity to continue writing prescriptions. The disciplinary database accessible on the BON website is not an effective control for stopping illegal prescriptions from being filled.

Nurses must apply with BON in order to receive authorization to write prescriptions. Once the state grants authorization, the nurse must receive a registration number from the federal Drug Enforcement Agency (DEA) before they can start writing prescriptions. The DEA keeps a database listing the current status of registration numbers. Currently, there is no statute or regulation in place requiring the board to notify the DEA if a nurse's ability to write prescriptions has been revoked. Not notifying the DEA that a prescriber's authorization has been revoked or suspended can result in illegal prescriptions being filled.

BON is established under AS 08.68 for the purpose of controlling and regulating the practice of nursing, including: ANPs, nurse anesthetists, registered nurses (RN), licensed practical nurses (LPN), and certified nurse aides (CNA). BON's mission statement is: "*to* actively *promote and protect the health of the citizens of Alaska through the safe and effective practice of nursing as defined by law.*" We recommend BON establish procedures to ensure that the DEA is notified whenever authorization to write prescriptions is revoked or suspended. We also recommend that BON ensure in-state pharmacies, hospitals, and clinics are aware of the disciplinary proceedings database on BON's website.

Recommendation No. 2

The BON chairman should take steps to ensure that the required training program reviews are being conducted.

BON is not consistently providing the required oversight of CNA training programs.

The required site reviews are not being conducted for all the CNA training programs. As of June 30, 2010, only 11 of the 21 required reviews for the year had been performed. As a result, training programs are being given approval to operate for another two years without the reviews being conducted or processed.

Additionally, in years the on-site reviews are not done, the self-evaluation forms completed by the training program staff are not being processed. As a result, BON is not aware of any issues that are highlighted in the self-evaluations.

According to regulation 12 AAC 44.857, Training Program Review:

> *(a) The board will approve a certified nurse aide training program for a two-year period. Within two years after the date of the initial approval of a certified nurse aide training program, the board will conduct an on-site review of the training program to determine continued compliance with regulations 12 AAC 44.835 - 12 AAC 44.847 and 12 AAC 44.852 - 12 AAC 44.860. If the board determines that the training program complies with those requirements, the board will extend its approval of that program for another two years.... (c) During a year in which on-site review is not scheduled, the program provider shall complete a self-evaluation form provided by the board.*

When the Nurse Consultant I position was vacated in 2002, the vacancy was not filled. As a result, the site reviews were only done sporadically. In June 2009, the board contracted for a part-time person to complete the site reviews. However, this has not fully addressed the problem.

We recommend that BON take steps to ensure that the onsite reviews and self evaluations are being completed in a timely manner to ensure that the training programs are presenting qualified applicants.

Recommendation No. 3

The Division of Corporations, Businesses, and Professional Licensing's (DCBPL) chief investigator should take steps to ensure that complaints and cases are investigated timely.

DCBPL's investigative section often does not complete investigations in a timely manner. The section's effectiveness is further diminished by the outdated and unreliable Enforcer database system currently in use.

It is DCBPL's responsibility to provide investigative support for BON. Investigators examine and research each complaint to determine jurisdiction and whether a violation exists. If the complaint meets these conditions, a case is opened and a priority is assigned. The priority reflects the level of imminent danger to the public.

During the period of July 1, 2006, through March 31, 2010, there were a total of 136 complaints and 412 cases active. Of these, 6 complaints and 20 cases were inspected for a more in-depth analysis.

Nine cases and two complaints experienced lengthy periods of inactivity (six months or more). One of those cases was assigned a priority level of "2".[1]

Investigative staff attributed the delays to higher priority cases and tasks taking precedence. Staff also believed that the investigative database contributed to the problem. The database does not have a user-friendly mechanism for flagging inactive cases. Consequently, supervisors and investigators are not effectively monitoring caseloads. Ineffective monitoring leads to unnecessary delays.

Complaints and cases that are not investigated timely may allow an individual who is practicing inappropriately, or outside of his or her scope, to continue these violations.

Cases with life threatening repercussions should take priority. However, it is still reasonable for the public to expect that all complaints against licensees will be addressed as efficiently as possible. We recommend that the DCBPL chief investigator establish procedures to ensure that priorities within each assigned level are outlined and that cases and complaints with periods of inactivity are identified and addressed.

---

[1]A priority level of "1" signifies incidents which represent an immediate danger to the public health and safety.
A priority level of "2" signifies incidents which, by the severity of their nature, dictate a high priority.
A priority level of "3" signifies incidents that are less serious in nature and do not appear to constitute immediate or severe public danger or serious damages.
A priority level of "4" signifies incidents involving failure to comply with statutes or regulations which are discovered through the course of proactive enforcement, but do not meet the criteria of priority 1 through 3.

Recommendation No. 4

The director of Boards and Commissions, Office of the Governor should fill the LPN board position with an LPN currently involved in institutional nursing services.[2]

The LPN board member appointed on June 12, 2007, for the institutional nursing services position is not currently involved in that field. She is currently an emergency medical technician and works for an emergency medical services company conducting training. There is no evidence on file that she has ever been involved in institutional nursing services.

The prior board member appointed to this position did not meet statutory requirements either. That board member was a clinical nurse, not an institutional nurse.

Under AS 08.68.010, BON is made up of seven members: one LPN currently involved in institutional nursing services, one RN engaged in baccalaureate nursing education, three RNs at large, and two public members.

It is the responsibility of the LPN currently involved in the institutional nursing services board member position to give technical advice related to the special needs of those in long-term care facilities and nursing homes. Without representation by an LPN involved in institutional nursing services, the long term care facilities and nursing homes are being underrepresented on the board. Accordingly, we recommend that the current LPN member be removed from the LPN board position and replaced with an individual meeting the statutory requirement.

[2]Institutional nursing services include facilities such as long-term care, Pioneer's Homes, and nursing homes.

ANALYSIS OF PUBLIC NEED

The following analyses of board activities relate to the public need factors defined in AS 44.66.050(c). These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

Determine the extent to which the board, commission, or program has operated in the public interest.

The Board of Nursing (BON) has served the public by ensuring that qualified applicants are licensed as nurses or certified as nurse aides. Regulations related to licensure and certification provide reasonable assurance of competence, without being overly restrictive to entry into the nursing profession.

BON has generally displayed an ability to conduct its business in a professional, competent, and efficient manner - with the exception of the areas noted in the recommendations. BON has consistently proposed changes to statutes and regulations to improve its effectiveness in regulating the nursing profession in Alaska.

Determine the extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices that it has adopted, and any other matter, including budgetary, resource, and personnel matters.

BON has changed many regulations as well as added several new ones, to bring the nursing profession in Alaska into line with the Model Nurse Practice Act that was commissioned by the National Council of State Boards of Nursing (NCSBN). The idea is to standardize as many of the regulations as possible across the United States and Canada so that nurses can be licensed in multiple states. BON has also worked on implementing the commitment to ongoing regulatory excellence (CORE) best practices. These best practices are based on data collected by the NCSBN from boards of nursing and stakeholder groups to measure outcomes, outputs, and efficiencies of nursing regulations during 2000 and 2002. This data was analyzed to discover those boards with consistently high ratings in outputs and effectiveness in each of five functional groups: discipline, licensure, education program approval, practice and governance. BON has adopted the CORE format and has formed a strategic plan around the five functional groups.

Under AS 08.01.065(c), the Department of Commerce, Community, and Economic Development (DCCED) must *"establish fee levels... so that the total amount of fees collected for an occupation approximately equals the actual regulatory costs of the occupation."* BON reviews and provides feedback on changes to fees proposed by the division.

BON revenues come from licensing and renewal fees. Renewals are conducted on a biennial basis. This creates a two-year cycle in board revenues, with BON receiving most of its revenues during the odd-numbered fiscal years. We reviewed the Division of Corporations, Business, and Professional Licensing's (DCBPL) internal records to identify BON revenues and expenditures. Exhibit 2 (shown below) presents BON's revenues and expenditures for FY 07 through FY 10.

Exhibit 2

Board of Nursing
Schedule of Revenues and Expenditures
FY 07 – FY 10
(Unaudited)

	FY 07	FY 08	FY 09	FY 10
Revenue	$ 2,436,683	1,055,587	2,688,408	1,055,141
Direct Expenditures				
Personal Services	555,647	580,516	646,370	627,158
Travel	23,289	14,867	12,615	23,081
Contractual	316,439	205,323	318,455	253,686
Supplies	4,459	4,083	7,534	5,169
Total Direct Expenditures	899,834	804,789	984,974	909,094
Indirect Expenditures	761,660	721,682	751,754	876,908
Total Expenditures	1,661,494	1,526,471	1,736,728	1,786,002
Annual Surplus (Deficit)	775,189	(470,884)	951,680	(730,861)
Beginning Cumulative Surplus (Deficit)	883,330	1,658,519	1,187,635	2,139,315
Ending Cumulative Surplus (Deficit)	$ 1,658,519	1,187,635	2,139,315	1,408,454

Due to errors in the reporting of information to BON and DCBPL, there was a large cumulative surplus at the end of FY 10. The errors were the result of a past DCBPL employee who did not have the accounting experience necessary to schedule expenditures and revenues properly or to forecast future revenues and expenditures - experience which is necessary to set fees for future periods. To address this, DCCED is recommending to BON that licensing fees for the occupations regulated by the board be dropped approximately 20% for the FY 11 and FY 12 renewal cycles.

that licensing fees for the occupations regulated by the board be dropped approximately 20% for the FY 11 and FY 12 renewal cycles.

Determine the extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.

New regulations were enacted to address the passing rate for registered nurse (RN) and certified nurse aide (CNA) training program students. Programs are monitored for their pass rates and if one falls below a cumulative pass rate of 80% annually, then the program must submit a plan for improvement to the board and come into compliance prior to being approved for continuing the program (12 AAC 44.055).

BON instituted new regulations regarding criminal background checks for licensees and required photographs with applications (12 AAC 44.319 and 12 AAC 44.290(a)(1)(A) respectively).

BON passed regulations allowing RN's to administer Food and Drug Administration regulated vitamins and minerals as provided by their health care provider (12 AAC 44.945(d)). BON also passed standards for the delegation of nursing duties to other persons (12 AAC Article 9).

BON made several suggestions for statutory changes. These changes included rescinding obsolete statutes, as well as changing the wording for other existing statutes, and were ordered by priority. To date, none of these changes have been made.

Determine the extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.

BON's website has information on licensing, agendas, board meetings, minutes, regulations and complaints. The board's website contains several helpful links for obtaining additional information regarding the profession of nursing. Interested persons are encouraged to call the BON office to schedule testimony time and get information for up-coming board meetings. The location, date and time for board meetings are also posted on the State of Alaska Online Public Notice website and are published in the Anchorage Daily News.

Determine the extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

Public notices of proposed regulations are published in major newspapers. Meetings are adequately advertised, and time is set aside for public testimony.

There is evidence of extensive participation from the public in the continued development of BON regulations. Meeting minutes evidenced public comment on existing regulations and on proposed regulations. Public comments were heard by teleconference during times when interested persons were unable to attend the meetings in person.

Determine the efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.

There have been 136 complaints and 412 cases active during the time period from July 1, 2006, to March 31, 2010. Listed in Exhibit 3 (shown below) is a summary of the actions taken for those complaints and cases.

Exhibit 3

Complaints	**Number of Actions**
Case Opened	68
No Action (no violation, insufficient evidence, etc.)	41
Corrective Action Taken	4
Other	4
Advisement Letter	2
Still Under Investigation	17
Total Complaints	**136**
Cases	
Advisement Letter	14
No action (no violation, insufficient evidence, etc.)	52
License Action	231
Corrective Action Taken	21
Other	43
Still Under Investigation	51
Total Cases	**412**

Of these, 6 complaints and 20 cases were inspected for a more in-depth analysis. Of the 26 files reviewed, 11 were not investigated in a timely manner (see Recommendation No. 3).

No complaints or investigations specifically involving the actions and activities of BON were received, or undertaken by, either the Office of the Ombudsman or the Office of Victim's Rights within the past six fiscal years.

Determine the extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.

BON is adequately regulating entry into the profession of nursing. Controls are in place and consistently performed to ensure it has presented only qualified applicants to serve the public. When received, the applications are subjected to a checklist to verify that all required documentation, such as test scores and proof of education or experience, are present, ensuring that the applicant meets all statutory and regulatory requirements.

Exhibit 4 (shown below) is a summary of new licenses and permits issued by BON for the time period from July 1, 2005, to June 30, 2009. This information was compiled from annual reports issued by the board.

Exhibit 4

New LIcenses Issued (Exclusive of Renewals)	FY 05	FY 06	FY 07	FY 08	FY 09	Total Licenses (as of June 30, 2009)
Registered Nurse	815	1084	1561	1251	1611	9304
Licensed Practical Nurse	110	114	176	129	188	958
Advanced Nurse Practitioner	51	47	60	58	60	635
Registered Nurse Anesthetist	4	17	25	22	11	135
Certified Nurse Aide	692	907	1201	1077	544	2842

Fiscal year 2009 experienced a sharp decline in the number of CNAs licensed as a result of some training programs closing and others limiting the numbers of students they would accept.

We reviewed the requirements for licensure and they appear reasonable and appropriate to ensure that qualified professionals are licensed and the public's best interest is protected. Continuing education requirements are reasonable and are audited in accordance with statute.

Determine the extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

We found no evidence that the board has not complied with state personnel practices, including affirmative action, in the qualifying process of applicants. Each time the board has denied an applicant's licensure or certification, reasoning has been based on requirements set out by statute and regulation, not on the personal attributes of applicants. The reasons for denials are stated in writing, with the applicant always informed of their rights and of the process by which they can contest or appeal any denial of licensure or certification.

Determine the extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interests of the public and to comply with the factors enumerated in this subsection.

See discussion in Recommendations No. 1 through No. 4 in the Findings and Recommendations section of this report. DCBPL, along with BON, should take measures to address the following:

1. Establish procedures to ensure that the Drug Enforcement Agency is notified when prescriptive authority is revoked or suspended and establish procedures to ensure in-

state pharmacies, hospitals, and clinics are aware of the disciplinary proceedings database on the board's website.

2. Ensure that onsite reviews and self evaluation forms are completed in a timely manner for all CNA training programs.

3. Ensure complaints and cases are investigated timely.

4. Fill the licensed practical nurse (LPN) board member position with an LPN meeting statutory requirements.

Determine the extent to which the board, commission, or agency has effectively attained its objectives and purposes and the efficiency with which the board, commission, or agency has operated.

In FY 09, BON adopted a balanced scorecard form of strategic planning based on the CORE best practices and set their strategic goals by the five functional groups: discipline, licensure, education program approval, practice and governance. They set their agendas to complement their strategic goals and revisit their plan annually in October. The board is continuing to implement these best practices and is improving their strategic goals.

Determine the extent to which the board, commission, or agency duplicates the activities of another governmental agency or the private sector.

There are several state and national organizations that provide newsletters, continuing education, and legislative support. The NCSBN provides national licensing exams for the nursing professions, acts as a clearing house for applicants of licensure by reciprocity, provides legislative support, and assists state boards in the standardization of regulations. We conclude that there is no evidence that any of these organizations provide the same public protection or duplicate the operations of BON. In addition, we did not find evidence of other state or private sector agencies that conduct or duplicate the efforts of BON.

STATE CAPITOL
PO Box 110001
Juneau, Alaska 99811-0001
907-465-3500
fax: 907-465-3532

550 West 7th Avenue # 1700
Anchorage, Alaska 99501
907- 269-7450
fax 907- 269-7463
www.gov..alaska.gov
Governor@alaska.gov

Office of Governor Sean Parnell
STATE OF ALASKA

November 22, 2010

RECEIVED
NOV 2 2 2010
LEGISLATIVE AUDIT

Ms. Pat Davidson
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

Dear Ms. Davidson,

This letter is in response to your October 29, 2010 letter to Governor Parnell regarding the "CONFIDENTIAL" preliminary audit report on the Board of Nursing (BON).

Recommendation No. 4: The director of Boards and Commissions, Office of the Governor should fill the LPN board position with an LPN currently involved in institutional nursing services.

The Office of the Governor agrees that the member appointed to the LPN seat is not currently involved in institutional nursing services. We are working to appoint an LPN who meets the statutory criteria.

If you need additional information, please contact me at 907-465-3934.

Sincerely,

Jason Hooley
Director
Boards and Commissions

cc: Mike Nizich, Chief of Staff, Office of the Governor

(Intentionally left blank)

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT
Office of the Commissioner

Sean Parnell, Governor
Susan K. Bell, Commissioner

RECEIVED
NOV 19 2010
LEGISLATIVE AUDIT

November 18, 2010

Ms. Katina Holmberg
Alaska State Legislature
Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

Re: Preliminary Report, Board of Nursing, Department of Commerce, Community and Economic Development (DCCED)
Dear Ms. Holmberg:

Thank you for report dated September 30, 2010 regarding audit conclusions and recommendations concerning the State Board of Nursing (BON). I appreciate your review and the opportunity to provide input into the process. In general, the department concurs with the report conclusion and recommendation and our comments are provided below.

Report Conclusions
DCCED agrees with the report conclusion that the BON "is operating in an efficient and effective manner and should continue to regulate the profession it governs. We believe the board is safeguarding the public interest by ensuring the competence and integrity of those who present themselves to the public as LPNs and CNAs." DCCED diligently strives to fulfill its duty of supporting licensed professionals and State boards to protect the public.

Recommendation No. 1
DCCED concurs that notification to the Federal Drug Enforcement Agency and other appropriate entities should occur when an advanced nurse practitioner's authority to write prescriptions is revoked or suspended. The Department will work with the BON, the Board of Pharmacy and other affected healthcare agencies and professionals to establish protocols for awareness of disciplinary proceedings and sanctions on a licensee.

Recommendation No. 2
DCCED supports the report recommendation for timely certified nurse aide training program reviews and/or training program self-evaluations. One difficulty in finding equitable solutions to this issue is past budget cuts and the resulting reduction in state personnel. A part time contract employee has not sufficiently filled the training inspection service gap. DCCED will endeavor to assist the BON chairman in finding solutions that provide adequate levels of inspection and self-evaluation review.

P.O. Box 110800, Juneau, Alaska 99811-0800
Telephone: (907) 465-2500 Fax: (907) 465-5442 Text Telephone: (907) 465-5437
Email: questions@alaska.gov Website: http://www.commerce.alaska.gov/

Recommendation No. 3
DCCED concurs that the Division of Corporations, Business and Professional Licensing (CBPL) chief investigator should take steps to ensure complaints and cases are investigated timely, and the division has already implemented positive measures toward that end. Specifically, the preliminary report recommends establishing procedures to ensure consistent treatment of complaints and cases in the priority levels assigned, that priorities are outlined and that cases and complaints with periods of inactivity are identified and addressed. The preliminary report also presents that staff believe the existing database did not have a user-friendly mechanism for flagging inactive cases and this contributed to delays.

CBPL was previously aware of the above described issues and took steps to improve timely investigations, including management changes, investments in updated technology, and staff training. A new Chief Investigator was hired in July 2010 and will be establishing procedures to outline priorities and to identify cases with inactive periods. In June 2010 CBPL implemented a new database system (GLSuite) that has significant functionality improvements over the prior outdated "Enforcer" system, including a more user-friendly mechanism for flagging inactive cases. In addition, staff training has and will continue to occur to maximize the utilization of the new system. CBPL expects that these steps will help ensure complaints and cases are investigated in a timely manner.

Recommendation No. 4
DCCED supports the management letter comments that the Licensed Practical Nurse board member should represent the institutional nursing services discipline as outlined in AS 08.68.010. We will work with the BON and the Office of the Governor Boards and Commissions to ensure that the LPN Board seat meets the statutory requirements.

Analysis of Public Need
CBPL reviewed the information presented in this section of the preliminary report and concurs with the reports comments.

We have no other comments on this section.

Again, thank you for an opportunity to provide input. We are pleased your review has, in general, found the Board of Nursing to be working in an efficient and effective manner. Should you have any questions about the content of this letter, please do not hesitate to contact me at 907-465-2500.

Regards,

Susan K. Bell
Commissioner

RECEIVED
NOV 17 2010
LEGISLATIVE AUDIT

Beth Farnstrom
Chair of the Board of Nursing
18751 Villages Scenic Parkway
Anchorage, AK 99516
b_gartner@yahoo.com
Phone (h) 907-349-6074

Pat Davidson
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, AK 99811-3300

November 14, 2010

Dear Ms. Davidson,

As the Chair of the Board of Nursing, I have reviewed the preliminary audit report on the Department of Commerce, Community and Economic Development (DCCED), Board of Nursing Sunset Review, September 30, 2010. A few clarifications I would like to address.

Recommendation No. 1
BON should take steps to ensure all appropriate entities are notified when an advanced nurse practitioner's (ANP) authority to write prescriptions has been revoked or suspended.

The Board's plan is when an ANP's authority to write prescriptions has been revoked or suspended by the BON the Executive Administrator will:

- notify the DEA on the first day after the BON meeting concludes
- Submit the ANP's name to the Board of Pharmacy on the first day after the BON meeting concludes. The Board of Pharmacy will notify the pharmacies in the State of Alaska.
- notify the employer of an ANP on the first day after the BON meeting concludes
- update the ANP disciplinary data base found on the BON website with in two weeks after the BON meeting has concluded

Within 3 weeks after the BON meeting, the Executive Administrator will send out a message on the BON listserv stating when an ANP's authority to write prescriptions is revoked or suspended.

Recommendation No. 2
The BON chairman should take steps to ensure that the required CNA training program reviews are being conducted.

Recommendation No. 2 is for the required review of the CNA training programs. This issue has been addressed with Director Urion, Director Davis, Director Smith and Director Habeger. The Board of Nursing has had 4 Directors since I was appointed to the Board in March 2007. As found in the audit, the position of nurse consultant 1 was vacated in 2002. The Board identified that the posted position was not being filled due to the low salary compared to other nursing positions available. The best the Board has been able to do is a contract position. The contract employee has completed 3/4 of the first reviews of CNA programs as of July 2010 and others are in progress since then. The Board has recommended the position needs to be posted but with a competitive salary to ensure an experienced qualified candidate will apply. Director Habeger attended the October BON meeting and the issue of needing this position filled was addressed. I will continue to address this issue until the position is filled and in the interim the contract employee will continue the reviews.

Recommendation No. 3
The Division of Corporations, Business, and Professional Licensing's chief investigator should take steps to ensure that complaints and cases are investigated timely.

The Board of Nursing takes the responsibility that all complaints are investigated in a timely manner. I have learned that the Board of Nursing has some "older" cases due to a previous investigator who had some complaints that were never investigated. The current investigators are working to prioritize and complete the investigations. Chief, Quinten Warren has added another investigator to the BON and made Ken Weimer the senior investigator so there will now be a great deal more help to catch up the backlog plus deal with the daily intake. Also, the case situation will be monitored much more now than in the past as new procedures and computer system get up and running. The average of most cases would be that they are open from 3 months to one year if they do not involve litigation prior to the attorney general being involved, expert review and that type of process. Of course more complex cases or cases involving legal counsel and such do not fit these time frames. Cases are prioritized. The system is a 1-4 system with 1 being the highest priority, which would be cases of great potential for public harm and 4 being cases with low potential such as falsified application cases. The new GLS system is being used. However, it has many "bugs" in it which are still be rectified and causing all sort of disruptions and such. This system is actively being perfected each week. The chief and senior staff meet with other Division users in banking and security and them a meeting is held each week with the GLS people to address problems and working on correcting them. Hopefully by year's end the system will be working as expected. The Board will obtain an update with the investigative team at the January 2011 Board meeting.

Recommendation No.4
The Director of Boards and Commissions, Office of the Governor, should fill the LPN position with an LPN currently involved in institutional nursing services.

Recommendation No. 4 is the appointment of a qualified LPN. The previous Chair for the Board of Nursing recognized that the present LPN did not meet the requirements. The Chair contacted the previous Governor's office but no action was taken. The Board agrees that we need a practicing LPN for input on practice issues. The present LPN on the Board term ends March 2011. I have contacted Jason Hooley to address the issue for the future LPN appointment to the BON and have offered to evaluate potential LPN candidates prior to their appointment.

Analysis of Public Need on page 7 accounting error. I would like to highlight that the Volunteer Board of Nursing found the large accounting error that the state paid employees made. The Board will take credit for finding this error. With this error corrected, The Board was able to reduce our 2010 renewal fees.

Analysis of Public Need on Page 8 about statutory changes. The Board was asked by Director Davis in April 2008 to submit obsolete statutes. The Board promptly submitted 8 pages of changes with the rationale for the changes and the priority of these changes. The Board meets with the Director on a quarterly basis at our meeting. We have repeatedly asked our Director about where these statutory changes are in the system. The Board again asked Director Habeger at our October 2010 meeting if these statues are going to be presented as a Division or should the BON present these changes on our own. Director Habeger informed the Board that there is an omnibus with our statute requests in place. Director Habeger will follow up on this and report back to the Board at the January 2011 meeting.

Thank you for the opportunity to address a few of the items that required clarification and actions to rectify the deficiencies addressed in the preliminary BON sunset audit.

Sincerely,

Beth Gartner Farnstrom, RN

Beth Gartner Farnstrom, RN
BON Chair

SB

14

<TARGET><BILL>SB 14</BILL><SUBJECT>SB
14</SUBJECT><COMM>SHSS27</COMM></TARGET>

Senator Fred Dyson

SPONSOR STATEMENT

SB 14 - Health Care Provider Protection of Conscience

The purpose of this bill is to provide for the protection and reasonable accommodation of a health care provider's expression of professional conscience in the provision of health care services.

Today we are experiencing an unprecedented explosion in science and technology which in turn influences concepts in medical practice. While they have benefited mankind in many areas, these advances pose dilemmas of an ethical and professional nature. The issue of a right to conscience in health care is one of the most pressing public issues of our time.

A health care professional's view of health, sickness, patient care and purpose of medicine comprise a well-formed professional conscience. This conscience is changed with new information and technology. A broad application of a right of conscience applies to the issues of end of life care, consumer genetic testing, the practice of pain management, psychotropic drug use, sterilizations, race-specific medications, infant circumcision, physician and nurse complicity in capital punishment, physician assisted suicide, abortion, etc.

This bill recognizes the societal benefits that divergent organizational identities bring; the relational dimension of professional conscience between health care institutions and providers, between providers and patients, and between providers and communities; and helps ensure the conditions necessary for the conversations of conscience to continue concerning the health care profession.

Most states have laws protecting the conscience rights of health care providers. Alaska law currently does not provide for a general health care provider protection of conscience.

SB 14 provides a guarantee for the exercise of health care provider conscience in an increasingly pluralistic environment. All health care providers must be treated equally, and must have recourse to the exception made for conscience.

Contact: Chuck Kopp, Staff to Senator Fred Dyson, (907)465-2199

February 21, 2011
P.O. Box 1117
Soldotna, AK 99669

Senator Fred Dyson
Alaska State Capitol Room 121
Juneau, Alaska 99801

Dear Senator Dyson,

Recently I have been in discussion with other health care providers over concerns of the possibility of being forced to be involved in medical procedures that would be considered unethical to them. I would like to commend you and support you in your proposal of Senate Bill 14. I feel this is needed protection which needs to be guaranteed.

Thank you,
Pamela Howard RN

WK: (907) 283-1723

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Division of Corporations, Business and Professional Licensing

Sean Parnell, Governor
Emil Notti, Commissioner
Don Habeger, Director

February 24, 2011

Honorable Senator Fred Dyson
State Capitol, Room 121
Juneau AK 99801

RE: Alaska Board of Pharmacy Letter of Support –
Senate Bill 14: Protect Health Care Provider Conscience, as offered by Senator Dyson in the First Session of the 27th Alaska Legislature

Dear Senator Dyson,

Thank you for your presentation regarding Senate Bill 14 during the February 18th meeting of Alaska Board of Pharmacy. The members and audience gained valuable insight into the goals and parameters of your bill.

The mission of the Board of Pharmacy is taken very seriously. It is, per Alaska Statute Sec 08.80.005, *to promote, preserve and protect the public health, safety and welfare through effective control and regulation of the practice of pharmacy*. Senate Bill 14 is consistent with that mission.

As Chairman, and without reservation, the Alaska Board of Pharmacy announces its support of Senate Bill 14 regarding Conscience Objection by Heath Care Providers and wishes you continued success in its forward movement through the house and senate.

Respectfully Submitted,

Richard "Dick" Holm, RPh, Chairman
Alaska Board of Pharmacy

PO Box 110806, Juneau, AK 99811-0806
Telephone: (907) 465-2550 Fax: (907) 465-2974 Text Tel: (907) 465-5437 Website: www.commerce.state.ak.us/occ

Chuck Kopp

From: Thomas Wells [tomwells@gci.net]
Sent: Thursday, January 27, 2011 3:13 PM
To: Chuck Kopp
Subject: SB 14

Dear Senator Dyson:

I have reviewed Senate Bill 14 concerning health care provider protection of conscience. I feel this is a good bill that protects the actions of providers who in good conscience do not provide drugs or treatment to patients who request treatment, medications or procedures that the provider feels is unethical or detrimental to the patient's health. A prescription by one provider should not obligate another provider to perform procedures that could be harmful to the patient or unethical in the eyes of the second provider. Pharmacists should not be obligated to provide large volumes of addictive drugs to patients who are prone to drug addiction. I am sure there are a multitude of other circumstances in which the conscience provider needs protection.

Sincerely,

Thomas J. Wells DDS, MS

William W. Resinger, M.D.
P.O. Box 839
Palmer, Alaska 99645

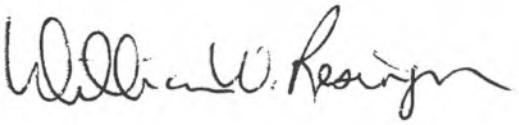
1/27/11

Senator Fred Dyson
Alaska State Capitol, Room 121
Juneau, Alaska 99801

Dear Senator Dyson:

I have reviewed your proposed bill, SB 14 -Health Provider Protection of Conscience, and I wish to extend my strong support for your proposal. I have been a physician since 1969 and I have indeed seen great changes in the practice of medicine over the years. There are increasing pressures coming to bear on medical workers which pose ethical and professional dilemmas. I have personally given written notice that I would not participate in certain procedures except for life threatening circumstances and, even then, I have faced considerable pressure to force my assistance. Fortunately I have been able to withstand the pressure so far, but I can see how your bill would provide much needed protection and strengthening of my position of conscience and would give further help to many other medical workers who might face even greater coercive pressure. Your bill is a well directed effort to provide legal protection of conscience for health care workers and it fills a real need in a complex, diverse, and highly technical modern society. While I would never have anticipated this need in 1969, I can now see the great necessity for your bill today. If I can be of any help in your efforts, please feel free to contact me.

Sincerely,



William W. Resinger, M.D.

SENATE BILL NO. 14

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY SENATORS DYSON AND COGHILL

Introduced: 1/7/11
Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

"An Act providing for the protection and reasonable accommodation of a health care provider's expression of conscience pertaining to a health care service; and providing for immunity, an exception, and prohibition of discrimination for an expression of conscience by a health care provider."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.95 is amended by adding a new section to read:

Sec. 18.95.015. Protection, reasonable accommodation, and notice of conscience objection by health care provider. (a) Except as provided in (c) of this section, an employer who receives a notice of objection described in (b) of this section shall make reasonable accommodations for the employee providing the notice and may not discriminate against an employee who provides the notice.

(b) A person who is employed as a health care provider may provide advance written notice to the person's employer of an objection to providing health care services. A health care provider is not required to provide a written explanation of the

reason for the objection, but the objection must be related to the provider's conscience. The objection may not be based on a patient's race, religion, sex, age, disability, or national origin.

(c) An employer is not required to accommodate an employee who has provided notice under (b) of this section if the employer demonstrates that the accommodation poses an undue hardship on the employer or the objecting employee is the only health care provider available to assist in the provision of health care services in a life-threatening circumstance.

(d) Notwithstanding the provision of a written notice of objection under (b) of this section, a health care provider may not refuse to provide treatment or care to a patient seeking health care services in a life-threatening circumstance until an alternate health care provider is available.

(e) A person who refuses to provide health care services in compliance with this section may not be held civilly or criminally liable for consequences resulting from the compliance.

(f) This section shall be construed in a manner consistent with 42 U.S.C. 2000e - 2000e-17 (Title VII, Civil Rights Act of 1964), as amended.

(g) In this section,

(1) "health care provider" means a person licensed, certified, or registered in the state who provides health care services; in this paragraph, "provide" means to counsel, advise, perform, dispense, assist, or refer;

(2) "health care services" means treatment, management, and research of illness and health;

(3) "life-threatening circumstance" means a situation that poses an immediate risk to a person's life or long-term health.

SENATOR FRED DYSON

SB 14 – SECTIONAL ANALYSIS

Section 1.

1. Provides within Alaska Statutes, *Title 18 - Health, Safety, and Housing,* a protection and reasonable accommodation for a health care provider's expression of conscience pertaining to provision of a health care service; and
2. Establishes written notice as the method of communicating an expression of conscience, and that the employer will reasonably accommodate and not discriminate against the employee providing notice; and
3. Provides that the notice does not have to include the reason for the objection, but must be related to the provider's conscience and not to a protected status of the patient; and
4. Provides that an employer is not required to accommodate the employee if the employer demonstrates the accommodation poses undue hardship or the objecting employee is the only health care provider available in a life-threatening circumstance, and that the health care provider may not refuse to provide treatment or care in a life-threatening circumstance until an alternate health care provider is available; and
5. Provides civil and criminal immunity to health care providers who express conscience in compliance with this section; and
6. Provides that this section will be construed in a manner consistent with Title VII of the Civil Rights Act of 1964; and
7. Defines terms.

During Session (January - May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 (fax)
During Interim (June-December): 10928 Eagle River Road, Suite 238 • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 (fax)
senator.fred.dyson@legis.state.ak.us • www.akrepublicans.org

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB014
() Publish Date:

Identifier (file name): SB014-DHSS-PHA-03-04-11
Dept. Affected: Health and Social Services
Title: Object to Providing Health Care Services
Appropriation: Public Health
Allocation: PH Administration
Sponsor: Sen. Dyson, Sen. Coghill
Requester: Senate HSS Committee
OMB Component Number: 292

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Ward B. Hurlburt, M.D., MPH - Chief Medical Officer/ Director
Phone 269-6680
Division: Public Health
Date/Time 3/3/11 12:00 AM
Approved by: Alison Elgee, Assistant Commissioner
Date 3/4/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB014

Analysis:

This bill protects a health care provider who objects to performing a health care service based on his or her professional conscience. This bill has no financial impact on the Department.

RECEIVED
MAR 07 2011

ACLU
AMERICAN CIVIL LIBERTIES UNION of ALASKA

March 7, 2011

AMERICAN CIVIL LIBERTIES UNION OF ALASKA
1057 W. Fireweed, Suite 207
Anchorage, AK 99503
(907) 258-0044
(907) 258-0288 (fax)
WWW.AKCLU.ORG

OFFICERS AND DIRECTORS
SUSAN WINGROVE, Anchorage
PRESIDENT

RICH CURTNER, Anchorage
VICE PRESIDENT

LLOYD EGGAN, Anchorage
TREASURER

TONY STRONG, Juneau
SECRETARY

WILLIE ANDERSON, Juneau
AFFIRMATIVE ACTION OFFICER

KIRSTEN BEY, Nome
DONNA GOLDSMITH, Anchorage
PAUL GRANT, Juneau
SCOTT HENDERSON, Anchorage
KATIE HURLEY, Wasilla
MARJORIE KAISER, Anchorage
MICHAEL KING, Anchorage
KAY MARTIN, Anchorage
CONNIE OZER, Anchorage
GALEN PAINE, Sitka
STEPHANIE PAWLOWSKI, Anchorage
JUNE PINNELL-STEPHENS, Fairbanks
NADINE WINTERS, Fairbanks

ZACH FICK, Anchorage
STUDENT ADVISOR

The Honorable Bettye Davis, Chair
Senate Health & Social Services Committee
Alaska State Senate
Juneau, AK 99801-1182
via email: Senator_Bettye_Davis@legis.state.ak.us

Re: Senate Bill 14
ACLU Statement in Opposition

Chair Davis:

Thank you for the opportunity to submit written testimony with respect to Senate Bill 14.

As you know, the American Civil Liberties Union of Alaska represents thousands of members and activists throughout the state who seek to preserve and expand individual freedoms and civil liberties guaranteed under the United States and Alaska Constitutions. In that regard, we would like to advise the Committee of several issues with respect to SB 14, and register our **strong opposition to the proposed legislation**.

Importance of Religious Liberty

The ACLU has long been a defender of religious liberty. Our work in defending the free exercise rights of people of faith is robust – both at the National and State levels. For example, the ACLU of Alaska worked with the Russian Old Believer Community in the Homer area to ensure that the state would not improperly interfere with their practice of Holy Week. *See*, http://homernews.com/stories/021810/news_wto.shtml.

A quick review of the website ACLU Fights for Christians, at: http://www.aclufightsforchristians.com/, reveals the continuing work of our sister Affiliates to protect the rights of all Americans to practice and believe free of government interference.

Importance of Privacy and Right to Bodily Integrity

Pursuant to our mandate to protect the constitutional rights of Americans, the ACLU also defends the right to privacy, including medical privacy and reproductive freedom. Individuals must control decisions about their bodies and their health, and the government should not make those decisions for them.

SB 14 allows health care providers to refuse to provide health services, even if they are the only available provider, unless there are "life threatening circumstances." It gives civil and criminal immunity to those health care providers regardless of the grievous harm that could be inflicted on a patient.

SB 14 does not draw the proper balance in protecting religious liberty and individual privacy, and in ensuring Alaskans' health.

Refusals to Provide Health Care Services Threaten Public Health

An employee's refusal to provide health care threatens the health and safety of Alaskans – particularly in rural areas where medical services are limited. ***SB 14 is a dangerous step away from government's responsibility to protect public health.***

Instead of putting patients' health first, it seeks to protect individuals ***who have otherwise taken an oath to provide medical services to those in need.*** A refusal can conflict with a health care provider's ethical duty to her patient. And SB 14 does not provide the safeguards medically recommended:

> Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. . . . In resource poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place.

http://www.acog.org/from_home/publications/ethics/co385.pdf, American College of Obstetricians and Gynecologists, Committee on Ethics, Opinion No. 385, November 2007, (Reaffirmed 2010).

The Proper Balance of Patients' Rights & Public Health with Religious Belief

The debate over religious refusals and health services need not be cast as a "winner take all contest" between "opposing" sides. The ACLU believes in a solution that balances protecting patients' rights and the public health with individual religious belief and institutional religious worship.

Institutions that operate in the public world ought to play by public rules. Health care providers serve and employ religiously diverse populations. Too, they often accept government funding. They are in the business of providing health services – not practicing religion. But SB 14 would permit a health care provider – even if that individual is the only provider on the premises – to refuse to provide care on the basis of "conscience" unless the patient was seeking care in life-threatening circumstances. It sanctions behaviors that are contrary to the interests of patients, and the standards of care required of Alaska health care providers.

This is bad public policy. Moreover, as written, SB 14 could come into conflict with the Alaska Supreme Court's decision in *Valley Hospital Association, Inc., v. Mat-Su Coalition for Choice* (1997) 948 P.2d 963, and result in needless, costly, and extended litigation. (In light of existing federal law, *see below*, passage of SB 14 would thus be doubly unwise.)

Clearly, institutions such as churches, temples, or mosques, whose main purpose is to inculcate religious values, ***ought generally to be free from having to comply with health care requirements repugnant to their beliefs***. But SB 14 dangerously goes beyond this principle.

SB 14 is Unnecessary

SB 14 is an unnecessary effort to protect an individual's right to not participate in procedures he or she finds objectionable because ***that right is already protected under the Civil Rights Act***. Title VII of that act requires an employer to attempt to accommodate current and prospective employees' refusals to provide any health care service on the basis of their religious beliefs so long as the accommodation does not pose an undue hardship on the employer's overall ability to provide health care services to its patients.

Title VII contemplates a careful balancing of interests. It gives employers leeway to take into account the effect of an employee's refusal on public health and safety, and at the same time, Title VII seeks the maximum possible accommodation of an individual's religious objection. The Civil Rights Act finds the middle ground between an employee's moral and religious objections and the needs of the patient to have access to the best healthcare possible.

Except for a "life-threatening circumstance," SB 14 makes no mention of the **patient's needs**. It implies that the patient's health is a low priority and that the patient's own moral grounding on what is and is not acceptable is unimportant. In addition – other than "life-threatening circumstances" – SB 14 includes no provision requiring the healthcare provider to find the means

for the patient to have access to the procedure in question. If the employee refuses to give the patient the necessary treatment, the patient is harmed with no recourse.

As Bad Public Policy, SB 14 Should Die in Committee

For the reasons set forth above, the ACLU believes SB 14 is bad for Alaska and particularly threatens the health of those in rural areas who are most vulnerable and in need of improved medical care.

We trust that the Health and Social Services Committee will take the necessary steps to ensure this bill does not proceed any further through the legislative process.

Thank you again permitting us to share our concerns. Please feel free to contact the undersigned should you require any additional information.

Sincerely,

Jeffrey Mittman
Executive Director
ACLU of Alaska

cc: Senator Dennis Egan, Senator_Dennis_Egan@legis.state.ak.us
Senator Johnny Ellis, Senator_Johnny_Ellis@legis.state.ak.us
Senator Kevin Meyer, Senator_Kevin_Meyer@legis.state.ak.us
Senator Fred Dyson, Senator_Fred_Dyson@legis.state.ak.us

ALASKA STATE SENATE

SENATOR FRED DYSON

SB 14 Witness & Contact Info

William W. Resinger, MD	(907)745-1763
Thomas J. Wells, DDS, MS	(907)277-4546
Paul J. Gionet, RPh	(907)279-2425
Julie McDonald, RPh	(907)826-5750
Stephen L. Hileman, MD	(907)262-2629
Pamela Howard, RN	(907)283-1723

During Session (January - May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 (fax)

During Interim (June-December): 10928 Eagle River Road, Suite 238 • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 (fax)

senator.fred.dyson@legis.state.ak.us • www.akrepublicans.org

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 18, 2011

SUBJECT: Effect of bill (SB 14 (Work Order No. 27-LS0105\B))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Celeste Hodge

FROM: Jean M. Mischel
Legislative Counsel

You have asked about the effect of SB 14, if passed by the legislature. SB 14 requires an employer to make reasonable accommodation and prohibits discrimination against an employee who has provided a notice of an objection, without explanation, to providing health care services. Health care services in the bill is defined broadly to include the treatment, management, and research of illness and health. Employer is not defined. An exception to the accommodation by the employer applies when the employer can demonstrate undue hardship or the lack of availability of another employee. The bill also precludes refusal of services in a life-threatening circumstance until an alternate employee is available. The bill provides for the objecting employee with immunity from civil and criminal liability. If you would like information about the societal benefits and need for the bill, please contact the sponsor directly.

If I may be of further assistance, please advise.

JMM:plm
11-098.plm

SB14 - OBJECT TO PROVIDING HEALTH CARE SERVICES

DOESN'T SUPPORT	SUPPORTS
Jeffrey Mittman, ACLU	Pamela Howard RN, 283-1723
Planned Parenthood	William W. Resinger, M.D., Palmer, AK
	Thomas Wells DDS, MS
	Richard "Dick" Holm, RPh, Chairman, Alaska Board of Pharmacy

LEGISLATIVE RESEARCH REPORT

FEBRUARY 25, 2011

REPORT NUMBER 11.188

GENERAL PROTECTION OF CONSCIENCE LAWS FOR HEALTHCARE PROVIDERS

PREPARED FOR SENATOR FRED DYSON

BY TIM SPENGLER, LEGISLATIVE ANALYST

You asked about states with generally-worded protection of conscience laws. Specifically, you wanted to know which states have enacted provisions allowing a healthcare provider to abstain from participating in medical procedures (not specific to abortion) that go against her or his conscience.[1]

We identified four states (Idaho, Illinois, Louisiana, and Mississippi) that have enacted general protection of conscience laws for healthcare providers.[2] According to Sean Murphy, administrator of the Protection of Conscience Project, conscience provisions that are broadly worded (as in these states) are preferable to more narrowly articulated statutes. He asserts that as new medical procedures can arise at any time, attempting to enumerate all potential issues of conscience for healthcare professionals in statute is impractical.[3]

Below we provide excerpts from Idaho, Illinois, Louisiana, and Mississippi statutes regarding protection of conscience for healthcare providers. We include the complete relevant statutes from these states as Attachment A.

Idaho (IC 18-611):

> IC 18-611(2) No health care professional shall be required to provide any health care service that violates his or her conscience.
>
> IC 18-611(4) No health care professional or employer of the health care professional shall be civilly, criminally or administratively liable for the health care professional

[1] Alaska and 46 other states (all but Alabama, New Hampshire, and Vermont) have laws that allow healthcare providers to refuse to participate in abortions.

[2] While we believe this list to be complete, it is possible that relevant provisions from other states may have eluded us.

[3] Sean Murphy can be reached at (604) 485-9765. The Protection of Conscience Project is a Canada-based organization that works to ensure that people are not forced to facilitate practices or procedures to which they object for reasons of conscience. These practices include abortion, capital punishment, contraception, sterilization, artificial reproduction, euthanasia, embryonic experimentation, assisted suicide, human experimentation, and torture (*http://www.consciencelaws.org/*).

declining to provide health care services that violate his or her conscience, except for life threatening situations as provided for in subsection (6) of this section.

Illinois (745 ILCS 70/1, Sec. 4):

No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.

Louisiana (La. Rev. Stat. Ann. tit. 40, § 1299.35.9):

A. (1) Any person has the right not to participate in, and no person shall be required to participate in any health care service that violates his conscience to the extent that patient access to health care is not compromised. No person shall be held civilly or criminally liable, discriminated against, dismissed, demoted, or in any way prejudiced or damaged for declining to participate in any health care service that violates his conscience.

Mississippi (MC § 41-107-5):

(1) Rights of Conscience. A health care provider has the right not to participate, and no health care provider shall be required to participate in a health care service that violates his or her conscience. However, this subsection does not allow a health care provider to refuse to participate in a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

We hope you find this information to be useful. Please let us know if you have questions or need additional information.

Attachment A

Idaho, Illinois, Louisiana, and Mississippi provisions regarding protection of conscience for healthcare providers.

West's Idaho Code Annotated Currentness
Title 18. Crimes and Punishments
Chapter 6. Abortion and Contraceptives
§ 18-611. Freedom of conscience for health care professionals

(1) As used in this section:

(a) "Abortifacient" means any drug that causes an abortion as defined in 18-604, Idaho Code, emergency contraception or any drug the primary purpose of which is to cause the destruction of an embryo or fetus.

(b) "Conscience" means the religious, moral or ethical principles sincerely held by any person.

(c) "Embryo" means the developing human life from fertilization until the end of the eighth week of gestation.

(d) "Fetus" means the developing human life from the start of the ninth week of gestation until birth.

(e) "Health care professional" means any person licensed, certified or registered by the state of Idaho to deliver health care.

(f) "Health care service" means an abortion, dispensation of an abortifacient drug, human embryonic stem cell research, treatment regimens utilizing human embryonic stem cells, human embryo cloning or end of life treatment and care.

(g) "Provide" means to counsel, advise, perform, dispense, assist in or refer for any health care service.

(h) "Religious, moral or ethical principles," "sincerely held," "reasonably accommodate" and "undue hardship" shall be construed consistently with Title VII of the federal civil rights act of 1964, as amended.

(2) No health care professional shall be required to provide any health care service that violates his or her conscience.

(3) Employers of health care professionals shall reasonably accommodate the conscience rights of their employees as provided in this section, upon advanced written notification by the employee. Such notice shall suffice without specification of the reason therefor. It shall be unlawful for any employer to discriminate against any health care professional based upon his or her declining to provide a health care service that violates his or her conscience, unless the employer can demonstrate that such accommodation poses an undue hardship.

(4) No health care professional or employer of the health care professional shall be civilly, criminally or administratively liable for the health care professional declining to provide health care services that violate his or her conscience, except for life-threatening situations as provided for in subsection (6) of this section.

(5) The provisions of this section do not allow a health care professional or employer of the health care professional to refuse to provide health care services because of a patient's race, color, religion, sex, age, disability or national origin.

© 2011 Thomson Reuters. No Claim to Orig. US Gov. Works.

(6) If a health care professional invokes a conscience right in a life-threatening situation where no other health care professional capable of treating the emergency is available, such health care professional shall provide treatment and care until an alternate health care professional capable of treating the emergency is found.

(7) Nothing in this section shall affect the rights of conscience provided for in section 18-612, Idaho Code, to the extent that those rights are broader in scope than those provided for in this section.

CREDIT(S)

Added by S.L. 2010, ch. 127, § 1, eff. July 1, 2010.

HISTORICAL AND STATUTORY NOTES

2010 Legislation

S.L. 2010, ch. 127, § 2, provides:

"The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

Former Section:

Former § 18-611, repealed by S.L. 2000, ch. 7, § 6, which related to patient's representations that physicians and hospitals may accept, was derived from S.L. 1973, ch. 197, § 10, p. 442.

RESEARCH REFERENCES

Treatises and Practice Aids

Wharton's Criminal Law § 254, First Trimester.

I.C. § 18-611, ID ST § 18-611

Current through the end of the 2010 Second Regular Session of the 60th Legislature

(c) 2011 Thomson Reuters

END OF DOCUMENT

© 2011 Thomson Reuters. No Claim to Orig. US Gov. Works.

West's Smith-Hurd Illinois Compiled Statutes Annotated Currentness
Chapter 745. Civil Immunities
➡ Act 70. Health Care Right of Conscience Act (Refs & Annos)
➡ **70/1. Short title**

§ 1. Short title. This Act may be cited as the Health Care Right of Conscience Act.

70/2. Findings and policy

§ 2. Findings and policy. The General Assembly finds and declares that people and organizations hold different beliefs about whether certain health care services are morally acceptable. It is the public policy of the State of Illinois to respect and protect the right of conscience of all persons who refuse to obtain, receive or accept, or who are engaged in, the delivery of, arrangement for, or payment of health care services and medical care whether acting individually, corporately, or in association with other persons; and to prohibit all forms of discrimination, disqualification, coercion, disability or imposition of liability upon such persons or entities by reason of their refusing to act contrary to their conscience or conscientious convictions in refusing to obtain, receive, accept, deliver, pay for, or arrange for the payment of health care services and medical care.

70/3. Definitions

§ 3. Definitions. As used in this Act, unless the context clearly otherwise requires:

(a) "Health care" means any phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning, counselling, referrals, or any other advice in connection with the use or procurement of contraceptives and sterilization or abortion procedures; medication; or surgery or other care or treatment rendered by a physician or physicians, nurses, paraprofessionals or health care facility, intended for the physical, emotional, and mental well-being of persons;

(b) "Physician" means any person who is licensed by the State of Illinois under the Medical Practice Act of 1987; [FN1]

(c) "Health care personnel" means any nurse, nurses' aide, medical school student, professional, paraprofessional or any other person who furnishes, or assists in the furnishing of, health care services;

(d) "Health care facility" means any public or private hospital, clinic, center, medical school, medical training institution, laboratory or diagnostic facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center or other institution or location wherein health care services are provided to any person, including physician organizations and associations, networks, joint ventures, and all other combinations of those organizations;

(e) "Conscience" means a sincerely held set of moral convictions arising from belief in and relation to God, or which, though not so derived, arises from a place in the life of its possessor parallel to that filled by God among adherents to religious faiths; and

(f) "Health care payer" means a health maintenance organization, insurance company, management services organization, or any other entity that pays for or arranges for the payment of any health care or medical care service,

© 2011 Thomson Reuters. No Claim to Orig. US Gov. Works.

procedure, or product.

The above definitions include not only the traditional combinations and forms of these persons and organizations but also all new and emerging forms and combinations of these persons and organizations.

[FN1] 225 ILCS 60/1 et seq.

70/4. Liability

§ 4. Liability. No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.

70/5. Discrimination

§ 5. Discrimination. It shall be unlawful for any person, public or private institution, or public official to discriminate against any person in any manner, including but not limited to, licensing, hiring, promotion, transfer, staff appointment, hospital, managed care entity, or any other privileges, because of such person's conscientious refusal to receive, obtain, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care services contrary to his or her conscience.

70/6. Duty of physicians and other health care personnel

§ 6. Duty of physicians and other health care personnel. Nothing in this Act shall relieve a physician from any duty, which may exist under any laws concerning current standards, of normal medical practices and procedures, to inform his or her patient of the patient's condition, prognosis and risks, provided, however, that such physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience.

Nothing in this Act shall be construed so as to relieve a physician or other health care personnel from obligations under the law of providing emergency medical care.

70/7. Discrimination by employers or institutions

§ 7. Discrimination by employers or institutions. It shall be unlawful for any public or private employer, entity, agency, institution, official or person, including but not limited to, a medical, nursing or other medical training institution, to deny admission because of, to place any reference in its application form concerning, to orally question about, to impose any burdens in terms or conditions of employment on, or to otherwise discriminate against, any applicant, in terms of employment, admission to or participation in any programs for which the applicant is eligible, or to discriminate in relation thereto, in any other manner, on account of the applicant's refusal to receive, obtain, accept, perform, counsel, suggest, recommend, refer, assist or participate in any way in any forms of health care services contrary to his or her conscience.

70/8. Denial of aid or benefits

§ 8. Denial of aid or benefits. It shall be unlawful for any public official, guardian, agency, institution or entity to deny any form of aid, assistance or benefits, or to condition the reception in any way of any form of aid, assistance or benefits, or in any other manner to coerce, disqualify or discriminate against any person, otherwise entitled to such

© 2011 Thomson Reuters. No Claim to Orig. US Gov. Works.

aid, assistance or benefits, because that person refuses to obtain, receive, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of health care services contrary to his or her conscience.

70/9. Liability

§ 9. Liability. No person, association, or corporation, which owns, operates, supervises, or manages a health care facility shall be civilly or criminally liable to any person, estate, or public or private entity by reason of refusal of the health care facility to permit or provide any particular form of health care service which violates the facility's conscience as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents.

Nothing in this act shall be construed so as to relieve a physician or other health care personnel from obligations under the law of providing emergency medical care.

70/10. Discrimination against facility

§ 10. Discrimination against facility. It shall be unlawful for any person, public or private institution or public official to discriminate against any person, association or corporation attempting to establish a new health care facility or operating an existing health care facility, in any manner, including but not limited to, denial, deprivation or disqualification in licensing, granting of authorizations, aids, assistance, benefits, medical staff or any other privileges, and granting authorization to expand, improve, or create any health care facility, by reason of the refusal of such person, association or corporation planning, proposing or operating a health care facility, to permit or perform any particular form of health care service which violates the health care facility's conscience as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents.

70/11. Denial of aid or benefit to a facility

§ 11. Denial of aid or benefit to a facility. It shall be unlawful for any public official, agency, institution or entity to deny any form of aid, assistance, grants or benefits; or in any other manner to coerce, disqualify or discriminate against any person, association or corporation attempting to establish a new health care facility or operating an existing health care facility which otherwise would be entitled to the aid, assistance, grant or benefit because the existing or proposed health care facility refuses to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of health care services contrary to the health care facility's conscience as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents.

70/11.2. Liability of health care payer

§ 11.2. Liability of health care payer. No health care payer and no person, association, or corporation that owns, operates, supervises, or manages a health care payer shall be civilly or criminally liable to any person, estate, or public or private entity by reason of refusal of the health care payer to pay for or arrange for the payment of any particular form of health care services that violate the health care payer's conscience as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents.

70/11.3. Discrimination against health care payer in licensing

§ 11.3. Discrimination against health care payer in licensing. It shall be unlawful for any person, public or private institution, or public official to discriminate against any person, association, or corporation (i) attempting to estab-

© 2011 Thomson Reuters. No Claim to Orig. US Gov. Works.

lish a new health care payer or (ii) operating an existing health care payer, in any manner, including but not limited to, denial, deprivation, or disqualification in licensing; granting of authorizations, aids, assistance, benefits, or any other privileges; and granting authorization to expand, improve, or create any health care payer, because the person, association, or corporation planning, proposing, or operating a health care payer refuses to pay for or arrange for the payment of any particular form of health care services that violates the health care payer's conscience as documented in the existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other governing documents.

70/11.4. Denial of aid or benefits to health care payer for refusal to participate in certain health care

§ 11.4. Denial of aid or benefits to health care payer for refusal to participate in certain health care. It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits; or in any other manner to coerce, disqualify, or discriminate against any person, association, or corporation attempting to establish a new health care payer or operating an existing health care payer that otherwise would be entitled to the aid, assistance, grant, or benefit because the existing or proposed health care payer refuses to pay for, arrange for the payment of, or participate in any way in any form of health care services contrary to the health care payer's conscience as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents.

70/12. Actions; damages

§ 12. Actions; damages. Any person, association, corporation, entity or health care facility injured by any public or private person, association, agency, entity or corporation by reason of any action prohibited by this Act may commence a suit therefor, and shall recover threefold the actual damages, including pain and suffering, sustained by such person, association, corporation, entity or health care facility, the costs of the suit and reasonable attorney's fees; but in no case shall recovery be less than $2,500 for each violation in addition to costs of the suit and reasonable attorney's fees. These damage remedies shall be cumulative, and not exclusive of other remedies afforded under any other state or federal law.

70/13. Liability for refusal to provide certain health care

§ 13. Liability for refusal to provide certain health care. Nothing in this Act shall be construed as excusing any person, public or private institution, or public official from liability for refusal to permit or provide a particular form of health care service if:

(a) the person, public or private institution or public official has entered into a contract specifically to provide that particular form of health care service; or

(b) the person, public or private institution or public official has accepted federal or state funds for the sole purpose of, and specifically conditioned upon, permitting or providing that particular form of health care service.

70/14. Supersedes other Acts

§ 14. Supersedes other Acts. This Act shall supersede all other Acts or parts of Acts to the extent that any Acts or parts of Acts are inconsistent with the terms or operation of this Act.

END OF DOCUMENT

© 2011 Thomson Reuters. No Claim to Orig. US Gov. Works.

1 of 40 DOCUMENTS

LOUISIANA STATUTES ANNOTATED
Copyright (c) 2011 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** THIS DOCUMENT IS CURRENT THROUGH THE 2010 REGULAR SESSION ***
*** ANNOTATIONS ARE CURRENT THROUGH JANUARY 11, 2011 ***

LOUISIANA REVISED STATUTES
TITLE 40. PUBLIC HEALTH AND SAFETY
CHAPTER 5. MISCELLANEOUS HEALTH PROVISIONS
PART 18. ABORTION

GO TO LOUISIANA STATUTES ARCHIVE DIRECTORY

La. R.S. 40:1299.35.9 (2011)

§ 40:1299.35.9. Conscience in health care protection; definitions

A. (1) Any person has the right not to participate in, and no person shall be required to participate in any health care service that violates his conscience to the extent that patient access to health care is not compromised. No person shall be held civilly or criminally liable, discriminated against, dismissed, demoted, or in any way prejudiced or damaged for declining to participate in any health care service that violates his conscience.

(2) This Section shall not prevent an inquiry by an employer or patient regarding whether a person declines to participate in any health care service that violates its conscience. When a patient requests health care services, a person shall identify, in writing, as soon as practicable, his declination to provide a service in accordance with the provisions of this Section. All persons who have a sincerely held religious belief or moral conviction and who seek employment at a health care facility shall notify the prospective employer of the existence of any sincerely held religious belief or moral conviction. Any health care facility that employs a person with a sincerely held religious belief or moral conviction shall ensure that the health care facility has sufficient staff to provide patient care in the event an employee declines to participate in any health care service that violates his conscience.

(3) The provisions of this Section shall not be construed to relieve any health care provider from providing emergency care as required by state or federal law.

(4) A person shall notify his employer in writing as soon as practicable of any health care service that violates his conscience. A person shall notify any patient before such person provides any consultation or service to the patient of the existence of a health care service that he will decline to provide because the health care service violates his conscience.

B. For purposes of this Section:

(1) "Conscience" means sincerely held religious belief or moral conviction.

(2) "Health care service" is limited to abortion, dispensation of abortifacient drugs, human embryonic stem cell research, human embryo cloning, euthanasia, or physician-assisted suicide.

C. A suit alleging a violation of this Section shall be brought in a district court in accordance with *R.S. 23:303*.

NOTES:

LexisNexis 50 State Surveys, Legislation & Regulations

Abortion

HISTORY: Acts 2009, No. 372, § 1, eff. Aug. 15, 2009.

1 of 1 DOCUMENT

MISSISSIPPI CODE of 1972 ANNOTATED
Copyright; 2010 by The State of Mississippi
All rights reserved.

*** Current through the 2010 2nd Extraordinary Session ***
*** State Court Annotations current through April 15, 2010 ***

TITLE 41. PUBLIC HEALTH
CHAPTER 107. HEALTH CARE RIGHTS OF CONSCIENCE

GO TO MISSISSIPPI STATUTES ARCHIVE DIRECTORY

Miss. Code Ann. § 41-107-5 (2010)

§ 41-107-5. Rights of Conscience of Health-Care Providers

(1) *Rights of Conscience.* A health-care provider has the right not to participate, and no health-care provider shall be required to participate in a health-care service that violates his or her conscience. However, this subsection does not allow a health-care provider to refuse to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(2) *Immunity from Liability.* No health-care provider shall be civilly, criminally, or administratively liable for declining to participate in a health-care service that violates his or her conscience. However, this subsection does not exempt a health-care provider from liability for refusing to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(3) *Discrimination.* It shall be unlawful for any person, health-care provider, health-care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health-care provider in any manner based on his or her declining to participate in a health-care service that violates his or her conscience. For purposes of this chapter, discrimination includes, but is not limited to: termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training opportunities, or any other penalty, disciplinary or retaliatory action.

HISTORY: SOURCES: Laws, 2004, ch. 568, § 3, eff from and after July 1, 2004.

NOTES: JOINT LEGISLATIVE COMMITTEE NOTE. --Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in (3). "This chapter" was substituted for "this act" following "Purposes of" in the second sentence.

LEGISLATIVE RESEARCH REPORT

MARCH 2, 2011

REPORT NUMBER 11.190

STATE CONSCIENCE LAWS FOR HEALTHCARE PROVIDERS

PREPARED FOR SENATOR BETTYE DAVIS

BY TIM SPENGLER, LEGISLATIVE ANALYST

You asked for information on state laws pertaining to "protection of conscience" for health care providers. Additionally, you wanted copies of relevant statutes.

Briefly, 47 states—including Alaska—have enacted, to varying degrees, protection of conscience laws; these provisions allow providers of health care and certain institutions to refuse to provide, or participate in, medical services that go against an individual's conscience or the religious affiliation of the hospital.[1] The provisions often relate to issues regarding reproduction, especially abortion and contraception.

Proponents of conscience laws assert that without such measures health care providers may be forced to choose between providing medical services that go against their deeply held moral or religious beliefs and declining to do so with the possibility of losing their jobs. Opponents of such laws believe providers and hospitals have a duty to supply patients with their legal medical options, regardless of the moral standpoints of individuals or institutions. Opponents typically see conscience laws as an attempt to limit reproductive rights.

Alaska Statute

Alaska has enacted one provision in statute that pertains to protection of conscience. Alaska Statute 18.16.010(b) reads as follow:

> Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section.

[1] Hospitals that invoke protection of conscience provisions are often affiliated with Catholic or other religious denominations. According to our review, nearly 20 percent of hospitals in the United States are religiously affiliated.

Laws in Other States

As we mentioned, 47 states (all except Alabama, New Hampshire and Vermont) have protection of conscience laws.[2] The statutory language and scope of such laws differ from state to state. We identified information on these laws from a number of sources including the Protection of Conscience Project (POCP) and the Guttmacher Institute.[3] Despite their differing standpoints on the issue (POCP advocates for conscience laws while Guttmacher has a more skeptical view of such laws), the information we gleaned on state laws from both of these entities was largely consistent.

Some of the highlights from state laws regarding protection of conscience are as follows:

- 47 states permit individual health care providers to abstain from providing abortions;
- 45 states allow health care institutions to refuse to provide abortions; 15 limit the exemption to private health care institutions;
- 9 states allow individual health care providers to refuse to provide services related to contraception; and
- 17 states allow individual health care providers to refuse to provide sterilization services while 16 states allow health care institutions to refuse to provide these services (four limit the exemption to private entities).

We include, as Attachment A, a February 2011 document from the Guttmacher Institute, which includes a table that disaggregates state conscience laws regarding abortion, contraception and sterilization.[4]

We also include, as Attachment B, statutes from 47 states that pertain to protection of conscience for health care workers. As we mentioned above, the great majority of these provisions relate to abortion. We made every attempt to ensure that the list of state laws in Attachment B is comprehensive, accurate, and up-to-date; however, it is possible that relevant provisions may have eluded us.

We identified four states (Idaho, Illinois, Louisiana, and Mississippi) that have enacted *general* (not specific to abortion or another particular medical procedure) protection of conscience laws for healthcare providers. According to Sean Murphy, administrator of the Protection of Conscience Project, conscience provisions that are broadly worded (as in these states) are preferable to more narrowly articulated statutes. He asserts that as new medical procedures can arise at any time, attempting to enumerate all potential issues of conscience for healthcare professionals in statute is impractical.[5]

---

[2] Even in the states without such provisions, an individual health care professional's actions may be legally protected by statutes prohibiting discrimination against employees based on religious objections. At the federal level, health care institutions and providers may refuse to participate in abortion services on the basis of their religious or moral beliefs under 42 USC § 300a-7(b).

[3] The Protection of Conscience Project is a Canadian-based organization that works to ensure that people are not forced to facilitate practices or procedures to which they object for reasons of conscience. These practices include abortion, capital punishment, contraception, sterilization, artificial reproduction, euthanasia, assisted suicide, human experimentation, and torture (*http://www.consciencelaws.org/*). The Guttmacher Institute works to advance sexual and reproductive health in the U.S. and worldwide through an interrelated program of social science research, policy analysis, and education (*http://www.guttmacher.org/*).

[4] The only inaccuracy we found in this document is the absence of a West Virginia law (§16-2F-7) that allows providers to refuse to participate in abortions.

[5] Sean Murphy can be reached at (604) 485-9765.

Below we provide excerpts of generally-worded statutes from Idaho, Illinois, Louisiana, and Mississippi regarding protection of conscience for healthcare providers.

Idaho (IC 18-611):

> IC 18-611(2) No health care professional shall be required to provide any health care service that violates his or her conscience.
>
> IC 18-611(4) No health care professional or employer of the health care professional shall be civilly, criminally or administratively liable for the health care professional declining to provide health care services that violate his or her conscience, except for life threatening situations as provided for in subsection (6) of this section.

Illinois (745 ILCS 70/1, Sec. 4):

> No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.

Louisiana (La. Rev. Stat. Ann. tit. 40, § 1299.35.9):

> A. (1) Any person has the right not to participate in, and no person shall be required to participate in any health care service that violates his conscience to the extent that patient access to health care is not compromised. No person shall be held civilly or criminally liable, discriminated against, dismissed, demoted, or in any way prejudiced or damaged for declining to participate in any health care service that violates his conscience.

Mississippi (MC § 41-107-5):

> (1) Rights of Conscience. A health care provider has the right not to participate, and no health care provider shall be required to participate in a health care service that violates his or her conscience. However, this subsection does not allow a health care provider to refuse to participate in a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

We hope you find this information to be useful. Please let us know if you have questions or need additional information.

Attachment A

"Refusing to Provide Health Services," Guttmacher Institute, February 1, 2011

GUTTMACHER INSTITUTE

STATE POLICIES IN BRIEF

As of FEBRUARY 1, 2011

Refusing to Provide Health Services

BACKGROUND: Almost every state has a policy explicitly allowing some health care professionals or certain institutions to refuse to provide or participate in abortion, contraceptive services or sterilization services. Even in states without explicit refusal statutes, an individual health care professional's actions may be legally protected by statutes prohibiting discrimination against employees, based on their religious objections. While some of the institutional policies are limited to private, or even religious, health care institutions, others apply to all institutions providing health care. (At the federal level, health care institutions and providers may refuse to participate in abortion services on the basis of their religious or moral beliefs.)

A few states have enacted laws that specifically allow pharmacists or pharmacies to refuse to provide health care due to religious or moral objections. Several other states have broadly worded refusal clause statutes that might protect pharmacists or pharmacies from liability for their refusal. (See Emergency Contraception.)

HIGHLIGHTS:

- 46 states allow some health care providers to refuse to provide abortion services.
  - All of these states permit individual health care providers to refuse to provide abortion services.
  - 45 states allow health care institutions to refuse to provide abortion services, 15 limit the exemption to private health care institutions and 1 state allows only religious health care entities to refuse to provide such care.

- 14 states allow some health care providers to refuse to provide services related to contraception.
  - 9 states allow individual health care providers to refuse to provide services related to contraception
  - 5 states explicitly permit pharmacists to refuse to dispense contraceptives. (5 additional states have broad refusal clauses that do not specifically include pharmacists, but may apply to them.)
  - 1 state explicitly permits pharmacies to refuse to dispense contraceptives.
  - 4 states have broad refusal clauses that do not specifically include pharmacies, but may apply to them.
  - 9 states allow health care institutions to refuse to provide services related to contraception, 6 states limit the exemption to private entities.

- 18 states allow some health care providers to refuse to provide sterilization services.
  - 17 states allow individual health care providers to refuse to provide sterilization services.
  - 16 states allow health care institutions to refuse to provide sterilization services; 4 limit the exemption to private entities.

GUTTMACHER INSTITUTE

Advancing sexual and reproductive health worldwide through research, policy analysis and public education.

125 Maiden Lane
New York, NY 10038
212.248.1111
www.guttmacher.org
info@guttmacher.org

1301 Connecticut Avenue, N.W.
Washington, DC 20036
202.296.4012
www.guttmacher.org
policyworks@guttmacher.org

© 2011, Guttmacher Institute

CONTINUED

POLICIES ALLOWING PROVIDERS TO REFUSE

STATE	ABORTION		CONTRACEPTION				STERILIZATION	
	Individual Providers	Institutions	Individual Providers	Pharmacists	Pharmacies	Institutions	Individual Providers	Institutions
Alaska	X	Private						
Arizona	X$^{\Psi}$	X$^{\Psi}$	§	§	§	§		
Arkansas	X	X	X	X	*	Private	X	X
California	X	Religious		†				
Colorado	X	X	X	*	*	Private		
Connecticut	X							
Delaware	X	X						
Florida	X	X	X	*				
Georgia	X	X		X			X	X
Hawaii	X	X						
Idaho	X	X	X	X			X	X
Illinois	X	Private	X	*	‡	X	X	X
Indiana	X	Private						
Iowa	X	Private						
Kansas	X	X					X	X
Kentucky	X	X					X	
Louisiana	X	X						
Maine	X	X	X	*	*	Private	X	X
Maryland	X	X					X	X
Massachusetts	X	Private				Private	X	Private
Michigan	X	X						
Minnesota	X	Private						
Mississippi	X	X	X	X	X	X	X	X
Missouri	X	X						
Montana	X	Private					X	Private
Nebraska	X	X						
Nevada	X	Private						
New Jersey	X	Private			‡	Private	X	Private
New Mexico	X	X						X
New York	X	X						
North Carolina	X	X						
North Dakota	X	X						
Ohio	X	X						
Oklahoma	X	X						
Oregon	X	Private						
Pennsylvania	X	Private					X	Private
Rhode Island	X	X					X	
South Carolina	X	Private						
South Dakota	X	X		X				
Tennessee	X	X	X	*	*	Private		
Texas	X	Private						
Utah	X	Private						
Virginia	X	X						
Washington	X	X	X		‡	X	X	X
West Virginia							X	X
Wisconsin	X	X			Ω		X	X
Wyoming	X	Private						
TOTAL	**46**	**45**	**9**	**5**	**1**	**9**	**17**	**16**

Note: Unless indicated, the right to refuse applies to all institutions– private, religious and public.

§ Temporarily enjoined; law not in effect pending the outcome of litigation.

Ψ An expansion of the state's abortion refusal clause is temporarily enjoined pending the outcome of litigation; the prior law is in effect.

* A broadly worded refusal clause may apply.

† Pharmacists have a duty to dispense valid prescriptions and can only refuse to dispense a prescription, including contraceptives, when their employers approves the refusal and the woman can still access her prescription in a timely manner.

‡ Pharmacies are required to dispense valid prescriptions and in Illinois and Washington deliver FDA-approved drugs, such as emergency contraception.

Ω State law requires pharmacies to fill valid contraceptive prescriptions.

CONTINUED

FOR MORE INFORMATION:

For information on state legislative and policy activity, click on Guttmacher's Monthly State Update, and for state-level information and data on reproductive health issues, click on Guttmacher's State Center. To see state-specific abortion information, click on State Facts About Abortion and Guttmacher's Data Center.

Sonfield A, Delineating the obligations that come with conscientious refusal: a question of balance, *Guttmacher Policy Review*, 2009, 12(3):6–10.

Sonfield A, Proposed 'conscience' regulation opposed widely as threat to reproductive health and beyond, *Guttmacher Policy Review*, 2008, 11(4):17–19.

Sonfield A, Provider refusal and access to reproductive health services: approaching a new balance, *Guttmacher Policy Review*, 2008, 11(2):2–6.

Guttmacher Institute, Striking a balance between a provider's right to refuse and a patient's right to receive care, 2005.

Dailard C, Beyond the issue of pharmacist refusals: pharmacies that won't sell emergency contraceptives, *The Guttmacher Report on Public Policy*, 2005, 8(3):10–12.

Sonfield A, Rights vs. responsibilities: professional standards and provider refusals, *The Guttmacher Report on Public Policy*, 2005, 8(3):7–9.

Sonfield A, New refusal clauses shatter balance between provider 'conscience,' patient needs, *The Guttmacher Report on Public Policy*, 2004, 7(3):1–3.

Gold RB, Future uncertain for Catholic plans' creative approaches to providing contraceptive access, *The Guttmacher Report on Public Policy*, 2000, 3(6):1–2 & 14.

Gold RB and Sonfield A, Refusing to participate in health care: a continuing debate, *The Guttmacher Report on Public Policy*, 2000, 3(1):8–11.

Dailard C, State contraceptive coverage laws: creative responses to questions of 'conscience', *The Guttmacher Report on Public Policy*, 1999, 2(4):1–2 & 14.

Cohen SA, Objections, confusion among pharmacists threaten access to emergency contraception, *The Guttmacher Report on Public Policy*, 1999, 2(3):1–3.

Gold RB, Contraceptive coverage: toward ensuring access while respecting conscience, *The Guttmacher Report on Public Policy*, 1998, 1(6):1–2 & 14.

Donovan P, When plans opt out: family planning access in Medicaid managed care, *The Guttmacher Report on Public Policy*, 1998, 1(4):8–11.

Gold RB, Conscience makes a comeback in the age of managed care, *The Guttmacher Report on Public Policy*, 1998, 1(1):1–2.

Attachment B

State statutes (47 states) regarding "protection of conscience" for health care providers.

Alaska

AS 18.16. Regulation of Abortions

(b) Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section.

Arizona

36-2151 . Right to refuse to participate in abortion

No hospital is required to admit any patient for the purpose of performing an abortion. A physician, or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital, doctor, clinic, or other medical or surgical facility in which an abortion has been authorized, who shall state in writing an objection to such abortion on moral or religious grounds shall not be required to participate in the medical or surgical procedures which will result in the abortion.

36-3205 . Health care providers; immunity from liability; conditions

C. A health care provider is not subject to criminal or civil liability or professional discipline for any of the following:
1. Failing to comply with a decision or a direction that violates the provider's conscience if the provider promptly makes known the provider's unwillingness and promptly transfers the responsibility for the patient's care to another provider who is willing to act in accordance with the agent's direction.

Arkansas

20-16-304. Public policy – Availability of Procedures, Supplies, and Information –Exceptions.

(5) No private institution or physician, nor any agent or employee of such institution or physician, nor any employee of a public institution acting under directions of a physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when the refusal is based upon religious or conscientious objection. No such institution, employee, agent, or physician shall be held liable for the refusal.
History. Acts 1973, No.235, §4.

§ 20-16-601. Refusal to perform, participate, consent, or submit
(a) No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy. The refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or any other recriminatory action against him.

(b) No hospital, hospital director, or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit the procedures shall not be grounds for civil liability to any person nor a basis for any disciplinary or other recriminatory action against it by the state or any person.

(c) The refusal of any person to submit to an abortion or to give consent for an abortion shall not be grounds for loss of any privileges or immunities to which the person would otherwise be entitled, nor shall submission to an

abortion or the granting of consent for an abortion be a condition precedent to the receipt of any public benefits. History. Acts 1969, No. 61, § 8; A.S.A. 1947, § 41-2560.

California

California Health and Safety Code
Section 123400-123450 Therapeutic Abortion Act.

123400. This article shall be known and may be cited as the Therapeutic Abortion Act.

123420. (a) No employer or other person shall require a physician, a registered nurse, a licensed vocational nurse, or any other person employed or with staff privileges at a hospital, facility, or clinic to directly participate in the induction or performance of an abortion, if the employee or other person has filed a written statement with the employer or the hospital, facility, or clinic indicating a moral, ethical, or religious basis for refusal to participate in the abortion.

No such employee or person with staff privileges in a hospital, facility, or clinic shall be subject to any penalty or discipline by reason of his or her refusal to participate in an abortion.

No such employee of a hospital, facility, or clinic that does not permit the performance of abortions, or person with staff privileges therein, shall be subject to any penalty or discipline on account of the person's participation in the performance of an abortion in other than the hospital, facility, or clinic.

No employer shall refuse to employ any person because of the person's refusal for moral, ethical, or religious reasons to participate in an abortion, unless the person would be assigned in the normal course of business of any hospital, facility, or clinic to work in those parts of the hospital, facility, or clinic where abortion patients are cared for.

No provision of this article prohibits any hospital, facility, or clinic that permits the performance of abortions from inquiring whether an employee or prospective employee would advance a moral, ethical, or religious basis for refusal to participate in an abortion before hiring or assigning that person to that part of a hospital, facility, or clinic where abortion patients are cared for.

The refusal of a physician, nurse, or any other person to participate or aid in the induction or performance of an abortion pursuant to this subdivision shall not form the basis of any claim for damages.

(b) No medical school or other facility for the education or training of physicians, nurses, or other medical personnel shall refuse admission to a person or penalize the person in any way because of the person's unwillingness to participate in the performance of an abortion for moral, ethical, or religious reasons.

No hospital, facility, or clinic shall refuse staff privileges to a physician because of the physician's refusal to participate in the performance of abortion for moral, ethical, or religious reasons.

(c) Nothing in this article shall require a nonprofit hospital or other facility or clinic that is organized or operated by a religious corporation or other religious organization and licensed pursuant to Chapter 1 (commencing with

Section 1200) or Chapter 2 (commencing with Section 1250) of Division 2, or any administrative officer, employee, agent, or member of the governing board thereof, to perform or to permit the performance of an abortion in the facility or clinic or to provide abortion services.

No such nonprofit facility or clinic organized or operated by a religious corporation or other religious organization, nor its administrative officers, employees, agents, or members of its governing board shall be liable, individually or collectively, for failure or refusal to participate in any such act. The failure or refusal of any such corporation, unincorporated association or individual person to perform or to permit the performance of such medical procedures shall not be the basis for any disciplinary or other recriminatory action against such corporations, unincorporated associations, or individuals. Any such facility or clinic that does not permit the performance of abortions on its premises shall post notice of that proscription in an area of the facility or clinic that is open to patients and prospective admittees.

(d) This section shall not apply to medical emergency situations and spontaneous abortions. Any violation of this section is a misdemeanor.

Colorado

18-6-104 - Failure to comply.

Nothing in sections 18-6-101 to 18-6-104 requires a hospital to admit any patient under said sections for the purposes of performing an abortion, nor is any hospital required to appoint a special hospital board as defined in section 18-6-101 (4). A person who is a member of or associated with the staff of a hospital or any employee of a hospital in which a justified medical termination has been authorized and who states in writing an objection to the termination on moral or religious grounds is not required to participate in the medical procedures which result in the termination of a pregnancy, and the refusal of any such person to participate does not form the basis for any disciplinary or other recriminatory action against the person.

25-3-110

(2) Notwithstanding any other provision of law to the contrary, all health care facilities that are licensed pursuant to this Part I and provide emergency care to sexual assault survivors shall amend their evidence collection protocols for the treatment of sexual assault survivors to include informing the survivor in a timely manner of the availability of emergency contraception as a means of pregnancy prophylaxis and educating the survivor on the proper use of emergency contraception and the appropriate follow-up care.

(3) Nothing in this section shall be interpreted to require:

(a) a health care professional who is employed by a health care facility that provides emergency care to a sexual assault survivor to inform the survivor of the availability of emergency contraception if the professional refuses to provide the information on the basis of religious or moral beliefs; or

(b) a health care facility to provide emergency contraception to a sexual assault survivor who is not at risk of becoming pregnant as a result of the sexual assault or who was already pregnant at the time of the assault.

(4) If any licensed pharmacy does not have non-prescription emergency contraception in stock, the pharmacy shall place a conspicuous notice in the area where customers obtain prescription drugs that states "Plan B emergency contraception not available."

25-6-102. Policy, authority, and prohibitions against restrictions.

(9) No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal.

Connecticut

Sec. 19-13-D54. Abortions (f) No person shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs . .

Delaware

§ 1791. Refusal to perform or submit to medical procedures.

(a) No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person, nor a basis for any disciplinary or other recriminatory action against the person.

(b) No hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution, and the refusal to permit such procedures shall not be grounds for civil liability to any person, nor a basis for any disciplinary or other recriminatory action against it by the State or any person.

(c) The refusal of any person to submit to an abortion or to give consent shall not be grounds for loss of any privileges or immunities to which such person would otherwise be entitled, nor shall submission to an abortion or the granting of consent be a condition precedent to the receipt of any public benefits.
(24 Del. C. 1953, § 1791; 57 Del. Laws, c. 145, § 2; 70 Del. Laws, c. 186, § 1.)

Florida

381.0051 Family planning
(6) Refusal for Religious or Medical Reasons.

--The provisions of this section shall not be interpreted so as to prevent a physician or other person from refusing to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons; and the physician or other person shall not be held liable for such refusal.

Chapter 390 Termination of Pregnancies
390.0111 Termination of pregnancies.--
(8) Refusal to participate in termination procedure

Nothing in this section shall require any hospital or any person to participate in the termination of a pregnancy, nor shall any hospital or any person be liable for such refusal. No person who is a member of, or associated with, the staff of a hospital, nor any employee of a hospital or physician in which or by whom the termination of a pregnancy has been authorized or performed, who shall state an objection to such procedure on moral or religious grounds shall be required to participate in the procedure which will result in the termination of pregnancy. The refusal of any such person or employee to participate shall not form the basis for any disciplinary or other recriminatory action against such person. \

Georgia

Official Code 16-12-142G

Nothing in this article shall require a hospital or other medical facility or physician to admit any patient under the provisions of this article for the purpose of performing an abortion. In addition, any person who states in writing an objection to any abortion or all abortions on moral or religious grounds shall not be required to participate in procedures which will result in such abortion; and the refusal of the person to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against the person. The written objection shall remain in effect until the person revokes it or terminates his association with the facility with which it is filed.

Official Code 49-7-5.

The refusal of any person to accept family-planning services shall in no way affect the right of such person to receive public assistance or public health services or to avail himself of any other public benefit. The employees of the agencies engaged in the administration of this chapter shall recognize that the right to make decisions concerning family planning and birth control is a fundamental personal right of the individual; and nothing in this chapter shall in any way abridge such individual right, nor shall any individual be required to state his reason for refusing the offer of family-planning services.

Official Code 49-7-6.

Any employee of the agencies engaged in the administration of this chapter may refuse to accept the duty of offering family-planning services to the extent that such duty is contrary to such employee's personal religious beliefs; and such refusal shall not be grounds for any disciplinary action, for dismissal, for any interdepartmental transfer, for any other discrimination in his employment, for suspension from employment, or for any loss in pay or other benefits. The directors or supervisors of such agencies shall be authorized, however, to reassign the duties of any such employees in order to carry out this chapter effectively.

Hawaii

[§453-16]

(d) Nothing in this section shall require any hospital or any person to participate in such abortion nor shall any hospital or any person be liable for such refusal. [L 1970, c 1, §2]

Idaho

5-334. Act or Omission Preventing Abortion Not Actionable

(1) A cause of action shall not arise, and damages shall not be awarded, on behalf of any person, based on the claim that but for the act or omission of another, a person would not have been permitted to have been born alive but would have been aborted.

(2) The provisions of this section shall not preclude causes of action based on claims that, but for a wrongful act or omission, fertilization would not have occurred, maternal death would not have occurred or handicap, disease, defect or deficiency of an individual prior to birth would have been prevented, cured or ameliorated in a manner that preserved the health and life of the affected individual.

18-611. Freedom of Conscience for Health Care Professionals

(1) As used in this section:

(a) "Abortifacient" means any drug that causes an abortion as defined in 18-604, Idaho Code, emergency contraception or any drug the primary purpose of which is to cause the destruction of an embryo or fetus.

(b) "Conscience" means the religious, moral or ethical principles sincerely held by any person.

(c) "Embryo" means the developing human life from fertilization until the end of the eighth week of gestation.

(d) "Fetus" means the developing human life from the start of the ninth week of gestation until birth.

(e) "Health care professional" means any person licensed, certified or registered by the state of Idaho to deliver health care.

(f) "Health care service" means an abortion, dispensation of an abortifacient drug, human embryonic stem cell research, treatment regimens utilizing human embryonic stem cells, human embryo cloning or end of life treatment and care.

(g) "Provide" means to counsel, advise, perform, dispense, assist in or refer for any health care service.

(h) "Religious, moral or ethical principles," "sincerely held," "reasonably accommodate" and "undue hardship" shall be construed consistently with Title VII of the federal civil rights act of 1964, as amended.

(2) No health care professional shall be required to provide any health care service that violates his or her conscience.

(3) Employers of health care professionals shall reasonably accommodate the conscience rights of their employees as provided in this section, upon advanced written notification by the employee. Such notice shall suffice without specification of the reason therefor. It shall be unlawful for any employer to discriminate against any health care professional based upon his or her declining to provide a health care service that violates his or her conscience, unless the employer can demonstrate that such accommodation poses an undue hardship.

(4) No health care professional or employer of the health care professional shall be civilly, criminally or administratively liable for the health care professional declining to provide health care services that violate his or her conscience, except for lifethreatening situations as provided for in subsection (6) of this section.

(5) The provisions of this section do not allow a health care professional or employer of the health care professional to refuse to provide health care services because of a patient's race, color, religion, sex, age, disability or national origin.

(6) If a health care professional invokes a conscience right in a lifethreatening situation where no other health care professional capable of treating the emergency is available, such health care professional shall provide treatment and care until an alternate health care professional capable of treating the emergency is found.

(7) Nothing in this section shall affect the rights of conscience provided for in section 18-612, Idaho Code, to the extent that those rights are broader in scope than those provided for in this section.

18-612. Refusal to Perform Abortions- - Physicians and Hospitals Not Liable [Effective contingent on Governor's Proclamation]

Nothing in this act shall be deemed to require any hospital to furnish facilities or admit any patient for any abortion if, upon determination by its governing board, it elects not to do so. Neither shall any physician be required to perform or assist in any abortion, nor shall any nurse, technician or other employee of any physician or hospital be required by law or otherwise to assist or participate in the performance or provision of any abortion if he or she, for personal, moral or religious reasons, objects thereto. Any such person in the employ or under the control of a hospital shall be deemed to have sufficiently objected to participation in such procedures only if he or she has advised such hospital in writing that he or she generally or specifically objects to assisting or otherwise participating in such procedures. Such notice will suffice without specification of the reason therefor. No refusal to accept a patient for abortion or to perform, assist or participate in any such abortion as herein provided shall form the basis of any claim for damages or recriminatory action against the declining person, agency or institution.

Illinois

745 ILCS 30/0.01 Abortion Performance Refusal Act

Sec. 0.01. Short title.
This Act may be cited as the Abortion Performance Refusal Act. (Source: P.A. 86-1324.) (745 ILCS 30/1)

Sec. 1.
(a) No physician, nurse or other person who refuses to recommend, perform or assist in the performance of an abortion, whether such abortion be a crime or not, shall be liable to any person for damages allegedly arising from such refusal.

(b) No hospital that refuses to permit the performance of an abortion upon its premises, whether such

abortion be a crime or not, shall be liable to any person for damages allegedly arising from such refusal.

(c) Any person, association, partnership or corporation that discriminates against another person in any way, including, but not limited to, hiring, promotion, advancement, transfer, licensing, granting of hospital privileges, or staff appointments, because of that person's refusal to recommend, perform or assist in the performance of an abortion, whether such abortion be a crime or not, shall be answerable in civil damages equal to 3 times the amount of proved damages, but in no case less than $2,000.

(d) The license of any hospital, doctor, nurse or any other medical personnel shall not be revoked or suspended because of a refusal to permit, recommend, perform or assist in the performance of an abortion. (Source: P. A. 78-228.)

745 ILCS 70/1 Health Care Right of Conscience Act.

Sec. 1. Short title.
This Act may be cited as the Health Care Right of Conscience Act. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/2)

Sec. 2. Findings and policy.

The General Assembly finds and declares that people and organizations hold different beliefs about whether certain health care services are morally acceptable. It is the public policy of the State of Illinois to respect and protect the right of conscience of all persons who refuse to obtain, receive or accept, or who are engaged in, the delivery of, arrangement for, or payment of health care services and medical care whether acting individually, corporately, or in association with other persons; and to prohibit all forms of discrimination, disqualification, coercion, disability or imposition of liability upon such persons or entities by reason of their refusing to act contrary to their conscience or conscientious convictions in refusing to obtain, receive, accept, deliver, pay for, or arrange for the payment of health care services and medical care. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/3)

Sec. 3. Definitions.

As used in this Act, unless the context clearly otherwise requires:

(a) **"Health care"** means any phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning, counselling, referrals, or any other advice in connection with the use or procurement of contraceptives and sterilization or abortion procedures; medication; or surgery or other care or treatment rendered by a physician or physicians, nurses, paraprofessionals or health care facility, intended for the physical, emotional, and mental well-being of persons;

(b) **"Physician"** means any person who is licensed by the State of Illinois under the Medical Practice Act of 1987;

(c) **"Health care personnel"** means any nurse, nurses' aide, medical school student, professional, paraprofessional or any other person who furnishes, or assists in the furnishing of, health care services;

(d) **"Health care facility"** means any public or private hospital, clinic, center, medical school, medical training institution, laboratory or diagnostic facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center or other institution or location wherein health care services are provided to any person, including physician organizations and associations, networks, joint ventures, and all other combinations of those organizations;

(e) **"Conscience"** means a sincerely held set of moral convictions arising from belief in and relation to God, or which, though not so derived, arises from a place in the life of its possessor parallel to that filled by God among adherents to religious faiths; and

(f) **"Health care payer"** means a health maintenance organization, insurance company, management services organization, or any other entity that pays for or arranges for the payment of any health care or medical care service, procedure, or product. The above definitions include not only the traditional combinations and forms of these persons and organizations but also all new and emerging forms and combinations of these persons and organizations. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/4)

Sec. 4. Liability.

No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/5)

Sec. 5. Discrimination.

It shall be unlawful for any person, public or private institution, or public official to discriminate against any person in any manner, including but not limited to, licensing, hiring, promotion, transfer, staff appointment, hospital, managed care entity, or any other privileges, because of such person's conscientious refusal to receive, obtain, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care services contrary to his or her conscience. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/6)

Sec. 6. Duty of physicians and other health care personnel. Nothing in this Act shall relieve a physician from any duty, which may exist under any laws concerning current standards, of normal medical practices and procedures, to inform his or her patient of the patient's condition, prognosis and risks, provided, however, that such physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience. Nothing in this Act shall be construed so as to relieve a physician or other health care personnel from obligations under the law of providing emergency medical care. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/7)

Sec. 7. Discrimination by employers or institutions.

It shall be unlawful for any public or private employer, entity, agency, institution, official or person, including but not limited to, a medical, nursing or other medical training institution, to deny admission because of, to place any reference in its application form concerning, to orally question about, to impose any burdens in terms or conditions of employment on, or to otherwise discriminate against, any applicant, in terms of employment, admission to or participation in any programs for which the applicant is eligible, or to discriminate in relation thereto, in any other manner, on account of the applicant's refusal to receive, obtain, accept, perform, counsel, suggest, recommend, refer, assist or participate in any way in any forms of health care services contrary to his or her conscience. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/8)

Sec. 8. Denial of aid or benefits.

It shall be unlawful for any public official, guardian, agency, institution or entity to deny any form of aid, assistance or benefits, or to condition the reception in any way of any form of aid, assistance or benefits, or in any other manner to coerce, disqualify or discriminate against any person, otherwise entitled to such aid, assistance or benefits, because that person refuses to obtain, receive, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of health care services contrary to his or her conscience. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/9)

Sec. 9. Liability.

No person, association, or corporation, which owns, operates, supervises, or manages a health care facility shall be civilly or criminally liable to any person, estate, or public or private entity by reason of refusal of the health care facility to permit or provide any particular form of health care service which violates the facility's conscience as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. Nothing in this act shall be construed so as to relieve a physician or other health care personnel from obligations under the law of providing emergency medical care. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/10)

Sec. 10. Discrimination against facility.

It shall be unlawful for any person, public or private institution or public official to discriminate against any person, association or corporation attempting to establish a new health care facility or operating an existing health care facility, in any manner, including but not limited to, denial, deprivation or disqualification in licensing, granting of authorizations, aids, assistance, benefits, medical staff or any other privileges, and granting authorization to expand, improve, or create any health care facility, by reason of the refusal of such person, association or corporation planning, proposing or operating a health care facility, to permit or perform any particular form of health care service which violates the health care facility's conscience as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/11)

Sec. 11. Denial of aid or benefit to a facility.

It shall be unlawful for any public official, agency, institution or entity to deny any form of aid, assistance, grants or benefits; or in any other manner to coerce, disqualify or discriminate against any person, association or corporation attempting to establish a new health care facility or operating an existing health care facility which otherwise would be entitled to the aid, assistance, grant or benefit because the existing or proposed health care facility refuses to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of health care services contrary to the health care facility's conscience as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/11.2)

Sec. 11.2. Liability of health care payer.

No health care payer and no person, association, or corporation that owns, operates, supervises, or manages a health care payer shall be civilly or criminally liable to any person, estate, or public or private entity by reason of

refusal of the health care payer to pay for or arrange for the payment of any particular form of health care services that violate the health care payer's conscience as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/11.3)

Sec. 11.3. Discrimination against health care payer in licensing.

It shall be unlawful for any person, public or private institution, or public official to discriminate against any person, association, or corporation

(i) attempting to establish a new health care payer or

(ii) operating an existing health care payer, in any manner, including but not limited to, denial, deprivation, or disqualification in licensing; granting of authorizations, aids, assistance, benefits, or any other privileges; and granting authorization to expand, improve, or create any health care payer, because the person, association, or corporation planning, proposing, or operating a health care payer refuses to pay for or arrange for the payment of any particular form of health care services that violates the health care payer's conscience as documented in the existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other governing documents. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/11.4)

Sec. 11.4. Denial of aid or benefits to health care payer for refusal to participate in certain health care.

It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits; or in any other manner to coerce, disqualify, or discriminate against any person, association, or corporation attempting to establish a new health care payer or operating an existing health care payer that otherwise would be entitled to the aid, assistance, grant, or benefit because the existing or proposed health care payer refuses to pay for, arrange for the payment of, or participate in any way in any form of health care services contrary to the health care payer's conscience as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/12)

Sec. 12. Actions; damages.

Any person, association, corporation, entity or health care facility injured by any public or private person, association, agency, entity or corporation by reason of any action prohibited by this Act may commence a suit therefor, and shall recover threefold the actual damages, including pain and suffering, sustained by such person, association, corporation, entity or health care facility, the costs of the suit and reasonable attorney's fees; but in no case shall recovery be less than $2,500 for each violation in addition to costs of the suit and reasonable attorney's fees. These damage remedies shall be cumulative, and not exclusive of other remedies afforded under any other state or federal law. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/13)

Sec. 13. Liability for refusal to provide certain health care.

Nothing in this Act shall be construed as excusing any person, public or private institution, or public official from liability for refusal to permit or provide a particular form of health care service if:

(a) the person, public or private institution or public official has entered into a contract specifically to provide that particular form of health care service; or

(b) the person, public or private institution or public official has accepted federal or state funds for the sole purpose of, and specifically conditioned upon, permitting or providing that particular form of health care service. (Source: P.A. 90-246, eff. 1-1-98.) (745 ILCS 70/14)

Sec. 14. Supersedes other Acts.

This Act shall supersede all other Acts or parts of Acts to the extent that any Acts or parts of Acts are inconsistent with the terms or operation of this Act. (Source: P.A. 90-246, eff. 1-1-98.)

Indiana

Indiana Code 16-34-1-3

Sec. 3. No private or denominational hospital shall be required to permit its facilities to be utilized for the performance of abortions. As added by P.L.2-1993, SEC.17.

IC16-34-1-4

Sec. 4. No: (1) physician; or (2) employee or member of the staff of a hospital or other facility in which an abortion may be performed; shall be required to perform an abortion or to assist or participate in the medical procedures resulting in or intended to result in an abortion, if that individual objects to such procedures on ethical, moral, or religious grounds. As added by P.L.2-1993, SEC.17.

IC16-34-1-5

Sec. 5. No person shall be required, as a condition of training, employment, pay, promotion, or privileges, to agree to perform or participate in the performing of abortions. As added by P.L.2-1993, SEC.17.

IC16-34-1-6

Sec. 6. No hospital or other person shall discriminate against or discipline a person because of the person's moral beliefs concerning abortion. As added by P.L.2-1993, SEC.17.

IC16-34-1-7

Sec. 7. A civil action for damages or reinstatement of employment, or both, may be brought for any violation of sections 4 through 6 of this chapter.

Iowa

Iowa Code 146.1 Liability of persons relating to performance of abortions.

An individual who may lawfully perform, assist, or participate in medical procedures which will result in an abortion shall not be required against that individual's religious beliefs or moral convictions to perform, assist, or participate in such procedures. A person shall not discriminate against any individual in any way, including but not limited to employment, promotion, advancement, transfer, licensing, education, training or the granting of hospital privileges or staff appointments, because of the individual's participation in or refusal to participate in recommending, performing or assisting in an abortion procedure. For the purposes of this chapter, "abortion" means the termination of a human pregnancy with the intent other than to produce a live birth or to remove a dead fetus. Abortion does not include medical care which has as its primary purpose the treatment of a serious physical condition requiring emergency medical treatment necessary to save the life of a mother.

146.2 Liability of hospitals refusing to perform abortions.

A hospital, which is not controlled, maintained and supported by a public authority, shall not be required to permit the performance of an abortion. The refusal to permit such procedures shall not be grounds for civil liability to any person nor a basis for any disciplinary or other recriminatory action against the hospital.

Kansas

65-443. Termination of human pregnancy; performance or participation in medical procedures not required.

No person shall be required to perform or participate in medical procedures which result in the termination of a pregnancy, and the refusal of any person to perform or participate in those medical procedures shall not be a basis for civil liability to any person. No hospital, hospital administrator or governing board of any hospital shall terminate the employment of, prevent or impair the practice or occupation of or impose any other sanction on any person because of such person's refusal to perform or participate in the termination of any human pregnancy. History: L. 1969, ch. 182, § 1; L. 1975, ch. 313, § 1; July 1.

Kentucky

Kentucky Revised Statutes 311.800

(3) No private hospital or private health care facility shall be required to, or held liable for refusal to, perform or permit the performance of abortion contrary to its stated ethical policy.

(4) No physician, nurse staff member or employee of a public or private hospital or employee of a public or private health care facility, who shall state in writing to such hospital or health care facility his objection to performing, participating in, or cooperating in, abortion on moral, religious or professional grounds, be required to, or held liable for refusal to, perform, participate in, or cooperate in such abortion.

(5) It shall be an unlawful discriminatory practice for the following:

(a) Any person to impose penalties or take disciplinary action against, or to deny or limit public funds, licenses, certifications, degrees, or other approvals or documents of qualification to, any hospital or other health care facility due to the refusal of such hospital or health care facility to perform or permit to be performed, participate in, or cooperate in, abortion by reason of objection thereto on moral, religious or professional grounds, or because of any statement or other manifestation of attitude by such hospital or health care facility with respect to abortion; or,

(b) Any person to impose penalties or take disciplinary action against, or to deny or limit public funds, licenses, certifications, degrees, or other approvals or documents of qualification to any physician, nurse or staff member or employee of any hospital or health care facility, due to the willingness or refusal of such physician, nurse or staff member or employee to perform or participate in abortion by reason of objection thereto on moral, religious or professional grounds, or because of any statement or other manifestation of attitude by such physician, nurse or staff member or employee with respect to abortion; or,

(c) Any public or private agency, institution or person, including a medical, nursing or other school, to deny admission to, impose any burdens in terms of conditions of employment upon, or otherwise discriminate against any applicant for admission thereto or any physician, nurse, staff member, student or employee thereof, on account of the willingness or refusal of such applicant, physician, nurse, staff member, student or employee to perform or participate in abortion or sterilization by reason of objection thereto on moral, religious or professional grounds, or because of any statement or other manifestation of attitude by such person with respect to abortion or sterilization if that health care facility is not operated exclusively for the purposes of performing abortions or sterilizations.

Effective: July 15, 1980
History: Amended 1980 Ky. Acts ch. 225, sec. 1, effective July 15, 1980. -- Created 1974 Ky. Acts ch. 255, sec. 11.

311.810 Discrimination for refusal to submit to abortion prohibited.

No woman may be denied governmental assistance or be otherwise discriminated against or otherwise subjected to coercion in any way for accepting or refusing to accept or submit to an abortion, which she may do or not do for any reason without explanation. History: Created 1974 Ky. Acts ch. 255, sec. 12.

Louisiana

La. Rev. Stat. Ann. tit. 40, § 1299.31.

No . . . person or corporation shall be held civilly . . . liable, discriminated against, . . . or in any way prejudiced or damaged because of his refusal for any reason to recommend, counsel, perform, assist with or accommodate an abortion.

La. Rev. Stat. Ann. tit. 40, § 1299.32.

No hospital, clinic or other facility or institution of any kind shall be held civilly. . . liable, discriminated against, or in any way prejudiced or damaged because of any refusal to permit or accommodate the performance of any abortion in said facility or under its auspices.

La. Rev. Stat. Ann. tit. 40, § 1299.33.

No hospital, clinic, or other medical or health facility, whether public or private, shall ever be denied governmental assistance or be otherwise discriminated against or otherwise be pressured in any way for refusing to permit its facilities, staff or employees to be used in any way for the purpose of performing any abortion.

La. Rev. Stat. Ann. tit. 40, § 1299.35.9

Conscience in health care protection; definitions

A.(1) Any person has the right not to participate in, and no person shall be required to participate in any health care service that violates his conscience to the extent that patient access to health care is not compromised. No person shall be held civilly or criminally liable, discriminated against, dismissed, demoted, or in any way prejudiced or damaged for declining to participate in any health care service that violates his conscience.

(2) This Section shall not prevent an inquiry by an employer or patient regarding whether a person declines to participate in any health care service that violates its conscience. When a patient requests health care services, a person shall identify, in writing, as soon as practicable, his declination to provide a service in accordance with the provisions of this Section. All persons who have a sincerely held religious belief or moral conviction and who seek employment at a health care facility shall notify the prospective employer of the existence of any sincerely held religious belief or moral conviction. Any health care facility that employs a person with a sincerely held religious belief or moral conviction shall ensure that the health care facility has sufficient staff to provide patient care in the event an employee declines to participate in any health care service that violates his conscience.

(3) The provisions of this Section shall not be construed to relieve any health care provider from providing emergency care as required by state or federal law.

(4) A person shall notify his employer in writing as soon as practicable of any health care service that violates his conscience. A person shall notify any patient before such person provides any consultation or service to the patient of the existence of a health care service that he will decline to provide because the health care service violates his conscience.

B. For purposes of this Section:

(1) "Conscience" means sincerely held religious belief or moral conviction.

(2) "Health care service" is limited to abortion, dispensation of abortifacient drugs, human embryonic stem cell research, human embryo cloning, euthanasia, or physician-assisted suicide.

C. A suit alleging a violation of this Section shall be brought in a district court in accordance with R.S. 23:303.

Maine

Maine Revised Statutes
Title 22
Subtitle 2: Health

Part 3: Public Health (Heading: PL 1989, c. 487, @11 (rpr))
Chapter 263-B: Abortions
§ 1591. Immunity and employment protection

No physician, nurse or other person who refuses to perform or assist in the performance of an abortion, and no hospital or health care facility that refuses to permit the performance of an abortion upon its premises, shall be liable to any person, firm, association or corporation for damages allegedly arising from the refusal, nor shall such refusal constitute a basis for any civil liability to any physician, nurse or other person, hospital or health care facility nor a basis for any disciplinary or other recriminatory action against them or any of them by the State or any person. [1977, c. 696, § 186 (new).]

No physician, nurse or other person, who refuses to perform or assist in the performance of an abortion, shall, because of that refusal, be dismissed, suspended, demoted or otherwise prejudiced or damaged by a hospital, health care facility, firm, association, professional association, corporation or educational institution with which he or she is affiliated or requests to be affiliated or by which he or she is employed, nor shall such refusal constitute grounds for loss of any privileges or immunities to which such physician, nurse or other person would otherwise be entitled nor shall submission to an abortion or the granting of consent therefor be a condition precedent to the receipt of any public benefits. [1977, c. 696, § 186 (new).]

§ 1592. Discrimination for refusal

No person, hospital, health care facility, firm, association, corporation or educational institution, directly or indirectly, by himself or another, shall discriminate against any physician, nurse or other person by refusing or withholding employment from or denying admittance, when such physician, nurse or other person refuses to perform, or assist in the performance of an abortion, nor shall such refusal constitute grounds for loss of any privileges or immunities to which such physician, nurse or other person would otherwise be entitled. [1977, c. 696, § 186 (new).]

§1903. Authority and policy

4. Objections. No private institution or physician or no agent or employee of such institution or physician shall be prohibited from refusing to provide family planning services when such refusal is based upon religious or conscientious objection. [1973, c. 624, §1 (NEW)]

Maryland

Maryland Statutes § 20-214. Health - General

(a) (1) A person may not be required to perform or participate in, or refer to any source for, any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy.

(2) The refusal of a person to perform or participate in, or refer to a source for, these medical procedures may not be a basis for:

(i) Civil liability to another person; or
(ii) Disciplinary or other recriminatory action against the person.

(b)(1) A licensed hospital, hospital director, or hospital governing board may not be required:

(i) To permit, within the hospital, the performance of any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy; or
(ii) To refer to any source for these medical procedures.

(2) The refusal to permit or to refer to a source for these procedures may not be grounds for:

(i) Civil liability to another person; or
(ii) Disciplinary or other recriminatory action against the person by this State or any person.

(d) Notwithstanding any other provision of this section, a health care provider, a licensed hospital, a hospital director, or a hospital governing board is not immune from civil damages, if available at law, or from disciplinary or other recriminatory action, if the failure to refer a patient to a source for any medical procedure that results in sterilization or termination of pregnancy would reasonably be determined as:

(1) The cause of death or serious physical injury or serious long-lasting injury to the patient; and
(2) Otherwise contrary to the standards of medical care.

Massachusetts

General Laws of Massachusetts Chapter 112: Section 12I. Abortion or sterilization procedures; refusal of hospital or health facility staff members or employees to participate.

Section 12I. A physician or any other person who is a member of or associated with the medical staff of a hospital or other health facility or any employee of a hospital or other health facility in which an abortion or any sterilization procedure is scheduled and who shall state in writing an objection to such abortion or sterilization procedure on moral or religious grounds, shall not be required to participate in the medical procedures which result in such abortion or sterilization, and the refusal of any such person to participate therein shall not form the basis for any claim of damages on account of such refusal or for any disciplinary or recriminatory action against such person. The refusal of any person who has made application to a medical, premedical, nursing, social work, or psychology program in the commonwealth to agree to counsel, suggest, recommend, assist, or in any way participate in the performance of an abortion or sterilization contrary to his religious beliefs or moral convictions shall not form the basis for any discriminatory action against such person. Conscientious objection to abortion shall not be grounds for dismissal, suspension, demotion, failure to promote, discrimination in hiring, withholding of pay or refusal to grant financial assistance under any state aided project, or used in any way to the detriment of the individual in any hospital, clinic, medical, premedical, nursing, social work, or psychology school or state aided program or institution which is supported in whole or in part by the commonwealth.

Chapter 272: Section 21B. Privately controlled hospital or health facility not required to perform abortion or sterilization procedures, or to furnish contraceptive devices or information or family planning services.

Section 21B. No privately controlled hospital or other health facility shall be required to admit any patient for the purpose of performing an abortion, performing any sterilization procedure, or receiving contraceptive devices or information.

No privately controlled hospital or other privately controlled health facility shall be required to permit any patient to have an abortion, or any sterilization procedure performed in said hospital or other health facility, or to furnish contraceptive devices or information to such patient, nor shall such a hospital or other health facility be required to furnish any family planning services within or through said hospital or other health facility or to make referrals to any other hospital or health facility for such services when said services or referrals are contrary to the religious or moral principles of said hospital or said health facility as expressed in its charter, by-laws or code of ethics, or vote of its governing body.

Any such hospital or other health facility exercising the rights granted in this section shall not on account of the exercise thereof, be disciplined or discriminated against in any manner or suffer any adverse determination by any

person, firm, corporation, or other entity, including but in no way limited to any political subdivision, board, commission, department, authority, or agency of the commonwealth.

Michigan

333.20181 Abortion ; admitting patient not required; refusal to perform, participate in, or allow; immunity. [M.S.A. 14.15(20181)]

Sec. 20181. A hospital, clinic, institution, teaching institution, or other health facility is not required to admit a patient for the purpose of performing an abortion . A hospital, clinic, institution, teaching institution, or other health facility or a physician, member, or associate of the staff, or other person connected therewith, may refuse to perform, participate in, or allow to be performed on its premises an abortion . The refusal shall be with immunity from any civil or criminal liability or penalty.
History: 1978, Act 368, Eff. Sept. 30, 1978

333.20182 Abortion ; objection; participation in medical procedures not required; immunity. [M.S.A. 14.15(20182)]

Sec. 20182. A physician, or other individual who is a member of or associated with a hospital, clinic, institution, teaching institution, or other health facility, or a nurse, medical student, student nurse, or other employee of a hospital, clinic, institution, teaching institution, or other health facility in which an abortion is performed, who states an objection to abortion on professional, ethical, moral, or religious grounds, is not required to participate in the medical procedures which will result in abortion . The refusal by the individual to participate does not create a liability for damages on account of the refusal or for any disciplinary or discriminatory action by the patient, hospital, clinic, institution, teaching institution, or other health facility against the individual. History: 1978, Act 368, Eff. Sept. 30, 1978

333.20183 Abortion ; refusal to give advice; refusal to participate in; immunity. [M.S.A. 14.15(20183)]

Sec. 20183. (1) A physician who informs a patient that he or she refuses to give advice concerning, or participate in, an abortion is not liable to the hospital, clinic, institution, teaching institution, health facility, or patient for the refusal.

(2) A civil action for negligence or malpractice or a disciplinary or discriminatory action may not be maintained against a person refusing to give advice as to, or participating in, an abortion based on the refusal. History: 1978, Act 368, Eff. Sept. 30, 1978

Minnesota

145.42 Abortions; nonliability for refusal to perform.

Subdivision 1. Damages. No physician, nurse, or other person who refuses to perform or assist in the performance of an abortion, and no hospital that refuses to permit the performance of an abortion upon its premises, shall be liable to any person for damages allegedly arising from the refusal.

Subd. 2. Related actions. No physician, nurse, or other person who refuses to perform or assist in the

performance of an abortion shall, because of that refusal, be dismissed, suspended, demoted, or otherwise prejudiced or damaged by a hospital with which the person is affiliated or by which the person is employed.
HIST: 1971 c 693 s 1,2; 1986 c 444

Section: 145.414
145.414 Abortion not mandatory.

(a) No person and no hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion for any reason.

(b) It is the policy of the state of Minnesota that no health plan company as defined under section 62Q.01, subdivision 4, or health care cooperative as defined under section 62R.04, subdivision 2, shall be required to provide or provide coverage for an abortion. No provision of this chapter; of chapter 62A, 62C, 62D, 62H, 62L, 62M, 62N, 62R, 64B, or of any other chapter; of Minnesota Rules; or of Laws 1995, chapter 234, shall be construed as requiring a health plan company as defined under section 62Q.01, subdivision 4, or a health care cooperative as defined under section 62R.04, subdivision 2, to provide or provide coverage for an abortion.

(c) This section supersedes any provision of Laws 1995, chapter 234, or any act enacted prior to enactment of Laws 1995, chapter 234, that in any way limits or is inconsistent with this section. No provision of any act enacted subsequent to Laws 1995, chapter 234 shall be construed as in any way limiting or being inconsistent with this section, unless the act amends this section or expressly provides that it is intended to limit or be inconsistent with this section.
HIST: 1974 c 177 s 4; 1995 c 234 art 2 s 30

Section: 145.424
145.424 Prohibition of tort actions.

Subdivision 1. Wrongful life action prohibited.

No person shall maintain a cause of action or receive an award of damages on behalf of that person based on the claim that but for the negligent conduct of another, the person would have been aborted.

Subd. 2. Wrongful birth action prohibited.

No person shall maintain a cause of action or receive an award of damages on the claim that but for the negligent conduct of another, a child would have been aborted.

Subd. 3. Failure or refusal to prevent a live birth.

Nothing in this section shall be construed to preclude a cause of action for intentional or negligent malpractice or any other action arising in tort based on the failure of a contraceptive method or sterilization procedure or on a claim that, but for the negligent conduct of another, tests or treatment would have been provided or would have been provided properly which would have made possible the prevention, cure, or amelioration of any disease, defect, deficiency, or handicap; provided, however, that abortion shall not have been deemed to prevent, cure, or ameliorate any disease, defect, deficiency, or handicap. The failure or refusal of any person to perform or have an abortion shall not be a defense in any action, nor shall that failure or refusal be considered in awarding damages

or in imposing a penalty in any action.
HIST: 1982 c 521 s 1; 1986 c 444

Mississippi

Mississippi Code Ann. § 41-107-1. Title
This chapter may be known and cited as the "Mississippi Health Care Rights of Conscience Act."

§ 41-107-3. Definitions.

As used in this chapter:

(a) **"Health care service"** means any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions.

(b) **"Health care provider"** means any individual who may be asked to participate in any way in a health care service, including, but not limited to: a physician, physician's assistant, nurse, nurses' aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student or employee, counselor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure.

(c) **"Health care institution"** means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing health care services, including, but not limited to: hospitals, clinics, medical centers, ambulatory surgical centers, private physician's offices, pharmacies, nursing homes, university medical schools and nursing schools, medical training facilities, or other institutions or locations where health care procedures are provided to any person.

(d) **"Health care payer"** means any entity or employer that contracts for, pays for, or arranges for the payment of, in whole or in part, a health care service, including, but not limited to, health maintenance organizations, health plans, insurance companies or management services organizations.

(e) **"Employer"** means any individual or entity that pays for or provides health benefits or health insurance coverage as a benefit to its employees, whether through a third party, a health maintenance organization, a program of self-insurance, or some other means.

(f) **"Participate"** in a health care service means to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, any health care service or any form of such service.

(g) **"Pay" or "payment"** means pay, contract for, or otherwise arrange for the payment of, in whole or in part.

(h) **"Conscience"** means the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer. For purposes of this chapter, a health care institution or health care payer's conscience shall be determined by reference to its existing or proposed religious, moral or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other relevant documents.

§ 41-107-5. Rights of Conscience of Health Care Providers.

(1) ***Rights of Conscience.*** A health care provider has the right not to participate, and no health care provider shall be required to participate in a health care service that violates his or her conscience. However, this subsection does not allow a health care provider to refuse to participate in a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(2) ***Immunity from Liability.*** No health care provider shall be civilly, criminally, or administratively liable for declining to participate in a health care service that violates his or her conscience. However, this subsection does not exempt a health care provider from liability for refusing to participate in a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(3) ***Discrimination.*** It shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health care provider in any manner based on his or her declining to participate in a health care service that violates his or her conscience. For purposes of this chapter, discrimination includes, but is not limited to: termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training opportunities, or any other penalty, disciplinary or retaliatory action.

§ 41-107-7. Rights of Conscience of Health Care Institutions

(1) ***Rights of Conscience.*** A health care institution has the right not to participate, and no health care institution shall be required to participate in a health care service that violates its conscience. However, this subsection does not allow a health care institution to refuse to participate in a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(2) ***Immunity from Liability.*** A health care institution that declines to provide or participate in a health care service that violates its conscience shall not be civilly, criminally or administratively liable if the institution provides a consent form to be signed by a patient before admission to the institution stating that it reserves the right to decline to provide or participate in a health care service that violates its conscience. However, this subsection does not exempt a health care institution from liability for refusing to participate in a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(3) ***Discrimination.*** It shall be unlawful for any person, public or private institution, or public official to discriminate against any health care institution, or any person, association, corporation, or other entity attempting to establish a new health care institution or operating an existing health care institution, in any manner, including, but not limited to, any denial, deprivation or disqualification with respect to licensure, any aid assistance, benefit or privilege, including staff privileges, or any authorization, including authorization to create, expand, improve, acquire, or affiliate or merge with any health care institution, because such health care institution, or person, association, or corporation planning, proposing, or operating a health care institution, declines to participate in a health care service which violates the health care institution's conscience.

(4) ***Denial of Aid or Benefit.*** It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants or benefits, or in any other manner to coerce, disqualify or discriminate against any person, association, corporation or other entity attempting to establish a new health care institution or operating

an existing health care institution because the existing or proposed health care institution declines to participate in a health care service contrary to the health care institution's conscience.

§ 41-107-9. Rights of conscience of health care payers.

(1) ***Rights of Conscience.*** A health care payer has the right to decline to pay, and no health care payer shall be required to pay for or arrange for the payment of a health care service that violates its conscience. However, this subsection does not allow a health care payer to decline to pay or arrange for the payment of a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(2) ***Immunity from Liability.*** No health care payer and no person, association, corporation or other entity that owns, operates, supervises or manages a health care payer shall be civilly or criminally liable by reason of the health care payer's declining to pay for or arrange for the payment of a health care service that violates its conscience. However, this subsection does not exempt from liability a health care payer, or the owner, operator, supervisor or manager of a health care payer, for declining to pay or arranging for the payment of a health care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(3) ***Discrimination.*** It shall be unlawful for any person, public or private institution, or public official to discriminate against any health care payer, or any person, association, corporation, or other entity (a) attempting to establish a new health care payer, or (b) operating an existing health care payer, in any manner, including, but not limited to, any denial, deprivation, or disqualification with respect to licensure, aid, assistance, benefit, privilege or authorization, including, but not limited to, any authorization to create, expand, improve, acquire, affiliate or merge with any health care payer, because a health care payer, or a person, association, corporation or other entity planning, proposing or operating a health care payer declines to pay for or arrange for the payment of any health care service that violates its conscience.

(4) ***Denial of Aid or Benefits.*** It shall be unlawful for any public official, agency, institution or entity to deny any form of aid, assistance, grants, or benefits or in any other manner coerce, disqualify or discriminate against any health care payer, or any person, association, corporation or other entity attempting to establish a new health care payer or operating an existing health care payer because the existing or proposed health care payer declines to pay for, or arrange for the payment of, any health care service that is contrary to its conscience.

§ 41-107-11. Civil remedies

(1) A civil action for damages or injunctive relief, or both, may be brought for the violation of any provision of this chapter. It shall not be a defense to any claim arising out of the violation of this chapter that such violation was necessary to prevent additional burden or expense on any other health care provider, health care institution, individual or patient.

(2) ***Damage Remedies.*** Any individual, association, corporation, entity or health care institution injured by any public or private individual, association, agency, entity or corporation by reason of any conduct prohibited by this chapter may commence a civil action. Upon finding a violation of this chapter, the aggrieved party shall be entitled to recover threefold the actual damages, including pain and suffering, sustained by such individual, association, corporation, entity or health care institution, the costs of the action, and reasonable attorney's fees; but in no case shall recovery be less than Five Thousand Dollars ($5,000.00) for each violation in addition to costs of the action

and reasonable attorney's fees. These damage remedies shall be cumulative, and not exclusive of other remedies afforded under any other state or federal law.

(3) ***Injunctive Remedies.*** The court in such civil action may award injunctive relief, including, but not limited to, ordering reinstatement of a health care provider to his or her prior job position.

§ 41-107-13. Severability.

The provisions of this chapter are declared to be severable, and if any provision, word, phrase or clause of this chapter or the application thereof to any person shall be held invalid, such invalidity shall not affect the validity of the remaining portions of this chapter.

Missouri

Section 188.105
Discrimination by employer prohibited because of failure of employee to participate in abortion--exceptions.

188.105. 1. It shall be unlawful:

(1) For an employer:

(a) To fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his or her compensation, terms, conditions, or privileges of employment, because of such individual's refusal to participate in abortion;

(b) To limit, segregate, or classify his, her, or its employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his or her status as an employee, because of such individual's refusal to participate in abortion;

(c) To discharge, expel, or otherwise discriminate against any person because he or she has opposed any practices forbidden under sections 188.100 to 188.120 or because he or she has filed a complaint, testified, or assisted in any legal proceeding under sections 188.100 to 188.120;

(2) For any person, whether an employer or employee, or not, to aid, abet, incite, compel, or coerce the doing of any of the acts forbidden under sections 188.100 to 188.120, or to attempt to do so.

2. Notwithstanding any other provision of sections 188.100 to 188.120, the acts proscribed in subsection 1 of this section shall not be unlawful if there can be demonstrated an inability to reasonably accommodate an individual's refusal to participate in abortion without undue hardship on the conduct of that particular business or enterprise, or in those certain instances where participation in abortion is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.

3. Nothing contained in sections 188.100 to 188.120 shall be interpreted to require any employer to grant preferential treatment to any individual because of such individual's refusal to participate in abortion.
(L. 1986 H.B. 1596)

Section 188.110
Discrimination by colleges, universities and hospitals prohibited-- no requirement to pay fees, when.

188.110. 1. No public or private college, university or hospital shall discriminate against any person for refusal to participate in abortion.

2. No applicant, student, teacher, or employee of any school shall be required to pay any fees that would in whole or in part fund an abortion for any other applicant, student, teacher, or employee of that school, if the individual required to pay the fee gives written notice to the proper school authorities that it would be in violation of his or her conscience or beliefs to pay for or fund abortions. The school may require the individual to pay that part of the fees not funding abortions, if the school makes reasonable precautions and gives reasonable assurance that the fees that are paid are segregated from any fund for the payment of abortions.
(L. 1986 H.B. 1596)

Chapter 197 Medical Treatment Facility Licenses
Section 197.032
Hospitals and medical personnel may refuse abortions--no denial of public benefits for such refusal--civil action, when.

197.032. 1. No physician or surgeon, registered nurse, practical nurse, midwife or hospital, public or private, shall be required to treat or admit for treatment any woman for the purpose of abortion if such treatment or admission for treatment is contrary to the established policy of, or the moral, ethical or religious beliefs of, such physician, surgeon, registered nurse, midwife, practical nurse or hospital. No cause of action shall accrue against any such physician, surgeon, registered nurse, midwife, practical nurse or hospital on account of such refusal to treat or admit for treatment any woman for abortion purposes.

2. No person or institution shall be denied or discriminated against in the reception of any public benefit, assistance or privilege whatsoever or in any employment, public or private, on the grounds that they refuse to undergo an abortion, to advise, consent to, assist in or perform an abortion.

3. Any person who shall deny or discriminate against another for refusal to perform or participate in an abortion shall be liable to the party injured in an action at law, suit in equity or other redress.
(L. 1973 H.B. 731 & 793 §§ 1, 2, 3)

Coverage for certain obstetrical/gynecological services--exclusion of contraceptive coverage permitted, when--rulemaking authority.

376.1199. 1. Each health carrier or health benefit plan that offers or issues health benefit plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:

(1) . . . Nothing in this subsection shall be construed to require a health carrier to perform, induce, pay for, reimburse, guarantee, arrange, provide any resources for or refer a patient for an abortion, as defined in section 188.015, RSMo, other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed, or to supersede or conflict with section 376.805 . . .

4. Notwithstanding the provisions of subdivision (4) of subsection 1 of this section to the contrary:

(1) Any health carrier may issue to any person or entity purchasing a health benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person or entity;

(2) Upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives. Any administrative costs to a group health benefit plan associated with such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by the group policyholder or group plan holder;

(3) Any health carrier which is owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use or provision of contraceptives shall be exempt from the provisions of subdivision (4) of subsection 1 of this section.

For purposes of this subsection, if new premiums are charged for a contract, plan or policy, it shall be determined to be a new contract, plan or policy.

5. Except for a health carrier that is exempted from providing coverage for contraceptives pursuant to this section, a health carrier shall allow enrollees in a health benefit plan that excludes coverage for contraceptives pursuant to subsection 4 of this section to purchase a health benefit plan that includes coverage for contraceptives.

6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide clear and conspicuous written notice on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan contract:

(1) Whether coverage for contraceptives is or is not included;

(2) That an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs; and

(3) That an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives.

7. Health carriers shall not disclose to the person or entity who purchased the health benefit plan the names of enrollees who exclude coverage for contraceptives in the health benefit plan or who purchase a health benefit plan that includes coverage for contraceptives. Health carriers and the person or entity who purchased the health benefit plan shall not discriminate against an enrollee because the enrollee excluded coverage for contraceptives in the health benefit plan or purchased a health benefit plan that includes coverage for contraceptives.

Chapter 404- Durable Powers of Attorney for Health Care

Physician, health care facility, may refuse decision of attorney in fact, when--transfer from facility allowed.

404.830. 1. No physician, nurse, or other individual who is a health care provider or an employee of a health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the individual's religious beliefs, or sincerely held moral convictions.

2. No hospital, nursing facility, residential care facility, or other health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the hospital's or facility's institutional policy based on religious beliefs or sincerely held moral convictions unless the hospital or facility received a copy of the durable power of attorney for health care prior to commencing the current series of treatments or current confinement.

3. Any health care provider or facility which, pursuant to subsection 1 or 2 of this section, refuses to honor a health care decision of an attorney in fact shall not impede the attorney in fact from transferring the patient to another health care provider or facility.

Refusal to honor health care decision, discrimination prohibited, when.

404.872. No physician, nurse, or other individual who is a health care provider or an employee of a health care facility shall be discharged or otherwise discriminated against in his employment or employment application for refusing to honor a health care decision withholding or withdrawing life-sustaining treatment if such refusal is based upon the individual's religious beliefs, or sincerely held moral convictions.

Montana

50-20-111. Right to refuse participation in abortion.

(1) No private hospital or health care facility shall be required contrary to the religious or moral tenets or the stated religious beliefs or moral convictions of its staff or governing board to admit any person for the purpose of abortion or to permit the use of its facilities for such purpose. Such refusal shall not give rise to liability of such hospital or health care facility or any personnel or agent or governing board thereof to any person for damages allegedly arising from such refusal or be the basis for any discriminatory, disciplinary, or other recriminatory action against such hospital or health care facility or any personnel, agent, or governing board thereof.

(2) All persons shall have the right to refuse to advise concerning, perform, assist, or participate in abortion because of religious beliefs or moral convictions. If requested by any hospital or health care facility or person desiring an abortion, such refusal shall be in writing signed by the person refusing, but may refer generally to the grounds of "religious beliefs and moral convictions". The refusal of any person to advise concerning, perform, assist, or participate in abortion shall not be a consideration in respect of staff privileges of any hospital or health care facility or a basis for any discriminatory, disciplinary, or other recriminatory action against such person, nor shall such person be liable to any person for damages allegedly arising from refusal.

(3) It shall be unlawful to interfere or attempt to interfere with the right of refusal authorized by this section. The person injured thereby shall be entitled to injunctive relief, when appropriate, and shall further be entitled to monetary damages for injuries suffered.

(4) Such refusal by any hospital or health care facility or person shall not be grounds for loss of any privileges or immunities to which the granting of consent may otherwise be a condition precedent or for the loss of any public

benefits.

(5) As used in this section, the term "person" includes one or more individuals, partnerships, associations, and corporations.

Nebraska

LAW 28-337. Hospital, clinic, institution; not required to admit patient for abortion

No hospital, clinic, institution, or other facility in this state shall be required to admit any patient for the purpose of performing an abortion nor required to allow the performance of an abortion therein, but the hospital, clinic, institution, or other facility shall inform the patient of its policy not to participate in abortion procedures. No cause of action shall arise against any hospital, clinic, institution, or other facility for refusing to perform or allow an abortion.

LAW 28-338. No person required to perform an abortion; no liability for refusal.

No person shall be required to perform or participate in any abortion, and the refusal of any person to participate in an abortion shall not be a basis for civil liability to any person. No hospital, governing board, or any other person, firm, association, or group shall terminate the employment or alter the position of, prevent or impair the practice or occupation of, or impose any other sanction or otherwise discriminate against any person who refuses to participate in an abortion.

LAW 28-339 Discrimination against person refusing to participate in an abortion; violation; penalty.

Any violation of section 28-338 is a Class II misdemeanor.

LAW 28-340 Discrimination against person refusing to participate in an abortion; damages.

Any person whose employment or position has been in any way altered, impaired, or terminated in violation of sections 28-325 to 28-345 may sue in the district court for all consequential damages, lost wages, reasonable attorney's fees incurred, and the cost of litigation.

LAW 28-341 Discrimination against person refusing to participate in an abortion; injunctive relief.

Any person whose employment or position has in any way been altered, impaired, or terminated because of his refusal to participate in an abortion shall have the right to injunctive relief, including temporary relief, pending trial upon showing of an emergency, in the district court, in accordance with the statutes, rules, and practices applicable in other similar cases.

Nevada

Nevada revised Statutes 632.475 Unlawful to require participation in abortion.

1. An employer shall not require a registered nurse, a licensed practical nurse, a nursing assistant or any other person employed to furnish direct personal health service to a patient to participate directly in the induction or performance of an abortion if the employee has filed a written statement with the employer indicating a moral, ethical or religious basis for refusal to participate in the abortion.

2. If the statement provided for in subsection 1 is filed with the employer, the employer shall not penalize or discipline the employee for declining to participate directly in the induction or performance of an abortion.

3. The provisions of subsections 1 and 2 do not apply to medical emergency situations.

4. Any person violating the provisions of this section is guilty of a misdemeanor.
(Added to NRS by 1973, 898, 1639; A 1989, 2017)

New Jersey

2A:65A-1. Requirement of person to perform; prohibition

No person shall be required to perform or assist in the performance of an abortion or sterilization.
L.1974, c. 111, s. 1, eff. Oct. 2, 1974.

2A:65A-2. Requirement of hospital or other health care facility to provide services or procedures; prohibition

No hospital or other health care facility shall be required to provide abortion or sterilization services or procedures.

L.1974, c. 111, s. 2, eff. Oct. 2, 1974.

2A:65A-3. Refusal to perform or provide services or procedures; nonliability

The refusal to perform, assist in the performance of, or provide abortion services or sterilization procedures shall not constitute grounds for civil or criminal liability, disciplinary action or discriminatory treatment.
L.1974, c. 111, s. 3, eff. Oct. 2, 1974.

New Mexico

New Mexico Statutes Unannotated 30-5-2 Persons and institutions exempt (1994 Repl.)

This article does not require a hospital to admit any patient for the purposes of performing an abortion, nor is any hospital required to create a special hospital board. A person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital, in which a justified medical termination has been authorized and who objects to the justified medical termination on moral or religious grounds shall not be required to participate in medical procedures which will result in the termination of pregnancy, and the refusal of any such person to

participate shall not form the basis of any disciplinary or other recriminatory action against such person.
History: 1953 Comp., § 40A-5-2, enacted by Laws 1969, ch. 67, § 2.

New York

New York Civil Rights Law s.79-i (Consol.1989) Discrimination against person who refuses to perform certain act prohibited.

1. When the performing of an abortion on a human being or assisting thereat is contrary to the conscience or religious beliefs of any person, he may refuse to perform or assist in such abortion by filing a prior written refusal setting forth the reasons therefor with the appropriate and responsible hospital, person, firm, corporation or association, and no such hospital, person, firm, corporation or association shall discriminate against the person so refusing to act. A violation of the provisions of this section shall constitute a misdemeanor.

2. No civil action for negligence or malpractice shall be maintained against a person so refusing to act based on such refusal.

North Carolina

§ 14-45.1. When abortion not unlawful

(e) Nothing in this section shall require a physician licensed to practice medicine in North Carolina or any nurse who shall state an objection to abortion on moral, ethical, or religious grounds, to perform or participate in medical procedures which result in an abortion. The refusal of such physician to perform or participate in these medical procedures shall not be a basis for damages for such refusal, or for any disciplinary or any other recriminatory action against such physician.

(f) Nothing in this section shall require a hospital or other health care institution to perform an abortion or to provide abortion services. (1967, c. 367, s. 2; 1971, c. 383, ss. 1, 11/2; 1973, c. 139; c. 476, s. 128; c. 711; 1997-443, s. 11A.118(a).)

North Dakota

23-16-14. Participation in abortion - Not mandatory.

No hospital, physician, nurse, hospital employee, nor any other person is under any duty, by law or contract, nor may such
hospital or person in any circumstances be required to participate in the performance of an abortion, if such hospital or person objects to such abortion. No such person or institution may be discriminated against because he or they so object.

Ohio

Ohio Revised Code Section 4731.91

(A) No private hospital, private hospital director, or governing board of a private hospital is required to permit an abortion.

(B) No public hospital, public hospital director, or governing board of a public hospital is required to permit an abortion.

(C) Refusal to permit an abortion is not grounds for civil liability nor a basis for disciplinary or other recriminatory action.

(D) No person is required to perform or participate in medical procedures which result in abortion, and refusal to perform or participate in the medical procedures is not grounds for civil liability nor a basis for disciplinary or other recriminatory action.

(E) Whoever violates division (D) of this section is liable in civil damages.

Oklahoma

1998 Oklahoma State Statutes §63-1-741.

A. No private hospital, hospital director or governing board of a private hospital in Oklahoma, is required to permit abortions to be performed or induced in such hospital. Refusal to permit an abortion, in accordance with a standard policy, is not grounds for civil liability nor a basis for disciplinary or other recriminatory action.

B. No person may be required to perform, induce or participate in medical procedures which result in an abortion which are in preparation for an abortion or which involve aftercare of an abortion patient, except when the aftercare involves emergency medical procedures which are necessary to protect the life of the patient, and refusal to perform or participate in such medical procedures is not grounds for civil liability nor a basis for disciplinary or other recriminatory action.

C. The rights and immunities granted by this section shall not include medical procedures in which a woman is in the process of the spontaneous, inevitable abortion of an unborn child, the death of thechild is imminent, and the procedures are necessary to prevent the death of the mother.

§63-1-728 *Freedom of Conscience Act*

§63-1-728. Short title.

This act shall be known and may be cited as the "*Freedom of Conscience Act*".

§63-1-728.1. Definitions.

As used in the *Freedom of Conscience Act*:

1. "Health care facility" means any public or private organization, corporation, authority, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing health care services, including a hospital, clinic, medical center, ambulatory surgical center, private physician's office, pharmacy, nursing home, university hospital, medical school, nursing school, medical training facility, inpatient health care facility, or other place where health care services are provided;

2. "Human embryo" means a human organism that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells;

3. "In vitro human embryo" means a human embryo, whether cryopreserved or not, living outside of a woman's body;

4. "Participate in" means to perform, practice, engage in, assist in, recommend, counsel in favor of, make referrals for, prescribe, dispense, or administer drugs or devices or otherwise promote or encourage; and

5. "Person" means any individual, corporation, industry, firm, partnership, association, venture, trust, institution, federal, state or local governmental instrumentality, agency or body or any other legal entity however organized.

§63-1-728.2. Reasonable accommodation of religious observances or practices.

An employer shall not discriminate against an employee or prospective employee by refusing to reasonably accommodate the religious observance or practice of the employee or prospective employee, unless the employer can demonstrate that the accommodation would pose an undue hardship on the program, enterprise, or business of the employer, in the following circumstances:

1. An abortion as defined in Section 1-730 of Title 63 of the Oklahoma Statutes. The provisions of this section shall not apply if the pregnant woman suffers from a physical disorder, physical injury, or physical illness which, as certified by a physician, causes the woman to be in imminent danger of death unless an abortion is immediately performed or induced and there are no other competent personnel available to attend to the woman. As used in this act, the term "abortion" shall not include the prescription of contraceptives;

2. An experiment or medical procedure that destroys an in vitro human embryo or uses cells or tissue derived from the destruction of an in vitro human embryo;

3. An experiment or medical procedure on an in vitro human embryo that is not related to the beneficial treatment of the in vitro human embryo;

4. An experiment or medical procedure on a developing child in an artificial womb, at any stage of development, that is not related to the beneficial treatment of the developing child;

5. A procedure, including a transplant procedure, that uses fetal tissue or organs that come from a source other than a stillbirth or miscarriage; or

6. An act that intentionally causes or assists in causing the death of an individual by assisted suicide, euthanasia, or mercy killing.

§63-1-728.3. Health care facilities, professionals or employees - Refusal to participate in specified acts - Discipline prohibited - Immunity.

A. No health care facility is required to admit any patient or to allow the use of the health care facility for the purpose of performing any of the acts specified in Section 3 of this act.

B. A physician, physician's assistant, registered nurse, practical nurse, pharmacist, or any employee thereof, or any other person who is an employee of, member of, or associated with the staff of a health care facility in which the performance of an activity specified in Section 3 of this act has been authorized, who in writing, refuses or states an intention to refuse to participate in the activity on moral or religious grounds shall not be required to participate in the activity and shall not be disciplined by the respective licensing board or authorized regulatory department for refusing or stating an intention to refuse to participate in the practice with respect to the activity.

C. A physician, physician's assistant, registered nurse, practical nurse, pharmacist, or any employee thereof, or any other person who is an employee of, member of, or associated with the staff of a health care facility is immune from liability for any damage caused by the refusal of the person to participate in an activity specified in Section 3 of this act on moral or religious grounds.

§63-1-728.4. Refusal to participate in specified acts - Discrimination, mandatory participation prohibited.

A. No health care facility, school, or employer shall discriminate against any person with regard to admission, hiring or firing, tenure, term, condition, or privilege of employment, student status, or staff status on the ground that the person refuses or states an intention to refuse, whether or not in writing, to participate in an activity specified in Section 3 of this act, if the refusal is based on religious or moral precepts.

B. No person shall be required to:

1. Participate in an activity specified in Section 3 of this act if the individual's participation in the activity is contrary to the person's religious beliefs or moral convictions;

2. Make facilities available for an individual to participate in an activity specified in Section 3 of this act if the person prohibits the activity from taking place in the facilities on the basis of religious beliefs or moral convictions; or

3. Provide any personnel to participate in an activity specified in Section 3 of this act if the activity is contrary to the religious beliefs or moral convictions of the personnel.

§63-1-728.5. Action for equitable relief - Attorney fees - Limitation.

A. For the purposes of this section, "damages" do not include noneconomic damages, as defined in Section 1-1708.1C of Title 63 of the Oklahoma Statutes.

B. A person who is adversely affected by conduct that is in violation of the Freedom of Conscience Act may bring a civil action for equitable relief, including reinstatement or damages, or both reinstatement and damages. An action under this subsection may be commenced against the state and any office, department, independent agency, authority, institution, association, or other body in state government created or authorized to be created by the state constitution or any law. In an action under this subsection, the court shall award reasonable attorney fees to a person who obtains equitable relief, damages, or both. An action under this subsection shall be commenced within one (1) year after the cause of action accrues or be barred.

Oregon

Oregon Revised Statutes (Death With Dignity Act) 127.885 s.4.01.

Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or

on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 s.4.01; 1999 c.423 s.10]

Note: As originally enacted by the people, the leadline to section 4.01 read "Immunities." The remainder of the leadline was added by editorial action.

Oregon Revised Statutes (Family planning & abortion)

435.215 Right to refuse services protected.

The refusal of any person to accept family planning and birth control services shall in no way affect the right of such person to receive public assistance or any other public benefit and every person to whom such services are offered shall be so advised initially both orally and in writing. Employees engaged in the administration of ORS 435.205 to 435.235 shall recognize that the right to make decisions concerning family planning and birth control is a fundamental personal right of the individual and nothing in ORS 435.205 to 435.235 shall in any way abridge such individual right, nor shall any individual be required to state the reason for refusing the offer of family planning and birth control services. [1967 c.491 s.3; 1971 c.779 s.66; 1987 c.158 s.81]

435.225 Refusal by employee to offer services.

Any employee of the Adult and Family Services Division may refuse to accept the duty of offering family planning and birth control services to the extent that such duty is contrary to the personal or religious beliefs of the employee. However, such employee shall notify the immediate supervisor in writing of such refusal in order that arrangements may be made for eligible persons to obtain such information and services from another employee. Such refusal shall not be grounds for any disciplinary action, for dismissal, for any interdepartmental transfer, for any other discrimination in employment, or for suspension from employment, or for any loss in pay or other benefits. [1967 c.491 s.4; 1971 c.779 s.67]

435.235 Construction of ORS 435.205 to 435.235.

ORS 435.205 to 435.235 shall be liberally construed to protect the rights of all individuals to pursue their religious beliefs, to follow the dictates of their own consciences, to prevent the imposition upon any individual of practices offensive to the individual's moral standards, to respect the right of every individual to self-determination in the procreation of children, and to insure a complete freedom of choice in pursuance of constitutional rights. [1967 c.491 s.5]

435.435 Effect of refusal to consent to termination.

The refusal of any person to consent to a termination of pregnancy or to submit thereto shall not be grounds for loss of any privilege or immunity to which the person is otherwise entitled nor shall consent to or submission to a termination of pregnancy be imposed as a condition to the receipt of any public benefits. [1969 c.684 ss.7,12; 1983 c.470 s.5]

435.475 Refusal to admit patient for termination.

(1) Except as provided in subsection (3) of this section, no hospital is required to admit any patient for the purpose of terminating a pregnancy. No hospital is liable for its failure or refusal to participate in such termination if the hospital has adopted a policy not to admit patients for the purposes of terminating pregnancies. However, the hospital must notify the person seeking admission to the hospital of its policy.

(2) All hospitals that have not adopted a policy not to admit patients seeking termination of a pregnancy shall admit patients seeking such termination in the same manner and subject to the same conditions as imposed on any other patient seeking admission to the hospital.

(3) No hospital operated by this state or by a political subdivision in this state is authorized to adopt a policy of

excluding or denying admission to any person seeking termination of a pregnancy. [1969 c.684 s.9; 1983 c.470 s.2]

435.485 Medical personnel not required to participate in termination.
(1) No physician is required to give advice with respect to or participate in any termination of a pregnancy if the refusal to do so is based on an election not to give such advice or to participate in such terminations and the physician so advises the patient.

(2) No hospital employee or member of the hospital medical staff is required to participate in any termination of a pregnancy if the employee or staff member notifies the hospital of the election not to participate in such terminations. [1969 c.684 ss.10,11; 1983 c.470 s.3]

Insurance Code

(*The following provisions from HB 2700, 9 March, 2007, have been incorporated into the Oregon Revised Statutes, 750.055 and 750.333. The bill was signed by the Governor on 31 May, 2007*)

(1) A prescription drug benefit program, or a prescription drug benefit offered under a health benefit plan as defined in ORS 743.730 or under a student health insurance policy, must provide payment, coverage or reimbursement for:

(a) Prescription contraceptives; and
(b) If covered for other drug benefits under the program, plan or policy, outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive.

(2) The coverage required by subsection (1) of this section may be subject to provisions of the program, plan or policy that apply equally to other prescription drugs covered by the program, plan or policy, including but not limited to required copayments, deductibles and coinsurance.

(3) As used in this section, 'contraceptive' means a drug or device approved by the United States Food and Drug Administration to prevent pregnancy.

(4) A religious employer is exempt from the requirements of this section with respect to a prescription drug benefit program or a health benefit plan it provides to its employees. A 'religious employer' is an employer:

(a) Whose purpose is the inculcation of religious values;
(b) That primarily employs persons who share the religious tenets of the employer;
(c) That primarily serves persons who share the religious tenets of the employer; and
(d) That is a nonprofit organization under section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code

Pennsylvania

§ 3213. Prohibited acts.

(d) Participation in abortion.--Except for a facility devoted exclusively to the performance of abortions, no medical personnel or medical facility, nor any employee, agent or student thereof, shall be required against his or its conscience to aid, abet or facilitate performance of an abortion or dispensing of an abortifacient and failure or refusal to do so shall not be a basis for any civil, criminal, administrative or disciplinary action, penalty or

proceeding, nor may it be the basis for refusing to hire or admit anyone. Nothing herein shall be construed to limit the provisions of the act of October 27, 1955 (P.L.744, No.222), known as the "Pennsylvania Human Relations Act." Any person who knowingly violates the provisions of this subsection shall be civilly liable to the person thereby injured and, in addition, shall be liable to that person for punitive damages in the amount of $5,000.

Rhode Island

Section 23-17-11 § 23-17-11
Abortion and sterilization -- Protection for nonparticipation -- Procedure. --

A physician or any other person who is a member of or associated with the medical staff of a health care facility or any employee of a health care facility in which an abortion or any sterilization procedure is scheduled, and who shall state in writing an objection to the abortion or sterilization procedure on moral or religious grounds, shall not be required to participate in the medical procedures which result in the abortion or sterilization, and the refusal of the person to participate therein shall not form the basis for any claim of damages on account of the refusal or for any disciplinary or recriminatory action against the person.

South Carolina

Section 44-41-40. Certain hospitals or clinics may refuse to perform abortions

No private or nongovernmental hospital or clinic shall be required to admit any patient for the purpose of terminating a pregnancy, nor shall such institutions be required to permit their facilities to be utilized for the performance of abortions. No cause of action shall arise against any such hospital or clinic for refusal to perform or to allow the performance of an abortion if the institution has adopted a policy not to admit patients for the purpose of terminating pregnancies; provided, that no hospital or clinic shall refuse an emergency admittance.

SECTION 44-41-50. Medical employees shall not be required to aid in abortions; providing necessary aftercare following abortion.
(a) No physician, nurse, technician or other employee of a hospital, clinic or physician shall be required to recommend, perform or assist in the performance of an abortion if he advises the hospital, clinic or employing physician in writing that he objects to performing, assisting or otherwise participating in such procedures. Such notice will suffice without specification of the reason therefor.

(b) No physician, nurse, technician or other person who refuses to perform or assist in the performance of an abortion shall be liable to any person for damages allegedly arising from such refusal.

(c) No physician, nurse, technician or other person who refuses to perform or assist in the performance of an abortion shall because of that refusal be dismissed, suspended, demoted, or otherwise disciplined or discriminated against by the hospital or clinic with which he is affiliated or by which he is employed. A civil action for damages or reinstatement of employment, or both, may be prosecuted by any person whose employment or affiliation with a hospital or clinic has been altered or terminated in violation of this chapter.

South Dakota

South Dakota Codified Law 34-23A-11. Counselor or social worker not liable for arranging abortion -- Retaliation from employer prohibited.

No counselor, social worker or anyone else who may be in such a position where the abortion question may appear as a part of their workday routine, shall be liable to any person for damages allegedly arising from advising or helping to arrange for or for refusal to arrange or encourage abortion, and there shall be no retaliation from any agency or institution with which such person may be affiliated or by which he may be employed.

34-23A-12. No liability for refusal to perform abortion.

No physician, nurse or other person who refuses to perform or assist in the performance of an abortion shall be liable to any person for damages arising from that refusal.

34-23A-13. Medical facility not to discriminate for performance or refusal to perform abortion.

No physician, nurse or other person who performs or refuses to perform or assist in the performance of an abortion shall, because of that performance or refusal, be dismissed, suspended, demoted, or otherwise prejudiced or damaged by a hospital or other medical facility with which he is affiliated or by which he is employed.

34-23A-14. Hospital not required to perform abortions -- No liability for refusal of abortion as policy.

No hospital licensed pursuant to the provisions of chapter 34-12 is required to admit any patient for the purpose of terminating a pregnancy pursuant to the provisions of this chapter. No hospital is liable for its failure or refusal to participate in such termination if the hospital has adopted a policy not to admit patients for the purpose of terminating pregnancies as provided in this chapter.

36-11-70. Refusal to dispense medication.

No pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to:

(1) Cause an abortion; or

(2) Destroy an unborn child as defined in subdivision 22-1-2(50A); or

(3) Cause the death of any person by means of an assisted suicide, euthanasia, or mercy killing.

No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy of the pharmacist or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist.

Tennessee

Tennessee Code 39-15-204. Right to refuse to perform abortions.

No physician shall be required to perform an abortion and no person shall be required to participate in the performance of an abortion. No hospital shall be required to permit abortions to be performed therein. [Acts 1989, ch. 591, § 1.]

39-15-205. Right of hospitals to refuse to accept abortion patients.

No section of this part shall be construed to force a hospital to accept a patient for an abortion.
[Acts 1989, ch. 591, § 1.]

68-34-104. Contraceptives — Availability — Information — Religious belief. —

(5) No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal;

Texas

Vernon's Civil Statutes Art. 4512.7. Right not to perform abortions.

Sec. 1. Personnel Not Required to Participate in Abortion Procedures.

A physician, nurse, staff member, or employee of a hospital or other health care facility who objects to performing or participating, directly or indirectly, in an abortion procedure may not be required to perform or participate, directly or indirectly, in an abortion procedure.

Sec. 2. Private Hospitals Not Required to Make Facilities Available.

A private hospital or private health care facility may not be required to make its facilities available for the performance of an abortion unless a physician determines that the life of the mother is immediately endangered.

Sec. 3. Discrimination Prohibited.

A hospital or health care facility may not discriminate in any manner against a physician, nurse, staff member, or employee or against an applicant for such positions, who refuses to perform or participate in an abortion procedure. No physician, nurse, staff person, or employee shall be discriminated against for their willingness to participate in abortion procedures at other facilities. An educational institution may not discriminate against applicants for admission or employment as students, interns, or residents because of their attitudes concerning

abortion.

Sec. 4. Remedies.

A person whose rights under this Act are violated may sue a hospital, health care facility, or educational institution in district court in the county where the hospital, facility, or institution is located to enjoin further violations of this Act and for such affirmative relief as may be appropriate, including, but not limited to, admission or reinstatement of employment with back pay plus 10 percent interest, and any other relief necessary to ensure compliance with the provisions of this Act.
Acts 1977, 65th Leg., p. 1870, ch. 745, eff. Aug. 29, 1977.

Utah

Utah Code 76-7-306. Physician, hospital employee, or hospital not required to participate in abortion.

(1) A physician, or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital in which an abortion has been authorized, who states an objection to an abortion or the practice of abortion in general on moral or religious grounds shall not be required to participate in the medical procedures which will result in the abortion, and the refusal of any person to participate shall not form the basis of any claim for damages on account of the refusal or for any disciplinary or recriminatory action against such person, nor shall any moral or religious scruples or objections to abortions be the grounds for any discrimination in hiring in this state.

(2) Nothing in this part shall require any private and/or denominational hospital to admit any patient for the purpose of performing an abortion.
Amended by Chapter 20, 1995 General Session

78-11-24. Act or omission preventing abortion not actionable.
A cause of action shall not arise, and damages shall not be awarded, on behalf of any person, based on the claim that but for the act or omission of another, a person would not have been permitted to have been born alive but would have been aborted.
Enacted by Chapter 167, 1983 General Session

Virginia

Code of Virginia § 18.2-75 Conscience clause

Nothing in §§18.2-72, 18.2-73 or §18.2-74 shall require a hospital or other medical facility or physician to admit any patient under the provisions hereof for the purpose of performing an abortion. In addition, any person who shall state in writing an objection to any abortion or all abortions on personal, ethical, moral or religious grounds shall not be required to participate in procedures which will result in such abortion, and the refusal of such person, hospital or other medical facility to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person, nor shall any such person be denied employment because of such objection or refusal. The written objection shall remain in effect until such person shall revoke it in writing or terminate his association with the facility with which it is filed.

Washington

Revised Code of Washington RCW 9.02.150 Refusing to perform

No person or private medical facility may be required by law or contract in any circumstances to participate in the performance of an abortion if such person or private medical facility objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the termination of a pregnancy.

Washington Death With Dignity Act RCW 70.245.190

Note: This law legalizes assisted suicide. It includes the following protection of conscience provisions. Note that, under Section 2(a), objecting hospitals can prohibit assisted suicide on their premises, but under 2(d)ii are forced to permit health care workers on their premises to refer patients for assisted suicide.

Immunities — Basis for prohibiting health care provider from participation — Notification — Permissible sanctions. (Effective March 5, 2009.)

(1) Except as provided in RCW 70.245.200 and subsection (2) of this section:

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;

(b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and

(d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under chapter 1, Laws of 2009 on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under chapter 1, Laws of 2009. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under chapter 1, Laws of 2009.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if

the sanctioning health care provider has notified the sanctioned provider before participation in chapter 1, Laws of 2009 that it prohibits participation in chapter 1, Laws of 2009:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in chapter 1, Laws of 2009 while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in chapter 1, Laws of 2009 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in chapter 1, Laws of 2009 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in chapter 1, Laws of 2009 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions under (b) of this subsection shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in chapter 1, Laws of 2009 of the sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in chapter 1, Laws of 2009" means to perform the duties of an attending physician under RCW 70.245.040, the consulting physician function under RCW 70.245.050, or the counseling function under RCW 70.245.060. "Participate in chapter 1, Laws of 2009" does not include:

(A) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

(C) Providing a patient, upon the request of the patient, with a referral to another physician; or

(D) A patient contracting with his or her attending physician and consulting physician to act outside of the course

and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(3) Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under RCW 70.245.030, 70.245.040, 70.245.050, or 70.245.060 may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to "good faith" in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

[2009 c 1 § 19 (Initiative Measure No. 1000, approved November 4, 2008).]

West Virginia

West Virginia Code §16-2F-7. Article not to be construed to require abortion.

Nothing in this article, nor in any order issued pursuant thereto, shall require that a physician perform an abortion or that any person be required to assist in the performance of an abortion if such physician or person, for any reason, medical or otherwise, does not wish to perform or assist in such abortion.

Wisconsin

Wisconsin Statutes 253.09 Abortion refused; no liability; no discrimination.

253.09(1) No hospital shall be required to admit any patient or to allow the use of the hospital facilities for the purpose of performing a sterilization procedure or removing a human embryo or fetus. A physician or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital in which such a procedure has been authorized, who shall state in writing his or her objection to the performance of or providing assistance to such a procedure on moral or religious grounds shall not be required to participate in such medical procedure, and the refusal of any such person to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person.

253.09(2) No hospital or employee of any hospital shall be liable for any civil damages resulting from a refusal to perform sterilization procedures or remove a human embryo or fetus from a person, if such refusal is based on religious or moral precepts.

253.09(3) No hospital, school or employer may discriminate against any person with regard to admission, hiring or firing, tenure, term, condition or privilege of employment, student status or staff status on the ground that the person refuses to recommend, aid or perform procedures for sterilization or the removal of a human embryo or fetus, if the refusal is based on religious or moral precepts.

253.09(4) The receipt of any grant, contract, loan or loan guarantee under any state or federal law does not authorize any court or any public official or other public authority to require: 253.09(4)(a) (a) Such individual to perform or assist in the performance of any sterilization procedure or removal of a human embryo or fetus if the individual's performance or assistance in the performance of such a procedure would be contrary to the individual's religious beliefs or moral convictions; or 253.09(4)(b) (b) Such entity to:

(b)1. Make its facilities available for the performance of any sterilization procedure or removal of a human embryo or fetus if the performance of such a procedure in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions; or

(b)2. Provide any personnel for the performance or assistance in the performance of any sterilization procedure or assistance if the performance or assistance in the performance of such procedure or the removal of a human embryo or fetus by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

253.09 - ANNOT.History: *1973 c. 159; Stats. 1973 s. 140.275; 1973 c. 336 s. 54; Stats. 1973 s. 140.42; 1979 c. 34; 1993 a. 27 s. 222; Stats. 1993 s. 253.09; 1993 a. 482.*

441.06(6)
(6) No person licensed as a registered nurse under this section is liable for any civil damages resulting from his or her refusal to perform sterilization procedures or to remove or aid in the removal of a human embryo or fetus from a person, if the refusal is based on religious or moral precepts.
441.06 - ANNOT. History: 1971 c. 125, 215; 1973 c. 159; 1975 c. 39, 199; 1977 c. 29, 164; 1979 c. 34, 162; 1987 a. 27, 264; 1991 a. 39.

448.03(5)
(5) Civil liability; certain medical procedures and reports.
448.03(5)(a)
(a) No person licensed or certified under this subchapter shall be liable for any civil damages resulting from such person's refusal to perform sterilization procedures or to remove or aid in the removal of a human embryo or fetus from a person if such refusal is based on religious or moral precepts.

Wyoming

35-6-105. Private institutions not required to perform abortions; no liability for refusal to perform abortion.

No private hospital, clinic, institution or other private facility in this state is required to admit any patient for the purpose of performing an abortion nor to allow the performance of an abortion therein. The private hospital, clinic, institution or any other private facility shall inform any prospective patient seeking an abortion of its policy not to participate in abortion procedures. No cause of action shall arise against any private hospital, clinic, institution or any other private facility for refusing to perform or allow an abortion.

35-6-106. Persons not required to perform abortion; no civil liability for refusal; sanctions or discrimination for refusal forbidden.
No person shall, in any way, be required to perform or participate in any abortion or in any act or thing which accomplishes or performs or assists in accomplishing or performing a human miscarriage, euthanasia or any other death of a human fetus or human embryo. The refusal of any person to do so is not a basis for civil liability to any person. No hospital, governing board or any other person, firm, association or group shall terminate the employment of, alter the position of, prevent or impair the practice or occupation of, or impose any other sanction or otherwise discriminate against any person who refuses to perform or participate in any abortion or in any act or thing which accomplishes, performs or assists in accomplishing or performing a human miscarriage, euthanasia or any other death of a human fetus or embryo.

GUTTMACHER INSTITUTE

STATE POLICIES IN BRIEF

As of FEBRUARY 1, 2011

Refusing to Provide Health Services

BACKGROUND: Almost every state has a policy explicitly allowing some health care professionals or certain institutions to refuse to provide or participate in abortion, contraceptive services or sterilization services. Even in states without explicit refusal statutes, an individual health care professional's actions may be legally protected by statutes prohibiting discrimination against employees, based on their religious objections. While some of the institutional policies are limited to private, or even religious, health care institutions, others apply to all institutions providing health care. (At the federal level, health care institutions and providers may refuse to participate in abortion services on the basis of their religious or moral beliefs.)

A few states have enacted laws that specifically allow pharmacists or pharmacies to refuse to provide health care due to religious or moral objections. Several other states have broadly worded refusal clause statutes that might protect pharmacists or pharmacies from liability for their refusal. (See Emergency Contraception.)

HIGHLIGHTS:

- 46 states allow some health care providers to refuse to provide abortion services.
  - All of these states permit individual health care providers to refuse to provide abortion services.
  - 45 states allow health care institutions to refuse to provide abortion services, 15 limit the exemption to private health care institutions and 1 state allows only religious health care entities to refuse to provide such care.

- 14 states allow some health care providers to refuse to provide services related to contraception.
  - 9 states allow individual health care providers to refuse to provide services related to contraception
  - 5 states explicitly permit pharmacists to refuse to dispense contraceptives. (5 additional states have broad refusal clauses that do not specifically include pharmacists, but may apply to them.)
  - 1 state explicitly permits pharmacies to refuse to dispense contraceptives.
  - 4 states have broad refusal clauses that do not specifically include pharmacies, but may apply to them.
  - 9 states allow health care institutions to refuse to provide services related to contraception, 6 states limit the exemption to private entities.

- 18 states allow some health care providers to refuse to provide sterilization services.
  - 17 states allow individual health care providers to refuse to provide sterilization services.
  - 16 states allow health care institutions to refuse to provide sterilization services; 4 limit the exemption to private entities.

GUTTMACHER INSTITUTE

Advancing sexual and reproductive health worldwide through research, policy analysis and public education.

125 Maiden Lane
New York, NY 10038
212.248.1111
www.guttmacher.org
info@guttmacher.org

1301 Connecticut Avenue, N.W.
Washington, DC 20036
202.296.4012
www.guttmacher.org
policyworks@guttmacher.org

© 2011, Guttmacher Institute

CONTINUED

POLICIES ALLOWING PROVIDERS TO REFUSE

STATE	ABORTION		CONTRACEPTION				STERILIZATION	
	Individual Providers	Institutions	Individual Providers	Pharmacists	Pharmacies	Institutions	Individual Providers	Institutions
Alaska	X	Private						
Arizona	X$^{\Psi}$	X$^{\Psi}$	§	§	§	§		
Arkansas	X	X	X	X	*	Private	X	X
California	X	Religious		†				
Colorado	X	X	X	*	*	Private		
Connecticut	X							
Delaware	X	X						
Florida	X	X	X	*				
Georgia	X	X		X			X	X
Hawaii	X	X						
Idaho	X	X	X	X			X	X
Illinois	X	Private	X	*	‡	X	X	X
Indiana	X	Private						
Iowa	X	Private						
Kansas	X	X					X	X
Kentucky	X	X					X	
Louisiana	X	X						
Maine	X	X	X	*	*	Private	X	X
Maryland	X	X					X	X
Massachusetts	X	Private				Private	X	Private
Michigan	X	X						
Minnesota	X	Private						
Mississippi	X	X	X	X	X	X	X	X
Missouri	X	X						
Montana	X	Private					X	Private
Nebraska	X	X						
Nevada	X	Private						
New Jersey	X	Private			‡	Private	X	Private
New Mexico	X	X						X
New York	X	X						
North Carolina	X	X						
North Dakota	X	X						
Ohio	X	X						
Oklahoma	X	X						
Oregon	X	Private						
Pennsylvania	X	Private					X	Private
Rhode Island	X	X					X	
South Carolina	X	Private						
South Dakota	X	X		X				
Tennessee	X	X	X	*	*	Private		
Texas	X	Private						
Utah	X	Private						
Virginia	X	X						
Washington	X	X	X		‡	X	X	X
West Virginia							X	X
Wisconsin	X	X			Ω		X	X
Wyoming	X	Private						
TOTAL	**46**	**45**	**9**	**5**	**1**	**9**	**17**	**16**

Note: Unless indicated, the right to refuse applies to all institutions– private, religious and public.

§ Temporarily enjoined; law not in effect pending the outcome of litigation.

Ψ An expansion of the state's abortion refusal clause is temporarily enjoined pending the outcome of litigation; the prior law is in effect.

* A broadly worded refusal clause may apply.

† Pharmacists have a duty to dispense valid prescriptions and can only refuse to dispense a prescription, including contraceptives, when their employers approves the refusal and the woman can still access her prescription in a timely manner.

‡ Pharmacies are required to dispense valid prescriptions and in Illinois and Washington deliver FDA-approved drugs, such as emergency contraception.

Ω State law requires pharmacies to fill valid contraceptive prescriptions.

CONTINUED

FOR MORE INFORMATION:

For information on state legislative and policy activity, click on Guttmacher's Monthly State Update, and for state-level information and data on reproductive health issues, click on Guttmacher's State Center. To see state-specific abortion information, click on State Facts About Abortion and Guttmacher's Data Center.

Sonfield A, Delineating the obligations that come with conscientious refusal: a question of balance, *Guttmacher Policy Review*, 2009, 12(3):6–10.

Sonfield A, Proposed 'conscience' regulation opposed widely as threat to reproductive health and beyond, *Guttmacher Policy Review*, 2008, 11(4):17–19.

Sonfield A, Provider refusal and access to reproductive health services: approaching a new balance, *Guttmacher Policy Review*, 2008, 11(2):2–6.

Guttmacher Institute, Striking a balance between a provider's right to refuse and a patient's right to receive care, 2005.

Dailard C, Beyond the issue of pharmacist refusals: pharmacies that won't sell emergency contraceptives, *The Guttmacher Report on Public Policy*, 2005, 8(3):10–12.

Sonfield A, Rights vs. responsibilities: professional standards and provider refusals, *The Guttmacher Report on Public Policy*, 2005, 8(3):7–9.

Sonfield A, New refusal clauses shatter balance between provider 'conscience,' patient needs, *The Guttmacher Report on Public Policy*, 2004, 7(3):1–3.

Gold RB, Future uncertain for Catholic plans' creative approaches to providing contraceptive access, *The Guttmacher Report on Public Policy*, 2000, 3(6):1–2 & 14.

Gold RB and Sonfield A, Refusing to participate in health care: a continuing debate, *The Guttmacher Report on Public Policy*, 2000, 3(1):8–11.

Dailard C, State contraceptive coverage laws: creative responses to questions of 'conscience', *The Guttmacher Report on Public Policy*, 1999, 2(4):1–2 & 14.

Cohen SA, Objections, confusion among pharmacists threaten access to emergency contraception, *The Guttmacher Report on Public Policy*, 1999, 2(3):1–3.

Gold RB, Contraceptive coverage: toward ensuring access while respecting conscience, *The Guttmacher Report on Public Policy*, 1998, 1(6):1–2 & 14.

Donovan P, When plans opt out: family planning access in Medicaid managed care, *The Guttmacher Report on Public Policy*, 1998, 1(4):8–11.

Gold RB, Conscience makes a comeback in the age of managed care, *The Guttmacher Report on Public Policy*, 1998, 1(1):1–2.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

GO

Issues & Research » Health » Pharmacist Conscience Clauses Laws and Legislation Go 14380 Share Comment

Pharmacist Conscience Clauses: Laws and Legislation

Updated October 2010

Health provider "refusal clauses" (also known as "conscience clauses") were first enacted in response to the United States Supreme Court's decision in the Roe v. Wade case, 410 U.S. 113 (1973). Roe v. Wade was the landmark decision establishing that most laws against abortion violate a constitutional righy to privacy, overturning all state laws outlawing or restricting abortion. Some states have subsequently proposed legislation and passed laws designed to allow doctors and other direct providers of health care to refuse to perform or assist in an abortion, and hospitals to refuse to allow abortion on their premises. Now, the issue is expanding as pharmacists are refusing to fill emergency contraception and contraception prescriptions. This movement resulted in the term "conscience clause," which gives pharmacists the right to refuse to perform certain services based on a violation of personal beliefs or values. Most of the debate revolves around a pharmacist dispensing emergency contraception. Emergency contraception is used to prevent a pregnancy, not terminate a pregnancy, and is a general term used to describe several different types of birth control pills that are used in increased doses within 72 hours of unprotected intercourse. Emergency contraception is not the same thing as Mifeprex, which is the brand name of mifepristone in the United States and is sometimes referred to as non-surgical abortion, medical abortion, or RU-486. Pharmacists do not play a role in administering these medications.

In some states, legislators are introducing bills that would explicitly grant pharmacists the right to refuse to dispense drugs related to contraception on moral grounds. Other state legislators are introducing legislation that would require pharmacies to fill any legal prescription for birth control, much like Governor Blagojevich's emergency rule in Illinois, which requires pharmacies to provide the morning after pill. Four States (**Arkansas, Georgia, Mississippi,** and **South Dakota**) have passed laws allowing a pharmacist to refuse to dispense emergency contraception drugs. **Illinois** passed an emergency rule that requires a pharmacist to dispense FDA approved contraception. **Colorado, Florida**, **Maine** and **Tennesee** have broad refusal clauses that do not specifically mention pharmacists.

California pharmacists have a duty to dispense prescriptions and can only refuse to dispense a prescription, including contraceptives, when their employer approves the refusal and the woman can still access her prescription in a timely manner.

New Jersey's law (effective November 2007), prohibits pharmacists for refusing to fill prescriptions solely on moral, religious or ethical grounds.

Conscience Clause Laws (allowing the refusal to fill)

Arkansas § 20-9-1001 allows certain individuals or entities to refuse to perform abortion services and provide or dispense contraceptives in all or most circumstances.

California SB 644 Chapter No. 417 prohibits a health care licentiate from obstructing a patient in obtaining a prescription drug or device and would require the licentiate to dispense drugs and devices pursuant to a lawful prescription or order except in specified circumstances, including on ethical, moral, or religious grounds asserted by the licentiate.

Colorado Rev. Stat. 25-6-102 states that no private institution, it employees, or physicians may be held liable for refusing to dispense contraceptive supplies, procedures or information if their refusal is based on a moral or religious objection to such activities.

Florida 2003 Stat. XXIX 381.0051 states that physicians or other people may not be held liable for refusing to dispense contraceptive or family planning devices, services or information.

Georgia Admin. Code § 480-5-.03 provides that a pharmacist shall not be required to fill a prescription for an emergency contraceptive drug; provides that such refusal shall not be the basis for any claim for damages; provides for the duration of the effectiveness of the written objection; provides for related matters; repeals conflicting laws.

Idaho Code § 18-611 provides that no health care professional shall be required to provide any health care service that violates his or her conscience.

Illinois requires pharmacies to dispense contraception. Gov. Rod Blagojevich (D) issued emergency rules that require pharmacies in the state to dispense FDA-approved contraceptives. If the pharmacy does not have the drug or a suitable substitute in stock, then the pharmacy must order the medication through standard procedures, transfer the prescription to another local pharmacy or return the prescription to the patient. The emergency rules will be in effect only for 150 days, after which the state is expected to begin the normal rulemaking process in order to make the requirement rule permanent.

Maine Rev. Stat. tit. 22, 1903 (1973) gives physicians and agents of medical and related facilities the right to refuse to provide family planning services when such actions would interfere with moral or religious beliefs.

Mississippi Code Ann. § 41-41-215 permits health care providers, including pharmacists or other pharmacy employees, counselors, social workers, health insures and health care facilities to refuse to provide [any] medical services, including counseling and referral, on religious or ethical grounds (SB 2619).

South Dakota Codified Laws § 36-11-70 allows pharmacists the right to refuse to provide services.

Tennessee Code Ann. 68-34-104 allows physicians or any agent of such an entity to refuse to offer contraceptive services, supplies, or information if it interferes with a moral or religious belief. States that physicians or other agents may not be held liable for this refusal.

Washington RCW 48.43.065 allows for no individual health care provider, religiously sponsored carrier, or health care facility be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion.
Also: On June 1, 2006 the Washington Board of Pharmacy approved proposed rule language regarding a pharmacist's responsibilities in dispensing a lawful prescription. This language would amend **Washington Admin. Code 246-863-095** to prohibit a pharmacist from delegating the decision not to dispense prescriptions for any reason.

Sources: National Conference of State Legislatures; Denver, Colorado.

Compiled by NCSL Health Program, Denver.

Note: List may not be comprehensive, but is representative of state laws that exist. NCSL appreciates additions and corrections.

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

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

©2011 National Conference of State Legislatures. All Rights Reserved.

Sign In Register Now Subscribe Mobile Multimedia Today's Paper Going Out Guide Jobs Cars Real Estate Rentals Classifieds

NEWS LOCAL POLITICS OPINIONS SPORTS Business Arts & Living

Search The Washington Post

Hot Topics Obama Tim Kaine Jeff Bingaman to retire All-Star Weekend Uganda Wisconsin protests Carolyn Hax

Advertisement

washingtonpost.com > Nation

» FOLLOW THE POST ON:

Advertisement

» THIS STORY: READ + | Comments

Obama administration replaces controversial 'conscience' regulation for health-care workers

By Rob Stein
Washington Post Staff Writer
Friday, February 18, 2011; 1:27 PM

The Obama administration rescinded most of a federal regulation Friday designed to protect health workers who refuse to provide care they find objectionable on personal or religious grounds.

THIS STORY
Obama administration replaces controversial 'conscience' regulation for health-care workers
May 11, 2009: On Faith: "Conscience Rules" Ignore Patient
Feb. 28, 2009: Health Workers' 'Conscience' Rule Set to Be Voided
View All Items In This Story

The Health and Human Services Department eliminated nearly the entire rule put into effect by the administration of President George W. Bush during his final days in office that was widely interpreted as allowing such workers to opt out of a broad range of medical services, such as providing the emergency contraceptive Plan B, treating gay men and lesbians and prescribing birth control to single women.

Calling the Bush-era rule "unclear and potentially overbroad in scope," the new, much narrower version essentially leaves in place only long-standing federal protections for workers who object to performing abortions or sterilizations. It also retains the Bush rule's formal process for workers to file complaints.

"The department supports clear and strong conscience protections for health-care providers who are opposed to performing abortions," the rule states.

The new regulation, which goes into effect in 30 days, also ensures that no federal money can be used to "support coercive or discriminatory policies or practices in violation of federal law."

Advertisement

The Bush regulation, if enforced, would have cut off federal funding for thousands of entities, including state and local governments, hospitals, health plans and clinics, if they did not accommodate doctors, nurses, pharmacists or other employees who refused to participate in care they felt violated their personal, moral or religious beliefs.

The rule was sought by conservative groups, which argued that workers were increasingly being fired, disciplined or penalized in other ways for trying to exercise their "right of conscience."

Network News PROFILE X

Opinion 107

View More Activity

TOOLBOX
Resize Print E-mail
Yahoo! Buzz Reprints

COMMENT
80 Comments | View All »

POST A COMMENT
You must be logged in to leave a comment.
Log In | Register
Why Do I Have to Log In Again?

Post

Discussion Policy

Sponsored Links

Wrinkles Hate This...
Mom's shocking $5 wrinkle trick. The closely guarded secret revealed!
ConsumerDigestReports.com/Wrinkl...

Spinal Stenosis Pain?
See where laser Spine Surgery Began-No Hospitalization!
www.bonati.com

Buy a link here

TOP JOBS The Washington Post

- Business Jobs
- Computer Jobs
- Construction Jobs
- Education Jobs
- Engineering Jobs
- Healthcare Jobs
- Legal Jobs
- Management Jobs
- Media Jobs
- Non-Profit Jobs
- Sales Jobs
- Science Jobs

Find Your Dream Job Now!
keywords location
FIND JOBS
Jobs by SimplyHired

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

Looking to buy a home? Visit TWP Real Estate section for the latest open houses.

Enjoy a Taste of Ireland Tour, one week all inclusive from $658

Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Network News MY PROFILE X

Friends' Activity Most Popular Twitter Activity

Your Friends' Most Recent Activity

Advertisement

Health Workers' 'Conscience' Rule Set to Be Voided

By Rob Stein
Washington Post Staff Writer
Saturday, February 28, 2009

The Obama administration's move to rescind broad new job protections for health workers who refuse to provide care they find objectionable triggered an immediate political storm yesterday, underscoring the difficulties the president faces in his effort to find common ground on anything related to the explosive issue of abortion.

The administration's plans, revealed quietly with a terse posting on a federal Web site, unleashed a flood of heated reaction, with supporters praising the proposal as a crucial victory for women's health and reproductive rights, and opponents condemning it as a devastating setback for freedom of religion.

Perhaps most tellingly, the move drew deep disappointment from some conservatives who have been hopeful about working with the administration to try to defuse the debate on abortion, long one of the most divisive political issues.

"This is going to be a political hit for the administration," said Joel Hunter, senior pastor of the Northland Church in Longwood, Fla., whom Obama recently named to his Advisory Council on Faith-Based and Neighborhood Partnerships. "This will be one of those things that kind of says, 'I knew it. They talk about common ground, but really what they want is their own way.' "

Administration officials stressed that the proposal will be subject to 30 days of public comment, which could result in a compromise. They said they remain committed to seeking a middle ground but acknowledged that will not always be possible.

"We recognize we are not going to be able to agree on every issue," said an administration official, who spoke on the condition of anonymity because the process has just begun. "But there remains a substantive area of common ground, and we continue to believe we can make progress and will make progress."

The Rev. Joel Hunter said the move raises skepticism about the White House's talk of common ground. (John Raoux - AP)

Enlarge Photo

TOOLBOX
Resize Print E-mail
Yahoo! Buzz

COMMENT
1171 Comments | View All »
COMMENTS ARE CLOSED

WHO'S BLOGGING powered by sphere
» Links to this article

Sponsored Links

$65/Hr Job - 25 Openings
Part-Time job ($20-$65/hr). Requirements: Home Internet Access
Channel11NewsReport.com/Money

$39/mo Car Insurance?
Most pay $700 twice a year. Do you pay too much? Compare Quotes now!
http://www.1minuteautoinsurance.com

Buy a link here

The announcement capped a week when anger among conservatives was already running high because of the ambitious progressive agenda outlined in the administration's proposed $3.6 trillion budget.

The debate centers on a Bush administration regulation, enacted in December, that cuts off federal funding for thousands of state and

Advertisement

Advertorials By SmarterLifestyles

How To Stay Asleep
Scientists in Cambridge discover an all natural sleep aid to help you sleep all night... Learn more

SHOCKING Muscle Photos
Muscle building miracle discovered by scientists is a catalyst for huge muscle gains... Learn more

Joint discomfort Warning
Shocking discovery by Cambridge Researcher's for amazing joint relief. Learn more

Why Snoring Can Kill
Snoring is a silent killer. Stop your snoring tonight... Learn more

Juneau: Time To Travel
The most breathtaking vacation you'll ever experience... Learn more

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

Looking to buy a home? Visit TWP Real Estate section for the latest open houses.

Enjoy a Taste of Ireland Tour, one week all inclusive from $658

Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Slate HIGHLIGHTS

Wisconsin Dems Fled the Statehouse To Stop a Bill They Hate. ...

What's the Difference Between "Rape" and "Sexu
How Oman Is Keeping Its Protests Peaceful
Clinic Catastrophes: Some Abortion Providers A..

See All of Slate »

RECENT POSTS

- How evangelicals lost political credibility
- The divine mystery of human genius
- Serious Catholics more likely to vote their beliefs
- Catholics don't want to be told how to vote
- Christian right noticeably absent in conservatives' fight to "save America"
- Deviant theology of violent extremists
- Muslim extremism stems from alienation
- Rallying for reason: a little atheism goes a long way
- Going in "Muslim garb" for Halloween
- Preisthood Sunday: The case for married priests

Posts By Category

Posts By Date

- Full Archive

MORE ON FAITH

- On Faith: Main Page
- A Modern Muslim
- Catholic America
- For God's Sake
- Georgetown/On Faith
- God in Government
- Guest Voices
- HealthCentral/On Faith
- Religion From the Heart
- The Faith Divide
- The Spirited Atheist
- Under God
- Women On Faith

SUBSCRIBE TO THIS BLOG

RSS Feed

"Conscience Rules" Ignore Patient

By Sally Steenland
senior policy adviser, Center for American Progress

What happens when consciences collide? In the field of health care, the provider's conscience is given great consideration. For over 30 years, we've had federal and state laws that allow health care providers to refuse to provide certain treatments that they object to on religious or moral grounds. In fact, the public debate is usually framed as one of provider conscience vs. patient access. The problem is that this frame ignores the conscience of the patient.

Let's say a patient needs a prescription for contraception. She is a mother of two and takes birth control pills in order to be a spiritually and emotionally responsible parent. Her decision is one of conscience. When a pharmacist refuses to fill her prescription for religious reasons, he or she is defying the patient's conscience in favor of his or her own. That is wrong.

In a pluralistic democracy where people hold different beliefs and values, one conscience should never trump all others. Instead, we must find ways to negotiate conflicting consciences so that religious liberty is respected and health care is safeguarded.

The conflict over conscience refusals has been in the news lately because the Obama administration is rescinding a harmful Bush rule that took effect his last day in office. The Bush rule, which is currently in effect, goes too far in expanding provider refusals.

The rule jeopardizes patient health and well-being, and allows the religious beliefs of the provider to be imposed on the conscience of the patient. And not just that. The rule is also unnecessary because there are existing laws on the books to protect the religious beliefs of health care providers. The good news is that the new rule, soon to be issued by the Obama administration, should set a fairer balance between the rights, needs and responsibilities of providers and patients.

In some areas, this is not overly difficult to do. In large pharmacies, medical practices, and hospitals, for instance, provisions can be made to meet the needs of the patient and of the health care provider. However, in areas where there are fewer providers, those who refuse to provide treatment place a great burden on patients. One could also argue that they place a burden on their own professional conscience and ethical responsibility because of their chosen profession.

It must be said that most of the "conscience" issues being debated involve women's reproductive health, such as abortion, sterilization and contraception. It must also be said that one rarely hears in public debates a clear argument supporting women's moral agency, or conscience, as they make a difficult decision. For some women, the moral decision is to continue their pregnancy. For others, the moral decision is to have an abortion.

It is important to acknowledge this reality if we want to move forward and find real solutions and common ground. It is also important to look beyond reproductive health issues regarding conscience clauses, since other issues, such as end-of-life care and genetic technologies, increasingly present difficult moral choices.

As we debate and decide these issues, it is important not to demonize opposing views or claim a monopoly on morality. It is also important to put systems in place so that cases are not decided on an ad-hoc basis which can jeopardize patient care. Finally, it is important to be persistent in our search for solutions and common ground, no matter how difficult it may

Sign In Register Now Subscribe Mobile Multimedia Today's Paper Going Out Guide Jobs Cars Real Estate Rentals Classifieds
NEWS LOCAL POLITICS OPINIONS SPORTS Business Arts & Living Search The Washington Post

Advertisement

washingtonpost.com > Health > Women

» THIS STORY: READ + | Comments

Protections Set for Antiabortion Health Workers

Opponents Denounce Proposed Regulation Allowing Federal Officials to Pull Funding

By Rob Stein
Washington Post Staff Writer
Friday, August 22, 2008; Page A01

TOOLBOX
Resize Print E-mail
Yahoo! Buzz Save/Share +

COMMENT
0 Comments
COMMENTS ARE CLOSED

WHO'S BLOGGING powered by sphere
» Links to this article

The Bush administration yesterday announced plans to implement a controversial regulation designed to protect doctors, nurses and other health-care workers who object to abortion from being forced to deliver services that violate their personal beliefs.

THIS STORY
Protections Set for Antiabortion Health Workers
Birth Control Fears Addressed
Workers' Religious Freedom vs. Patients' Rights
View All Items in This Story

The rule empowers federal health officials to pull funding from more than 584,000 hospitals, clinics, health plans, doctors' offices and other entities if they do not accommodate employees who refuse to participate in care they find objectionable on personal, moral or religious grounds.

Advertisement

"People should not be forced to say or do things they believe are morally wrong," Health and Human Services Secretary Mike Leavitt said. "Health-care workers should not be forced to provide services that violate their own conscience."

The proposed regulation, which could go into effect after a 30-day comment period, was welcomed by conservative groups, abortion opponents and others as necessary to safeguard workers from being fired, disciplined or penalized in other ways. Women's health advocates, family planning advocates, abortion rights activists and others, however, condemned the regulation, saying it could create sweeping obstacles to a variety of health services, including abortion, family planning, end-of-life care and possibly a wide range of scientific research.

"It's breathtaking," said Robyn S. Shapiro, a bioethicist and lawyer at the Medical College of Wisconsin. "The impact could be enormous."

The regulation drops the most controversial language in a draft version that would have explicitly defined abortion for the first time in a federal law or regulation as anything that interfered with a fertilized egg after conception. But both supporters and critics said the regulation remains broad enough to protect pharmacists, doctors, nurses and others from providing birth control pills, Plan B emergency contraception and other forms of

Advertisement

FEATURED ADVERTISER LINKS
Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill
Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling
Looking to buy a home? Visit TWP Real Estate section for the latest open houses.
Enjoy a Taste of Ireland Tour, one week all inclusive from $658
Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Advertisement

Birth Control Fears Addressed

HHS Chief Says Draft Rule Is Not Redefining Abortion

By Rob Stein
Washington Post Staff Writer
Saturday, August 9, 2008

Health and Human Services Secretary Mike Leavitt has denied that a controversial draft regulation would redefine common birth control methods as abortion and protect the rights of doctors and other health-care workers who refuse to provide them.

THIS STORY
Protections Set for Antiabortion Health Workers
Birth Control Fears Addressed
Workers' Religious Freedom vs. Patients' Rights
View All Items in This Story

Mike Leavitt blogged on the issue. (Eugene Hoshiko - AP)

Enlarge Photo

TOOLBOX
Resize Print E-mail
Yahoo! Buzz

COMMENT
54 Comments | View All »
COMMENTS ARE CLOSED

WHO'S BLOGGING powered by sphere
» Links to this article

Sponsored Links

Top-Rated MBA Online
Earn Your MBA In 2 Years. No GMAT Required. 100% Online Program! FloridaTechOnlineMBA.com?

Groupon.com Official Site
1 huge daily deal on the best stuff to do in your city. Try it today! www.Groupon.com

Buy a link here

In a statement posted on his blog on Thursday, Leavitt appeared to try to allay fears that the proposed regulation would create sweeping new obstacles to women seeking a variety of commonly used contraceptives, such as birth control pills and the Plan B emergency contraceptive.

"An early draft of the regulation found its way into public circulation before it had reached my review," Leavitt said. "It contained words that lead some to conclude my intent is to deal with the subject of contraceptives, somehow defining them as abortion. Not true."

Leavitt's statement, however, failed to alleviate concerns among members of Congress, family planning advocates, women's health activists and others.

"It does not alleviate my concerns at all," said Jill Morrison of the National Women's Law Center, noting that a major section of the draft regulation titled "The Problem" cites state laws designed to make sure that women have access to birth control pills and Plan B. "I will wait to see if a 'clean' version of the rule is released for publication in the Federal Register, and then I will believe it."

Advertisement

The draft regulation would deny federal funding to any hospital, clinic, health plan or other entity that does not accommodate employees who want to opt out of participating in care that runs counter to their personal convictions.

Advertisement

TOP JOBS The Washington Post

- Business Jobs
- Computer Jobs
- Construction Jobs
- Education Jobs
- Engineering Jobs
- Healthcare Jobs
- Legal Jobs
- Management Jobs
- Media Jobs
- Non-Profit Jobs
- Sales Jobs
- Science Jobs

Find Your Dream Job Now!
keywords location
FIND JOBS
Jobs by SimplyHired

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

Looking to buy a home? Visit TWP Real Estate section for the latest open houses.

Enjoy a Taste of Ireland Tour, one week all inclusive from $658

Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Slate HIGHLIGHTS

Clinic Catastrophes: Some Abortion Providers Are Idealists. S...

How Oman Is Keeping Its Protests Peaceful
What's the Difference Between "Rape" and "Sexu...
Wisconsin Dems Fled the Statehouse To Stop a B...

See All of Slate »

One trick athletes use to build muscle fast

A computer nerd's tip for fixing a slow computer

How to access your favorite TV shows 24/7

Workers' Religious Freedom vs. Patients' Rights

Proposal Would Deny Federal Money if Employees Must Provide Care to Which They Object

By Rob Stein
Washington Post Staff Writer
Thursday, July 31, 2008

TOOLBOX
Resize Print E-mail
Yahoo! Buzz

COMMENT
0 Comments
COMMENTS ARE CLOSED

WHO'S BLOGGING powered by sphere
» Links to this article

A Bush administration proposal aimed at protecting health-care workers who object to abortion, and to birth-control methods they consider tantamount to abortion, has escalated a bitter debate over the balance between religious freedom and patients' rights.

THIS STORY
Protections Set for Antiabortion Health Workers
Birth Control Fears Addressed
Workers' Religious Freedom vs. Patients' Rights
View All Items in This Story

Sponsored Links

Spinal Stenosis Pain?
See where laser Spine Surgery Began-No Hospitalization!
www.bonati.com

Dermatologists Hate Her
Clever Mom Uses $5 Trick to Erase Wrinkles and Look Younger Instantly.
www.vanityreports.com/wrinkle-free

Buy a link here

The Department of Health and Human Services is reviewing a draft regulation that would deny federal funding to any hospital, clinic, health plan or other entity that does not accommodate employees who want to opt out of participating in care that runs counter to their personal convictions, including providing birth-control pills, IUDs and the Plan B emergency contraceptive.

Advertisement

Conservative groups, abortion opponents and some members of Congress are welcoming the initiative as necessary to safeguard doctors, nurses and other health workers who, they say, are increasingly facing discrimination because of their beliefs or are being coerced into delivering services they find repugnant.

But the draft proposal has sparked intense criticism by family planning advocates, women's health activists, and members of Congress who say the regulation would create overwhelming obstacles for women seeking abortions and birth control.

There is also deep concern that the rule could have far-reaching, but less obvious, implications. Because of its wide scope and because it would -- apparently for the first time -- define abortion in a federal regulation as anything that affects a fertilized egg, the regulation could raise questions about a broad spectrum of scientific research and care, critics say.

Advertisement

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

Looking to buy a home? Visit TWP Real Estate section for the latest open houses.

Enjoy a Taste of Ireland Tour, one week all inclusive from $658

Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Slate HIGHLIGHTS

Clinic Catastrophes: Some Abortion Providers Are Idealists. S...

What's the Difference Between "Rape" and "Sexu...
Wisconsin Dems Fled the Statehouse To Stop a B...
How Oman Is Keeping Its Protests Peaceful

See All of Slate »

Advertisement

Rule Shields Health Workers Who Withhold Care Based on Beliefs

By Rob Stein
Washington Post Staff Writer
Friday, December 19, 2008

TOOLBOX
Resize Print E-mail
Yahoo! Buzz

COMMENT
393 Comments | View All »
COMMENTS ARE CLOSED

WHO'S BLOGGING powered by sphere
» Links to this article

Sponsored Links

Top-Rated MBA Online
Earn Your MBA In 2 Years. No GMAT Required. 100% Online Program! FloridaTechOnlineMBA.com?

Groupon.com Official Site
1 huge daily deal on the best stuff to do in your city. Try it today! www.Groupon.com

Buy a link here

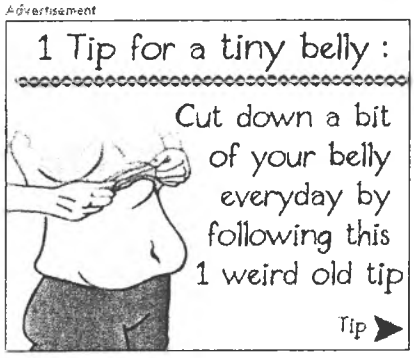
The Bush administration yesterday granted sweeping new protections to health workers who refuse to provide care that violates their personal beliefs, setting off an intense battle over opponents' plans to try to repeal the measure.

Critics began consulting with the incoming Obama administration on strategies to reverse the regulation as quickly as possible while supporters started mobilizing to fight such efforts.

The far-reaching regulation cuts off federal funding for any state or local government, hospital, health plan, clinic or other entity that does not accommodate doctors, nurses, pharmacists and other employees who refuse to participate in care they find ethically, morally or religiously objectionable. It was sought by conservative groups, abortion opponents and others to safeguard workers from being fired, disciplined or penalized in other ways.

But women's health advocates, family planning proponents, abortion rights activists and some members of Congress condemned the regulation, saying it will be a major obstacle to providing many health services, including abortion, family planning, infertility treatment, and end-of-life care, as well as possibly a wide range of scientific research.

Advertisement



The 127-page rule, which was issued just in time to take effect in the 30 days before the change in administrations, is the latest that the administration is implementing before President Bush's term ends.

The "right of conscience" rule could become one of the first contentious tests for the Obama administration, which could seek to reverse the rule either by initiating a lengthy new rulemaking process or by supporting legislation already pending in Congress.

President-elect Barack Obama's transition team did not specifically address the rule yesterday, but spokesman Nick Shapiro issued a statement that said Obama "will review all eleventh-hour regulations and will address them once he is president." Obama criticized the regulation when it was proposed last summer.

Sen. Patty Murray (D-Wash.), who with Sen. Hillary Rodham Clinton (D-N.Y.) introduced a bill last month to repeal the rule, said: "We will not allow this rule to stand. It threatens the health and well-being of women and the rights of patients across the country." Similar legislation is pending in the House.

Donna Crane, policy director for NARAL Pro-Choice America, noted that Congress has a

Advertisement

TOP JOBS The Washington Post

- Business Jobs
- Computer Jobs
- Construction Jobs
- Education Jobs
- Engineering Jobs
- Healthcare Jobs
- Legal Jobs
- Management Jobs
- Media Jobs
- Non-Profit Jobs
- Sales Jobs
- Science Jobs

Find Your Dream Job Now!
keywords location
FIND JOBS
Jobs by SimplyHired

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

Looking to buy a home? Visit TWP Real Estate section for the latest open houses.

Enjoy a Taste of Ireland Tour, one week all inclusive from $658

Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Slate HIGHLIGHTS

How Oman Is Keeping Its Protests Peaceful

Clinic Catastrophes: Some Abortion Providers A...
What's the Difference Between "Rape" and "Sexu...
Wisconsin Dems Fled the Statehouse To Stop a B...

See All of Slate »

One trick athletes use to build muscle fast

A computer nerd's tip for fixing a slow computer

How to access your favorite TV shows 24/7

Values Play Into Treatment Recommendations, Study Finds

By Rob Stein
Washington Post Staff Writer
Thursday, February 8, 2007

TOOLBOX
Resize Print
E-mail

COMMENT
0 Comments
COMMENTS ARE CLOSED

WHO'S BLOGGING powered by sphere
» Links to this article

Many doctors believe they have the right not to tell patients about treatments that they object to on moral or religious grounds and to refuse to refer patients elsewhere for the care, according to the first study to examine physicians' views on such situations.

In the survey of 1,144 doctors nationwide, 8 percent said they had no obligation to present all possible options to patients, and 18 percent said they did not have to tell patients about other doctors who provide care they found objectionable.

Based on the findings, the researchers estimate that more than 40 million Americans may be seeing physicians who do not believe that they are obligated to disclose information about legal treatments the doctor objects to, and 100 million have doctors who do not feel the need to refer patients to another provider.

"They are a minority of doctors, but it's fairly substantial minority," said Farr A. Curlin, a bioethicist at the University of Chicago who led the study, published in today's issue of the New England Journal of Medicine.

Advertisement

The survey was prompted by an intense debate over medical workers who refuse to deliver care that runs contrary to their moral or religious beliefs, asserting a "right of conscience" or "right of refusal." Some pharmacists, for example, refuse to fill prescriptions for birth control and emergency contraceptive "morning-after" pills. Some doctors and nurses refuse to participate in abortions, prescribe birth control pills or withdraw or withhold care from dying patients.

The refusals have led to bitter clashes between medical workers and patients around the country. Dozens of states have considered legislation that would either require medical workers to deliver all legal forms of care or protect those who refuse. The issue is expected to intensify as medicine continues to move into controversial areas, such as therapies based on embryonic stem cells.

Curlin and his colleagues mailed 12-page questionnaires to 2,000 physicians from all specialties in 2003 asking them if they had objections to three controversial practices -- sedating dying patients to the point of unconsciousness; prescribing birth control to teenagers without parental consent; and performing abortions after failed contraception.

Of the 1,144 who responded, 17 percent objected to "terminal sedation," 42 percent objected to providing birth control to teens without parents' consent and 52 percent objected to abortion after failed contraception.

Advertisement

TOP JOBS The Washington Post

- Business Jobs
- Computer Jobs
- Construction Jobs
- Education Jobs
- Engineering Jobs
- Healthcare Jobs
- Legal Jobs
- Management Jobs
- Media Jobs
- Non-Profit Jobs
- Sales Jobs
- Science Jobs

Find Your Dream Job Now!
keywords location
FIND JOBS
Jobs by SimplyHired

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

Looking to buy a home? Visit TWP Real Estate section for the latest open houses.

Enjoy a Taste of Ireland Tour, one week all inclusive from $658

Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

Slate HIGHLIGHTS

How Oman Is Keeping Its Protests Peaceful

Wisconsin Dems Fled the Statehouse To Stop a B...
What's the Difference Between "Rape" and "Sexu...
Clinic Catastrophes: Some Abortion Providers A...

See All of Slate »

Sign In Register Now Subscribe Mobile Multimedia Today's Paper Going Out Guide Jobs Cars Real Estate Rentals Classifieds

NEWS LOCAL POLITICS OPINIONS SPORTS Business Arts & Living Search The Washington Post

One trick athletes use to build muscle fast

A computer nerd's tip for fixing a slow computer

How to access your favorite TV shows 24/7

Print This Article
E-Mail This Article

A Medical Crisis of Conscience

Faith Drives Some To Refuse Patients Medication or Care

By Rob Stein
Washington Post Staff Writer
Sunday, July 16, 2006; Page A01

In Chicago, an ambulance driver refused to transport a patient for an a
fertility specialists rebuffed a gay woman seeking artificial inseminatio
pharmacist turned away a rape victim seeking the morning-after pill.

Around the United States, health workers and patients are clashing wh
giving care that they feel violates their beliefs, sparking an intense, cor
debate over religious freedom vs. patients' rights.

Legal and political battles have followed. Patients are suing and filing complaints after being spurned. Workers are charging religious discrimination after being disciplined or fired. Congress and more than a dozen states are considering laws to compel workers to provide care -- or, conversely, to shield them from punishment.

Proponents of a "right of conscience" for health workers argue that there is nothing more American than protecting citizens from being forced to violate their moral and religious values. Patient advocates and others point to a deep tradition in medicine of healers having an ethical and professional responsibility to put patients first.

The issue is driven by the rise in religious expression and its political prominence in the United States, and by medicine's push into controversial new areas. And it is likely to intensify as doctors start using embryonic stem cells to treat disease, as more states legalize physician-assisted suicide and as other wrenching issues emerge.

"What constitutes an ethical right of conscience in medicine, and what are the limits?" asked Nancy Berlinger of the Hastings Center, a bioethics think tank. "This keeps getting harder and harder for us."

For Debra Shipley, her duties as a nurse began to conflict with her Christian faith when the county health clinic where she worked near Memphis required she dispense the morning-after pill.

"I felt like my religious liberties were being violated," said Shipley, 49, of Atoka, Tenn. "I could not live with myself if it did it. I answer to God first and foremost."

But Paige Gerson, 37, of Leawood, Kan., believes doctors and nurses should never let their personal values interfere with patient care. Her doctor refused to give her the morning-after pill, citing religious objections.

"I was incredibly angry and just scared to death," Gerson said. "I think it's absolutely wrong

E-MAIL NEWSLETTERS
View a Sample and Sign Up
Lean Plate Club
Manage Your Newsletters
Advertisement

Advertisement

FEATURED ADVERTISER LINKS
Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill
Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling
Looking to buy a home? Visit TWP Real Estate section for the latest open houses.
Enjoy a Taste of Ireland Tour, one week all inclusive from $658
Make Your Vanguard Investing More Profitable - Free Research Report Reveals Best & Worst Funds

TRANSCRIPT

Right of Conscience
Washington Post staff writer Rob Stein was online to discuss the debate over religious freedom of healthcare workers vs. patients' rights.

Seeking Care, and Refused
Desperate to have a baby, Guadalupe Benitez was hoping her next try would finally work. So Benitez was stunned when a crucial moment arrived in her cycle and her fertility clinic refused to do the insemination procedure.

For Some, There Is No Choice
When the dispatcher called, Stephanie Adamson knew this might be the run she had feared. But it wasn't until her ambulance arrived at the hospital and she saw the words "elective abortion" on the patient's chart that she knew she had to make a choice.

WHO'S BLOGGING?

Read what bloggers are saying about this article.

Work It, Mom! | A Community for Professional Moms
CULTURE CAMPAIGN
||: Neutral Source Home Page
Full List of Blogs (146 links) »

Most Blogged About Articles
On washingtonpost.com | On the web

POWERED BY Technorati

SAVE & SHARE ARTICLE What's This?

Digg Google
del.icio.us Yahoo!
Reddit Facebook

Advertisement

Advertisement

Health Workers' Choice Debated

Proposals Back Right Not to Treat

By Rob Stein
Washington Post Staff Writer
Monday, January 30, 2006

TOOLBOX
Resize Print
E-mail
COMMENT
Comments
COMMENTS ARE CLOSED
WHO'S BLOGGING powered by sphere
» Links to this article

More than a dozen states are considering new laws to protect health workers who do not want to provide care that conflicts with their personal beliefs, a surge of legislation that reflects the intensifying tension between asserting individual religious values and defending patients' rights.

About half of the proposals would shield pharmacists who refuse to fill prescriptions for birth control and "morning-after" pills because they believe the drugs cause abortions. But many are far broader measures that would shelter a doctor, nurse, aide, technician or other employee who objects to any therapy. That might include in-vitro fertilization, physician-assisted suicide, embryonic stem cells and perhaps even providing treatment to gays and lesbians.

Because many legislatures have just convened, advocates on both sides are predicting that the number debating such proposals will increase. At least 18 states are already considering 36 bills.

"It's already a very hot issue," said Edward R. Martin Jr. of the Americans United for Life, who is advising legislators around the country pushing such bills. "I think it's going to get even hotter, for lots of reasons and in lots of places."

Advertisement

The flurry of political activity is being welcomed by conservative groups that consider it crucial to prevent health workers from being coerced into participating in care they find morally repugnant -- protecting their "right of conscience" or "right of refusal."

"This goes to the core of what it means to be an American," said David Stevens, executive director of the Christian Medical & Dental Associations. "Conscience is the most sacred of all property. Doctors, dentists, nurses and other health care workers should not be forced to violate their consciences."

The swell of propositions is raising alarm among advocates for abortion rights, family planning, AIDS prevention, the right to die, gays and lesbians, and others who see the push as the latest manifestation of the growing political power of social conservatives.

"This is a very significant threat to patients' rights in the United States," said Lois Uttley of the MergerWatch project, who is helping organize a conference in New York to plot a counterstrategy. "We need to protect the patient's right to use their own religious or ethical values to make medical decisions."

Both sides agree that the struggle between personal beliefs and professional medical responsibilities is likely to escalate as more states consider approving physician-assisted

Advertisement
Advertorials By SmarterLifestyles

How To Stay Asleep
Scientists in Cambridge discover an all natural sleep aid to help you sleep all night... Learn more

SHOCKING Muscle Photos
Muscle building miracle discovered by scientists is a catalyst for huge muscle gains... Learn more

Why Snoring Can Kill
Snoring is a silent killer. Stop your snoring tonight... Learn more

Joint discomfort Warning
Shocking discovery by Cambridge Researcher's for amazing joint relief. Learn more

Juneau: Time To Travel
The most breathtaking vacation you'll ever experience... Learn more

TOP JOBS The Washington Post

- Business Jobs
- Computer Jobs
- Construction Jobs
- Education Jobs
- Engineering Jobs
- Healthcare Jobs
- Legal Jobs
- Management Jobs
- Media Jobs
- Non-Profit Jobs
- Sales Jobs
- Science Jobs

Find Your Dream Job Now!
keywords location
FIND JOBS
Jobs by SimplyHired

FEATURED ADVERTISER LINKS

Mesothelioma, Defective Drugs/Medical Devices, Environmental Pollution, Accidents, Asbestos Cancer, BP Oil Spill

Medical Malpractice, Personal Injury, Fosamax Femur Fracture, DePuy Hip Replacement, Gas Drilling

SB

15

<TARGET><BILL>SB 15</BILL><SUBJECT>SB
15</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/11

FURTHER: Judiciary

Date of 5-Day Notice: 3/10/11
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/17/11

Health and Social Services Committee considered SENATE BILL NO. 15

SB 15-SEX OFFENDER/UNDERAGE ALCOHOL OFFENSE

"An Act relating to penalties for certain alcohol offenses involving persons under 21 years of age committed by a sex offender or child kidnapper."

and recommends:

[X] be **replaced** with **CS** SB15 (HSS) [ ] *Same Title* [ ] *New Title*

[ ] adopt **previous CS** _____ (_____) [ ] *Same Title* [ ] *New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DOC	✓			
LAW		✓		

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
K. Meyer	Meyer	X			
[illegible]	[illegible]	X			
[illegible]	DYSON	X			
CHAIR: Bettye Davis	DAVIS	X			

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version **SB015**
() Publish Date 1/19/2011

Identifier (file name) SB015-DOC-OC-03-14-11
Title "An Act relating to penalties for certain alcohol offenses involving
Sponsor Senator Kevin Meyer
Requester Senate Health and Social Services

Dept. Affected DOC
Appropriation Administration & Support
Allocation Office of the Commissioner
OMB Component Number 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities	469.2	469.2	821.1	1,173.0	1,173.0	1,524.9	1,876.8
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**469.2**	**469.2**	**821.1**	**1,173.0**	**1,173.0**	**1,524.9**	**1,876.8**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	469.2	469.2	821.1	1,173.0	1,173.0	1,524.9	1,876.8
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**469.2**	**469.2**	**821.1**	**1,173.0**	**1,173.0**	**1,524.9**	**1,876.8**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial version; not applicable

Prepared by Leslie Houston, Director
Division Dept. of Corrections - Administrative Services
Approved by Joseph D. Schmidt, Commissioner
Dept. of Corrections

Phone 465-3339
Date/Time 3/15/11 11:00 AM
Date 3/15/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB015

Analysis

This bill would elevate the offenses of furnishing alcohol to persons under the age of 21 (under AS 04.16.051 - AS 04.16.057) if the offense is committed by a sex offender or child kidnapper. For example, if the offense committed under AS 04.16.051 - AS 04.16.057 is a class C felony, the offense would be elevated to a class B felony.

Should this legislation pass, the Department of Corrections has data to support an average of 3.5 convictions per year under the following sections:

Section 1(2): if the underlying offense is a class A misemeanor, a sex offender or child kidnapper committing the offense is guilty of a class C felony and shall be punished as provided in AS 12.55;

3.5 convictions per year represents an increase of 860 mandays per year @ $136.44/da = $117.3/yr

Section 1(3) : if the underlying offense is a class C felony, a sex offender or child kidnapper committing the offense is guilty of a class B felony and shall be punished as provided in AS 12.55.

3.5 convictions per year represents an increase of 2,579 mandays per year @ $136.44/day = $351.9/yr

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB015 \M**
() Publish Date

Identifier (file name): SB015-LAW-CRIM-03-11-11
Dept. Affected: Law
Title: An Act relating to penalties for certain alcohol offenses involving persons under 21 years of age committed by a sex offender or child kidnapper.
Appropriation: Criminal
Allocation: Criminal Justice Litigation
Sponsor: SENATOR(S) MEYER
Requester: (S) HEALTH & SOCIAL SERVICES
OMB Component Number: 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	***	***	***	***	***	***	***
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	***	***	***	***	***	***	***

Estimate of any current year (FY2011) cost ***

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version.

Prepared by: Eileen Donahue, Division Operations Manager — Phone 465-5427
Division: Administrative Services — Date/Time 3/11/11 4:30 PM
Approved by: John J. Burns, Attorney General — Date 3/11/2011
Department of Law

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 015 \M

Analysis

SB 15 raises one level the severity of offenses for providing alcohol to persons under 21 years of age if the offender is a sex offender or child kidnapper. For example, a nonlicensee who furnishes alcohol to a person under 21 years of age commits a class A misdemeanor for a first offense. SB 15 would make this offense a class C felony if the offender was a sex offender or child kidnapper.

This would have an indeterminate fiscal impact on the Department of Law. Any time an offense is raised from a misdemeanor to a felony there is an impact. Felony prosecutions require more time – for example, a felony requires a grand jury indictment and a jury of 12 persons.

CS FOR SENATE BILL NO. 15(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR MEYER

A BILL

FOR AN ACT ENTITLED

"An Act relating to penalties for certain alcohol offenses involving persons under 21 years of age committed by a sex offender or child kidnapper."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 04.16 is amended by adding a new section to read:

Sec. 04.16.059. Aggravated penalties for violations of AS 04.16.051, 04.16.055, and 04.16.057 involving a person under 21 years of age and committed by a sex offender or child kidnapper. (a) Notwithstanding AS 04.16.051, 04.16.055, 04.16.057, and 04.16.180, the penalty for a violation of AS 04.16.051, 04.16.055, or 04.16.057 that involved a person under 21 years of age and that was committed by a sex offender or child kidnapper is as follows:

(1) if the underlying offense is a violation, a sex offender or child kidnapper committing the offense is guilty of a class B misdemeanor and shall be punished as provided in AS 12.55;

(2) if the underlying offense is a class A misdemeanor, a sex offender

or child kidnapper committing the offense is guilty of a class C felony and shall be punished as provided in AS 12.55;

(3) if the underlying offense is a class C felony, a sex offender or child kidnapper committing the offense is guilty of a class B felony and shall be punished as provided in AS 12.55.

(b) In this section, "sex offender or child kidnapper" has the meaning given in AS 12.63.100.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act applies to offenses committed on or after the effective date of this Act.

Alaska State Legislature

Interim:
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0199

Session:
State Capitol Building
Juneau, Alaska 99801-1182
(907) 465-4945

Senator Kevin Meyer
Senate District O

SPONSOR STATEMENT FOR SB 15

"an Act relating to penalties for certain alcohol offenses involving persons under 21 years of age committed by a sex offender or a child kidnapper."

Senate Bill 15 makes providing alcohol for those who are under 21 years of age by people with a history or background as a sex offender an aggravating offense.

If SB 15 is enacted, penalties could increase a violation to a Class B misdemeanor, a class A misdemeanor would be punishable as a class C felony and a class C felony goes to a class B felony.

Currently there are laws against those who would commit each crime separately. However, what is being discovered that those who are providing alcohol to people under 21 have the intent to commit a sexual offense. There have been instances where sex trafficking and sex offenses are preceded by providing alcohol to those under 21 years of age.

27-LS0119\I
Luckhaupt
3/16/11

CS FOR SENATE BILL NO. 15( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR MEYER

A BILL

FOR AN ACT ENTITLED

"An Act relating to penalties for certain alcohol offenses involving persons under 21 years of age committed by a sex offender or child kidnapper."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 04.16 is amended by adding a new section to read:

Sec. 04.16.059. Aggravated penalties for violations of AS 04.16.051, 04.16.055, and 04.16.057 involving a person under 21 years of age and committed by a sex offender or child kidnapper. (a) Notwithstanding AS 04.16.051, 04.16.055, 04.16.057, and 04.16.180, the penalty for a violation of AS 04.16.051, 04.16.055, or 04.16.057 that involved a person under 21 years of age and that was committed by a sex offender or child kidnapper is as follows:

(1) if the underlying offense is a violation, a sex offender or child kidnapper committing the offense is guilty of a class B misdemeanor and shall be punished as provided in AS 12.55;

(2) if the underlying offense is a class A misdemeanor, a sex offender

or child kidnapper committing the offense is guilty of a class C felony and shall be punished as provided in AS 12.55;

(3) if the underlying offense is a class C felony, a sex offender or child kidnapper committing the offense is guilty of a class B felony and shall be punished as provided in AS 12.55.

(b) In this section, "sex offender or child kidnapper" has the meaning given in AS 12.63.100.

* **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. This Act applies to offenses committed on or after the effective date of this Act.

APOA
ALASKA PEACE OFFICERS ASSOCIATION

ALASKA ASSOCIATION CHIEFS OF POLICE

Women Police of Alaska

February 14, 2011

Senator Kevin Meyer
Alaska State Senate
State Capitol
Juneau AK 99801-1182

Dear Senator Meyer:

On behalf of our respective organizations, we would like to thank you for introducing SB 15, an Act relating to penalties for certain alcohol offenses involving persons under 21 years of age committed by a sex offender or child kidnapper.

We met recently to review proposed legislation and decided to unanimously support this bill.

Again, thank you for addressing this issue. Please contact the APOA office in Anchorage at 277-0515 if there is anything our organizations can do to assist in the passage of this bill.

Sincerely,

John Lucking Jr., President
Alaska Peace Officers Association
PO Box 240106
Anchorage AK 99524

Tom Clemons, President
Alaska Association of Chiefs of Police
183 Nelson Ave
Wasilla AK 99654

Michele Logan, President
Women Police of Alaska
PO Box 233306
Anchorage AK 99523

SB 17

<TARGET><BILL>SB 17</BILL><SUBJECT>SB 17</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

AGENDA

WEDNESDAY, FEBRUARY 9, 1:30 PM

Butrovich Room #205

1:30 PM – Call to Order

Time:

Members Present:

BILLS TO BE HEARD:

SB17 – SYNTHETIC CANNIBINOIDS (Can-na-bin-oids)
(Senator Meyer)

PRESENTATIONS:

- CITIZENS REVIEW PANEL, SYLVAN ROBB
- OFFICE OF CHILDREN'S SERVICES, CHRISTY LAWTON, ACTING DIRECTOR, OFFICE OF CHILDREN'S SERVICES

ADJOURNMENT:

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

[redacted] [redacted]

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/11

Date of 5-Day Notice: Feb 3-2011
(in accordance with Uniform Rule 23)

FURTHER: Judiciary

DATE TURNED IN TO OFFICE: Feb 10, 2011

Health and Social Services Committee considered SENATE BILL NO. 17

SB 17-SYNTHETIC CANNABINOIDS AS SCHEDULE IIA

"An Act classifying certain synthetic cannabinoids as schedule IIA controlled substances; and providing for an effective date."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DPS			✓	1
DPS	✓			2
LAW			✓	3
DOC		✓	✓	4

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	X			
	Meyer	X			
	ECHAUER	X			
	DYSON	X			
CHAIR:	DAVIS	X			

Alaska State Legislature

Interim:
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0199

Session:
State Capitol Building
Juneau, Alaska 99801-1182
(907) 465-4945

Senator Kevin Meyer

Senate District O

SPONSOR STATEMENT FOR SB 17

"An Act classifying certain synthetic cannabinoids as schedule IIA controlled substances; and providing for an effective date."

SB 17 would classify certain synthetic cannabinoids, commonly known as K2 or Spice as a schedule IIA controlled substance.

This new drug is dangerous, cheap and legally available. Sold in smoke shops and gas stations as incense, it is marketed to people who are interested in herbal alternatives to cannabis. Synthetic cannabinoids are inexpensive, accessible and undetectable in drug tests. Here in Alaska, the drug enjoys some popularity amongst North Slope workers, U.S. Military members and students. The U.S. Drug Enforcement Administration, Municipality of Anchorage and the U.S. Military have all taken action to control and prohibit use of this drug.

Synthetic cannabinoid is abused mainly by smoking or prepared as drink. Users experience severe adverse reactions including hallucinations, nausea, vomiting, agitation, and panic attacks. The chemical composition of synthetic cannabinoids is considerably more potent to tetrahydrocannabinol or THC, the active ingredient in marijuana).

11 states have passed legislation classifying synthetic marijuana as a controlled substance. 21 states, including Alaska, have introduced similar legislation. Should SB 17 pass, it will be unlawful to sell, use, purchase, possess, manufacture, transport or deliver synthetic cannabinoids.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 27, 2011

SUBJECT: Sectional Summary - SB 17 (Work Order No. 27-LS0121\B)

TO: Senator Kevin Meyer
Attn: Christine Marasigan

FROM: Gerald P. Luckhaupt
Assistant Revisor

You have requested a sectional summary of the above-described bill. As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill -- the bill itself is the best statement of its contents.

Section 1 of the bill amends AS 11.71.150(b), by adding certain compounds to the list of Schedule IIA controlled substances contained in that section. The compounds that are being included:

(21) (6aR,10aR)-9-(hydroxymethyl)-6, 6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol, also known as HU-210;

(22) (6aS,10aS)-9-(hydroxymethyl)-6, 6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol, also known as Dexanabinol or HU-211;

(23) 1-Pentyl-3-(1-naphthoyl)indole, also known as JWH-018;

(24) 1-Butyl-3-(1-naphthoyl)indole, also known as JWH-073;

(25) (2-methyl-1-propyl-1H-indol-3-yl)-1-naphthalenyl-methanone, also known as JWH-015;

(26) 1-pentyl-3-(4-chloro-1-naphthoyl)indole, also known as JWH-398;

(27) 1-pentyl-3-(2-methoxyphenylacetyl)indole, also known as JWH-250;

(28) 1-hexyl-3-(1-naphthoyl)indole, also known as JWH-019;

(29) 1-(2-(4-(morpholinyl)ethyl))-3-(1-naphthoyl)indole, also known as JWH-200;

(30) 2-[(1R,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol, also known as CP 47, 497, and homologues

are commonly known, or have been identified by other states or the federal government, as forms of synthetic marijuana.

Section 2 of the bill provides an effective date.

GPL:ljw
11-053.ljw

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: SB017
() Publish Date

Identifier (file name): SB017-DPS-DET-02-07-11
Title: "An Act classifying certain synthetic cannabinoids as controlled substances."
Sponsor: Senator Meyer
Requester: Senate Health & Social Services

Dept. Affected: Public Safety
Appropriation: Alaska State Troopers
Allocation: AST Detachments
OMB Component Number: 2325

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version

Not applicable, initial version.

Prepared by: Lt. Rodney Dial — Phone: (907) 247-4480
Division: Alaska State Troopers — Date/Time: 2/7/11 3:38 PM
Approved by: Joseph Masters, Commissioner, Department of Public Safety — Date: 2/7/2011

(Revised 12/29/2010 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB017

Analysis

This legislation would amend AS 11.71.150 by adding several synthetic drugs as schedule IIA controlled substances. It is not estimated that this bill will significantly increase the workload of the division of Alaska State Troopers. There is no fiscal cost to the AST as a result of this legislation.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: SB017
() Publish Date

Identifier (file name): SB017-DPS-LAB-02-02-11
Title: "An Act Relating to Synthetic Cannabinoids As Schedule IIA"
Sponsor: Senator Meyer
Requester: Senate Health & Social Services

Dept. Affected: Public Safety
Appropriation: Statewide Support
Allocation: Laboratory Services
OMB Component Number: 527

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	96.0		96.0	96.0	96.0	96.0	96.0
Travel	3.0		3.0	3.0	3.0	3.0	3.0
Services	8.5		5.6	5.6	5.6	5.6	5.6
Commodities	12.0		2.0	2.0	2.0	2.0	2.0
Capital Outlay	7.3						
Grants							
Miscellaneous							
TOTAL OPERATING	**126.8**		**106.6**	**106.6**	**106.6**	**106.6**	**106.6**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	126.8		106.6	106.6	106.6	106.6	106.6
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**126.8**	**0.0**	**106.6**	**106.6**	**106.6**	**106.6**	**106.6**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time	**1.0**		1	1	1	1	1
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable; initial version.

Prepared by: Orin Dym, Laboratory Manager — Phone (907) 269-5743
Division: Scientific Crime Detection Laboratory — Date/Time 2/02/2011 3:30PM
Approved by: Joseph A Masters, Commissioner — Date 2/4/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB017

Analysis

This proposed legislation would add certain synthetic cannabinoids to the schedule IIA list of controlled substances. This bill would become effective immediately upon passage.

The Alaska Scientific Crime Detection Laboratory (Crime Laboratory) provides analysis of suspected controlled substances, issues reports, and provides expert testimony for the state of Alaska. For calendar year 2010 the laboratory received 1,267 requests for controlled substances analysis. A full time position is capable of analyzing 480 requests per year. The Controlled Substances Section of the Crime Lab currently has 2.5 full time staff assigned to it.

Once controlled, it is anticipated that the Crime Laboratory will receive significant requests for analysis related to the newly controlled substances. With the large presence of internet sales, and the ability for manufacturers to rapidly change the substances present in the materials sold, any suspected of containing these newly controlled substances will require scientific analysis at the Crime Laboratory.

This new position would come at an initial cost of $126,800. This includes a starting salary with benefits of $96,000, a work station start up cost of $7,300 for equipment , $2,000 for supplies, and there will be $3,000 in travel funds required for the ongoing training and education necessary for an analyst to maintain their expertise and certifications. There is an expected $5,000 in contractual costs as well, and this position also requires an initial $3,500 to obtain licensing required for the laboratory's LIMS database. Subsequently, there is a yearly 18% maintenance fee for that license. In addition to the above considerations involved with this new position, the Crime Laboratory would be required to obtain the standards necessary to analyze these nine new chemicals and their various isomers. This would be a one-time cost of $10,000.

In addition to the ongoing salary, benefits, and necessary travel costs relative to this position, all positions utilize an ongoing $2,000 for supply needs, and there is an ongoing licensing and maintenance cost of $5,600 per year. Therefore, the initial cost for this position would be $126,800, with a subsequent ongoing cost of $106,600.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB017**
() Publish Date

Identifier (file name): SB017-LAW-CRIM-02-04-11
Dept. Affected: Law

Title: An Act classifying certain synthetic cannabinoids as schedule IIA controlled substances; and providing for an effective date.
Appropriation: Criminal
Allocation: Criminal Justice Litigation

Sponsor: Senator(s) Meyer
Requester: (S) Health and Social Services
OMB Component Number: 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Prepared by: Eileen Donahue, Division Operations Manager — Phone: 465-5427
Division: Administrative Services — Date/Time: 2/4/11 4:30 PM
Approved by: John J. Burns, Attorney General — Date: 2/4/2011
Department of Law

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB017

Analysis

This bill adds several chemical forms of Synthetic cannabinoids to Schedule IIA of Alaska's prohibited substance Schedules. Currently, marijuana, a natural form of cannabis, is a Schedule VIA prohibited substance. The anticipated fiscal impact is zero, however, if litigation ensues there will be addition costs in defending this litigation.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB 17**
() Publish Date: 1/18/2011

Identifier (file name) SB017-DOC-OC-02-04-11
Title: "An Act classifying synthetic cannabinoids as schedule IIA
Sponsor: Senator Meyer
Requester: Health & Social Services Committee

Dept. Affected: DOC
Appropriation: Admin & Support
Allocation: Commissioner's Office
OMB Component Number: 684

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**	**	**	**	**	**	**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**	**	**	**	**	**	**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

This is the first version of the bill.

Prepared by: Leslie Houston, Director — Phone: 465-3339
Division: Dept. of Corrections - Administrative Services — Date/Time: 2/4/2011 9:00 a.m.
Approved by: Joseph D. Schmidt, Commissioner — Date: 2/4/2011
Dept. of Corrections

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 17

Analysis

This legislation makes synthetic cannabinoids a schedule IIA controlled substance. Currently, possession of a schedule IIA is a Class C felony with a possible sentence of 0-2 years. Manufacturing or delivering a schedule IIA controlled substance is a Class B felony with a possible sentence of 0-4 years. The current average daily cost to house an inmate is $136.44. Therefore, housing an offender could cost the department anywhere from $0.0 (no time served) to $199.2 (for a 4-year sentence).

Department of Corrections is unable to determine the fiscal impacts of the passage of this legislation, as we cannot estimate the total number of actual violations that will occur.

FAIRBANKS POLICE
911 Cushman Street
Fairbanks, Alaska 99701-4616
Phone (907) 450-6500
Fax (907) 452-1588
Email: fpd@ci.fairbanks.ak.us

January 21, 2011

Senator Kevin Meyer
State Capitol Room 103
Juneau AK 99801

Dear Senator Meyer:

As the Chief of Police for the Fairbanks Police Department, I would like to extend my support of Senate Bill No. 17 "An Act classifying certain synthetic cannabinoids as schedule IIA controlled substances."

According to the U.S. Department of Justice Drug Enforcement Administration, these substances have no known therapeutic use and are known to cause a variety of effects including seizures, hallucinations, psychotic episodes, and non-responsiveness. In addition the Alaska Information Analysis Center (AKIAC) has reported in studies that subjects have reported having difficulties with balance, slurred speech, and being light headed.

These cannabinoids present a significant threat to the safety of Alaska's citizens as long as they remain unclassified. Without this new legislation a person who is under the influence of synthetic cannabinoids while operating a motor vehicle is not in violation of the law. This presents a clear danger to the citizens of Alaska, as someone could potentially be under the influence of a synthetic cannabinoid while driving and experience hallucinations, seizures, or a psychotic episode. This is not a hypothetical situation and the Fairbanks Police Department has already investigated a motor vehicle accident where the driver of the vehicle was having seizures as a result of consuming synthetic cannabinoids.

By classifying synthetic cannabinoids as a schedule II controlled substance, the act of operating a motor vehicle under the influence of a synthetic cannabinoid would become an illegal act. This bill would therefore have a direct impact on the safety of the citizens of the State of Alaska.

Sincerely

Laren Zager
Chief of Police
Fairbanks Police Department

adn.com
Anchorage Daily News

Print Page Close Window

Army punishes 36 for using synthetic pot

SPICE AND K2: U.S. Army Alaska banned head shop product in August.

The Associated Press

(12/21/10 11:33:48)

The U.S. Army Alaska says it has punished 36 soldiers for the use of synthetic marijuana since it banned the substance.

Seven soldiers were tried at courts-martial, and 29 received nonjudicial punishments, the Fairbanks Daily News-Miner reported.

Synthetic marijuana is known as Spice or K2. It's a blend of spices and herbs sprayed with a compound similar to the psychoactive ingredient in marijuana. It's commonly sold in head shops.

Some users think the substance can't be detected in drugs tests. But the Army says its urine tests can now find the chemicals used in Spice.

In March, a 25-year-old Fort Richardson soldier just back from Iraq was convicted of driving under the influence of Spice. He was arrested after driving his Chevrolet Avalanche over three raised medians, into a concrete wall and down a sidewalk with flat tires and a broken axle.

The U.S. Army Alaska banned Spice in August.

It had seen an increase in users with high blood pressure and heart rates admitted to hospitals at Fort Richardson in Anchorage and Fort Wainwright in Fairbanks.

The soldiers have had life-threatening reactions in some cases, the commander of U.S. Army Alaska, Brig. Gen. Raymond Palumbo, wrote in a commentary published in the Fort Richardson and Fort Wainwright newspapers.

"We have no idea what the long-term effects are since the chemicals vary and have not been fully tested," Palumbo wrote. "But we do know that in the short term, bad things happen when people use Spice."

This month, the Anchorage Assembly voted unanimously to make the chemicals illegal in the city as of Jan. 6. It will be a misdemeanor to sell, make, have or use products containing cannabinoids, which are versions of the active ingredients in marijuana. The products are found in convenience stores and tobacco shops in parts of the country where they're not illegal.

In October, state Sen. Kevin Meyer, R-Anchorage, proposed a bill to outlaw Spice after state troopers arrested a Fairbanks man who used the substance, broke into a house, stripped naked and slept in the homeowners' bed. He told troopers God had told him to do so.

The U.S. Drug Enforcement Agency has started a process to outlaw five chemicals commonly used in synthetic marijuana.

adn.com
Anchorage Daily News

Print Page Close Window

Assembly outlaws chemical known as 'synthetic marijuana'

By ROSEMARY SHINOHARA
rshinohara@adn.com
(12/08/10 20:59:04)

A street chemical that authorities say can cause severe reactions will be illegal in Anchorage starting in early January.

The Anchorage Assembly on Tuesday voted unanimously to ban the sale, possession or use of products containing synthetic versions of cannabinoids. The products go by a variety of names such as K2, Spice and Spike, and are found in convenience stores and tobacco shops in parts of the country where they're not illegal.

Cannabinoids, natural and synthetic, are versions of the active ingredients in marijuana.

"These products pose serious and significant health risks up to and including death, and they offer nothing positive to anyone ingesting it," said Assembly member Paul Honeman, a former police officer. Assembly members Honeman, Dick Traini and Mike Gutierrez and Mayor Dan Sullivan sponsored the new city law.

State Sen. Kevin Meyer, R-Anchorage, has pre-filed a legislative bill for consideration next year that would criminalize such products on a statewide basis.

In Anchorage, it will be a misdemeanor to sell, make, have or use products containing cannabinoids starting on Jan. 6.

The Anchorage School District made public its fears about use of the synthetic chemical last April, and said some Anchorage teens have been hospitalized. In October, school district spokeswoman Heidi Embley said regular marijuana is still much more prevalent, and that the district knew of probably only a handful of synthetic cannabinoid cases.

Print Page Close Window

Copyright © Wed Jan 26 10:52:56 UTC-0900 20111900 The Anchorage Daily News (www.adn.com)

adn.com
Anchorage Daily News

Print Page Close Window

Lawmakers seek ban on Spice, legal synthetic marijuana

SYNTHETIC: Alarming trend sweeps nation, finally gets to Alaska.

By CASEY GROVE
casey.grove@adn.com

(10/20/10 11:41:47)

A new street drug that authorities claim is capable of causing everything from hallucinations and slurred speech to death is sweeping the nation and has made its way to Alaska, according to local police and public officials.

It goes by many names -- Spice, Spike, K2 -- but the new craze among kids, the military and others looking for a high is essentially synthetic marijuana: plant material that can hold any number of various sprayed-on psychotropic compounds.

And for now, it is legal.

State Sen. Kevin Meyer and Anchorage Assembly members Mike Gutierrez and Paul Honeman hope to change that.

The drug can be 600 to 800 times stronger than pot and can cause a physical addiction similar to methamphetamine, Gutierrez said at a press conference Tuesday.

"It's a lot more dangerous than marijuana," Guttierez said. "Your 14-year-old can walk into a convenience store and, right next to the energy drinks, they can buy it."

Meyer has pre-filed a bill for the state Legislature that would criminalize the drug, and Honeman and Gutierrez plan to introduce a resolution to the Assembly Oct. 26 that would ask local retailers to voluntarily remove it from their shelves until the Legislature has a chance to make it illegal.

Until then, the various types of synthetic pot continue to be marketed as incense and sold in convenience stores and tobacco shops across the country. Everywhere, that is, except 10 states that have already criminalized it.

Driving under the influence of synthetic marijuana can lead to an impaired driving arrest with the same penalties as drunken driving, according to local law enforcement. Hallucinations from smoking it can also compel people to commit other crimes, they say.

A 28-year-old Fairbanks man who told Alaska State Troopers he'd smoked synthetic marijuana early Tuesday morning kicked in the door of an unoccupied home on Goldhill Road, took off all of his clothes and went to sleep in a bed, according to a trooper report.

He did it because "God told him to," troopers said.

In a separate case, in March, a Fort Richardson soldier just back from Iraq was convicted of operating a vehicle while under the influence of Spike. He was arrested after driving his Chevrolet Avalanche over three raised medians, into a concrete wall, and then driving down a sidewalk on flat tires and with a broken axle, according to a police report. The 25-year-old man later admitted to

smoking some Spike, according to the police report.

The arresting officer noted some strange behavior in his report.

"I asked him who was drinking and driving and he said, 'You were,'" wrote Officer Earl Ernest in his report. "He then hollered, 'You drink, you drive, you die.' I asked if he was saying he was going to kill me and he said, 'Yes.' He then threw the cell phone he'd been holding."

The man, who later pleaded guilty to driving under the influence, had no alcohol in his system, according to a breath-alcohol test noted in the police report.

"You may not always have a bad trip, so to speak, but if you do, chances are, you're going to end up in the emergency room, you're going to be seeing the EMTs, you're going to be seeing an ER doc," Gutierrez said.

Some Anchorage teens have been hospitalized, according to the Anchorage School District, which publicized its fears about synthetic marijuana use last April. Still, use of drugs like Spice by Anchorage students does not come close to the number of cases of marijuana use, school district spokeswoman Heidi Embley said.

"You could probably count the number of cases on one hand," Embley said.

Gutierrez and Honeman had not yet compiled a list of Anchorage stores selling Spice and similar smokeable products, but they planned to do so in order to notify stores of their upcoming resolution.

Print Page Close Window

Copyright © Wed Jan 26 11:01:20 UTC-0900 20111900 The Anchorage Daily News (www.adn.com)

Health

Fake Weed, Real Drug: K2 Causing Hallucinations in Teens

By Jeanna Bryner, LiveScience Managing Editor
posted: 03 March 2010 04:46 pm ET

Teens are getting high on an emerging drug called "fake weed," a concoction also known as K2 and "spice" that is also causing hallucinations, vomiting, agitation and other dangerous effects.

In the last month, Dr. Anthony Scalzo, a professor of toxicology at Saint Louis University, has seen nearly 30 cases of teenagers experiencing these adverse effects after smoking the fake weed, a legal substance that reportedly offers a marijuana-like high.

"K2 use is not limited to the Midwest; reports of its use are cropping up all over the country," Scalzo said. "I think K2 is likely a bigger problem than we're aware of at this time." For instance, Atlanta has seen about 12 cases recently.

Ads by Google

Drug Dependence Quiz
Identify substance abuse problems
Confidential, free online survey
TurnToHelp.com

 # 1 Rated Addiction Rehab
Adult Rehab and Detox Center All
Private Bedrooms & Insurance ok
TransformationsTreatment.com

Substance Abuse Counselor
Become A Substance Abuse
Counselor & Help Fight Addiction.
Learn More.
ChooseICDCCollege.com/Counselor

K2 has been sold since 2006 as incense or potpourri for about $30 to $40 per three gram bag – comparable in cost to marijuana.

"K2 may be a mixture of herbal and spice plant products, but it is sprayed with a potent psychotropic drug and likely contaminated with an unknown toxic substance that is causing many adverse effects," said Scalzo, who also directs the Missouri Regional Poison Control Center.

Origin of K2

This K2 compound was first created in the mid-1990s in the lab of organic chemist John W. Huffman of Clemson University, who studies cannabinoid receptors. He's not sure how the recipe for what is named JWH-018 (his initials) got picked up, but he did publish details on a series of compounds including JWH-018 in a book chapter. Even before that book came out, he recalls learning that in China and Korea people were selling the compound as a plant growth stimulant.

As for where it was first smoked or used as a recreational drug, Huffman thinks perhaps somewhere in Europe.

"Apparently somebody picked it up, I think in Europe, on the idea of doping this incense mixture with the compound and smoking it," Huffman told LiveScience. "You can get very high on it. It's about 10 times more active than THC," the active ingredient in marijuana.

From a chemist's perspective, that means K2 has an affinity for the cannabinoid brain receptor (CB1) that's about 10 times greater than THC. For the less chemically inclined, it means you can smoke a lot less K2 to get just as high.

The compound works on the brain in the same way as marijuana's active ingredient THC, or tetrahydrocannabinol. Both compounds bind to the CB1 receptors, which primarily affect the central nervous system. JWH-018 also binds to the peripheral brain (CB2) receptors, which are involved in the immune system, Huffman said.

Hallucinations and delusions

Since JWH-018 or K2 acts like marijuana, you'd expect to see the same effects, including sleepiness, relaxation, reduced blood pressure, and at high doses, hallucinations and delusions.

While some patients between the ages of 14 and 21 were showing up with hallucinations, other symptoms, such as increased agitation and elevated blood pressure and heart rates, didn't match up with marijuana.

Scalza speculates either another compound is responsible for the nasty side effects, or the concentration of JWH-018 is too high.

To answer this question, Scalzo is having doctors test patients' urine for JWH-018 and other compounds, but he is having trouble getting patients to agree to the test.

"This is *not* something that people are agreeing to," Scalzo said during a telephone interview. "Here's a legal substance that we don't know really that much about that people are putting into their bodies without quality control."

And even though doctors like Scalzo say they'd like to help the teens, that's not enough. "Phenomenally, people are saying no. They're afraid someone is going to find something," though Scalzo has no idea why they'd be afraid.

Dangerous drug

Both Scalzo and Huffman agree the drug is dangerous.

Further testing is needed, but Scalzo says the symptoms, such as fast heart beat, dangerously elevated blood pressure, pale skin and vomiting suggest that K2 is affecting the cardiovascular system of users. It also is believed to affect the central nervous system, causing severe, potentially life-threatening hallucinations and, in some cases, seizures.

"It's like playing Russian roulette. You don't know what it's going to do to you," Huffman said. "You're a potential winner of a Darwin award," referring to the tongue-in-cheek awards given to people who "do a service to humanity by removing themselves from the gene pool."

In addition to the compound being made without strict quality control or any regulation, as far as anyone knows, the compound itself has never been tested on humans. And when it was tested on mice, Huffman said, the animals were euthanized at the end of the experiment, so scientists don't even know how it affects mice long-term. "And mice are not humans," Huffman said.

It's a Dog's Life

Concerned that animals were not being treated as well as they should in some shelters, several state legislatures in the past few years have passed measures to improve shelter practices.

California lawmakers passed the Hayden Shelter Reform Law in 1999 that started the trend. It lengthens the state's previously short holding time—the period before an animal can be euthanized—from 72 hours to six business days. It recommends healthy, non-suffering animals should be euthanized only if they cannot be placed in a suitable home; these would include vicious dogs or those that pose a public health hazard. It also required shelters to release any requested animal to a qualifying non-profit rescue center or adoption group as an alternative to euthanasia.

In 2010, Delaware passed a bill similar to the Hayden Law, making its shelter regulations some of the most comprehensive in the country. The Delaware law requires all shelters to immediately inspect animals for identification and to wait at least three days before putting animals up for adoption or transferring them to another facility so owners have a chance to find lost pets. The law requires shelters to stay open beyond normal business hours so the public has a greater chance to adopt animals. And it requires shelters to post quarterly statistics on their websites regarding intake, adoption, reclamation, transfer and euthanasia rates.

Although the American Veterinary Medical Association has OK'd the use of gas chambers, animal rights groups assert they are cruel and unnecessarily frightening to dogs and cats. They have advocated for more humane methods, usually intravenous injection of sodium pentobarbital.

In the past two years, Georgia, Illinois, Louisiana, New Mexico, New York and West Virginia passed legislation that changed their euthanasia standards, joining the 13 other states that ban the use of gas chambers for animals.

Synthetic Pot Peril

Synthetic cannabinoids—commonly known as "Spice," "K2," "Genie," "Yucatan Fire," "Sence," "Smoke," "Skunk" and "Zohai" —have become a popular legal alternative to marijuana. Until now, that is. At least ten states outlawed the drug this year.

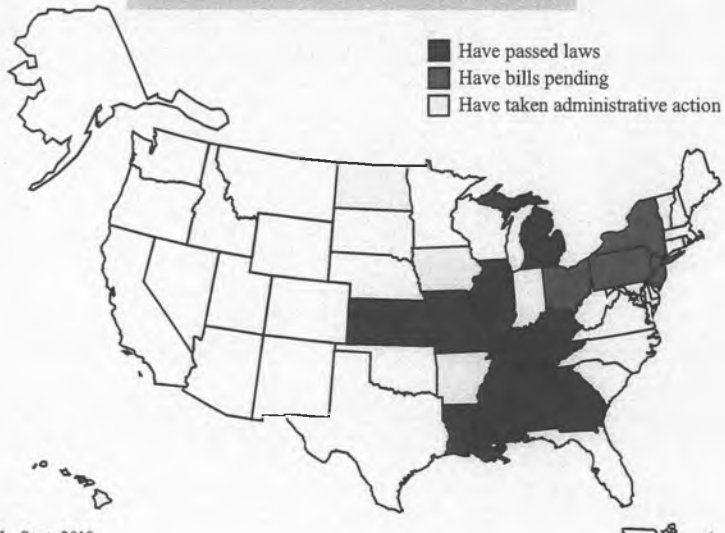
The drug is sprayed onto dried herbs, marketed as "novelty herbal incense" or potpourri, and then smoked or ingested by consumers. It produces a high similar to marijuana and is sold in local convenience stores and over the Web. Although the product labels often read "not for human consumption," abuse of these substances appears to be increasing. The American Association of Poison Control Centers reports that, as of Sept. 27, more than 1,503 calls have been made to poison centers for symptoms such as racing heartbeat, elevated blood pressure and nausea. This is up from a total of only 14 calls in 2009.

There also have been reports linking use of these drugs to hallucinations, seizures and even death. After a Minnesota teenager ended up in the hospital from using K2, Minnesota Senator Kathy Sieben announced plans to introduce legislation next session. She says protecting kids by outlawing these substances will be a top priority.

Kansas was the first state to pass legislation this year banning synthetic cannabinoids. Nine other states have passed similar measures making it illegal to possess, use, manufacture or sell the substances. Bills are pending in at least four other states as of the end of September.

Other action at the state level includes administrative bans in Arkansas, Hawaii, Iowa and North Dakota. The Hawaii Narcotics Enforcement Division, for example, applied an emergency ban on "chemicals in Spice/K2." The ban is temporary, pending action by the Hawaii Legislature in the 2011 session. And in Idaho, a newly formed advisory committee is reviewing whether synthetic cannabinoids should be added to the list of controlled substances. They will make a recommendation to the Legislature before the 2011 session begins.

BANS ON SYNTHETIC CANNABINOIDS



Source: NCSL, Sept. 2010.

U.S. Department of Justice

NEWS RELEASE NEWS RELEASE

November 24, 2010

DEA MOVES TO EMERGENCY CONTROL SYNTHETIC MARIJUANA

Agency Will Study Whether To Permanently Control Five Substances

WASHINGTON, D.C. – The United States Drug Enforcement Administration (DEA) is using its emergency scheduling authority to temporarily control five chemicals (JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol) used to make "fake pot" products. Except as authorized by law, this action will make possessing and selling these chemicals or the products that contain them illegal in the U.S. for at least one year while the DEA and the United States Department of Health and Human Services (DHHS) further study whether these chemicals and products should be permanently controlled.

A Notice of Intent to Temporarily Control was published in the *Federal Register* today to alert the public to this action. After no fewer than 30 days, DEA will publish in the *Federal Register* a Final Rule to Temporarily Control these chemicals for at least 12 months with the possibility of a six-month extension. They will be designated as Schedule I substances, the most restrictive category, which is reserved for unsafe, highly abused substances with no medical usage.

Over the past year, smokable herbal blends marketed as being "legal" and providing a marijuana-like high, have become increasingly popular, particularly among teens and young adults. These products consist of plant material that has been coated with research chemicals that mimic THC, the active ingredient in marijuana, and are sold at a variety of retail outlets, in head shops and over the Internet. These chemicals, however, have not been approved by the FDA for human consumption and there is no oversight of the manufacturing process. Brands such as "Spice," "K2," "Blaze," and "Red X Dawn" are labeled as incense to mask their intended purpose.

Since 2009, DEA has received an increasing number of reports from poison centers, hospitals and law enforcement regarding these products. Fifteen states have already taken action to control one or more of these chemicals. The Comprehensive Crime Control Act of 1984 amends the Controlled Substances Act (CSA) to allow the DEA Administrator to emergency schedule an abused, harmful, non-medical substance in order to avoid an imminent public health crisis while the formal rule-making procedures described in the CSA are being conducted.

"The American public looks to the DEA to protect its children and communities from those who would exploit them for their own gain," said DEA Acting Administrator Michele M. Leonhart. "Makers of these harmful products mislead their customers into thinking that 'fake pot' is a harmless alternative to illegal drugs, but that is not the case. Today's action will call further attention to the risks of ingesting unknown compounds and will hopefully take away any incentive to try these products."

##

CLERK'S OFFICE
AMENDED AND APPROVED
Date: 12-7-10

Submitted by: ASSEMBLY CHAIR TRAINI, MAYOR DAN SULLIVAN, AND ASSEMBLY MEMBERS HONEMAN AND GUTIERREZ
Prepared by: Dept. of Law
For reading: December 7, 2010

ANCHORAGE, ALASKA
AO No. 2010-87(S)

AN ORDINANCE AMENDING ANCHORAGE MUNICIPAL CODE CHAPTER 8.35 TO PROHIBIT THE MANUFACTURE, ASSEMBLY, DISTRIBUTION, MARKETING, SALE, USE OR POSSESSION OF SUBSTANCES CONTAINING SYNTHETIC CANNABINOIDS, TO PROHIBIT THE SALE OR POSSESSION OF PARAPHERNALIA RELATED TO THE USE OF SYNTHETIC CANNABINOIDS, TO PROVIDE PENALTIES, AND AMENDING SECTION 14.60.030 TO PROVIDE FOR CIVIL PENALTIES.

WHEREAS, the Municipality is aware that substances containing synthetic cannabinoids were and are manufactured, or assembled for, or marketed, sold or offered for sale to, residents of the Municipality, including minors; and

WHEREAS, local law enforcement personnel and "first responders" indicate there is an increased use of synthetic cannabinoids, currently marketed and sold under a variety of names, including "K2", "Spice", "Black Mamba", "Blue Pearl", "Genie", "DaScents", "Spike", "Space" and "Zohai"; and

WHEREAS, some users of the synthetic cannabinoids endanger the public by operating vehicles while under the influence and endanger the welfare of first responders; and

WHEREAS, some users experience severe reactions, resulting in unconsciousness, seizures, and hospitalization; and

WHEREAS, users of the drug report the effects are similar to marijuana and LSD usage, including blurred vision, extremely elevated blood pressure, irregular heart rates, hallucinations, delusions, vomiting, euphoria, "highs", and disturbing side effects including feelings of excruciating pain, agitation and loss of control; and

WHEREAS, representatives of businesses selling the substance indicate it is available to minors as well as adults; and

WHEREAS, products containing synthetic cannabinoids are not tested by the Food and Drug Administration (U.S. Department of Agriculture) or other governmental regulatory agency for human consumption and may contain chemicals detrimental to the health and welfare of those ingesting them; and

WHEREAS, medical studies and treatises note deleterious health risks and adverse effects associated with the use of synthetic cannabinoids and products containing the synthetic cannabinoids; and

WHEREAS, despite packaging warning purchasers the products are not for human consumption, the warnings are not being heeded; and

WHEREAS, synthetic cannabinoids are banned in many states and municipalities throughout the United States as a danger to public health and welfare; and

WHEREAS, the smoke emanating from the burning or incineration of synthetic cannabinoids may cause adverse effects on bystanders or those in the vicinity of such activity; and

WHEREAS, it is in the best interest of the Municipality to prohibit the manufacture, assembly, possession, use, sale, marketing, or offering for sale of synthetic cannabinoids within the boundaries of the Municipality to protect the health, safety and welfare of its citizens; now, therefore,

THE ANCHORAGE ASSEMBLY ORDAINS:

Section 1. Anchorage Municipal Code chapter 8.35 is amended by adding a new section to read as follows:

8.35.100 [SALE OF] [s] **Synthetic cannabinoids.**

A. It shall be unlawful for any person or **entity** [~~organization~~] to knowingly manufacture, assemble, distribute, dispense, sell, attempt to sell, give, trade, barter, transfer, or to otherwise furnish in a single transaction any product or combination of products containing synthetic cannabinoids, such as products commonly known as "K2", "Spice", "Genie", "DaScents", "Zohai" or similar products. [,] **Synthetic cannabinoids** contain[~~ing~~] one or more of the following chemical compounds:

1. HU-210: (6aR, 1OaR)-9-(hydroxymehty1)-6,6 dimethyl-3-(2methyloctan-2-yl)-6a,7,10,1Oa-tetrahydrobenzo[c]chromen- 1-o1, or 6aR-trans-3-(1,1-Dimethylheptyl)-6a,7,10,10a-tetrahydro-1-hydroxy-6,6-dimethyl-6H-dibenzo[b,d]pran-9-methanol;

2. HU-211: (6aS, 10aS)-9- (hydroxmethy1)-6,6-dimethyl-3-(2-methyloctan-2-y1)-6a,7,10,10a-tetsahydrobenzo[c]chromen-1-ol)(also known as Dexanabinol);

3. CP47,497 and homologues: 2-[(IR,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-y1)phenol;

4. JWH-018: 1-Pentyl-3-(1-naphthoyl)indole;

5. JWH-019: 1-Hexyl-1-(1-naphthoyl)indole);

6. JWH-073: 1-Butyl-3-(1 -napthoyl)indole;

7. JWH-081: 1-pentyl-3-(4-methoxy-1-napthoyl)indole, (also known as 4-methoxynapthalen-1-yl-(1-pehtylindol-3-yl)methanon);

8. JWH-200: 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole;

9. JWH-250: 1-pentyl-3-(2-methoxyphenlacetyl)indole, (also known as 2-(2-methoxypehyl)-1-(1-pentylindol-3-yl)ethonone;

10. JWH-398: 1-Pentyl-3-(4-chloro-1-napthoyl)indole)

11[12]. TEMPP: 1-(3 trifluoromethylphenyl) piperazine;
[~~Salvia Divnorum or Salvinorum A; all parts of the plant presently classified botanically as Salvia Divinorum, whether growing or not, the seeds thereof, any extract from any part of the plant, and every compound, manufacture, salts, derivative, mixture or preparation of the plant, its seeds or extracts;~~]

12 [13].BZP: N-benzylpiperazine; or

13 [14].Any other synthetic cannabinoids or derivatives, salts, isomers, or salts of isomers with similar chemical structure and pharmacological activity as the substances described above.

14. This prohibition shall also apply to any other equivalent compound, substance, or derivative, whether described as tobacco, herbs, incense, food, nutrient, spice or any blend thereof which, when smoked or ingested, mimics the effects of a controlled substance, regardless of whether the substance is marketed for the purpose of being smoked or ingested.

B. It shall be unlawful to manufacture synthetic cannabinoids described in subsection A. within the Municipality.

C. It shall be unlawful for any person or **entity** [~~organization~~] to recklessly manufacture, assemble, distribute, sell, market, display for sale, or offer for sale within the Municipality products containing synthetic cannabinoids described in subsection A.

D. Products containing synthetic cannabinoids may not be possessed, ingested, burned, incinerated or ignited in ~~any public place or on any property owned, leased or controlled by~~ the Municipality. ~~For purposes of this section, "public place" includes any public transit vehicle, any public street or other right of way, and any public school building or grounds.~~

E. A person or **entity** [~~organization~~] violating the provisions of subsections A. or B. shall be guilty of a misdemeanor and shall be punishable by:

1. A fine of not more than $5,000 or imprisonment of not more than one year, or both.

F. A person or **entity** [~~organization~~] violating the provisions of subsection C. shall be guilty of a misdemeanor and shall be punishable by:

1. A fine of not more than $5,000 or imprisonment of not more than 6 months, or both.

G. A person or **entity** [~~organization~~] violating the provisions of subsection D. shall be guilty of a misdemeanor and shall be punishable by:

1. A fine of not more than $5,000 or imprisonment of not more than 6 months, or both.

H. As an alternative to the remedies, procedures and penalties provided in this title and section 1.45.010, a violation of subsection C. **or D.** may be charged as a civil violation subject to and prosecuted in accordance with title 14, and in such case shall be punishable by a civil penalty in accordance with chapter 14.60.

I. If, after multiple violations by the same person or entity, the Municipal Attorney and the Anchorage Police Department determine the imposition of criminal penalties or civil fines will not be effective in enforcing this section, the Municipal Attorney may seek any other remedies provided by law, including injunctive relief.

J. It is not an offense under this section if the person **or entity** was acting at the direction of an authorized agent of the municipality to enforce or ensure compliance with this section.

K. Any product described in subsection A. found in the illegal possession of any person **or entity** may be confiscated and destroyed by the municipality.

L. This section does not apply to drugs or substances lawfully prescribed or drugs or substances approved by the federal Food and Drug Administration or drugs or substances specifically permitted by state law.

Section 2. Anchorage Municipal Code section 8.35.010 is hereby amended to read as follows (*the remainder of the section is not affected and therefore not set out*):

A. The following words, terms and phrases, when used in this chapter, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

*** *** ***

Drug paraphernalia means any items whose objective characteristics or objective manufacturer's design indicate that it is intended for use in the consumption, ingestion, inhalation, injection or other method of introduction of:

1. A [A] controlled substance into the human body or to facilitate a violation of AS 11.71; or [.]
2. A product containing illegal synthetic cannabinoids under section 8.35.100.

Section 3. Anchorage Municipal Code section 14.60.030 is hereby amended to add to the fine schedule (*the remainder of the schedule is not affected and therefore not set out*):

14.60.030 Fine schedule.

Code Section	Offense	Penalty/Fine
***	***	***
8.35.100 C. or 8.35.100 D. [~~8.36.100B~~]	Possession or use of synthetic cannabinoid	$150 for the first violation; $300 for the second violation; $600 for subsequent violations
***	***	***

(AO No. 93-167(S-1), § 1, 4-13-94; AO No. 94-108, § 1, 10-5-94; AO No. 94-134, § 2, 9-8-94; AO No. 95-42, § 2, 3-23-95; AO No. 95-67(S), § 9, 7-1-95; AO No. 95-102, § 1, 4-26-95; AO No. 95-118, § 3, 9-1-95; AO No. 95-163(S), § 21, 8-8-95; AO No. 95-195(S-1), 1-1-96; AO No. 96-51(S-1), § 2, 8-1-96; AO No. 96-96(S-1), § 2, 2-1-97; AO No. 96-126(S), § 3, 10-1-96; AO No. 96-137(S), § 9, 1-2-97; AO No. 97-88, § 3, 6-3-97; AO No. 97-107, § 3, 11-17-97; AO No. 97-133(S), § 1, 11-11-97; AO No. 98-27(S-1), § 2, 11-11-97; AO No. 98-160, § 2, 12-8-98; AO No. 99-13(S), 2-9-99; AO No. 99-91(S), § 4, 7-13-99; AO No. 2000-64, § 1, 4-18-00; AO No. 2000-116(S), § 4, 7-18-00; AO No. 2000-127(S), § 2, 10-14-00; AO No. 2000-129(S), § 26, 11-21-00; AO No. 2001-48, § 1, 3-13-01; AO No. 2001-74(S), § 2, 4-17-01; AO No. 2001-4, § 2, 2-6-01; AO No. 2001-145(S-1), § 11, 12-11-01; AO No. 2003-68, § 1, 9-30-03; AO No. 2003-97, § 4, 9-30-03; AO No. 2003-117, § 2, 1-28-03; AO No. 2003-130, § 8, 10-7-03; AO No. 2003-152S, § 10, 1-1-04; AO No. 2004-1, § 2, 1-1-03; AO No. 2004-99, § 2, 6-22-04; AO No. 2004-100(S-1), § 6, 1-1-05; AO No. 2004-171, § 1, 1-11-05; AO No. 2005-160, § 9, 11-1-05; AO No. 2005-84(S), § 3, 1-1-06; AO No. 2005-185(S), § 35, 2-28-06; AO No. 2005-124(S-1A), § 33, 4-18-06; AO No. 2006-39, § 6, 4-11-06; AO No. 2006-54, § 1, 5-2-06; AO No. 2006-80, § 1, 6-6-06; AO No. 2007-50, § 4, 4-10-07; AO No. 2007-60, § 4, 11-1-07; AO No. 2007-70, § 3, 5-15-07; AO No. 2008-84(S), § 5, 7-15-08; AO No. 2009-61, § 3, 7-7-09; AO No. 2009-82, § 5, 7-7-09; AO No. 2009-40(S), § 3, 7-21-09; AO No. 2009-112, § 4, 10-13-09; AO No. 2009-122, § 2, 12-17-09)

Section 4. The sections, paragraphs, sentences, clauses, phrases and words of this ordinance are separable, and if any word, phrase, clause, sentence, paragraph or section of this ordinance shall be declared unconstitutional, invalid or

unenforceable by the valid judgment or decree of a Court of competent jurisdiction, such unconstitutionality, invalidity or unenforceability shall not affect any of the remaining words, phrases, clauses, sentences, paragraphs and sections of this ordinance.

Section 5. This ordinance shall be effective ~~on _____, 2010~~ **upon 30 days of passage by the Anchorage Assembly**.

PASSED AND APPROVED by the Anchorage Assembly this 7th day of December, 2010.

Chair of the Assembly

ATTEST:

Municipal Clerk

MedlinePlus®
Trusted Health Information for You

U.S. National Library of Medicine
NIH National Institutes of Health

'Fake Marijuana' Users Showing Up in Emergency Rooms

Called 'K2' or 'Spice,' the drug is legal in many states

URL of this page: http://www.nlm.nih.gov/medlineplus/news/fullstory_105434.html (*this news item will not be available after 02/09/2011)

Thursday, November 11, 2010

HealthDay

Photo courtesy: Wikimedia/Schorle

THURSDAY, Nov. 11 --(HealthDay News) -- A form of synthetic marijuana known as "K2" is sending young people to the hospital with racing heart beats, extreme anxiety and hallucinations, toxicologists warn.

In recent months, physicians and toxicologists say more young people have been showing up in emergency rooms after smoking synthetic marijuana. Despite the side effects, K2 is legal in many states, although many state legislators are rushing to pass legislation banning it.

Since the start of 2010, the American Association of Poison Control Centers has received nearly 2,000 reports of people who became ill after smoking K2, compared to about a dozen in 2009. Poison control officials described some of the symptoms as "life-threatening."

K2 is often marketed as incense and sold in packets of herbs laced with synthetic marijuana at "head shops," gas stations, convenience stores and online for about $30 to $40 per three-gram bag. The drug also goes by other names, including Spice, Spice Gold, Spice Diamond, Yucatan Fire, Solar Flare, K2 Summit, Genie, PEP Spice, and Fire n Ice, according to the U.S. Drug Intelligence Center.

While people who smoke K2 think they're going to experience deep relaxation and euphoria, those who end up in the hospital report unpleasant experiences, said Dr. Anthony Scalzo, medical director of the Missouri Poison Center and chief of toxicology at St. Louis University.

"The classic symptoms are agitation, anxiety, racing heart beat, elevated blood pressure," Scalzo said. "And some kids are having very negative psychotropic experiences. One said, 'I felt like I went down to hell'."

In some cases, the drug also causes vomiting, tremors and seizures, according to federal drug abuse agencies.

Scalzo was the first to sound the alarm about K2 earlier this year after seeing a couple of dozen of reports of young people treated at emergency rooms who said they'd smoked K2.

The drug, also sold under the name Happy Shaman Herbs, Smoke, Skunk and Zohai, among others, was developed for study purposes in the mid-'90s in the lab of John Huffman, a Clemson University chemist, who was conducting National Institute on Drug Abuse-supported research on cannabinoids.

The chemical makeup of the drug, which he called JWH-018 and JWH-073, was similar to tetrahydrocannabinol (THC), the active ingredient in marijuana, only considerably more potent.

While THC is a cannabinoid, it's one of many, Huffman said. There are many other substances that interact with the cannabinoid receptors in the brain and other organs, Huffman said.

"These receptors don't exist so that people can smoke marijuana and get high; they play a role in regulating appetite, nausea, mood, pain and inflammation. They may be involved in the development of conditions such as osteoporosis, liver disease and some kinds of cancer," Huffman said. "Synthetic cannabinoids can help us understand these interactions and ultimately this knowledge may contribute to the development of new therapies.

Huffman and his colleagues described JWH-018 and JWH-073 in scientific literature. "Evidently some people have figured out how to make them," Huffman said.

Huffman warned that the drugs were only meant to be used in the lab and were not designed for use in people, Huffman said. "These compounds were not meant for human consumption," Huffman said. "Their effects in humans have not been studied and they could very well have toxic effects. They absolutely should not be used as recreational drugs."

And while the makers of K2 seem to have latched on to JWH-018, many other labs have developed their own synthetic cannabinoids that may also find their way into synthetic marijuana products, Scalzo said.

The K2 craze caught on several years ago Europe, prompting several countries to make synthetic cannabis products illegal.

In the United States, the Drug Enforcement Agency has listed K2 as a "drug or chemical of concern." But because it isn't officially "scheduled," it remains legal under federal law, according to published reports.

Alarmed by the rise in popularity, several states have rushed to outlaw K2. Earlier this year, Kansas became the first state to ban K2. Other states that have outlawed it include Iowa, Missouri, Arkansas, Kentucky, Alabama, Michigan and Illinois (where K2 remains legal until the end of the year). There are similar bills pending in many other states, including Nebraska, North Dakota, Ohio, New York, New Jersey and Louisiana.

Scalzo said the prohibitions don't come a moment too soon. Little is known about the health effects of the drug. But he's heard enough anecdotal reports about strange behavior -- ranging from extreme agitation to withdrawal to a suicide after smoking K2 -- to be concerned.

"This chemical was not meant to be used in any kind of pharmaceutical manner," Scalzo said.

SOURCES: Anthony Scalzo, M.D., chief of toxicology, St. Louis University, St. Louis, Mo.; John Huffman, Ph.D., research professor, organic chemistry, Clemson University, Clemson, S.C.

HealthDay

Copyright (c) 2010 HealthDay [http://www.healthday.com/] . All rights reserved.

Related MedlinePlus Pages

Drug Abuse [http://www.nlm.nih.gov/medlineplus/drugabuse.html]
Emergency Medical Services [http://www.nlm.nih.gov/medlineplus/emergencymedicalservices.html]
Marijuana [http://www.nlm.nih.gov/medlineplus/marijuana.html]

Page last updated on 12 November 2010

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

February 3, 2011

Senator Kevin Meyer
Alaska State Legislature
Capitol Building, Room 103
Juneau, Alaska 99801

Re: SB 17 – Regulation of Synthetic Cannabinoids

Dear Senator Meyer,

On behalf of the Advisory Board on Alcoholism and Drug Abuse, I would like to express our thanks for your efforts to regulate synthetic marijuana or "cannabinoids." These products pose a grave risk to youth and adults, causing serious health consequences and impairments to users of these drugs.

The dangers posed by synthetic marijuana are serious. While the base products may be natural, the chemicals used to mimic the properties of THC are not approved for human consumption. National news reports on the effects of these products include elevated heart rate and blood pressure, extreme anxiety, poisoning, nausea and vomiting, hallucinations, overdoses, and even addiction.

The American Association of Poison Control Centers reported more than 3,000 calls related to poisoning by synthetic marijuana products in 2010 – and nearly 400 calls since January 1 of this year. The U.S. Army banned use of synthetic marijuana by service members in August 2010. The U.S. Drug Enforcement Agency (DEA) exercised its emergency scheduling authority to **temporarily** control five chemicals used in synthetic marijuana products (JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol). This federal regulation is limited in duration (12-18 months), leaving Alaskans at risk after that time without the state taking action.

The effects of synthetic marijuana are being felt right here in Alaska. News reports of crimes involving these products have come from Fairbanks and Anchorage. The U.S. Army reported courts martial and non-judicial discipline of more than thirty soldiers in Alaska by December 2010. The Anchorage School District reports situations requiring medical care due to use by students (though not to the same extent as actual marijuana).

Given the health consequences and the role synthetic marijuana can play in criminal activity, there is a more than adequate basis for the regulation of these products to protect the health and safety of Alaskans. Thank you for your work to protect Alaskans from these harmful products.

Sincerely,

J. Kate Burkhart
Executive Director

MUNICIPALITY OF ANCHORAGE

Office of the Mayor

Phone: 907-343-7100
FAX: 907-343-7180

Mayor Dan Sullivan

January 28, 2011

The Honorable Kevin Meyer
Alaska State Legislature
State Capitol
Juneau, AK 99801

Re: Senate Bill 17

Dear Senator Meyer,

Thank you for introducing Senate Bill 17, *"An Act classifying certain synthetic cannabinoids as schedule IIA controlled substances; and providing for an effective date."*

The Municipality of Anchorage fully supports the passage of SB 17 and its companion bill, HB 7. In the last few years, the use of synthetic cannabinoids has quickly become a significant health and public safety issue.

Due to the huge range in potency between the various compounds and products, municipal first responders have encountered users of these drugs having severe reactions, including from bizarre and dangerous behavior to unconsciousness and death. Users who operate machinery, especially motor vehicles, have had significant accidents and present a danger to others that is on par with operating under the influence of alcohol.

In response, the Municipality has enacted its own local code, but does not have the jurisdiction to deal with the influx of the drug on a state-wide basis or impose the kinds of meaningful criminal sentences that are needed to stem the manufacture, distribution, and sale of these drugs.

Thank you again for introducing this important legislation.

Sincerely,

Dan Sullivan

Dan Sullivan
Mayor

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

State Legislation on Synthetic Cannabinoids Pending on January 18, 2011

As of January 18, 2011, 21 states had legislation pending to modify existing laws or create new laws relating synthetic cannabinoids.

2011 PENDING LEGISLATION

Alaska H 7
Classifies certain synthetic cannabinoids as schedule IIA controlled substances.

Alaska S 17
Classifies certain synthetic cannabinoids as schedule IIA controlled substances.

Arkansas S 2
Amends the schedule VI substances regarding drugs in the criminal code; declares an emergency.

Arizona H 2167
Relates to definition of dangerous drugs; relates to synthetic.

Florida H 39
Relates to controlled substances; defines term homologue for purposes of Florida Comprehensive Drug Abuse Prevention and Control Act; includes certain hallucinogenic substances on list of controlled substances in Schedule I; reenacts provisions to incorporate amendment.

Florida S 336
Revises the list of controlled substances included in Schedules I, II, III, IV, and V.

Florida S 204
Relates to controlled substances; defines the term homologue for purposes of the Florida Comprehensive Drug Abuse Prevention and Control Act; includes certain hallucinogenic substances on the list of controlled substances in Schedule I; reenacts specified provisions relating to prohibited acts and penalties regarding controlled substances and the offense severity chart of the Criminal Punishment Code.

Iowa H 33
Adds hallucinogenic substances to the list of schedule I controlled substances; adds salvia divinorum and salvinorin A to the list of schedule I controlled substances; adds certain synthetic cannabinoids to the list of schedule I controlled substances in addition to the tetrahydrocannabinols and synthetic equivalents listed in schedule I.

Iowa S 35
Adds certain synthetic cannabinoids to the list of schedule I controlled substances; adds certain synthetic cannabinoids, also known as K2, to the list of schedule I controlled substances in addition to the tetrahydrocannabinols and synthetic equivalents listed in schedule I under Code section 124.204; A schedule I

controlled substance is considered to have a high potential for abuse and no medical purpose in treatment in the United States.

Iowa SSB 1016
Revises the lists of drugs on the controlled substances schedules, and provides penalties; removes marijuana from schedule I and reclassifies it as a schedule II controlled substance; strikes references to the authority of the board of pharmacy to adopt rules for the use of marijuana or tetrahydrocannabinols for medicinal purposes.

Iowa HSB 5
Adds hallucinogenic substances to the list of schedule I controlled substances; adds salvia divinorum and salvinorin A", also known as divinorin A to the list of schedule I controlled substances; adds certain synthetic cannabinoids, also known as "K2", to the list of schedule I controlled substances in addition to the tetrahydrocannabinols and synthetic equivalents listed in schedule I under Code section 124.204(4)(u); A schedule I controlled substance is considered to have a high potential.

Indiana S 152
Relates to synthetic cannabinoids; defines synthetic cannabinoid and makes possessing, dealing in, manufacturing, or delivering a synthetic cannabinoid equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; makes conforming amendments and corrections.

Indiana S 5
Relates to synthetic cannabinoids; defines synthetic cannabinoid and makes possessing, dealing in, manufacturing, or delivering a synthetic cannabinoid equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; makes conforming amendments.

Indiana H 1102
Relates to possession or manufacture of synthetic cannabinoid; defines synthetic cannabinoid and makes possessing, dealing in, manufacturing, or delivering a synthetic cannabinoid equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; makes conforming amendments.

Indiana H 1277
Prohibits sale of synthetic cannabinoids; defines "synthetic cannabinoid" and makes dealing in, manufacturing, or delivering a synthetic cannabinoid equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; enhances the penalty based on the same weights used to enhance the penalty for dealing in, manufacturing, or delivering hash oil or hashish; makes conforming amendments and a technical correction.

Indiana S 448
elates to spice; defines "synthetic cannabinoid" and makes possessing, dealing in, manufacturing, or delivering a synthetic cannabinoid equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; makes conforming amendments.

Indiana S 57
Relates to synthetic cannabinoids; defines synthetic cannabinoid and makes possessing, dealing in, manufacturing, or delivering a synthetic cannabinoid equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; makes conforming amendments.

Indiana H 1315

Relates to spice and salvia divinorum; defines synthetic cannabinoid and makes possessing, dealing in, manufacturing, or delivering a synthetic cannabinoid or salvia divinorum equivalent to possessing, dealing in, manufacturing, or delivering marijuana, hash oil, or hashish; makes conforming amendments and a technical correction.

Kentucky H 121
Relates to crimes and punishments and declaring an emergency; bans possession, trafficking, or manufacture of 3,4-methylenedioxypyrovalerone the primary ingredient of a drug with a street name "dove"; amend various sections of KRS Chapters 217 and 218A and KRS 530.064 relating to unlawful transaction with a minor to conform.

Minnesota H 57
Relates to public safety; establishes the crimes of sale or possession of synthetic cannabinoids; provides for a penalty.

Minnesota S 7
Relates to public safety; adds synthetic marijuana to the list of Schedule I controlled substances; prescribes criminal penalties.

Mississippi S 2163
Conforms the punishment for the illegal possession, manufacture and sale of synthetic cannabinoids to the punishment for the illegal possession, manufacture and sale of marihuana.

Mississippi S 2226
Includes cathinone derivatives in Schedule I; clarifies the punishment for offenses involving synthetic cannabinoids; clarifies the punishment for offenses involving synthetic cannabinoids.

Mississippi H 518
Includes synthetic Cannabinoids in schedule I.

Mississippi S 2369
Relates to cathinone derivatives in schedule I and to clarify the punishment for offenses involving synthetic cannabinoids; clarifies the punishment for offenses involving synthetic cannabinoids.

Mississippi H 869
Amends existing code, to include cathinone derivatives in Schedule I and to clarify the punishment for offenses involving synthetic cannabinoids; clarifies the punishment for offenses involving synthetic cannabinoids.

Montana H 185
Bans synthetic marijuana; relates to crimes; relates to alcohol and drugs.

North Dakota S 2119
Relates to the scheduling of controlled substances; modifies provisions of the controlled substance schedule relating to certain substances, including tetrahydrocannabinols and synthetic cannabinoids.

New Jersey A 2644
Adds certain cannabis-like chemical substances to list of controlled dangerous substances.

New Jersey S 2606

Adds certain cannabis-like chemical substances to list of controlled dangerous substances.

New York S 1834
Prohibits sale or distribution of any product containing a synthetic cannabinoid; defines the chemical compounds which constitute a synthetic cannabinoid; imposes a civil penalty of not more than $500 for a violation thereof; creates defenses based on over the counter drugs approved by the federal food and drug administration or lack of knowledge that the product contained a synthetic cannabinoid.

Oregon H 2462
Directs State Board of Pharmacy to classify certain synthetic cannabinoid compounds as Schedule I controlled substances; declares emergency, effective on passage.

Oregon H 2709
Directs State Board of Pharmacy to classify certain synthetic cannabinoid compounds as Schedule I controlled substances; declares emergency, effective on passage.

South Carolina H 3137
Relates to materials, compounds, mixtures, and preparations classified as schedule i drugs, add synthetic cannabis to the list of schedule I drugs.

South Carolina H 3144
Relates to materials, compounds, mixtures, and preparations classified as schedule i drugs, add synthetic cannabis to the list of schedule I drugs.

South Carolina S 78
Relates to materials, compounds, mixtures, and preparations classified as schedule I drugs; adds synthetic cannabis to the list of schedule I drugs.

Texas H 49
Relates to the addition of certain synthetic derivatives of marihuana to Penalty Group 2 of the Texas Controlled Substances Act.

Texas H 108
Relates to the addition of a synthetic derivative of marihuana to Penalty Group 2 of the Texas Controlled Substances Act.

Texas H 597
Relates to adding certain synthetic cannabinoids to Penalty Group 2 of the Texas Controlled Substances Act.

Texas S 331
Relates to adding certain synthetic cannabinoids to Penalty Group 2 of the Texas Controlled Substances Act.

Utah H 23
Modifies provisions relating to the Utah Controlled Substances Act by creating a controlled class of listed synthetic cannabinoid substances found in products often referred to as spice.

Utah H 200
Modifies the Criminal Code prohibiting the sale, distribution, and other activities relating to products containing a synthetic cannabinoid to any person under 19 years of age; provides advertising restrictions for

products containing a synthetic cannabinoid; prohibits a person from providing a product containing a synthetic cannabinoid to any person under 19 years of age.

Virginia H 1243
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act, notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 1427
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act, notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 1434
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 1473
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act; relates that notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 1481
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act; relates that the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 1778
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 (Section 54.1-3446) of the Drug Control Act ([Section] 54.1-3400 et seq.); provides that the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 1878
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act; provides that the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia H 2049
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 (Section 54.1-3446) of the Drug Control Act ([Section] 54.1-3400 et seq.); notwithstands the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for

possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia S 745
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act, notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia S 746
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act, notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia S 748
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act, notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia S 749
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 of the Drug Control Act, notwithstanding the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia S 926
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule I (Section 54.1-3446) of the Drug Control Act ([Section] 54.1-3400 et seq.); Notwithstands the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule I, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana.

Virginia S 1082
Adds synthetic marijuana (known as K2 and Spice and various other names) to Schedule I of the Drug Control Act.

Virginia S 1186
Creates a new category for synthetic marijuana as a series of controlled substances listed in Schedule 1 (Section 54.1-3446) of the Drug Control Act ([Section] 54.1-3400 et seq.); Notwithstands the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule 1, punishment for possession and distribution of synthetic marijuana is largely in accord with the provisions for actual marijuana; provides that has an emergency clause.

Virginia S 1373
Creates a new category for synthetic cannabinoids as a series of controlled substances listed in Schedule I (Section 54.1-3446) of the Drug Control Act ([Section] 54.1-3400 et seq.); Notwithstands the provisions regarding punishment for possession and distribution of controlled substances listed in Schedule I,

punishment for possession and distribution of synthetic cannabinoids is largely in accord with the provisions for actual marijuana.

Washington S 5101
Places certain synthetic cannabinoids into schedule I of the uniform controlled substances act.

West Virginia H 2505
Adds synthetic cannabinoids and hallucinogens and stimulants to the Schedule I list of controlled substances (K2).

West Virginia S 63
Extends number of prohibited products included in definition of salvia divinorum.

Wyoming H 62
Relates to the Wyoming Controlled Substances Act; conforms punctuation and spelling in the act to terminology in federal law; adds and deleting substances in the various schedules of the act as specified; amends registration requirements as specified; amends methamphetamine precursor sales restrictions to match federal requirements; specifies penalties; authorizes a person to sign a consent for a third party to receive prescription tracking reports; specifies applicability of new registration requirements.

Wyoming S 59
Relates to the Wyoming Controlled Substances Act; adds specified controlled substances to schedule I of the act; authorizes additional positions.

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

Synthetic Cannabinoid State Laws

(Updated: January 18, 2011)

State	Related Bill Numbers	Classified as a Schedule I Controlled Substance	Crimes and Penalties	Chemical Substances*
Alabama	HB 697 (2010)	No	Subject to the same penalties as possession of marijuana in the first and second degree.	HU-210; JWH-018; and JWH-073.
Georgia	HB 1309 (2010)	Yes	Not Specified	CP 47, 497 and homologues; HU-210; and JWH-018.
Illinois	HB 6459 (2010)	Yes	Not Specified	JWH-018 and JWH-073.
Kansas	HB 2411 (2010)	Yes	Not Specified	HU-210; JWH-018; and JWH-073.
Kentucky	HB 265 (2010)	Yes	Possession of synthetic cannabinoid is a class B misdemeanor. Trafficking in synthetic cannabinoid and manufacturing synthetic cannabinoids are class A misdemeanors. Subject to the same penalties and exclusions as marijuana for certain controlled substances crimes.	Any chemical compound that contains CP 47, 497 and homologues; dexanabinol; JWH-018; or JWH-073. Excludes synthetic cannabinoids that require a prescription, are approved by the USDA and are legally dispensed.

State	Related Bill Numbers	Classified as a Schedule I Controlled Substance	Crimes and Penalties	Chemical Substances*
Louisiana	HB 121 (2010), HB 173 (2010), and SB 37 (2010)	Yes	Subject to the same penalties as possession, distribution and possession with intent to distribute of marijuana.	CP 47, 497 and homologues; HU-210; JWH-018; and JWH-073.
Michigan	HB 6038 (2010)	Yes	Not Specified	CP 47,497; HU-210; JWH-015; JWH-018; JWH-073; JWH-200; and JWH-250.
Mississippi	SB 2004 (2010)	Yes	Subject to the same penalties and exclusions as marijuana for certain controlled substances crimes.	CP-47, 497 and homologues; HU-210; JWH-018; JWH-019; JWH-073; JWH-200; JWH-250; and JWH-398.
Missouri	HB 1472 (2010)	Yes	Possession of 35 grams or less of synthetic cannabinoids is a class A misdemeanor, and possession of more than 35 grams is a class C felony.	HU-211; Indole or JWH-018; Indole or JWH-073; and Phenol CP 47, 497 and homologues.
Oklahoma	HB 3241 (2010)	Yes	Not Specified	HU-210; JWH-018; and JWH-073.
Tennessee	SB 2982 (2010)	No	Subject to the same penalties as producing, manufacturing, distributing, possessing or possessing with intent to produce, manufacture or distribute salvia divinorium.	HU-210; HU-211; JWH-018; and JWH-073. Excludes synthetic cannabinoids lawfully prescribed or substances approved by the Food and Drug Administration.

*Synthetic Cannabinoid Chemical Substances and Trade Names:

- 1-(2-(4-(morpholinyl)ethyl))-3-(1-naphthoyl) indole [**trade name: JWH-200**]
- 1-Butyl-3-(1-naphthoyl)indole [**trade name: JWH-073**]
- 1-hexyl-3-(1-naphthoyl)indole [**trade name: JWH-019**]
- 1-pentyl-3-(1-naphthoyl)indole [**trade name: JWH-018**]
- 1-pentyl-3-(2-methoxyphenylacetyl)indole [**trade name: JWH-250**]

- 1-pentyl-3-(4-chloro-1-naphthoyl)indole [**trade name: JWH-398**]
- 2-[(1R,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol) [**trade name: CP 47, 497 and homologues**]
- [(6a*R*,10a*R*)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c] chromen-1-ol)] [**trade name: HU-210**]
- (2-methyl-1-propyl-1H-indol-3-yl)-1-naphthalenyl-methanone [**trade name: JWH-015**]
- Dexanabinol
- dexanabinol, (6a*S*,10a*S*)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol [**trade name: HU-211**]

Alaska's Citizen Review Panel

Citizen Review Panel

Citizen Review Panel: Who

- The CRP is composed of volunteer members who are broadly representative of the state, including members who have expertise in the prevention and treatment of child abuse and neglect.
- Susan Heuer, Anchorage (Chair)
- Bonnie Edmondson, North Pole
- Dana Hallett, Haines
- Kristin Hull, Wasilla
- George Kirchner, Fairbanks
- Ralph Taylor, Eagle River
- Fred Van Wallinga, Willow

Citizen Review Panel: What

To provide oversight to the Office of Children's Services and gather public input on how well the child protection system is working. The Panel does this primarily by visiting different regions of the state and talking to OCS staff and partner agencies about how well the system is working. The Panel produces an annual report for OCS which is also distributed to all members of Legislature.

Citizen Review Panel: Where

Statewide! Since 2008 we're been to the following communities.

- Anchorage
- Aniak
- Barrow
- Bethel
- Cantwell
- Chitina
- Copper Center
- Delta Junction
- Dillingham
- Fairbanks
- Gakona
- Glennallen
- Healy
- Hooper Bay
- Juneau
- Kenny Lake
- Ketchikan
- King Salmon
- Kodiak
- Kwigillingok
- Naknek
- Northway
- Nuquisut
- Palmer
- Petersburg
- Point Hope
- Saint Mary's
- Sitka
- Tok
- Unalaska
- Valdez
- Wainwright
- Wasilla
- Wrangell

Citizen Review Panel: When

The Panel has been active in Alaska since 2002.

Citizen Review Panel: Why

The Citizen Review Panel is mandated by state and federal law. The Panel was created through the federal Child Abuse Prevention & Treatment Act (CAPTA); Keeping Children & Families Safe Act of 2003 and through Alaska statute Sec. 47.14.205.

Benefits of CRP

- Seven volunteer members all contributing a minimum of 250 active hours annually
- We're the eyes and ears of the public for the Legislature and OCS
- Unique function of identifying and advocating for ancillary services that OCS cannot request
- Jointly we can achieve a vastly improved child protection system for the children of Alaska

Overview of presentation

- Last year's recommendations
- OCS' response
- This year's site reviews
- This year's recommendations

CRP recommendations from our work last year

Recommendations to OCS

1. The discrepancy between rural, bush and urban child protection be acknowledged and addressed.

Citizen Review Panel

CRP recommendations from our work last year

Recommendations to OCS

2. OCS front line workers have adequate support staff to allow them to focus on social work, not paperwork.

Citizen Review Panel

CRP recommendations from our work last year

Recommendations to OCS

3. Training for new OCS workers be modified to better reflect the on-the-ground reality of the job.

Citizen Review Panel

CRP recommendations from our work last year

Recommendations to the Legislature

1. The discrepancy between rural, bush and urban child protection be acknowledged and addressed.

Citizen Review Panel

CRP recommendations from our work last year

Recommendations to the Legislature

2. Fiscal responsibility for transportation of children to a child advocacy center be clarified.

Citizen Review Panel

CRP recommendations from our work last year

Recommendations to the Legislature

3. That a capital budget be formed to fund housing and facility work for OCS and its workers.

Citizen Review Panel

CRP recommendations from our work last year

Recommendations to the Legislature

4. That the State standardize resources available to all state agencies (internet, housing).

Citizen Review Panel

OCS Response to CRP Recommendations

1. Discrepancy of child protective services between urban and rural areas
   - "Safety is safety" regardless of location - same expectations, resources have been allocated to accomplish this
   - Acknowledged staff retention problems as a barrier - used staff from other areas when local staff could not be hired

OCS Response to CRP Recommendations

2. Lack of adequate support staff
   - Request updated workload study to determine additional staff requirements and what could be picked up by support staff
   - Undertaking in-house data study to examine caseload and resource distribution within the state
   - Commission a study to determine the best ratio of support staff to social workers

OCS Response to CRP Recommendations

3. Training for new workers
   - Updated training curriculum
   - Created supervisory strategic plan

Citizen Review Panel

CRP: This year's report card

- Overall, OCS doing a good job addressing the most pressing agency-wide issues
- It is a huge, ponderous, bureaucratic agency with a very challenging mission
- They are working hard to comply with the requirements from the federal Program Improvement Plan
- Those changes are reflected in better child protection policies and evolving practices

Visited Bethel & Wasilla

- Our mandate is to collect input from recipients of child protection services - families, foster families, community partners - and let legislature know what the grass roots perception is.
- This year we did that through two site visits.
  - Bethel and four surrounding villages
  - Wasilla, Palmer and Glennallen
- In May, Bethel was at a critical place because of staffing and administrative issues. The Western Region was funded and it is slowly becoming a reality. Staff recruitment and retention remains the biggest barrier.
- We did two site visits to Wasilla in August and December. Wasilla continues to struggle with its own unique set of challenges.

Site Visit Feedback on the Impact of Poor Worker Retention

- Our overall impression from the visiting communities is that the worker retention problem continues to affect child protection delivery and frustrate families and affiliated community agencies that partner with OCS.
- The shortage of workers in the field has been exacerbated due to vacancies and new workers out for training.
- There is a problem retaining experienced workers.
- There are continued complaints about lack of basic social work - returning phone calls, scheduling family visits, etc.
- There are frustrations in the court system because of continuances, late reports, detrimental court rulings, and children remaining in custody for too long.

2011 CRP Recommendations

1. Staff retention and allocation
   - Support OCS's efforts to evaluate staff ratios - PCN locations, social worker workload ratios, and ratios for social worker/support staff
   - Resources are scarce; they need to be spent as effectively as possible (e.g. not paying social workers to transport children, etc.)
   - Once the studies are completed, OCS will need financial support to implement the recommendations.

2011 CRP Recommendations

2. We renew our request from last year for legislative changes to standardize resources between state agencies
   - The Internet connection speed has certainly improved in the Bethel region, but needs to be on par with the Troopers, schools, etc. in other areas.
   - Housing is critical to retain staff in rural areas. No matter now excellent the policies and practices of OCS are, they will fail without staff to implement them.

2011 CRP Recommendations

3. External audit of Wasilla office
   - We support an external audit of the Wasilla OCS office
   - Should find opportunities to be more efficient; examine why cases stay open so long
   - There are staffing dynamics that are not successful, the audit will look for ways to resolve the problems

Most importantly

There is a widespread and consistent impression that the safety of children in Alaska remains compromised and is getting worse. This impression comes first and foremost from the line workers themselves in both regions. Community partners echoed this concern.

Alaska does not want to be a state that will not make changes until a child dies.

Citizen Review Panel

Alaska's Citizen Review Panel

For more information, please visit our website

www.crpalaska.org

Citizen Review Panel

SB

22

<TARGET><BILL>SB 22</BILL><SUBJECT>SB
22</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/11

Date of 5-Day Notice: 3/24/11
(in accordance with Uniform Rule 23)

FURTHER: Finance

DATE TURNED IN TO OFFICE: 3/30/11

Health and Social Services Committee considered SENATE BILL NO. 22

SB 22-STUDENT ATHLETE TRAUMATIC BRAIN INJURIES

"An Act relating to prevention and evaluation of and liability for traumatic brain injuries in student athletes."

and recommends:

[X] be **replaced** with **CS** SB 22 (HSS) [ ] *Same Title* [X] *New Title*

[ ] adopt **previous CS** _____ (_____) [ ] *Same Title* [ ] *New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
EED			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	DYSON	X			
		X			
	ELLIS	X			
	Meyer	X			
CHAIR:	DAVIS	X			

CS FOR SENATE BILL NO. 22(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR MCGUIRE

A BILL

FOR AN ACT ENTITLED

"An Act relating to prevention and evaluation of and liability for concussions in student athletes."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONCUSSIONS IN STUDENT ATHLETES; FINDINGS. The legislature finds that

(1) concussions rank among the most commonly reported traumatic brain injuries in children and adolescents who participate in sports and recreational activities;

(2) the United States Centers for Disease Control and Prevention estimates that as many as 3,900,000 concussions occur each year in the United States as a result of sports and recreational activities;

(3) a concussion is caused by a blow to or jarring of the head or body that causes the brain to move rapidly inside the skull, resulting in a mild to severe traumatic brain injury, which may occur with or without loss of consciousness, and may disrupt normal brain

function;

(4) a concussion may occur during an organized or unorganized sport or recreational activity as a result of a fall or from players colliding with each other or another obstacle;

(5) the risk of catastrophic injury or death from a concussion or other head injury increases when the injury is not properly evaluated and managed, and the athlete is allowed to continue to participate in sports or recreational activities following the concussion;

(6) although voluntary nationwide guidelines for managing concussion in sports recommend assessing concussions on an individual basis, with gradual return to play, athletes continue to be returned to play prematurely, putting them at risk for greater injury or death.

*** Sec. 2.** AS 14.30 is amended by adding new sections to article 3 to read:

Sec. 14.30.142. Concussions in student athletes: prevention and reporting. (a) The governing body of a school district shall consult with the Alaska School Activities Association to develop and publish guidelines and other information to educate coaches, student athletes, and parents of student athletes regarding the nature and risks of concussions. Guidelines developed under this section must include a description of the risks of return to play and standards for return to play, including the procedures required under (c) and (d) of this section.

(b) A school shall annually provide to a student and the parent or guardian of a student who is under 18 years of age written information on the nature and risks of concussions. A student may not participate in school athletic activities unless the student and the parent or guardian of a student who is under 18 years of age have signed a verification of receipt of the information required under this subsection.

(c) A student who is suspected of having sustained a concussion during a practice or game shall be immediately removed from the practice or game.

(d) A student who has been removed from participation in a practice or game for suspicion of concussion may not return to play until the student has been evaluated and cleared for participation in writing by a qualified person who has received training and is currently certified in the evaluation and management of concussions, as verified in writing by the qualified person. In this subsection, "qualified person" means either a

(1) licensed health care provider; or

(2) person who is acting at the direction and under the supervision of a licensed physician.

(e) A person who conducts an evaluation under (d) of this section and who is not paid for conducting the evaluation may not be held liable for civil damages resulting from an act or omission during the evaluation, except that the person may be held liable for reckless or intentional misconduct and for gross negligence.

Sec. 14.30.143. Concussions in student athletes: school district immunity. (a) A school district may not be held liable for an injury to or the death of a person resulting from the action or inaction of a person employed by or under contract with a nonprofit youth organization if

(1) the action or inaction occurred on school property during the delivery of services by the district or organization;

(2) the organization is under contract with the district to provide the services; and

(3) before the provision of services, the organization provided to the district written verification of

(A) a valid insurance policy covering the injury or death in an amount not less than $50,000 for each person and $100,000 for each incident;

(B) compliance with the protocol for prevention and reporting of concussions required in AS 14.30.142.

(b) This section may not be construed to impair or modify the ability of a person to recover damages for harm caused by the negligent or reckless actions of an employee or contractor of a school district or by the existence of a condition, equipment, program, or structure known by the school district or organization to be unsafe.

(c) In this section, "youth organization" means a public or private entity qualified to do business in the state that provides a program or service to persons under 19 years of age.

27-LS0250\B
Mischel
3/24/11

CS FOR SENATE BILL NO. 22( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR MCGUIRE

A BILL

FOR AN ACT ENTITLED

"An Act relating to prevention and evaluation of and liability for concussions in student athletes."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONCUSSIONS IN STUDENT ATHLETES; FINDINGS. The legislature finds that

(1) concussions rank among the most commonly reported traumatic brain injuries in children and adolescents who participate in sports and recreational activities;

(2) the United States Centers for Disease Control and Prevention estimates that as many as 3,900,000 concussions occur each year in the United States as a result of sports and recreational activities;

(3) a concussion is caused by a blow to or jarring of the head or body that causes the brain to move rapidly inside the skull, resulting in a mild to severe traumatic brain injury, which may occur with or without loss of consciousness, and may disrupt normal brain

function;

(4) a concussion may occur during an organized or unorganized sport or recreational activity as a result of a fall or from players colliding with each other or another obstacle;

(5) the risk of catastrophic injury or death from a concussion or other head injury increases when the injury is not properly evaluated and managed, and the athlete is allowed to continue to participate in sports or recreational activities following the concussion;

(6) although voluntary nationwide guidelines for managing concussion in sports recommend assessing concussions on an individual basis, with gradual return to play, athletes continue to be returned to play prematurely, putting them at risk for greater injury or death.

* **Sec. 2.** AS 14.30 is amended by adding new sections to article 3 to read:

Sec. 14.30.142. Concussions in student athletes: prevention and reporting. (a) The governing body of a school district shall consult with the Alaska School Activities Association to develop and publish guidelines and other information to educate coaches, student athletes, and parents of student athletes regarding the nature and risks of concussions. Guidelines developed under this section must include a description of the risks of return to play and standards for return to play, including the procedures required under (c) and (d) of this section.

(b) A school shall annually provide to a student and the parent or guardian of a student who is under 18 years of age written information on the nature and risks of concussions. A student may not participate in school athletic activities unless the student and the parent or guardian of a student who is under 18 years of age have signed a verification of receipt of the information required under this subsection.

(c) A student who is suspected of having sustained a concussion during a practice or game shall be immediately removed from the practice or game.

(d) A student who has been removed from participation in a practice or game for suspicion of concussion may not return to play until the student has been evaluated and cleared for participation in writing by a qualified person who has received training and is currently certified in the evaluation and management of concussions. In this subsection, "qualified person" means either a

(1) licensed health care provider; or

(2) person who is acting at the direction and under the supervision of a licensed physician.

(e) A person who conducts an evaluation under (d) of this section and who is not paid for conducting the evaluation may not be held liable for civil damages resulting from an act or omission during the evaluation, except that the person may be held liable for reckless or intentional misconduct and for gross negligence.

Sec. 14.30.143. Concussions in student athletes: school district immunity. (a) A school district may not be held liable for an injury to or the death of a person resulting from the action or inaction of a person employed by or under contract with a nonprofit youth organization if

(1) the action or inaction occurred on school property during the delivery of services by the district or organization;

(2) the organization is under contract with the district to provide the services; and

(3) before the provision of services, the organization provided to the district written verification of

(A) a valid insurance policy covering the injury or death in an amount not less than $50,000 for each person and $100,000 for each incident;

(B) compliance with the protocol for prevention and reporting of concussions required in AS 14.30.142.

(b) This section may not be construed to impair or modify the ability of a person to recover damages for harm caused by the negligent or reckless actions of an employee or contractor of a school district or by the existence of a condition, equipment, program, or structure known by the school district or organization to be unsafe.

(c) In this section, "youth organization" means a public or private entity qualified to do business in the state that provides a program or service to persons under 19 years of age.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Member

Senate Finance Committee
Senate Resources Committee
Senate Judiciary Committee
Senate Special Committee on World Trade, Technology, and Innovations

SENATOR LESIL MCGUIRE

SECTIONAL ANALYSIS

Senate Bill No. 22 (27-LS0250\A)

Section 1. Adds a new section to the uncodified law of the State of Alaska that lists findings related to Traumatic Brain Injury, especially with respect to children and adolescents who participate in sports and recreational activities. The section also defines what constitutes a concussion and points out that despite national guidelines recommending individual assessment and gradual return to play following concussions, student athletes are often returned to play prematurely resulting in risks of greater injury.

Section 2. Amends AS 14.30 by adding new sections to article 3 that would establish requirements for the governing body of a school district relating to consult with the Alaska School Activities Association relating to prevention and reporting of concussions.

Section 14.30.142 is a new section that includes provisions regarding prevention of concussions and reporting. It states that students will be immediately removed from practice or a game if suspected of having a concussion or traumatic brain injury and that before returning to play or practice, the student must be cleared by a licensed health care provider who has received training in evaluating and managing traumatic brain injuries. This Section also explains that an evaluator may not be held liable for civil damages unless he/she acted recklessly, with intentional misconduct, or gross negligence.

Section AS 14.30.143 additionally states that a school district may not be held liable for injury or death resulting from the action or inaction of an employee or contractor with a non-profit youth organization under certain circumstances.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB 22**
() Publish Date

Identifier (file name) SB022-EED-TLS-3-25-11
Dept. Affected: EED
Title: "An Act relating to prevention and evaluation of and liability for traumatic brain injuries in student athletes."
Appropriation: Teaching & Learning Support
Allocation: Student & School Achievement
Sponsor: Sen. McGuire
Requester: (S)H&SS
OMB Component Number: 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

initial version

Prepared by: Cynthia Curran, Director — Phone: 465-2857
Division: Teaching & Learning Support — Date/Time: 3/25/11 4:52 PM
Approved by: Mike Hanley, Commissioner — Date: 3/25/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 22

Analysis

This legislation has no fiscal impact on the Department of Education and Early Development.

alaska brain injury network

3745 Community Park Loop, Ste. 140
Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

The Honorable Lesil McGuire
Alaska Senate
Alaska State Capitol, Rm 125
Juneau, Alaska 99801

Dear Senator McGuire,

Thank you for introducing HB 15, an act relating to prevention and evaluation of and liability for concussions in student athletes.

The Alaska Brain Injury Network, Inc (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury. ABIN's eighteen member board represents all regions of Alaska and at least 50 percent are TBI survivors or family members. We fully support HB 15.

ABIN has become the leader in understanding the needs of Alaskans with brain injury. ABIN has heard from 800 Alaskans requesting brain injury services since 2007. In addition, ABIN has heard public testimony from hundreds of Alaskans from Anchorage, Juneau, Fairbanks, Kenai, Barrow, Nome, Kodiak, Dillingham, Bethel, Copper River Basin, Tok, Ketchikan, Sitka, Homer, and more.

There are an estimated 10,000 Alaskans who have experienced long-term difficulties from a moderate to severe brain injury. The number of Alaskans experiencing a concussion or Mild TBI (mTBI) who visit the emergency department is estimated at 3,000 per year. Concussion and brain injury need to be taken seriously. With proper diagnoses, management, and treatment, research shows 80-90 percent of people experiencing a concussion or mTBI will recover fully. HB 15 is vital to ensuring our youth athletes have the best chance of recovery after an injury. When a concussion is not properly managed, prolonged recovery or even death from a second impact may result.

The National Football League, National Hockey League, the United States Olympic teams, majority of collegiate teams, and most recently in many states, even high school and youth sports teams have protocols and guidelines for concussion identification and return to play. Many of the leagues also require a cognitive baseline which is the first step to providing the best data to assess for a concussion when symptoms appear. If an athlete is suspected of a concussion, the assessment guidelines and return to play protocol are in place for the safety of the athlete, as well as ensuring the team has the strongest players in the game. A player who is normally elite, but then suffers a concussion, may temporarily have difficulty making quick decisions, their speed and reaction time may be compromised, and they may clumsily handle the ball. This compromised state caused by the concussion may hinder the team, and more importantly may put the athlete at risk for serious, life-long disability. No one wants to see an athletic child or young adult become disabled due to a decision to keep a kid in the game for a win or because of lack of education of what concussion symptoms may look like.

HB 15 will ensure that coaches have a basic understanding of concussion, student athletes will begin to understand the seriousness of concussion on and off the field, and parents may begin to understand brain injury better as well. This legislation is an opportunity to improve the public's awareness of the seriousness of concussion and brain injury, and keep our student athletes safe.

The future of our state depends on the brains of the individuals that reside here. HB 15 is one tool to giving Alaska's youth the best opportunity to become community and business leaders as adults.

The Alaska Brain Injury Network appreciates your leadership in sponsoring this important legislation. You have our support.

Sincerely,

Jill Hodges
Executive Director

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

March 15, 2011

Representative Doogan,

The Alaska Athletic Trainers Association fully supports the language of House Bill 15 and Senate Bill 22, *Student Athlete Traumatic Brain Injuries*. This legislation serves to raise awareness and protect youth athletes from the risks of concussions. The Alaska Athletic Trainers Association pledges to support the following key elements: (1) concussion education for young athletes, parents and coaches; (2) immediate removal of a student athlete who appears to have suffered a concussion from play or practice; and (3) mandatory clearance of that student by a health care professional who is trained in the evaluation and management of concussions before returning to play or practice.

Athletic trainers are health care professionals who specialize in the prevention, diagnosis, treatment and rehabilitation of injuries and sport-related illnesses. We prevent and treat chronic musculoskeletal injuries from sports, physical and occupational activity, and provide immediate care for acute injuries. Athletic trainers offer a continuum of care that is unparalleled in health care.

The Alaska Athletic Trainers Association is also working toward licensing athletic trainers in the state of Alaska. A licensed athletic trainer is one who has established qualifications and works within a scope of practice. Alaska is one of only three states that do not regulate athletic trainers and we feel it is time to change that. We hope you will support our professional endeavor for licensing athletic trainers in Alaska.

Sincerely,

B. Shelden

Brenda Shelden
Certified Athletic Trainer
President of the Alaska Athletic Trainers Association
(907)841-8942

HEADS UP!

NFL Commissioner Roger Goodell talks about the importance of protecting student athletes from traumatic head injuries.

Roger Goodell, the eighth chief executive in the NFL's 90-year history, took office in 2006. He spoke with State Legislatures about the importance of laws to help prevent young athletes from suffering traumatic brain injuries.

STATE LEGISLATURES: Why is the NFL working with state legislatures on laws dealing with youth sports concussions?

Goodell: Together, we can make sports, which are essential for so many of our kids, safer. Sports teach teamwork, perseverance, dedication and commitment that will serve kids well throughout their lives. Youth sports are safe, but we can make them even safer, especially with regard to head injuries.

We are changing the culture in the NFL with regard to concussions. Doctors—not coaches—are making the decisions regarding when a player returns to a game. When we in the NFL change our approach, we are told by youth coaches and parents that others on all levels take notice and follow.

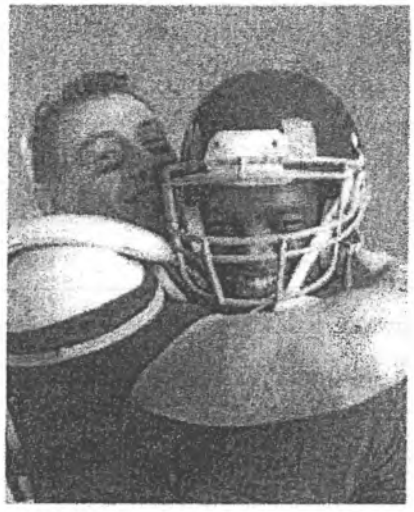
As more is learned about the ways to manage concussions, the NFL will continue to lead by example. The medical literature says risks associated with concussion are greatest when the brain is still developing, so the greatest care must be taken with young athletes.

We have made it a priority to support laws that address youth concussions across the country. We are building on the work done in the Washington Legislature with the 2009 Zackery Lystedt law, which is a model we encourage all states to follow.

SL: What are the primary elements of a substantive law?

Goodell: It is a remarkably simple idea, but one that protects our young athletes from the worst risks of concussion. The law contains three core principles:

◆ Educate athletes and their parents or guardians about concussions.



◆ Remove an athlete who may have suffered a concussion from play.

◆ Allow athletes to return to play only after being cleared by a licensed health care provider.

The law requires every child, as well as the parent or guardian, to sign an information sheet regarding concussions and their symptoms every year. Second, since children are at risk if they have suffered a concussion, they must be removed from competition immediately. Finally, only a licensed health care provider trained in the management of concussions should determine whether the child is able to return to play. These three simple steps will help prevent unnecessary head injuries to our children.

SL: Why should states pass this law?

Goodell: Concussions are brain injuries. They are an important public health concern in all sports. Girls experience concussions at significant rates in soccer; boys who play football, wrestle or play hockey suffer concussions as well. Experts also tell us that removing children immediately from play or practice and allowing them to recover completely is the best way to keep concussions from having long-term effects. We owe it to our children to adopt this law.

SL: Why aren't medical guidelines sufficient?

Goodell: In a matter as important as the health of our children's brains, we owe them the best, most comprehensive response. Laws raise awareness. Laws mandate change. Laws create uniform application of these standards. Guidelines are a second best alternative but they risk sporadic or inconsistent enforcement in different regions in a state.

SL: What does this law cost?

Goodell: There is no cost. There are no state expenditures, or costs borne by the school district. Washington Governor Christine Gregoire has told us that her state passed this law without creating any new costs to the taxpayers. There is, however, a significant cost associated with the emergency care and long-term rehabilitation in the tragic circumstances when a child suffers a traumatic brain injury. This law helps prevent burdens on the health care system and on the school district. Most important, this law spares the emotional cost to the family and the child associated with these injuries.

SL: Which states have passed these laws?

Goodell: New Jersey, in December 2010, became the ninth state to pass a substantive law. The other states are Connecticut, Massachusetts, New Mexico, Oklahoma, Oregon, Rhode Island, Virginia and Washington. We congratulate all of them and thank these legislators for their leadership.

SL: What can the NFL do?

Goodell: First of all, we can help raise awareness in a positive way on this issue. I am on record that we will help pass laws in at least 10 more states in 2011. My office and the 32 NFL clubs will contribute to legislative advocacy around youth concussions in the states that choose to address this important public health issue this year.

SL ONLINE

Check out more from the NFL on preventing youth concussions and who to contact at the league for additional information at www.ncsl.org/magazine.

Doctors Throw Flags On High School Concussions

by JON HAMILTON

Matt Strasen/AP

Malcom Brown (left) is hit by Jake Smith on a kickoff return during a high school state championship game in Arlington, Texas, in December. Sports medicine professionals and the NFL are calling for tougher regulations on head injuries sustained by young athletes.

February 2, 2011

In the Super Bowl this weekend, any player who takes a shot to the head and shows signs of a concussion will be taken out of the game. But it's a different story for high school athletes, who sometimes play on despite a head injury.

So the NFL, the American College of Sports Medicine and a long list of other groups are joining together to support state laws designed to protect the brains of young athletes.

Enlarge Bill Pugliano/Getty Images

The groups say they're concerned because each year more than 60,000 high school athletes sustain a concussion. It's an injury that temporarily affects brain function, though it may or may not cause a person to lose consciousness.

It's not just football players who get concussions — it's male and female athletes involved in soccer, wrestling, basketball, baseball, field hockey — even volleyball. Many of these athletes never get an evaluation that would reveal their injury.

Steve Cohen, a member of the House Judiciary Committee, examines the helmet of Lem Barney, a former player for the Detroit Lions. A committee hearing last year evaluated steps taken at the professional, college and high school levels to deal with football brain injuries.

"Unfortunately, kids at the youth sports level don't have neurosurgeons, neurologists and some of the finest doctors on the sidelines," says Jeff Miller, a senior vice president of the National Football League. "It's just not practicable."

The coalition wants every state to have a law like the Lystedt Law, passed in Washington in 2009 and named after Zackery Lystedt, a teenager who sustained a serious brain injury during a middle school football game in 2006. Lystedt's head struck the ground in the first half, but he was allowed to keep playing. When he took another shot to the head late in the game, the result was devastating.

The Lystedt Law says an athlete suspected of having a head injury must be removed from competition. That's because even a minor injury to the brain can make it highly vulnerable to further damage.

You don't want coaches making medical decisions. That isn't their core competency.

- Jim Whitehead, executive vice president, American College of Sports Medicine

Easing Back Into The Classroom

A concussion law might have helped Sarah Rainey, a high school soccer player in Alexandria, Va., who took a violent hit during a game 10 months ago.

"I thought I just got the wind knocked out of me, and I told my coaches and the trainer that I was OK," she says. "I passed the sideline evaluation. I played the remaining five minutes and then two overtime periods."

But after the game, Rainey began experiencing headaches, nausea and fuzzy thinking. Her father took her to an emergency room where doctors told her she'd suffered a concussion and sent her home.

Damien Meyer/AFP/Getty Images

Not only football players are at risk for head injuries — soccer, basketball and volleyball players can sustain concussions, too. Michael Ciani, a defender for the French soccer team Bordeaux, heads the ball during a French Cup match on Jan. 22.

When she returned to school just a few days after the injury, she found that trying to read small print, looking at a computer screen and even her teachers' voices could trigger headaches and nausea.

It was two months before Rainey could get through a full day of school, and four months before her brain was back to normal.

She was treated by Gerry Gioia, who runs the Safe Concussion Outcome Recovery & Education (SCORE) Program at Children's National Medical Center in Washington, D.C. Gioia is also part of the coalition pushing for concussion laws.

No law could have prevented Rainey's concussion, Gioia says. But a law might have helped limit the damage.

"The problem is that she was let back into the game later on," he says. "It's hard to know exactly the contribution of that. She didn't take another hit, but certainly she was overworking that body and brain during the period of this metabolic crisis."

Rainey also returned to class too soon — something else a law could have prevented, Gioia says. He says an injured brain is like a sprained ankle. It heals faster if you don't use it too much.

"As you're learning and thinking and doing all that good performance activity in the school, that's demanding more from your brain than it can handle," Gioia says. "It's taking away the important energy toward recovery, and it basically then is affecting negatively your recovery."

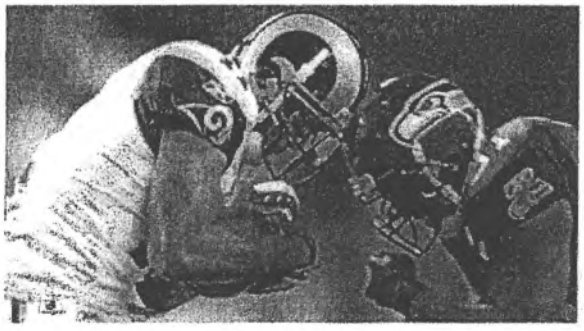
Unfortunately kids at the youth sports level don't have neurosurgeons, neurologists and some of the finest doctors on the sidelines.

- Jeff Miller, senior vice president, NFL

The coalition wants concussion laws to include provisions for easing injured students back into the classroom.

Relying On Medical Professionals

But for any of the laws to work, athletes who take a blow to the head need a proper evaluation from a trained medical professional, says Jim Whitehead, executive vice president of the American College of Sports Medicine.



Otto Greule Jr./Getty Images
Seahawks defensive end Chris Clemons (right) hits Brandon Gibbons during a game on Jan. 2 in Seattle. Clemons' head-first hit drew a personal foul.

"You don't want coaches making medical decisions," he says. "That isn't their core competency. So you want to take any of those things out of the hands of people who really aren't qualified to make those judgments, and put it in the hands of professionals who are."

That's why the coalition supports laws that call for training coaches and others on the sideline not to diagnose a concussion, but to recognize subtle signs in an athlete that could mean a concussion.

"And if there's any doubt whatsoever, you sit the athlete until he or she has been cleared by a health professional," Whitehead says.

About 10 states, including Virginia, have passed youth concussion laws. The coalition's goal is to get laws in at least 10 more states by the end of the year.

Youth Concussion Education, Awareness and Advocacy

AMERICAN COLLEGE of SPORTS MEDICINE

USA Football — Football's National Governing Body

NFL

BRAIN INJURY ASSOCIATION OF WASHINGTON

Table of Contents

Introductory Letter

Frequently Asked Questions about Concussion-Prevention Laws

Zackery Lystedt Law
- Washington State Law
- Washington State Concussion Information Sheet
- Letter from Governor Gregoire to NFL Commissioner Goodell

CDC *Heads Up: Concussion in Youth Sports* Materials
- Training Course
- Fact Sheet for Parents
- Fact Sheet for Athletes
- Concussion: A Must Read for Young Athletes Poster

USA Football Materials

National Athletic Trainers' Association Press Release

Contacts

The National Football League, USA Football, the Brain Injury Association of Washington, and the American College of Sports Medicine, among many other organizations, strongly support the adoption of laws to prevent traumatic brain injury in youth athletes in all fifty states. The Zackery Lystedt law, passed in Washington state, through the efforts and hard work of advocates in the medical, educational and athletic fields represents model legislation. The bill includes three elements essential to protecting youth athletes in all sports:

(1) Inform and educate youth athletes, their parents and guardians and require them to sign a concussion information form;
(2) Removal of a youth athlete who appears to have suffered a concussion from play or practice at the time of the suspected concussion; and
(3) Requiring a youth athlete to be cleared by a licensed health care professional trained in the evaluation and management of concussions before returning to play or practice.

This packet of materials includes information about the Zackery Lystedt law and frequently asked questions regarding it. In addition, educational materials on the topic of youth concussions are included. These documents published by the Centers for Disease Control and Prevention and USA Football and endorsed by the American College of Sports Medicine, the National Football League, USA Football, and the Brain Injury Association of Washington will provide significant information about youth concussions.

As of November 2010, nine states have adopted laws containing the three key provisions of the Zackery Lystedt law. We encourage you to adopt a similar law in your state and encourage you to reach out to our organizations if we can be of assistance.

Sincerely,

Jeffrey A. Miller
Vice President
Government Relations and Public Policy
National Football League

Stanley A. Herring, M.D.
Chairman
Advocacy and Education Subcommittee
NFL Head, Neck and Spine Committee

Richard Adler
Chairman/President
Executive Board
Brain Injury Association-Washington

James R. Whitehead
Executive Vice President and CEO
American College of Sports Medicine

Scott Hallenbeck
Executive Director
USA Football

FREQUENTLY ASKED QUESTIONS ABOUT CONCUSSION-PREVENTION LAWS

How widespread are concussions among youth athletes?

An estimated 400,000 high school athletes sustained concussions while participating in five major male sports and four major female sports during the 2005-2008 school years[i]. In addition, experts believe that the prevalence of sports-related concussions among young people in all sports is significantly higher than reported.

Moreover, the number of youth athletes taken to emergency rooms with sports-related concussions doubled during the 10-year-period from 1997 to 2007[ii]. Meanwhile, among youth aged 14 to 19, emergency room visits for concussions sustained during team sports more than tripled over the same period[iii].

What dangers do these head injuries pose to young athletes?

A concussion is a type of traumatic brain injury, or TBI, which changes the way the brain normally works. Recognizing and responding to concussions when they first occur help to aid recovery and to prevent prolonging concussion symptoms, chronic brain damage or even death. Yet, a recent study estimated that more than 40 percent of high school athletes return to participate in school athletics before they have fully recovered from these serious head injuries[iv].

Do concussions involve youth athletes in all sports and at any age or is it just an injury sustained by boys who play football?

Concussions can occur in athletes of any age and in any sport or recreational activity. In fact, each year, U.S. emergency departments treat an estimated 135,000 sports-related and recreation-related TBIs, including concussions, among children ages 5 to 18[v]. In addition, children and teens are more likely to get a concussion and take longer to recover than adults. While youth sports concussions often are associated with football, the rate of concussions in girl's high school soccer is almost as high. Research also indicates that there may be gender differences in how boys and girls recover from concussions.[vi]

How many states have enacted laws related to concussion-awareness, prevention and management?

As of October 2010, eight states have adopted similar concussion-awareness and prevention laws initially adopted in Washington, known as the Zackery Lystedt law, including Oregon, New Mexico, Connecticut, Oklahoma, Virginia, Massachusetts and Rhode Island. In many other states, active coalitions are pushing to enact similar legislation.

What are the key elements of a concussion-prevention and management bill?

An effective concussion-prevention bill follows the example of the State of Washington's Zackery Lystedt law. It includes three essential elements: (1) inform and educate student athletes, their parents and guardians and require them to sign a concussion information form; (2) removal of a student-athlete who appears to have suffered a concussion from play or practice at the time of the suspected

concussion; and (3) requiring an athlete to be cleared by a licensed medical professional trained in the evaluation and management of concussions before returning to play or practice.

There is an international consensus on return to play guidelines for youth, adopted at the 3rd International Conference on Concussion in Sport in Zurich, in November 2008, which states that "It is not appropriate for a child or adolescent athlete with concussion to RTP on the same day as the injury regardless of the level of athletic performance."[vii]

What is the cost of implementing a concussion prevention and awareness bill?

Zero. The bill is revenue neutral. There are no mandates in the bill and no requirements that resources be spent to hire or train medical professionals or to purchase equipment. Free information on concussions for high school and youth coaches, parents, athletes, as well as school professionals is publicly available on the Centers for Disease Control and Prevention's (CDC) website at www.cdc.gov/Concussion, including a youth concussions poster found at www.cdc.gov/concussion/pdf/poster_Eng.pdf designed to hang in every locker room across the country.

What are the penalties for violating the concussion prevention and awareness law? Who is liable if the law is not followed?

There is no liability attached to Washington's Zackery Lystedt law. It does not mandate any civil or criminal penalties, nor does it create greater liability for individuals and/or organizations. Indeed, the education and awareness efforts and requirement of medical clearance before return to play has decreased the variability of care and decreased liability. Wherever the law is passed, the community can determine if and how to monitor and enforce the law.

What about implementing the law in rural areas where it may be more challenging to find medical professionals?

The law does not require a specific medical specialist to participate in every evaluation. Rather, the language of the Washington statute requiring an athlete "to be cleared by a licensed medical professional trained in the evaluation and management of concussions before returning to play or practice" permits a wide range of qualified individuals to determine a youth athlete's suitability for returning to play. For example, in Washington State, the Washington Interscholastic Activities Association decided that qualifying medical professionals included: medical doctors, osteopaths, nurse practitioners, athletic trainers, and physician assistants.

What is the impact of concussion-prevention laws on private sports organizations?

These laws may be written in such a way as to apply not only to public sports organizations but also to private sports organizations, many of which maintain public-sector connections/affiliations (such as the use of public facilities). For example, in Washington private sports groups are required by law to carry insurance to play on publicly-owned playing fields. The Zackery Lystedt law amended that insurance-based law to require private nonprofits to comply with the policies on the management of concussions and head injuries in youth sports.

What impact have concussion-prevention laws had in states that have passed them?

The Zackery Lystedt law was the first concussion-prevention state law to pass in 2009. While no comprehensive and detailed assessment can yet be made, early and anecdotal data suggests that the law is having an immediate and positive impact. It is helping meet a critical goal -- preventing preventable brain injuries and making sports and recreational activities safer for youth.

What organizations have supported such measures?

A broad coalition of groups representing teachers and parents, sports medicine, medical professionals, school administrators, the disability community and athletic organizations have supported concussion-prevention legislation at the state and federal level. These organizations include the National Football League, American College of Sports Medicine, USA Football, National School Boards Association, Parent Teacher Association, National Association of School Nurses, National Council of Youth Sports, The Sarah Jane Brain Foundation, National Disability Rights Network, National Athletic Trainers' Association, National Association of Health and Fitness, the Brain Injury Association of America, the Brain Injury Association of Washington, and many others.

What law, if any, has Congress proposed or passed regarding concussion prevention and awareness?

The "Protecting Student Athletes from Concussions Act of 2010" incorporates the same core principles of the Lystedt law and was introduced in Congress in September of 2010. If passed, the bill would require school districts to develop and implement a minimum standard, community-based plan for concussion safety and management. Of course, states would be able to implement standards far exceeding these basic, minimum standards.

Where may I find/read a copy of the Zackery Lystedt law?

The Zackery Lystedt law may be found in this packet. It may also be found online by visiting: http://www.leg.wa.gov/CodeReviser/documents/sessionlaw/2009pam3.pdf

Where may I find more information about the dangers of concussions and passing a law in my state?

More information about concussions may be found on the website of the CDC. You also may watch an NFL-produced video about enacting a concussions-prevention law in your state, which is available at NFL.com/youthconcussions and on the CDC's website as well.

---

[i] Nationwide Children's Hospital, Concussions Clinic, Ohio State University
[ii] Bakhos L., Linakis J., et al. "Emergency Department Visits for Concussions in Young Child Athletes," Pediatrics, 2010.
[iii] Ibid.
[iv] Center for Injury Research and Policy at Nationwide Children's Hospital, Columbus, Ohio
[v] Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, 2007.
[vi] Journal of Athletic Training, 2007
[vii] McCrory P, Meeuwisse W, et al. "Consensus Statement on Concussion in Sport, 3rd International Conference on Concussion in Sport," Clinical Journal of Sports Medicine, 2009.

CERTIFICATION OF ENROLLMENT

ENGROSSED HOUSE BILL 1824

Chapter 475, Laws of 2009

61st Legislature
2009 Regular Session

YOUTH SPORTS--HEAD INJURY POLICIES

EFFECTIVE DATE: 07/26/09

Passed by the House April 20, 2009
Yeas 98 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 2, 2009
Yeas 45 Nays 0

BRAD OWEN

President of the Senate

Approved May 14, 2009, 11:24 a.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED HOUSE BILL 1824** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

May 18, 2009

Secretary of State
State of Washington

ENGROSSED HOUSE BILL 1824

AS AMENDED BY THE SENATE

Passed Legislature - 2009 Regular Session

State of Washington 61st Legislature 2009 Regular Session

By Representatives Rodne, Quall, Anderson, Liias, Walsh, Pettigrew, Priest, Simpson, Kessler, Rolfes, Johnson, Sullivan, and Morrell

Read first time 01/30/09. Referred to Committee on Education.

AN ACT Relating to requiring the adoption of policies for the management of concussion and head injury in youth sports; amending RCW 4.24.660; and adding a new section to chapter 28A.600 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 4.24.660 and 1999 c 316 s 3 are each amended to read as follows:

(1) A school district shall not be liable for an injury to or the death of a person due to action or inaction of persons employed by, or under contract with, a youth program if:

(a) The action or inaction takes place on school property and during the delivery of services of the youth program;

(b) The private nonprofit group provides proof of being insured, under an accident and liability policy issued by an insurance company authorized to do business in this state, that covers any injury or damage arising from delivery of its services. Coverage for a policy meeting the requirements of this section must be at least fifty thousand dollars due to bodily injury or death of one person, or at least one hundred thousand dollars due to bodily injury or death of two or more persons in any incident. The private nonprofit shall also

provide a statement of compliance with the policies for the management of concussion and head injury in youth sports as set forth in section 2 of this act; and

(c) The group provides proof of such insurance before the first use of the school facilities. The immunity granted shall last only as long as the insurance remains in effect.

(2) Immunity under this section does not apply to any school district before January 1, 2000.

(3) As used in this section, "youth programs" means any program or service, offered by a private nonprofit group, that is operated primarily to provide persons under the age of eighteen with opportunities to participate in services or programs.

(4) This section does not impair or change the ability of any person to recover damages for harm done by: (a) Any contractor or employee of a school district acting in his or her capacity as a contractor or employee; or (b) the existence of unsafe facilities or structures or programs of any school district.

NEW SECTION. **Sec. 2.** A new section is added to chapter 28A.600 RCW to read as follows:

(1)(a) Concussions are one of the most commonly reported injuries in children and adolescents who participate in sports and recreational activities. The centers for disease control and prevention estimates that as many as three million nine hundred thousand sports-related and recreation-related concussions occur in the United States each year. A concussion is caused by a blow or motion to the head or body that causes the brain to move rapidly inside the skull. The risk of catastrophic injuries or death are significant when a concussion or head injury is not properly evaluated and managed.

(b) Concussions are a type of brain injury that can range from mild to severe and can disrupt the way the brain normally works. Concussions can occur in any organized or unorganized sport or recreational activity and can result from a fall or from players colliding with each other, the ground, or with obstacles. Concussions occur with or without loss of consciousness, but the vast majority occurs without loss of consciousness.

(c) Continuing to play with a concussion or symptoms of head injury leaves the young athlete especially vulnerable to greater injury and

even death. The legislature recognizes that, despite having generally recognized return to play standards for concussion and head injury, some affected youth athletes are prematurely returned to play resulting in actual or potential physical injury or death to youth athletes in the state of Washington.

(2) Each school district's board of directors shall work in concert with the Washington interscholastic activities association to develop the guidelines and other pertinent information and forms to inform and educate coaches, youth athletes, and their parents and/or guardians of the nature and risk of concussion and head injury including continuing to play after concussion or head injury. On a yearly basis, a concussion and head injury information sheet shall be signed and returned by the youth athlete and the athlete's parent and/or guardian prior to the youth athlete's initiating practice or competition.

(3) A youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time.

(4) A youth athlete who has been removed from play may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives written clearance to return to play from that health care provider. The health care provider may be a volunteer. A volunteer who authorizes a youth athlete to return to play is not liable for civil damages resulting from any act or omission in the rendering of such care, other than acts or omissions constituting gross negligence or willful or wanton misconduct.

(5) This section may be known and cited as the Zackery Lystedt law.

Passed by the House April 20, 2009.
Passed by the Senate April 2, 2009.
Approved by the Governor May 14, 2009.
Filed in Office of Secretary of State May 18, 2009.

(INSERT SCHOOL/ORGANIZATION NAME HERE)
Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
• Headaches • "Pressure in head" • Nausea or vomiting • Neck pain • Balance problems or dizziness • Blurred, double, or fuzzy vision • Sensitivity to light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns	• Amnesia • "Don't feel right" • Fatigue or low energy • Sadness • Nervousness or anxiety • Irritability • More emotional • Confusion • Concentration or memory problems (forgetting game plays) • Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
• Appears dazed • Vacant facial expression • Confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or displays incoordination • Answers questions slowly • Slurred speech • Shows behavior or personality changes • Can't recall events prior to hit • Can't recall events after hit • Seizures or convulsions • Any change in typical behavior or personality • Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 6/15/2009

(INSERT SCHOOL/ORGANIZATION NAME HERE)

Concussion Information Sheet

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new "Zackery Lystedt Law" in Washington now requires the consistent and uniform implementation of long and well-established return-to-play concussion guidelines that have been recommended for several years:

> "a youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time"
>
> and
>
> "...may not return to play until the athlete is evaluated by a licensed heath care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Student-athlete Name Printed	Student-athlete Signature	Date
Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 6/15/2009

CHRISTINE O. GREGOIRE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • www.governor.wa.gov

December 8, 2010

Roger Goodell, Commissioner
National Football League
280 Park Avenue, Floor 12W
New York, NY 10017-1206

Dear Commissioner Goodell:

From the time I was first approached to support a law to protect youth athletes from the risks of concussions, I have focused on, and learned much about, this important issue. We all share the desire to protect our children from serious, yet preventable, health risks. This is why I am pleased to share Washington State's experience with the Zackery Lystedt Law.

I feel it is my responsibility to protect the health and safety of our young athletes while carefully limiting the cost to Washington State taxpayers. Our state, like many others in our country, is facing significant budget challenges, so any new expenditures have to be carefully scrutinized.

I am thrilled to report that the Zackery Lystedt Law is working. We are seeing a decrease in concussions and other head injuries in our student athlete population. I believe the adoption of this important legislation has saved our state money in emergency medical care, rehabilitation, and other services children need when they suffer the consequences of untreated brain injuries. In addition, school districts have not been required to hire medical professionals or trainers, and no additional significant investments were needed to comply with this law.

Thank you for your leadership in working to have a version of the Zackery Lystedt Law adopted around the country. Please feel free to share this with other states as you work to keep our country's children active and safe.

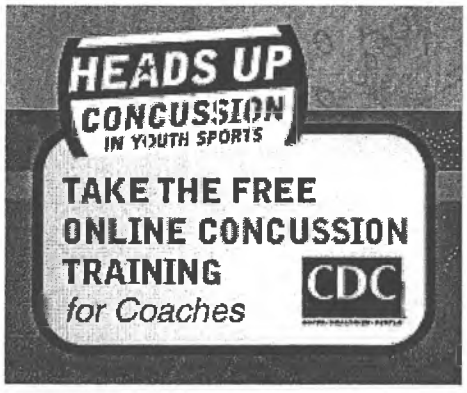
Sincerely,

Chris

Christine O. Gregoire
Governor

Happy holidays!

Centers for Disease Control and Prevention
Your Online Source for Credible Health Information



Heads Up Online Training Course

Heads Up: Concussion in Youth Sports is a free, online course available to coaches, parents, and others helping to keep athletes safe from concussion. It features interviews with leading experts, dynamic graphics and interactive exercises, and compelling storytelling to help you recognize a concussion and know how to respond if you think that your athlete might have a concussion.

What You Will Learn

This course will help you:

- Understand a concussion and the potential consequences of this injury,
- Recognize concussion signs and symptoms and how to respond,
- Learn about steps for returning to activity (play and school) after a concussion, and
- Focus on prevention and preparedness to help keep athletes safe season-to-season.

You can help make your league and school sports safer and healthier for all athletes. Learn when to make the call to pull an athlete off the field, ice, court, or track, and work with athletes, parents, and league and school officials to implement a concussion action plan and prevention strategies.

Course Highlights

Concussion Basics

- Understand concussion and what happens to the brain,
- Discover what causes a concussion, and
- Learn the potential consequences of concussion.

Recognize and Respond to a Suspected Concussion

- Focus on what to look for and when to pull athletes out of play,
- Watch for danger signs and seeking immediate medical attention, and
- Learn the four-step, "Heads Up" action plan when a concussion is suspected.

Helping Athletes Get Back to Play and to School

- Characterize the gradual steps for returning to activity (play and school), and
- Review a concussion preparedness checklist to guide you through pre-, mid-, and post-seasons.

Resource Center

- Access additional concussion information, videos, presentations by leading experts, fact sheets, communication strategies for talking with parents and athletes, and other tools.

Click here to take the training

Follow us on Facebook and learn more about concussion: www.cdc.gov/Concussion.

Page last reviewed: August 24, 2010
Page last updated: August 24, 2010
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day - cdcinfo@cdc.gov

USA.gov Government Made Easy

HEADS·UP CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports ***one or more*** symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed by Parents or Guardians	Symptoms Reported by Athlete
• Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness *(even briefly)* • Shows mood, behavior, or personality changes • Can't recall events *prior* to hit or fall • Can't recall events *after* hit or fall	• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first—usually within a short period of time (hours, days, or weeks)—can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine."
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

If you think your teen has a concussion:
Don't assess it yourself. Take him/her out of play. Seek the advice of a health care professional.

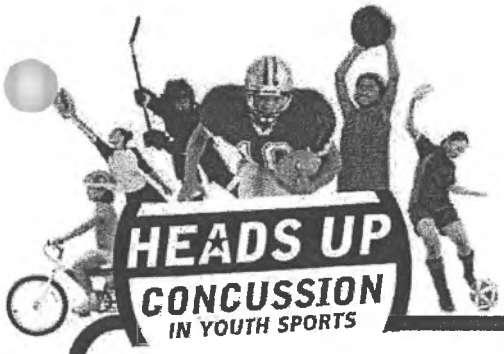
It's better to miss one game than the whole season.

For more information and to order additional materials ***free-of-charge***, visit: **www.cdc.gov/Concussion.**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

June 2010

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



A Fact Sheet for **ATHLETES**

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practices or games in any sport
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged"

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.
- **Get a medical check up.** A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

HOW CAN I PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be:
  - > The right equipment for the game, position, or activity
  - > Worn correctly and fit well
  - > Used every time you play

It's better to miss one game than the whole season.

For more information and to order additional materials free-of-charge, visit:
www.cdc.gov/ConcussionInYouthSports

For more detailed information on concussion and traumatic brain injury, visit:
www.cdc.gov/injury

July 2007

CONCUSSION

A Must Read for Young Athletes | Let's Take Brain Injuries Out of Play

CONCUSSION FACTS

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a blow to the head or body:
  - from contact with another player, hitting a hard surface such as the ground, ice, or court, or
  - being hit by a piece of equipment such as a lacrosse stick, hockey puck, or field hockey ball.
- A concussion can happen even if you haven't been knocked unconscious.
- If you think you have a concussion, you should not return to play on the day of the injury and until a health care professional says you are OK to return to play.

CONCUSSION SYMPTOMS

- Concussion symptoms differ with each person and with each injury, and may not be noticeable for hours or days. Common symptoms include:
  - Headache
  - Confusion
  - Difficulty remembering or paying attention
  - Balance problems or dizziness
  - Feeling sluggish, hazy, foggy, or groggy
  - Feeling irritable, more emotional, or "down"
  - Nausea or vomiting
  - Bothered by light or noise
  - Double or blurry vision
  - Slowed reaction time
  - Sleep problems
  - Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

WHY SHOULD I REPORT MY SYMPTOMS?

- Unlike with some other injuries, playing or practicing with concussion symptoms is dangerous and can lead to a longer recovery and a delay in your return to play.
- While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and the likelihood of long term problems.
- In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to your brain. They can even be fatal.

For more information about concussion and other types of traumatic brain injuries, go to

www.cdc.gov/Concussion

A part of CDC's Heads Up series

What Should I Do if I Think I Have a Concussion?

DON'T HIDE IT, REPORT IT. Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.

GET CHECKED OUT. Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

TAKE CARE OF YOUR BRAIN. A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

All concussions are serious. *Don't hide it, report it. Take time to recover.*

It's better to miss one game than the whole season.

Football's National Governing Body

USA Football serves as the sport's national governing body on youth and amateur levels. An independent non-profit based in downtown Indianapolis, USA Football leads the game's development, inspires participation and ensures a positive experience for all youth and amateur players. USA Football was endowed by the NFL Youth Football Fund in 2002.

Working in partnership with the Centers for Disease Control and Prevention since 2007 as well as other credentialed medical organizations and doctors regarding player health and safety, USA Football stands among leaders in youth sports concussion education, particularly in youth football. The organization has built the first football-specific online youth football coaching course that includes chapters and comprehension quizzes encompassing concussion education and management, heat and hydration preparedness and equipment fitting guidelines. USA Football's members – youth football coaches, players, league commissioners and game officials – reside in all 50 states.

USA Football partners with collegiate athletic conferences, the NFL and its teams to promote concussion education through its 80-plus annual football training events and national campaigns. Dozens of articles, downloadable online resources and video promoting concussion education and management reside at usafootball.com and are available at no cost. Approximately 1 million visitors reach usafootball.com annually.

What Youth Football Coaches Should Know About Concussions

By Michael D. Goodlett, M.D., Lawrence J. Lemak, M.D.
March 11, 2009, revised December 28, 2009

Recognize the signs and symptoms of a concussion to ensure your players' safety. An easy rule of thumb to follow is when in doubt, sit them out.

WHAT COACHES SHOULD KNOW

*A concussion is any change in an athlete's behavior, awareness, and/or physical feelings caused by a direct or indirect blow to the head.

*Any concussion has the potential to be a serious injury.

*Before letting an athlete go back to play, a concussion should be evaluated by a doctor.

*An athlete should never return to play while exhibiting any signs or symptoms of a concussion either at rest or with exertion. When in doubt, sit them out!

*There is an increased risk of suffering subsequent concussions after a first concussion.

*Any head injury associated with loss of consciousness must be treated as a suspected head, neck, or back injury.

Knowing the signs and symptoms of a concussion will help a youth football coach feel more comfortable and be more prepared in case of an emergency.

*The only instances in which an athlete's helmet and shoulder pads should be removed is when a medical authority believes that it is necessary for the care of the athlete, or if the equipment interferes with the rescuers' ability to provide required CPR.

*If necessary to provide care for life-threatening conditions, it is recommended that the facemask be removed rather than the whole helmet. A tool to remove the facemask should be in the first aid kit.

*For any head injury, activate the Emergency Action Plan and follow the emergency action steps, Check-Call-Care.

When a player is hit, he may receive a blow to the head and become unconscious or demonstrate changes in behavior. If the player regains consciousness, seems to be alert and oriented, and is eager to play, a coach may feel the player is fully recovered and allow him back into the game or practice. However, the player has suffered a concussion. Failure to recognize a concussion can potentially lead to coma and death particularly if a second impact occurs. Coaches need to be aware of the signs of concussions and treat the situation properly.

Concussions are caused by a force being transmitted to the head. The force may be caused by any direct or indirect hit to the head or body and can cause changes in behavior, awareness, or physical feeling in the injured person. Concussions often go unrecognized by coaches because they are underreported by athletes who want to continue competing. Athletes often will minimize or deny symptoms. Maintaining a high level of suspicion and having some knowledge of the individual athlete's personality helps coaches in early detection of the signals of concussion. This awareness can prevent additional concussive injury, potential long-term brain damage, or other possible catastrophic outcomes.

On-The-Field Evaluations

If there is a forceful blow to the head, with or without loss of consciousness, the coach should suspect a head injury and also be concerned that the neck or back has been injured. When caring for the player on the field, tell him not to nod or shake his head during the assessment, but to say yes or no. The player's helmet should also be left in place. The goal is to minimize movement. If the head impact has caused the player to become unconscious or show the signs of concussion listed below, activate the Emergency Action Plan and follow the emergency action steps, **Check-Call-Care**. **Check** the scene for safety and check the ill or injured athlete, **Call** 9-1-1 or the local emergency number when needed, and

MEMBERSHIP
Username email address
Password
Remember Me Log In
Join now! Forgot password?

PLAY AGAINST ME FREE
PLAY NOW
QUICKHIT FOOTBALL

USA Football COACH
BECOME A BETTER COACH
SIGN UP TODAY

USA Football COACHES HANDBOOK
AVAILABLE NOW!

Care for the injured player until EMS personnel arrive.

To Care For Serious Injuries To The Head, Neck, And Back
Follow basic precautions to prevent disease transmission.

Minimize movement of the player's head, neck, and back by putting your hands on both sides of the player's helmet or head. Maintain an open airway using a jaw-thrust maneuver. Have the player remain in the position that you found him until EMS personnel arrive and take over.

Monitor the player's airway, breathing, and circulation.

If life-threatening symptoms are present, it is recommended that the facemask of the athlete's helmet be removed, rather than removing the entire helmet. This will allow access to an airway should the athlete stop breathing.

A tool for removing the facemask should be in the team's first aid kit.

The coach should evaluate the symptoms listed below if he suspects a player may have a concussion requiring immediate care.

The only instance in which an athlete's helmet and shoulder pads should be removed is when a medical authority believes that it is necessary for the care of the athlete, or if the equipment interferes with the rescuers' ability to provide CPR.

Symptoms that require immediate activation of the Emergency Action Plan and immediate removal to a medical facility are:

- *Period of unconsciousness;
- *Confusion, disorientation to time and place;
- *Severe headache or vomiting;
- *Appears sleepy, pale, and is sweating;
- *Blurred vision, slurred speech, and muscle weakness;
- *Neck pain.

Checking For Concussion
If the player is removed from the field after receiving a head impact, it is important to continue evaluating the player every five minutes for at least 30 minutes.

Look at the facial expression of the athlete.

- *Does the athlete have a vacant stare or a confused facial expression?

Check the athlete's behavior.

- *Is the athlete easily distracted or slow to answer questions or follow directions?
- *Does the athlete display unusual emotional reactions, such as *crying or laughing?
- *Does the athlete have a headache or complain of nausea?
- *Is the athlete irritable and easily frustrated?
- *Does the athlete appear unusually anxious or depressed?
- *Does the athlete appear sleepy?
- *Does the athlete have significantly decreased playing ability from earlier in the contest?

Check the athlete's orientation and memory.

- *Is the athlete aware of the time of day and date?
- *Is the athlete generally confused? Questions to ask
- *Which quarter or period is it?
- *Where are we? Which field or arena?
- *Which team are we playing?
- *Which side scored the last points?
- *Which team did the athlete play in the last game?
- *Did the athlete's team win or lose in the last game?

Check for posttraumatic amnesia (the athlete's ability to remember events after the injury).

- *Ask the athlete how he got injured?
- *Ask the athlete the first thing he remembers after the injury?
- *Ask the last thing the athlete remembers before the injury?

Medical attention is required if the athlete's expression, behavior, or memory is affected. Attention should be immediate if symptoms show a deteriorating situation. When an athlete has had a concussion, he should not be allowed to return to the current game or practice, and should not be left alone. Medical evaluation following the concussion is required before a return to participation is permitted.

Postconcussion syndrome
After a player is removed from the field, he may develop symptoms of postconcussion syndrome. This can occur immediately after the injury or many hours or days later. Symptoms of postconcussion syndrome include:

- *Blurred vision
- *Fatigue
- *Ringing in the ears
- *Trouble falling asleep
- *Dizziness

- *Sleeping more or less than usual
- *Headache
- *Increased sensitivity to light and noise
- *Nausea and vomiting
- *Feeling more emotional than normal
- *Poor coordination or balance
- *Difficulty concentrating
- *Increased irritability
- *Difficulty remembering
- *Slurred speech
- *Feeling dazed or stunned
- *Seeing stars or flashing lights
- *Having double vision.

A physician may conduct neuropsychological testing or neuroimaging to assess exactly when the athlete has recovered from a concussion. No athlete should go back to play before being free of all symptoms and signs, both at rest and during exertion, and a physician has indicated the player is ready to return to competition.

© 2010 USA Football, Inc. All rights reserved. **Terms** | **Privacy Policy**
Designed by **HeadRush Creative** | Powered by **Orases** technology

CDC, NFL unite national governing bodies of sport to teach young athletes about concussions

By Joe Frollo
October 11, 2010, revised October 28, 2010

Free poster available for download and distribution to all youth leagues

The Centers for Disease Control and Prevention (CDC), the NFL and 14 national governing bodies of sport, including USA Football, are promoting a free poster designed to increase concussion awareness among young athletes, parents and coaches.

The poster, created by the NFL's Head, Neck and Spine Medical Committee, the CDC and the NFL Players Association, is similar to the one displayed in NFL locker rooms but geared toward a younger audience. It stresses the importance of recognizing a concussion, taking time to recover and not returning to play too soon. By walking through the steps to recognize if the athlete - or a teammate - has suffered a concussion, the goal is increased concussion awareness in all sports.

Players, coaches and parents can better recognize concussion symptoms thanks to a poster being distributed by the Centers for Disease Control and Prevention, NFL, USA Football and other national governing bodies of sport.

"The NFL understands its obligation to educate and inform parents, teachers, coaches and especially young athletes about the risks of concussions," NFL Commissioner Roger Goodell said. "This poster is one element of the NFL's program to assist in the development and broad dissemination of reliable medical information on concussions, which will give players, parents, coaches and others the information they need."

The poster is available online for download and order at no cost at CDC's website or by calling (800) CDC-INFO. Information on recognizing and reacting to concussions also can be found at usafootball.com and through USA Football's Put Pride Aside For Player Safety program as well as through the following national governing bodies:

USA Football's Certified Coaching Education Program, employed by youth football coaches in all 50 states, includes chapters on concussion awareness and management as well as hydration and proper equipment fitting. Health and safety videos also are available at USA Football's Health and Safety page.

"Having more than one dozen different sports be part of this initiative underscores the point that coaches, athletes and parents across all youth athletics need to be informed about this issue," USA Football Executive Director ScottHallenbeck said.

"USA Football has worked with the CDC on concussion education since 2007, and we will continue to emphasize it while teaching coaches and players proper football fundamentals for fun and safe play."

Links related to this article:

NFL and CDC create poster to educate young atheltes about concussions

More media for this article

MEMBERSHIP
Username: email address
Password:
Remember Me Log in
Join now! Forgot password?

NEW REVOLUTION SPEED YOUTH
Riddell

USA Football COACH
BECOME A BETTER COACH
SIGN UP TODAY

USA Football COACHES HANDBOOK
AVAILABLE NOW!

HEALTH & SAFETY

Concussion Awareness

Redskins and USA Football Welcome High School Coaches for Concussion Education

By Steve Alic
April 23, 2010, revised April 29, 2010

The Washington Redskins and USA Football partnered for the Redskins' inaugural Concussion Awareness and Education Forum on April 17 at Redskins Park.

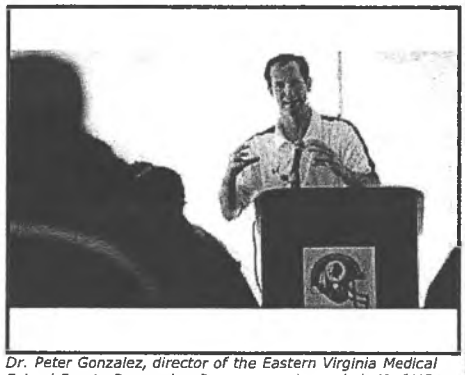
Redskins Park has a history of preparing football teams for success.

Successful preparation at the football training facility earned a new and vital definition on April 17 when the Washington Redskins and USA Football partnered for the Redskins' inaugural Concussion Awareness and Education Forum for Maryland, Virginia and Washington, D.C. high school head football coaches.

Nearly 200 high school coaches traveled to Redskins Park as guests of the team to watch minicamp practice and participate in a 90-minute concussion education seminar led by USA Football's Peter Gonzalez, M.D.

Dr. Gonzalez is the director of the Eastern Virginia Medical School Sports Concussion Program in Norfolk, Va.

Redskins General Manager Bruce Allen opened the day by welcoming the coaches and introduced Dr. Gonzalez. Each coach received a USA Football/CDC concussion awareness clipboard sticker listing concussion signs, symptoms and an action plan. This same material is given to thousands of coaches who attend USA Football's full-day coaching schools across the country. Concussion-related information is available at no cost throughout usafootball.com.



Dr. Peter Gonzalez, director of the Eastern Virginia Medical School Sports Concussion Program, spoke on behalf of USA Football regarding concussion awareness and management to 170 high school head football coaches at Redskins Park. The session was part of a full-day minicamp invitation that the Washington Redskins extended to high school coaches throughout Maryland, Virginia and Washington, D.C. (Photo courtesy of Ned Dishman/Washington Redskins)

"The coaches asked good questions," Dr. Gonzalez said after the presentation. "The Redskins are to be commended - this was a great discussion and also was the largest group of high school coaches I've spoken to at any one time."

"I came to learn all I can," said Jason Meade, head football coach of Lee-Davis High School in Mechanicsville, Va., a two-hour drive from Redskins Park. Coach Meade enters his eighth season as head coach this fall. "Learning more when it comes to putting our players in a better, safer situation is important to us."

"We can't allow high school athletes who suffer concussions to return to play too soon," Dr. Gonzalez added. "If there's one thing a coach takes away from our session today, it's not allowing an athlete to return to play while still possessing the symptoms of a concussion.

"And if we even suspect someone to have suffered a concussion, there is no same-day return to play."

Concussion awareness and management is an important part of USA Football's online coaching education courses and its 80-plus training events held across the country for players, coaches and youth league commissioners.

USA Football is the official youth football development partner of the NFL, its 32 teams and the NFL Players Association. More than 60 of USA Football's events in 2010 are conducted in partnership with NFL clubs.

MEMBERSHIP
Username email address
Password
Remember Me Log in
Join now! Forgot password?

PLAY AGAINST ME FREE
PLAY NOW
QUICKHIT FOOTBALL

USA Football COACH
BECOME A BETTER COACH
SIGN UP TODAY

GIVE YOUR ATHLETE THE ADVANTAGE THEY NEED TO SUCCEED . . .
GET YOUR ATHLETE TO VELOCITY SPORTS PERFORMANCE.
www.velocitysp.com

For Immediate Release
Tuesday, December 7, 2010

Contact: Jeff Miller
National Football League
(202) 662-5593

Ellen Satlof
National Athletic Trainers' Association
(214) 637-6282 x159

NATIONAL FOOTBALL LEAGUE AND THE NATIONAL ATHLETIC TRAINERS' ASSOCIATION TEAM TO PASS STATE LAWS TO PROTECT YOUTH ATHLETES FROM THE RISKS OF CONCUSSIONS

Washington, D.C., December 7, 2010 – The National Football League and the National Athletic Trainers' Association today announced a joint effort to promote legislation to raise awareness and protect youth athletes from the risks of concussions. The new partnership was announced during the Youth Sports Safety Summit in the nation's capital.

"We are pleased to team with the National Athletic Trainers' Association on a state-based legislative effort to protect youth athletes," said Jeff Miller, the NFL's vice president of government relations. "We will advance a simple, but significant shared goal -- to help prevent concussions and make sports and recreational activities safer for young athletes around the country."

The NFL and NATA have agreed to work together to pass concussion awareness and prevention laws in every state throughout the country. The league and the association will promote laws modeled on the Zackery Lystedt law in Washington State, which contains three key elements: (1) concussion education for young athletes, parents and coaches on an annual basis; (2) immediate removal of a student athlete who appears to have suffered a concussion from play or practice; and (3) mandatory clearance of that student by a health care professional who is trained in the evaluation and management of concussions before returning to play or practice.

Marjorie J. Albohm, MS, ATC, president of the National Athletic Trainers' Association added, "We know from recent cases and studies that far too many youth athletes are either playing with undiagnosed symptoms of concussions or returning to play before fully recovering from them. That's why our organization of trained health care professionals supports legislation in every state that will help coaches, youth athletes, their parents and school officials to recognize and respond appropriately to concussions. Doing so will help prevent injury, chronic impairment and even death."

-more-

The NFL and NATA also have pledged to encourage and enlist the participation of other stakeholders and advocates. Organizations already supporting the adoption of such laws include USA Football, the American College of Sports Medicine and the Brain Injury Association of Washington. To date, nine states have enacted adequate concussion awareness and prevention laws including Washington, Oregon, New Mexico, Virginia, Rhode Island, Massachusetts, Oklahoma, Connecticut and New Jersey.

National Athletic Trainers' Association (NATA) – Health Care for Life & Sport

Athletic trainers are health care professionals who specialize in the prevention, diagnosis, treatment and rehabilitation of injuries and sport-related illnesses. They prevent and treat chronic musculoskeletal injuries from sports, physical and occupational activity, and provide immediate care for acute injuries. Athletic trainers offer a continuum of care that is unparalleled in health care. The National Athletic Trainers' Association represents and supports 32,000 members of the athletic training profession. Visit www.nata.org

# # #

CONTACTS

Jeffrey A. Miller
Senior Vice President
National Football League
202-662-5593
Jeff.Miller@NFL.com

Dr. Stanley A. Herring, M.D.
Chairman
Advocacy and Education Subcommittee
NFL Head, Neck and Spine Committee
206-744-0401
sherring@u.washington.edu

Richard H. Adler
Chairman/President
Brain Injury Association of Washington
206-682-0300
radler@adlergiersch.com

Jim Whitehead
Executive Vice President and CEO
American College of Sports Medicine
317-637-9200
jwhitehead@acsm.org

Scott Hallenbeck
Executive Director
USA Football
317-614-7750
shallenbeck@usafootball.com

BRAIN INJURY ASSOCIATION OF WASHINGTON

Journey Toward Understanding: Concussion & Mild Brain Injury

Introduction

Three little monkeys jumping on the bed.
One fell off and bumped his head.
Took him to the doctor and the doctor said,
"That's what you get for jumping on the bed!"

This nursery rhyme tells a story about concussion--the bumps, bangs and shakings to the brain that many adults and children experience. Unfortunately, just like the monkeys jumping on the bed, professionals may not understand concussion well enough to offer support and to help individuals who sustain concussions. People with concussions may just try and "shake it off" and, thus, not be evaluated and treated properly by professionals. It is not uncommon for individuals to be sent home from emergency rooms (ERs) with no follow-up care or to end up with long-term problems that no one understands. This paper will define concussion, present the common symptoms of concussions and discuss ways to help people who sustain concussions.

Each year, it is estimated that approximately 1.5 million people experience concussions. Vehicular crashes (cars, motorcycles, bicycles), sports/recreational activities (football, hockey, playgrounds), abuse/assault (shaken baby syndrome, beatings), falls (young children and the elderly) and other events all have been implicated. It is easy to see that almost any activity can put a person at risk for a concussion. It is a little surprising that people do so well avoiding concussions and equally not surprising that many of us have had concussions.

It is important to note that concussions clearly are associated with lifestyle and parallel other similar lifestyle injuries. If you are involved actively in sports that put your body at risk for muscle pulls, strains, sprains and broken bones, then your chances of a concussion also are great. The Centers for Disease Control and Prevention (CDC) estimates 300,000 sports-related concussions in the United States each year. The more risk to your body, the more risk of serious harm and permanent damage, and the greater the chances that a concussion or more permanent brain injury can occur.

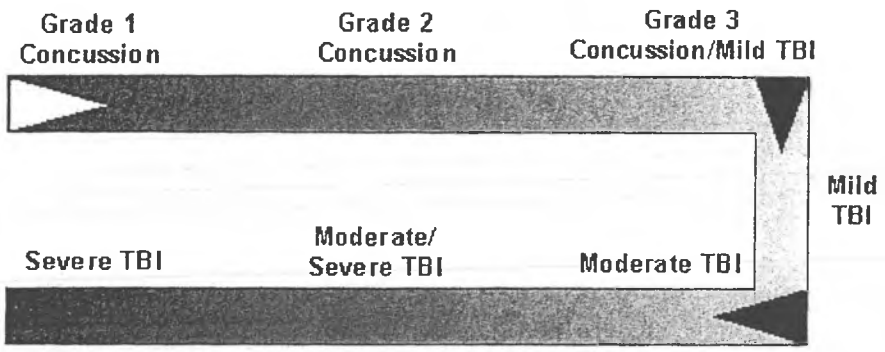
If your job involves heavy labor in farm or construction settings, your chances of physical injury increase and the chances of a concussion increases as well. The use of substances, such as alcohol, that alter your judgment and coordination about everyday activities, like driving or even walking, put you at risk for physical injury and, therefore, at similar risk for a concussion or more serious brain injury. Children--especially younger children--are susceptible to sustaining concussions from falls, play activities and abuse. Lastly, older individuals with balance problems may be prone to falls that can result in not only broken hips, but concussions as well.

What is Concussion?

It is important to understand that a concussion is a physical injury to the brain that causes a disruption of normal functioning just like any other physical injury disrupts your normal functioning. For example, some ankle injuries (i.e., sprains and fractures) are more disruptive

than others, just as some brain injuries are more disruptive than others. The better we understand any injury, the better our chances are for a speedier and healthier recovery.

There is some confusion as to the definition of a concussion and the definition of a mild traumatic brain injury (MTBI). Brain injury can be viewed along a continuum that incorporates concussion, mild brain injury, moderate brain injury and severe brain injury. Each type of brain injury varies depending upon: 1) whether the person was unconscious, 2) how long he/she was unconscious, 3) the length of their amnesia, 4) the resulting cognitive, behavioral and physical problems and 5) the recovery. Viewed as a continuum, the severity of brain injuries can be represented as follows:



As one can see, the definition for a Grade 3 concussion and a MTBI tend to overlap on this continuum.

To further clarify, a concussion is defined as a trauma (i.e., a blow to the head or a serious whiplash) that induces an alteration in mental status (physical or cognitive abilities) that may or may not involve a loss of consciousness.
Concussion as detailed by guidelines developed by the American Academy of Neurology (AAN) and the Brain Injury Association (BIA), commonly is divided into three different types.

Grade 1 Concussion

- Person is confused but remains conscious.
- SIGNS: Temporarily confused, dazed, unable to think clearly, has trouble following directions
- TIME: Symptoms clear within 15 minutes

Grade 2 Concussion

- Person remains conscious, but develops amnesia
- SIGNS: Similar to Grade 1
- TIME: Symptoms last more than 15 minutes

Grade 3 Concussion

- Person loses consciousness
- SIGNS: Noticeable disruption of brain function exhibited in physical, cognitive and behavioral ways.
- TIME: Unconsciousness for seconds or minutes

It is important to note that a person can sustain a concussion (Grades 1 & 2) without losing consciousness. A Grade 3 concussion involves the loss of consciousness, even if only briefly. As defined by the American Congress of Rehabilitation Medicine, MTBI is a traumatically induced physiological disruption of brain function as manifested by some or all of the following:

- Any period of loss of consciousness
- Any loss of memory for events immediately before or after the incident
- Any alteration in mental state at the time of incident
- Focal neurological deficits that may or may not be transient but does not exceed:
  1. Loss of consciousness of approximately 30 minutes or less
  2. An initial Glasgow Coma Scale score of 13-15 after 30 minutes
  3. Post-traumatic amnesia (PTA) of no more than 24 hours

If concussion and MTBI are seen as part of the brain injury continuum, with Grade 3 concussion and MTBI overlapping, one can get a better understanding of how these definitions compliment each other and enhance our understanding. BIA estimates that approximately 75% of all brain injuries fall in the "concussion-MTBI continuum."

The Functional Mechanics of Concussion

Two mechanisms currently are believed to underlie the changes following concussion. In the first, a sudden movement or direct force applied to the head can set the neural matter of the brain in motion even though the brain is well protected in the skull and very resilient. This motion squeezes, stretches and sometimes tears the neural cells, changing the precise balance and distance the cell's axons and dendrites maintain to transmit or process information.

The second mechanism involves changes that occur in the neuron's ability to produce energy for the cell's vital functions in structures called mitochondria. An initial increase in energy production occurs followed by a dramatic decrease that affects the ability of the cell to produce structural proteins to preserve the diameter of the axon. This change occurs gradually after the time of impact and may be responsible for the delay in symptoms sometimes observed.

The changes that occur affect the electrical or chemical aspects of neural cell functioning and result in unusual processing of normal information. (For this reason, radiologic studies that look at the structure of the brain, such as CT scans and MRI, are most frequently read as normal after concussion/MTBI.) This actually is quite adaptive because the brain cells automatically keep working to reconnect or establish normal impulse transmission. Even the loss of consciousness is adaptive, because the brain shuts down all unnecessary functions until the most important life sustaining neural adjustments are made. Unfortunately, sometimes these neural adjustments cannot be made quickly enough and death can occur.

As a person recovers, the cells re-establish the precise balance needed to ensure effective information processing, but this may mean some compensation or adjustments to the neural cell's original alignments. The more often neural cells must compensate or adjust to injury, the more likely the task takes longer and may not be as complete. For example, when a person sprains or fractures an ankle, professionals recommend cold/heat treatments, rest and supports (i.e., cast, brace) and specific exercises to help the ankle adjust to the injury and recover maximal function. Depending on the severity of the ankle injury (i.e., sprain, fracture) and what is required after recovery (i.e., long distance running, ballet), the severity of the injury to the ankle can disrupt a person's life. Obviously, a human brain is much more complicated than an ankle. Yet similarly, rest, supports (i.e., compensations, modifications) and "exercises" (i.e., therapies, education) for the brain may be recommended to rehabilitate and restore useful

function. Depending on the severity of the concussion and what the person needs to do (i.e., care for a family, return to work or school, manage a large company), a concussion can disrupt a person's life for a short period of time or even longer.

To review, a concussion causes a disruption of normal brain function that may be a temporary inconvenience or result in permanent changes in brain function. Where there are complicating factors, the disturbance in brain function can be fatal. Because of the potential life-threatening danger associated with brain injury, the severity of any brain injury--including concussion--is determined at the time of the injury, based on measures of physical, cognitive and behavioral responsiveness. Again, the three categories commonly used to describe brain injury--mild, moderate and severe--indicate only how seriously impaired the person was at the time of the injury. Thus, on the brain injury scale of severity, a concussion usually is classified as a MTBI because the alterations in brain function are not severe enough or do not last long enough to be classified as moderate or severe brain injury. In the moderate and severe classifications, there appears to be direct damage to the brains neural network with long-term difficulties related to the sites of the damage. The long-term effects of MTBI on brain cell recovery and functioning and behavior vary across individuals. However, for most individuals, no long-term neuronal changes are noted after three to four months and the cognitive and behavioral adjustments return to normal.

Exceptions to this rule exist. Studies indicate that age (i.e., 40 years or older), the presence of a systemic disease (i.e., diabetes mellitus), and possibly female gender affect the recovery process. Other risk factors for delayed recovery include a history of previous brain injury or when situational and personality factors play a role in recovery. For example, individuals who sustain a second concussion while still symptomatic from the first one may sustain what is termed "second impact syndrome." This condition is very serious and can result in lifelong impairments, coma and even death. Individuals who sustain a series of multiple concussions over time (i.e., boxers, abused children) may be left with permanent impairments and disabilities. People who have mental health issues or other disabilities (i.e., attention deficits, learning disabilities) may find that a concussion further complicates their behavioral and learning challenges. Also, even litigation issues may complicate a person's recovery.

The symptoms of concussions cover a wide range of perceptual, sensory, cognitive, emotional and behavioral features. The TABLE below lists the common early and late symptoms of concussion:

Early Symptoms:

- Headache
- Dizziness or vertigo
- Lack of awareness of surroundings
- Nausea with or without memory dysfunction
- Vomiting

Later Symptoms:

- Persistent low grade headache
- Lightheadedness
- Poor attention and concentration
- Excessiveness or easy fatigue
- Intolerance of bright light or difficulty focusing vision
- Intolerance of loud noises
- Ringing in the ears

- Anxiety and depressed mood
- Irritability and low frustration tolerance

As you can see, many of the symptoms listed above are common to a variety of other natural human experiences. Feeling scared or anxious can make our vision change and cause dizzy feelings and numerous "fight or flight" reactions. Muscle cramps in the neck can give headaches, just as not having our usual dose of caffeine causes headaches. A virus can make us feel "spaced-out" and affect our balance. Depression can affect our cognitive abilities and memory. Being angry over changes due to an injury such as a broken arm can make us irritable and affect our motivation. And, as with concussion, if everyone else feels you "should be over it by now," being treated unfairly may cause hopelessness that makes it difficult to concentrate and sleep.

Recovery Variations after Concussion

Concussions vary, depending upon the type and the individual, hence, recovery varies as well. Some commonly asked questions by individuals who sustained concussions include:

Why is there so much variation in symptom presentations? This variation can best be explained because people differ and their perceptual experience of sensations such as pain and distress remains subjective. Without a technology (i.e., more sophisticated CT/MRI scanning technology) to measure these individual experiences, it remains difficult to determine when the brain's coping or healing has taken place and when the individual's reaction to the process has left perceptual and learned phenomena. Thus, we need to monitor the symptoms of concussion in order to monitor recovery. The following checklist can help individuals and their families monitor their recovery one to three months after a concussion so they can report this information to their physician or therapist. Symptoms that persist beyond the usual recovery time for concussion need to be evaluated and treated more carefully.

Physical Symptoms

- Headache, dizziness, lightheadedness
- Vomiting or nausea
- Numbness or tingling
- Balance problems, clumsiness, drops things, trips often
- Fatigue, tires easily, needs extra sleep, drowsiness, trouble falling asleep or staying asleep
- Sensitivity to light and noise
- Blurry vision
- Ringing in ears

Cognitive Symptoms

- Confusion, in a "fog," has befuddled expression, gets mixed up about time and place
- Attention or concentration problems, inability to do more than one thing at a time, unable to return to a task if interrupted
- Memory problems, forgets things
- Takes longer to get things done or complete assignments
- Has problems organizing thoughts or words, misunderstands things

Behavioral Symptoms

- Restless, irritable, fussy
- Acts without thinking

- Becomes upset easily, loses temper
- Sadness, depressed mood
- Anxiety, nervousness

Why some people adjust better after a concussion than others? Research in cognitive-behavioral therapy supports the notion that: 1) looking at the positive aspects of recovery, 2) taking steps to gain control of your rehabilitation and 3) knowing that fundamental healthy behavior requires a focused rehearsed plan all can contribute to dealing better with the many sensations and feelings that often follow concussion. Concussion needs to be taken seriously and modifications to a person's life (i.e., home, work, school) need to be made during the recovery period. Just because a person "looks great" does not mean that they are recovered fully. Having a good plan for recovery and knowledge about concussion helps individuals feel more in control and lessens their anxiety.

Why do concussive symptoms change over time? It now appears that during the first months after concussion the brain begins to heal and evidence suggests that there is little trace of brain damage after three to four months. During this period of time, sleep patterns return to normal, sensations mirror the brains recovery and efforts to return to normal and develop a sense of self are influenced by the rehabilitation process. For example, many strange sensations accompany recovery from a sprained or fractured ankle, including pain from the efforts a person makes to accommodate the recovery time (such as muscle atrophy), as well as sleeping and exercise changes due to limitations. Brain function is much more complex to understand and monitor. Yet, just as an ankle can "return to normal" over time, so can the brain after concussion.

Why can't professionals tell if there is permanent brain injury over time? Without doing an autopsy, brain function can only be estimated. For example, neurological testing can provide information about what a person might be able to do at this point in time, but without the same information from before the concussion, it is only possible to estimate how a concussion affected performance. Many professionals use various tools to help them understand the degree of brain damage (i.e., CAT scans, MRI, neuropsychological batteries, neurolinguistic assessment, functional behavioral analysis), but these tools are only approximations and it is difficult to predict the total impact a brain injury may have on a person's life. The best "predictor" is the person with the injury working with a dedicated team of professionals to identify and compensate for permanent damage.

Is permanent brain damage always bad? This is a trick question because the easy answer is that damage always means a loss of brain cells. Yet, many people can attest that the loss of brain cells does not mean that they themselves are "lost". Rather, many individuals have found the strategies and techniques they have used to cope with brain injury have been helpful in assisting them to become the person they felt they wanted to be all along--happy, loved, productive and important. The experience of coping with a rehabilitation or treatment program has helped them: 1) appreciate their talents, 2) give up bad habits and 3) become more mindful of what they truly wanted out of life. This is not to minimize the tremendous changes brain injury causes for people and their families, but rather to emphasize the importance of good treatment programs and community support to help people re-define their lives.

Treatment Recommendations

The only cure for brain injury is prevention. Obviously, the treatment of concussion starts with prevention. Thoughtful preparation before activities--knowing your limits; minimizing risk to one's head by wearing protective gear such as seat belts, helmets, hard hats; and being

substance free when activities require concentration such as driving, bicycling, swimming, boating and skiing--all will reduce the likelihood of injury. Unfortunately, concussions often are difficult to prevent even with careful preparation and protective gear.

Immediately after a concussion, emergency care may be required. Since life-threatening complications--usually due to brain swelling and bleeding--can occur from any brain injury regardless of the type, all brain injuries must be taken seriously. The proper assessment of concussion by emergency medical professionals and physicians is critical.

AAN and the BIA have developed a clear, scientifically based set of guidelines for the medical management of concussion in sports that is used by team physicians, coaches and athletic trainers and can easily be adapted for all concussions. Thus, after the type of concussion has been determined, management guidelines are implemented. If an adult sustains a Grade 1 or 2 concussion, it may be wise for that person to rest for two or three days before returning to regular activities and not operate a motor vehicle for at least a week. If a child crashes a bicycle and the physician has examined and given them a clean bill of health, it is wise to keep the child off the bicycle for a week. As always with children, the rule should be that if it has wheels, you need a helmet.

The potential danger with concussion is sustaining a second one before allowing the brain time to rest and recovery from the first one (as we would for a broken ankle). The chart below summarizes AAN's management recommendations for athletes returning to play after concussion, but reworded for the general audience. Please remember that all concussions are potentially serious and an individual should be examined by a physician if there is any doubt about their safety.

Grade 1 Concussion Management Guidelines

If the person has no symptoms or mental status abnormalities 15 minutes after the injury, he/she can resume normal activities. All symptoms from the concussion must have disappeared, first at rest and then with exertional testing, before the individual can return to regular activities.

Grade 2 Concussion Management Guidelines

The individual should refrain from activities for at least one week, again only after the person is asymptomatic at rest and during exertion. Additionally, a physician should perform a neurological exam before the individual is allowed to go back to regular activities. If the individual experiences a worsening in headaches and other concussion symptoms and/or these symptoms last longer than a week, a CT scan or MRI is recommended.

Grade 3 Concussion Management Guidelines

One month should be the minimum period for an individual to return to rigorous activity. For an individual with a brief loss of consciousness (i.e., seconds), he/she can return to regular activities only after being asymptomatic for at least one week. For a person who had a prolonged loss of consciousness (i.e., minutes), he/she can resume normal activities no sooner than after two weeks of rest. A thorough neurological examination and a neuro-imaging study (i.e., CT scan, MRI) should be performed on all individuals who have been rendered unconscious for brief periods of time. The individual should be admitted to the hospital if any signs of pathology are detected and/or the mental status of the person remains abnormal.

Recovery after concussion--just like a sprained or fractured ankle--takes time. An individual with a broken ankle would not go out the next day and run a marathon. That individual likely would take time out from work, rest and put the leg up, use crutches, attend therapy, if necessary, and allow the ankle time to recover. Too often after concussion, many individuals immediately return to work or school, push themselves to think as well and as quickly as they did before and expect that in a day or two they are recovered fully. One of the problems with concussion is that people try and "get back on the horse" too quickly. The danger in doing this is that the person could sustain a second concussion (i.e., the athlete returns to the game; the child gets back on his/her bicycle; the person resumes driving a car) that could cause more serious injury to the brain. Or, if individuals push themselves to perform and/or are expected to perform by their colleagues and family too soon after the concussion, the symptoms may become exacerbated.
After a concussion, it is wise for people to modify their lives by: 1) reducing workloads, 2) building in rest periods, 3) giving more time to finishing projects, 4) developing a written plan to refer to when confused or uncertain, 5) using a notebook/calendar to write things down and check-off when completed, 6) writing down schedules with time, place and person and 7) avoiding the use of alcohol or other substances that may slow recovery.

It is also important to monitor symptoms over the next one to three months and report this data to one's physician and other treating professionals. Family members can become more knowledgeable about concussion and help the person make accommodations, monitor symptoms and ensure that--just like with a broken ankle--the person is given ample healing time. The use of other professionals, such as a Neuropsychologist, can help through testing to determine a person's strengths, needs and preferences. Psychologists and counselors may be extremely beneficial in helping people with more serious injuries to understand and adjust to any changes caused by the concussion. BIA, its chartered state affiliates and support groups may provide the person with education about concussion and where to go for additional help.

Conclusion

Concussion is the most common of all brain injuries. It needs to be better understood, evaluated and treated. Individuals who sustain concussions may experience an array of symptoms, both short, and long term. The important thing is to take any concussion seriously and recognize that recovery is dependent on many things.

About the Authors...

William Frey, PhD, maintains a private clinical psychology practice in Rutland, VT, specializing in behavioral medicine with a focus on traumatic brain in jury rehabilitation. He received his BA from Villanova University (1967) and his MS (1969) and PhD (1976) from the University of Vermont. In addition to his clinical practice, he has held faculty positions at the University of Vermont, St. Michael's College and Middlebury College and, most recently, had been interim Dean of Student Development at Green Mountain College in Poultney,.VT. He has been a President of the Vermont Psychological Association (1985-1987) and a founding board member or the Vermont Head Injury/Stroke Independence Project (1983-1986). He has published articles on mild traumatic brain injury and the impact of brain injury on sense of self and has developed an ecologically-based rehabilitation model for traumatic brain injury.

Ronald C. Savage, EdD, has worked with children, adolescents and young adults with neurological injuries and disabilities for over 25 years. Presently, Dr. Savage is Executive Vice President for Professional Development at Bancroft NeuroHealth in New Jersey. He is the former Senior Vice President of Behavioral Health and Rehabilitative Services at The May

Institute in Massachusetts and the former Director of Clinical Services for Rehabilitative Services of New York and the company's for rehabilitation facilities. In addition, Dr. Savage has taught at the elementary and secondary school level as a classroom teacher and as a special educator, as well as teaching at several colleges and universities. Dr. Savage presently holds academic appointments at Tufts University, Department of Rehabilitation Medicine; Northeastern University, Department of Psychology; The George Washington University School of Education; and the Laboratorio de Neuropsicologia, Universidad de Sevilla, Spain. Dr. Savage has presented at over 200 conferences, training seminars and grand rounds presentations in the past four years. He has published numerous articles, chapters, manuals and books on children, adolescents and adults with traumatic brain injuries and other neurological disabilities.

References

Centers for Disease Control and Prevention: Facts about Concussion and Brain Injury. U.S. Dept of Health and Human Resources, Washington, DC, 2000.

Frey WF: Psychotherapeutic interventions for mild traumatic brain injury. In: Educational Dimensions of Acquired Brain Injury. RC Savage & GF Wolcott (Eds). Austin, TX: PRO-ED, 1995.

Kelly J & Savage RC: Concussions in Sports. Brain Injury Source. 3(2): 34-37, 1999.

Kelly J & Rosenberg J: The development of guidelines for the management of concussion in sports. Journal of Head Trauma Rehabilitation. 13(2): 53-65, 1998.

McCrea M, Kelly J & Randolph C: The Standardized Assessment of Concussion (SAC) Manual. Alexandria, VA: Brain Injury Association, 1997.

Savage RC: Bing, Bang, Bong: When your Child has a Concussion. Wake Forest, NC: L&A Publishing, 2000.

Content Edited By

Lisa Ward, Director of Communications, Brain Injury Association
Monique J. Marino, Publications Manager, Brain Injury Association

Click here to find out more!

Back to Article Click to Print

TIME IN PARTNERSHIP WITH CNN

Thursday, Feb. 03, 2011

Headbanger Nation

By Jeffrey Kluger

I didn't get a good look at the little boy who injured my daughter in the science museum in Mexico City. He seemed to be about 7, my daughter Elisa was not yet 3, and the two of them were part of a scrum of kids playing on an indoor patio. At precisely the wrong moment, she turned left, he turned right, and they collided. Physics being physics, the smaller mass yielded to the larger one, and my daughter fell down. She landed first on her bottom, then tipped backward and hit her head on the floor.

The sound was one that parents dread: the singular clunk of skull striking cement. I winced, Elisa wailed, and I gathered her up. Soon she stopped crying and went off to play, but even as she did, a dangerous process had begun to unfold inside her skull. (Read Dr. Mehmet Oz's column about concussions.)

When Elisa's head hit the floor, the deceleration was sudden, but — physics again — her brain stayed in motion for an instant, moving through the small intracranial space until it collided with the back of the inside of her skull. Concussive energy radiated through the tissue. As it did, channels in the neurons opened wide, allowing calcium ions to flow into the cells, depressing their ability to metabolize energy. Brain tissue began swelling, but with nowhere to go, it squeezed up against the skull wall. Shearing forces tore axons connecting the cells, damaging their myelin sheathing, which can disrupt nerve signals. All of that was the best-case scenario. The worst case was a brain bleed, which could be fatal without immediate surgery.

Within 20 minutes, Elisa grew withdrawn. An hour later, back in our hotel, she vomited and then began thrashing convulsively. We rushed her to a hospital, where doctors struggled to get a line into one of the tiny veins in her arm, shouting at her to stay awake.

"Open your eyes!" I shouted at her in English. "*Abre tus ojitos!*" my wife echoed. Elisa understood both languages; she answered in neither.

Finally, the doctors got her into a CT scanner, then administered an EEG. There was no bleeding, but there was swelling. Elisa spent three days in the hospital taking antiseizure and antiswelling medication and finally was released. On the flight home, she was a terror — but only in the way a toddler is supposed to be. (See a graphic on the physics behind concussions.)

For us, that was a first-time — and, we dearly hoped, last-time — experience, but we're hardly alone in having gone through it. In the U.S., concussions are an alarmingly commonplace injury, particularly among kids and most particularly among active, athletic ones. Up to 3.8 million Americans are getting concussed per year, according to the Centers for Disease Control and Prevention, and even that big a figure is a moving target. In 2005, the number of children who visited emergency rooms for treatment of concussions was more than twice what it had been in 1997, according to a new study in the journal *Pediatrics*. High school football players alone sustain 100,000 full-blown, diagnosed concussions per year. Flying under the radar are injuries mild enough to get passed off by coaches as a mere ding or ignored by players anxious to get back on the field.

According to a study by neuroscientist Kevin Guskiewicz of the University of North Carolina, the average college football player sustains a breathtaking 950 to 1,100 subconcussive blows per season — hits that are enough to do cumulative damage to young brain tissue but not enough to cause immediate symptoms. "There's what we call a dose response," Guskiewicz says. "After a certain number of hits, the damage starts to show."

But while football is responsible for more than half the concussions kids suffer playing team sports, there's a lot more blame to go around. The success of Title IX, which forbids gender discrimination in scholastic athletics, has led to a 900% increase in girls' sports teams since the law's passage in 1972. But guaranteeing girls equal access to sports also guarantees them equal access to injuries. Girls' soccer accounts for nearly 12% of total team-sports concussions, compared with just 6.6% for boys' soccer. Girls' basketball causes 7%. Even volleyball weighs in at 1.1%. (See a special report on women and health.)

What's more, a third of all concussions among kids are caused by nonteam activities such as ice skating, bicycling and playground recreation. Gaining fast too are newer head-cracking activities like snowboarding and extreme skateboarding. Kids may be the first group to fall in love with such sports, but they're the last group — neurologically speaking — that should engage in them.

"The immature brain is still developing," says Julian Bailes, a neurologist at West Virginia University and the medical director for the Pop Warner Youth Football program. "That makes it more susceptible to damage and more likely to suffer repetitive injury." How this shapes overall development is unknown. A child's brain is like a ship en route to somewhere: a concussion can blow it off course.

The severity of the damage — both acute and chronic — is what researchers are now trying to understand and what legislators and the sports-equipment industry are trying to control. Even as scientists look deeper into the physics, neurochemistry and genetics of brain injury, lawmakers are imposing new rules governing how kids should be assessed for concussions and when they should and should not be eligible to play. Equipment manufacturers, particularly those who make football helmets, are being pushed to redesign their product lines and reform the testing standards that essentially allow the industry to police itself. Pro teams too are feeling the heat for selling an elbow-throwing, stick-swinging, head-butting ethos that may be

fine for millionaire athletes who know what they're getting into but is hurting, and in some cases killing, the kids who emulate them.

"I keep telling kids, Your brain is not your knee. It's not your shoulder. It's your future," says neuropsychologist Gerard Gioia, chief of pediatric neuropsychology at Children's National Medical Center in Washington. "We have to protect it better than we are." (See TIME's special report "How to Live 100 Years.")

The Science of a Hit

If it's football that receives most of the attention in conversations about concussions, it's partly because the hits inflicted in the game can be so shocking. In soccer, basketball or even hockey, violence is typically a by-product of aggressive play. In football, it is the play. Guskiewicz conducts his studies by placing accelerometers in players' helmets and recording not just how often they get hit but also how hard. The unit of measure he uses is g-force. Liftoff of a Saturn V moon rocket exposed its crew to a maximum of four g's. A roller coaster may exceed six g's. College football players, by contrast, collide with each other with an impact of nearly 23 g's — and that's the average. Higher-end blows range from 85 to 100 g's. "The highest we ever recorded was 180 g's," says Guskiewicz.

Worse, it's not necessary to be hit in the head for that kind of impact to do concussive damage. A player struck in the chest can suffer whiplash just like a passenger in a car accident, and when the head snaps back and forth, the brain sloshes around with it. "One sign," says Gioia, "is when a player complains of neck pain. That's often an indicator that the head has moved around hard."

Many of those blows don't necessarily lead to a concussion, and in a way, that's unfortunate. Only about 10% of concussions lead to loss of consciousness, but the other signs are hard to miss, including headache, vomiting, dizziness, balance problems, sensitivity to light or noise, confusion, irritability and amnesia. A player with any of those symptoms is likely to be sent to the bench — at least for a while. A player whose brain has been jolted at a subconcussive level is much likelier to stay on the field and return there week after week with no recuperation time. The damage that does can be deadly. (Read Dr. Mehmet Oz's column about concussions.)

In April 2010, University of Pennsylvania football star Owen Thomas committed suicide in his off-campus apartment, having never before exhibited any sign of mental illness. When researchers at Boston University examined his brain, they found it flecked with what are called tau proteins, telltale signs of a condition known as chronic traumatic encephalopathy (CTE), which is often seen among dementia patients and NFL players with a lifetime of concussions behind them. Thomas had never sustained a concussion, but that might not have mattered.

"He'd been playing since he was 9," says neuropsychologist Robert Stern, part of the team that conducted the analysis. "That suggests he had a great deal of exposure to repeated subconcussive blows."

The link between tau and brain damage is straightforward. The protein is one of the major structural materials of nerve tissues. When the brain is shaken too hard, nerve fibers are torn and the tau is released. The brain tries to clean up the mess, and given enough time, it could. If the hits keep coming, however, the proteins just accumulate. "I describe [the tau deposits] as a form of sludge," says Bailes.

It's not unusual for players like Thomas suffering from CTE to die in violent or otherwise dramatic ways. Bailes was part of a team that found tau protein in the brain of Chris Henry, a player for the Cincinnati Bengals who was killed in 2009 when he got into an argument with his fiancée and jumped on the back of her pickup truck as she drove away — taking a fatal tumble onto the road. In 2007 wrestler Chris Benoit murdered his wife and son and then hanged himself. In 2004 former Pittsburgh Steeler Justin Strzelczyk, who suffered from hallucinations, died when he drove his car into a tractor trailer while fleeing police. Both Benoit and Strzelczyk had CTE. "This disease starts young and progresses through life," says Stern.

Until recently, doctors didn't know just how young, but they're getting an idea. Michael (not his real name) is a ninth-grade football player visiting an outpatient concussion clinic Gioia runs in Rockville, Md. Michael got clobbered in a game in mid-September, suffered many of the immediate concussion symptoms and four months later is still not well. Recovery time varies for all patients, though three months is a good benchmark; four months suggests trouble. Michael's sleep remains disturbed, his temper remains erratic, and his school performance has cratered. An honor-roll student in eighth grade, he has gotten mostly D's and F's this year. "The change," says his mother, "it's shocking."

It's not possible to diagnose anything like CTE from just those symptoms, particularly because Michael's recent academic problems began before his concussion. But he already had a history of what he calls stingers, or head blows — none of which kept him off the field. What's more, his coach allowed him to return to play only a month or so after his recent concussion, a game in which he took another blow to the head, then lost his temper and got ejected.

Michael is hardly the only student athlete playing roulette with his brain, and his coach is hardly alone in abetting such recklessness. One study has shown that up to 40% of players who experience a concussion are back on the field before their brains have fully healed. That, Gioia says, is especially worrisome since sometimes two mild injuries can do more damage than one severe one. In some cases — mercifully rare — players who return to the field before they're fully recovered may even suffer what is known as malignant brain edema, or second-impact syndrome, in which another blow to the head leads to a fatal brain bleed. About half a dozen kids per year die from second impact. (Read Dr. Mehmet Oz's column about concussions.)

It's easy enough to make the case that any person who has suffered a brain injury needs a long period of recuperation before returning to vigorous physical activity. But what about vigorous intellectual activity? The brain is a cognitive machine, and it requires an enormous amount of energy to keep its gears moving. That's a fact concussed kids often confront when they resume their classwork after an injury and find that their symptoms return the moment they crack a book. "Cognitive exertion requires a high degree of

metabolic activity," says Gioia. "If you have a brain that's already impaired, that ability is going to be reduced."

Mary, a high school junior and another patient at Gioia's clinic, has suffered three concussions over the past three years as a goalie for her soccer team. Surprisingly, it is not heading the ball that leads to most concussions in soccer — though the limited studies that have been done have looked only at young adults, and none have explored subconcussive injury. Rather, the damage is done mostly by collisions with other players or, as in Mary's case, with equipment. Her third concussion came last November, when she hit her head against the frame of the goal. She remains an honors student in the International Baccalaureate program in her high school, but the struggle to keep up that level of academic excellence has been grueling.

"I didn't have any exams until two months after the injury," she says. "But when I did, the headaches and fatigue came back immediately. I lost focus during one test and had no idea what I'd just written." She got through all the same and has gone back to school full time, but every day is a battle with pain, exhaustion and sensitivity to noise and light. She has also accepted that soccer — which was a passion — is just not an option anymore. "I can't afford another concussion," she says. (See a graphic on the physics behind concussions.)

Digging Deep

The fact that no two concussions follow the same recovery arc is one of the things that makes them so challenging to diagnose and treat. But that same particularity of injury also provides scientists insights into which people are at the greatest concussive risk.

Gender, for one thing, seems to play a role. Mary may be recovering faster from her injury than Michael is, but on the whole, females are both more susceptible to concussions than males are and suffer more-severe symptoms. So far, the reason for that gap is unclear. There is some thought that a girl's comparatively weaker neck muscles may leave her head more susceptible to violent shock. Hormones too may play a role. Among epileptic girls and women, rising and falling estrogen levels are known to make the brain more or less vulnerable to seizures. The thinking is that this may apply to concussion symptoms as well — though it's unclear whether a girl's hormonal makeup leaves her more concussion-prone throughout the month or just during menstruation. (See a special report on women and health.)

Genes may also be involved. The fact is, plenty of athletes make it through their careers battered and scarred but cerebrally intact, while others who may not get hit with any greater frequency suffer all manner of brain damage. Researchers at the Children's National Medical Center are studying the genomes of both concussed and nonconcussed kids, looking for markers that may explain the difference.

"There could be a genetic predisposition that affects metabolic activity," says geneticist Susan Knoblach. "People always assume that there's a genetic component in degenerative conditions but not acute ones, but of course there can be."

Maryland's Fairfax County has instituted a program in which student athletes spit into cups so their genetic profiles can be taken. The genomes of the ones who come down with concussions can then be compared for key similarities. Early attention is focusing on a gene that codes for a protein called ApoE, which has been implicated in Alzheimer's disease. In the long run, teasing out concussion genes could lead to better drugs or gene therapy to treat or prevent the injury. In the short run, it could help parents and coaches determine in advance which sports kids are best suited to play. Says Gioia: "We may actually find out, 'You know what? You're not set up to be a football player. You might be a better tennis player.'"

Newer brain-scanning technology is also making a difference, helping doctors diagnose concussions and track recovery. The microscopic size of tau proteins and nerve fibers makes them impossible to see without a postmortem exam, but three noninvasive techniques can help sidestep that problem. Magnetic resonance spectroscopy measures not direct damage to the brain but its metabolic activity — a good way to evaluate the very system that breaks down first when a brain is concussed. Diffusion tensor imaging can observe transmission along nerve-fiber tracks, providing a sense of the integrity of the neural wiring. And resting fMRI allows physicians to watch the brain when it's not performing a task, providing a look at basic function. (See TIME's special report "How to Live 100 Years.")

Changing the Rules

Smart medicine, of course, can do only so much to reverse the number of concussions. Smart policy must do the rest. To keep kids from hurting themselves — and to prevent coaches from enabling them — 10 states, including New Jersey, Oregon, Virginia and football-mad Oklahoma, have passed return-to-play laws requiring kids who have sustained even a suspected concussion in any sport to be pulled from play and not returned until a doctor or certified athletic trainer declares them fit. A handful of other states are considering similar legislation, and last year two separate bills along the same lines were introduced in the House of Representatives. Both will have to be resubmitted under the new GOP majority. Still, the national trend is clear: "When in doubt, sit them out" is how the advocates put it.

Most major professional sports leagues in the U.S., as well as most large universities and 4,000 high schools, now also use a computer program known as ImPACT (for Immediate Post-Concussion Assessment and Cognitive Testing) that measures such basic skills as memory, word recognition and pattern recognition. Players are required to take a baseline test at the beginning of the season and are periodically retested, especially postconcussion, to determine if there's been any erosion of skills. "I used to sit across from athletes doing paper-and-pencil memory tests," says ImPACT developer Mark Lovell, a neuropsychologist at the University of Pittsburgh Medical Center. "That would never work with large groups of kids. There aren't that many neuropsychologists alive."

Reform is also coming — slowly — to the major manufacturers of football helmets, driven mostly by the NFL, which has imposed much stricter concussion and tackling rules in the past season. The NFL is anxious both to protect its players and to shake its image as a weekly tutorial for student athletes learning all the wrong safety lessons from pros who should know better. Currently, the group that certifies helmets is the National Operating Committee on Standards for Athletic Equipment (NOCSAE), which sounds

reassuringly official except for the fact that it's essentially funded by the manufacturers themselves. NOCSAE has come under fire not only for this seeming conflict of interest but also for what critics consider unreliable testing. The larger problem, though, is that the standard football helmet was designed to prevent only lacerations and fractures — a job it does very well — and to do little or nothing to prevent concussions. "The science just isn't there today," says Dr. Robert Cantu, a neurosurgeon at Boston University and a member of NOCSAE's board. (See a graphic on the physics behind concussions.)

That's not NOCSAE's or the NFL's fault, but they're trying to do something about it. In December the league and the helmet manufacturers convened a sort of head-injury summit in New York — a gathering that also included officials from NASCAR and the military — to consider helmet modifications that could reduce the concussive carnage. For football, those modifications could include better padding, stronger chin straps and redesigned face masks that distribute shock differently. Kids' helmets must also be more than simply smaller versions of those used by adults. The padding inside all helmets is designed to compress at the forces generated by colliding adult bodies. With the smaller forces kids produce, the padding stays rigid, essentially becoming one more hard surface for the head to strike. Innovations introduced in football could ripple out to other sports' playing fields, to say nothing of battlefields.

Athletics will never be stripped of all danger, and terrible as the blown knee or wrecked elbow may be, there is always an assumption of those risks when you elect to play the game. But the brain is more than a joint or a limb. It's the seat of the self. We overlook that fact at our peril and — much worse — at our children's.

Click to Print

Find this article at:
http://www.time.com/time/specials/packages/article/0,28804,2043395_2043506_2043494,00.html

Copyright © 2011 Time Inc. All rights reserved. Reproduction in whole or in part without permission is prohibited.
Privacy Policy | Add TIME Headlines to your Site | Contact Us | Customer Service

BU

Boston University School of Medicine

sportslegacy INSTITUTE

Department of Veterans Affairs

EMBARGOED UNTIL August 18, 2010, 8 a.m. E.T.

Contact: Gina DiGravio, 617-638-8480, **gina.digravio@bmc.org**
Jenny Eriksen, 617-638-6841, **jenny.eriksen@bmc.org**
Kristin Pressly, 781-687-4988, **kristin.pressly@va.gov**

BOSTON UNIVERSITY AND DEPARTMENT OF VETERANS AFFAIRS RESEARCHERS DISCOVER BRAIN TRAUMA IN SPORTS MAY CAUSE A NEW DISEASE THAT MIMICS ALS

Two former NFL players died after being diagnosed with Lou Gehrig's Disease; New findings suggest they had a new disease associated with repetitive brain trauma

(BOSTON) – The Center for the Study of Traumatic Encephalopathy (CSTE) at Boston University School of Medicine (BUSM) and Department of Veterans Affairs (VA) announced today that they have provided the first pathological evidence that repetitive head trauma experienced in collision sports is associated with motor neuron disease, a neurological condition that affects voluntary muscle movements. The most common form of motor neuron disease is amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease. The findings will be published in the September issue of the *Journal of Neuropathology and Experimental Neurology* (**http://journals.lww.com/jneuropath**).

The finding was discovered by Ann McKee, MD, and colleagues at the CSTE. McKee, a CSTE Co-Director, is an associate professor of neurology and pathology at BUSM, as well as Director of Neuropathology for the Department of Veterans Affairs at the Bedford VA Medical Center, where this research was conducted.

McKee and the CSTE researchers made this groundbreaking pathological discovery while examining the brains and spinal cords of 12 athletes donated by family members to the CSTE Brain Bank at the Bedford VA Medical Center. Three of these 12 athletes, including former professional football players Wally Hilgenberg and Eric Scoggins, as well as an unidentified former military veteran and professional boxer, developed motor neuron disease late in their lives. The former football players were diagnosed clinically with ALS, which is a progressive neurodegenerative disease that attacks motor nerve cells in the brain and spinal cord, resulting in muscle weakness and atrophy. ALS affects fewer than two in 100,000 patients annually, and 30,000 Americans currently live with the disease. The majority of ALS cases (90-95 percent) are considered "sporadic," meaning of unknown cause, although it has long been suspected to involve a complex interaction between multiple genetic and environmental risk factors.

In this study, funded in part by an unrestricted gift from the National Football League (NFL) to the CSTE, McKee found that when they died, all 12 athletes showed neuropathological evidence of chronic traumatic encephalopathy (CTE), a progressive degenerative brain disease characterized by deposits of an abnormal form of *tau* protein and believed to be caused by repetitive head trauma. In the three athletes with motor neuron disease, abnormal *tau* protein deposits were not only found throughout the brain, but also in the spinal cord.

CSTE researchers also discovered that 10 of 12 CTE victims had a second abnormal protein, TDP-43, in their brains. Of those 10, only three had TDP-43 in the brain *and* the spinal cord, and those were the three athletes diagnosed with motor neuron disease. TDP-43 is also found in individuals with sporadic ALS although in the athletes with repetitive brain trauma, the TDP-43 pathology was more severe than found in sporadic ALS and was accompanied by extensive *tau* pathology. The brains and spinal cords of normal individuals show no TDP-43 or *tau* deposition.

These new findings suggest that the motor neuron disease that affected the three athletes is similar to, but distinct from sporadic ALS and represents a disease never described previously in the medical literature. This new disease, referred to as chronic traumatic encephalomyopathy (CTEM) by McKee and colleagues is likely caused by the repetitive head trauma experienced by athletes in contact sports.

The association between head trauma and ALS is supported by the medical literature, in which the risk of ALS has been reported to be higher among contact sport athletes and veterans. A study of professional soccer players in Italy found that the incidence rate of ALS was 6.5 times higher than in the general population. An increased incidence of ALS has also been reported in American football players, including three players from the 1964 San Francisco 49ers who died from ALS. Based on the number of retired NFL players with ALS, it is estimated that the risk is at least 8 times higher than in the adult male population. Among Veterans with a history of head injuries, their risk of ALS was 2.3 times higher than normal, and Gulf War Veterans have a twofold increased risk. In fact, since 2008, the US Department of Veterans Affairs has considered ALS as a presumptively compensable illness for all veterans. The discovery of this new ALS-like disease by the BU CSTE investigators suggests that one possible reason for the increased risk of clinically diagnosed ALS in veterans and in contact sport athletes may be the exposure to repetitive head trauma, including concussions, subconcussive blows and blast injuries.

These findings raise the question of whether head injuries may have contributed to Lou Gehrig's motor neuron disease, and whether he also suffered from CTEM. Gehrig, nicknamed the "Iron Horse," played football at Columbia University before becoming a legendary member of the New York Yankees and playing in 2,036 consecutive games, a record that stood for more than 60 years. Gehrig suffered at least five documented concussions and was reported to have been knocked unconscious for five minutes after taking a pitch to the head while not wearing a helmet. He played the next day.

"When we read reports about cases of the disease being linked to specific activities or experiences, such as the increased risk associated with military service, or this one regarding professional athletes, we are reminded of just how complex of a disorder ALS is. We're hopeful that this new work may shed light on potentially exciting new possibilities for biomarker and therapy development," said Steve Perrin, PhD, CEO and Chief Scientific Officer of the ALS Therapy Development Institute.

Responding to these new findings, Hunt Batjer, MD and Richard Ellenbogen, MD, the co-chairmen of the NFL's new Head, Neck and Spine Committee, stated, "We are pleased that the NFL has provided the support necessary for this research and look forward to continued discussion of the findings within our medical committee and with other researchers to better understand their clinical implications."

McKee now has analyzed the brains of more than 35 athletes and found evidence of CTE in 12 of 13 former NFL players. These brains were acquired primarily through the efforts of CSTE co-director Chris Nowinski who is also president of the non-profit Sports Legacy Institute. The CSTE maintains a registry of more than 350 living athletes who have agreed to donate their brain and spinal cord following death and to undergo telephone-based interviews and assessments during life. Robert Stern, PhD, CSTE co-director and an associate professor of neurology at BUSM, oversees the CSTE registry as well as a study about to begin of retired NFL players who undergo extensive neurological, cognitive, psychiatric, cerebrospinal fluid and neuroimaging studies. Robert Cantu, MD, a clinical professor of neurosurgery at BUSM and co-director of the CSTE, was recently appointed senior advisor to the NFL Head, Neck and Spine Committee.

COORDINATES WOULD BE PLACED HERE

****

Wally Hilgenberg died in 2008 at the age of 66 after a three-year battle with ALS. After graduating from the University of Iowa, Mr. Hilgenberg played 12 seasons with the Minnesota Vikings and three with the Detroit Lions as a linebacker.

Eric Scoggins died in 2009 at the age of 49 after a two-year battle with ALS. After graduating from the University of Southern California, he played one season for the San Francisco 49ers before playing two seasons in the United States Football League, for the Los Angeles Express and the Houston Gamblers.

Early symptoms of ALS often include increasing muscle weakness, especially involving the arms and legs, and progressive problems with speech, swallowing and breathing. Because voluntary muscle action is progressively affected, patients in the later stages of the disease may become totally paralyzed. In nearly all cases, ALS is fatal.

The CSTE (**www.bu.edu/cste/**) was founded in 2008 and is the leading center in the world studying the long-term effects of repetitive brain trauma in sports and the military. The CSTE was created as a collaboration between Boston University (BU), Sports Legacy Institute (SLI) and the Department of Veterans Affairs. Co-directors of the BU CSTE include Robert Cantu, MD, a clinical professor of neurosurgery at BUSM, Ann McKee, MD, an associate professor of neurology and pathology at BUSM, Chris Nowinski, and Robert Stern, PhD, an associate professor of neurology at BUSM. The mission of the CSTE is to conduct state-of-the-art research of CTE, including its neuropathology and pathogenesis, the clinical presentation, biomarkers, and course, the genetics and other risk factors for CTE, and ways of preventing and treating this cause of dementia. Brain trauma is increasingly seen as a public health crisis due to the discovery of CTE in a number of recently deceased athletes, most of whom have been studied at the CSTE. McKee also identified CTE in the only former NHL player examined, Reggie Fleming. The CSTE's groundbreaking research created a dramatic change in the understanding of and response to brain trauma and concussions in all sports, especially football. The BU CSTE has received grants from the National Institute on Aging and the National Operating Committee on Standards in Athletic Equipment (NOCSAE), and has received an unrestricted gift from the NFL.

CTE, originally referred to as "dementia pugilistica" because it was believed to only affect boxers, is a progressive brain disease believed to be caused by repetitive trauma to the brain, including concussions and subconcussive blows. It is characterized by deposits of an abnormal protein called *tau* in the form of neurofibrillary tangles, glial tangles, and neuropil threads throughout the brain, and, in some cases, the presence of another abnormal protein – associated with motor neuron disease – known as TDP-43. These abnormal proteins are associated with the impaired functioning and eventual death of brain cells. Early on, CTE sufferers may display symptoms such as memory impairment, emotional instability, erratic behavior, depression and problems with impulse control. CTE may eventually progress to full-blown dementia. Although similar to Alzheimer's disease, CTE is pathologically distinct, and it is the only known preventable cause of dementia.

CSTE co-directors Cantu, McKee and Nowinski serve on the NFL Players Association Mackey/White Traumatic Brain Injury Committee, which includes, and is chaired by, CSTE registry member Sean Morey. In addition, Cantu serves as a senior advisor to the newly created NFL Head, Neck and Spine Committee.

Sports Legacy Institute is a 501(c)(3) nonprofit corporation founded in 2007 to solve the sports concussion crisis. SLI is dedicated to education, prevention, treatment and research on the effects of concussions and other brain injuries in athletes and the military. SLI partnered with Boston University School of Medicine to form the Center for the Study of Traumatic Encephalopathy in 2008.

27-LS0250\B
Mischel
3/24/11

CS FOR SENATE BILL NO. 22( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR MCGUIRE

A BILL

FOR AN ACT ENTITLED

"An Act relating to prevention and evaluation of and liability for concussions in student athletes."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONCUSSIONS IN STUDENT ATHLETES; FINDINGS. The legislature finds that

(1) concussions rank among the most commonly reported traumatic brain injuries in children and adolescents who participate in sports and recreational activities;

(2) the United States Centers for Disease Control and Prevention estimates that as many as 3,900,000 concussions occur each year in the United States as a result of sports and recreational activities;

(3) a concussion is caused by a blow to or jarring of the head or body that causes the brain to move rapidly inside the skull, resulting in a mild to severe traumatic brain injury, which may occur with or without loss of consciousness, and may disrupt normal brain

function;

(4) a concussion may occur during an organized or unorganized sport or recreational activity as a result of a fall or from players colliding with each other or another obstacle;

(5) the risk of catastrophic injury or death from a concussion or other head injury increases when the injury is not properly evaluated and managed, and the athlete is allowed to continue to participate in sports or recreational activities following the concussion;

(6) although voluntary nationwide guidelines for managing concussion in sports recommend assessing concussions on an individual basis, with gradual return to play, athletes continue to be returned to play prematurely, putting them at risk for greater injury or death.

* **Sec. 2.** AS 14.30 is amended by adding new sections to article 3 to read:

Sec. 14.30.142. Concussions in student athletes: prevention and reporting. (a) The governing body of a school district shall consult with the Alaska School Activities Association to develop and publish guidelines and other information to educate coaches, student athletes, and parents of student athletes regarding the nature and risks of concussions. Guidelines developed under this section must include a description of the risks of return to play and standards for return to play, including the procedures required under (c) and (d) of this section.

(b) A school shall annually provide to a student and the parent or guardian of a student who is under 18 years of age written information on the nature and risks of concussions. A student may not participate in school athletic activities unless the student and the parent or guardian of a student who is under 18 years of age have signed a verification of receipt of the information required under this subsection.

(c) A student who is suspected of having sustained a concussion during a practice or game shall be immediately removed from the practice or game.

(d) A student who has been removed from participation in a practice or game for suspicion of concussion may not return to play until the student has been evaluated and cleared for participation in writing by a qualified person who has received training and is currently certified in the evaluation and management of concussions. In this subsection, "qualified person" means either a

(1) licensed health care provider; or

(2) person who is acting at the direction and under the supervision of a licensed physician.

(e) A person who conducts an evaluation under (d) of this section and who is not paid for conducting the evaluation may not be held liable for civil damages resulting from an act or omission during the evaluation, except that the person may be held liable for reckless or intentional misconduct and for gross negligence.

Sec. 14.30.143. Concussions in student athletes: school district immunity. (a) A school district may not be held liable for an injury to or the death of a person resulting from the action or inaction of a person employed by or under contract with a nonprofit youth organization if

(1) the action or inaction occurred on school property during the delivery of services by the district or organization;

(2) the organization is under contract with the district to provide the services; and

(3) before the provision of services, the organization provided to the district written verification of

(A) a valid insurance policy covering the injury or death in an amount not less than $50,000 for each person and $100,000 for each incident;

(B) compliance with the protocol for prevention and reporting of concussions required in AS 14.30.142.

(b) This section may not be construed to impair or modify the ability of a person to recover damages for harm caused by the negligent or reckless actions of an employee or contractor of a school district or by the existence of a condition, equipment, program, or structure known by the school district or organization to be unsafe.

(c) In this section, "youth organization" means a public or private entity qualified to do business in the state that provides a program or service to persons under 19 years of age.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Member

Senate Finance Committee
Senate Resources Committee
Senate Judiciary Committee
Senate Special Committee on World Trade, Technology, and Innovations

SENATOR LESIL MCGUIRE

SPONSOR STATEMENT

SENATE BILL NO. 22

More than 60,000 high school student athletes sustain concussions each year. The number is much greater when you include middle school and younger children. The National Football League (NFL) has implemented concussion and brain trauma procedures for many years, but it has recently partnered with the Centers for Disease Control and Prevention (CDC) to raise public awareness of this serious problem. Many states are now moving to add protections for students who participate in sports or other potentially dangerous activities. While concussions and brain trauma are more prevalent in football, many other sports and activities are also dangerous, with girls' soccer resulting in the second-most concussions.

A concussion results from the brain impacting the inside of the skull, and can be caused by a blow to the head, or by violent motion of the head. Though the risk can be somewhat reduced with a helmet, it cannot be prevented with external equipment. While it is nearly impossible to completely prevent an initial concussion or brain trauma, this legislation seeks to minimize complications and more permanent conditions that can be caused when athletes continue to practice or play after receiving a concussion.

HB 15 is modeled after legislation that recently passed in Washington State, known as the Zackery Lystedt Law. Zackery was a middle-school football player who was returned to a game after receiving a concussion. He sat out for about 15 minutes, and then returned to the game, forcing a game-saving fumble, but suffered a further head injury on the play. The second injury caused a brain hemorrhage that ultimately led to the removal of both sides of Zackery's cranium, leaving him drifting in and out of a coma for three months. He has battled his way back to some sense of normalcy, but will never fully recover from this avoidable injury.

SB 22 simply requires school districts, in consultation with the Alaska School Activities Association, to develop and publish guidelines and information to educate coaches, student athletes and parents about the nature and risks of concussions and traumatic brain injuries. The bill will require that a student athlete suspected of suffering a concussion or brain trauma be removed from practice or play, and not be allowed to return until cleared by a licensed health care professional.

While there is no way to completely prevent concussions or traumatic brain injuries, we can strive to prevent the serious complications and potentially life-altering or life-threatening ramifications that can occur from continuing to practice or compete once a brain injury has occurred. This is a critical public health issue, and a responsibility to our children we should take seriously.

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Member

Senate Finance Committee
Senate Resources Committee
Senate Judiciary Committee
Senate Special Committee on World Trade, Technology, and Innovations

SENATOR LESIL MCGUIRE

Summary of Changes
Between SB 22\A and CS for SB 22\B

This document is an identification of the changes between W.O. 27-LS0250\A and W.O. 27-LS0250\B. The changes between SB 22 and the CS are based on recommendations from the Alaska School Activities Association (ASAA) and the Alaska Brain Injury Network (ABIN).

The CS for SB 22 replaces "traumatic brain injuries" with "concussions". This request was based on recommendations from ASAA who felt that traumatic brain injuries were outside their scope of expertise. However, it is recognized that concussions are a mild form of traumatic brain injury. This change is reflected in the CS on: page 1, line 6; page 2, line 13; page 3, lines 8 and 21.

Section 2 in CS SB 22 adds a new section 14.30.142(b) [page 2, lines 20-24] that requires a school to provide students and their parents with written information on the nature and risks of concussions based on recommendations by ASAA. Also required is signed verification by parents that the information is received. Page 2, line 19 in the CS amends the reference to subsections based on the addition of subsection 14.30.142(b).

14.30.142(d) [previously subsection (c)] changes the language that determines who can evaluate a student suspected of sustaining a concussion. Originally, SB 22 designated that only a licensed health care provider could return a student to play or practice. However, after discussion with ASAA and ABIN, it was determined that this requirement may be difficult to meet in rural Alaska.

Subsection 14.30.142(d) designates what constitutes a qualified person in subsections: (1) a licensed health care provider and (2) a person who is acting at the direction and under the supervision of a licensed physician.

Subsection 14.30.142(e) [previously subsection (d)] adds additional language "and who is not paid for conducting the evaluation" (page 3, lines 4-5).

SB

27

<TARGET><BILL>SB 27</BILL><SUBJECT>SB
27</SUBJECT><COMM>SHSS27</COMM></TARGET>

CS for Senate Bill 27(HSS) – Hazardous Flame Retardants

The CS for Senate Bill 27(HSS) sponsored by Senator Wielechowski bans the manufacture, sale or import of products which contain certain toxic flame retardants.

These have been proven to be toxic not only to residents in homes but to Fire Firefighters in fighting fires.

ALASKA FIRE CHIEF'S ASSOCIATION

2358 Bradway Road, North Pole, Alaska 99705
Phone: (907) 488-3400 FAX: (907) 488-6118

March 4, 2011

Representative Lindsey Holmes
State Capitol Room 405
Juneau AK, 99801

Senator Bill Wielechowski
State Capitol Room 101
Juneau AK, 99801

Reference: HB 63 & SB 27

On behalf of the Alaska Fire Chiefs Association I am writing to give our support for HB 63 and SB 27; **TITLE:** "An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date."

Polybrominated Fire Retardants (PBDEs) have been proven to be toxic chemicals and hazardous not only to residents in homes with PBDEs but to Fire Firefighters who may be called to fight fires in structures where these chemicals are present.

We support the passage of HB 63 and SB 27.

Sincerely,

Jeff Tucker, President
Alaska Fire Chiefs Association

adn.com
Anchorage Daily News

Print Page Close Window

Bill to ban PBDEs would protect Alaskans

COMPASS: *Other points of view*

By FRANK VON HIPPEL

(02/20/11 17:16:56)

The Alaska State Legislature is considering a bill backed by Sen. Bill Wielechowski and Rep. Lindsay Holmes that would ban the import of furniture and electronics containing a class of toxic flame retardants known as PBDEs (polybrominated diphenyl ethers).

PBDEs are man-made chemicals produced for the manufacture of fire-resistant products. As products break down or release PBDEs into the atmosphere, the PBDEs find their way into the environment. PBDEs are highly persistent; they may remain unchanged for many decades or break down into daughter compounds that are also toxic.

Unfortunately, they are fat soluble and bioaccumulate in the fatty tissues of exposed animals. As these animals are consumed by predators, the PBDEs biomagnify up the food web, resulting in the highest levels in the top carnivores. Many of these top carnivores, such as fish and marine mammals, are important subsistence foods in Alaska.

People are exposed to PBDEs in multiple ways, including through the ingestion of fatty foods as well as contact with household dust. PBDEs have been found in human breast milk and in the blood of mothers and their babies. A Centers for Disease Control and Prevention study found that over 93% of Americans had detectable levels of PBDEs in their bodies, some at levels that are associated with health problems in laboratory animals. PBDEs have been found to disrupt the hormone system of numerous animals and have widespread effects on neurodevelopment and reproductive development.

The laboratory animals chosen for these studies have proven to be excellent models for human medical research time and time again. The hormone system of other vertebrates is almost exactly the same as the hormone system of humans. Therefore, disruption of hormone pathways in laboratory animals indicates that PBDEs likely cause similar developmental and health effects in humans.

PBDEs interfere with thyroid hormone, which regulates many aspects of development, and male and female sex steroids, which regulate sexual development and behavior. For example, PBDE exposure may cause undescended testes in newborn boys and reduced testosterone and sperm counts in men. Some PBDEs may be carcinogens. Although we do not fully understand the mechanisms by which PBDEs disrupt multiple hormone pathways, the evidence is sufficient to take a prudent approach and ban their import to Alaska where feasible.

Washington became the first state to ban all forms of PBDEs in 2007, with key support coming from firefighter associations. Firefighters advocated against PBDEs because when products containing PBDEs burn, they release highly toxic dioxins and furans. Associations of nurses and doctors also supported the legislation.

Maine, Oregon, Vermont, Rhode Island, Illinois and Massachusetts also have banned some or all of the PBDEs, and similar legislation is under consideration in other states. Similar bans are in effect in Canada and most European nations.

The Washington law required that safer and technically feasible alternatives to PBDEs be identified before the ban would go into effect. These alternatives, which meet fire-safety standards, were identified by Washington state agencies in December 2008; the identification of alternative flame

retardants allowed restrictions on the use of PBDEs in electrical products and furniture to take effect Jan. 1, 2011.

Many companies have taken a proactive approach in phasing out PBDE use. For example, Intel, IBM and Ericsson no longer produce products with PBDEs, and Hewlett-Packard, Sony, Motorola, Panasonic, NEC, Samsung and Toshiba are all working to phase out PBDEs.

Alaskans experience unusual levels of PBDE exposure for three reasons: The Arctic is a global sink for persistent pollutants that settle out of the atmosphere in cold temperatures; Alaskans who rely on a subsistence diet eat fish and marine mammals that accumulate PBDEs because of their position at the top of the food web; and we spend most of the winter sealed in our homes, where we are exposed to household dust containing PBDEs.

Therefore, Alaska has extraordinary cause to ban the importation of products containing these chemicals. We cannot control the atmospheric deposition of PBDEs into the Arctic or their delivery by ocean currents, but we can control their importation in consumer products.

Frank von Hippel is a professor of biological sciences at the University of Alaska Anchorage.

Print Page Close Window

Copyright © Mon Feb 21 2011 09:29:43 GMT-0900 (Alaskan Standard Time)1900 The Anchorage Daily News (www.adn.com)

27-LS0300\~~A~~I
Bannister
~~12/17/10~~

2/28/11

CS FOR SENATE BILL NO. 27(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

~~**BY SENATOR WIELECHOWSKI**~~

~~Introduced~~**BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE**

Offered:
Referred:

Sponsor(s): SENATOR WIELECHOWSKI

A BILL

FOR AN ACT ENTITLED

"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to ~~bioaccumulative toxic~~a multistate chemicals clearinghouse; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 18.31 is amended by adding new sections to read:

Article 4. ~~Toxic~~ Chemicals in Products.

Sec. 18.31.600. Prohibitions. (a) A person may not manufacture, sell, or distribute a product ~~that~~if one or more components of the product contains more than 0.1 percent by mass of pentaBDE, octaBDE, or a combination of pentaBDE and octaBDE.

(b) A person may not manufacture, sell, or distribute a mattress, a mattress pad, or upholstered furniture if one or more components of the mattress, mattress pad, or upholstered furniture ~~has a textile component containing~~contains more than 0.1

percent by mass of decaBDE.

(c) A person may not manufacture, sell, or distribute an electronic product if the electronic product has a plastic housing or other external component that contains more than 0.1 percent by mass of decaBDE.

(d) A person may not manufacture, sell, or distribute a product that is prohibited by the department under AS 18.31.610.

Sec. 18.31.610. Prohibition by department. (a) The department may prohibit by regulation the manufacture, sale, and distribution of a product that contains a flame retardant that is not ~~a brominated flame retardant~~already prohibited under AS 18.31.600(a) - (c), if the department determines that

(1) the flame retardant is harmful to public health or the environment; and

(2) an alternative to the flame retardant exists, is safer for the public health or the environment, and is available on a nationwide basis.

(b) Before establishing a prohibition under (a) of this section, the department shall consult with the Department of Health and Social Services, and the state fire marshal shall determine that the flame retardant alternative identified in (a)(2) of this section satisfies applicable fire safety standards.

(c) In this section, "product" means

(1) a mattress, a mattress pad, or upholstered furniture if the mattress, mattress pad, or upholstered furniture contains plastic fibers that contain the flame retardant; or

(2) an electronic product that has a plastic housing that contains the flame retardant.

Sec. 18.31.620. Exemptions. The prohibitions in AS 18.31.600 do not apply if the product that is prohibited is part of

(1) a transportation vehicle or a product or part used in a transportation vehicle or transportation equipment;

(2) a product or equipment used in an industrial, mining, or manufacturing process;

(3) electronic wiring or cable used for power transmission;

(4) a used item that is resold; or

(5) a new item that is brought into the state before the effective date of ~~AS 18.31.600 - 18.31.790~~this section.

Sec. 18.31.630. Notification by manufacturer. A person who manufactures products whose sale and distribution are prohibited by AS 18.31.600 shall inform its retailers in the state of the prohibitions under AS 18.31.600 and the penalty under AS 18.31.~~660~~650.

~~**Sec. 18.31.640. Retailer assistance.** The department shall develop a program to assist retailers to identify products in their inventories that violate AS 18.31.600.~~

~~**Sec. 18.31.650.**~~**Sec. 18.31.640. Enforcement.** If the department determines that there are grounds to suspect that a retailer is selling a product in violation of AS 18.31.600, the department may request that, within 10 days, the manufacturer of the product

(1) provide the department with a sworn certificate indicating that the sale of the product does not violate AS 18.31.600; or

(2) notify each retailer who sells the product in the state that the sale of the product is prohibited by AS 18.31.600 and provide the department with a list of the names and addresses of the retailers notified.

Sec. 18.31.~~660~~650. Civil penalty. A person who violates AS 18.31.600 - 18.31.~~650~~640 is liable to the state for a civil penalty of up to $1,000 for each violation.

Sec. 18.31.~~670. Review by departments.~~ ~~The department, along with and the Department of Health and Social Services, shall review~~

~~(1) the hazards and risks of brominated flame retardants and possible alternatives to brominated flame retardants; and~~

~~(2) the findings and rulings by the United States Environmental Protection Agency that are related to brominated flame retardants and possible alternatives to brominated flame retardants.~~

~~**Sec. 18.31.680. List of toxic**~~**660. Multistate chemicals.** ~~(a) The department shall, in consultation with the Department of Health and Social Services, establish by regulation and update every three years on or before February 1 a list of persistent bioaccumulative toxic chemicals that occur or are used in products used by human~~

~~beings.~~

~~(b) When establishing the list required by (a) of this section, the department shall consider~~

~~(1) the persistent bioaccumulative toxins list prepared by the State of Washington;~~

~~(2) the chemical data developed by the United States Environmental Protection Agency under the high production volume challenge program; and~~

~~(3) other sources the department determines are relevant.~~

~~**Sec. 18.31.690. Interstate** **clearinghouse.** The department may~~shall participate in ~~the establishment and implementation of a regional~~a multistate chemicals clearinghouse to

~~(1) assist the department to carry out the department's duties under AS 18.31.600 - 18.31.790; and~~

~~(2) help coordinate education and outreach activities related to brominated flame retardants, including risk assessments and possible alternatives to brominated flame retardants.~~

(1) build governmental capacity to identify and promote safer chemicals and products;

(2) avoid duplication of state initiatives on chemicals and enhance the efficiency and effectiveness of state initiatives on chemicals through collaboration and coordination;

(3) ensure that state agencies, businesses, and the public have easy access to high quality and authoritative information on chemicals.

Sec. 18.31.~~700~~670. Regulations. In addition to the regulations allowed under AS 18.31.610, the department may adopt regulations to implement AS 18.31.600 - 18.31.~~790~~690. The department shall adopt the regulations for AS 18.31.600 - 18.31.~~790~~690 under AS 44.62 (Administrative Procedure Act).

Sec. 18.31.~~790~~690. Definitions for AS 18.31.600 - 18.31.~~790~~690. In AS 18.31.600 - 18.31.~~790~~690, unless the context indicates otherwise,

~~(1) "brominated flame retardant" means a flame retardant that contains pentaBDE, octaBDE, or decaBDE;~~

~~(2~~(1) "congener" means a specific polybromodiphenyl ether molecule;

(~~3~~2) "decaBDE" means decabromodiphenyl ether or a technical mixture in which decabromodiphenyl ether is the predominant congener;

(~~4~~3) "department" means the Department of Environmental Conservation;

(~~5~~4) "distribution" means distribution for sale or for a commercial purpose;

(~~6~~5) "electronic product" means a television, a computer, or another piece of electronic equipment;

(~~7~~6) "flame retardant" means a chemical that is added to plastic, foam, or a textile to inhibit flame formation;

(~~8~~7) "manufacture" means manufacture for sale;

(~~9~~8) "manufacturer" means a person who

(A) manufactures a product or whose brand name is affixed to the product; or

(B) imports or distributes a product in the United States if the person who manufactured or assembled the product or whose brand name is affixed to the product does not do business in the United States;

(~~10~~9) "octaBDE" means octabromodiphenyl ether or a technical mixture in which octabromodiphenyl ether is the predominant congener;

(~~11~~10) "pentaBDE" means pentabromodiphenyl ether or a technical mixture in which pentabromodiphenyl ether is the predominant congener;

~~(12) "persistent bioaccumulative toxic chemicals" includes carcinogens, mutagens, reproductive toxicants, developmental toxicants, neurotoxicants, endocrine disruptors, and other toxins; in this paragraph,~~

~~(A) "bioaccumulative" means increasing in concentration in living organisms as the living organisms take in contaminated air, water, soil, sediment, or food;~~

~~(B) "persistent" means remaining in the environment without transformation or breakdown into another chemical form;~~

(~~13~~11) "sell" includes an offer to sell;

(~~14~~12) "technical mixture" means a mixture that is named for the predominant congener and that is not exclusively composed of the predominant congener;

(~~15~~13) "transportation vehicle" means a mechanized vehicle that is used to transport goods or individuals, and includes an airplane, an automobile, a motorcycle, a truck, a bus, a train, and a ship.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Environmental Conservation may ~~proceed to~~ adopt regulations necessary to implement this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

~~TRANSITION: FIRST LIST. On or before February 1, 2014, the Department of Environmental Conservation shall establish the first list required by AS 18.31.680, added by sec. 1 of this Act.~~

~~*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:~~

REVISOR'S INSTRUCTION. Wherever "chapter" appears in AS 18.31.010 - 18.31.500, the revisor of statutes shall substitute "AS 18.31.010 - 18.31.500."

*** Sec.** ~~**5. Section**~~**4.** AS 18.31.660, enacted by sec. 1 of this Act, and sec. 2 of this Act ~~takes~~take effect immediately under AS 01.10.070(c).

*** Sec.** ~~**6**~~**5.** Except as provided in sec. ~~5~~4 of this Act, this Act takes effect January 1, 2013.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 9, 2011

SUBJECT: CSSB 27( ) relating to flame retardants and bioaccumulative toxic chemicals (Work Order No. 27-LS0300\M)

TO: Senator Bill Wielechowski
Attn: Karla Hart

FROM: Theresa Bannister
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Adds a new article on toxic chemicals in products.

Sec. 18.31.600. Prohibits a person from manufacturing, selling, or distributing certain products that contain a specified percentage of the brominated flame retardants pentaBDE, octaBDE, or decaBDE. Prohibits a person from manufacturing, selling, or distributing a product that the Department of Environmental Conservation prohibits under sec. 18.31.610.

Sec. 18.31.610. Authorizes the department to prohibit the manufacture, sale, and distribution of certain products that contain a flame retardant that is not already prohibited under sec. 18.31.600(a) - (c) if the department makes certain determinations regarding public health, the environment, and alternatives to the flame retardant. Requires the department to consult with the Department of Health and Social Services (DHSS). Requires the state fire marshal to determine whether an alternative satisfies fire safety standards.

Sec. 18.31.620. Lists five exemptions from the prohibitions in sec. 18.31.600.

Sec. 18.31.630. Requires a person who manufactures products whose sale and distribution are prohibited by sec. 18.31.600 to inform its retailers in the state of the prohibition and the penalty.

Sec. 18.31.640. Directs the department to develop a program to assist retailers to identify products that violate sec. 18.31.600.

Sec. 18.31.650. Authorizes the department to request that the manufacturer of a product it suspects of being sold in violation of sec. 18.31.600 either (1) provide the department with a sworn certificate indicating the sale does not violate sec. 18.31.600, or (2) notify its retailers in the state that the sale is prohibited and provide the department with a list of the retailers notified.

Sec. 18.31.660. Establishes a civil penalty for violating secs. 18.31.600 - 18.31.650.

Sec. 18.31.670. Directs the department and DHSS to review the hazards, risks, and certain federal findings and rulings related to brominated flame retardants and their possible alternatives.

Sec. 18.31.680. Directs the department to establish and update every three years a list of persistent bioaccumulative toxic chemicals in products. Lists some sources of information for the department to consider.

Sec. 18.31.690. Authorizes the department to participate in the establishment and implementation of a regional multistate clearinghouse to help the department carry out its duties under these sections and to help coordinate educational and outreach activities related to brominated flame retardants.

Sec. 18.31.700. Authorizes the department to adopt regulations to implement the new sections.

Sec. 18.31.790. Defines terms for the new sections.

Section 2. Authorizes the department to begin adopting regulations for these provisions.

Section 3. Directs the department to establish by February 1, 2014, the first list of persistent bioaccumulative toxic chemicals used in products.

Section 4. Directs the Revisor of Statutes to make a conforming change to the existing statutes in AS 18.31.

Section 5. Gives bill sec. 2 an immediate effective date.

Section 6. Gives the Act (except sec. 2) an effective date of January 1, 2013.

If I may be of further assistance, please advise.

TLB:plm
11-061.plm

SB 27

An Act Relating to Flame Retardants

Changes from 27-LS0300\M to version _____

The first changes make enforcement easier by clarifying the limit of PBDE by mass applies to each individual component. Technology exists to quickly test components of products without damage to identify if any bromines are present at the stated 0.1 percent.

Page 1, line 8 clarifies that **no component of a product** may contain more than 0.1 percent by mass

line 12 changes "a textile component" to "any component"

line 14 changes to: "a plastic housing or other external component that contains..." to account for parts of an electronic product, not just the housing, that someone may come into contact with in the routine use of the product, such as handles and knobs.

Page 3, lines 5-6. Deletes **Sec. 18.31.640. Retailer Assistance.**

Lines 17-23. Deletes **Sec. 18.31.670. Review by departments.**

Lines 24-Page 4, line 4. Deletes **Sec. 18.31.680. List of Toxic Chemicals.**

Page 4, lines 5-11. **Sec. 18.31.690. Interstate clearinghouse.** Requires the department to participate in the interstate clearinghouse and provides reasons.

The department shall participate in a multi-state chemicals clearinghouse to:

- Avoid duplication and enhance efficiency and effectiveness of agency initiatives on chemicals through collaboration and coordination
- Build governmental capacity to identify and promote safer chemicals and products
- Ensure that agencies, businesses, and the public have ready access to high quality and authoritative chemicals data, information, and assessment methods

The new bill provides for an immediate effective date for participation in the Interstate Clearinghouse.

The new bill renumbers sections to account for changes.

Prepared by Karla Hart, Aide to Senator Wielechowski, 2/24/2011

American Public Health Association
800 I Street, NW • Washington, DC 20001-3710
(202) 777-APHA • Fax: (202) 777-2534
comments@apha.org • http://www.apha.org

Policy Statement Database

New Search »

Preventing Human Exposure to Polybrominated diphenyl ether (PBDE) Flame Retardants to Protect Public Health

Policy Date: 11/9/2004
Policy Number: 2004-05

This policy, acknowledging that polybrominated diphenyl ether (PBDE) flame retardant compounds are widely used and chemically similar to PCBs, and noting more recent recognition that PBDEs are environmentally persistent, rapidly bioaccumulate in human tissue including breast milk and function as developmental neurotoxicants in animals, urges proactive steps to reduce human exposure citing especially APHA policy (#200011) encouraging "precautionary action to prevent potential harm to reproductive health, infants, and children, even if some cause and effect relationships have not been established with scientific certainty."1

More specifically, PBDEs are commonly used flame retardants found in foam products, textiles, electrical equipment, building materials and transportation. Penta-BDE, octa-BDE and deca-BDE are three of the most common commercial classes, with varying numbers of bromine atoms per molecule. Chemically, they look very much like PCBs, which were banned in 1976 due to their high toxicity and persistence and now conclusive evidence that they cause neurodevelopmental problems in children.2 Aside from their fire-retardant properties, PBDES are potent toxins that persist in the environment and bioaccumulate in the food chain and in human tissues.3 Like PCBs, PBDEs are lipophilic and have been found in fish, bird eggs and marine mammals as well as in human milk, fat and blood. While PCB levels in fish and breast milk have slowly declined since being banned, PBDE levels are increasing at an exponential rate. A 100-fold increase in total PBDEs was noted in Lake Ontario trout between 1978 and 1998.4 Body burdens of PBDEs in San Francisco Bay Harbor seals increased by a factor of 100 between 1989 and 1998.5 Total PBDE levels in human milk, blood and tissues have increased by a factor of 100 during the past 30 years, doubling about every five years.6 PBDE levels in U.S. women's breast milk are typically 10-100 times higher than levels in European women7,8 and are now approaching concentrations at which health effects have been observed in laboratory animals.9-17 Although human data on health effects are still lacking for PBDEs, ample data on toxicity are available from animal studies. These studies document that PBDEs are toxic to the brain, reproductive system and liver and disrupt thyroid function.18 Effects on thyroid function provide a plausible mechanism for PBDEs' possible adverse effects on child development. Human studies already document adverse effects on intelligence and psychomotor skills in children with disruptions in thyroid levels in the womb through the second year of life.19-22 One study found that workers exposed to PBDEs experienced higher prevalence of hypothyroidism.23 Concurrent exposure to both PBDEs and PCBs, as from consuming some fatty fish, may present an increased risk since some researchers have found additive or synergistic effects between the two chemicals.24

PBDEs have been detected in household dust,25 food, and in air drawn from a warm TV,26 but the major human exposure pathways have yet to be identified. PBDEs with fewer bromines, such as penta, have the highest potential for bioaccumulation and are typically the most common classes found in humans, fish and other wildlife. Scientists, however, have increasingly been finding deca-BDEs and other higher brominated congeners in biota.27-29 Moreover, it is clear that deca can debrominate and convert to the more bioavailable forms in the environment and potentially during metabolism as well, making them a greater health risk than originally thought.

Global PBDE production totaled 150 million pounds in 1999, over 50 percent of which was used in the Americas.30 Deca-BDE is the most widely used class of BDE at 80 percent of worldwide production.31 Like PCBs, PBDEs flame retardants are now ubiquitous in the environment. The European Chemicals Bureau estimates that 75 percent of penta-BDE emissions will end up in soil and 24.9 percent in surface water and sediment.32 Measured levels of PBDEs in U.S. sewage sludge are 40 times that of European sludge.33

Eliminating most uses of PBDE flame retardants is possible, and a prudent step to protect public health. Concerns about rising levels of PBDEs in the breast milk of Swedish women led to efforts by industrial users in both Sweden and Germany to phase out the use of these chemicals. These actions have led to a decline in PBDE levels in breast milk of Swedish women.34 The European Union has enacted a ban on penta and octa-BDEs and is considering a ban on deca-BDEs as well. The states of California, Hawaii, New York, and Maine have enacted phase-outs of penta and octa-BDEs. Minnesota, Massachusetts, Michigan, Washington and Maryland have proposed similar state-level phase-outs.

Alternatives to the use of PBDE flame retardants are available and cost effective. Alternatives include: product redesign to

eliminate the need for added chemicals; use of naturally flame retardant materials like wool and leather or plastics containing sulfur; and use of less toxic alternatives.35 The German Environmental Agency selected red phosphorus, ammonium polyphosphate and aluminum trihydroxide as alternatives with the least adverse environmental impact.36

Some computer and electronics manufacturers like Apple, Ericsson, IBM, Intel, Motorola, Panasonic, Phillips, and Sony are using alternatives. For example, Motorola now uses a halogen-free laminate that is cost effective, while meeting fire safety standards.37 Toshiba has replaced BFR-containing plastic casings in electronic parts with inherently flame-resistant polyphenylene sulfide. IKEA furniture, Crate and Barrel and Eddie Bauer are requesting PBDE-free polyurethane foam from their manufacturer Hickory Springs.

Although global manufacturers of these compounds continue to produce, as well as export, their products to the United States, one of the two U.S. manufacturers of PBDEs, Great Lakes Chemical, has already announced that they will phase out production of penta and octa-BDEs by 2005. The remaining U.S. manufacturer, Albemarle, continues to manufacture deca-BDE. By calling for a reasonable time frame for phase-out of deca-BDEs, impacts on businesses and workers could be minimized. Phasing out these compounds and substituting safer alternatives protects U.S. manufacturers of PBDEs and companies that use them in their products from potential liability and helps maintain a European market for products requiring flame retardant properties. Since exposure to PBDEs may include an inhalation route of exposure, phasing out the manufacture of these chemicals should better protect the health of workers in industries dealing with PBDEs.

A PBDE phase-out may result in job loss for existing production workers. APHA policy statement 9304 acknowledges potential worker impacts and calls for assistance to workers who are displaced by technological changes.38 New research further supports the need for Work Environment Impact Assessments prior to chemical phase-outs/bans in order to prevent the shifting of risks to workers within the affected industry.39 A PBDE phase-out also provides economic opportunities for workers in industries which make safer alternatives to PBDE flame retardants.40

In light of the aforementioned emerging science on the inherent toxicity and persistence of PBDEs, evidence of adverse health effects on animals and the prevalence and rising levels in fish, biota and human breast milk, immediate action is needed to prevent further environmental contamination and to protect public health.

Therefore, The American Public Health Association hereby:

1. Resolves: That APHA urge state and federal governments to require the use of PBDE flame retardants be phased out in all products manufactured and sold in the United States by a date certain; and

2. Resolves: That APHA urge state and federal governments, in enacting such phase-outs, to consider policies that alleviate short-term economic impacts on the PBDE production workforce, and to also consider economic benefits to workers in industries making safer alternatives; and

3. Resolves: That APHA urge state and federal governments to provide financial incentives for development and use of alternative flame retardants or preferably changes in product design to increase fire resistance without use of chemicals, to assure fire safety, while protecting the public from toxic exposures; that alternative flame retardants be adequately tested for toxicity; and that environmental and health safety must be assured prior to use; and

4. Resolves: That APHA urge state and federal governments to require labeling of chemical flame retardants used in products; and

5. Resolves: That APHA urge state, federal and local governments to regulate the safe disposal of products containing brominated flame retardants and to prohibit land application of sewage sludge until testing can assure that such material does not contain measurable levels of PBDEs; and

6. Resolves: That APHA urge the U.S. Centers for Disease Control and Prevention to expand the national biomonitoring program to include PBDEs and to increase the number of people studied; and

7. Resolves: That APHA urge Congress to increase funding for research on PBDE flame retardants, including monitoring levels of PBDEs in fish, sediments, human milk, blood and tissue, and additional research into exposure routes and human health effects from these exposures.

References

1. American Public Health Association Policy #200011, The Precautionary Principle and Children's Health.
2. Jacobson JL, Jacobson SW. Intellectual impairment in children exposed to PCBs in utero. N Engl J Med 1996;335:783-789.
3. McDonald T. A perspective on the potential health risks of PBDEs. Chemosphere 2002;46(5):745-755.
4. Luross, et al. Spatial and temporal distribution of polybrominated diphenyl ethers in lake trout from the Great Lakes. Organohalogen Compounds 2000;47:73-76.
5. She J, et al, PBDEs in the San Francisco Bay area: measurement in harbor seal blubber and human breast adipose tissue. Chemosphere 2002;46(5):697-707.
6. Hites RA. Polybrominated diphenyl ethers in the environment and in people: a meta-analysis of concentrations. Environ Sci Technol. To be published 2004.
7. Schecter A, et al. Polybrominated diphenyl ethers (PBDEs) in U.S. mother's milk. Environ Health Perspect 2003;111(14):1723-1729.
8. Mazdai A, et al. Polybrominated diphenyl ethers in maternal and fetal blood samples. Environ Health Perspect 2003;111(9):1249-1252.
9. Eriksson P, et al. Brominated flame retardants: a novel class of developmental neurotoxicants in our environment? Environ Health Perspect 2001;109(9):903-908.

10. Darnerud PO, et al. Polybrominated dephenyl ethers: occurrence, dietary exposure, and toxicology. Environ Health Perspect 2001;109(suppl 1):49-68.
2011 © American Public Health Association
11. Eriksson P, et al. A brominated flame-retardant, 2,2',4,4',5-pentabromodiphenyl ether: uptake, retention, and induction of neurobehavioral alterations in mice during a critical phase of neonatal brain development. Toxicol Sci 2002;67:98-103.
12. Viberg H, et al. Neonatal exposure to the brominated flame retardant 2,2',4,4',5-pentabromodiphenyl ether causes altered susceptibility in the cholinergic transmitter system in the adult mouse. Toxicol Sci 2002;67:104-107.
13. Viberg H, Jakobsson E. Developmental neurotoxic effects of 2,2',4,4',5-pentabromodiphenyl ether in the neonatal mouse. Toxicologist 2000;54:1360.
14. Viberg H, et al. Brominated flame retardant: Uptake retention, and developmental neurotoxic effects of decabromodiphenyl ether in the neonatal mouse. Toxicologist 2001;61:1034.
15. Branchi I, et al. Effects of perinatal exposure to a polybrominated diphenyl ether (PBDE 99) on mouse neurobehavioural development. Neurotoxicology 2002;23:375-384.
16. Lichtensteiger W, et al. Effect of polybrominated diphenylether and PCB on the development of the brain-gonadal axis and gene expression in rats. Organohalogen Compounds 2003;61:84-87.
17. Kuriyama S, Chahoud I. Maternal exposure to low dose 2,2', 4,4' 5pentabromo diphenyl ether (PBDE 99) impairs male reproductive performance in adult rat offspring, Organohalogen Compounds 2003;61:92-95.
18. See notes 9-17.
19. Pop VJ, et al. Low maternal free thyroxine concentrations during early pregnancy are associated with impaired psychomotor development in infancy. Clinical Endocrinology 1999;50:149-155.
20. Haddow JE, et al. Maternal thyroid deficiency during pregnancy and subsequent neuropsychologicql development of the child. N Engl J Med 1999;341:549-555.
21. Morreale G, et al. Is neuropsychological development related to maternal hypothyroidism or to maternal hypothyroxinemia? J Clin Endocrinology Metab 2000;85:3975-3987.
22. Howdeshell K. A model of the development of the brain as a construct of the thyroid hormone system. Environ Health Perspect 2002;110:337-348.
23. Bahn A, et al. Health assessment of occupational exposure to polybrominated biphenyl (PBB) and polybrominated biphenyl oxide (PBBO). ISS EPA 560/6-80-001: NTIS PB81-159675. Washington, DC: U.S. Environmental Protection Agency. 1980.
24. Eriksson P, et al. Co-exposure to a polybrominated diphenyl ether (PBDE 99) and an ortho-substituted PCB (PCB 52) enhances developmental neurotoxic effects, Organohalogen Compounds 2003;60-65: Dioxin 2003.
25. Rudel RA, et al. Phthalates, alkyphenols, pesticides, polybrominated diphenyl ethers, and other endocrine disrupting compounds in indoor air and dust. Environ Health Perspect 2003;37(20):4543-4553.
26. Ball M, et al. Further investigation on the formation of polybrominated dioxins and furans during thermal stress of flameproof plastics and textiles. Sub-project1. Research Report no 10403364/01. UBA-FB 91-082 (in German). Federal Office for the Environment. 1991.
27. Stapleton HM, et al. Debromination of the flame retardant decabromodiophenyl ether by juvenile carp (Cyprinus carpio) following dietary exposure. Environ Sci Technol 2004;38(1):112-119.
28. Tomy GT, et al. Bioaccumulation, biotransformation, and biochemical effects of brominated diphenyl ethers in juvenile lake trout (Salvelinus namacush). Environ Sci Technol To be published 2004.
29. Lunder S, Sharp R. Mother's Milk: record levels of flame retardants found in American mother's breast milk. Environmental Working Group, www.ewg.org, 2003:36.
30. Bromine Science and Environmental Forum, An Introduction to Flame retardants, October 19, 2000.
31. Birnbaum L, Staskal D. Brominated flame retardants: cause for concern? Environ Health Perspect 2004;112(1):9-17.
32. European Chemicals Bureau. European Union Risk Assessment Report: diphenyl ether, pentabromo derivative. August 2000.
33. Hale R, et al. Brominated diphenyl ethers in land-applied sewage sludges in the U.S. The second international workshop on brominated flame retardants, Stockholm May 14-16, 2001:149-52.
34. Guvenius DM, Noren K. Polybrominated diphenyl ethers in Swedish human milk: the follow-up study. In: Proceedings of the Second International Workshop on Brominated Flame retardants (Asplund et al, eds) Stockholm: Firmatryck, 2001:303-305.
35. Environment California Research and Policy Center. Growing Threats, Toxic Flame Retardants and Children's Health. 2003.
36. Umweltbundesamt (Germany's Federal Environment Agency), Substituting Environmentally Relevant Flame Retardants: Assessment Fundamentals. ISSN 0722-186X. March 2001.
37. Scheifers S, Motorola, Bromine Free Alternatives in Electronic Products. Presented at the EFC9 Brominated Flame Retardants and Electronics Conference and Roundtable, San Francisco, September 29, 2002.
38. American Public Health Association Policy #9304, Recognizing and Addressing the Environmental and Occupational Health Problems Posed.
39. Rosenberg BJ, et al. The work environment impact assessment: A methodologic framework for evaluating health-based interventions. Am J Industrial Med 2001;39(2):218-226.
40. Examples: Faribault Mills makes 100% wool blankets which are naturally flame resistant (http://www.faribowool.com/); RTP Company makes a non-halogenated, non-brominated flame retardant for use in plastics (http://www.rtpcompany.com/.

ALASKA STATE LEGISLATURE

Session

State Capitol, Rm. 101
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

Interim

716 W. 4th Ave, Ste. 540
Anchorage, AK 99501
(907) 269-0120
Fax: (907) 269-0122

Senator_Bill_Wielechowski@legis.state.ak.us

Chair
State Affairs Committee

Co-chair
Joint Armed Services Committee

Vice Chair
Resources Committee
Judiciary Committee

Member
Administrative Regulation Review

SENATOR BILL WIELECHOWSKI

CS SB 27 (HSS)

Sectional Analysis

Section 1. Adds a new article on toxic chemicals in products.

Sec. 18.31.600. Prohibits a person from manufacturing, selling, or distributing certain products that contain a specified percentage of the brominated flame retardants pentaBDE, octaBDE, or decaBDE. Prohibits a person from manufacturing, selling, or distributing a product that the Department of Environmental Conservation prohibits under sec. 18.31.610.

Sec. 18.31.610. Authorizes the department to prohibit the manufacture, sale, and distribution of certain products that contain a flame retardant that is not already prohibited under sec. 18.31.600(a) - (c) if the department makes certain determinations regarding public health, the environment, and alternatives to the flame retardant. Requires the department to consult with the Department of Health and Social Services (DHSS). Requires the state fire marshal to determine whether an alternative satisfies fire safety standards.

Sec. 18.31.620. Lists five exemptions from the prohibitions in sec. 18.31.600.

Sec. 18.31.630. Requires a person who manufactures products whose sale and distribution are prohibited by sec. 18.31.600 to inform its retailers in the state of the prohibition and the penalty.

Sec. 18.31.640. Authorizes the department to request that the manufacturer of a product it suspects of being sold in violation of sec. 18.31.600 either (1) provide the department with a sworn certificate indicating the sale does not violate sec. 18.31.600, or (2) notify its retailers in the state that the sale is prohibited and provide the department with a list of the retailers notified.

Sec. 18.31.650. Establishes a civil penalty for violating sees. 18.31.600 - 18.31.640.

Sec. 18.31.660. Requires the department to participate in a multistate chemicals clearinghouse to build capacity to identify and promote safer chemicals and products; avoid duplication and enhance efficiency and effectiveness; and ensure access to high quality and authoritative information on chemicals.

Sec. 18.31.670. Authorizes the department to adopt regulations to implement the new sections.

Sec. 18.31.690. Defines terms for the new sections.

Section 2. Authorizes the department to begin adopting regulations for these provisions.

Section 3. Directs the Revisor of Statutes to make a conforming change to the existing statutes in AS 18.31.

Section 4. Gives participation in the chemicals clearinghouse and bill sec. 2 an immediate effective date.

Section 5. Gives the Act (except chemical clearinghouse participation and and sec. 2) an effective date of January 1,2013.

Prepared by Karla Hart, 2/28/11

ALASKA STATE LEGISLATURE

Session

State Capitol, Rm. 101
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

Interim

716 W. 4th Ave, Ste. 540
Anchorage, AK 99501
(907) 269-0120
Fax: (907) 269-0122

Senator_Bill_Wielechowski@legis.state.ak.us

Chair
State Affairs Committee

Co-chair
Joint Armed Services Committee

Vice Chair
Resources Committee
Judiciary Committee

Member
Administrative Regulation Review

SENATOR BILL WIELECHOWSKI

SB 27
SPONSOR STATEMENT

> "Still one thing more, fellow-citizens -- a wise and frugal Government, which shall restrain men from injuring one another, shall leave them otherwise free to regulate their own pursuits of industry and improvement, and shall not take from the mouth of labor the bread it has earned. This is the sum of good government, and this is necessary to close the circle of our felicities."
>
> Thomas Jefferson, First Inaugural Address, March 4, 1801[1]

SB 27 will support Safer Homes and Healthier Families by banning the use of polybrominated fire retardants (PBDEs) in mattresses, upholstered furniture and the plastic housing of electronics. In addition, it will give the Department of Environmental Conservation the authority to prohibit the use of other toxic flame retardants when safer alternatives exist. It will also move Alaska a step forward in protecting people from a variety of toxins by allowing the Department to participate with other states in learning about and sharing information on toxins.

PBDEs are persistent toxins that are included in furniture and electronics found in households to enhance flame retardancy. These toxins bio-accumulate, becoming more concentrated in humans and animals high in the food chain. Fetuses and infants are at particular risk as accumulated toxins are transferred from mother to child in utero and through breast milk. Pre-natal exposure may have lifelong health impacts that are not manifested until decades later.

Alaskans are particularly vulnerable for three reasons: 1) we spend a lot of time indoors with little ventilation, increasing our exposure to and ingestion of the microscopic particles of toxins found in household dust that are released from our furniture and electronics; 2) we eat subsistence foods that may concentrate toxins; and 3) through a process known as global distillation, toxins such as PBDEs are carried in the atmosphere for great distances from points of manufacture and concentrate in cold climates.

The impact and legacy of 30 years of producing and using these chemicals is yet to be fully realized and revealed. Alaska should join the 12 other states that have stepped forward to protect their citizens without delay in the face of federal inaction.

---

[1] http://avalon.law.yale.edu/19th_century/jefinau1.asp, emphasis added.

27-LS0300\M
Bannister
2/8/11

CS FOR SENATE BILL NO. 27( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR WIELECHOWSKI

A BILL

FOR AN ACT ENTITLED

"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 18.31 is amended by adding new sections to read:

Article 4. Toxic Chemicals in Products.

Sec. 18.31.600. Prohibitions. (a) A person may not manufacture, sell, or distribute a product that contains more than 0.1 percent by mass of pentaBDE, octaBDE, or a combination of pentaBDE and octaBDE.

(b) A person may not manufacture, sell, or distribute a mattress, a mattress pad, or upholstered furniture if the mattress, mattress pad, or upholstered furniture has a textile component containing more than 0.1 percent by mass of decaBDE.

(c) A person may not manufacture, sell, or distribute an electronic product if the electronic product has a plastic housing that contains more than 0.1 percent by

mass of decaBDE.

(d) A person may not manufacture, sell, or distribute a product that is prohibited by the department under AS 18.31.610.

Sec. 18.31.610. Prohibition by department. (a) The department may prohibit by regulation the manufacture, sale, and distribution of a product that contains a flame retardant that is not already prohibited under AS 18.31.600(a) - (c), if the department determines that

(1) the flame retardant is harmful to public health or the environment; and

(2) an alternative to the flame retardant exists, is safer for the public health or the environment, and is available on a nationwide basis.

(b) Before establishing a prohibition under (a) of this section, the department shall consult with the Department of Health and Social Services, and the state fire marshal shall determine that the flame retardant alternative identified in (a)(2) of this section satisfies applicable fire safety standards.

(c) In this section, "product" means

(1) a mattress, a mattress pad, or upholstered furniture if the mattress, mattress pad, or upholstered furniture contains plastic fibers that contain the flame retardant; or

(2) an electronic product that has a plastic housing that contains the flame retardant.

Sec. 18.31.620. Exemptions. The prohibitions in AS 18.31.600 do not apply if the product that is prohibited is part of

(1) a transportation vehicle or a product or part used in a transportation vehicle or transportation equipment;

(2) a product or equipment used in an industrial, mining, or manufacturing process;

(3) electronic wiring or cable used for power transmission;

(4) a used item that is resold; or

(5) a new item that is brought into the state before the effective date of AS 18.31.600 - 18.31.790.

Sec. 18.31.630. Notification by manufacturer. A person who manufactures products whose sale and distribution are prohibited by AS 18.31.600 shall inform its retailers in the state of the prohibitions under AS 18.31.600 and the penalty under AS 18.31.660.

Sec. 18.31.640. Retailer assistance. The department shall develop a program to assist retailers to identify products in their inventories that violate AS 18.31.600.

Sec. 18.31.650. Enforcement. If the department determines that there are grounds to suspect that a retailer is selling a product in violation of AS 18.31.600, the department may request that, within 10 days, the manufacturer of the product

(1) provide the department with a sworn certificate indicating that the sale of the product does not violate AS 18.31.600; or

(2) notify each retailer who sells the product in the state that the sale of the product is prohibited by AS 18.31.600 and provide the department with a list of the names and addresses of the retailers notified.

Sec. 18.31.660. Civil penalty. A person who violates AS 18.31.600 - 18.31.650 is liable to the state for a civil penalty of up to $1,000 for each violation.

Sec. 18.31.670. Review by departments. The department, along with and the Department of Health and Social Services, shall review

(1) the hazards and risks of brominated flame retardants and possible alternatives to brominated flame retardants; and

(2) the findings and rulings by the United States Environmental Protection Agency that are related to brominated flame retardants and possible alternatives to brominated flame retardants.

Sec. 18.31.680. List of toxic chemicals. (a) The department shall, in consultation with the Department of Health and Social Services, establish by regulation and update every three years on or before February 1 a list of persistent bioaccumulative toxic chemicals that occur or are used in products used by human beings.

(b) When establishing the list required by (a) of this section, the department shall consider

(1) the persistent bioaccumulative toxins list prepared by the State of

Washington;

(2) the chemical data developed by the United States Environmental Protection Agency; and

(3) other sources the department determines are relevant.

Sec. 18.31.690. Interstate clearinghouse. The department may participate in the establishment and implementation of a regional multistate clearinghouse to

(1) assist the department to carry out the department's duties under AS 18.31.600 - 18.31.790; and

(2) help coordinate education and outreach activities related to brominated flame retardants, including risk assessments and possible alternatives to brominated flame retardants.

Sec. 18.31.700. Regulations. In addition to the regulations allowed under AS 18.31.610, the department may adopt regulations to implement AS 18.31.600 - 18.31.790. The department shall adopt the regulations for AS 18.31.600 - 18.31.790 under AS 44.62 (Administrative Procedure Act).

Sec. 18.31.790. Definitions for AS 18.31.600 - 18.31.790. In AS 18.31.600 - 18.31.790, unless the context indicates otherwise,

(1) "brominated flame retardant" means a flame retardant that contains pentaBDE, octaBDE, or decaBDE;

(2) "congener" means a specific polybromodiphenyl ether molecule;

(3) "decaBDE" means decabromodiphenyl ether or a technical mixture in which decabromodiphenyl ether is the predominant congener;

(4) "department" means the Department of Environmental Conservation;

(5) "distribution" means distribution for sale or for a commercial purpose;

(6) "electronic product" means a television, a computer, or another piece of electronic equipment;

(7) "flame retardant" means a chemical that is added to plastic, foam, or a textile to inhibit flame formation;

(8) "manufacture" means manufacture for sale;

(9) "manufacturer" means a person who

(A) manufactures a product or whose brand name is affixed to the product; or

(B) imports or distributes a product in the United States if the person who manufactured or assembled the product or whose brand name is affixed to the product does not do business in the United States;

(10) "octaBDE" means octabromodiphenyl ether or a technical mixture in which octabromodiphenyl ether is the predominant congener;

(11) "pentaBDE" means pentabromodiphenyl ether or a technical mixture in which pentabromodiphenyl ether is the predominant congener;

(12) "persistent bioaccumulative toxic chemicals" includes carcinogens, mutagens, reproductive toxicants, developmental toxicants, neurotoxicants, endocrine disruptors, and other toxins; in this paragraph,

(A) "bioaccumulative" means increasing in concentration in a living organism to a concentration greater than the concentration of the toxic chemical in the environment in which the organism lives;

(B) "persistent" means remaining in the environment in a toxic form;

(13) "sell" includes an offer to sell;

(14) "technical mixture" means a mixture that is named for the predominant congener and that is not exclusively composed of the predominant congener;

(15) "transportation vehicle" means a mechanized vehicle that is used to transport goods or individuals, and includes an airplane, an automobile, a motorcycle, a truck, a bus, a train, and a ship.

* **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Environmental Conservation may adopt regulations necessary to implement this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: FIRST LIST. On or before February 1, 2014, the Department of Environmental Conservation shall establish the first list required by AS 18.31.680, added by sec. 1 of this Act.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTION. Wherever "chapter" appears in AS 18.31.010 - 18.31.500, the revisor of statutes shall substitute "AS 18.31.010 - 18.31.500."

*** Sec. 5.** Section 2 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 6.** Except as provided in sec. 5 of this Act, this Act takes effect January 1, 2013.

adn.com
Anchorage Daily News

Print Page Close Window

Bill to ban PBDEs would protect Alaskans

COMPASS: ***Other points of view***

By FRANK VON HIPPEL

(02/20/11 17:16:56)

The Alaska State Legislature is considering a bill backed by Sen. Bill Wielechowski and Rep. Lindsay Holmes that would ban the import of furniture and electronics containing a class of toxic flame retardants known as PBDEs (polybrominated diphenyl ethers).

PBDEs are man-made chemicals produced for the manufacture of fire-resistant products. As products break down or release PBDEs into the atmosphere, the PBDEs find their way into the environment. PBDEs are highly persistent; they may remain unchanged for many decades or break down into daughter compounds that are also toxic.

Unfortunately, they are fat soluble and bioaccumulate in the fatty tissues of exposed animals. As these animals are consumed by predators, the PBDEs biomagnify up the food web, resulting in the highest levels in the top carnivores. Many of these top carnivores, such as fish and marine mammals, are important subsistence foods in Alaska.

People are exposed to PBDEs in multiple ways, including through the ingestion of fatty foods as well as contact with household dust. PBDEs have been found in human breast milk and in the blood of mothers and their babies. A Centers for Disease Control and Prevention study found that over 93% of Americans had detectable levels of PBDEs in their bodies, some at levels that are associated with health problems in laboratory animals. PBDEs have been found to disrupt the hormone system of numerous animals and have widespread effects on neurodevelopment and reproductive development.

The laboratory animals chosen for these studies have proven to be excellent models for human medical research time and time again. The hormone system of other vertebrates is almost exactly the same as the hormone system of humans. Therefore, disruption of hormone pathways in laboratory animals indicates that PBDEs likely cause similar developmental and health effects in humans.

PBDEs interfere with thyroid hormone, which regulates many aspects of development, and male and female sex steroids, which regulate sexual development and behavior. For example, PBDE exposure may cause undescended testes in newborn boys and reduced testosterone and sperm counts in men. Some PBDEs may be carcinogens. Although we do not fully understand the mechanisms by which PBDEs disrupt multiple hormone pathways, the evidence is sufficient to take a prudent approach and ban their import to Alaska where feasible.

Washington became the first state to ban all forms of PBDEs in 2007, with key support coming from firefighter associations. Firefighters advocated against PBDEs because when products containing PBDEs burn, they release highly toxic dioxins and furans. Associations of nurses and doctors also supported the legislation.

Maine, Oregon, Vermont, Rhode Island, Illinois and Massachusetts also have banned some or all of the PBDEs, and similar legislation is under consideration in other states. Similar bans are in effect in Canada and most European nations.

The Washington law required that safer and technically feasible alternatives to PBDEs be identified before the ban would go into effect. These alternatives, which meet fire-safety standards, were identified by Washington state agencies in December 2008; the identification of alternative flame

retardants allowed restrictions on the use of PBDEs in electrical products and furniture to take effect Jan. 1, 2011.

Many companies have taken a proactive approach in phasing out PBDE use. For example, Intel, IBM and Ericsson no longer produce products with PBDEs, and Hewlett-Packard, Sony, Motorola, Panasonic, NEC, Samsung and Toshiba are all working to phase out PBDEs.

Alaskans experience unusual levels of PBDE exposure for three reasons: The Arctic is a global sink for persistent pollutants that settle out of the atmosphere in cold temperatures; Alaskans who rely on a subsistence diet eat fish and marine mammals that accumulate PBDEs because of their position at the top of the food web; and we spend most of the winter sealed in our homes, where we are exposed to household dust containing PBDEs.

Therefore, Alaska has extraordinary cause to ban the importation of products containing these chemicals. We cannot control the atmospheric deposition of PBDEs into the Arctic or their delivery by ocean currents, but we can control their importation in consumer products.

Frank von Hippel is a professor of biological sciences at the University of Alaska Anchorage.

Print Page Close Window

Copyright © Mon Feb 21 2011 09:29:43 GMT-0900 (Alaskan Standard Time)1900 The Anchorage Daily News (www.adn.com)

SB 27, FLAME RETARDANTS AND TOXIC CHEMICALS

Packet to support testimony before the Senate Health & Social Service Committee on February 21, 2011 includes:

- Wal-Mart announcement banning PBDEs in products
- DfE Partnership that evaluated alternatives to penta PDE
  See: http://www.epa.gov/dfe/pubs/projects/flameret/index.htm
- DfE Partnership about alternatives to decaBDE.
  See: http://www.epa.gov/dfe/pubs/projects/decaBDE/index.htm
- Greening Consumer Electronics Executive Summary. Full report
  at: http://www.cleanproduction.org/library/GreeningConsumerElectronics.pdf
- Report about evaluating alternatives to decaBDE in television casings (executive summary). Full report
  at: http://www.cleanproduction.org/library/Green_Screen_Report.pdf

Contact information:
Lauren Heine, Ph.D.
Science Director/Partner, Clean Production Action
M: 360-220-2069
lauren@cleanproduction.org
www.cleanproduction.org

Product Safety and Regulatory Notice

Certain Polybrominated Diphenyl Ethers (PBDEs) Banned

URGENT

BANNED! Certain Chemical Flame Retardants Banned
Pentabrominated diphenyl ether (pentaBDE); Octabrominated diphenyl ether (octaBDE); Decabrominated diphenyl ether (decaBDE)

ATTENTION:

- **Merchants and Suppliers of hardware, infant/toddler, electronics, cameras, toys, pet toys and pet supplies, sporting goods, cosmetics and skincare products, electrical appliances, furniture, luggage, outdoor living, home furnishings, impulse merchandise, wireless products, curtains and drapes, and bedding for Walmart, Walmart.com, Sam's Club and Samsclub.com**
- **Global Sourcing**

December 28, 2010

ACTION NEEDED:

Merchants and Global Sourcing – Please forward this notice to any suppliers of the applicable products. In addition, you will need to review this notice and ensure that all requirements are met for all new and replenishable inventories of the applicable products.

Suppliers – Review this notice and ensure that all requirements are met for all new and replenishable inventories of the applicable products.

BACKGROUND:

All consumer products must comply with applicable federal, state, and industry fire safety regulations of the specific product. Several states (including California, Hawaii, Maine, Maryland, Oregon, Vermont, and Washington) have established restrictions on the use of specific chemical flame retardants (polybrominated diphenyl ethers or PBDEs) in all consumer products, and many other states have introduced similar legislation.

GENERAL REQUIREMENTS:

Beginning **June 1, 2011**, Walmart will enhance its testing of the use of polybrominated diphenyl ethers in all consumer products.

ALTERNATIVE SUBSTANCES:

Halogenated flame retardants, other than the above-mentioned PBDEs, are involved in legislative debate and suppliers should evaluate alternatives for halogenated flame retardants (other than PBDEs, which are already prohibited). Halogenated flame retardants, other than the above-specified PBDEs, are not currently banned from use, and this Notice will be updated if the status changes in the future.

PRODUCT TESTING REQUIREMENT:

Testing should be performed to verify that Pentabrominated diphenyl ether (pentaBDE), Octabrominated diphenyl ether (octaBDE), and Decabrominated diphenyl ether (decaBDE) are not detected in consumer products.

AUTHORITY:

Various federal, state, and industry fire safety regulations.

QUESTIONS OR COMMENTS:

Suppliers may submit questions or comments by emailing them to gmcomply@wal-mart.com.

http://www.epa.gov/dfe/pubs/projects/flameret/index.htm

EPA United States Environmental Protection Agency

Share

About Us Consumers Manufacturers Purchasers Publications

Design for the Environment An EPA Partnership Program

Design for the Environment U.S. EPA

Furniture Flame Retardancy Partnership

About This Project | Milestones | Publications | Partners

The Furniture Flame Retardancy Partnership is a joint venture between the Furniture Industry, Chemical Manufacturers, Environmental Groups and the Environmental Protection Agency to better understand fire safety options for the furniture industry.

Publications

The report, "Environmental Profiles of Chemical Flame-Retardant Alternatives for Low-Density Polyurethane Foam," is now available. This report contains a summary of the environmental and human health attributes of selected flame retardants as alternatives to pentabromodiphenyl ether (pentaBDE).

The primary flame retardant historically used in low-density flexible polyurethane foam (pentabromodiphenyl ether - pentaBDE) was voluntarily phased out of production by the sole U.S. manufacturer on December 31, 2004. PentaBDE, with its ability to delay ignition of materials, has saved lives, but there are concerns over its use. Studies worldwide have found pentaBDE to be widespread in the environment and in human tissue and breast milk. More information is available on the polybrominated diphenyl ethers (PBDEs) webpage.

The Consumer Product Safety Commission is also considering more stringent fire safety standards for residential furniture. These new standards could result in more flame retardants being used in furniture foam and fabric in the future.

The decisions the industry must make now on flame retardant alternatives offer a real opportunity to protect public health and the environment. Through the Furniture Flame Retardancy Partnership, EPA and its partners are working to identify and move toward environmentally safer approaches to meeting fire safety standards. The partnership's first objective has been to provide up-to-date toxicological and environmental information on flame retardants used in furniture foam so that furniture manufacturers and suppliers can make informed decisions about which chemicals to use. This work is captured in the partnership's report: "Environmental Profiles of Chemical Flame-Retardant Alternatives for Low-Density Polyurethane Foam," which focuses on flame retardants in furniture foam as alternatives to pentaBDE.

Next, the partnership plans to develop and implement a process to identify additional toxicological data needed for adequately assessing the flame-retardant alternatives reviewed in this report. In the future, the partnership intends to evaluate additional chemical flame retardants and other materials that may be necessary to meet planned national fire safety standards.

Find out more from our pamphlet, Environmentally Preferable Approaches for Achieving Furniture Fire Safety Standards.[2 p., 210 Kb PDF] For more information about the Furniture Flame Retardancy Partnership, contact DfE

Top DfE Questions

- What does the DfE label mean?
- Where can I find a list of products with the DfE label?
- How do I apply to get the DfE label on my products?

Design for the Environment U.S. EPA

Look for the label!

Last updated on Wednesday, January 06, 2010

Flame-Retardant Alternatives for DecaBDE Partnership

About This Project | Milestones | Participants

DfE has convened a multi-stakeholder partnership to explore the human health and environmental profiles of functional and viable alternatives to decabromodiphenyl ether (decaBDE), a chemical of potential concern. Participation of all interest groups is aimed at ensuring that the full range of views are considered from the start of the project and that they are incorporated appropriately into the project objective and methodology. The goal is for the resulting information to help inform the process of substituting to safer alternatives, with reduced health and environmental concerns, for decaBDE.

DecaBDE is a flame retardant used widely in a number of materials to meet flammability standards. Uses of DecaBDE include electronics, wire and cable, building materials, automotive and aviation parts, shipping pallets, and textile coatings.

Why is DfE conducting an alternatives assessment?

EPA is concerned that certain polybrominated diphenyl ethers (PBDEs), are persistent, bioaccumulative, and toxic to both humans and the environment. This concern extends to decaBDE, which breaks down into other PBDE congeners. Various PBDEs have been studied for ecotoxicity in mammals, birds, fish, and invertebrates. In some cases, current levels of PBDE exposure for wildlife may be at or near adverse effect levels. Human exposure to decaBDE can occur through the diet, at the workplace, and in the home. In December 2009, the largest commercial producers and suppliers of decaBDE in the United States agreed to phase out use of the chemical by 2012.

How do I get more information?

If you are interested in participating in this partnership, or if you would like more information, please contact Emma Lavoie of DfE at 202-564-0951 or Lavoie.Emma@epa.gov.

Top Labeling Questions

- What does the DfE label mean?
- Where can I find a list of products with the DfE label?
- How do I apply to get the DfE label on my products?

Look for the label!

Last updated on Thursday, February 17, 2011

Report on Greening Consumer Electronics with case studies on electronic manufacturers who eliminate the use of halogenated flame retardants including PBDEs. Apple eliminated the use of halogenated chemicals completely. Full report is online at: http://www.cleanproduction.org/library/GreeningConsumerElectronics.pdf

PREFACE

Electronics manufacturers, standards bodies, and legislators have begun to take notice of the human health and environmental concerns associated with the use of brominated and chlorinated compounds in electronic products. An array of conflicting definitions and policies have emerged to address these concerns at various levels. This report is intended to show the feasibility of re-engineering consumer electronic products to avoid the use of these compounds and recommends a definition to address human health and environmental concerns that is implementable by industry.

CPA and ChemSec have compiled case studies that provide examples of seven companies that have removed most forms of bromine and chlorine from their product lines. The purpose of this report is to allow parties outside the industry to see the level of conformance that can be met today, as well as provide a tool for engineers designing the next generation of greener electronic devices.

September, 2009

Nardono Nimpuno, ChemSec, and Alexandra McPherson, CPA

INDEX

Preface	1
Index	3
Executive Summary	4
1. Bromine and Chlorine Use in Electronic Components	6
2. Human Health and Environmental Concerns	10
3. E-waste and Recycling Infrastructure	14
4. Establishing Verifiable Bromine and Chlorine Restrictions	20
5. Alternatives to Bromine- and Chlorine-Based Compounds	22
6. Case Studies	24
• Apple, *Restriction of Elemental Bromine and Chlorine to Achieve Elimination of BFRs and PVC in Consumer Electronic Products*	26
• Sony Ericsson, *Bromine- and Chlorine-Free Mobile Phones*	32
• DSM EP, *Bromine- and Chlorine-Free Plastic Components*	36
• NanYa/Indium, *Bromine- and Chlorine-Free Printed Circuit Boards (PCBs)*	40
• Seagate, *Bromine- and Chlorine-Free Hard Disk Drives*	46
• SST, *Bromine-Free Semiconductor Chips*	50
References	54
Conclusion	56

Report about evaluating alternatives to decaBDE in television casings. Executive summary from: http://www.cleanproduction.org/library/Green_Screen_Report.pdf

Executive Summary

The Green Screen for Safer Chemicals defines a path to chemicals that are safer for humans and the environment. It is a rigorous, hazard-based screening method that is designed to inform decision making by businesses, governments, and individuals concerned with the risks posed by chemicals and to advance the development of green chemistry. The Green Screen defines four benchmarks on the path to safer chemicals, with each benchmark defining a progressively safer chemical:

- Benchmark 1:
  Avoid—Chemical of high concern
- Benchmark 2:
  Use but search for safer substitutes
- Benchmark 3:
  Use but still opportunity for improvement
- Benchmark 4:
  Prefer—Safer chemical

Each benchmark includes a set of criteria that a chemical, along with its known and predicted breakdown products and metabolites, must pass. To progress from Benchmark 1 to Benchmark 2, a chemical (and its breakdown products and metabolites) must pass all the criteria specified under Benchmark 1. For example, a chemical (along with its breakdown products and metabolites) that is persistent, bioaccumulative and toxic would not pass beyond Benchmark 1. Similarly, to progress from Benchmark 2 to Benchmark 3 and from Benchmark 3 to Benchmark 4, the chemical (along with its breakdown products and metabolites) must pass all criteria specified under each respective benchmark. The criteria become increasingly more demanding for environmental and human health and safety for each benchmark, with the hazard criteria of Benchmark 4 representing the safest chemical. All of the hazard and benchmark criteria developed for the Green Screen are presented in this report, along with information on government and other precedents for classification that were used to help establish the thresholds.

In order to test the Green Screen, three flame retardants that currently meet performance criteria for use in the external plastic housing of televisions (TVs) were evaluated. With the European Union restricting decabromodiphenyl ether (decaBDE) in electronics and with similar legislative initiatives under consideration at the state level in the United States, a recurring question emerges: are the alternative flame retardants safer than decaBDE from the perspective of human and environmental health and safety? Flame retardant use in TVs is of particular interest

because TVs represent the largest end use for decaBDE.

We use the Green Screen to evaluate three flame retardants: decaBDE and two phosphorous-based alternatives, resorcinol bis (diphenylphosphate) (RDP), and bisphenol A diphosphate (BAPP or BPADP). Of the three flame retardants, RDP was the only flame retardant to pass all criteria under Benchmark 1 of the Green Screen. An integral element of the Green Screen is taking into account potential degradation products and metabolites. This is important given that chemicals in the environment are not static, they integrate into human and natural environments. Both decaBDE and BPADP scored lower on the Green Screen because of their degradation products. While RDP is not a "green chemical" per se, based on assessment via the Green Screen for Safer Chemicals, it achieves a higher level of human and environmental health and safety than the alternatives. Thus RDP (and its breakdown products), based upon a Green Screen assessment, is a safer chemical.

Version 1 of the Green Screen is intended for public use and dissemination. We hope that as the Green Screen is applied, further refinements and improvements will be made. The Green Screen for Safer Chemicals represents a needed building block on the path to sustainable material flows in our economic and ecological systems. It is our goal that companies, government agencies, academia, and nonprofits will use the Green Screen to select inherently safer chemicals, thereby reducing the risks of exposure to toxic chemicals and increasing the availability of safer, healthier products.

ALASKA INTER-TRIBAL COUNCIL
Advocating for Tribal Governments Across Alaska

445 East 5th Avenue
Anchorage, AK 99501

907.563.9334
907.563.9337 *fax*
www.aitc.org

February 17, 2011

Senator Bill Wielechowski
State Capitol
Juneau, AK 99801

Dear Senator Bill Wielechowski:

The Alaska Inter-Tribal Council is writing in support of SB 27, a bill that would prohibit the manufacture and sale of toxic flame retardants in common consumer products. The Alaska Inter-Tribal Council is a tribally-governed organization advocating on behalf of 232 Federally Recognized tribal governments throughout Alaska. We recognize increasing evidence that flame retardants, such as polybrominated diphenyl ethers (PBDEs) named in SB 27, are being found in the Arctic. We are concerned about PBDEs leaving a lasting toxic legacy in people and the environment.

PBDEs are potent toxins that persist in the environment and bioaccumulate in the food chain and in human tissues. They can travel long distances and move readily between the water, soil and air. PBDEs are associated with a variety of negative toxic effects including memory impairment, learning and behavioral problems, the disruption of thyroid hormone balance and reproductive health issues. In Alaska, PBDEs have been detected in seabird eggs, marine mammals, otters, and polar bears. The presence of such chemicals in wildlife is cause of concern, not only for the survival and well-being of wildlife, but for the human consequences of bioaccumulative exposure through the food we eat.

We need to enact legislation to phase out PBDEs from consumer products. Fortunately, fire safety can be achieved without the use of toxic chemicals because there are safe, economical, and effective alternatives to PBDEs currently in widespread use.

Eliminating most uses of PBDE flame retardants is possible and an important step to protecting public health.

Thank you for sponsoring this bill,

David Harrison

David Harrison
Executive Director
Alaska Inter-Tribal Council

the Arc of anchorage
2211 Arca Drive • Anchorage, Alaska 99508
(907) 277-6677
Fax (907) 272-2161
TTY (907) 258-2232
E-mail: info@arc-anchorage.org
www.arc-anchorage.org

February 16, 2011

Senator Bill Wielechowski
State Capitol
Juneau, AK 99801

Dear Senator Wielechowski:

The Arc of Anchorage would like to thank you for introducing SB 27, *"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date."* The Arc of Anchorage is a private not-for-profit organization that serves people with developmental disabilities and mental health issues so they can lead rich and productive lives. The Arc looks forward to a day when it is no longer needed because all preventable disabilities have been prevented, but we need legislative help to address prevention.

Learning and developmental disabilities influence the quality of life for affected children and their families, and also impose a heavy financial burden on the state through required Special Education, increased health care costs, lost work time for parents, and a lifelong loss of work productivity for severely affected children. Scientific evidence has demonstrated that some chemicals, including decaBDE, can cause learning and developmental disorders. We must not expose our children to toxicants that we know or suspect can harm their developing brains and bodies. We know safe alternatives can replace the need for these toxic chemicals without compromising fire safety.

Developing children are more susceptible to toxic exposures than adults. When certain exposures occur at certain times, sometimes even at very low doses, the development of children's brains, other organs, and reproductive, hormonal, and immune systems can be permanently altered. Recent evidence has shown children who had higher cord blood concentrations of polybrominated diphenyl ethers (PBDEs) scored lower on tests of mental and motor development at 1–4 and 6 years of age. This work was initiated based on a large body of research indicating that prenatal PBDE exposure has the potential to disrupt neurodevelopment.

PBDE residues, particularly highly brominated PBDEs such as deca-BDE, have been found consistently in tissue samples of both new mothers and their newborn infants, as well as in mothers' breast milk. Ingestion of contaminated milk is one of the two major routes of PBDE exposure in children, and there are concerns about the high concentrations ingested, given the

susceptibility of newborns. This trend has been found to occur around the globe. Yupik women from the Yukon Kuskokwim Delta of Alaska have the highest known concentrations of PBDEs in human populations in the Arctic.

Children rely on adults to keep them safe from harm. Therefore, it is up to us to do everything we can to keep them safe and to minimize their exposures to toxics. SB 27 is important legislation that will help protect children from needless exposures to this persistent, toxic chemical.

Thank you,

Patti J. Saunders

Patti Saunders
Director of Development
The Arc of Anchorage

Alaska Nurses Association (AaNA)
2010 Resolution #7
Resolution on Polybrominated Diphenylethers (PBDEs)
10/17/2010

Whereas, PBDEs are toxic, endocrine-disrupting flame retardant chemicals added to plastics, foam products and textiles; and

Whereas, prenatal exposures to PBDEs at levels commonly found in households have been shown in studies to be associated with adverse neurodevelopmental effects in young children; and

Whereas, people living in North America have levels of PDBEs that are 10-40 times higher than individuals living in Europe or Japan and people living in northern regions are particularly vulnerable to PBDE exposure; and

Whereas, safer and economically viable alternatives are available and are already being used by some manufacturers of computers and other products; and

Whereas, the American Public Health Association and International Association of Fire Fighters have urged the phase-out of PDBEs and other harmful chemicals when safe alternatives are readily available;

Therefore be it resolved, that the Alaska Nurses Association supports the passage of SB295.

____X___approved _____rejected

Alaska Conservation Alliance

"A Strong Economy and Healthy Environment Go Hand in Hand"

2/17/11

Senator Bill Wielechowski
State Capitol, Rm. 101
Juneau, AK 99801-1182

Dear Sen. Wielechowski:

The Alaska Conservation Alliance supports SB 27, which phases out the sale and manufacture of a dangerous class of chemicals in Alaska, and selected the issue as one of three legislative priorities for the 2011 Legislative Session. The Conservation Alliance is an umbrella group for approximately 40 member organizations with a combined membership of over 38,000 Alaskans. We serve as a powerful voice to advance conservation with decision-makers in Alaska. The Conservation Alliance believes that a healthy environment and a strong economy go hand in hand.

Alaskans deserve safe homes for their families. Unfortunately, many common household items including mattresses, textiles, and plastic casings for electronics (primarily in TVs and computers) contain a dangerous class of chemicals known as PBDEs. PBDEs are used as flame retardants but cause cancer and developmental disabilities in our children. Other flames retardants are safer and cost effective. In fact, a number of manufacturers already use these safer flame retardants voluntarily.

The risk posed to Alaskans by PBDEs is higher than people in other parts of the country. Studies show that Alaskans have the highest concentrations of PBDEs in their bodies of any state population due, in part, to us spending more time indoors during our long winters. SB 27 is a smart first step to solving this problem.

SB 27 is a well-balanced approached to make our homes safer and allowing businesses to smoothly transition from selling harmful products to safer ones. Thank you for bringing this legislation forward.

Sincerely,

Caitlin Higgins

Caitlin Higgins
Executive Director
Alaska Conservation Alliance

810 N Street, Suite 203 | Anchorage, AK 99501 | 907-258-6171 | F: 907-258-6177
www.akvoice.org | www.twitter.com/ACAAlliance
www.facebook.com/AlaskaConservationAlliance

Representative Lindsey Holmes
State Capitol
Juneau, AK 99801

February 18, 2011

Dear Representative Holmes:

I am writing to you in support of HB 63, which would ban polybrominated fire retardants in consumer products, while giving the Department of Environmental Conservation additional powers and encouraging cooperation with other states in such activities. Rather than elaborating on the rationale for this legislation, which is effectively presented in your sponsor statement, I'll describe the issue of PBDE toxicity as it relates to the burn injury community. This is in order because the brominated flame retardant (BFR) chemical industry often seeks our support when their products are challenged by such legislation

I support HB 63 in my role as a founding director (in 1985) and emeritus Board member of the Federation of Burn Foundations (FBF), and as a former major committee chair, honoree (twice) and member of the Board of Trustees of the American Burn Association (ABA).

It is understandable that anyone who treats severely burned patients or works closely with both care providers and survivors, as I have for 35 years, would be inclined to support any action which might save a life or prevent such an injury. That was my own position until four years ago, when I first became aware of the increasing public health and environmental threat posed by the accumulating presence of toxic frame retardant chemicals in the environment and human tissue, --along with the lack of any data supporting their effectiveness. Many of us in the ABA share such concerns,

I have also felt a special responsibility to monitor fire and burn injury statistics, as the ABA member trusted with updating the Association's annual burn incidence fact sheet. In tracking the steady decline in fire and burn death and injury over the past 30 years, I have noted the many reasons for those trends. These include numerous safety efforts, such as smoke alarms, more public education, stronger building codes and safer designs of cigarettes, cigarette lighters and candles. Unlike PBDEs, none of these influences on fire casualties have negative side effects, and they have had a far greater positive impact than any that can be claimed for these chemicals.

Other recent changes in society which are not motivated by fire safety have also helped reduce fire casualties. These include the major decline in smoking, the transition in cooking from the stove to the microwave and our growing reliance on restaurants and fast food outlets.

For these reasons, I strongly encourage support for HB 63 in this session of your legislature.

Sincerely,

Peter A. Brigham

Peter A. Brigham, MSW
346 Trevor Lane
Bala Cynwyd, PA 19004

From: Marc! <marcslinger@yahoo.com>
Date: February 19, 2011 12:57:20 PM AKST
To: "Sen. Bill Wielechowski" <Senator_Bill_Wielechowski@legis.state.ak.us>
Subject: SB 27

Dear Representative Wielechowski,

Thank you for your support in the prevention of toxic exposures! As a member of the Anchorage Fire Department, I proudly protect and serve our community without hesitation. Thank you for doing your part and protecting not only us as public servants, but everyone in our state, current and future.

Support SB 27.

With much gratitude,
Marc Esslinger
Firefighter/Paramedic

Karla Hart

From: Briana Sullivan [brianasull@gmail.com]
Sent: Friday, February 18, 2011 9:15 PM
To: Sen. Bill Wielechowski
Subject: SB 27

Follow Up Flag: Follow Up
Flag Status: Flagged

Dear Senator,
Please make a healthy change to Alaska and its future; support Preventing Toxic Exposures.

Thank you for making a difference.
Peace,
Briana Sullivan

Karla Hart

From: Justine Bishop [jerica.b1967@gmail.com]
Sent: Saturday, February 19, 2011 3:54 PM
To: Sen. Dennis Egan
Cc: Sen. Bill Wielechowski; Rep. Cathy Munoz; Rep. Beth Kerttula
Subject: SB 27...

Hello, Senator Egan.

I am writing to ask you to support SB 27 to reduce our exposure to household toxins. These toxic fire-retardants are "kissing cousins" to PCBs and has been used in large quantities, up to 5-7% by weight, in foams in upholstered furniture. It flakes off in microscopic particles which are then ingested. Kids are at particular risk of exposure and ingestion because many of them eat close to the floor... the one second rule isn't fast enough to avoid picking up the toxins when eating food off the floor or with greasy fingers that touched the sofa.

Thank you for your consideration.

Justine Bishop
Lifelong Juneau Resident

NATIVE VILLAGE OF SAVOONGA • P.O. BOX 120, SAVOONGA, AK 99769 • PHONE 984-6414 • FAX 984-6027

March 11, 2010

To: Honorable Senators and Representatives of the Alaska Legislature

From: Native Village of Savoonga

Regarding: Support of HB 385 and SB 295

Dear Legislator:

The Native Village of Savoonga is submitting this letter in support of HB 385 and SB 295, legislation to phase out the manufacturing, sale, and distribution of products that contain polybrominated biphenyl ethers (PBDEs). We believe that action on this class of persistent toxic chemicals is necessary to protect the health and well-being of our people and future generations. We must do everything we can to protect the health of our children who are especially vulnerable because exposure to these chemicals can harm their developing brain and their ability to learn. We know that there is also increasing evidence that links exposure to PBDEs with other serious health problems such as permanent developmental disorders, reproductive harm, thyroid disease, and certain types of cancer.

We are aware that PBDEs are transported on wind and ocean currents into our region and are accumulating in the north/Artic at an alarming rate. PBDEs are now found in our traditional foods, including fish, seabird eggs, and marine mammals. Our people are also at risk because of the presence of PBDEs in products that we use in our homes and that we may be experiencing higher exposures because our homes are closed in for a greater part of the year than in lower latitudes. We are concerned that in a recent study of the Arctic Monitoring and Assessment Program, Yupik women from the Yukon-Kuskokwim Delta had the highest levels of PBDEs of any human population of the circumpolar Arctic. It is necessary to take action to prevent exposures to PBDEs and other persistent, bioaccumulative and toxic chemicals.

We urge you to take this opportunity to pass this important piece of legislation in order to protect our health and the health of all Alaskans. Thank you for your attention to our

concerns.

Sincerely, Verna Emmingham Vice President

For Kenneth Kingeekuk

President, IRA Council, Native Village of Savoonga

From: Roxanne Chan [mailto:chan.rox@gmail.com]
Sent: Wednesday, March 17, 2010 12:46 AM
To: chan.rox@gmail.com
Subject: support for SB 295

Senator Bettye Davis and Members of the Committee
Senate Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

March 16, 2010

Dear Chair Davis and Members of the Senate Health and Social Services Committee:

Thank you for taking the opportunity to hear testimony on SB 295, an important bill to phase out octa-, penta-, and decaBDE from certain uses, for which safer, effective alternatives are in widespread, successful use. I am unable to attend the hearing scheduled on Wednesday, March 17, 2010 but appreciate the opportunity to submit written support of this bill. I urge that the Committee support this bill.

My name is Roxanne Chan and I am a Registered Nurse and Licensed Acupuncturist currently residing in Anchorage. Since moving to Alaska in 2005, I have had the opportunity to practice nursing in communities such as Barrow, Nome,Â and Anchorage. I also recently had the opportunity to participate in a biomonitoring study where my blood was tested for PBDEs.

In October of 2009, the report *Hazardous Chemicals in Health Care: A Snapshot of Chemicals in Doctors and Nurses* (

http://www.psr-la.org/files/hazardous-chemicals-in-health-care.pdf), was released documenting the levels of different chemicals of twelve doctors and eight nurses from around the country including myself and a physician from Alaska. My results showed that I have at least 19 different PBDEs in my body including the ones this bill aims to phase out.

As someone who is generally aware of chemical exposure from consumer products, I was alarmed to see my results showing that these chemicals were found in my blood. PBDEs have been linked to a wide range of health problems and it made me wonder if my exposure to chronic low levels due to consumer products could result in adverse health in the future.

As I am sure you are aware, a central tenant of health care isâ€"put simplyâ€"first, do not harm. Allowing chemicals on the market which are correlated to adverse health effects is contrary to this principal. Reducing chemical exposures, through policy measures such as SB 295, is an important primary prevention measure to help improve the health of our state overall.

I hope that you will join me and others in supporting SB 295, an important step in reducing Alaskans exposure to toxic chemicals and creating an environment where people can be healthier.

Sincerely,

ã€€

Roxanne Chan, RN, LAc

ã€€

--
Roxanne Chan, Licensed Acupuncturist
Spring Wind Acupuncture
610 W. 2nd Ave, Suite 100
Anchorage, AK 99501
tel: (907) 440-8660
fax: 1-866-747-3256
www.springwindacupuncture.com

From: Karen McLane [mailto:gusskimo@yahoo.com]
Sent: Saturday, March 20, 2010 9:17 AM
To: Senator_Bettye_Davis@legis.state.ak.us; Senator_Joe_Paskvan@legis.state.ak.us; Senator_Fred_Dyson@legis.state.ak.us; Senator_Johnny_Ellis@legis.state.ak.us; Senator_Joe_Thomas@legis.state.ak.us; Senator_Bill_Wielechowski@legis.state.ak.us
Subject: Senate Bill 295 support

Dear Senators,

I am writing regarding this important piece of legislation that Sen Wielechowski has submitted for approval. I live in Nome and have for most of my life. My family moved here when I was 4 years old and I graduated from Nome Beltz High School in 1984. I continued my education to the Masters level in Nursing Science and am now back in Nome teaching Community Health Aides so we can have medical services in our remotest villages. As health care providers we are acutely aware of the health hazards that toxins have in our environment and how they get there.

We have the highest rates of cancers in Alaska. I have seen many, many thyroid cancers and gastrointestinal types of cancers as well. It is my belief that toxins in our Native people's environment play a part in these high rates as does tobacco use.

SB 295 would require the phase out of polybrominated diphenyl ethers (PBDEs). PBDEs are toxic flame retardant chemicals added to plastics, foam products, and textiles to make them difficult to burn. The EPA is concerned that certain PBDEs are persistent, bioaccumulative, and toxic to both humans and the environment. The American Public Health Association and International Association of Fire Fighters have urged the phase out of PBDEs. Safer and economically viable alternatives are available and are already being used by some manufacturers of computers and other products.

Please think about the affects this particular toxin has on the health of our people and vote to phase it out of use.

Thank you for your help,

Karen McLane FNP-BC
P.O. Box 1169
Nome, AK 99762
(907) 304-3768
gusskimo@yahoo.com

From: Simon, Clover [mailto:Clover.Simon@ppgnw.org]
Sent: Friday, March 19, 2010 5:46 PM
To: Senator_Bettye_Davis@legis.state.ak.us; Senator_Joe_Paskvan@legis.state.ak.us; Senator_Fred_Dyson@legis.state.ak.us; Senator_Johnny_Ellis@legis.state.ak.us; Senator_Joe_Thomas@legis.state.ak.us
Subject: Senate Bill 295

Senators:

On behalf of Planned Parenthood of the Great Northwest, our thousands of supporters in Alaska and the more than 9,000 women and men we provide services to I am writing to urge you to support and pass SB 295. Providing Alaskans with a safe environment in which to raise their children is paramount to our mission and will help ensure that when families do plan to have children they will be the healthiest possible. With safe alternatives that still provide excellent fire protection there is no reason not to pass this important legislation. PPGNW is a proud member of the Healthy Families Alliance with many other agencies across Alaska, formed to promote fundamental reform to current chemical laws to protect children, workers, communities and the environment. As PPGNW 'goes green' in our health centers we hope that we can help promote cleaner, toxic free environments for everyone in the State. This bill is the first step.

PBDEs are toxic, endocrine-disrupting flame retardant chemicals added to plastics, foam products, and textiles. They leach from household products and we are exposed through foods, indoor air, and household dust.

A brand new study conducted by researchers at Columbia University showed that prenatal exposure to PBDEs at levels commonly found in households is associated with adverse neurodevelopmental effects in young children. The researchers found that "children with higher concentrations of PBDEs in their umbilical cord blood at birth scored lower on tests of mental and physical development between the ages of one and six. Developmental effects were particularly evident at four years of age, when verbal and full IQ scores were reduced 5.5 to 8.0 points for those with the highest prenatal exposures. "

Thank you for hearing this important legislation and please do not hesitate to contact me directly if you would like further information on our position.

Clover

Clover Simon, MSW
Planned Parenthood of the Great Northwest
VP of Alaska
4050 Lake Otis Pkwy Suite 205
Anchorage AK 99508
907.770.9705 (office)
907.240.7449 (cell)

Please note the Anchorage administrative offices have moved, find our new address above*

Donate Online PPGNW is a 501(c)(3) not-for-profit organization. We rely on the generous support of donors to safeguard reproductive rights, healthcare, and education.

CSPA®
Representing Household & Institutional Products
Aerosol - Air Care - Cleaners - Polishes
Automotive Care - Antimicrobial - Pest Management

February 18, 2011

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

Re: SB 27 - Development of PBT Chemicals List – OPPOSE

The Consumer Specialty Products Association must respectfully oppose SB 27 (Wielechowski), which would, among other things, direct the Department of Health and Social Services to establish, and update every three years a list of "persistent bioaccumulative toxic chemicals (PBTs)" that occur or are used in products used by human beings.

The Consumer Specialty Products Association (CSPA) is the premier trade association representing the interests of some 250 companies engaged in the manufacture, formulation, distribution and sale of $80 billion annually in the U.S. of hundreds of familiar consumer products that help household and institutional customers create cleaner and healthier environments. Our products include disinfectants that kill germs in homes, hospitals and restaurants; candles, and fragrances and air fresheners that eliminate odors; pest management products for home, garden and pets; cleaning products and polishes for use throughout the home and institutions; products used to protect and improve the performance and appearance of automobiles; aerosol products and a host of other products used every day.

CSPA members are committed to manufacturing and marketing safe products that are protective of human health and the environment while providing essential benefits to consumers. CSPA has adopted its members' commitment into the CSPA Principles for Chemicals Management Policy, available online at http://www.cspa.org/infocenter/our-issues/principles-for-chemicals-management-policy/.

CSPA supports programs that are risk based and use sound science. Programs should be governed by an advisory panel in which all stakeholders have a voice. CSPA supports programs that encourage resource pooling and build on existing statutory and regulatory structures, voluntary initiatives and data development efforts.

We are unclear why a PBT list is being drafted and how the list will be used in the future. SB 27 should include specific language that clearly describes the intent and future plans for creating and utilizing a state-specific PBT list.

To provide consistency with other regulatory structures, the PBT screening criteria used by the United States Environmental Protection Agency (USEPA) should be adopted. As currently drafted, Section 18.31.680 does not contain a clear set of definitions for the characteristics of P or B or T that is consistent with generally accepted PBT screening criteria. Though the bill does ask the Department to consider other sources of PBT information (e.g. Washington State PBT program, USEPA high production volume challenge program), CSPA believes that the bill should establish a clear definition to help ensure a focus on priority substances.

In addition, CSPA believes the bill should include language that directs the Department to develop and implement a stakeholder process through which interested parties can participate and provide input into the development and potential use of any PBT lists or potential alternative chemicals. A formal stakeholder process will help ensure that the overall process is informed by the best available scientific information.

SB 27 could be appreciably improved with the addition of language that provides transparent and objective parameters for selecting the best available scientific information. An example is the European Chemicals Agency's (ECHA)'s guidance document titled "Guidance on Information Requirements for Chemical Safety Assessment." The ECHA's guidance provides four specific parameters for selecting the best available scientific information based on relevance, reliability, and adequacy. The fundamental importance of having screening parameters is embodied in a quote by the ECHA, which stated "[t]he knowledge of how a study was carried out and consequently its relevance and reliability, is a prerequisite for the subsequent evaluation [and use] of [the] information."

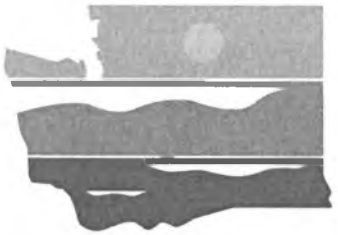
For the reasons expressed above, we must oppose SB 27. Please contact me at (916) 838-3587 or kpower@cspa.org if you have questions regarding CSPA's concerns.

Sincerely,

Kristin Power

Kristin Power
Director, State Affairs – West Region

cc: Senator Wielechowski
Members, Senate Health and Social Services Committee
CSPA State Government Affairs Advisory Committee



Alternatives to Deca-BDE in Televisions and Computers and Residential Upholstered Furniture

Implementation of RCW 70.76: Identifying safer and technically feasible alternatives to the flame retardant called Deca-BDE used in the electronic enclosures of televisions and computers and in residential upholstered furniture

Final Report

December 29, 2008

Department of Ecology Publication No. 09-07-041
Department of Health Publication No. 334-181

Executive Summary

This report fulfills the requirements of RCW 70.76, signed into law by Governor Gregoire in 2007. This law restricts the manufacture, sale and distribution of products containing a type of chemical flame retardant called PBDEs (polybrominated diphenyl ethers). The three types of PBDEs used in consumer products are Penta-BDE, Octa-BDE and Deca-BDE. The prohibition became effective for all products containing Penta-BDE and Octa-BDE, and for mattresses containing Deca-BDE in January, 2008. At the time the law was passed, safer alternatives for Deca-BDE had not been identified for other products, specifically, residential upholstered furniture, and electronic enclosures used in televisions and computers. RCW 70.76 lays out a process for identifying the availability of safer, technically feasible alternatives to Deca-BDE that meet fire safety standards for these applications. When safer alternatives are identified, the manufacture, sale or distribution of upholstery and electronic enclosures containing Deca-BDE will be prohibited two years from the date of identification.

As required by RCW 70.76, the Departments of Ecology (Ecology) and Health (DOH) reviewed risk assessments, scientific studies, and other relevant findings regarding alternatives to the use of Deca-BDE in residential upholstered furniture, televisions, and computers.

The agencies identified a safer, technically feasible alternative chemical flame retardant for TVs and computers. Non-chemical alternatives were identified for upholstered furniture. These alternatives were presented to a committee of fire safety experts appointed by the governor to determine if they can provide appropriate fire retardant capacity. The Fire Safety Committee met on November 7, 2008 and found that the identified alternatives meet applicable fire safety standards. The Fire Safety Committee reported its findings to the Office of the State Fire Marshal who, on November 18, 2008, determined that the identified alternatives meet applicable fire safety standards.

Ecology posted the draft report on its web page and notified the public and stakeholders about its availability. Public comment was accepted from November 20 until December 17, 2008. A notice was placed in the State Register on December 3, 2008 as well. A response to these comments in included in Appendix 6.

Alternatives Assessment Approach

RCW 70.76 requires that Ecology and DOH review risk assessments, scientific studies and other relevant findings to determine if a safer and technically feasible alternative to Deca-BDE is available. The statute requires that the agencies assure that at least one safer alternative is available. The agencies interpret "safer and technically feasible" as including:

- A chemical alternative to Deca-BDE that is less toxic, less persistent or less bioaccumulative than Deca-BDE, and that is currently being used in products, or

- A technology, material or other design strategy, currently in use and reasonably available, that provides fire safety for televisions, computers or upholstered furniture without the addition of chemical flame retardants. For example, while some electronic enclosures achieve fire protection through the use of metal instead of plastic, Ecology believes that requiring redesign to this extent may go beyond the definition of "feasibility" in the statute.

The agencies did not evaluate every option and therefore this report makes no assertion as to the relative safety of flame retardants or technologies we did not evaluate. Ecology and DOH do not have the regulatory authority to dictate what method furniture manufacturers select to maintain fire safety.

The statute does not require that the identified safer alternative be a direct substitute for Deca-BDE but does require that the alternative be "technically feasible". Ecology determined that a good indicator of technical feasibility is the presence and reasonable availability of the product on the market using the alternative. For example, if Ecology demonstrates that currently available computers are employing the identified alternative to Deca-BDE, then that alternative is considered technically feasible.

Electronic Enclosures for TVs and Computers

There are many available chemical flame retardants that can be used to provide fire safety for televisions and computers. In evaluating alternatives to the use of Deca-BDE in electronic enclosures, Ecology and DOH focused on non-halogenated flame retardants which are less likely to persist in the environment and to bioaccumulate in organisms. Non-halogenated alternatives also have the added benefit of being much more easily degraded than their halogen equivalents, thereby reducing their potential long-term impact on human health and the environment.

Technical feasibility was evaluated using indirect information because manufacturers do not generally reveal which chemicals are actually being used to provide fire safety in their electronic products. Ecology looked first to Europe, where Deca-BDE has been banned in electronic products since July, 2008. Ecology assumed that if these products can be made cost effectively and sold in Europe they can be made cost effectively and sold in the U.S. as well. Several European studies demonstrate that resorcinol bis(diphenyl phosphate) (RDP) has been used in electronic enclosures for televisions and computers sold in Europe. Also, the computer industry has largely moved away from use of halogenated flame retardants. Ecology and DOH did not identify technically feasible design options for televisions and computers that do not require the use of added flame retardants so these alternatives were not considered feasible.

After reviewing recent studies, reports and other information, most of which became available after the PBDE Chemical Action Plan was completed, Ecology and DOH identified two possible phosphate-based flame retardants: resorcinol bis diphenyl phosphate (RDP) and triphenyl phosphate (TPP), as technically feasible alternatives.

The agencies then conducted a review of information available on these two flame retardants to determine if both could be recommended as safer alternatives to Deca-BDE. This review included a comparison of toxic effects levels observed in animal studies and an evaluation of aquatic toxicity information.
Based upon this evaluation, the agencies found that RDP is a safer and technically feasible alternative to Deca-BDE. TPP was eliminated due to concerns related to its aquatic toxicity.

Plastics used in electronic products are rated for their flame retardation capacity using a voluntary standard identified by the National Fire Protection Association (NFPA) in conjunction with the Underwriters Laboratory (UL), which defines the specific method. The agencies presented information to the Fire Safety Committee on the performance of RDP compared with Deca-BDE when used in electronic enclosures. RDP performs as well as Deca-BDE, although a different type of plastic has to be used. As required by RCW 70.76, the Fire Safety Committee voted on whether or not RDP provides appropriate fire protection. The committee unanimously found that RDP meets applicable fire safety standards.

FINDING
A safer, technically feasible alternative to Deca-BDE, which meets applicable fire safety standards, is available for use in televisions and computers.

Residential Upholstered Furniture

For residential upholstered furniture, Ecology and DOH relied on information from the Consumer Product Safety Commission (CPSC) about the current use of Deca-BDE in furniture sold in the U.S. and the availability of furniture design options that do not require the addition of chemical flame retardants. Ecology and DOH decided to focus on design alternatives that use inherently flame resistant materials, rather than evaluate options that use added chemical flame retardants. Since there are currently available design options that can be used to achieve fire safety, the agencies focused on these instead of evaluating the safety of other chemical flame retardants that could be used to comply with the proposed standards.

The CPSC recently published a proposed flammability standard for residential upholstered furniture. Under the CPSC's proposed standard, fire safety in upholstered furniture can be achieved through the use of compliant cover materials (fabrics) or internal barrier layers. The proposed standard does not rely on the addition of chemical flame retardants, such as Deca-BDE, for compliance although flame retardants could be used. If the proposed standard is finalized as such, furniture manufacturers will have the option to meet fire safety requirements through several currently available design options that use inherently flame resistant cover fabrics or internal barriers. For example, many existing cover materials, especially those made from synthetic fibers, can meet the proposed standard without the addition of chemical flame retardants.

Furniture manufacturers could also comply with the CPSC proposed standard by using internal barrier materials, some of which may require the addition of chemical flame retardants. Inherently flame retardant barrier technologies that do not require the addition of chemical flame

retardants are available similar to those currently being used to achieve fire safety in mattresses. The CPSC estimates that the use of barrier materials in general as a method to comply with these standards is not a popular choice among manufacturers and would likely be used in only about 5 percent of upholstered furniture. Chemical flame retardants are most likely to be used in internal barriers under the CPSC proposed standard, but they are not expected to be widely used because many cover fabrics will comply. Although the CPSC flammability standard for residential furniture has not been finalized, it is expected that design options will be available to meet any additional requirements in a final standard.

California is the only state that currently has a flammability standard for residential upholstered furniture and Deca-BDE has not been used to meet this standard. According to CPSC staff, Deca-BDE is currently not being used by furniture manufacturers to comply with the California standards nor would it be used to comply with the proposed CPSC standards. Therefore, any ban on the use of Deca-BDE for this purpose in Washington would not impose new costs or require manufacturers to retool their processes or redesign their products in order to comply with this prohibition.

Based on furniture design options that are already available, the agencies concluded that the safer, technically feasible alternative to Deca-BDE in residential furniture is non-chemical design options. The Fire Safety Committee voted on whether or not these non-chemical design changes can provide appropriate flame retardation. The committee unanimously found that non-chemical alternatives meet the proposed federal CPSC fire safety standards for residential upholstered furniture.

FINDING

Safer, technically feasible alternatives to the use of Deca-BDE, which meet the current and proposed applicable fire safety standards, are available for use in residential upholstered furniture.

CONCLUSIONS

Safer, technically feasible alternatives to the use of Deca-BDE in TVs, computers and residential upholstered furniture are available and meet applicable fire safety standards. The restrictions on the use of Deca-BDE in these products as defined by RCW 70.76 will take effect on January 1, 2011.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

GO

State Regulation of PBDEs

Updated February 2011

Polybrominated diphenylethers (PBDEs) are used widely as flame retardants in a number of consumer products, including mattresses, furniture foam, consumer electronics, wire insulation, draperies and upholstery. However, there is concern about the potential environmental and human health effects of PBDEs. Studies have shown that PBDEs accumulate in the environment and living organisms. These compounds have also been associated with liver toxicity, thyroid toxicity, and neurodevelopmental toxicity in humans.

State legislative activity has focused on three types of PBDEs: pentaBDE, octaBDE and decaBDE. Twelve states regulate pentaBDE and octaBDE in certain consumer products. Of these, eight states also regulate decaBDE or have authorized studies into its environmental or human health effects. Illinois, Indiana, Minnesota, New York and Rhode Island require manufacturers of certain electronic products to notify the state if their products exceed the European Union's maximum concentration values for PBDEs. Minnesota also requires that PBDE-free equipment, supplies and products be made available for purchase and use by state agencies.

For state legislation addressing PBDEs, visit NCSL's Environmental Health Legislation Database.

Featured Items

- State Statutes Regulating PBDEs
- Other State Statutes Addressing PBDEs

NCSL Staff Contacts

- Doug Farquhar
- Scott Hendrick

State Statutes Regulating PBDEs

State	Citation	Summary
California	West's Ann.Cal.Health & Safety Code § 108920 to 108923	Prohibits a person from manufacturing, processing or distributing a product, or a flame- retarded part of a product, containing more than one-tenth of 1 percent of pentaBDE or octaBDE, except for products containing small quantities of PBDEs that are produced or used for scientific research on the health or environmental effects of PBDEs.
Hawaii	HRS § 332D-1 to 332D-3	Prohibits a person from manufacturing, processing or distributing a product, or a flame-retarded part of a product, containing more than one-tenth of one per cent, by mass, of pentaBDE, octaBDE, or any other chemical formulation that is part of these classifications. This prohibition does not apply to the processing of metallic recyclables containing pentaBDE or octaBDE.
Illinois	410 ILCS 48/1 to 48/99	Prohibits a person from manufacturing, processing or distributing a product, or a flame- retarded part of a product, containing more than one-tenth of 1 percent of pentaBDE or octaBDE. Exempts used products and the processing of recyclable material containing pentaBDE or octaBDE. Authorizes a study of the health and environmental effects of decaBDE.

Maine	38 M.R.S.A. § 1609	Prohibits a person from selling or distributing a product containing more than 0.1% of the "penta" or "octa" mixtures of polybrominated diphenyl ethers. Prohibits a person from manufacturing, selling or distributing certain products containing the "deca" mixture of polybrominated diphenyl ethers. These products include mattresses, mattress pads, upholstered furniture, shipping pallets, televisions, and computers. Exempts transportation vehicles and parts, parts and equipment used in industrial manufacturing, and electronic cable and wiring used in power transmission. Requires manufacturers of products containing PBDE to notify retailers of prohibitions.
Maryland	MD Code, Environment, § 6-1201 to -1205	Prohibits a person from manufacturing, processing or distributing a product, or a flame- retarded part of a product, containing more than one-tenth of 1 percent of pentaBDE or octaBDE. Prohibits the manufacture, lease, sale or distribution of certain products containing decaBDE. Makes certain exemptions.
Michigan	M.C.L.A. 324.14721 to .14725	Prohibits the manufacturing, processing or distribution of products or materials containing than 1/10 of 1% of penta-BDE or octa-BDE. Authorizes PBDE advisory committee to study human health and environmental risks of PBDEs.
Minnesota	M.S.A. § 325E.385 and .386	Prohibits a person from manufacturing, processing or distributing a product or flame-retardant part of a product containing more than one-tenth of one percent of pentabromodiphenyl ether or octabromodiphenyl ether by mass. Makes certain exemptions.
	M.S.A. § 325E.387	Requires state to review the commercial use and health and environmental risks of decaBDE.
New York	McKinney's ECL § 37-0111	Prohibits a person from manufacturing, processing or distributing a product, or a flame-retardant part of a product, containing more than one-tenth of one per centum of pentabrominated diphenyl ether or octabrominated diphenyl ether, by mass. Makes certain exemptions.
Oregon	O.R.S. § 453.005	Lists pentaBDE, octaBDE and decaBDE as hazardous substances and therefore subject to labeling and product restrictions under O.R.S. §§ 453.005 to 435.185.
Rhode Island	Gen.Laws 1956, § 23-13.4-1	Codifies legislative finding that the state should develop a precautionary approach regarding the production, use, storage, and disposal of products containing brominated fire retardants. Prohibits a person from manufacturing, processing or distributing a

		product or a flame-retardant part of a product containing more than one-tenth (1/10 %) of one percent (1%) of pentaBDE or octaBDE. Makes certain exemptions. Authorizes a study of the health and environmental effects of decaBDE.
Vermont	9 V.S.A. § 2971	Prohibits a person from manufacturing, processing or distributing a product, or a flame- retarded part of a product, containing greater than 0.1 percent of pentaBDE or octaBDE by weight. Prohibits a person from manufacturing, selling or distributing certain products containing the deca BDE. These products include mattresses, mattress pads, upholstered furniture, televisions, and computers. Exempts motor vehicles and parts, and the sale or resale of used products. Requires manufacturers of products containing decaBDE to notify retailers of prohibitions. Requires decaBDE be replaced with safer alternatives.
Washington	West's RCWA 70.76.005 to .110	Prohibits a person from manufacturing, selling or distributing noncombustible products containing pentaBDE and octaBDE. Makes certain exemptions. Prohibits a person from manufacturing, selling or distributing mattresses containing the deca BDE. This prohibition extends to upholstered furniture, televisions, and computers if the state, in consultation with a fire safety committee, finds that a safer and technically feasible alternative to decaBDE is available. Requires manufacturers of products containing PBDEs to notify retailers of the prohibitions.

Other State Statutes Addressing PBDEs

State	Citation	Summary
Illinois	415 ILCS 150/30	Requires certain electronic manufacturers to submit registration to the state that discloses whether any covered electronic device exceeds the maximum concentration values established for lead, mercury, cadmium, hexavalent chromium, polybrominated biphenyls (PBBs), and polybrominated diphenyl ethers (PBDEEs) under the European Union standards.
Indiana	IC 13-20.5-1-1	Requires video display device manufacturers to submit registration to the state that discloses whether any covered video display device exceeds the maximum concentration values established for lead, mercury, cadmium, hexavalent chromium, polybrominated biphenyls (PBBs), and polybrominated diphenyl ethers (PBDEEs) under the European Union standards.
Minnesota	M.S.A. § 115A.1312	Requires video display device manufacturers to submit registration to the state that discloses whether any covered

		video display device exceeds the maximum concentration values established for lead, mercury, cadmium, hexavalent chromium, polybrominated biphenyls (PBBs), and polybrominated diphenyl ethers (PBDEEs) under the European Union standards.
	M.S.A. § 325E.387	Requires that the commissioner of administration make available for purchase and use by all state agencies equipment, supplies, and other products that do not contain polybrominated diphenyl ethers.
New York	McKinney's ECL § 27-2605	Requires certain electronic manufacturers to submit registration to the state that discloses whether any covered electronic device exceeds the maximum concentration values established for lead, mercury, cadmium, hexavalent chromium, polybrominated biphenyls (PBBs), and polybrominated diphenyl ethers (PBDEEs) under the European Union standards.
Rhode Island	Gen.Laws 1956, § 23-24.10-9	Requires video display device manufacturers to submit registration to the state that discloses whether any covered video display device exceeds the maximum concentration values established for lead, mercury, cadmium, hexavalent chromium, polybrominated biphenyls (PBBs), and polybrominated diphenyl ethers (PBDEEs) under the European Union standards.

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

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

©2011 National Conference of State Legislatures. All Rights Reserved.

http://www.epa.gov/oppt/existingchemicals/pubs/actionplans/pbde.html
Last updated on Wednesday, May 26, 2010

Existing Chemicals

Polybrominated Diphenyl Ethers (PBDEs) Action Plan Summary

- What chemicals are addressed in the Action Plan?
- Why is EPA concerned about these chemicals?
- What action is EPA taking?
- Previous Actions
- Current Actions

Download the complete Polybrominated Diphenyl Ethers (PBDEs) Action Plan (PDF), (16 pp., 170KB, About PDF)

Access the public comment docket for the Polybrominated Diphenyl Ethers (PBDEs) Action Plan (Docket ID EPA-HQ-OPPT-2010-0146) on Regulations.gov.

What chemicals are addressed in the action plan?

Polybrominated diphenyl ethers (PBDEs) include the commercial versions of pentabromodiphenyl ether (c-pentaBDE), octabromodiphenyl ether (c-octaBDE), and decabromodiphenyl ether (c-decaBDE). Each of these commercial products is a mixture composed of several PBDE congeners. PBDEs are used as flame retardants in a number of applications, including textiles, plastics, wire insulation, and automobiles.

Why is EPA concerned about these chemicals?

EPA is concerned that certain PBDE congeners are persistent, bioaccumulative, and toxic to both humans and the environment. The critical endpoint of concern for human health is neurobehavioral effects. Various PBDEs have also been studied for ecotoxicity in mammals, birds, fish, and invertebrates. In some cases, current levels of exposure for wildlife may be at or near adverse effect levels.

PBDEs are not chemically bound to plastics, foam, fabrics, or other products in which they are used, making them more likely to leach out of these products. Despite the United States having phased out the manufacture and import of penta- and octaBDE in 2004, their component congeners are being detected in humans and the environment. Some reports indicate that levels are increasing. One potential source is imported articles to which these compounds have been added. Another is the possible breakdown of decaBDE in the environment to more toxic and bioaccumulative PBDE congeners.

EPA has concerns with decaBDE's hazards as well as its potential to be transformed to other PBDE congeners. DecaBDE was included in EPA's Voluntary Children's Chemical Evaluation Program (VCCEP), which identified a number of tests needed to better understand decaBDE's potential for transformation.

What action is EPA taking?

On the basis of existing information, the Agency believes that the following actions would be

warranted:

EPA intends to initiate rulemaking in autumn 2010 to add these commercial PDBE mixtures and/or the congeners they contain to the Concern List under TSCA section 5(b)(4) as chemicals that present or may present an unreasonable risk of injury to health or the environment.

EPA intends to initiate rulemaking to propose a TSCA section 5(a)(2) significant new use rule (SNUR) requiring notice to the Agency prior to the manufacture or import of articles to which c-pentaBDE or c-octaBDE have been added. A notice of proposed rulemaking is intended to publish in 2010.

EPA also intends to support and encourage the voluntary phase-out of manufacture and import of c-decaBDE. EPA has received commitments from the principal manufacturers and importers of c-decaBDE to initiate reductions in the manufacture, import and sales of c-decaBDE starting in 2010, with all sales to cease by December 31, 2013. EPA intends to encourage other importers of c-decaBDE to join this initiative. As part of this encouragement, EPA intends to develop Design for the Environment and Green Chemistry alternatives analysis for c-decaBDE to aid users in selecting suitable alternatives. The alternatives analysis is intended to begin in spring 2010

EPA also intends to initiate rulemaking to propose a simultaneous SNUR and the previously announced test rule for c-decaBDE. The significant new use would be manufacture, (including import) of c-decaBDE or articles to which c-decaBDE has been added. The TSCA section 4 test rule would require development of information necessary to determine the effects of manufacturing, use or other activities involving c-decaBDE on human health or the environment. If the Agency determines that manufacture (including import) of c-decaBDE or of articles to which c-decaBDE has been added has not ceased, EPA intends to promulgate the test rule. Notices of proposed rulemaking for the SNUR and the test rule are intended to publish in 2010.

Previous Actions:

Read about the previous phase-out and existing significant new use rule on penta- and octaBDE.

Read about commercial decaBDE in VCCEP.

Current Actions:

Download the complete Polybrominated Diphenyl Ethers (PBDEs) Action Plan (PDF), (16 pp., 170KB, About PDF)

Access the public comment docket for the Polybrominated Diphenyl Ethers (PBDEs) Action Plan (Docket ID EPA-HQ-OPPT-2010-0146) on Regulations.gov.

Read about the commitments to phase-out commercial decaBDE.

Read the EPA report, An Exposure Assessment of Polybrominated Diphenyl Ethers (Final Report), released May 24, 2010.

San Antonio Statement on Brominated and Chlorinated Flame Retardants

doi:10.1289/ehp1003089

Joseph DiGangi,[1] Arlene Blum,[2,3] Åke Bergman,[4] Cynthia A. de Wit,[5] Donald Lucas,[6] David Mortimer,[7] Arnold Schecter,[8] Martin Scheringer,[9] Susan D. Shaw,[10] and Thomas F. Webster[11]

[1]International POPs Elimination Network, Berkeley, California, USA; [2]Department of Chemistry, University of California, Berkeley, California, USA; [3]Green Science Policy Institute, Berkeley, California, USA; [4]Department of Materials and Environmental Chemistry, and [5]Department of Applied Environmental Science, Stockholm University, Stockholm, Sweden; [6]Lawrence Berkeley National Laboratory, Berkeley, California, USA ; [7]Food Standards Agency, London, United Kingdom; [8]University of Texas School of Public Health, Dallas, Texas, USA; [9]Institute for Chemical and Bioengineering, ETH Zürich, Zürich, Switzerland; [10]Marine Environmental Research Institute, Center for Marine Studies, Blue Hill, Maine, USA; [11]Department of Environmental Health, Boston University School of Public Health, Boston, Massachusetts, USA

The authors declare they have no actual or potential competing financial interests.

The statement is signed by the individual scientists and other professionals listed separately below. Please note that the views expressed are those of the authors and signatories; institutional affiliations are provided for identification purposes only. Abbreviations and an Annotated Statement are available as Supplemental Material (doi:10.1289/ehp.1003089).

We, scientists from a variety of disciplines, declare the following:

1. Parties to the Stockholm Convention have taken action on three brominated flame retardants that have been listed in the treaty for global elimination. These substances include components of commercial pentabromodiphenyl ether and commercial octabromodiphenyl ether, along with hexabromobiphenyl. Another brominated flame retardant, hexabromocyclododecane, is under evaluation.
2. Many commonly used brominated and chlorinated flame retardants can undergo long-range environmental transport.
3. Many brominated and chlorinated flame retardants appear to be persistent and bioaccumulative, resulting in food chain contamination, including human milk.
4. Many brominated and chlorinated flame retardants lack adequate toxicity information, but the available data raise concerns.
5. Many different types of brominated and chlorinated flame retardants have been incorporated into products even though comprehensive toxicological information is lacking.
6. Brominated and chlorinated flame retardants present in a variety of products are released to the indoor and outdoor environments.
7. Near-end-of-life and end-of-life electrical and electronic products are a growing concern as a result of dumping in developing countries, which results in the illegal transboundary movement of their hazardous constituents. These include brominated and chlorinated flame retardants.
8. There is a lack of capacity to handle electronic waste in an environmentally sound manner in almost all developing countries and countries with economies in transition, leading to the release of hazardous substances that cause harm to human health and the environment. These substances include brominated and chlorinated flame retardants.
9. Brominated and chlorinated flame retardants can increase fire toxicity, but their overall benefit in improving fire safety has not been proven.
10. When brominated and chlorinated flame retardants burn, highly toxic dioxins and furans are formed.

Therefore, these data support the following:

11. Brominated and chlorinated flame retardants as classes of substances are a concern for persistence, bioaccumulation, long-range transport, and toxicity.
12. There is a need to improve the availability of and access to information on brominated and chlorinated flame retardants and other chemicals in products in the supply chain and throughout each product's life cycle.
13. Consumers can play a role in the adoption of alternatives to harmful flame retardants if they are made aware of the presence of the substances, for example, through product labeling.
14. The process of identifying alternatives to flame retardants should include not only alternative chemicals but also innovative changes in the design of products, industrial processes, and other practices that do not require the use of any flame retardant.
15. Efforts should be made to ensure that current and alternative chemical flame retardants do not have hazardous properties, such as mutagenicity and carcinogenicity, or adverse effects on the reproductive, developmental, endocrine, immune, or nervous systems.
16. When seeking exemptions for certain applications of flame retardants, the party requesting the exemption should supply some information indicating why the exemption is technically or scientifically necessary and why potential alternatives are not technically or scientifically viable; a description of potential alternative processes, products, materials, or systems that eliminate the need for the chemical; and a list of sources researched.
17. Wastes containing flame retardants with persistent organic pollutant (POP) characteristics, including products and articles, should be disposed of in such a way that the POP content is destroyed or irreversibly transformed so that they do not exhibit the characteristics of POPs.
18. Flame retardants with POP characteristics should not be permitted to be subjected to disposal operations that may lead to recovery, recycling, reclamation, direct reuse, or alternative uses of the substances.
19. Wastes containing flame retardants with POP properties should not be transported across international boundaries unless it is for disposal in such a way that the POP content is destroyed or irreversibly transformed.
20. It is important to consider product stewardship and extended producer responsibility aspects in the life-cycle management of products containing flame retardants with POP properties, including electronic and electrical products.

Signatories

San Antonio Statement on Brominated and Chlorinated Flame Retardants

(Signatories as of publication date. Institutions are for identification purposes only.)

Sam Adu-Kumi, M.S.
Deputy Director, Environmental Protection Agency, Accra, Ghana

Björn Albinson
Fire Protection Engineer (retired), Karlstad, Sweden

Henrik Alm, M.S.
Doctoral Student, Pharmaceutical Biosciences, Division of Toxicology, Uppsala University, Uppsala, Sweden

Misha Askren, M.D., F.A.A.F.P.
Physician, Southern California Permanente Medical Group, Pasadena, CA, USA

Ralph Baker, M.S., Ph.D.
Chief Scientist, TerraTherm Inc., Fitchburg, MA, USA

John Balmes, M.D.
Professor of Medicine, University of California, San Francisco, San Francisco, CA, USA, and Professor of Environmental Health Sciences, University of California, Berkeley, Berkeley, CA, USA

Scott Bartell, Ph.D.
Assistant Professor, University of California, Irvine, Irvine, CA, USA

Georg Becher, Ph.D.
Department Director and Professor, Analytical Chemistry, Norwegian Institute of Public Health, Oslo, Norway

David C. Bellinger, Ph.D.
Professor, Harvard Medical School and Harvard School of Public Health, Boston, MA, USA

Stephen Bent, M.D.
Associate Professor of Medicine, Psychiatry, Epidemiology & Biostatistics, University of California, San Francisco, San Francisco, CA, USA

Åke Bergman, Ph.D.
Professor, Environmental Chemistry, Stockholm University, Stockholm, Sweden, and Board Member, International Panel on Chemical Pollution, Zürich, Switzerland

Anders Bignert, Ph.D.
Professor, Contaminant Research, Swedish Museum of Natural History, Stockholm, Sweden

Justina Björklund, M.S.
Graduate Student, Applied Environmental Science, Stockholm University, Stockholm, Sweden

Arlene Blum, Ph.D.
Visiting Scholar, Chemistry, University of California, Berkeley, Berkeley, CA, USA, and Executive Director, Green Science Policy Institute, Berkeley, CA, USA

Christian Bogdal, Ph.D.
Researcher, Swiss Federal Institute of Technology, Zürich, Switzerland

Phil Brown, Ph.D.
Professor, Sociology and Environmental Studies, Brown University, Providence, RI, USA

David Camann, M.S.
Staff Scientist, Southwest Research Institute, San Antonio, TX, USA

Carmela Centeno, M.S., Ph.D.
Industrial Development Officer, United Nations Industrial Development Organization, Vienna, Austria

Ibrahim Chahoud, Ph.D.
Professor of Reproductive Toxicology, Institute of Clinical Pharmacology and Toxicology, Charité-Universitätsmedizin Berlin, Berlin, Germany

Eliza Chin, M.D., M.P.H.
President, American Medical Women's Association, Philadelphia, PA, USA

Brock Chittim, M.S.
General Manager, Wellington Laboratories, Guelph, Ontario, Canada

Carsten Christophersen, Ph.D.
Associate Professor, Chemistry, University of Copenhagen, Copenhagen, Denmark

Bradley Clarke, Ph.D.
Research Fellow, Imperial College, London, United Kingdom

Theo Colborn, Ph.D.
Professor Emeritus, University of Florida, Gainesville, Florida, USA

Kathleen Collins, Ph.D.
Professor, Molecular and Cell Biology, University of California, Berkeley, Berkeley, CA, USA

Terrence Collins, Ph.D.
Teresa Heinz Professor of Green Chemistry and Director of the Institute for Green Science, Carnegie Mellon University, Pittsburgh, PA, USA

Adrian Covaci, Ph.D.
Professor, University of Antwerp, Antwerp, Belgium

Craig Criddle, Ph.D.
Professor, Civil and Environmental Engineering, Stanford University, Palo Alto, CA, USA

Margarita Curras-Collazo, Ph.D.
Associate Professor, Cell Biology and Neuroscience, University of California, Riverside, Riverside, CA, USA

Kyle D'Silva, Ph.D.
Product Manager, Thermo Fisher Scientific, Dreieich, Germany

Devra Davis, M.A., Ph.D., M.P.H.
Visiting Professor, Georgetown University, Washington, DC, USA, and Founder, Environmental Health Trust, Teton Village, WY, USA

Joao De Assuncao, M.S., Ph.D.
Professor and Department Head, Environmental Health, University of Sao Paulo School of Public Health, Sao Paulo, Brazil

Cynthia A. de Wit, Ph.D.
Professor, Applied Environmental Science, Stockholm University, Stockholm, Sweden

Mike Denison, Ph.D.
Professor of Environmental Toxicology, University of California, Davis, Davis, CA, USA

Miriam Diamond, Ph.D.
Professor, Geography, University of Toronto, Toronto, Ontario, Canada

Joseph DiGangi, Ph.D.
Senior Scientist and Technical Advisor, International POPs Elimination Network, Berkeley, CA, USA

Alin Dirtu, Ph.D.
Researcher, University of Antwerp, Antwerp, Belgium

Michelle Douskey, Ph.D.
Lecturer, Chemistry, University of California, Berkeley, Berkley, CA, USA

Anne Ehrlich, Ph.D.
Senior Research Scientist, Biology, Stanford University, Palo Alto, CA, USA

David Epel, Ph.D.
Jane & Marshall Steel Jr. Professor Emeritus in Marine Sciences, Cell and Developmental Biology, Stanford University, Palo Alto, CA, USA

Brenda Eskenazi, M.A., Ph.D.
Jennifer and Brian Maxwell Professor of Maternal Health and Epidemiology, University of California, Berkeley, Berkeley, CA, USA

Tim Evans, Ph.D.
Cancer Registration Information Manager, West Midlands Cancer Intelligence Unit, Birmingham, United Kingdom

Peter Fantke, Ph.D.
Research Associate, Institute of Energy Economics and the Rational Use of Energy, University of Stuttgart, Stuttgart, Germany

Joseph Gardella Jr., Ph.D.
Professor and Larkin Chair of Chemistry, University at Buffalo, State University of New York, Buffalo, NY, USA

Philip Germansderfer, D.Sc.
International Marketing Sales, Fluid Managment Systems, Watertown, MA, USA

Gillian Gibson, M.Sc.
Environmental Scientist, Gibson Consulting and Training, Cheshire, United Kingdom

Andreas Gies, Ph.D.
Director and Professor, Department for Environmental Hygiene, Federal Environment Agency, Berlin, Germany

Robert Gould, M.D.
President, San Francisco Bay Area Chapter of Physicians for Social Responsibility, Berkeley, CA, USA

Konstanze Grote, Ph.D.
Institute of Clinical Pharmacology and Toxicology, Charité University Medical School Berlin, Berlin, Germany

Rui Guo
Ministry of Environment, Toronto, Ontario, Canada

Jana Hajslova, Ph.D.
Head of Department of Food Analysis, Institute of Chemical Technology, Prague, Czech Republic

Ralph Hall, Ph.D.
Assistant Professor, Virginia Polytechnic Institute, Blacksburg, VA, USA

Bruce Hammock, Ph.D.
Distinguished Professor of Entomology, University of California, Davis, and Cancer Center UC Davis Medical Center, Davis, CA, USA

Tran Thi Tuyet Hanh, M.P.H.
Lecturer in Environmental Health, Hanoi School of Public Health, Hanoi, Vietnam

Kim Harley, Ph.D.
Associate Director, Center for Children's Environmental Health Research, University of California, Berkeley, Berkeley, CA, USA

Stuart Harrad, Ph.D.
Professor, Environmental Chemistry, University of Birmingham, Birmingham, United Kingdom

Robert Harrison, M.D., M.P.H.
Clinical Professor, Occupational and Environmental Medicine, University of California, San Francisco, San Francisco, CA, USA

Line Smastuen Haug
Doctoral Student, Norwegian Institute of Public Health, Oslo, Norway

Yasuhiro Hirai, Ph.D.
Associate Professor, Environment Preservation Engineering, Kyoto University, Kyoto, Japan

Ivan Holoubek, Ph.D.
Director and Professor, Masaryk University, Research Centre for Toxic Compounds in the Environment, Brno, Czech Republic, and Board Member, International Panel on Chemical Pollution, Zürich, Switzerland

Ron Hoogenboom, Ph.D.
Toxicologist, RIKILT Institute of Food Safety, Wageningen University and Research Center, Wageningen, the Netherlands

David Hope
CEO, Pacific Rim Laboratories, Surrey, British Columbia, Canada

William J. Hirzy, Ph.D.
Chemist in Residence, American University, Washington, DC, USA

Heinrich Huehnerfuss, Ph.D.
Professor, University of Hamburg, Hamburg, Germany

Alastair Iles, Ph.D.
Assistant Professor, Environmental Science, Policy, and Management, University of California, Berkeley, Berkeley, CA, USA

Tomohiko Isobe, Ph.D.
Senior Research Fellow, Ehime University, Matsuyama City, Japan

Kristina Jakobsson, Ph.D.
Associate Professor, Occupational and Environmental Medicine, Lund University, Lund, Sweden

Sarah Janssen, M.D., Ph.D., M.P.H.
Senior Scientist, Natural Resources Defense Council, San Francisco, CA, USA

Niklas Johansson
Scientist, Karolinska Institute, Stockholm, Sweden

Catherine Karr, M.D., Ph.D., M.S.
Assistant Professor and Director, Pediatric Environmental Health Specialty Unit, Pediatrics, University of Washington, Seattle, WA, USA

Donald Kennedy, Ph.D.
Bing Professor of Environmental Science, Emeritus, Stanford University
Palo Alto, CA, USA

Sergio Kuriyama, Ph.D.
Guest Scientist, Laboratory of Environmental Toxicology, National School of Public Health, Fiocruz, Brazil

(continued >>)

Signatories (continued)

San Antonio Statement on Brominated and Chlorinated Flame Retardants

(Signatories as of publication date. Institutions are for identification purposes only.)

James Leckie, M.S., Ph.D.
C.L. Peck, Class of 1906 Professor of Engineering and Director, Center for Sustainable Development and Global Competitiveness, Stanford University, Palo Alto, CA, USA

Pamela Lein, Ph.D.
Professor, Molecular Biosciences, University of California, Davis, Davis, CA, USA

Juliana Leonel, Ph.D.
Postdoctoral Researcher, Universidade Federal do Rio Grande, Rio Grande, Brazil

Mark Levine, Ph.D.
Leader, China Energy Group, and Former Director, Environmental Energy Technologies Division, Lawrence Berkeley National Laboratory, Berkeley, CA, USA

Donald Lucas, Ph.D.
Deputy Director, Environment, Health, and Safety Division, Lawrence Berkeley National Laboratory, Berkeley, CA, USA

Richard Luthy, Ph.D.
Silas H. Palmer Professor, Civil and Environmental Engineering, Stanford University, Palo Alto, CA, USA

Karl Mair, D.Sc.
Senior Scientist, Eco Research SRL, Bolzano, Italy

Govindan Malarvannan, Ph.D.
Research Fellow, Center for Marine Environmental Studies, Ehime University, Matsuyama City, Japan

John Meeker, M.S., Sc.D.
Assistant Professor, Environmental Health Sciences, University of Michigan School of Public Health, Ann Arbor, MI, USA

Richard Meigs, P.E.
Senior Principal Engineer, RJR Engineering, Ventura, CA, USA

Mark Miller, M.D., M.P.H.
Director, Pediatric Environmental Health Specialty Unit, and Assistant Clinical Professor, Pediatrics, University of California, San Francisco, San Francisco, CA, USA

Paolo Mocarelli, M.D.
Professor and Director, Department of Clinical Pathology, University of Milano Bicocca, Milano, Italy

Rachel Morello-Frosch, M.P.H., Ph.D.
Associate Professor, Department of Environmental Science Policy and Management, University of California, Berkeley, Berkeley, CA, USA

Jochen Mueller, Ph.D.
Professor, University of Queensland, Brisbane, Australia

Tom Muir, M.S.
Retired, Environment Canada, Burlington, Ontario, Canada

Martin Mulvihill, Ph.D.
Associate Director for Education and Outreach, Center for Green Chemistry, University of California, Berkeley, Berkeley, CA, USA

Anbu Munasamy, M.S., Ph.D.
National Institute for Interdisciplinary Science and Technology–Council of Scientific and Industrial Research, Thiruvananthapuran, Kerala, India

Richard Murphy, Ph.D.
Director of Science and Education, Jean-Michel Cousteau Ocean Futures Society, Santa Barbara, CA, USA

Takeshi Nakano, Ph.D.
Research Professor, Center for Advanced Science and Innovation, Osaka University, Osaka, Japan

Shoji Nakayama, M.D., Ph.D.
National Research Council Associate, U.S. Environmental Protection Agency, Washington, DC, USA

Amgalan Natsagdorj, Ph.D.
Department Head, Environmental Chemistry, National University of Mongolia, Ulaanbaatar, China

William Nazaroff, Ph.D.
Daniel Tellep Distinguished Professor and Vice Chair for Academic Affairs, Civil and Environmental Engineering, University of California, Berkeley, Berkeley, CA, USA

John Neuberger, Dr.Ph., M.P.H., M.B.A.
Professor, Preventative Medicine and Public Health, University of Kansas School of Medicine, Kansas City, KS, USA

Jessica Norrgran
Doctoral Student, Stockholm University, Stockholm, Sweden

Fardin Oliaei, Ph.D., M.P.A.
Consultant, Cambridge EnviroScience Consulting, LLC, Cambridge, MA, USA

Kees Olie, Ph.D.
Associate Professor, University of Amsterdam, Amsterdam, the Netherlands

Olaf Paepke
Eurofins, Hamburg, Germany

Victoria Persky, M.D.
Professor, University of Illinois at Chicago School of Public Health, Chicago, IL, USA

Agneta Rannug, Ph.D.
Professor, Institute of Environmental Medicine, Karolinska Institute, Stockholm, Sweden

Ulf Rannug, Ph.D.
Professor, Genetics, Microbiology and Toxicology, Stockholm University, Stockholm, Sweden

Eric Reiner, Ph.D.
Senior Research Scientist, Ontario Ministry of Environment, Toronto, Ontario, Canada

Martin Reinhard, Ph.D.
Professor, Civil and Environmental Engineering, Stanford University, Palo Alto, CA, USA

Karen Rice, M.D.
Physician, Obstetrics and Gynecology, Walnut Creek Kaiser, Walnut Creek, CA, USA

Robert H. Rice, Ph.D.
Professor of Environmental Toxicology, University of California, Davis, Davis, CA, USA

Anthony Roach, Ph.D.
Senior Research Scientist, Government of New South Wales, Sydney, Australia

David Roberts, Ph.D.
William R. Kenan, Jr. Professor of Astrophysics, Brandeis University, Waltham, MA, USA

Mary Roberts, Ph.D.
Professor, Chemistry, Boston College, Boston, MA, USA

Christina Ruden, Ph.D.
Professor, Philosophy and the History of Technology, Royal Institute of Technology, Stockholm, Sweden

Cindy Lee Russell, M.D.
Vice President of Community Health, Santa Clara County Medical Association, San Jose, CA, USA

Kenneth Sauer, Ph.D.
Professor Emeritus of Chemistry, University of California, Berkeley, Berkeley, CA, USA

Arnold Schecter, M.D., M.P.H.
Professor, Environmental and Occupational Health Sciences, University of Texas School of Public Health, Dallas, TX, USA

Martin Scheringer, D.Sc.
Senior Scientist, ETH Zürich, Zürich, Switzerland, and Board Member, International Panel on Chemical Pollution, Zürich, Switzerland

Ted Schettler, M.D., M.P.H.
Science Director, Science and Environmental Health Network, Ames, IA, USA

Karl-Werner Schramm, Ph.D.
Professor and Chair, German Research Center for Environmental Health, Neuherberg, Germany

Megan Schwarzman, M.D., M.P.H.
Research Scientist, University of California, Berkeley, Berkeley, CA, USA, and Associate Physician, University of California, San Francisco, San Francisco, CA, USA

Susan D. Shaw, Dr.PH.
Director, Marine Environmental Research Institute, Blue Hill, ME, USA

Heather Stapleton, Ph.D.
Assistant Professor, Nicholas School of the Environment, Duke University, Durham, NC, USA

Kristina Sundqvist, Ph.D.
Project Assistant, Chemistry, Umeå University, Umeå, Sweden

Patrice Sutton, M.P.H.
Research Scientist, Program on Reproductive Health and the Environment, University of California, San Francisco, San Francisco, CA, USA

Shanna Swan, Ph.D.
Professor and Associate Chair for Research, Obstetrics and Gynecology, and Director, Center for Reproductive Epidemiology, University of Rochester School of Medicine, Rochester, NY, USA

Takumi Takasuga, Ph.D.
Director, Shimadzu Techno-Research Inc., Kyoto, Japan

Chris Talsness, D.V.M.
Working Group Leader in Reproductive Toxicology, Charite Universitätsmedizin Berlin, Berlin, Germany

Cathrine Thomsen, Ph.D.
Senior Scientist, Norwegian Institute of Public Health, Oslo, Norway

Gregg Tomy, Ph.D.
Adjunct Assistant Professor, Fisheries and Oceans, University of Manitoba, Winnipeg, Manitoba, Canada

Joao Paulo Machado Torres, Sc.D.
Associate Professor, Universidade Federal do Rio de Janeiro, Rio de Janeiro, Brazil

James Trosko, Ph.D.
Professor, Pediatrics and Human Development, Center for Integrative Toxicology, Michigan State University, East Lansing, MI, USA

Mary Turyk, Ph.D., M.P.H.
Research Assistant Professor, University of Illinois at Chicago, Chicago, IL, USA

Gunther Umlauf, Ph.D.
European Commission Joint Research Center, Ispra, Italy

Bryan Vining, Ph.D.
Analytical Perspectives, Wilmington, NC, USA

Qiuquan Wang, Ph.D.
Professor of Chemistry, Xiamen University, Xiamen, China

Yawei Wang, Ph.D.
Research Center for Eco Environmental Science, Beijing, China

Julie Shu-Li Wang, Ph.D.
Investigator, National Health Research Institute, Taipei, Taiwan

Rosemary Waring, Ph.D.
Honorary Reader, Human Toxicology, University of Birmingham, Birmingham, United Kingdom

Thomas F. Webster, D.Sc.
Associate Professor and Associate Chair, Department of Environmental Health, Boston University School of Public Health, Boston, MA, USA

Charles Weschler, Ph.D.
Adjunct Professor, UMDNJ–Robert Wood Johnson Medical School and Rutgers University, New Brunswick, NJ, USA, and Continuing Visiting Professor, International Centre for Indoor Environment and Energy, Technical University of Denmark, Lyngby, Denmark

Stevie Wilding
Chemist, U.S. Environmental Protection Agency, Region 3, Philadelphia, PA, USA

Duane Wilding, M.E.
Senior Engineer, Maryland Environmental Service, Millersville, MD, USA

Gayle Windham, Ph.D.
Researcher, Breast Cancer and the Environment Research Program, Oakland, CA, USA

Tracey Woodruff, Ph.D., M.P.H.
Associate Professor and Director, Program on Reproductive Health and the Environment, University of California, San Francisco, San Francisco, CA, USA

Jae-Ho Yang, M.D., M.P.H.
Professor, Catholic University of Daegu, Gyeongsan, Korea

Tom Young, M.P.P., Ph.D.
Professor, Civil & Environmental Engineering, University of California, Davis, Davis, CA, USA

Bin Zhao
Doctoral Student, Environmental Toxicology, University of California, Davis, Davis, CA, USA

R. Thomas Zoeller, M.A., Ph.D.
Professor, Biology Department, University of Massachusetts, Amherst, Amherst, MA, USA

Ami Zota, Sc.D.
Postdoctoral Scholar, Program on Reproductive Health and the Environment, University of California, San Francisco, Oakland, CA, USA

ERRATUM

NOTE: The competing financial interest declaration was not included in this editorial published in the December issue of *Environmental Health Perspectives*; the statements is provided below.

J. DiGangi, A. Blum, A. Bergman, C. deWit, D. Lucas, D. Mortimer, A. Schecter, M. Scheringer, S Shaw, and T Webster, authors of the "San Antonio Statement on Brominated and Chlorinated Flame Retardants" [Environ Health Perspect 118:A516 (2010)], declare they have no actual or potential competing financial interests.

This omission has been corrected in the PDF version of this article.

Prenatal exposure to flame-retardant compounds affects neurodevelopment of young children

January 19th, 2010 in Medicine & Health / Health

Prenatal exposure to ambient levels of flame retardant compounds called polybrominated diphenyl ethers (PBDEs) is associated with adverse neurodevelopmental effects in young children, according to researchers at the Columbia Center for Children's Environmental Health (CCCEH) at Columbia University's Mailman School of Public Health.

The study is online in *Environmental Health Perspectives* and will be released in the April 2010 print issue.

PBDEs are endocrine-disrupting chemicals and widely used flame-retardant compounds that are applied to a broad array of textiles and consumer products, including mattresses, upholstery, building materials, and electronic equipment. Because the compounds are additives rather than chemically bound to consumer products, they can be released into the environment. Human exposure may occur through dietary ingestion or through inhalation of dust containing PBDEs.

The researchers found that children with higher concentrations of PBDEs in their umbilical cord blood at birth scored lower on tests of mental and physical development between the ages of one and six. Developmental effects were particularly evident at four years of age, when verbal and full IQ scores were reduced 5.5 to 8.0 points for those with the highest prenatal exposures.

"The neurodevelopmental effects of prenatal exposure to PBDEs have not previously been studied among children in North America, where levels are typically higher than in Europe or Asia," said Julie Herbstman, PhD, first author on the paper and a research scientist in Environmental Health Sciences at the Mailman School of Public Health. "The findings are consistent with effects observed in animal studies and, if replicated in other North American populations, they could have important public health implications."

Frederica Perera, DrPh, professor of Environmental Health Sciences at the Mailman School, CCCEH Director, and coauthor added, "These findings are of potential concern, because IQ is a predictor of future educational performance; and the observed reductions in IQ scores are in the range seen with low level lead exposure." This research underscores the need for preventive policies to reduce toxic exposures occurring in utero."

The investigators controlled for factors that have previously been linked to neurodevelopment in other studies, including ethnicity, mother's IQ, child's sex, gestational age at birth, maternal age, prenatal exposure to environmental tobacco smoke, maternal education, material hardship, and breast feeding.

The study is part of a broader project examining the effects of chemicals released by the World Trade Center's destruction on pregnant women and their children. However, residential proximity to the World Trade Center site did not affect levels of PBDE exposure.

Provided by The Earth Institute at Columbia University

"Prenatal exposure to flame-retardant compounds affects neurodevelopment of young children." January 19th, 2010. http://www.physorg.com/news183127197.html

Study links reduced fertility to flame retardant exposure

January 26th, 2010 in Medicine & Health / Health

Women with higher blood levels of PBDEs, a type of flame retardant commonly found in household consumer products, took longer to become pregnant compared with women who have lower PBDE levels, according to a new study by researchers at the University of California, Berkeley.

The study, to be published Jan. 26 in the journal *Environmental Health Perspectives*, found that each 10-fold increase in the blood concentration of four PBDE chemicals was linked to a 30 percent decrease in the odds of becoming pregnant each month.

"There have been numerous animal studies that have found a range of health effects from exposure to PBDEs, but very little research has been done in humans. This latest paper is the first to address the impact on human fertility, and the results are surprisingly strong," said the study's lead author, Kim Harley, adjunct assistant professor of maternal and child health and associate director of the Center for Children's Environmental Health Research at UC Berkeley's School of Public Health. "These findings need to be replicated, but they have important implications for regulators."

PBDEs, or polybrominated diphenyl ethers, are a class of organobromine compounds that became commonplace after the 1970s when new fire safety standards were implemented in the United States. The flame retardants are used in foam furniture, electronics, fabrics, carpets, plastics and other common items in the home.

Studies have found widespread contamination of house dust by PBDEs, which are known to leach out into the environment and accumulate in human fat cells. Studies also suggest that 97 percent of U.S. residents have detectable levels of PBDEs in their blood, and that the levels in Americans are 20 times higher than in their European counterparts. According to the researchers, residents in California are among those experiencing the highest exposures, most likely due to the state's relatively stringent flammability laws.

The researchers measured PBDE levels in blood samples from 223 pregnant women enrolled in a longitudinal study at the Center for the Health Assessment of Mothers and Children of Salinas (CHAMACOS) that examines environmental exposures and reproductive health.

The median concentrations of the four PBDE chemicals in the analysis were slightly lower in this study population than in the general U.S. population, possibly because many of the participants had grown up in Mexico where PBDE exposures are limited, said the authors of the study. The median number of months it took to get pregnant was three, with 15 percent of the participants taking longer than 12 months to conceive.

When the analysis was limited to women who were actively trying to become pregnant, the researchers found that they were half as likely to conceive in any given month if they had high levels of PBDE in their blood. "We aren't looking at infertility, just subfertility, because all the women in our study eventually became pregnant," said Harley. "Had we included infertile couples in our study, it is possible that we would have seen an even stronger effect from PBDE exposure."

It is not entirely clear how PBDEs might impact fertility. A number of animal studies have found that PBDEs can impair neurodevelopment, reduce thyroid hormones, and alter levels of sex hormones. Both high and low thyroid hormone levels can disrupt normal menstrual patterns in humans, but this study did not find a link between PBDE exposure and irregular menstrual cycles.

Because the participants were mostly young, Mexican immigrant women who lived in an agricultural community, the researchers controlled for exposure to pesticides in their analysis. The researchers also controlled for other variables known to impact fertility, such as irregularity of menstrual cycles, frequency of intercourse, pre-pregnancy body mass index, use of birth control pills in the year before conception, smoking, and alcohol and caffeine consumption.

There are some 209 different possible formulations of PBDEs, but only three mixtures - pentaBDE, octaBDE and decaBDE - have been developed for commercial use as flame retardants. The mixtures are distinguished by the average number of bromine atoms attached to each molecule. Like many other studies, the most prevalent PBDEs in the blood of women participating in the UC Berkeley study were four components of the pentaBDE mixture.

Penta- and octaBDE have both been banned for use in several U.S. states, including California, but they are still present in products made before 2004. Last month, the U.S. Environmental Protection Agency (EPA) announced an agreement with three major manufacturers of decaBDE to phase out its production by 2013.

"Although several types of PBDEs are being phased out in the United States, our exposure to the flame retardants is likely to continue for many years," said the study's principal investigator, Brenda Eskenazi, UC Berkeley professor of epidemiology and of maternal and child health at the School of Public Health. "PBDEs are present in many consumer products, and we know they leach out into our homes. In our research, we have found that low-income children in California are exposed to very high levels of PBDEs, and this has us concerned about the next generation of Californians."

Keeping up with the ever-expanding range of chemicals in our environment is challenging, the researchers noted. As PBDEs are being phased out, they are being replaced with other brominated compounds. "We know even less about the newer flame retardant chemicals that are coming out," said Harley. "We just don't have the human studies yet to show that they are safe."

A 2007 state assembly bill that would have banned all brominated and chlorinated chemical flame retardants from household furniture and bedding sold in California failed to pass.

Provided by University of California - Berkeley

"Study links reduced fertility to flame retardant exposure." January 26th, 2010. http://www.physorg.com/news183731384.html

Flame retardant linked to altered thyroid hormone levels during pregnancy

June 21st, 2010 in Medicine & Health / Health

Pregnant women with higher blood levels of a common flame retardant had altered thyroid hormone levels, a result that could have implications for fetal health, according to a new study led by researchers at the University of California, Berkeley.

"This is the first study with a sufficient sample size to evaluate the association between PBDE flame retardants and thyroid function in pregnant women," said the study's lead author, Jonathan Chevrier, a UC Berkeley researcher in epidemiology and in environmental health sciences. "Normal maternal thyroid hormone levels are essential for normal fetal growth and brain development, so our findings could have significant public health implications. These results suggest that a closer examination between PBDEs and these outcomes is needed."

PBDEs, or polybrominated diphenyl ethers, are a class of organobromine compounds found in common household items such as carpets, textiles, foam furnishings, electronics and plastics. U.S. fire safety standards implemented in the 1970s led to increased use of PBDEs, which can leach out into the environment and accumulate in human fat cells.

Studies suggest that PBDEs can be found in the blood of up to 97 percent of U.S. residents, and at levels 20 times higher than those of people in Europe. Because of California's flammability laws, residents in this state have some of the highest exposures to PBDEs in the world.

"Despite the prevalence of these flame retardants, there are few studies that have examined their impact on human health," said the study's principal investigator, Brenda Eskenazi, UC Berkeley professor of epidemiology and of maternal and child health. "Our results suggest that exposure to PBDE flame retardants may have unanticipated human health risks."

The new study, to be published June 21 in the journal *Environmental Health Perspectives*, is the second study to come out this year from Eskenazi's research group linking PBDEs to human health effects. Eskenazi was the principal investigator on the earlier study that found that women with higher exposures to flame retardants took longer to get pregnant.

In the new study, the researchers analyzed blood samples from 270 women taken around the end of their second trimester of pregnancy. The women in the study were part of a larger longitudinal study from the Center for the Health Assessment of Mothers and Children of Salinas (CHAMACOS) that examines environmental exposures and reproductive health.

The researchers measured concentrations of 10 PBDE chemicals, two types of thyroxine (T4) and thyroid-stimulating hormone (TSH). They controlled for such factors as maternal smoking, alcohol

and drug use, and exposure to lead and pesticides.

Analysis focused on the five PBDE chemicals that were detected most frequently and are components of a mixture called pentaBDE. The researchers found that a 10-fold increase in each of the PBDE chemicals was associated with decreases in TSH ranging from 10.9 percent to 18.7 percent. When the five PBDEs were analyzed together, a tenfold increase was linked to a 16.8 percent decrease in TSH.

The study did not find a statistically significant effect of PBDE concentrations on levels of T4. With one exception, all the women in the study with low TSH levels had normal free T4 levels, which corresponds to the definition of subclinical hyperthyroidism. The study found that odds of subclinical hyperthyroidism were increased 1.9 times for each tenfold increase in PBDE concentrations.

"Low TSH and normal T4 levels are an indication of subclinical hyperthyroidism, which is often the first step leading toward clinical hyperthyroidism," said Chevrier. "Though the health effect of subclinical hyperthyroidism during pregnancy is not well understood, maternal clinical hyperthyroidism is linked to altered fetal neurodevelopment, increased risk of miscarriage, premature birth and intrauterine growth retardation."

Exactly how flame retardants influence TSH levels is unclear, the researchers said, but animal studies have shown that certain PBDEs can mimic thyroid hormones.

In addition to the commercial mixture pentaBDE, octaBDE and decaBDE have been developed for use as commercial flame retardants. PentaBDE and octaBDE have both been banned for use by the Stockholm Convention on Persistent Organic Pollutants, the European Union and eight U.S. states, including California, but they are still present in products made before 2004.

The production of decaBDE by major manufacturers is scheduled to be phased out in the United States by 2013. However, pentaBDE and decaBDE are being replaced by new brominated and chlorinated compounds whose impact on human health is not yet clear, the researchers noted.

More information: The study is available for free online: http://ehponline.o … /ehp.1001905

Provided by University of California - Berkeley

"Flame retardant linked to altered thyroid hormone levels during pregnancy." June 21st, 2010. http://www.physorg.com/news196255783.html

print

Alaska lawmakers target toxin used to fireproof electronics, furniture

by Christopher Eshleman / ceshleman@newsminer.com
02.12.11 - 12:15 am

JUNEAU — Four Alaska legislators last month joined policymakers around the world in trying to eliminate a toxic chemical compound used to fireproof household electronics and furniture.

Scientists link the fire retardant to cancer and other health problems. People and animals can ingest it while eating food or breathing household dust. Environmental groups in Alaska have unanimously asked lawmakers this year to ban companies from selling electronics and furniture that contain more than trace amounts of the chemical.

Industry and governmental leaders around the world have already targeted the chemical, polybrominated diphenyl ether, for elimination. Roughly a dozen U.S. states have already banned PBDEs, which are used in bromine-based flame retardants.

Four Democrats last month sponsored measures in the state House and Senate. Rep. Scott Kawasaki, D-Fairbanks and one of the sponsors, cited scientific study that strongly suggests the compounds can cause neurological harm, cancer and hormone and endocrine disruption. He said legislators are still digging into the science behind the issue but suggested the scientific community's call for caution merits action.

"It boils down to community health ... I think it's a step in the right direction," he said of the bill.

The measures would also direct the state Departments of Environmental Conservation and Health and Social Services to draft and update a larger list of chemicals considered toxic by other state and federal agencies. It does not call for regulation beyond PBDEs, only that the list be updated every three years.

Scientists have studied the health implications of the fire retardant since at least the 1990s. The chemical is stored and carried in body fat and moves upward through the food chain, with concentrations compounding with each step and cresting in seals and other animals near the peak. That puts subsistence hunters and fishermen at greater risk than other people, said Frank von Hippel, a University of Alaska Anchorage biologist.

Von Hippel said PBDEs are shed by electronics and household products to become part of common dust, something the measures' proponents say is particularly relevant in Alaska given the need to keep doors and windows shut for much of the year.

The bills list three specific subtypes of the chemical. Companies in the United

States have generally stopped making two, but the third, called deca-PBDE, is still commonly manufactured, von Hippel said. He said they're generally banned in Europe as well.

The chemicals carry great significance for arctic communities. Von Hippel said atmospheric currents carry PBDEs and other persistent organic pollutants toward the poles and into arctic regions through a natural atmospheric process known as the "grasshopper effect." Cold weather then force the chemicals from their gaseous state and leave them to settle into the environment.

Greater concentrations here mean greater exposure to northern species of animals and to Alaskans, and von Hippel said it leaves Alaska on the front line in ongoing international discussion of how to regulate or eliminate the use of persistent organic pollutants, or POPs.

Von Hippel said mothers pass accumulated chemicals such as PBDEs to children during pregnancy and breast feeding. Pam Miller, with the Alaska Community Action on Toxics, cited a recent study that suggests women in the Yukon-Kuskokwim Delta had the highest PBDE levels of any population in the arctic.

Critics of full PBDE bans say the science behind the policy discussion falls short of justifying total prohibition, at least until substitutes are easily available. One critic is Dr. David Heimbach, a Seattle burn doctor who said he regularly saw Alaska patients over a three-decade career. He said policymakers in California voted to ban the chemical without collecting enough input from doctors first.

Heimbach said by phone Friday he'd prefer that governments phase out PBDEs instead of banning them, as Alaska's bills would do. He said the chemical's safety value should not be discounted.

"There's no question they work as fire retardants," he said.

Late last year, 145 scientists from around the world agreed to the "San Antonio Statement" outlining health hazards from exposure to bromine- and chlorine-based flame retardants. Some are already addressed in international environmental laws such as the Stockholm Convention on Persistent Organic Pollutants, but Congress is one of a handful of national legislatures or parliaments that have yet to ratify that convention. Even if Congress did adopt the treaty, it would still fall to federal and state government agencies to implement a ban.

The Alaska bills are House Bill 63 and Senate Bill 27, proposed by lead sponsors Sen. Bill Wielechowski and Rep. Lindsey Holmes, both Anchorage Democrats. They await hearings in committees focused, respectively, on commerce and health.

Contact staff writer Christopher Eshleman at 459-7582.

© newsminer.com 2011

www.ktuu.com/business/2onyourside/ktuu-state-lawmakers-propose-pbde-ban-012711,0,7924168.story

ktuu.com

State lawmakers propose ban on PBDE flame retardants

by Maria Downey

Channel 2 News

12:21 PM AKST, January 27, 2011

ANCHORAGE, Alaska

advertisement

While there's no question among safety advocates that flame retardants save lives, renewed health concerns about some retardants are causing Alaska to join states across the nation in trying to ban PBDE chemicals.

PBDEs are invisible but they're used in the manufacturing of countless everyday objects like furniture , electronics and appliances.

Two state Legislature bills introduced late last session to ban PBDEs by 2012 -- House Bill 63 and Senate Bill 27 -- are now in committee.

"I don't think that most people realize that when they put a child to bed at night, they probably put them on a bed that is full of dangerous toxins," said Sen. Bill Wielechowski. "I don't think most people realize when they're using their microwave, their cell phone, TV, their toaster -- even walking across their carpet -- they're being exposed to, they're exposing their family to very dangerous toxins."

The Environmental Protection Agency's website reports that traces of PBDEs have been found in breast milk, along with fish and other wildlife.

Health issues linked to the chemicals include thyroid problems, learning and memory disabilities, behavioral changes, delayed puberty and other reproductive issues.

"Another thing about these toxins are, they are getting into our food chain," said Rep. Lindsey Holmes, co-sponsor of House Bill 63. "They have been shown to have particularly high rates in the Yukon-Kuskokwim region of the state in Western Alaska, because they're getting into our salmon, they're getting into out other animals."

Holmes and other state lawmakers are trying to do what 12 other states have already done and get PBDEs out of people's homes.

"Because currently, there are some safe alternatives out there and no reason to be using these," Holmes said. "And the problem with these types of toxins, they're in our homes, which means our children are exposed to

them -- it also means if there's a fire, firefighters are exposed to the toxic chemicals."

"Chemicals that can cause cancer, chemicals that can cause developmental disabilities -- and I think as lawmakers we have an obligation to stand up and say, 'This is not something we want brought into our state,'" Wielechowski said.

"We want to do everything we can to protect families, protect the kids, protect the food chain," Holmes said. "And we want to make sure it's out there and protect everyone to the best of our ability."

According to lawmakers, firefighters across the country are supporting PBDE bans.

While some manufacturers are lobbying against the ban, some furniture companies like IKEA have already discontinued the use of PBDEs in their products.

Contact Maria Downey at mdowney@ktuu.com

Copyright © 2011, KTUU-TV

The Dutch Harbor Fisherman

Legislation would minimize impact of dangerous chemicals

Published on January 20th, 2011 5:32 pm

By MARGARET BAUMAN

Two bills introduced in the current Alaska Legislature session would phase out certain toxic flame retardant chemicals known to cause health problems which are found in consumer products such as furniture and electronics.

House Bill 63, introduced by Rep. Lindsey Holmes, D-Anchorage, and Senate Bill 27, introduced by Sen. Bill Wielechowski, D-Anchorage, target polybrominated diphenyl ethers, also known as PBDEs, which disrupt thyroid function and affect learning, memory and behavior.

The legislation would apply to mattresses, mattress pads and upholstered furniture containing plastic fibers that contain flame retardants and electronic products with plastic housing that contains flame retardants. It would not apply to transportation vehicles or products used in such equipment, nor products used in an industrial, mining or manufacturing process.

The legislation also calls for the state to develop a program to assist retailers in identifying products in their inventories that violate the chemical restrictions.

Children are particularly vulnerable to these flame retardant chemicals and safer and economical alternatives are available to replace the unnecessary use of hazardous flame retardants, according to Safer Chemicals Healthy Families and Safer States Coalitions, of which Alaska Community Action on Toxics is a member.

Similar legislation was introduced three years ago by former Alaska legislator Andrea doll of Juneau, but never made it out of committee, said Pam Miller of Alaska Community Action on Toxics.

"We think this legislation is extremely important, especially in Alaska, because people are exposed to these chemicals through atmospheric transport," Miller said.

In addition to toxic chemicals which may be contained in the manufacture of furniture and electronics, Alaskans are already being exposed to higher levels of toxic chemicals because of prevailing atmospheric and oceanic conditions, which transport such toxics through the air and water to polar points of the planet, said Bob Shavelson, executive director of Cook Inletkeeper. It has to do with the Coriolis effect, caused by the rotation of the earth, which can carry toxic particles produced thousands of miles away into Alaska's atmosphere.

"We think that wildlife and people living in the north are getting a double whammy," said Miller, in part because of the atmospheric conditions that draw toxics to the Arctic, and in part because homes in Alaska are closed in for a great proportion of the year, and well insulated. Many studies show that people are exposed through indoor air and dust to flame retardant chemicals leaching out into the atmosphere and found in household air and dust, she said.

Miller also pointed to a 2009 study done by the Arctic Monitoring Assessment Program, which showed that women of childbearing age in Alaska's Yukon-Kuskokwim Delta had the highest levels of toxics in the circumpolar Arctic, Miller said.

The study, online at http://epa.gov/osp/tribes/pres/webinar091210 shows how high levels of toxins are introduced into traditional subsistence foods.

Another study in the Gulf of Alaska found that orca whales have some of the highest concentrations of these toxic chemicals in the world, she said. Several studies have shown that the main environmental toxins of concern for populations of marine mammals are primarily persistent organic pollutants such as polychlorinated biphenyls, or PCBs, polybrominated diphenyl ethers, or PBDEs and dioxins and furans, closely related chemicals that are produced when organic material is burned in the presence of chlorine. One common source of dioxins and furans is from coal fired utilities.

30 state consider legislation

Similar legislation to rid furniture and electronics of toxic chemicals being considered in a total of 30 states includes bans on BPA and hazardous flame retardants in consumer products, requirements that children's product manufacturers use only the safest chemicals, and resolutions urging Congress to overhaul the 1976 Toxic Substances Control Act, the federal law that allows dangerous and untested chemicals to be used in everyday products and materials.

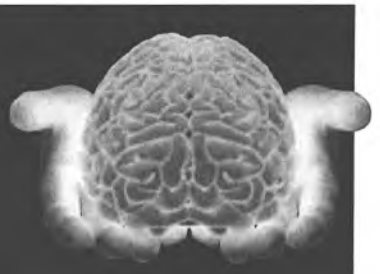
BPA is an abbreviation for Bisphenol A, an organic compound used to make polycarbonate plastic and epoxy resins. For more than two years now, several government reports have questioned its safety, particularly when fetuses, infants and young children are exposed to products containing BPA.

Margaret Bauman can be reached at mbauman@alaskanewspapers.com, or by phone at 907-348-2438

Copyright 2011
The Dutch Harbor Fisherman is a publication of Alaska Newspapers, Inc. This article is © 2011 and limited reproduction rights for personal use are granted for this printing only. This article, in any form, may not be further reproduced without written permission of the publisher and owner, including duplication for not-for-profit purposes. Portions of this article may belong to other agencies; those sections are reproduced here with permission and Alaska Newspapers, Inc. makes no provisions for further distribution.

MIND, DISRUPTED

How toxic chemicals change how we think and who we are



Polybrominated Diphenyl Ethers (PBDEs)

What Are PBDEs?

Polybrominated diphenyl ethers, or PBDEs, are a class of flame retardant chemicals added to many consumer products found in the home, office, automobiles, and airplanes.[1] Three mixtures used widely—penta-BDE, octa-BDE, and deca-BDE—made up 14%, 6%, and 80% of the 1999 worldwide production of PBDEs, respectively.[2] Usually found in electronics, such as TVs, and used in some furniture foams, fabrics, and kitchen appliances, the industry voluntarily ended production in the United States of the formulations of penta and octa in 2004 after high levels were found in breast milk. However, North America made up a large percentage of global demand for these PBDEs, 97.5 % for penta and 35.9% for octa, and there is still a large reservoir of products containing these PBDEs in the US.[3] The deca formulation is currently produced and used primarily in plastic electronics such as televisions and computer casings. It is also used in the upholstery covers of items such as furniture and car seats.[4,5]

PBDEs are part of a larger chemical class called polyhalogenated aromatic hydrocarbons (PHAHs) which include other highly toxic chemicals such as polychlorinated biphenyls (PCBs) and dioxins.[2] PHAHs are intrinsically hazardous because of their chemical make-up: (1) they are stable, meaning they persist in the environment and do not break down easily; (2) they are lipophilic, meaning they build up in fatty tissues of living organisms; and (3) they have toxic properties, including the potential to act as endocrine disruptors.[6] Their persistence and fat solubility allow them to both biomagnify and bioaccumulate, meaning they build up in the bodies of animals and humans as they move through the food chain. While not all PBDEs meet these criteria, a significant portion have been found to exhibit these characteristics. Although the main component in deca-BDE, BDE-209, has a relatively short half-life in people,[1] animal studies show that the liver breaks down BDE-209 into the more persistent and bioaccumulative forms of hepta-BDE, octa-BDE, and nona-BDE.[7,8] There are relatively few data available concerning the extent to which this occurs in humans.

How Are We Exposed?

There are many ways that humans are exposed to PBDEs, including ingestion of contaminated foods and incidental intake of PBDE-contaminated dust.[8] PBDEs are not permanently bound to the products in which they are used. Some PBDEs are semi-volatile and may be released from PBDE containing products. Other PBDEs are released from furniture, electronics and other products as they physically degrade. It is not entirely clear how deca is released from products, though some think it might be released from physical abrasion or deterioration of the product. Deca-BDE breaks down into more toxic by-products and may volatize when exposed to ultraviolet (UV) light.[9] Although penta-BDE and octa-BDE are no longer produced in the United States, exposure continues from old computers, furniture, fabrics, and other consumer sources that were made before the discontinuation.[10]

Occupational exposure may also occur for workers in electronics recycling, computer repair, and rubber manufacturing facilities.[11] PBDEs are found in sewage sludge used as agricultural fertilizers and may be a source of exposure for workers applying contaminated fertilizers.[11]

Ingestion of PBDEs in fatty foods such as meat and dairy products is thought to be a major route of exposure,[12] as PBDEs are fat-seeking and build up in the food web. Indoor exposures to dust and contaminated air are also thought to be major routes, as well as direct absorption through the skin from dust or products.[13] Relatively little is known about the routes of deca-BDE exposure. It is estimated that the highest intake of deca-BDE results from household dust.[13,14,15]

People may also be exposed through consumption of fish and other marine animals, because these organisms have been found to contain high levels of deca-BDE.[16] The high levels in marine environments may be due to atmospheric deposition (when contaminants from the air come down to the earth's surface through rain, snow, falling particles, and the absorption of gas) of deca-BDE as well as sewage discharge into the oceans.[16]

For infants, breast milk is a major source of PBDEs. The PBDEs that have accumulated in women may be passed to children through breastfeeding.[17] It is important to note that breastfeeding is still considered best for a baby's health.

PBDEs in Our Bodies

Due to their widespread use, persistence and bioaccumulative properties, PBDEs have been found in humans at high levels. A recent study by scientists from the U.S. Centers for Disease Control and Prevention (CDC) found PBDEs in nearly all 2,040 participants in a sample representative of the 2003–2004 U.S. population.[18] In this study, 3 congeners were found in over 90% of the participants: 97% had levels of BDE-47 (2,2′,4,4′-hexabromodiphenyl ether), 93% had levels of BDE-100 (2,2′,4,4′,6-pentabromodiphenyl ether), and 93% had levels of BDE-153 (2,2′,4,4′,5,5′-hexabromodiphenyl ether) above the limit of detection.[18] Another study showed that 5 percent of American women have levels of PBDEs that are close to the levels linked to reproductive problems in animals.[1] PBDEs have been found in mothers' breast milk and in the blood of mothers and their babies.[19,20] People of the Arctic may experience an even higher risk of exposure due to their traditional subsistence diet rich in fat from marine mammals.[21,] Concentrations of PBDEs have grown over the years in marine mammals due to atmospheric transport of chemicals into the north (transported long distances from areas of production and use via air and ocean currents) and bioaccumulation.[2]

What Does Exposure to PBDEs Mean for Our Health?

The presence of environmental chemicals in the human body does not necessarily imply that they are causing adverse health effects; however, environmental chemical exposures can and do affect human health. It is important to note that both the dosage and the timing of exposure have significant effects on any potential health outcome.

The following information is intended to inform the reader about the current state of knowledge on the health effects of PBDEs, including both human and animals studies.

Relatively little is known about the health effects of PBDEs. Overall there are few studies on health effects in the general population; however, health effects have been detected in rigorous animal based studies. Nevertheless, research has found associations between PBDEs and many adverse health effects, including:

Neurodevelopmental Effects

There are few published human studies on the health effects of environmental exposure to PDBEs. One study on Dutch children found that prenatal PBDE exposure affected childhood development. Exposed children had worse fine motor skills and

Reducing Your Exposure

You can minimize your exposure to PBDEs by taking the following steps:

PBDE-free Furniture

- Before purchasing furniture, find out which companies offer PBDE-free products. The following websites can help:
  - Clean Production Action: *www.cleanproduction.org/Flame.Alternatives.php*
  - Pollution in People: *www.pollutioninpeople.org/safer/products*
- Contact the company directly if you cannot figure out if the manufacturer uses PBDEs.
- Choose furniture made with less flammable fabrics like leather, wool and cotton.

PBDEs in Foam Padding

- Foam items purchased before 2005 can potentially contain PBDEs. Completely covering these items in fabric can limit potential exposure.
- Avoid reupholstering foam furniture.
- Be very careful when removing old carpet. Try to keep your work area separated from the rest of the house and thoroughly clean up the area.

Reduce Your Dust Exposure

- Wash your hands often to remove dust particles that your hands pick up throughout the day on everything you touch.
- Use a wet rag or cloth while dusting to avoid kicking up the dust in the air.
- If possible, use a vacuum fitted with a HEPA filter. These vacuums can trap smaller particles of dust and will be more likely to remove contaminants from your home.
- Vehicles have been exempt from recent PBDE laws and high levels have been found inside cars.[5] Removing dust with a wet cloth and keeping car seat cushions in good repair will help to reduce your exposure.

PBDE-free Electronics

- Many companies are beginning to make electronics with alternatives to PBDEs. Certain PBDE-free products are available from Canon, Dell, HP, Intel, Erickson, Apple, Acer, Nokia, Motorola, LG Electronics, and Sony.

Consider Eating Less Fat:

- Consider choosing leaner meat and poultry cuts.
- Consider removing fat that you see on meat and fish whenever possible.
- Choose cooking methods that remove excess fat such as broiling, grilling, and roasting.

attention, but better coordination, visual perception and behavior. The mothers in this study had serum PBDE concentrations in the low ppb range.[22] Another study of children prenatally exposed to PDBEs showed decreases in mental and physical development. PBDEs 47, 99 and 100 were correlated with lower developmental scores, while PBDE 153 was not. The most highly exposed children had significantly lower developmental scores than the less exposed children.[23]

A recent peer-reviewed scientific consensus statement by the Collaborative on Health and the Environment's Learning and Developmental Disabilities Initiative states, "Recent studies have left little doubt that PBDEs are developmental neurotoxicants in animals and lead to changes in motor activity and reduced performance on learning and memory tests."[24,25,26] Numerous studies on rodents suggest that neonatal exposure to PBDEs permanently affects learning and memory functions, impairs motor activity, and is linked to aberrations in spontaneous motor behavior and hyperactivity.[27,28,29,30,31,32,33]

Researchers have also found that some of the developmental effects of exposure become worse over time. In a study of PBDE exposure in mice, spontaneous behavior and habituation capability (both indicators of the ability of individuals and the species to survive in the wild) were permanently damaged by neonatal exposure to PBDEs and worsened with age.[27] Exposure to hexa-BDE has been linked to other developmental neurotoxic effects in mice, including changes in spontaneous behavior and impairments in learning and memory, which also appear to worsen with age.[34] A recent study in adult mice found consistent results which show that deca-BDE can be just as toxic to neurodevelopment as other PBDEs. In this study, exposure to deca-BDE was linked to hyperactivity and reduced or lack of habituation, also worsening with age.[35]

Thyroid Problems

Some PBDE congeners are structurally similar to thyroid hormone and have been shown to disrupt (by decreasing, increasing, or mimicking) the biological action of thyroid hormone.[36] In a study of newborn babies, high PBDE levels in cord blood were associated with decreased levels of thyroid hormones. PBDE concentrations ranged from below 10 ppb to several hundred ppb in the blood.[37] In a recent study of adult men who consume sport fish, researchers found that exposure to PBDEs at levels similar to those found in the general US population were associated with increased thyroid hormone T_4 (thyroxine).[38] Men in this study with the highest body burdens of PBDEs also showed increased thyroid antibodies, a risk factor for thyroid diseases such as chronic autoimmune thyroiditis and Graves' disease.[38] PBDE exposure has also been linked to hypothyroidism in adults. In an occupational exposure study at a deca-BDE and decabromobiphenyl manufacturing plant, 4 out of 35 exposed workers showed clinical hypothyroidism, while none of the 89 unexposed workers exhibited thyroid dysfunction.[39]

Corresponding animal studies have also shown that PBDE exposure is linked to decreased circulating concentrations of thyroid hormone[14,40] and decreased thyroid weight in adult rodent offspring.[12] Exposure to deca-BDE has been linked to thyroid hyperplasia in rodent studies. In a 2-year study by the National Toxicology Program, deca-BDE was found to increase the incidence of follicular cell hyperplasia (proliferation of follicular cells, which are responsible for making thyroid hormones) in the thyroid gland in male and female mice.[41]

Reproductive Effects

PBDEs can be both mildly estrogenic[42] and anti-androgenic compounds.[43,44] They have been correlated to cryptorchidism (undescended testes), in newborn boys exposed through breast milk with a median concentration of 4.16 ppb(lw) vs. 3.16 ppb(lw) for controls.[45] PBDEs have been shown to permanently impair sperm development in rodent studies.[14] Exposure to BDE-153, has been associated with a decrease in testicle size and the sperm concentration in humans.[46] Exposure to PBDEs in household dust at levels commonly encountered in the US has been linked with lower levels of androgens (male hormones) in adult men.[47] PBDEs have also been associated with delay of puberty in both male and female rodents and changes in sexual development and gender-specific sexual behavior.[48] Exposure to PBDEs has been linked to low birth weight, birth defects, reduced weight gain during pregnancy, changes in ovary cells and reduced sperm count.[49,50] The breakdown products of PBDEs may inhibit human aromatase, an enzyme important in the formation of androgens and estrogens (male and female hormones), and in skeletal development. However, these results were found at concentrations above current human exposure levels. [51]

Cancer

One study suggests that *in utero* exposure to PBDE concentrations is associated with an increased risk of testicular cancer in men, although the study has limitations and further studies would help to shed light on this association.[52] The Agency for Toxic Substances and Disease Registry (ATSDR) lists deca-BDE as a possible human carcinogen based on the development of liver tumors in rats.[8]

Regulation of PBDEs

There have been many steps forward in the regulation of PBDEs in recent years, but much more is needed to ensure the safety of public health. Internationally, Sweden was the first to initiate a phase-out of PBDEs in the late 1990s, followed by the European Union—first phasing out penta-BDE and octa-BDE in 2003 and then deca-BDE in 2006.[53] In 2008, Norway banned the use of deca-BDE in new consumer products.[54] Although no production occurred there, Canada prohibited the future manufacture of all PBDEs and placed resrictions on the import of certain PBDEs.[55]

The Stockholm Convention on Persistent Organic Pollutants, a United Nations treaty on persistent bioaccumulative substances, placed tetra-, penta-, hexa- and hepta-PBDEs under provisions

of the Convention for global phase-out after determining they posed a risk to environmental and human health.

In the United States, industry voluntarily ended production of penta-BDE and octa-BDE in 2004, but deca-BDE is still permitted for use in consumer products.[20] In December, 2009 two U.S. producers of deca-BDE and the largest U.S. importer announced commitments to end production, importation, and sales of deca-BDE for most uses by December, 2012.[56] Washington, Maine, Oregon, and Vermont are currently discontinuing the use and manufacture of deca-BDE,[57,58] and 12 states have banned penta- and octa-BDE, with other states across the nation aiming for similar legislation.

Endnotes

1 McDonald TA. 2005. Polybrominated diphenylether levels among United States residents: Daily intake and risk of harm to the developing brain and reproductive organs." *Integrated Environmental Assessment and Management* 1(4):343-354.

2 Ikonomou MG, Rayne S, Addision RF. 2002. Exponential increases of the brominated flame retardants, polybrominated diphenyl ethers, in the Canadian Arctic from 1981 to 2000. *Environmental Science & Technology* 36(6):1886-1892.

3 Hale RC, Alaee M, Manchester-Neesvig JB, Stapleton HM, Ikonomou MG. 2003. Polybrominated diphenyl ether flame retardant in the North American environment. *Environmental International* 29:771-779.

4 Toxic-Free Legacy Coalition Report. 2006. Pollution in People. Available: *www.toxicfreelegacy.org.*

Lagalante AF, Oswald TD, Calvosa FC. 2008. Polybrominated diphenyl ether (PBDE) levels in dust from previously owned automobiles at United States dealerships. *Environment International* 35(3):539-44.

6 Hooper K, McDonald TA. 2000. The PBDEs: An emerging environmental challenge and another reason for breast-milk monitoring programs. *Environmental Health Perspectives* 108(5):387-392.

7 Stapleton HM, Brazil B, Holbrook RD, Michelmore CL, Benedict R, Konstantinov A, Potter D. 2006. In vivo and in vitro debromination of decabomodiphenyl ether (BDE 209) by juvenile rainbow trout and common carp. *Environmental Science and Technology* 40(15): 4653-4658.

8 Van der ven LT, van de Kuil T, Leonards PE, Slob W, Canton RF, Germer S, Visser TJ, Litens S, Hakansson H, Schrenk D, van der Berg M, Piersma AH, Vos JG, Opperhuizen A. 2008. A 28-day oral dose toxicity study in Wistar rats enhanced to detect endocrine effects of decabromodipenyl ether (decaBDE). *Toxicology Letters* 179(1): 6-14.

9 Washington State Department of Health and Washington State Department of Ecology. 2006. Washington State Polybrominated Diphenyl Ether (PBDE) Chemical Action Plan: Final Plan. Available: *www.ecy.wa.gov/pubs/0507048.pdf*

10 Northwest Watch. 2004. Flame retardants in the bodies of pacific northwest residents: A study of toxic body burdens. Available: *www.sightline.org/*

11 Sjödin A, Patterson Jr DG, Bergman Å. 2003. A review on human exposure to brominated flame retardants—particularly polybrominated diphenyl ethers. *Environment International* 29(6): 829-40.

12 Agency for Toxic Substances and Disease Registry (ATSDR). 2004. Toxicological Profile for Polybrominated Biphenyls and Polybrominated Diphenyl Ethers. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Agency for Toxic Substances and Disease Registry. Available: www.atsdr.cdc.gov/toxprofiles/tp68.html.

13 Frederiksen M, Vorkamp K, Thomsen M, Knudsen LE. 2009. Human internal and external exposure to PBDEs – a review of levels and sources. *International Journal of Hygeine and Environmental Health* 212(2): 109-134.

14 Wilford BH, Shoeib M, Harner T, Zhu J, Jones KC. 2005. Polybrominated diphenyl ethers in indoor dust in Ottawa, Canada: implications for sources and exposure. *Environmental Science and Technology* 39(18): 7027-7035.

15 Huwe JK, Hakk H, Smith DJ, Diliberto JJ, Richardson V, Stapleton HM, Birnbaum LS. 2008. Comparative absorption and bioaccumulation of polybrominated diphenyl ethers following ingestion via dust and oil in male rats. *Environmental Science and Technology* 42(7): 2694-2700.

16 Ross PS, Couillard CM, Ikononmou MG, Johannessen SC, Lebeuf M, Macdonald RW, Tomy GT. 2009. Large and growing environmental reservoirs of Deca-BDE present an emerging health risk for fish and marine mammals. *Marine Pollution Bulletin* 58(1): 7-10.

17 Frederiksen M, Vorkamp K Thomsen M, Knudsen LE. 2009. Human internal and external exposure to PBDEs-A review of levels and sources. *Int J Hyg Environ Health 212:109-134*

18 Sjödin A, Wong L-Y, Jones RS, Park A, Zhang Y, Hodge C, Dipietro E, McClure C, Turner W, Needham LL, Patterson Jr. DG. 2008. Serum Concentrations of Polybrominated Diphenyl Ethers (PBDEs) and Polybrominated Biphenyl (PBB) in the United States Population: 2003–2004. *Environ Sci Technol* 42(4): 1377-84.

19 Schecter A, Pavuk M, Papke O, Ryan JJ, Birnbaum L, Rosen R. 2003. Polybrominated diphenyl ether (PBDEs) in U.S. mother's milk. *Environmental Health Perspectives* 111(14):1723-1729.

20 Mazadai A, Dodder NG, Abernathy MP, Hites RA, Bigsby RM. 2003. Polybrominated diphenyl ethers in maternal and fetal blood samples. *Environmental Health Perspectives* 111(9):1249-1252.

21 Letcher RJ, Bustnes JO, Dietz R, Jenssen BM, Jorgensen EH, Sonne C, Verreault J, Vijayan MM, Gabrielsen GW. 2009. Exposure and effects assessment of persistent organohalogen contaminants in arctic wildlife and fish. *Science of the Total Environment* doi:10.1016/j.scitotenv.2009.10.038

22 Roze E, Meijer L, Bakker A, Van Braeckel KNJA, Sauer PJJ, Bos AF. 2009. Prenatal exposure to organohalogens, including brominated flame retardants, influences motor, cognitive, and behavioral performance at school age. *Environmental Health perspectives* doi:10.1289/ehp.0901015.

23 Herbstman JB, Sjödin A, Jones R, Kurzon M, Lederman SA, Rauh VA, Needham LL, Wang R, Perera FP. 2008. Prenatal Exposure to PBDEs and Neurodevelopment. *Environmental Health Perspectives* doi:10.1289/ehp.0901340

24 Collaborative on Health & the Environment, Learning and Developmental Disabilities Initiative. 2008, February 20. *Scientific Consensus Statement on Environmental Agents Associated with Neurodevelopmental Disorders.* Available: www.iceh.org/pdfs/LDDI/LDDIStatement.pdf

25 Costa LG, Giordano G. 2007. Developmental neurotoxicity of polybrominated diphenyl ether (PBDE) flame retardants. *Neurotoxicology*.28 (6):1047-1067

26 Rice DC, Reeve EA, Herlihy A, Zoeller RT, Thompson WD, Markowski VP. 2007. Developmental delays and locomotor activity in the C57BL6/J mouse following neonatal exposure to the fullybrominated PBDE, decabromodiphenyl ether. *Neurotoxicol Teratol* 29(4):511-20.

27 Eriksson P, Jakobsson E, Fredriksson A. 2001. Brominated flame retardants: A novel class of developmental neurotoxicants in our environment? *Environmental Health Perspectives* 109(9):903-908.

28 Kuriyama SN, Talsness CE, Grote K, Chahoud I. 2005. Developmental exposure to low-dose PBDE-99: Effects on male fertility and neurobehavior in rat offspring. *Environmental Health Perspectives* 13(2):149-154.

29 Johansson N, Viberg H, Fredricksson A, Eriksson P. 2008. Neonatal exposure to deca-brominated diphenyl ether (PBDE 209) causes dose-response changes in spontaneous behavior and cholinergic susceptibility in adult mice. *Neurotoxicology* 29(6): 911-919.

30 US EPA. 2008a. Reference Dose for PBDE-47. 2,2',4,4'-Tetrabromodiphenyl ether (BDE-47) Quickview (CASRN 5436-43-1). Integrated Risk Information System. Available: *http://cfpub.epa.gov/ncea/iris/index.cfm?fuseaction=iris.showQuickView&substance_nmbr=1010 [NEED COPY]*

31 US EPA. 2008b. Reference Dose for PBDE-99. 2,2',4,4',5-Pentabromodiphenyl ether (BDE-99) Quickview (CASRN 60348-60-9). Integrated Risk Information System. Available: *http://cfpub.epa.gov/ncea/iris/index.cfm?fuseaction=iris.showQuickView&substance_nmbr=1008 [NEED COPY]*

32 Us EPA. 2008c. Reference Dose for PBDE-153. 2,2',4,4',5,5'-Hexabromodiphenyl ether (BDE-153) Quickview (CASRN 68631-49-2). Integrated Risk Information System. Available: *http://cfpub.epa.gov/ncea/iris/index.cfm?fuseaction=iris.showQuickView&&substance_nmbr=1009 [NEED COPY]*

33 US EPA. 2008d. Reference Dose for PBDE-209. 2,2',3,3',4,4',5,5',6,6'-Decabromodiphenyl ether (BDE-209) Quickview (CASRN 1163-19-5). Integrated Risk Information System. Available: http://cfpub.epa.gov/ncea/iris/index.cfm?fuseaction=iris.showQuickView&substance_nmbr=0035 [NEED COPY]

34 Viberg H, Fredriksson A, Eriksson P. 2003. Neonatal exposure to polybrominated diphenyl ether (PBDE 153) disrupts spontaneous behaviour, impairs learning and memory, and decreases hippocampal cholinergic receptors in adult mice. *Toxicol Appl Pharmacol* 192(2): 95-106. [NEED COPY]

35 Viberg H, Fredriksson A, Eriksson P. 2007. Changes in spontaneous behaviour and altered response to nicotine in the adult rat, after neonatal exposure to the brominated flame retardant, decabrominated diphenyl ether (PBDE 209). *Neurotoxicology* 28(1): 136-42. [NEED COPY]

36 Siddiqi MA, Laessig RH, Reed KD. 2003. Polybrominated diphenyl ethers (PBDEs): New pollutants-old diseases. *Clinical Medicine & Research* 1(4): 281-90.

37 Herbstman JB, Sjodin A, Apelberg BJ, Witter FR, Halden RU, Patterson DG, Panny SR, Needham LL, Goldman LR. 2008. Birth delivery mode modifies the associations between prenatal polychlorinated biphenyl (PCB) and polybrominated diphenyl ether (PBDE) and neonatal thyroid hormone levels. *Environmental Health Perspectives* 116(10): 1376-1382.

38 Turyk ME, Persky VW, Imm P, Knobeloch L, Chatterton R, Anderson HA. 2008. Hormone disruption by PBDEs in adult male sport fish consumers. *Environmental Health Perspectives* 116(12). Available: *www.ehponline.org/members/2008/11707/11707.html*

39 Bahn AK, Mills JL, Synder PJ, Gann PH, Houten L, Bialik O, Hollmann L, Utiger RD. 1980. Hypothyroidism in workers exposed to polybrominated biphenyls. *N Engl J Med* 302:31-33. [NEED COPY]

40 Tseng LH, Li MH, Tsai SS, Lee CW, Pan MH, Yao WJ, Hsu PC. 2008. Developmental exposure to decabromodiphenyl ether (PBDE 209): Effects on thyroid hormone and hepatic enzyme activity in male mouse offspring. *Chemosphere* 70(4): 640-647.

41 National Toxicology Program (NTP). 1986. Toxicology and carcinogenesis studies of decabromodiphenyl oxide (Case No. 1163-19-5) in F344/N rats and B6C3F1 mice (feed studies). Technical Report 309. Research Triangle Park, NC: National Toxicology Program. Available: *http://ntp.niehs.nih.gov/ntp/htdocs/LT_rpts/tr309.pdf.p. 47*

42 Mercado-Feliciano M, Bigsby RM. 2008. The polybrominated diphenyl ether mixture DE-71 is mildly estrogenic. *Environmental Health Perspectives* 116(5): 605-611.

43 Yang W, Mu Y, Giesy JP, Zhang A, Yu H. 2009. Anti-androgen activity of polybrominated diphenyl ethers determined by comparative molecular similarity indices and molecular docking. *Chemosphere.* 75:1159-1164

44 Stoker TE, Cooper RL, Lambright CS, Wilson VS, Furr J, Gray LE. 2005. In vivo and in vitro anti-androgenic effects of DE-71, a commercial polybrominated diphenyl ether (PBDE) mixture. *Toxicology and Applied Pharmacology.* 207:78-88

45 Main KM, Kivirant H, Virtanen HE, Sundqvist E, Tuomisto J, Vartiainen T, Skakkebaek NE, Toppari J. 2007. Flame retardants in placenta and breast milk and cryptorchidism in newborn boys. *Environmental Health Perspectives* 115(10): 1519-26.

46 Akutsu K, Takatori S, Nozawa S, Yoshiike M, Nakazawa H, Hayakawa K, Makino T, Iwamoto T. 2008. Polybrominated diphenyl ethers in human serum and sperm quality. *Bull Environ Contam Toxicol* 80:345-350

47 Meeker JD, Johnson PI, Camann D, Hauser R. 2009. Polybrominated diphenyl ether (PBDE) concentration in household dust are related to hormone levels in men. *Science of the Total Environment* doi: 10.1016/j.scitotenv2009.01.030.

48 Lilienthal H, Hack A, Roth-Harer A, Grande SW, Talsnesse CE. 2006. Effects of developmental exposure to 2,2',4,4',5-pentabromodiphenyl ether (PBDE-99) on sex steroids, sexual development, and sexually dimorphic behavior in rats. *Environmental Health Perspectives* 114(2):194-201.

49 Schreder E. 2006. Pollution in People: A Study of Toxic Chemicals in Washingtonians. Available: www.pollutioninpeople.org.

50 Chao HR, Wang SL, Lee WJ, Wang YF, Papke O. 2007. Levels of polybrominated diphenyl ethers (PBDEs) in breast milk from central Taiwan and their relation to infant birth outcome and maternal menstruation effects. *Environment International* 33(2): 239-245.

51 Canton RF, Scholten DE, Marsh G, de Jong PC, van den Berg M. 2008. Inhibition of human placental aromatase activity by hydroxylated ploybrominated diphenyl ethers (OH-PDBEs). *Toxicology and Applied Pharmacology* 227(1): 68-75.

52 Hardell L, van Bavel B, Lindström G, Eriksson M, Carlberg M. 2006. In utero exposure to persistent organic pollutants in relation to testicular cancer risk. *International Journal of Andrology* 29:228-234.

53 Northwest Watch. 2004. Flame retardants in the bodies of Pacific Northwest residents: A study of toxic body burdens. Available: *www.sightline.org.*

54 Norwegian Pollution Control Authority. 2008. Ban on Deca-BDE. Available: *http://www.sft.no/publikasjoner/2401/ta2401.pdf*

55 Government of Canada. 2008. Polybrominated diphenyl ether regulations. *Canada Gazette Part II* 142(14): 1663-1682.

56 US EPA. 2009. DecaBDE Phase-Out Initative. Available: *www.epa.gov/oppt/existingchemicals/pubs/actionplans/deccadbe.html. [NEED COPY]*

57 State of Maine. 2007. Title 38, Chapter 16, Section 1609: Restrictions on sale and distribution of brominated flame retardants. Available: *www.mainelegislature.org/legis/statutes/38/title38sec1609.html*

58 State of Washington. 2008. Revised Code of Washington, chapter 70.76: Polybrominated diphenyl ethers –flame retardants. Available: *http://apps.leg.wa.gov/RCW/default.aspx?cite=70.76*

ACAT Alaska Community Action on Toxics

COMMONWEAL

Fact sheets on toxic chemicals for the *Mind, Disrupted* Biomonitoring Project provided by the Alaska Community Action on Toxics (www.akaction.net) and Commonweal (www.commonweal.org). For more information, please visit the *Mind, Disrupted* website at www.minddisrupted.org, or contact Pam Miller at pkmiller@akaction.net or Sharyle Patton at spatton@igc.org.

www.minddisrupted.org

Fire Fighter Organizations across the U.S. Support Banning or Restricting Toxic Flame-Retardant Deca-BDE

Michigan Network for CHILDREN'S Environmental HEALTH

Fire Fighters and their professional organizations across the country have expressed their support for restricting the use of deca-BDE (deca-brominated diphenyl ether), a flame retardant commonly used in consumer products. HB 4699 would ban the sale in Michigan of any product containing deca-BDE by 2014. Fire fighters have expressed concerns about their occupational exposures when deca burns, particularly given the widespread use of cost-effective alternatives that can help prevent fires. Eleven states, including Michigan, have banned or restricted the only other polybrominated diphenyl ethers (PBDEs) that were in commercial use, penta- and octa-BDE, and these compounds have now been withdrawn by industry throughout the U.S. Four states have already banned or restricted deca-BDE.

INTERNATIONAL

International Assocation of Fire Fighters (IAFF)

- "Our union is concerned about the health and safety of our members as well as the health and safety of all of our citizens. Accordingly, the IAFF believes that the passage of legislation banning brominated flame retardants (Polybrominated diphenyl ethers (PBDEs) including Penta-, Octa-, and Deca-BDEs) is a step in the right direction for improving the health and safety of our fire-fighters and the citizens who are exposed to these chemicals."

  Source: Letter from Richard M. Duffy, Assistant to the General President, Occupational Health, Safety, and Medicine, IAFF, to Matthew Vinci, President, Professional Fire Fighters of Vermont, March 23, 2009.

- "Unlike other flame retardants, when PBDEs burn, they release dense fumes and black smoke that reduce visibility and a highly corrosive gas known as hydrogen bromide. In addition, PBDEs produce highly toxic byproducts of incomplete combustion. Although use of flame retardants saves lives and property, there have been unintended consequences. There is evidence that PBDEs persist in the environment and accumulate in living organisms, as well as toxicological testing that indicates these chemicals may cause liver toxicity, thyroid toxicity, and neurodevelopmental toxicity."
- "Many studies involving fire fighters exposed to these and other toxic gases during active fire fighting, overhaul, and long term exposure from these chemicals penetrating protective gear, have found that fire fighters have a much greater risk of contracting cancer, heart and lung disease, and other debilitating diseases. While we support the concept of flame retardant chemicals, there are alternatives that do not contain bromine or chlorine and are much safer for fire fighters than PBDEs."

  Source: Letter from Richard M. Duffy, Assistant to the General President, Occupational Health, Safety, and Medicine, IAFF, to Kelly Fox, President, Washington State Council of Fire Fighters, January 26, 2007.

MICHIGAN

Michigan Association of Fire Chiefs

- "The Executive Board of the Michigan Association of Fire Chiefs has passed a resolution supporting House Bill 4699, a bill banning DECA-BDE."
- "Deca-BDE and its family of flame retardant chemicals known as polybrominated diphenyl ether (PBDE) have been identified as having adverse physiological and developmental impact on humans."
- "When PBDE compounds are exposed to fire they burn and release dense fumes and a highly corrosive gas known as hydrogen bromide which exposes firefighters to additional chemical hazards."

  Source: Letter from David Peterson, President, Michigan Association of Fire Chiefs, to Michigan State Representative Deborah Kennedy, May 29, 2009.

ILLINOIS

Associated Fire Fighters of Illinois
Illinois Fire Fighters Association

- "Our organizations are concerned with ensuring public health and safety, preventing fires by maintaining high fire safety standards, and protecting our firefighters from harm in their working environments. We support the phase-out [of] PBDEs—including penta-, octa-, and deca-BDEs—because it will help accomplish all of these goals."
- "The elimination of deca-BDE will not compromise fire safety, but we believe it will be a step in the right direction for improving the health and safety of our firefighters."

Source: Memorandum from Eddy Crews, Associated Fire Fighters of Illinois, and Margaret Vaughn, Illinois Fire Fighters Association, to the Members of the Illinois Legislature, March 20, 2007.

MAINE

Professional Firefighters of Maine

- "If passed, the law would see these bromide based chemicals, commonly referred to as DECA, phased out and replaced with phosphorus-based retardants that provide fire prevention capabilities comparable to bromides but have none of the negative health dangers associated with DECA."

Source: Press release issued by the Professional Firefighters of Maine, April 10, 2007.

Portland Fire Fighter, Bobby Reynolds
Professional Fire Fighters of Maine

- "Maine's firefighting community stands with one voice in support of [restricting deca-BDE]. With safer alternatives readily available that meet the same fire safety standards, phasing out deca should be a no-brainer."

Source: Bobby Reynolds in phone communication with Matt Prindiville, Natural Resources Council of Maine, April 3, 2007.

MARYLAND

Baltimore Fire Chief James Clack

- "There are plenty of alternative nontoxic flame retardants available today, and some manufacturers have voluntarily switched to using them. Firefighters face risks every day, even without the added health threats posed by the use of unnecessary toxic chemicals in products we all use in our homes."

Source: Letter from James Clack, Baltimore Fire Chief, printed in the Baltimore Sun, April 9, 2009.

MINNESOTA

Minnesota Professional Fire Fighters

- "While flame retardants in general save lives and property, the continued use of deca is unnecessary, as safer alternatives that don't persist and accumulate in the environment and in the human body are available. As professional fire fighters we support effective fire safety standards and are convinced that phasing out the use of deca will not compromise fire safety in any way."

Source: Memorandum from Tom Thornberg, President, Minnesota Professional Fire Fighters, to the Members of the Minnesota State Legislature, January 2008.

NEW YORK

Firemen's Association of the State of New York (FASNY)

- "We are concerned with providing the safest working environment for these [first] responders and the need to maintain the highest safety standards; a big step toward achieving these goals can be made by banning the use of polybrominated diphenyl ethers (PBDEs)."

Source: Memorandum from the Firemen's Association of the State of New York in Support of A7977 and S5244 to restrict the use of deca-BDE, June 20, 2007.

WASHINGTON

Washington State Council of Fire Fighters
Washington Fire Chiefs
Washington State Fire Fighters' Association

- "Providing the safest working environment for firefighters, and the need to maintain the highest safety standards are of the utmost concern; it is clear that we can achieve both of these goals by banning the use of PBDEs."

Source: Letter from Keven E. Rojecki, Legislative Liaison, Washington State Council of Fire Fighters; Mike Brown, Executive Director, Washington Fire Chiefs; and T.J. Nedrow, Washington State Fire Fighters' Association, March 27, 2007.

Washington State Council of Fire Fighters

- "Many studies involving firefighters exposed to these and other toxic gases during active firefighting, overhaul, and long-term exposure from these chemicals penetrating protective gear have found that fire fighters have a much greater risk of contracting cancer, heart and lung disease, and

other debilitating diseases. While we clearly support the use of flame retardant chemicals, there are alternatives already in use that do not contain bromine or chlorine and are much safer for firefighters than PBDEs."

Source: Memorandum from Keven E. Rojecki, Legislative Liaison, Washington State Council of Fire Fighters, to the Members of the Washington Legislature, February 9, 2007.

VERMONT

Professional Fire Fighters of Vermont

- "Banning Deca will not affect fire safety."
- "Vermont needs fire safety without toxic chemicals."

Source: Burlington Free Press, February 18, 2009, quoting Matt Vinci, President, Professional Fire Fighters of Vermont.

MICHIGAN LEGISLATORS CAN PROTECT CHILDREN, FIRE FIGHTERS AND OUR GREAT LAKES FROM DECA-BDE!

Support HB 4699 to ban deca-BDE in all products sold in Michigan by 2014

Network Members:

American Academy of Pediatrics (Michigan Chapter) • Arab Community Center for Economic and Social Services (ACCESS) • Association for Children's Mental Health • Autism Society of Michigan • Citizens for Alternatives to Chemical Contamination • Clean Water Fund • Clinton County Family Resource Center • Detroiters Working for Environmental Justice • East Michigan Environmental Action Council • Ecology Center • Healthy Homes Coalition of West Michigan • Learning Disabilities Association (LDA) of Michigan • LocalMotionGreen • Michigan Chapter of the National Association of Pediatric Nurse Practitioners • Michigan Coalition for Children and Families • Michigan Environmental Council • Michigan League of Conservation Voters Education Fund • Michigan Nurses Association • Science and Environmental Health Network • Sierra Club Michigan Chapter • Voices for Earth Justice.

The Michigan Network for Children's Environmental Health is a coalition of health professionals, health-affected groups, environmental organizations, and others dedicated to a safe and less toxic world for Michigan's children. Through education, outreach, and advocacy, we seek to protect Michigan's children from adverse impacts caused by exposure to widespread hazardous chemicals.

For more information, contact Rebecca Meuninck, Environmental Health Campaign Director, at 734-761-3186 ext. 119 or Mike Shriberg, Ph.D., Policy Director, at 734-761-3186 ext. 108.

Citizens for Fire Safety

EXPOSED

A Chemical Industry Front Group for Manufacturers of Toxic Flame Retardants (PBDEs)

Front group \ FRUHNT groop \ *n* **:** An organization that purports to be independent voluntary association or charitable organization, but actually serves the interest of the sponsoring party whose identity is often hidden. Certain front groups are seemingly grassroots-based coalitions that are actually funded by an industry trade association or public relations firm.

PBDEs are polybrominated diphenyl ethers, toxic flame retardants added to products such as televisions, computers, textiles, building materials, infant car seats and strollers. Laboratory studies show that PBDEs may harm the developing brain, impair sperm development, and impair thyroid function.[1,2,3] Washington State and Maine have banned three of the most widely used PBDEs and many states are considering following suit, based upon evidence that these chemicals are persistent, bioaccumulative and toxic.[4] Chemical manufacturers of PBDEs have a direct financial interest in preventing limits on the use of their product. They have organized themselves to oppose policies to require non-toxic fire safety through PBDE restrictions that are advancing across the U.S.

The Industry Players

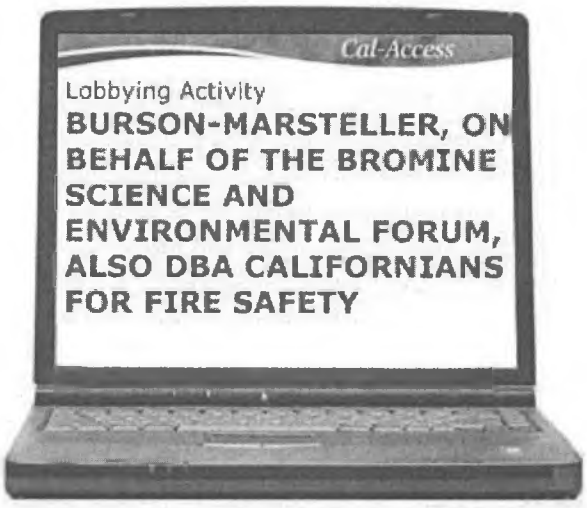
Four principal corporations that manufacture PBDEs are Albemarle, Israel Chemicals Limited (ICL), Chemtura, and Tosoh. When they saw that some of their flame retardant products were coming under regulatory pressure, they contracted with Burson-Marsteller, the giant global public relations firm, to change public and legislative perceptions about the hazards associated with PBDEs. Burson-Marsteller represents major chemical and oil companies such as Exxon-Mobil and Monsanto, as well as controversial businesses such as Blackwater and foreign military juntas.[5] Burson-Marsteller also represented Union Carbide, whose facility in India was responsible for the Bhopal Disaster.[6] It helped organize the Bromine Science and Environmental Forum (BSEF), as the neutral-sounding public relations arm of the four principle PBDE-producing companies. Lawrie McLaren, the BSEF Program Director,[7] is also European Practice Leader Public Affairs for Burson-Marsteller.[8]

In Burson-Marsteller, PBDE manufacturers picked a partner with vast experience in creating and managing front groups. Previously, Burson-Marsteller created the "National Smoker's Alliance" as a front group for the tobacco industry to fight against Clean Indoor Air acts and other anti-smoking legislative initiatives.[9] In Europe, the Merck pharmaceutical company engaged Burson-Marsteller to create a so-called "Coalition to Prevent Deep-Vein Thrombosis"[10] to market a product for that condition, and the star-studded "European Women for HPV Testing" was set up for the company that made the HPV tests.[11]

Front Group Formed: Citizens for Fire Safety

Just as in other campaigns to promote and defend its bottom line, industry has developed a strategy relying on a front group called "Citizens for Fire Safety" (CFFS) to campaign against state legislative initiatives regulating PBDE flame retardants, while attempting to influence state regulatory policy either by lobbying directly or paying firms who also lobby for the American Chemistry Council (ACC), Albemarle, Chemtura or BSEF. CFFS has formed "chapters" in a number of states where it actively lobbies, including Connecticut, Illinois, Maine, Maryland, Massachusetts and Minnesota. In California, a related organization called "Californians for Fire Safety" was created by the public relations consulting firm Jacobson Communications, and is explicitly listed on the lobbyist registration website. "Burson-Marsteller, on behalf of the Bromine Science and Environmental Forum, Doing Business As Californians for Fire Safety," spent $6,673,215.90 over the 4 quarters at the start of the

published Oct. 16, 2008



2007–2008 legislative session. It terminated its lobbying firms at the end of January 2008, and those firms picked up Citizens for Fire Safety Institute on Feb 1, 2008.[12]

Citizens for Fire Safety – Truth in Advertising?

Citizens for Fire Safety[13] describes itself as "... a coalition of fire professionals, educators, burn centers, doctors, fire departments and industry leaders..." but in fact is moving a special interest corporate agenda for a handful of actors. The primary purpose of CFFS is to work at the behest of PBDE manufacturers to defeat legislative initiatives calling for the prohibition of PBDE flame retardants. CFFS builds its membership list by attracting the support of organizations

continued on page 4

REAL PEOPLE FIGHT BACK:
Firefighters and Health Professionals Support Non-Toxic Fire Safety

The following organizations support phasing out PBDEs because of the health threats they pose and the availability of safer, effective fire protection methods.

- American Academy of Pediatrics – Maine Chapter
- American Academy of Pediatrics (Michigan Chapter)
- American Academy of Pediatrics District 2
- American College of Nurse Midwives, Region 1, Chapter 1
- American Nurses Association—Maine Chapter
- Amherst Health Department
- Associated Fire Fighters of Illinois
- Association of Comparative & Environmental Toxicology Students
- California Professional Firefighters
- Center for Children's Health and the Environment, Mount Sinai School of Medicine
- Columbia Center for Children's Environmental Health
- CT Association of Directors of Health (CADH)
- CT Association of Public Health Nurses (CAPHN)
- CT Association of School Nurses
- CT Nurses Association (CNA)
- CT Public Health Association (CPHA)
- Firemen's Association of the State of New York
- Greater Boston Physicians for Social Responsibility
- Illinois Fire Fighters Association
- Institute for Health and the Environment, University at Albany School of Public Health
- Institute of Neurotoxicology and Neurological Disorders
- Maine Fire Chiefs
- Maine Fire Commission
- Maine Public Health Association
- Maine State Fire Marshall
- Massachusetts Association of Registered Nurses
- Massachusetts Nurses Association
- Michigan Association of Fire Chiefs
- Michigan Nurses Association
- Michigan Professional Fire Fighters Union
- Minnesota Nurses Association
- Minnesota Professional Fire Fighters
- Minnesota Public Health Association
- New York State Nurses Association
- Nursing Program, University of Washington,Tacoma
- Physicians for Social Responsibility—Los Angeles
- Physicians for Social Responsibility—Maine Chapter
- Planned Parenthood Minnesota, North Dakota, South Dakota
- Professional Firefighters of Maine
- San Francisco Medical Society
- Student Nurses Association, Endicott College
- Uniformed Professional Firefighters Association of Connecticut
- Washington Physicians for Social Responsibility (WPSR)
- Washington State Association of Fire Chiefs
- Washington State Council of Fire Fighters
- Washington State Nurses Association (WSNA)

Coming Soon to a Statehouse Near You – Key Personnel

"Time and time again, I've seen good bills die because we are overwhelmed with corporate lobbyists. There are a finite number of us, and an increasing number of them. We're outgunned and outnumbered when it comes to passing policies to protect the environment and public health."

—Maryland State Delegate James W. Hubbard, President, National Caucus of Environmental Legislators

Kelley Cawthorne

In Michigan, CFFS hired the firm of Kelley Cawthorne, which retains several lobbyists, including David Ladd, once a staffer in former Governor John Engler's administration. Engler came under fire while in office for not holding Dow Chemical (another ACC member) accountable for dioxin and other contamination in Michigan. Dennis Cawthorne himself was in Engler's administration, and is currently active in Michigan politics.

Grant Gillham

Grant Gillman is the signatory to state lobbying forms for CFFS. Gillham is a former employee of R.J. Reynolds who also worked for lobbyist Joe Schumate under contract with the tobacco industry. Grant Gillham has said he is working in "15-20" state legislatures. Featured on CFFS's website are notices about:

- Alaska HB 271
- Maryland HB 1
- Maine LD 2048 (signed into public law April 15, 2007)
- Illinois HB 298 (now 1421)
- Minnesota HB 934
- Connecticut HB 5805

Seth Jacobson

Seth Jacobson, through his public relations firm Jacobson Communications, developed Californians for Fire Safety, which used false and misleading information to defeat AB 706, a bill to protect people from chlorinated and brominated flame retardants including PBDEs. Prior to creating Californians for Fire Safety, Jacobson created "Santa Monicans for Sensible Priorities" and "Santa Monicans for Change," an effort funded by hotel business interests. According to campaign documents, ET Whitehall Seascape LLC and Edward Thomas Management Co. (Casa Del Mar and the Shutters Hotels) made payments to SMSP for "public relations and consulting work," designed to gain control of city government. Prior to that, Jacobson was a spokesperson for "Fighting Against Irresponsible Regulation (FAIR), an anti-living wage group that was widely criticized for distributing false and misleading election mailers.[15]

George A. Morris

George Morris is Hawaii's chief lobbyist for CFFS. Morris is also the major lobbyist for the American Chemistry Council.

Laura Ruiz

Laura Ruiz is Albemarle's Corporate Director for Consumer Advocacy. She gives testimony opposing controls on PBDEs on behalf of CFFS at legislative hearings. She also signed a letter to California State Senator Ridley-Thomas opposing AB 706 as the Chair of the American Fire Safety Council in 2007.[16]

Peter Sparber

Peter Sparber is BSEF liaison and public relations specialist of Sparber and Associates. He was formerly a vice president at the Tobacco Institute, which supported fire experts to address other problems and deflected attention from the effort to make cigarettes more fire-safe. Cigarettes are a major source of house fires. BSEF supported tactics to oppose fire safe cigarettes, because reducing cigarette-caused fires would reduce the risk for fires, which would also reduce the market share for their flame retardant products.[17] Sparber devised the concept of creating fake grassroots groups to front tobacco industry lobbying objectives.[18]

Personnel in Connecticut

In Connecticut, many lobbying firms work to oppose legislation that restricts PBDEs. BSEF is represented by Hughes & Cronin Public Affairs Strategies. Albemarle Equity, a subsidiary of Albemarle Corporation, is represented by M.P. Guinan Associates. Citizens for Fire Safety Institute, (another name for CFFS), is represented by Capitol Strategies Group, which specializes in brokering deals between corporations and government. It has offices in Connecticut, Texas, Florida, New York and California.

continued from page 2

and individuals who may be unaware of its chemical industry motives by using misrepresentation of what a given proposed policy would accomplish.[14] The front group seeks to blunt the rising influence of actual citizen coalitions—of environmental health and justice communities working with physicians, "moms" groups, firefighters, children's health advocates and others—that have formed to support restricting brominated flame retardants, due to the environmental and public health concerns they pose, and the ready availability of safer, cost- and performance-effective alternatives.

Often the public face of CFFS is not what it appears to be. Sometimes, PBDEs manufacturers present themselves in public hearings as representatives of CFFS. For example, at a Minnesota hearing on brominated flame retardants, Ms. Laura Ruiz entered herself into testimony as being from CFFS, although she is Albemarle's Corporate Director for Consumer Advocacy. Albemarle is a founding member of BSEF.

The funding for CFFS is not described on their website. Although CFFS presents itself as a grassroots group, it does not appear to solicit funding from the communities it purports to represent. However, it spends significant resources to defeat legislation restricting flame retardants. For example, in California, CFFS reported spending $190,740.06 for the 2007–2008 legislative season with professional state lobbyists, who also lobby for Californians for Fire Safety (see above), the American Chemistry Council (which includes the four BSEF bromine corporations), the Bromine Science and Environmental Forum (BSEF), Albemarle and Chemtura. CFFS pays lobbying firms in California, Colorado, Connecticut, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Mississippi, New York, Texas, and Vermont. Another member of the ACC, ExxonMobil, lobbies for "fire safety" in New York.

Toxic Flame Retardants Hurt Firefighters

BSEF/Burson-Marstellar/CFFS has tried very hard to get firefighters to join their campaign. Their main strategy has been to get politically appointed fire and insurance commissioners on board. But the International Association of Firefighters, the organization which represents career firefighters in the U.S. and Canada, fully understands the risks posed by brominated flame retardants. Firefighters in Canada and in every state where bills restricting PBDEs have been introduced have gone on record to support those restrictions.

Firefighters have good reason to act in their own interests: In November 2006, the Journal of Occupational and Environmental Medicine published an analysis of 32 studies that found that fire fighters have significantly elevated rates of four types of cancer: multiple myeloma, non-Hodgkin's lymphoma, prostate, and testicular cancer, likely resulting from chemical exposures.[19]

In a recent letter to the International Electrotechnical Commission (IEC) signers representing many firefighter and other related organizations protested the industry push for adding brominated flame retardants to the television casing standards, including:

- International Association of Fire Fighters, Washington, D.C.
- John F. Hanley, San Francisco Fire Fighters Local 798,
- Tony Stefani, Executive Director and Founder San Francisco Firefighters Cancer Prevention Foundation
- Bob Shewbrooks, President, Hospital Fire Marshals Association, Philadelphia, PA
- Andrew McGuire, Executive Director Trauma Foundation, San Francisco General Hospital
- Elizabeth McLoughlin, Associate Director Ret.,Trauma Foundation, San Francisco General Hospital
- Peter A. Brigham, Founding and Emeritus Board Member, Federation of Burn Foundations.

In the letter, they state: "While the fire risk is very low, the health risk, especially for fire fighters, is very high. The proposed standard would lead to considerable levels of fire retardant chemicals in plastic TV housings. When these fire retardant chemicals burn, large amounts of toxic and cancer-causing brominated dioxins and furans can form. These combustion products present a significant health hazard for fire fighters.... The accumulation and health problems from the fire retardant chemicals, especially to fire fighters, have been documented in many dozens of peer-reviewed scientific research papers."[20]

This letter and others like it successfully defeated attempts by the chemical industry to mandate brominated flame retardants in the IEC television casing standard.

Conclusion

Everyone agrees we must protect people from fires, and do what we can to prevent them. Fortunately, we do not need to make the false choice between toxic chemical exposure and fire safety. If past is prologue, we can expect that this will not be the last front group the bromine industry uses to obscure its motives, manipulate public opinion and disrupt proposed legislative action. While the bromine industry attempts to use front groups like Citizens for Fire Safety to legitimize their profit-driven agenda, fire fighters, health professionals and truly grassroots organizations are taking a stand to protect people from fires *and* protect their health.

ACAT
Alaska Community Action on Toxics

505 W. Northern Lights; Suite 205
Anchorage, AK 99503
Phone: (907) 222-7714; Fax 222-7715
www.akaction.org

**Testimony of Pamela Miller, Executive Director,
Alaska Community Action on Toxics**

**For a Hearing of the
Alaska State Senate Health and Social Services Committee
Concerning Senate Bill 27—An Act Relating to Flame Retardants
and Other Bioaccumulative Toxic Chemicals**

February 21, 2011

I would like to begin by thanking Chair Davis and Members of the Senate Health and Social Services Committee for this opportunity to provide testimony on SB 27. My name is Pamela Miller, Biologist and Executive Director of Alaska Community Action on Toxics (ACAT). ACAT is a statewide environmental health organization that conducts research and provides educational programs, technical assistance, and training. Alaska Community Action on Toxics urges your support of SB 27, "*An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date.*"

SB 27 is an important measure to protect public health and especially the health of particularly vulnerable populations, including children as well as firefighters who are on the front lines of exposure to these dangerous chemicals. Polybrominated diphenyl ethers or PBDEs are similar in structure to the banned chemicals known as PCBs, polychlorinated biphenyls, and thus can have similar harmful effects on the body. PBDEs accumulate and are long-lasting, and we are concerned about them because they interfere with proper thyroid function in laboratory studies, cause problems with brain development and disrupt learning, memory, and behavior.

People are exposed to PBDEs through contaminated air, household dust, and foods. These chemicals leach out of products and we are exposed through indoor air and dust. PBDEs harm childhood brain development, and can contribute to learning disabilities that last into adulthood. Exposure to deca- and its breakdown products can harm women and children because they are passed to infants through

breast milk and to children through contact with household dust. Levels in wildlife and people are increasing exponentially. PBDEs in human breast milk are increasing and doubling every 2-5 years. Levels in the U.S. are the highest of all countries for which there are data and about 10-100 times greater than human tissue levels in Europe. PBDEs are persistent and can travel long distances via wind and ocean currents—PBDEs are now ubiquitous and found in northern air, sediments and wildlife. Alaskans are more vulnerable to exposures due to our higher levels of consumption of fish and marine mammals. Women of child-bearing age in the Yukon-Kuskokwim region of Alaska have the highest levels of any human population in the circumpolar Arctic.

Over the past year, new scientific evidence about the health effects of brominated flame retardants compels urgent action. Dr. Julie Herbstman of the Columbia University Center for Children's Environmental Health found that children who had higher prenatal exposures to PBDEs scored lower on tests of mental and physical development at ages 1, 4, and 6. Developing children are exposed to these toxic chemicals before they are born and this affects their learning and development throughout childhood and perhaps permanently. Concentrations of cord blood PBDEs in this study are similar to developing children throughout the U.S. As with public policy measures to reduce childhood exposure to lead, actions that we take now to reduce and eliminate exposure to PBDEs will have immeasurable benefits in preventing intellectual deficits in generations of children.

Also in the past year, more than 150 prominent scientists signed a consensus statement known as the San Antonio Statement on Brominated and Chlorinated Flame Retardants published in the December 2010 issue of Environmental Health Perspectives, the peer-reviewed journal of the National Institute of Environmental Health Sciences. The statement names brominated flame retardants as a class of substance of concern for persistence, bioaccumulation, long-range transport and toxicity. Among the twenty points, the scientists state: "Brominated and chlorinated flame retardants can increase fire toxicity, but their overall benefit in improving fire safety has not been proven."

The American Public Health Association recognizes the public health threat presented by the prevalence of toxic PBDE flame retardants and passed a resolution stating: "*In light of the emerging science on the inherent toxicity and persistence of PBDEs, evidence of adverse health effects on animals, and the prevalence and rising levels in fish, biota, and human breast milk, immediate action is needed to prevent further environmental contamination and to protect public health. The American Public Health Association urges state and federal*

governments to require the use of all PBDE flame retardants be phased out in all products manufactured and sold in the U.S. by a date certain."

No one disputes the importance of fire prevention and safety, however, with the availability and economic viability of safer alternatives, it does not make sense to expose people to these toxic chemicals. In summary, we urge you to pass SB 27 in order to protect health, particularly the health of vulnerable populations including pregnant women, developing children, fire fighters and other workers. Thank you.

ENDNOTES

1 Eriksson P, Jakobsson E, Fredriksson A. 2001. Brominated flame retardants: A novel class of developmental neurotoxicants in our environment? Environmental Health Perspectives 109(9):903-908.

2 Kuriyama SN, Talsness CE, Grote K, Chahoud I. 2005. Developmental exposure to low-dose PBDE-99: Effects on male fertility and neurobehavior in rat offspring. Environmental Health Perspectives 13(2):149-154.

3 Lilienthal, Hellmuth, et al. 2006. Effects of developmental exposure to 2,2',4,4',5-pentabromodiphenyl ether (PBDE-99) on sex steroids, sexual development, and sexually dimorphic behavior in rats. Environmental Health Perspectives 114(2):194-201.

4 Maine Department of Environmental Protection, Center for Disease Control. 2007. *Brominated Flame Retardants,* Third annual report to the Maine Legislature. www.maine.gov/dep/rwm/publications/legislativereports/pdf/finalrptjan07.pdf

5 http://en.wikipedia.org/wiki/Burson-Marsteller

6 Ibid.

7 As listed on their website, http://www.bsef.com/contact/, as of 9/12/08

8 As listed on their website, http://www.burson-marsteller.com/About_Us/Regional_Leadership/Pages/Europe_Africa.aspx, as of 9/12/08

9 http://www.sourcewatch.org/index.php?title=Burson-Marsteller_and_the_National_Smokers_Alliance

10 Barnett, Antony. 2004. Drug firm plays up long flights fear; Observer investigation reveals covert funding for health pressure groups. The Guardian.

11 www.guardian.co.uk/uk/2004/jan/25/society.research

12 http://cal-access.sos.ca.gov/Lobbying/Firms/Detail.aspx?id=1147235&session=2007

13 http://cffsi.org/about.html

14 Letter dated from Seth Jacobson on Citizens for Fire Safety letterhead to Dr. William Hickerson of Arkansas Children's Hospital in Little Rock, Arkansas. The letter conflates all state legislation, and claims uniformly that "these bills advocate the complete removal of this chemical without providing an alternative means of protection."

15 Santa Monica Daily Press, Volume 5, Issue 103, Monday, March 13th, 2006

16 Letter dated June 25, 2007 on American Fire Safety Council letterhead, subsequently circulated to fire fighter organizations.

17 Fighting for Safety *Washington Post* January 26, 2008 www.washingtonpost.com/wp-dyn/content/article/2008/01/25/AR2008012503170_pf.html

18 http://tobaccodocuments.org/landman/TI01770029-0100.html

19 "Cancer Risk Among Firefighters: A Review and Meta-analysis of 32 Studies" Journal of Occupational and Environmental Medicine November 2006 "http://www.joem.org/pt/re/joem/abstract.00043764-20061100000014.htm;jsessionid=LhZFMmHcv1D6KjLY2QdtyyKjGmX35pyQxT1KvBysQ1P1JTHWkcV4!1379360954!181195629!8091!-1

20 http://greensciencepolicy.org/

Sen. Bettye Davis

From: Marc! [marcslinger@yahoo.com]
Sent: Saturday, February 19, 2011 12:45 PM
To: Sen. Bettye Davis
Subject: Please support SB 27

Dear Representative Davis,

Please support the prevention of toxic exposures. As a member of the Anchorage Fire Department, I proudly protect and serve our community without hesitation. Please do your part and protect not only us as public servants, but everyone in our community, current and future.

Support SB 27.

With much gratitude,
Marc Esslinger

Sen. Bettye Davis

From: Briana Sullivan [brianasull@gmail.com]
Sent: Friday, February 18, 2011 9:16 PM
To: Sen. Bettye Davis
Subject: SB 27

RECEIVED
FEB 18 2011

Dear Senator,
Please make a healthy change to Alaska and its future; support Preventing Toxic Exposures.

Thank you for making a difference.
Peace,
Briana Sullivan

Celeste Hodge

From: Sen. Bettye Davis
Sent: Monday, February 21, 2011 12:29 PM
To: Celeste Hodge
Subject: FW: Thank you for supporting SB 27

-----Original Message-----
From: Christine Maack [mailto:cmaackster@gmail.com]
Sent: Monday, February 21, 2011 9:08 AM
To: Sen. Bettye Davis
Subject: Thank you for supporting SB 27

Dear Senator Davis,

Thank you for hearing SB 27, a bill to phase out the sale of PBDEs in Alaska, in Senate Health and Social Services. Alaskans deserve safe homes for their families and this piece of legislation is a smart first step to solve this problem. Thank you for your longtime support of this bill.

Sincerely,

Chris Maack

Christine Maack
[illegible]522 Alexander Ave
ANCHORAGE, AK 99508
907-278-4265

Celeste Hodge

From: Sen. Bettye Davis
Sent: Monday, February 21, 2011 12:01 PM
To: Celeste Hodge
Subject: FW: sb 27

From: james gilles [mailto:bigchief46@hotmail.com]
Sent: Monday, February 21, 2011 10:42 AM
To: Sen. Bettye Davis
Subject: sb 27

From: bigchief46@hotmail.com
To: senator_bettye_davis@legis.state.ak.usmember
Subject: sb 27
Date: Mon, 21 Feb 2011 19:37:36 +0000

Dear Committee,

I urge you to take careful look at sb 27. I feel this bill is a knee jerk reaction on fire retardants that have a proven safety record in the United States and have saved countless numbers of innocent lives.

Sincerely,

Pete Thering

The Association of Food, Beverage and Consumer Products Companies

February 20, 2011

The Honorable Bettye Davis
Chair, Senate Health and Social Services Committee
State Capitol Room 30
Juneau AK, 99801

VIA-ELECTRONIC MAIL ONLY

RE: SB 27 – OPPOSE

Dear Chair Davis:

On behalf of the Grocery Manufacturers Association (GMA[1]) I am writing to express our opposition to Senate Bill 27 because of its vagueness. As such, SB 27 appears to establish unfettered regulatory authority to the State to develop a potentially infinite list of bioaccumulative chemicals based on any number of potentially questionable authorities.

In reviewing SB 27 its ambiguity makes it difficult to assess the potential impacts to GMA members and their respective products. Therefore, it is impossible to provide substantive comments or specific amendments for consideration. For example, Section 18.31.680 assigns broad authority in the Departments of Environmental Conservation and Health and Social Services to establish "a list of persistent bioaccumulative toxic chemicals ["BTC"] that occur or are used in products used by human beings." Prior to granting such broad authority, GMA believes it would be helpful to know:

---

[1] Based in Washington, D.C., the Grocery Manufacturers Association is the voice of more than 300 leading food, beverage and consumer product companies that sustain and enhance the quality of life for hundreds of millions of people in the United States and around the globe.

Founded in 1908, GMA is an active, vocal advocate for its member companies and a trusted source of information about the industry and the products consumers rely on and enjoy every day. The association and its member companies are committed to meeting the needs of consumers through product innovation, responsible business practices and effective public policy solutions developed through a genuine partnership with policymakers and other stakeholders.

In keeping with its founding principles, GMA helps its members produce safe products through a strong and ongoing commitment to scientific research, testing and evaluation and to providing consumers with the products, tools and information they need to achieve a healthy diet and an active lifestyle.

The food, beverage and consumer packaged goods industry in the United States generates sales of $2.1 trillion annually, employs 14 million workers and contributes $1 trillion in added value to the economy every year.

Sen. Bettye Davis

From: Kristin Power [KPower@cspa.org]
Sent: Friday, February 18, 2011 3:56 PM
To: Sen. Bettye Davis; Sen. Dennis Egan; Sen. Johnny Ellis; Sen. Kevin Meyer; Sen. Fred Dyson
Cc: Sen. Bill Wielechowski
Subject: SB 27 (Wielechowski) - Scheduled for Hearing 2/21
Attachments: AK SB 27 SHealth.pdf

Senator Davis and Members of the Senate Health and Social Services Committee:

Attached please find CSPA's comments on Senate Bill 27 (Wielechowski), scheduled for hearing in the Senate Health and Social Services Committee on February 21. Please contact me at (916) 838-3587 or kpower@cspa.org if you have questions regarding our position on the measure.

Thank you,
Kristin Power

Kristin Power
Director, State Affairs – West Region

900 17th Street Suite 300
Washington, DC 20006

kpower@cspa.org
(202) 833-7314
(202) 872-8114

www.cspa.org

CSPA®
Representing Household & Institutional Products
Aerosol · Air Care · Cleaners · Polishes
Automotive Care · Antimicrobial · Pest Management

This e-mail, including any attachments, contains information from the Consumer Specialty Products Association (CSPA) and is intended solely for the use of the named recipient or recipients and CSPA member companies. This email, including any attachments or hyperlinks within it, may contain information that is confidential, legally privileged or otherwise protected from disclosure. If you are not the intended recipient of this email, you are not entitled to use, disclose, distribute, copy, print, disseminate or rely on this email in any way. Even if you are the intended recipient or a CSPA member company, you may not distribute, disclose or otherwise disseminate this email or its attachments outside the membership of CSPA, without CSPA's prior written consent.

CSPA®
Representing Household & Institutional Products

Aerosol - Air Care - Cleaners - Polishes
Automotive Care - Antimicrobial - Pest Management

February 18, 2011

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
State Capitol
Juneau, AK 99801-1182

Re: SB 27 - Development of PBT Chemicals List – OPPOSE

The Consumer Specialty Products Association must respectfully oppose SB 27 (Wielechowski), which would, among other things, direct the Department of Health and Social Services to establish, and update every three years a list of "persistent bioaccumulative toxic chemicals (PBTs)" that occur or are used in products used by human beings.

The Consumer Specialty Products Association (CSPA) is the premier trade association representing the interests of some 250 companies engaged in the manufacture, formulation, distribution and sale of $80 billion annually in the U.S. of hundreds of familiar consumer products that help household and institutional customers create cleaner and healthier environments. Our products include disinfectants that kill germs in homes, hospitals and restaurants; candles, and fragrances and air fresheners that eliminate odors; pest management products for home, garden and pets; cleaning products and polishes for use throughout the home and institutions; products used to protect and improve the performance and appearance of automobiles; aerosol products and a host of other products used every day.

CSPA members are committed to manufacturing and marketing safe products that are protective of human health and the environment while providing essential benefits to consumers. CSPA has adopted its members' commitment into the CSPA Principles for Chemicals Management Policy, available online at http://www.cspa.org/infocenter/our-issues/principles-for-chemicals-management-policy/.

CSPA supports programs that are risk based and use sound science. Programs should be governed by an advisory panel in which all stakeholders have a voice. CSPA supports programs that encourage resource pooling and build on existing statutory and regulatory structures, voluntary initiatives and data development efforts.

We are unclear why a PBT list is being drafted and how the list will be used in the future. SB 27 should include specific language that clearly describes the intent and future plans for creating and utilizing a state-specific PBT list.

To provide consistency with other regulatory structures, the PBT screening criteria used by the United States Environmental Protection Agency (USEPA) should be adopted. As currently drafted, Section 18.31.680 does not contain a clear set of definitions for the characteristics of P or B or T that is consistent with generally accepted PBT screening criteria. Though the bill does ask the Department to consider other sources of PBT information (e.g. Washington State PBT program, USEPA high production volume challenge program), CSPA believes that the bill should establish a clear definition to help ensure a focus on priority substances.

In addition, CSPA believes the bill should include language that directs the Department to develop and implement a stakeholder process through which interested parties can participate and provide input into the development and potential use of any PBT lists or potential alternative chemicals. A formal stakeholder process will help ensure that the overall process is informed by the best available scientific information.

SB 27 could be appreciably improved with the addition of language that provides transparent and objective parameters for selecting the best available scientific information. An example is the European Chemicals Agency's (ECHA)'s guidance document titled "Guidance on Information Requirements for Chemical Safety Assessment." The ECHA's guidance provides four specific parameters for selecting the best available scientific information based on relevance, reliability, and adequacy. The fundamental importance of having screening parameters is embodied in a quote by the ECHA, which stated "[t]he knowledge of how a study was carried out and consequently its relevance and reliability, is a prerequisite for the subsequent evaluation [and use] of [the] information."

For the reasons expressed above, we must oppose SB 27. Please contact me at (916) 838-3587 or kpower@cspa.org if you have questions regarding CSPA's concerns.

Sincerely,

Kristin Power

Kristin Power
Director, State Affairs – West Region

cc: Senator Wielechowski
Members, Senate Health and Social Services Committee
CSPA State Government Affairs Advisory Committee

- Does this list apply to BTC's at any level in a product (e.g., parts per million, parts per billion, etc)?
- Will this list include BTC's that are naturally occurring?
- Would this list include the packaging that accompanies the product?

SB 27's vagueness is also problematic because it provides the Departments of Environmental Conservation and Health and Social Services discretion to include "other sources the department determines are relevant" in establishing their list. As such, some additional questions that come to mind include, but are not limited to:

- What are the minimum scientific credentials required to be considered as a source?
- Can the Department rely on non peer-reviewed materials?
- Will the Department disclose the "other sources" it deems are relevant and will the public be allowed to question the scientific validity of these unnamed "sources".

Consumer safety is paramount to GMA and its members because it is the foundation of consumer trust and this consumer trust is built on providing safe and reliable products. Unfortunately, despite SB 27's laudable goal of consumer protection it creates more questions than it answers. As such, the Grocery Manufacturers Association must respectfully oppose SB 27.

Sincerely,

/s/

John Hewitt
Western Region Director
Grocery Manufacturers Association

American Chemistry Council

February 20, 2011

To: The Honorable Bettye Davis, Chair
Members, Alaska Senate Health & Social Services Committee

From: Tim Shestek, Senior Director
State Affairs

Re: **SB 27 – OPPOSE, AS DRAFTED**

The American Chemistry Council (ACC) must respectfully oppose as drafted SB 27, legislation that would, among other things, direct the Department of Health and Social Services to establish, and update every three years a list of "persistent bioaccumulative toxic chemicals (PBTs)" that occur or are used in products used by human beings.

ACC shares the objective of protecting human health and the environment from any significant risks associated with chemicals with PBT properties. PBT substances represent a very small percentage of chemicals in the United States. Many are either strictly regulated, are not currently in production, or are the by-products of human and natural activity. PBTs encompass a range of substances, including some metals and a variety of organic compounds.

DEFINITION OF PBT SHOULD BE CONSISTENT WITH RECOGNIZED STANDARDS

As currently drafted, Section 18.31.680 does not contain a clear set of definitions for the characteristics of P or B or T that is consistent with generally accepted PBT screening criteria. Though the bill does ask the Department to consider other sources of PBT information (e.g. Washington State PBT program, USEPA high production volume challenge program), ACC believes that the bill should establish a clear definition to help ensure a focus on priority substances.

ACC encourages you to consider the PBT screening criteria used by the United States Environmental Protection Agency (USEPA) as an example of specific criteria used to determine whether a chemical meets the generally recognized criteria for being a PBT. Information about the USEPA "PBT Profiler" can be found at: http://www.pbtprofiler.net/criteria.asp

FUTURE USE OF PBT LIST UNCLEAR

As drafted, the bill does not answer the question of why the PBT list is being created, nor does the bill provide any insight into the long-range plans for how the Department intends to utilize the list. SB 27 should include specific language that clearly describes the intent and future plans for creating and utilizing a state-specific PBT list.

In addition, ACC believes the bill should include language that directs the Department to provide a formal process by which stakeholders can participate and provide input into (1) the development and potential use of any PBT list and (2) any regulation or review by the Department of brominated flame retardants or potential alternative chemicals. Establishing a formal process – prior to implementing any regulatory action - will help ensure that the overall process is informed by the best available scientific information.

BEST AVAILABLE SCIENTIFIC INFORMATION

ACC believes that SB 27 could be significantly improved by adding a section that provides transparent and objective parameters for selecting the best available scientific information. One example of such parameters is the European Chemicals Agency's (ECHA)'s guidance document titled "Guidance on Information Requirements for Chemical Safety Assessment."

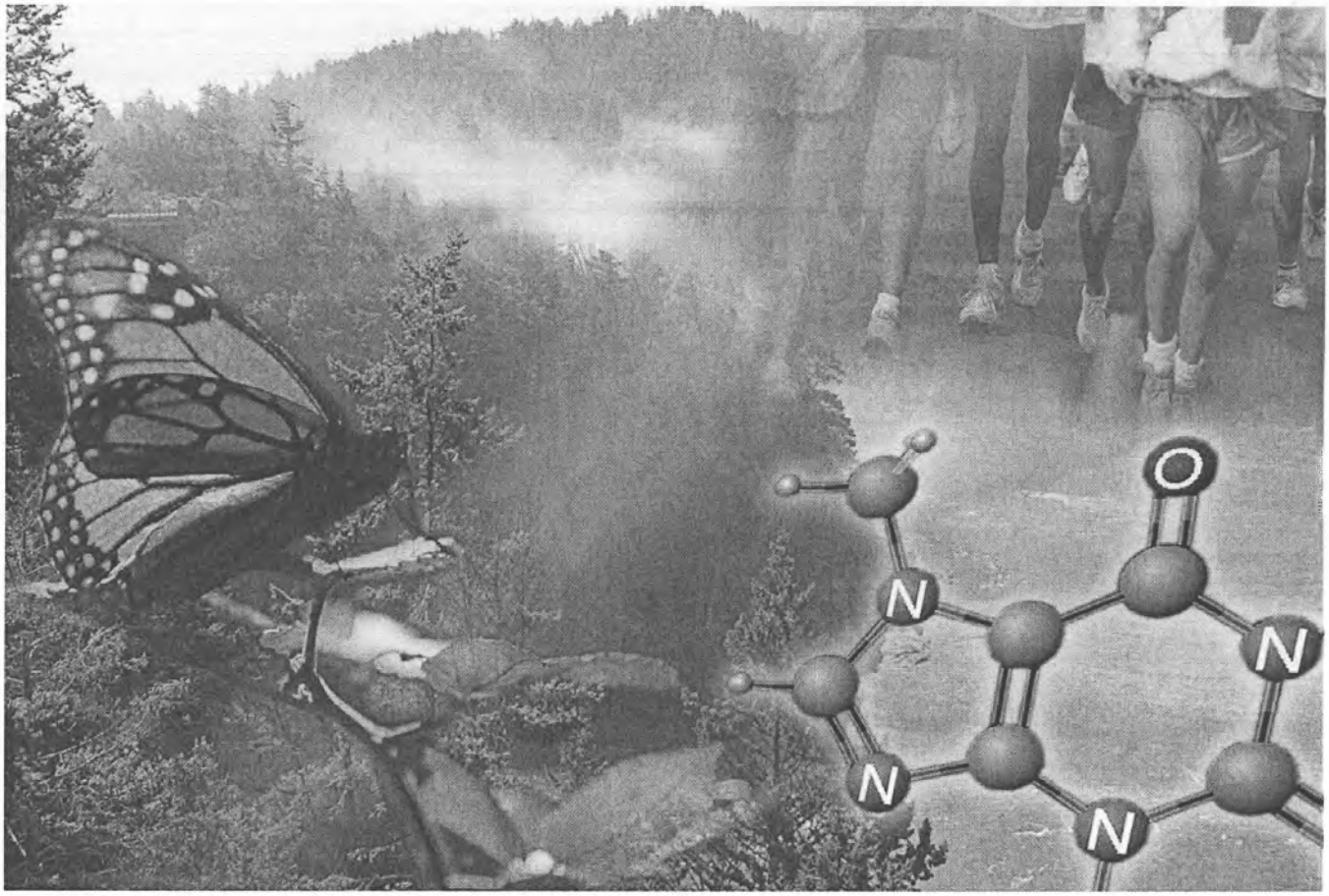
The ECHA's guidance provides four specific parameters for selecting the best available scientific information based on relevance, reliability, and adequacy. The fundamental importance of having screening parameters is embodied in a quote by the ECHA, which stated "[t]he knowledge of how a study was carried out and consequently its relevance and reliability, is a prerequisite for the subsequent evaluation [and use] of [the] information." Attached is the ECHA's guidance document for reference.

Thank you for the opportunity to share these comments. If you have any questions or comments, please do not hesitate to contact me at 916-448-2581or via email at tim_shestek@americanchemistry.com

ECHA

Guidance on information requirements and chemical safety assessment

Chapter R.4: Evaluation of available information



May 2008

Guidance for the implementation of REACH

LEGAL NOTICE

This document contains guidance on REACH explaining the REACH obligations and how to fulfil them. However, users are reminded that the text of the REACH regulation is the only authentic legal reference and that the information in this document does not constitute legal advice. The European Chemicals Agency does not accept any liability with regard to the contents of this document.

© European Chemicals Agency, 2008
Reproduction is authorised provided the source is acknowledged.

PREFACE

This document describes the information requirements under REACH with regard to substance properties, exposure, use and risk management measures, and the chemical safety assessment. It is part of a series of guidance documents that are aimed to help all stakeholders with their preparation for fulfilling their obligations under the REACH regulation. These documents cover detailed guidance for a range of essential REACH processes as well as for some specific scientific and/or technical methods that industry or authorities need to make use of under REACH.

The guidance documents were drafted and discussed within the REACH Implementation Projects (RIPs) led by the European Commission services, involving stakeholders from Member States, industry and non-governmental organisations. These guidance documents can be obtained via the website of the European Chemicals Agency (http://echa.europa.eu/reach_en.asp). Further guidance documents will be published on this website when they are finalised or updated.

This document relates to the REACH Regulation (EC) No 1907/2006 of the European Parliament and of the Council of 18 December 2006[1]

1 Corrigendum to Regulation (EC) No 1907/2006 of the European Parliament and of the Council of 18 December 2006 concerning the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH), establishing a European Chemicals Agency, amending Directive 1999/45/EC and repealing Council Regulation (EEC) No 793/93 and Commission Regulation (EC) No 1488/94 as well as Council Directive 76/769/EEC and Commission Directives 91/155/EEC, 93/67/EEC, 93/105/EC and 2000/21/EC (OJ L 396, 30.12.2006); amended by Council Regulation (EC) No 1354/2007 of 15 November 2007 adapting Regulation (EC) No 1907/2006 of the European Parliament and of the Council on the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH) by reason of the accession of Bulgaria and Romania (OJ L 304, 22.11.2007, p. 1).

Convention for citing the REACH regulation

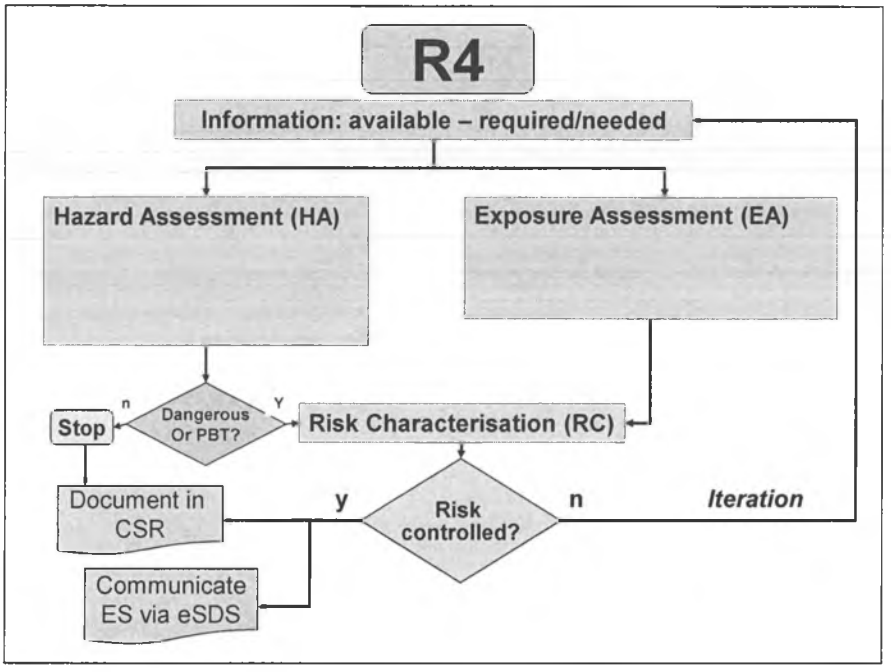
Where the REACH regulation is cited literally, this is indicated by text in italics between quotes.

Table of Terms and Abbreviations

See Chapter R.20

Pathfinder

The figure below indicates the location of Chapter R.4 within the Guidance Document



CONTENTS

R.4 EVALUATION OF AVAILABLE INFORMATION 7

R.4.1 Relevance of information 8

R.4.2 Reliability of information 9

R.4.3 Adequacy of information 11
R.4.3.1 Non-human data 11
R.4.3.1.1 In vitro data 12
R.4.3.2 Non-testing data 16
R.4.3.2.1 (Q)SAR data 16
R.4.3.2.2 Data obtained by grouping approaches 18
R.4.3.3 Human data 20

R.4.4 Evaluation and Integration of all available Information including Weight of Evidence 21

R.4.5 References 22

TABLES

Table R.4-1: The criteria for validation derived from the OECD GD 34 13
Table R.4-2: The criteria for suitability assessment according to the ECVAM criteria for entering the pre-validation study, (Curren *et al*, 1995). 15

R.4 EVALUATION OF AVAILABLE INFORMATION

This chapter aims to provide guidance on how to evaluate available information gathered in the context of REACH Annex VI-XI. The information should be evaluated for its *completeness* and *quality* for the purpose of REACH to assess whether:

1. it fulfils the specific requirements triggered by tonnage as described in REACH Annex VII-X, including application of REACH Annex XI.
2. it is appropriate for hazard classification and risk assessment, including CMR, PBT and vPvB assessment.

Practically, this assessment is usually performed by an evidence-based approach to determine whether the information requirements are already met by the available information. If this is not the case, the information gaps should be defined and appropriate action(s) taken to address these.

The evaluation of *data quality* includes assessment of *adequacy* of the information for hazard/risk assessment and C&L purposes (see above) and furthermore the two basic elements of *relevance* and *reliability*. These terms were defined by Klimisch *et al* (1997) as follows (see also OECD, 2005a):

> *"**Relevance** - covering the extent to which data and tests are appropriate for a particular hazard identification or risk characterisation.*
>
> ***Reliability** - evaluating the inherent quality of a test report or publication relating to preferably standardised methodology and the way the experimental procedure and results are described to give evidence of the clarity and plausibility of the findings. Reliability of data is closely linked to the reliability of the test method used to generate the data (see Section R.4.2).*
>
> ***Adequacy** - defining the usefulness of data for hazard/risk assessment purposes. Where there is more than one study for each endpoint, the greatest weight is attached to the studies that are the most relevant and reliable. For each endpoint, robust summaries need to be prepared for the key studies."*

The terms *relevance* and *reliability* are also used in the context of test methodology (see OECD GD 34 (OECD, 2005b)). The knowledge of how a study was carried out and consequently its relevance and reliability, is a prerequisite for the subsequent evaluation of information.

The *completeness* of the information refers to the conclusion on the comparison between the available information and the information that is required under the REACH registered for the tonnage level of the substance.

Available information on the individual substance should be evaluated in relation to the level of certainty and accuracy needed to meet the regulatory requirement under REACH; it should be considered whether generation of new data would impact such regulatory decision making. In other words, all information has to be *adequate for the purpose*.

A *Weight of Evidence* approach, mentioned in Annex XI Section1.2 of REACH, integrates available information from guideline tests, non-guideline tests, and other types of information which may justify adaptation of the standard testing regime.

R.4.1 Relevance of information

In order to evaluate the relevance of the available data the following aspects could for example be considered:

- Was the substance tested representative for the substance as being registered?
- Has the appropriate species been studied?
- Is the route of exposure relevant for the population?
- Were appropriate doses/concentrations tested?
- Were the critical parameters influencing the endpoint considered adequately?

Human data is in principle the most relevant source of information on human toxicity. Since there may be limitations with regard to the reliability of these studies, they are normally considered together with animal, *in vitro* and other information in order to be able to reach a conclusion about the relevance of the effects to humans.

The evaluation of the relevance for humans of data from studies in laboratory animals is aided by use of information (when available) on the toxicokinetics of the substance in both humans and the animals species used in the toxicity tests, even when such information is relatively limited. Further guidance on the value and use of toxicokinetics is given in Section R.7.12.

Normally, for human health hazard assessment, a *no* or *lowest observed (adverse) effect level* (NO(A)EL, LO(A)EL), or a *benchmark dose* (BMD) for adverse effects in laboratory animals are extrapolated to an exposure level (DNEL) below which it is assumed that adverse effects are unlikely to occur in humans exposed to the substance. For substances evoking effects that have no definable threshold, e.g. genotoxic carcinogens, it may not be possible to identify an exposure level without effects; in such cases, extrapolation is made to an exposure level that represents a risk level of very low concern for humans (DMEL). For more guidance on the derivation and application of these indices in the chemical safety assessment, see Chapter R.8.

For environmental compartments such as surface water, sediment and soil, a *predicted no effect concentration* (PNEC) is obtained by extrapolation based on the lowest *no observed effect concentration* (NOEC) or *effect concentration* causing marginal effects (ECx) by application of assessment factors. For more guidance on the derivation and application of these indices in the chemical safety assessment, see Chapter R.10.

When data are available, dose-response relationships in the animal studies (or the severity of the effect, when only a single dose has been tested) are also assessed as a part of the risk assessment process. Both aspects are taken into account at the risk characterisation stage when a judgement is made of whether adverse effects in humans or the environment would occur at a particular level of exposure.

Where the data suggest that an effect might be species specific, i.e. that the effects observed in the studies of one species are not likely to occur in a different species, specifically humans, clear, well-documented evidence is necessary (e.g. light hydrocarbon-induced nephropathy in the kidney of male rats) to justify the conclusion that a particular effect is not expected to occur in humans exposed to the substance.

In general, the results of *in vitro* tests provide supplementary information which may be used *inter alia* to facilitate the interpretation of the relevance of animal data for humans, or to gain a better understanding of the mechanism of action of a substance. Depending on the type of *in vitro* data and its predictivity for effects *in vivo*, such data may be also used as an alternative to test data on laboratory animals or as an important part of the basis for deciding whether such tests may be warranted.

R.4.2 Reliability of information

The quality of the study, the method, the reporting of the results, and the conclusions that are drawn, must be evaluated carefully. Reasons why existing study data may vary in quality include the use of outdated test guidelines, the failure to characterise the test substance properly (in terms of purity, physical characteristics, etc.), the use of crude techniques/procedures that have since become refined, and the fact that certain endpoint information, now recognised as being important, may have not been recorded or measured. Moreover, other reasons could be poor reporting of information and poor quality assurance.

Klimisch *et al* (1997) developed a scoring system to assess the reliability of data, particularly from toxicological and ecotoxicological studies, that may be extended to physico-chemical and environmental fate and behaviour studies:

> **1 = reliable without restrictions:** *"studies or data [...] generated according to generally valid and/or internationally accepted testing guidelines (preferably performed according to GLP) or in which the test parameters documented are based on a specific (national) testing guideline [...] or in which all parameters described are closely related/comparable to a guideline method."*
>
> **2 = reliable with restrictions:** *"studies or data [...] (mostly not performed according to GLP), in which the test parameters documented do not totally comply with the specific testing guideline, but are sufficient to accept the data or in which investigations are described which cannot be subsumed under a testing guideline, but which are nevertheless well documented and scientifically acceptable."*
>
> **3 = not reliable:** *"studies or data [...] in which there were interferences between the measuring system and the test substance or in which organisms/test systems were used which are not relevant in relation to the exposure (e.g. unphysiological pathways of application) or which were carried out or generated according to a method which is not acceptable, the documentation of which is not sufficient for assessment and which is not convincing for an expert judgment."*
>
> **4 = not assignable:** *"studies or data [...] which do not give sufficient experimental details and which are only listed in short abstracts or secondary literature (books, reviews, etc.)."*

The use of such scoring tools, e.g. the mentioned *Klimisch codes,* allows ranking the information, and organising it for further review. This implies focussing on the most relevant ones, taking into account the endpoint being measured or estimated. The evaluation of the reliability is performed considering certain formal criteria using international standards as references. The scoring of information, e.g. according to Klimisch codes, should not exclude all unreliable data from further consideration by expert judgement because of possible pertinence of these data related to the evaluated endpoints.

In general, some types of data that are not reliable (i.e. those where insufficient documentation exist for making an assessment) and data for which it is not possible to assign reliability, may only be used as supporting data.

For many existing substances, at least some of the available information could have been generated prior to the requirements of GLP and the standardisation of testing methods. While such information may still be usable for REACH purposes, both the data and the methodology used must be evaluated in order to determine their reliability. Such an evaluation needs evidence based decision making following established criteria and must be transparent to justify the use of a particular data set. For some substances, information may be available from tests conducted according to the methods included in EU Annex V of Directive 67/548/EEC or to OECD Test Guidelines (or other standards like CEN, ISO, ASTM, OSPAR methods, national standard methods), and in compliance with the principles of GLP or equivalent standards. REACH Article 13.3 states that any new tests should be "*conducted in accordance with the test methods laid down in a Commission Regulation or... other international test methods recognised by the Commission or the Agency as being appropriate.... Information on intrinsic properties may also be generated using other test methods provided they meet the conditions set out in Annex XI.*"

Furthermore, new ecotoxicological and toxicological tests shall be carried out in compliance with the principles of GLP (see Directive 2004/10/EC) or equivalent international standards. This does not apply to tests for physico-chemical properties.

The following are key points that an assessor should consider when evaluating data reliability:

- The proven ability of the laboratory to perform the test method
- The purity/impurities and origin of the test substance, as well as the reference substances, must be reported;
- The availability of the raw data from the study
- There must be an adequate description of the study e.g. a complete test report, or a sufficiently detailed description of the test procedure, which must be in accordance with generally accepted scientific standards. In these cases, the information may be considered reliable;
- When the test procedure used to generate the test data is found to differ significantly from that described by the recognised test method or generally accepted scientific standards, or the reliability of the data cannot be established fully, the assessor must decide if and how the information can be used, e.g. as supporting information where a reliable study already exists.

- The following factors, inter alia, can be used to support the view that these data may be acceptable for use in meeting the requirements of REACH:
  - there are other studies or calculations available on the substance, and the data under consideration are consistent with them,
  - other studies are available, for example on isomers with similar structure activity profile, homologues, relevant precursors, breakdown products or other chemical analogues, and the data under consideration are consistent with them,
  - an approximate value is sufficient for taking a decision on the endpoint of interest for the conclusion required by REACH;
- Where critical supporting information is not reported (e.g. species tested, substance identity and dosing procedure) the test data should be considered to be unreliable for the purposes of REACH.

In principle, the same criteria apply to test data reported in the published literature; the extent of the information provided will provide the basis for deciding upon the reliability of the data reported. In general, publications in peer-reviewed journals are preferable to those which are not. High-quality reviews, summaries or abstract publications may be used as supporting information.

R.4.3 Adequacy of information

Adequacy defines the usefulness of information for the purpose of hazard and risk assessment, in other words whether the available information allows clear decision-making by the registrant about (a) whether the substance meets the criteria for classification, (b) whether it is a potential PBT/vPvB and (c) whether appropriate DNEL/PNEC values can be derived for risk assessment purposes. The evaluation of adequacy of test results and documentation for the intended purpose is particularly important for substances under REACH where there may be (a number of) test results available for each effect, but where some or all of them have not been carried out according to current standards. Where there is more than one study for each endpoint, the greatest weight is attached to the studies that are the most relevant and reliable. For each endpoint, robust summaries need to be prepared for the key studies. Sound scientific judgement is an important principle in considering the adequacy of information and determining the key study.

The type of information that may be available consists of non-testing data, (the latter refer to (Q)SAR predictions or data on structurally-related substances, obtained by grouping approaches), *in vitro* data, data on living organisms, including data on laboratory animals, on humans or other data on (parts of) ecosystems.

R.4.3.1 Non-human data

The guidance given above on the evaluation of the adequacy (relevance and reliability) of information relates predominantly to information generated in tests on physico-chemical properties, animal studies, plant and micro-organism studies. Some specific guidance is given below for data generated *in vitro* systems.

R.4.3.1.1 In vitro data

When considering the adequacy of *in vitro* information it is important to distinguish between the suitability of the methodology per se and the adequacy of data that have been produced by such methods.

Use of *in vitro* methods within REACH

Suitable in vitro test methods are at least those that are sufficiently well developed according to internationally agreed test development criteria, e.g. fulfilling the ECVAM criteria for entry of the method into the pre-validation process (see details in Table R.4-2). In the frame of the Community Action Plan on the Protection and Welfare of Animals, a reference laboratory (CORRELATE) has been established at JRC-IHCP-ECVAM that assesses proposed *in vitro* test methods with regard to suitability and validation for the intended purpose.

At present the following two categories of *in vitro* methods are referred to within REACH as suitable:

- validated methods (e.g. *in vitro* tests for skin corrosion and *in vitro* genotoxicity tests, e.g. Ames salmonella typhimurium mutagenicity test) and
- those *in vitro* tests that meet the internationally agreed pre-validation criteria (e.g. meeting the ECVAM criteria of entering the pre-validation process).

There are clear definitions on what constitutes a fully validated *in vitro* assay. These criteria are detailed in OECD GD 34 (OECD, 2005b; see details in Table R.4-1) and were initially established by ECVAM and ECB and later refined by ECVAM (Hartung *et al*, 2004).

Use of adequate information derived from *in vitro* methods

Adequate information from *in vitro* studies can be used in two ways: first, the existing information from a validated and accepted *in vitro* test may fully or partly replace animal testing, and second, information derived from suitable *in vitro* methods can be used for adapting the standard testing regime as set out in Annex XI.

Information from validated in vitro tests may fully or partly replace an animal test

Article 25 (1) of the REACH Regulation states that testing on vertebrate animals shall only be performed as a last resort. Once scientifically validated according to internationally agreed validation principles (OECD GD 34 (OECD; 2005b)) *in vitro* test may fully or partly replace an *in vivo* test depending on the purpose for which the test method was validated and adopted. One of the main criteria for acceptance is the adequacy of the information generated using such a test(s) for the purpose of classification and labelling and/or risk assessment.

Information derived from suitable in vitro methods

Annex XI Section 1.4 opens the way for the use of results of *in vitro* methods that have not yet been scientifically validated but are identified as being *suitable*, meaning that the methods are sufficiently well developed according to internationally agreed test development criteria e.g. the ECVAM criteria for entry of the method into the pre-validation process (see Table R.4-2 and Section R.5.2.1.4 for a discussion of the use of *in vitro* testing to adapt the standard testing regime).

Table R.4-1: The criteria for validation derived from the OECD GD 34

Concerned items	Decision criteria to be considered
Rationale for the test method	Clear statement of: - scientific basis - regulatory purpose - need for the test method
Relationship between the test method's endpoint and (biological) phenomenon of interest	Description of the scientific relevance of the measured effects Mechanistic (biological) or empirical (correlative) relationship to the specific type of effect or toxicity of interest
Detailed protocol for the test method	Detailed protocol and SOP including: - description of materials - what is measured - how it is measured - how data will be analysed - decision criteria for evaluation - criteria for acceptable test performance
Test method performance using reference substances (accuracy assessment)	Sufficient number of reference substances measured in coded procedure Reference data and reference results for reference substances established
Performance evaluation	Performance evaluation in relation to: - relevant information from the species of concern - existing relevant toxicity testing data
Intra- and Inter-laboratory reproducibility	Data available on - Repeatability and reproducibility - Robustness (variability)
Relevance	- Demonstration of the predictive capacity of the method - Precise definition of the applicability domain
Test method data quality	Evidence that all data supporting the validity are gained under quality conditions, e.g. GLP, GCCP
Data availability	- All raw data should be available for expert review - Detailed method protocol public available

Information from in vitro test may provide mechanistic insight

Information from advanced *in vitro* assays may provide valuable information that aid and inform the risk assessment process. For example, with the growth of new technologies such as toxicogenomics, new possibilities are emerging that allow designer cell lines to assess specific mode of action (molecular pathways) of the potential toxicity of a substance or substance class. Such information is likely to be increasingly important in the future.

Adequacy of information from in vitro testing

The assessment of alternative testing data (to decide whether and how they can be used) in terms of adequacy for fulfilling the information requirements of REACH will follow the general criteria already discussed, e.g. applied quality measures, i.e. how they take into account the relevance, reliability and completeness of the information with regard to the regulatory decision to be taken. This includes how well the study is reported, how well the test substance is characterised and to what extent the information requirements have been met for the endpoint under consideration.

Table R.4-2: The criteria for suitability assessment according to the ECVAM criteria for entering the pre-validation study, (Curren *et al*, 1995).

Concerned items	**Decision criteria to be considered**
Purpose and proposed use	- Description of intended purpose and scientific basis - Fit of intended purpose with intended use - Position of the method in the context of regulatory testing and/or 3Rs
Evidence of the need for the test in comparison with other *in vivo/in vitro* test, state of the art	Complete and concise presentation of state of the art, human data, *in vivo*, non-testing and *in vitro* data Weighed judgment about the contribution of the proposed test method compared to state of the art, including weaknesses and limitations e.g.: improved reliability: accuracy, sensitivity, specificity, robustness, defined performance e.g. improved relevance: predictive capacity, applicability domain
Addressed endpoint described	- Demonstration of relevance for the *in vivo* situation - Description of data analysis and interpretation
Availability of a written procedure detailed enough to allow performance in another laboratory	Method protocol: - complete and readable - feasible and transferable - SOP standardised with respect to selected model and measurement performance
Reference substances, test materials and related results	- Description of reference substances, test materials and controls - Selection, identity, use in the measurement process including calibration and data interpretation
Data derived from the test using an appropriate set of test materials	- Data gained by measuring above reference substances or test materials - Test performance evaluation
Development of method according to GLP and GCCP conditions	Statement about data quality
Summary of how method has been derived and the biological basis for its relevance	- List of any additional documentation, which contributes to the above items - Statement about intellectual property rights and search for existence of any protection of intellectual property rights

R.4.3.2 Non-testing data

Non-testing data refers to data obtained by applying computational methods, such as SARs and QSARs (collectively referred to as (Q)SARs) as well as data obtained by grouping approaches (analogue and chemical category approaches).

R.4.3.2.1 (Q)SAR data

According to Article 13 (1) of REACH, information on intrinsic properties of substances may be generated by means other than tests, provided that the conditions set out in Annex XI are met. In particular for human toxicity, information shall be generated whenever possible by means other than vertebrate animal tests, through the use of alternative methods, for example, *in vitro* methods or qualitative or quantitative structure-activity relationship models or from information from structurally related substances (grouping or read-across) [see also REACH Article 25 (1)].

REACH Annex XI allows for the results of (Q)SARs to be used instead of testing when the following conditions are met:

- results are derived from a (Q)SAR model whose scientific validity has been established,
- the substance falls within the applicability domain of the (Q)SAR model,
- results are adequate for the purpose of classification and labelling and/or risk assessment, and,
- adequate and reliable documentation of the applied method is provided.

REACH Annex XI also indicate that the Agency in collaboration with the Commission, Member States and interested parties shall develop and provide guidance in assessing which (Q)SARs will meet these conditions and provide examples. In the meantime, a database has been developed to provide information on QSAR models and their validity (JRC QSAR Model Database (QMDB) http://qsardb.jrc.it). In addition to replacing the need for testing, (Q)SAR results may also in some cases indicate the need for further testing.

To apply the conditions of REACH Annex XI, it is important to distinguish between the validity of the (Q)SAR model, and the reliability and adequacy of an individual (Q)SAR estimate, and the appropriateness of the documentation associated with models and their predictions (see Section R.6.1 for detailed explanation).

The extent to which valid (Q)SARs are available for the different REACH endpoints is variable and is an evolving situation, as an increasing number of models are being characterised and documented according to the OECD validation principles described below. Information on the status of (Q)SARs for specific endpoints is given in Chapter R.7.

Valid (Q)SARs should be assessed for their applicability to the substance of interest, to determine the reliability of the QSAR estimate, and for their relevance to the regulatory purpose, to determine the adequacy of the (Q)SAR estimate. The adequacy of a (Q)SAR estimate (see Section R.6.1.5.4) takes into account the relevance and reliability of the (Q)SAR model and its prediction for the substance of interest as well as completeness of the information generated by the model.

A valid (Q)SAR is a model that has been characterised and documented according to the internationally agreed OECD Principles for the validation of (Q)SAR models. According to these principles, a (Q)SAR model that is proposed for regulatory use should be associated with a defined endpoint (principle 1), an unambiguous algorithm to ensure transparency in the model algorithm (principle 2), a defined domain of applicability (principle 3), and appropriate measures of internal performance and predictivity (principle 4). If possible, a mechanistic interpretation should also be provided, to add to the confidence in the model (principle 5).

Taken together, these five principles form the basis of a conceptual framework for characterising (Q)SAR models.

Preliminary guidance on how to characterise (Q)SARs according to the OECD validation principles is provided in this document (see Section R.6.1) This report was subsequently adopted, with minor revisions, by the OECD Member Countries and the Commission, as an OECD GD (OECD, 2007).

Whether the prediction from a scientifically valid QSAR model is reliable depends, *inter alia*, on whether the substance is within the applicability domain (see also Section R.6.1.5.3). Consideration of the applicability domain may include: 1) descriptor domain - do the descriptor values of the chemical fall within defined ranges; 2) structural fragment domain - does the chemical contain fragments that are not represented in the model training set; 3) mechanistic domain - does the chemical of interest act according to the same mode or mechanism of action as other chemicals for which the model is applicable; and 4) metabolic domain - does the chemical of interest undergo transformation or metabolism, and how does this affect reliance on the prediction for the parent compound.

The QSAR Model Reporting Format (QMRF) has been developed to provide a means of documenting (Q)SAR model characteristics in a transparent and consistent manner, in accordance with the OECD validation principles. Further information on QMRFs is given in Section R.6.1.9. In particular, the JRC QSAR Model Database (JRC QMDB) is being developed as a repository of quality-reviewed information on QSAR models and their validity. In this database, QSAR models will be linked with their corresponding QMRFs. Before developing a QMRF, the registrant should check whether it is already included in the JRC QMDB or other suitable source (e.g. OECD QSAR Toolbox[2]). If the appropriate QMRF for a given model is not already available, it will be necessary to develop one by applying the five validation principles and documenting the results. Since the general format of the QMRF is already defined, it is sufficient to fill this in with the appropriate information on the model. The ECB has developed a QMRF editor as a tool to facilitate the generation of new QMRFs.

To be used as a replacement for experimental data, it is necessary, but not sufficient, for a (Q)SAR model to be valid. The (Q)SAR model should also be shown to be applicable to the substance of interest, to determine whether the model estimate is reliable for the intended purpose. Whereas the (Q)SAR model should be reported in the form of a QMRF, individual model predictions should be documented according to the (Q)SAR Prediction Reporting Format (QPRF). Further information on QPRFs is given in Section R.6.1.10, and in the JRC QMDB.

QMRFs and QPRFs are important tools for documenting and reporting information on (Q)SARs and their estimates, respectively. It should be noted that these reporting formats are likely to evolve as experience is gained.

---

[2] http://www.oecd.org/dataoecd/33/41/37850114.pdf

The information in the QMRF and QPRF should be used when assessing whether a prediction is adequate for the purpose of classification and labelling and/or risk assessment. The assessment will also need to take into account the regulatory context. This means that the assessments of QSAR validity and QSAR estimate reliability need to be supplemented with an assessment of the relevance of the prediction for the regulatory purposes, which includes an assessment of *completeness*, i.e. whether the information is sufficient to make the regulatory decision, and if not, what additional (experimental) information is needed. The decision will be taken on a case-by-case basis (firstly by industry and then by the authorities working via an Agency committee). See Section R.6.1 for more detailed guidance.

(Q)SAR predictions may be gathered from databases (in which the predictions have already been generated and documented) or generated *de novo* through the applicable of available models. In the latter case, specialised expertise may be required.

Up to date information on QSAR models, QMRF, QPRF, editors, and examples is available in the JRC QMDB http://qsardb.jrc.it.

R.4.3.2.2 Data obtained by grouping approaches

Conclusions about the likely properties of a substance can also be based on the knowledge of the properties of one or more similar substances, by applying *grouping methods*. More details of such methods are provided in Section R.6.2.

REACH Annex XI contains under 1.5 a section on the use of grouping of substances and read-across approaches.

In this guidance, the terms *category approach* and *analogue approach* are used to describe techniques for grouping chemicals, whilst the term *read-across* is reserved for a technique of filling data gaps in either approach. The term *analogue approach* is sometimes used when the grouping is based on a very limited number of chemicals. A chemical category is a group of chemicals whose physico-chemical and human health and/or environmental toxicological properties and/or environmental fate properties are likely to be similar or follow a regular pattern as a result of structural similarity (or other similarity characteristic). In principle, more members are generally present in a chemical category, enabling the detection of trends across endpoints.

As with (Q)SARs, grouping approaches can be used to indicate either the presence or the absence of an effect.

Grouping approaches avoid the need to test all members of the group for all endpoints of interest, thereby reducing costs and animal testing. Additional benefits are described in Section R.6.2.

The assessment of chemicals by using a category approach differs from the approach of assessing them on an individual basis, since the effects of the individual chemicals within a category are assessed on the basis of the evaluation of the category as a whole, rather than based on measured data for any one particular substance alone.

The category approach has been applied successfully under the EU classification system, where all *similar* substances (sometimes identifying all the individual substances, sometimes leaving them as a generic group) are expected to have the same property as the substance[3]. Categories have also been developed in the context of the OECD HPV Chemicals Programme (http://www.oecd.org/document/21/0,3343,en_2649_34379_1939669_1_1_1_1,00.html Within a chemical category, data gaps may be filled by applying one or more of three general approaches: a) read-across; b) trend analysis (i.e. use of internal models, purposefully developed from the underlying data of the category); and c) use of external models (e.g. QSARs, Quantitative Activity-Activity Relationships (QAARs) and expert systems that were not specifically developed in the context of the category).

Read-across is a technique for data gap filling in which information for one or more *source* chemicals is used to make a prediction for a *target* chemical, which is considered to be *similar* in some way. Read-across can be used to fill data gaps in the context of both the analogue approach and the wider category approach.

The chemical category approach is, by its very nature, a *Weight of Evidence* approach, since it integrates estimated and experimental data, and involves expert judgement. The category approach also provides a means of strategic testing. The biggest challenge in this approach lays in defining the category itself (its underlying rationale/mechanistic basis) and in particular its boundaries.

The wider category approach is considered to be more robust than simple analogue approaches, which are more limited, ad-hoc ways of comparing small numbers of substances. As the number of possible chemicals being grouped into a category increases, the potential for developing hypotheses for specific endpoints and making generalisations about the trends within the category will also increase, and hence increase the robustness of the evaluation.

When applying the category approach, the robustness of the overall category is assessed, rather than the reliability for an individual substance (since in some cases, individual substances may display exceptional behaviour). Thus, the adequacy (relevance and reliability) of the approach needs to be assessed for individual substances of interest.

Grouping approaches can be used directly to fulfil information requirements in REACH, provided a number of conditions are met. Although REACH makes no explicit reference to the need for validation for grouping approaches, it will be necessary for the industry registrant making use of a grouping method to provide a scientific justification and to demonstrate that the grouping approach used is adequate for the regulatory purpose (classification and labelling and/or risk assessment). Guidance on how to demonstrate the adequacy of grouping approaches is provided in Section R.6.2.4.1. Furthermore, appropriate documentation of the grouping approach must be provided in the form of a suitable reporting format, as also described in Section R.6.2.6.

[3] Under EU legislation, these *categories* are the *group entries* in Annex I of Directive 67/548/EEC.

R.4.3.3 Human data

The evaluation and use of information derived from studies in humans usually requires more elaborate and in-depth critical assessment of the reliability than animal data (WHO, 1983). Four major types of human data may be submitted (1) analytical epidemiology studies on exposed populations, (2) descriptive or correlation epidemiology studies, (3) case reports and (4) in very rare, justified cases controlled studies in human volunteers.

Analytical epidemiology studies (1) are useful for identifying a relationship between human exposure and effects such as biological effect markers, early signs of chronic effects, disease occurrence, or mortality and may provide the best data for risk assessment. Study designs include:

- **Case-control (case-referent) studies**, where a group of individuals with (cases) and without (controls/referents) a particular effect are identified and compared to determine differences in exposure in the recent or more distant past;
- **Cohort studies**, where groups of variously exposed and *non-exposed* individuals are identified and differences between the groups in effect occurrence over time are studied;
- **Cross-sectional studies**, where a population (e.g. a workforce) is studied, so that morbidity at a given point in time can be assessed in relation to concurrent exposure.

The strength of the epidemiological evidence for specific health effects depends, among other things, on the type of analyses and on the magnitude and specificity of the response. Confidence in the findings is increased when comparable results are obtained in several independent studies on populations exposed to the same agent under different conditions. In general, cohort studies provide stronger evidence than case-control studies, because exposure is assessed independently of the health status or outcome of the subjects in the study. Other characteristics that support a causal association are presence of a dose-response association, a consistent relationship in time and (biological) plausibility.

Criteria for assessing the adequacy of epidemiology studies include the proper selection and characterisation of the case and control groups (in case-control studies), adequate characterisation of exposure, sufficient length of follow-up for disease occurrence (in cohort studies), valid ascertainment of effect, proper consideration of biases and confounding factors. Assessment of adequacy of the studies should be conducted by epidemiologists by training.

Due to both uncertainties in epidemiological studies and true variability in the association between exposure and health outcomes within and among human populations, the available body of epidemiological evidence should be systematically reviewed and, if possible, combined. A *Weight of Evidence* approach is essential for risk assessment based on epidemiological data to (a) assess (sources of) heterogeneity across the studies and (b) increase statistical stability of the risk estimates. The best option to combine and summarise epidemiological data is a pooled analysis of the original data sets of the contributing studies. A meta-analysis based on published study results is a good, but somewhat more restricted alternative.

A comprehensive guidance of both the evaluation and use of epidemiological evidence for risk assessment purposes is provided by Kryzanowski *et al* (WHO 2000).

Descriptive epidemiology studies (2) examine differences in disease rates among human populations in relation to age, gender, race, and differences in temporal or environmental conditions. These studies are useful for identifying areas for further research but are not very useful for risk assessment. Typically these studies can only identify patterns or trends in disease occurrence over time or in different geographical locations but cannot ascertain the causal agent or degree of human exposure.

Case reports (3) describe a particular health condition in an individual or a group of individuals who were exposed to a substance. They may be particularly relevant when they demonstrate effects which cannot be observed in experimental animal studies. In many such studies, information is lacking on critical aspects such as substance identity and purity, exposure, health status of the persons exposed and even the symptoms reported; thorough assessment of the reliability and relevance of case reports is therefore necessary. Case reports also trigger analytical studies.

When they are already available, well-conducted controlled human exposure studies (4) in volunteers, including low exposure toxicokinetics studies, can also be used in risk assessment. However, few human experimental toxicity studies are available due to the practical and ethical considerations involved in deliberate exposure of individuals. Such studies, e.g. studies carried out for the authorisation of a medical product, have to be conducted in line with the World Medical Association Declaration of Helsinki, which describes the general ethical principles for medical research involving human subjects (World Medical Association, 2000).

Criteria for a well-designed experimental study include the use of a double-blind study design, inclusion of a randomised control group, sufficient duration of exposure and an adequate number of subjects to detect an effect. A meta-analysis of available similar, even small, studies is a good option.

It is emphasised that testing with human volunteers is strongly discouraged, but when there are good quality data already available they should be used as appropriate, in well justified cases.

R.4.4 Evaluation and Integration of all available Information including Weight of Evidence

Within the REACH legislation, the so-called *Weight of Evidence* (WoE) approach is a component of the decision-making procedure on substance properties and thus an important part of the chemical safety assessment.

The term WoE does neither constitute a scientifically well-defined term nor an agreed formalised concept characterised by defined tools and procedures (Weed, 2005). Nevertheless, from daily life everybody is familiar with the essence of *Weight of Evidence* reasoning and its basic mechanism may be regarded as a matter of commons sense.

An evidence based approach involves an assessment of the relative values/weights of different pieces of the available information that has been retrieved and gathered in previous steps. To this end, a value needs to be assigned to each piece of information. These weights/values can be assigned either in an *objective* way by using a formalized procedure or by using expert judgement. The weight given to the available evidence will be influenced by factors such as the quality of the data, consistency of results/data, nature and severity of effects, relevance of the information for the given regulatory endpoint. In all cases the relevance and reliability and adequacy for the purpose have to be considered.

Examples of tools to identify the quality include the Klimisch scores (for toxicological studies, see also Section R.4.2), Hills criteria for evaluation of epidemiological data in Hill (1965), ranking of chemicals on their endocrine potential (Calabrese *et al*, 1997), evaluation of ecologic risk (Menzie *et al*, 1996).

An evidence based approach may imply formalised decision schemes where explicit rules for weighing information elements have been established. After having assessed/ranked the quality of the individual components the next step should be the integrating, comparing and putting together all information pieces with their relative values or weights and drawing a conclusion. This often includes expert judgement.

In the GHS, an evidence based approach is given a prominence for classification. All available information that can contribute to the determination of classification for an endpoint is considered together. Included is information such as epidemiological data and case reports in humans, and specific studies along with the sub-chronic, chronic and special study results in animals that provide relevant information, etc.

In REACH there will also be cases where data from sources other than tests specifically addressing an endpoint can provide valuable information. In addition, it is reasonable to expect that there will be cases where several pieces of *inadequate* data on a given REACH endpoint may exist. For example there may be several repeated dose studies available on a chemical, none of which would be acceptable by itself due to some deficiency (e.g. small group sizes, insufficient number of dose groups, insufficient parameters, etc). Collectively, however, the different studies show effects in the same target organ at approximately the same dose and time. If a rationale is given to show that such data adequately describe the REACH endpoint of concern, further information on that particular endpoint may not be necessary.

The way the *Weight of Evidence* is implemented is case-dependent. It is influenced by the relation between the amount of information needed and the importance of the decision to be taken and also by the likelihood of, and consequences for, the decision based on that information being wrong. It is important to document and communicate how the evidence based approach was used in a reliable, robust and transparent manner.

R.4.5 References

Calabrese, E. J., Baldwin, L. A.,Kostecki, P.T.,&Potter,T.L. (1997). A toxicologically based weight-of-evidence methodology for the relative ranking of chemicals of endocrine disruption potential. *Regulatory Toxicology and Pharmacology*, **26**, 36–40.

Curren, Southee, Spielmann, Liebsch, Fentem and Balls M. (1995) - The Role of Prevalidation in the Development, Validation and Acceptance of Alternative Methods - ECVAM Prevalidation Task Force Report 1. *ATLA,* **23**, 211-217.

Hartung T., Bremer S., Casati S., Coecke S., Corvi R., Fortaner S., Gribaldo L., Halder M., Hoffmann S., Roi A., Prieto P., Sabbioni E., Scott L., Worth A. and Zuang V. (2004) - A Modular approach to the ECVAM principles on test validity. *Altern Lab Anim,* **32,** 5, 467-472.

Hill, A. B. (1965).The environment and disease: Association or causation? *Journal of the Royal Society of Medicine*, **58**, 295–300.

Klimisch H., Andreae M. and Tillmann U. (1997) - A systematic approach for evaluating the quality of experimental toxicological and ecotoxicological data. *Regul Toxicol Pharm,* **25**, 1-5.

Menzie,C., Henning,M. H., Cura, J., Finkelstein, K., Gentile, J., Maughan, J., Mitchell, D., Petron, S., Potocki, B., Svirsky, S., & Tyler, P. (1996). Special report of the Massachusetts weight-of-evidence workgroup: A weight-of-evidence approach for evaluating ecological risks. *Human Ecological Risk Assessment*, **2**, 2, 277–304.

OECD (2005a) – Manual for Investigation of HPV Chemicals. Chapter 3 – Data Evaluation. Organization for Economic Co-operation and Development.

OECD (2005b) - Guidance Document n°34 on the Validation and International Acceptance of New or Updated Test Methods for Hazard Assessment. Organization for Economic Co-operation and Development.

OECD (2007) – Guidance Document on the Validation of (Quantitative) Structure Activity Relationship [(Q)SAR] Models. OECD Series on Testing and Assessment No. 69. ENV/JM/MONO(2007)2. Organisation for Economic Cooperation and Development, Paris, France. 154 pp.
http://www.oecd.org/document/30/0,2340,en_2649_34365_1916638_1_1_1_1,00.html.

Weed D. (2005) - Weight of evidence: a review of concept and methods. *Risk Anal,* **25,** 6, 1545-1557.

WHO (2000) Working Group report on Evaluation and use of epidemiological evidence for environmental health risk assessment: WHO Guideline Document. *Environm Health Perspect*, **108**, 997-1002.

World Medical Association (2000). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. Adopted by the 18th World Medical Association (WMA) General Assembly Helsinki, Finland, June 1964 and amended by the 29th WMA General Assembly, Tokyo, Japan, October 1975, 35th WMA General Assembly, Venice, Italy, October 1983, 41st WMA General Assembly, Hong Kong, September 1989, 48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996 and 52nd WMA General Assembly,

Edinburgh, Scotland, October 2000.

SENATE COMMITTEE

HEALTH & SOCIAL SERVICES

AGENDA

MONDAY, FEBRUARY 21, 1:30 PM

Butrovich Room #205

1:30 PM – Call to Order

Time:

Members Present:

BILL: Need to adopt CS

SB27 FLAME RETARDANTS AND TOXIC CHEMICALS

(Sen. Bill Wielechowski)

NEED TO allow 20 minutes for

PRESENTATION:

- *AKEELA ORGANIZATION (Rosale Nadeau, Exec. Dir.)*

ADJOURNMENT:

H&SS Committee: Sen. Bettye Davis, Chair; Sen. Johnny Ellis, Sen. Fred Dyson, Sen. Kevin Meyer, Sen. Dennis Egan

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/11

Date of 5-Day Notice: 2/24/11
(in accordance with Uniform Rule 23)

FURTHER: Finance

DATE TURNED IN TO OFFICE: 2/28/11

Health and Social Services Committee considered SENATE BILL NO. 27

SB 27-FLAME RETARDANTS AND TOXIC CHEMICALS

"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to bioaccumulative toxic chemicals; and providing for an effective date."

and recommends:

[X] be **replaced** with **CS** SB27 (HSS) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DPS	✓		✓	
DHS	✓			
DEC	✓			

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Meyer			✓	
	Ellis	✓			
	EGAN	X			
CHAIR:	DAVIS	X			

27-LS0300\B
Bannister
2/23/11

CS FOR SENATE BILL NO. 27( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR WIELECHOWSKI

A BILL

FOR AN ACT ENTITLED

"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to a multistate chemicals clearinghouse; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 18.31 is amended by adding new sections to read:

Article 4. Chemicals in Products.

Sec. 18.31.600. Prohibitions. (a) A person may not manufacture, sell, or distribute a product if one or more components of the product contains more than 0.1 percent by mass of pentaBDE, octaBDE, or a combination of pentaBDE and octaBDE.

(b) A person may not manufacture, sell, or distribute a mattress, a mattress pad, or upholstered furniture if one or more components of the mattress, mattress pad, or upholstered furniture contains more than 0.1 percent by mass of decaBDE.

(c) A person may not manufacture, sell, or distribute an electronic product if the electronic product has a plastic housing or other external component that contains

more than 0.1 percent by mass of decaBDE.

(d) A person may not manufacture, sell, or distribute a product that is prohibited by the department under AS 18.31.610.

Sec. 18.31.610. Prohibition by department. (a) The department may prohibit by regulation the manufacture, sale, and distribution of a product that contains a flame retardant that is not already prohibited under AS 18.31.600(a) - (c), if the department determines that

(1) the flame retardant is harmful to public health or the environment; and

(2) an alternative to the flame retardant exists, is safer for the public health or the environment, and is available on a nationwide basis.

(b) Before establishing a prohibition under (a) of this section, the department shall consult with the Department of Health and Social Services, and the state fire marshal shall determine that the flame retardant alternative identified in (a)(2) of this section satisfies applicable fire safety standards.

(c) In this section, "product" means

(1) a mattress, a mattress pad, or upholstered furniture if the mattress, mattress pad, or upholstered furniture contains plastic fibers that contain the flame retardant; or

(2) an electronic product that has a plastic housing that contains the flame retardant.

Sec. 18.31.620. Exemptions. The prohibitions in AS 18.31.600 do not apply if the product that is prohibited is part of

(1) a transportation vehicle or a product or part used in a transportation vehicle or transportation equipment;

(2) a product or equipment used in an industrial, mining, or manufacturing process;

(3) electronic wiring or cable used for power transmission;

(4) a used item that is resold; or

(5) a new item that is brought into the state before the effective date of this section.

Sec. 18.31.630. Notification by manufacturer. A person who manufactures products whose sale and distribution are prohibited by AS 18.31.600 shall inform its retailers in the state of the prohibitions under AS 18.31.600 and the penalty under AS 18.31.650.

Sec. 18.31.640. Enforcement. If the department determines that there are grounds to suspect that a retailer is selling a product in violation of AS 18.31.600, the department may request that, within 10 days, the manufacturer of the product

(1) provide the department with a sworn certificate indicating that the sale of the product does not violate AS 18.31.600; or

(2) notify each retailer who sells the product in the state that the sale of the product is prohibited by AS 18.31.600 and provide the department with a list of the names and addresses of the retailers notified.

Sec. 18.31.650. Civil penalty. A person who violates AS 18.31.600 - 18.31.640 is liable to the state for a civil penalty of up to $1,000 for each violation.

Sec. 18.31.660. Multistate chemicals clearinghouse. The department shall participate in a multistate chemicals clearinghouse to

(1) build governmental capacity to identify and promote safer chemicals and products;

(2) avoid duplication of state initiatives on chemicals and enhance the efficiency and effectiveness of state initiatives on chemicals through collaboration and coordination;

(3) ensure that state agencies, businesses, and the public have easy access to high quality and authoritative information on chemicals.

Sec. 18.31.670. Regulations. In addition to the regulations allowed under AS 18.31.610, the department may adopt regulations to implement AS 18.31.600 - 18.31.690. The department shall adopt the regulations for AS 18.31.600 - 18.31.690 under AS 44.62 (Administrative Procedure Act).

Sec. 18.31.690. Definitions for AS 18.31.600 - 18.31.690. In AS 18.31.600 - 18.31.690, unless the context indicates otherwise,

(1) "congener" means a specific polybromodiphenyl ether molecule;

(2) "decaBDE" means decabromodiphenyl ether or a technical mixture

in which decabromodiphenyl ether is the predominant congener;

(3) "department" means the Department of Environmental Conservation;

(4) "distribution" means distribution for sale or for a commercial purpose;

(5) "electronic product" means a television, a computer, or another piece of electronic equipment;

(6) "flame retardant" means a chemical that is added to plastic, foam, or a textile to inhibit flame formation;

(7) "manufacture" means manufacture for sale;

(8) "manufacturer" means a person who

(A) manufactures a product or whose brand name is affixed to the product; or

(B) imports or distributes a product in the United States if the person who manufactured or assembled the product or whose brand name is affixed to the product does not do business in the United States;

(9) "octaBDE" means octabromodiphenyl ether or a technical mixture in which octabromodiphenyl ether is the predominant congener;

(10) "pentaBDE" means pentabromodiphenyl ether or a technical mixture in which pentabromodiphenyl ether is the predominant congener;

(11) "sell" includes an offer to sell;

(12) "technical mixture" means a mixture that is named for the predominant congener and that is not exclusively composed of the predominant congener;

(13) "transportation vehicle" means a mechanized vehicle that is used to transport goods or individuals, and includes an airplane, an automobile, a motorcycle, a truck, a bus, a train, and a ship.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Environmental Conservation may adopt regulations necessary to implement this Act. The regulations take effect under

AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTION. Wherever "chapter" appears in AS 18.31.010 - 18.31.500, the revisor of statutes shall substitute "AS 18.31.010 - 18.31.500."

*** Sec. 4.** AS 18.31.660, enacted by sec. 1 of this Act, and sec. 2 of this Act take effect immediately under AS 01.10.070(c).

*** Sec. 5.** Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2013.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **27-LS0300\A**
() Publish Date

Identifier (file name) SB027-DEC-SWM-2-8-11
Title: Flame Retardants and Toxic Chemicals
Sponsor: Senator Wielechowski
Requester: Senate Health and Social Services Committee

Dept. Affected: Environmental Conser
Appropriation: Environmental Health
Allocation: Solid Waste Management
OMB Component Number: 2344

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	289.7		289.7	289.7	289.7	289.7	289.7
Travel	13.0		13.0	13.0	13.0	13.0	13.0
Services	60.0		60.0	60.0	60.0	60.0	60.0
Commodities	25.0		2.5	2.5	2.5	2.5	2.5
Capital Outlay	0.0		0.0	0.0	0.0	0.0	0.0
Grants	0.0		0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0		0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**387.7**	**0.0**	**365.2**	**365.2**	**365.2**	**365.2**	**365.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0		0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0		0.0	0.0	0.0	0.0	0.0
1004 GF	387.7		365.2	365.2	365.2	365.2	365.2
1005 GF/Program Receipts	0.0		0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0		0.0	0.0	0.0	0.0	0.0
Other (please identify)	0.0		0.0	0.0	0.0	0.0	0.0
TOTAL	**387.7**	**0.0**	**365.2**	**365.2**	**365.2**	**365.2**	**365.2**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time	**3.0**		3.0	3.0	3.0	3.0	3.0
Part-time	0.0		0.0	0.0	0.0	0.0	0.0
Temporary	0.0		0.0	0.0	0.0	0.0	0.0

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version.

Prepared by: Kristin Ryan, Director — Phone: 907-269-7645
Division: Environmental Health — Date/Time: 2/8/11 9:30 AM
Approved by: Dan Easton — Date: 2/18/2011
Deputy Commissioner

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB27

Analysis

The prohibition and regulation of products containing flame retardants will require significant outreach because we do not regulate or interact with these businesses currently. In addition, a public campaign to educate the public about brominated flame retardants and the risks associated with them would be necessary. A publication specialist will manage the outreach process and a toxicologist will evaluate the data and develop the regulations and list of persistent bioaccumulative toxic chemicals and update that list every three years. The research analyst will maintain statewide statistical information on those toxins.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB027**
() Publish Date:

Identifier (file name): SB027-DHSS-EPI-02-18-11
Title: Flame Retardants and Toxic Chemicals
Sponsor: Sen. Bill Wielechowski
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Public Health
Allocation: Epidemiology
OMB Component Number: 296

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	26.0		26.0				
Travel							
Services							
Commodities	0.5		0.5				
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**26.5**	**0.0**	**26.5**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	26.5		26.5				
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**26.5**	**0.0**	**26.5**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not Applicable. Initial version.

Prepared by: Ward B. Hurlburt, MD, MPH - Chief Medical Officer / Director — Phone 269-6680
Division: Public Health — Date/Time 2/18/11 5:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/18/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB027
2011 LEGISLATIVE SESSION

Analysis:

This bill requires the Department of Environmental Conservation (DEC) to work with the Department of Health & Social Services (DHSS) to establish a list of persistent bioaccumulative toxic chemicals that occur or are used in products used by human beings. DEC would seek consultation from DHSS in two situations when: (1) proposing to prohibit a flame retardant under Section 18.31.610; and (2) establishing a list every three years of persistent bioaccumulative toxic chemicals that occur or are used in products used by human beings, under Section 18.31.680. Additionally, DHSS and DEC would perform a one-time review of brominated flame retardants under Section 18.31.670. These environmental health efforts will require a total appropriation of $26.5 GF. This will not require a new position, as the work will be done by an existing position that is only partially funded. Personal Services for 0.25 FTE Health Program Manager III will be $26.0. The additional cost of $0.5 is for office supplies. No travel or equipment costs are expected. It is anticipated this project will not take more than two years to complete.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB027**
() Publish Date

	SB027-DPS-FLS-02-18-11	Dept. Affected	Public Safety
Title	"An Act relating to flame retardants and to the manufacture, sale...bioaccumulative toxic chemicals"	Appropriation	Fire and Life Safety
		Allocation	Fire and Life Safety Operations
Sponsor	Senator Wielechowski		
Requester	Senate Health & Social Services	OMB Component Number	2883

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time	**0.0**						
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable; initial version

Prepared by: David L. Tyler, State Fire Marshal — Phone: (907) 269-5491
Division: Fire & Life Safety — Date/Time: 2/18/11 12 00 PM
Approved by: Joseph A Masters — Date: 2/19/2011
Commissioner

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB027

Analysis

If passed, this legislation requires the state fire marshal ensure the flame retardant alternative satisfies applicable fire safety standards.

Passage of this legislation will have no fiscal impact on the division of Fire and Life Safety.

Celeste Hodge

From: Laughlin, Wilda J (HSS) [wilda.laughlin@alaska.gov]
Sent: Friday, February 18, 2011 12:57 PM
To: Karla Hart; Celeste Hodge
Cc: McLaughlin, Joseph B (HSS); Lewis, Jill (HSS); Ryan, Kristin J (DEC); Carlson-Van Dort, Marit K (DEC)
Subject: SB 27//flame retardant//HSS game plan

This is to let you know that Nim Ha, an education specialist in the DHSS Division of Public Health, will be available for questions regarding SB 27 at Monday's Senate HSS hearing. She will be participating from the Anchorage LIO.

w.

Wilda J. Laughlin
Legislative Liaison, Dept. of Health and Social Services
Phone (907) 465-1613
Fax (907) 465-3068
Cell (907) 723-3802

This e-mail, including attachments, is intended for the use of the person or entity to which it is addressed and may contain CONFIDENTIAL or privileged information that is protected by federal and state regulation. If the reader of this e-mail is not the intended recipient or his or her agent, the reader is notified that any dissemination, distribution or copying of this e-mail is prohibited. If you think you have received this e-mail in error, please advise the sender by reply e-mail and delete this e-mail immediately.

CS FOR SENATE BILL NO. 27(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR WIELECHOWSKI

A BILL

FOR AN ACT ENTITLED

"An Act relating to flame retardants and to the manufacture, sale, and distribution of products containing flame retardants; relating to a multistate chemicals clearinghouse; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 18.31 is amended by adding new sections to read:

Article 4. Chemicals in Products.

Sec. 18.31.600. Prohibitions. (a) A person may not manufacture, sell, or distribute a product if one or more components of the product contains more than 0.1 percent by mass of pentaBDE, octaBDE, or a combination of pentaBDE and octaBDE.

(b) A person may not manufacture, sell, or distribute a mattress, a mattress pad, or upholstered furniture if one or more components of the mattress, mattress pad, or upholstered furniture contains more than 0.1 percent by mass of decaBDE.

(c) A person may not manufacture, sell, or distribute an electronic product if the electronic product has a plastic housing or other external component that contains

more than 0.1 percent by mass of decaBDE.

(d) A person may not manufacture, sell, or distribute a product that is prohibited by the department under AS 18.31.610.

Sec. 18.31.610. Prohibition by department. (a) The department may prohibit by regulation the manufacture, sale, and distribution of a product that contains a flame retardant that is not already prohibited under AS 18.31.600(a) - (c), if the department determines that

(1) the flame retardant is harmful to public health or the environment; and

(2) an alternative to the flame retardant exists, is safer for the public health or the environment, and is available on a nationwide basis.

(b) Before establishing a prohibition under (a) of this section, the department shall consult with the Department of Health and Social Services, and the state fire marshal shall determine that the flame retardant alternative identified in (a)(2) of this section satisfies applicable fire safety standards.

(c) In this section, "product" means

(1) a mattress, a mattress pad, or upholstered furniture if the mattress, mattress pad, or upholstered furniture contains plastic fibers that contain the flame retardant; or

(2) an electronic product that has a plastic housing that contains the flame retardant.

Sec. 18.31.620. Exemptions. The prohibitions in AS 18.31.600 do not apply if the product that is prohibited is part of

(1) a transportation vehicle or a product or part used in a transportation vehicle or transportation equipment;

(2) a product or equipment used in an industrial, mining, or manufacturing process;

(3) electronic wiring or cable used for power transmission;

(4) a used item that is resold; or

(5) a new item that is brought into the state before the effective date of this section.

Sec. 18.31.630. Notification by manufacturer. A person who manufactures products whose sale and distribution are prohibited by AS 18.31.600 shall inform its retailers in the state of the prohibitions under AS 18.31.600 and the penalty under AS 18.31.650.

Sec. 18.31.640. Enforcement. If the department determines that there are grounds to suspect that a retailer is selling a product in violation of AS 18.31.600, the department may request that, within 10 days, the manufacturer of the product

(1) provide the department with a sworn certificate indicating that the sale of the product does not violate AS 18.31.600; or

(2) notify each retailer who sells the product in the state that the sale of the product is prohibited by AS 18.31.600 and provide the department with a list of the names and addresses of the retailers notified.

Sec. 18.31.650. Civil penalty. A person who violates AS 18.31.600 - 18.31.640 is liable to the state for a civil penalty of up to $1,000 for each violation.

Sec. 18.31.660. Multistate chemicals clearinghouse. The department shall participate in a multistate chemicals clearinghouse to

(1) build governmental capacity to identify and promote safer chemicals and products;

(2) avoid duplication of state initiatives on chemicals and enhance the efficiency and effectiveness of state initiatives on chemicals through collaboration and coordination;

(3) ensure that state agencies, businesses, and the public have easy access to high quality and authoritative information on chemicals.

Sec. 18.31.670. Regulations. In addition to the regulations allowed under AS 18.31.610, the department may adopt regulations to implement AS 18.31.600 - 18.31.690. The department shall adopt the regulations for AS 18.31.600 - 18.31.690 under AS 44.62 (Administrative Procedure Act).

Sec. 18.31.690. Definitions for AS 18.31.600 - 18.31.690. In AS 18.31.600 - 18.31.690, unless the context indicates otherwise,

(1) "congener" means a specific polybromodiphenyl ether molecule;

(2) "decaBDE" means decabromodiphenyl ether or a technical mixture

in which decabromodiphenyl ether is the predominant congener;

(3) "department" means the Department of Environmental Conservation;

(4) "distribution" means distribution for sale or for a commercial purpose;

(5) "electronic product" means a television, a computer, or another piece of electronic equipment;

(6) "flame retardant" means a chemical that is added to plastic, foam, or a textile to inhibit flame formation;

(7) "manufacture" means manufacture for sale;

(8) "manufacturer" means a person who

(A) manufactures a product or whose brand name is affixed to the product; or

(B) imports or distributes a product in the United States if the person who manufactured or assembled the product or whose brand name is affixed to the product does not do business in the United States;

(9) "octaBDE" means octabromodiphenyl ether or a technical mixture in which octabromodiphenyl ether is the predominant congener;

(10) "pentaBDE" means pentabromodiphenyl ether or a technical mixture in which pentabromodiphenyl ether is the predominant congener;

(11) "sell" includes an offer to sell;

(12) "technical mixture" means a mixture that is named for the predominant congener and that is not exclusively composed of the predominant congener;

(13) "transportation vehicle" means a mechanized vehicle that is used to transport goods or individuals, and includes an airplane, an automobile, a motorcycle, a truck, a bus, a train, and a ship.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Environmental Conservation may adopt regulations necessary to implement this Act. The regulations take effect under

AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

* **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTION. Wherever "chapter" appears in AS 18.31.010 - 18.31.500, the revisor of statutes shall substitute "AS 18.31.010 - 18.31.500."

* **Sec. 4.** AS 18.31.660, enacted by sec. 1 of this Act, and sec. 2 of this Act take effect immediately under AS 01.10.070(c).

* **Sec. 5.** Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2013.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB052
() Publish Date:

Identifier (file name): SB052-DHSS-BHMS-02-25-11
Title: Mental Health Care Insurance Benefit
Sponsor: Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health
Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Melissa W Stone — Phone 269-3410
Division: Behavioral Health — Date/Time 2/14/11 2:30PM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/25/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB052

Analysis:

Health plans have often treated mental health and substance abuse treatment services differently than they have medical and surgical benefits. This bill defines medical care to include mental health care or care for an alcoholism or substance abuse disorder and requires parity between health care insurance coverage for mental health, alcoholism, substance abuse benefits and other medical care benefits in order to prohibit benefit or service limitations that are more restrictive or financially burdensome.

Assumptions:

The Division of Behavioral Health believes that although the State Medicaid programs under our supervision will experience some minor relief as services are covered through private insurance rather than the state's Medicaid Program, the effect would be offset by increased premiums for group health insurance. Responses to this increase would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or substance benefits), and reductions in the scope of generosity of health insurance benefits, such as increased deductibles or higher copayments.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB052**
() Publish Date:

Identifier (file name): SB052-DHSS-BHMS-02-25-11
Title: Mental Health Care Insurance Benefit
Sponsor: Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health
Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Melissa W Stone — Phone 269-3410
Division: Behavioral Health — Date/Time 2/14/11 2:30PM
Approved by: Alison Elgee, Assistant Commissioner — Date 2/25/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB052

Analysis:

Health plans have often treated mental health and substance abuse treatment services differently than they have medical and surgical benefits. This bill defines medical care to include mental health care or care for an alcoholism or substance abuse disorder and requires parity between health care insurance coverage for mental health, alcoholism, substance abuse benefits and other medical care benefits in order to prohibit benefit or service limitations that are more restrictive or financially burdensome.

Assumptions:

The Division of Behavioral Health believes that although the State Medicaid programs under our supervision will experience some minor relief as services are covered through private insurance rather than the state's Medicaid Program, the effect would be offset by increased premiums for group health insurance. Responses to this increase would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or substance benefits), and reductions in the scope of generosity of health insurance benefits, such as increased deductibles or higher copayments.

SB 27

An Act Relating to Flame Retardants

Changes from 27-LS0300\M to version _____

The first changes make enforcement easier by clarifying the limit of PBDE by mass applies to each individual component. Technology exists to quickly test components of products without damage to identify if any bromines are present at the stated 0.1 percent.

Page 1, line 8 clarifies that **no component of a product** may contain more than 0.1 percent by mass

line 12 changes "a textile component" to "any component"

line 14 changes to: "a plastic housing or other external component that contains..." to account for parts of an electronic product, not just the housing, that someone may come into contact with in the routine use of the product, such as handles and knobs.

Page 3, lines 5-6. Deletes **Sec. 18.31.640. Retailer Assistance.**

Lines 17-23. Deletes **Sec. 18.31.670. Review by departments.**

Lines 24-Page 4, line 4. Deletes **Sec. 18.31.680. List of Toxic Chemicals.**

Page 4, lines 5-11. **Sec. 18.31.690. Interstate clearinghouse.** Requires the department to participate in the interstate clearinghouse and provides reasons.

The department shall participate in a multi-state chemicals clearinghouse to:

- Avoid duplication and enhance efficiency and effectiveness of agency initiatives on chemicals through collaboration and coordination
- Build governmental capacity to identify and promote safer chemicals and products
- Ensure that agencies, businesses, and the public have ready access to high quality and authoritative chemicals data, information, and assessment methods

The new bill provides for an immediate effective date for participation in the Interstate Clearinghouse.

The new bill renumbers sections to account for changes.

Prepared by Karla Hart, Aide to Senator Wielechowski, 2/24/2011

SB 27

An Act Relating to Flame Retardants

Changes from 27-LS0300\M to version B

➔ The first changes make enforcement easier by clarifying the limit of PBDE by mass applies to each individual component. Technology exists to quickly test components of products without damage to identify if any bromines are present at the stated 0.1 percent.

Page 1, line 8 and 12[1] clarifies that **no component of a product** may contain more than 0.1 percent by mass

line 14 changes to: "a plastic housing or other external component that contains..." to account for parts of an electronic product, not just the housing, that someone may come into contact with in the routine use of the product, such as handles and knobs.

➔ Three sections are deleted:

Page 3, lines 5-6. **Sec. 18.31.640. Retailer Assistance.**

Lines 17-23. **Sec. 18.31.670. Review by departments.**

Lines 24-Page 4, line 4. **Sec. 18.31.680. List of Toxic Chemicals.**

➔ And replaced with required participation in an interstate chemical clearinghouse which will more efficiently accomplish some of the review and list functions deleted above.

Page 4, lines 5-11. **Sec. 18.31.690. Interstate clearinghouse.** The department shall participate in a multi-state chemicals clearinghouse to:

- Avoid duplication and enhance efficiency and effectiveness of agency initiatives on chemicals through collaboration and coordination
- Build governmental capacity to identify and promote safer chemicals and products
- Ensure that agencies, businesses, and the public have ready access to high quality and authoritative chemicals data, information, and assessment methods

➔ The new bill provides for an immediate effective date for participation in the Interstate Clearinghouse.

The new bill renumbers sections to account for changes.

Prepared by Karla Hart, Aide to Senator Wielechowski, 2/25/2011

[1] Page and line numbers refer to version \M.

SB

52

<TARGET><BILL>SB 52</BILL><SUBJECT>SB
52</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Office of Senator Bettye Davis

Hearing Package

SB 52 27-LS0081\A – The Alaska Mental Health Insurance Parity Act

TITLE: "An Act requiring health care insurers to provide coverage for treatment of mental health conditions, and requiring parity between health care insurance coverage for mental health, alcoholism, and substance abuse benefits and other medical care benefits; eliminating different treatment for mental health conditions from the minimum benefits of the state health insurance plan; removing an exclusion for mental health services or alcohol or drug abuse from the definition of 'basic health care services' in the law relating to health maintenance organizations; repealing a definition of 'mental health benefits' that excludes treatment of substance abuse or chemical dependency; and providing for an effective date."

Included in this hearing package are the following:

1. Sponsor Statement
2. Current version of SB 52, 27-LS0081\A
3. Sectional Summary
4. Fiscal Notes (by committee request)
5. Supportive Documents –
   - Legal Services Memo 9/10/2010
   - Diagnostic and Statistical Manual Of Mental Disorders
   - 42 USCS section 300gg-23
   - 42 USCS section 300gg-26
   - NCSL-State laws Mandating or Regulating Mental Health Benefits; updated February, 2009; reposted with additions February 11, 2010

Please anticipate in-person and teleconference testimony.

Thomas S. Obermeyer
Legislative Assistant 465-3762

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 52 27-LS0081 - The Alaska Mental Health Insurance Parity Act

TITLE: "An Act requiring health care insurers to provide coverage for treatment of mental health conditions, and requiring parity between health care insurance coverage for mental health, alcoholism, and substance abuse benefits and other medical care benefits; eliminating different treatment for mental health conditions from the minimum benefits of the state health insurance plan; removing an exclusion for mental health services or alcohol or drug abuse from the definition of 'basic health care services' in the law relating to health maintenance organizations; repealing a definition of 'mental health benefits' that excludes treatment of substance abuse or chemical dependency; and providing for an effective date."

SPONSOR STATEMENT

This bill amends several sections of Alaska's health insurance code to require that health care insurers provide full "parity," *i.e.,* equal insurance coverage, or the same financial and treatment coverage for mental health conditions including alcohol and substance abuse as other physical illnesses. This bill expands on state compliance under HB 222 in 2009 with newly enacted federal parity law, the "*Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*" of 2008. That Act also applies to all Children's Health Insurance Programs and became effective April 1, 2009.

Historically, health insurers have been reluctant to cover mental health and substance abuse services on the same basis as general medical and surgical services. During the 1980s many states required insurers to provide coverage for mental health services and to offer freedom of choice among providers. However, concerns about the adequacy of this coverage persisted because insurers imposed increased cost sharing or restrictive benefit limits. This led to more federal and state intervention on behalf of consumers.

While current federal law does not mandate that group plans must provide mental health coverage, if they do, they must provide the same financial and treatment coverage offered for other physical illnesses. This bill differs from federal law in that it does mandate that "*a health care insurer which offers, issues for delivery, delivers, or renews a health care insurance plan to an employer or individual on a group or individual basis shall provide coverage for treatment of a mental health condition.*" Coverage of mental health conditions includes alcoholism and drug abuse as defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

This bill also requires parity with respect to all financial aspects including lifetime or annual limits, deductibles, copayments, coinsurances, benefits limitations with a $1,500 yearly maximum plus the deductible. It does not provide similar federal small business and business cost exemptions.

Self-funded health care plans are not state-regulated private "insurance" company plans and they usually are entirely exempt from state regulation because they are preempted by the federal ERISA law. Self-funded plans include the largest employers and the "Alaska Care" state health plan. The State Division of Insurance reportedly has not enforced insurance laws on the Alaska's union health trusts, and the Division's ability to do so is subject to legal debate. State laws generally do not apply to federally funded public programs such as Medicaid, Medicare and the Veterans Administration.

While the private insurers in Alaska have complained that insurance mandates only apply to about 40% of the insured in Alaska, voluntary compliance by large self-funded plans greatly increases this number. The self-funded state health plan historically has matched state mandates for private insurers, even though the state is not legally required to do. Currently, 46 states have passed some type of parity laws, the majority of which go beyond the federal mandate, including 28 that require full parity for mental health benefits. 38 states include coverage for substance abuse, alcohol or drug addiction.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB052
() Publish Date:

Identifier (file name): SB052-DHSS-BHMS-02-25-11
Title: Mental Health Care Insurance Benefit
Sponsor: Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Medicaid Services
Allocation: Behavioral Health
Medicaid Services
OMB Component Number: 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Melissa W Stone
Division: Behavioral Health
Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Phone 269-3410
Date/Time 2/14/11 2:30PM
Date 2/25/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB052

Analysis:

Health plans have often treated mental health and substance abuse treatment services differently than they have medical and surgical benefits. This bill defines medical care to include mental health care or care for an alcoholism or substance abuse disorder and requires parity between health care insurance coverage for mental health, alcoholism, substance abuse benefits and other medical care benefits in order to prohibit benefit or service limitations that are more restrictive or financially burdensome.

Assumptions:

The Division of Behavioral Health believes that although the State Medicaid programs under our supervision will experience some minor relief as services are covered through private insurance rather than the state's Medicaid Program, the effect would be offset by increased premiums for group health insurance. Responses to this increase would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or substance benefits), and reductions in the scope of generosity of health insurance benefits, such as increased deductibles or higher copayments.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM September 10, 2010

SUBJECT: Mental Health Parity (Work Order No. 27-LS0081\A)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Dennis C. Bailey DCB
Legislative Counsel

This memorandum accompanies the draft bill relating to mental health parity that you requested. Please note the following issues that have come to my attention during drafting.

In 2009, the legislature repealed and reenacted AS 21.54.151 to require a health care insurer that offers a health care insurance plan in the group market to comply with the mental health or substance abuse benefit requirements established under 42 U.S.C. 300gg-5. Sec. 6, ch. 55, SLA 2009. However, 42 U.S.C. 300gg[1] of the Public Health Service Act, including 42 U.S.C. 300gg-5, which addresses mental health parity, was significantly amended and rearranged by the Patient Protection and Affordable Care Act.[2] 42 U.S.C. 300gg-5 was re-designated as 42 U.S.C. 300gg-26.[3] Copy enclosed. The Patient Protection and Affordable Care Act also amended former sec. 300gg-26 to include individual health insurance coverage under the policies.[4] The changes to 42 U.S.C. 300gg, et seq. are effective for plan years beginning on or after September 23, 2010.[5]

---

[1] Part A of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg, et seq.) [see note preceding 42 U.S.C. 300gg].

[2] P.L. 111-148, Title 1, Subtitle A, Sec. 1001, 124 Stat. 130, March 23, 2010. It is not entirely clear whether this effective date was intended to apply to the amendments to sec. 300gg-26.

[3] See Explanatory note to current 42 U.S.C. 300gg-5.

[4] See Amendment note to 42 U.S.C. 300gg-26.

[5] P.L. 111-148, sec. 1004(a), 42 U.S.C. 300gg-11 note.

The current draft of the bill repeals and replaces AS 21.54.151. It removes the current reference adopting 42 U.S.C. 300gg-5 (the current reference) and eliminates the need to refer to 42 U.S.C. 300gg-26, the new reference as of September 23, 2010. However, the federal standards for parity for the treatment of mental health conditions under these federal statute sections remain effective. Subject to certain exceptions, the provisions of 42 U.S.C. 300gg et seq. do not supersede state law relating to health insurance issuers except to the extent that a state standard or requirement prevents the application of a requirement under 42 U.S.C. 300gg et seq. See 42 U.S.C. 300gg-23. Preemption; State flexibility; construction. Copy enclosed.

Note that the parity requirements for mental health benefits set out in AS 21.54.151(b), as repealed and reenacted by bill sec. 2, refer to "a mental health condition" but do not specifically refer to treatment for alcoholism or substance abuse. "Mental health condition" is defined in AS 21.54.151(c)(3) by reference to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. You should confirm that the designated manual adequately defines alcoholism or substance abuse as a mental health condition so that the parity provisions apply as you intend.

If I may be of further assistance, please advise.

DCB:ljw:plm
10-374.ljw

Enclosures

Thomas Obermeyer

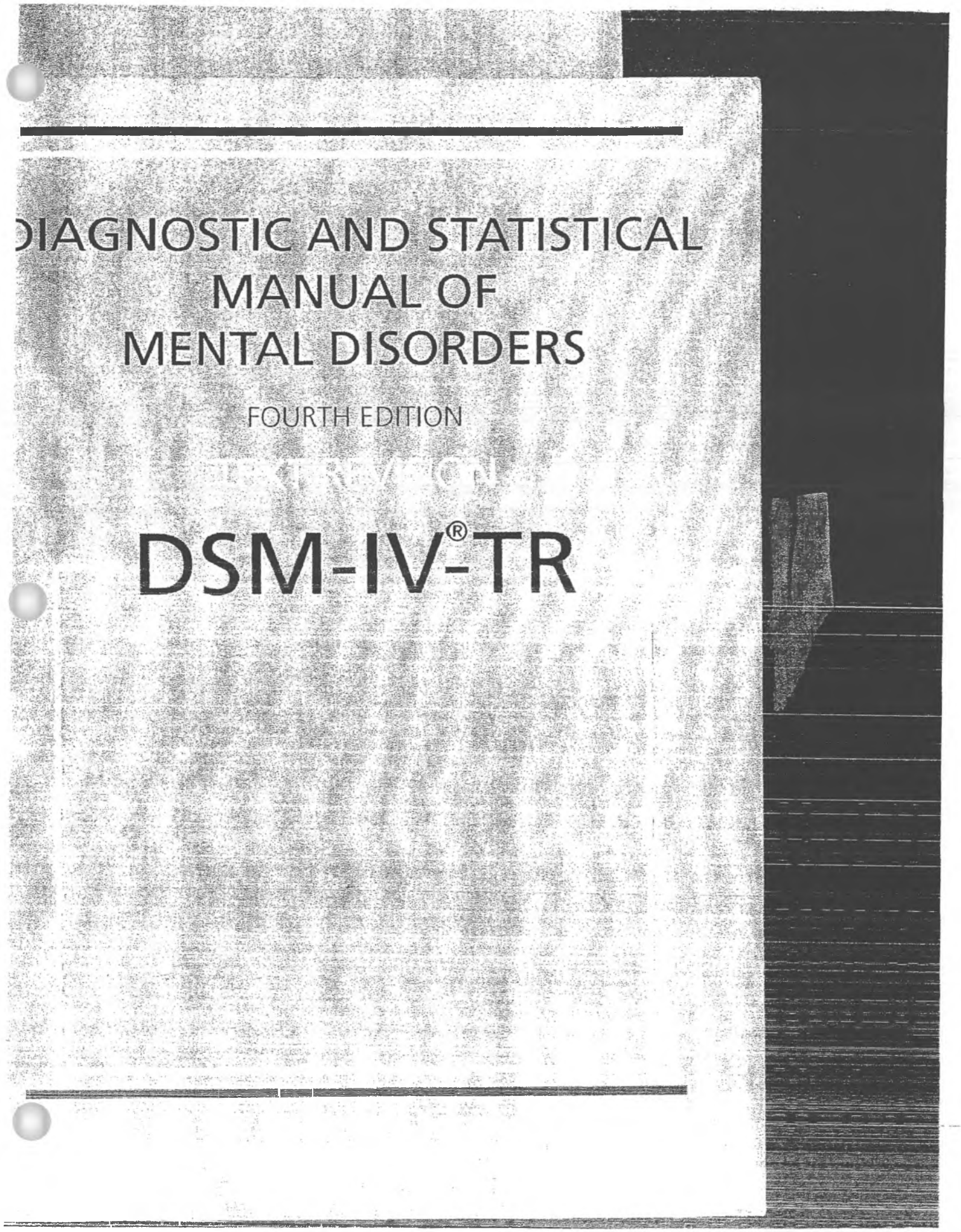
From: Nault, Richard L (HSS) [richard.nault@alaska.gov]
Sent: Friday, December 03, 2010 9:22 AM
To: Thomas Obermeyer
Cc: Toner, Stacy B (HSS)
Subject: RE: Mental health parity bill - definitions for 27-LS0081\A
Attachments: Substance Abuse_Dependence.pdf

Mr. Obermeyer,

Please find attached scanned pages of the DSM IV TR manual. You will note that pages 191 to 201 provide an overview of substance abuse disorders and subsequent pages list all of the various substance specific diagnoses. My approach was to, perhaps, provide more information than might be needed rather than less.

Do not hesitate to contact me if I can provide additional information,

Richard


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FOURTH EDITION
DSM-IV®-TR

Substance-Related Disorders

The Substance-Related Disorders include disorders related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure. In this manual, the term *substance* can refer to a drug of abuse, a medication, or a toxin. The substances discussed in this section are grouped into 11 classes: alcohol; amphetamine or similarly acting sympathomimetics; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics. Although these 11 classes appear in alphabetical order, the following classes share similar features: alcohol shares features with the sedatives, hypnotics, and anxiolytics; and cocaine shares features with amphetamines or similarly acting sympathomimetics. Also included in this section are Polysubstance Dependence and Other or Unknown Substance-Related Disorders (which include most disorders related to medications or toxins).

Many prescribed and over-the-counter medications can also cause Substance-Related Disorders. Symptoms generally occur at high doses of the medication and usually disappear when the dosage is lowered or the medication is stopped. Medications that may cause Substance-Related Disorders include, but are not limited to, anesthetics and analgesics, anticholinergic agents, anticonvulsants, antihistamines, antihypertensive and cardiovascular medications, antimicrobial medications, antiparkinsonian medications, chemotherapeutic agents, corticosteroids, gastrointestinal medications, muscle relaxants, nonsteroidal anti-inflammatory medications, other over-the-counter medications, antidepressant medications, and disulfiram.

Exposure to a wide range of other chemical substances can also lead to the development of a Substance-Related Disorder. Toxic substances that may cause Substance-Related Disorders include, but are not limited to, heavy metals (e.g., lead or aluminum), rat poisons containing strychnine, pesticides containing nicotine, or acetylcholinesterase inhibitors, nerve gases, ethylene glycol (antifreeze), carbon monoxide, and carbon dioxide. The volatile substances (e.g., fuel, paint) are classified as "inhalants" (see p. 257) if they are used for the purpose of becoming intoxicated; they are considered "toxins" if exposure is accidental or part of intentional poisoning. Impairments in cognition or mood are the most common symptoms associated with toxic substances, although anxiety, hallucinations, delusions, or seizures can also result. Symptoms usually disappear when the individual is no longer exposed to the substance, but resolution of symptoms can take weeks or months and may require treatment.

The Substance-Related Disorders are divided into two groups: the Substance Use Disorders (Substance Dependence and Substance Abuse) and the Substance-Induced Disorders (Substance Intoxication, Substance Withdrawal, Substance-Induced Delirium, Substance-Induced Persisting Dementia, Substance-Induced Persisting Am-

nestic Disorder, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder, Substance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction, and Substance-Induced Sleep Disorder). The section begins with the text and criteria sets for Substance Dependence, Abuse, Intoxication, and Withdrawal that are applicable across classes of substances. This is followed by general comments concerning associated features; culture, age, and gender features; course; impairment and complications; familial pattern; differential diagnosis; and recording procedures that apply to all substance classes. The remainder of the section is organized by class of substance and describes the specific aspects of Dependence, Abuse, Intoxication, and Withdrawal for each of the 11 classes of substances. It should be noted that the Prevalence sections of the substance-specific texts contain survey data indicating rates of substance use in various age groups, as well as the lifetime and 1-year prevalence of Dependence and Abuse. To facilitate differential diagnosis, the text and criteria for the remaining Substance-Induced Disorders are included in the sections of the manual with disorders with which they share phenomenology (e.g., Substance-Induced Mood Disorder is included in the "Mood Disorders" section). The diagnoses associated with each specific group of substances are shown in Table 1.

Substance Use Disorders

Substance Dependence

Features

The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine. The symptoms of Dependence are similar across the various categories of substances, but for certain classes some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for Hallucinogen Dependence). Although not specifically listed as a criterion item, "craving" (a strong subjective drive to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence. Dependence is defined as a cluster of three or more of the symptoms listed below occurring at any time in the same 12-month period.

Tolerance (Criterion 1) is the need for greatly increased amounts of the substance to achieve intoxication (or the desired effect) or a markedly diminished effect with continued use of the same amount of the substance. The degree to which tolerance develops varies greatly across substances. Furthermore, for a specific drug, varied degrees of tolerance may develop for its different central nervous system effects. For example, for opioids, tolerance to respiratory depression and tolerance to analgesia develop at different rates. Individuals with heavy use of opioids and stimulants can

Table 1. Diagnoses associated with class of substances

behavioral,
: of the sub-
of repeated
disive drug-
every class
r across the
are less se-
ymptoms are
ited as a cri-
likely to be
dependence
ring at any

e substance
effect with
h tolerance
rug, varied
effects. For
to analgesia
nulants can

uced Mood
al Dysfunc-
text and cri-
wal that are
ments con-
impairment
procedures
zed by class
ntoxication,
ted that the
indicating
l-year prev-
text and cri-
sections of
Substance-
e diagnoses

Table 1. Diagnoses associated with class of substances

	Dependence	Abuse	Intoxication	Withdrawal	Intoxication Delirium	Withdrawal Delirium	Dementia	Amnestic Disorder	Psychotic Disorders	Mood Disorders	Anxiety Disorders	Sexual Dysfunctions	Sleep Disorders
Alcohol	X	X	X	X	I	W	P	P	I/W	I/W	I/W	I	I/W
Amphetamines	X	X	X	X	I				I	I/W	I	I	I/W
Caffeine			X								I		I
Cannabis	X	X	X		I				I		I		
Cocaine	X	X	X	X	I				I	I/W	I/W	I	I/W
Hallucinogens	X	X	X		I				P*	I	I		
Inhalants	X	X	X		I		P		I	I	I		
Nicotine	X			X									
Opioids	X	X	X	X	I				I	I		I	I/W
Phencyclidine	X	X	X		I				I	I	I		
Sedatives, hypnotics, or anxiolytics	X	X	X	X	I	W	P	P	I/W	I/W	W	I	I/W
Polysubstance	X												
Other	X	X	X	X	I	W	P	P	I/W	I/W	I/W	I	I/W

*Also Hallucinogen Persisting Perception Disorder (Flashbacks).

Note: X, I, W, I/W, or P indicates that the category is recognized in DSM-IV. In addition, *I* indicates that the specifier With Onset During Intoxication may be noted for the category (except for Intoxication Delirium); *W* indicates that the specifier With Onset During Withdrawal may be noted for the category (except for Withdrawal Delirium); and *I/W* indicates that either With Onset During Intoxication or With Onset During Withdrawal may be noted for the category. *P* indicates that the disorder is Persisting.

develop substantial (e.g., 10-fold) levels of tolerance, often to a dosage that would b lethal to a nonuser. Alcohol tolerance can also be pronounced, but is usually less e› treme than for amphetamine. Many individuals who smoke cigarettes consume mor than 20 cigarettes a day, an amount that would have produced symptoms of toxicit when they first started smoking. Individuals with heavy use of cannabis or phencycl dine (PCP) are generally not aware of having developed tolerance (although it ha been demonstrated in animal studies and in some individuals). Tolerance may be dif ficult to determine by history alone when the substance used is illegal and perhap mixed with various diluents or with other substances. In such situations, laborator tests may be helpful (e.g., high blood levels of the substance coupled with little evi dence of intoxication suggest that tolerance is likely). Tolerance must also be distin guished from individual variability in the initial sensitivity to the effects of particula substances. For example, some first-time drinkers show very little evidence of intox ication with three or four drinks, whereas others of similar weight and drinking his tories have slurred speech and incoordination.

Withdrawal (Criterion 2a) is a maladaptive behavioral change, with physiologica and cognitive concomitants, that occurs when blood or tissue concentrations of a sub stance decline in an individual who had maintained prolonged heavy use of the sub stance. After developing unpleasant withdrawal symptoms, the person is likely t take the substance to relieve or to avoid those symptoms (Criterion 2b), typically us ing the substance throughout the day beginning soon after awakening. Withdrawa symptoms, which are generally the opposite of the acute effects of the substance, var greatly across the classes of substances, and separate criteria sets for Withdrawal ar provided for most of the classes. Marked and generally easily measured physiologi cal signs of withdrawal are common with alcohol, opioids, and sedatives, hypnotics and anxiolytics. Withdrawal signs and symptoms are often present, but may be les apparent, with stimulants such as amphetamines and cocaine, as well as with nicotin and cannabis. No significant withdrawal is seen even after repeated use of hallucino gens. Withdrawal from phencyclidine and related substances has not yet been de scribed in humans (although it has been demonstrated in animals). Neither tolerance nor withdrawal is necessary or sufficient for a diagnosis of Substance Dependence However, for most classes of substances, a past history of tolerance or withdrawal i associated with a more severe clinical course (i.e., an earlier onset of Dependence higher levels of substance intake, and a greater number of substance-related prob lems). Some individuals (e.g., those with Cannabis Dependence) show a pattern o compulsive use without obvious signs of tolerance or withdrawal. Conversely, som general medical and postsurgical patients without Opioid Dependence may develo a tolerance to prescribed opioids and experience withdrawal symptoms withou showing any signs of compulsive use. The specifiers With Physiological Dependenc and Without Physiological Dependence are provided to indicate the presence or ab sence of tolerance or withdrawal.

The following items describe the pattern of compulsive substance use that is char acteristic of Dependence. The individual may take the substance in larger amounts o over a longer period than was originally intended (e.g., continuing to drink until se verely intoxicated despite having set a limit of only one drink) (Criterion 3). The in dividual may express a persistent desire to cut down or regulate substance use. Often there have been many unsuccessful efforts to decrease or discontinue use (Criterion 4)

he individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 5). In some instances of Substance Dependence, virtually all of the person's daily activities revolve around the substance. mportant social, occupational, or recreational activities may be given up or reduced ecause of substance use (Criterion 6). The individual may withdraw from family activities and hobbies in order to use the substance in private or to spend more time vith substance-using friends. Despite recognizing the contributing role of the substance to a psychological or physical problem (e.g., severe depressive symptoms or amage to organ systems), the person continues to use the substance (Criterion 7). he key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite having evidence of the difficulty it is causing.

pecifiers

olerance and withdrawal may be associated with a higher risk for immediate general medical problems and a higher relapse rate. Specifiers are provided to note their resence or absence:

With Physiological Dependence. This specifier should be used when Substance Dependence is accompanied by evidence of tolerance (Criterion 1) or withdrawal (Criterion 2).

Without Physiological Dependence. This specifier should be used when there is no evidence of tolerance (Criterion 1) or withdrawal (Criterion 2). In these individuals, Substance Dependence is characterized by a pattern of compulsive use (at least three items from Criteria 3–7).

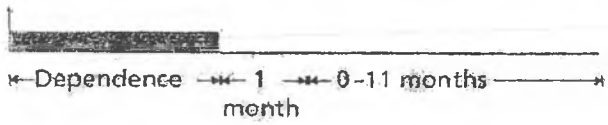
Course Specifiers

ix course specifiers are available for Substance Dependence. The four Remission pecifiers can be applied only after none of the criteria for Substance Dependence or Substance Abuse have been present for at least 1 month. For those criteria that require ecurrent problems, a remission specifier can apply only if no aspect of the criterion as been present (e.g., one incident of driving while intoxicated would suffice to disqualify the individual from being considered in remission). The definition of these our types of Remission is based on the interval of time that has elapsed since the cesation of Dependence (Early versus Sustained Remission) and whether there is continued presence of one or more of the items included in the criteria sets for Dependence or Abuse (Partial versus Full Remission). Because the first 12 months following Dependence is a time of particularly high risk for relapse, this period is designated Early Remission. After 12 months of Early Remission have passed without relapse to Dependence, the person enters into Sustained Remission. For both Early Remission and Sustained Remission, a further designation of Full is given if no criteria for Dependence or Abuse have been met during the period of remission; a designation of Partial is given if at least one of the criteria for Dependence or Abuse has been met, intermittently or continuously, during the period of remission. The differentiation of Sustained Full Remission from recovered (no current Substance Use Dis-

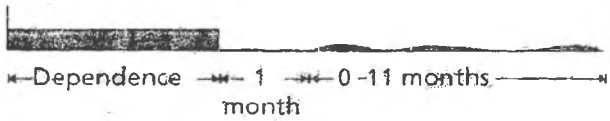
order) requires consideration of the length of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation. If, after a period of remission or recovery, the individual again becomes dependent, the application of the Early Remission specifier requires that there again be at least 1 month in which no criteria for Dependence or Abuse are met. Two additional specifiers have been provided: On Agonist Therapy and In a Controlled Environment. For an individual to qualify for Early Remission after cessation of agonist therapy or release from a controlled environment, there must be a 1-month period in which none of the criteria for Dependence or Abuse are met.

The following Remission specifiers can be applied only after no criteria for Dependence or Abuse have been met for at least 1 month. Note that these specifiers do not apply if the individual is on agonist therapy or in a controlled environment (see below).

Early Full Remission. This specifier is used if, for at least 1 month, but for less than 12 months, no criteria for Dependence or Abuse have been met.



Early Partial Remission. This specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).



Sustained Full Remission. This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during a period of 12 months or longer.

Sustained Partial Remission. This specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.

The following specifiers apply if the individual is on agonist therapy or in a controlled environment:

On Agonist Therapy. This specifier is used if the individual is on a prescribed agonist medication such as methadone and no criteria for Dependence or Abuse have been met for that class of medication for at least the past month (except tolerance to, or withdrawal from, the agonist). This category also applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.

In a Controlled Environment. This specifier is used if the individual is in an environment where access to alcohol and controlled substances is restricted, and no criteria for Dependence or Abuse have been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, or locked hospital units.

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Criteria for Substance Dependence *(continued)*

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)
Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Course specifiers (see text for definitions):

Early Full Remission
Early Partial Remission
Sustained Full Remission
Sustained Partial Remission
On Agonist Therapy
In a Controlled Environment

Substance Abuse

Features

The essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an Abuse criterion to be met, the substance-related problem must have occurred repeatedly during the same 12-month period or been persistent. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (Criterion A). Unlike the criteria for Substance Dependence, the criteria for Substance Abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use. A diagnosis of Substance Abuse is preempted by the diagnosis of Substance Dependence if the individual's pattern of substance use has ever met the criteria for Dependence for that class of substances (Criterion B). Although a diagnosis of Substance Abuse is more likely in individuals who have only recently started taking the substance, some individuals continue to have substance-related adverse social consequences over a long period of time without developing evidence of Substance Dependence. The category of Substance Abuse does not apply to caffeine and nicotine. The term *abuse* should be applied only to a pattern of substance use that meets the criteria for this disorder; the term should not be used as a synonym for "use," "misuse," or "hazardous use."

The individual may repeatedly demonstrate intoxication or other substance-related symptoms when expected to fulfill major role obligations at work, school, or home (Criterion A1). There may be repeated absences or poor work performance related to recurrent hangovers. A student might have substance-related absences, suspensions, or expulsions from school. While intoxicated, the individual may neglect children or household duties. The person may repeatedly be intoxicated in situations that are

physically hazardous (e.g., while driving a car, operating machinery, or engaging in risky recreational behavior such as swimming or rock climbing) (Criterion A2). There may be recurrent substance-related legal problems (e.g., arrests for disorderly conduct, assault and battery, driving under the influence) (Criterion A3). The person may continue to use the substance despite a history of undesirable persistent or recurrent social or interpersonal consequences (e.g., marital difficulties or divorce, verbal or physical fights) (Criterion A4).

Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance-Induced Disorders

Substance Intoxication

Diagnostic Features

The essential feature of Substance Intoxication is the development of a reversible substance-specific syndrome due to the recent ingestion of (or exposure to) a substance (Criterion A). The clinically significant maladaptive behavioral or psychological changes associated with intoxication (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, impaired social or occupational functioning) are due to the direct physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another

mental disorder (Criterion C). Substance Intoxication is often associated with Su stance Abuse or Dependence. This category does not apply to nicotine. Evidence f recent intake of the substance can be obtained from the history, physical examinati (e.g., smell of alcohol on the breath), or toxicological analysis of body fluids (e. urine or blood).

The most common changes involve disturbances of perception, wakefulness, a tention, thinking, judgment, psychomotor behavior, and interpersonal behavior. Th specific clinical picture in Substance Intoxication varies dramatically among indivi uals and also depends on which substance is involved, the dose, the duration or chr nicity of dosing, the person's tolerance for the substance, the period of time since th last dose, the expectations of the person as to the substance's effects, and the enviro ment or setting in which the substance is taken. Short-term or "acute" intoxicatior may have different signs and symptoms from sustained or "chronic" intoxication For example, moderate cocaine doses may initially produce gregariousness, bu social withdrawal may develop if such doses are frequently repeated over days c weeks.

Different substances (sometimes even different substance classes) may produc identical symptoms. For example, Amphetamine and Cocaine Intoxication can bot present with grandiosity and hyperactivity, accompanied by tachycardia, pupillar dilation, elevated blood pressure, and perspiration or chills. Also, alcohol and sub stances from the sedative, hypnotic, or anxiolytic class produce similar symptoms o intoxication.

When used in the physiological sense, the term *intoxication* is broader than Sub stance Intoxication as defined here. Many substances may produce physiological o psychological changes that are not necessarily maladaptive. For example, an individ ual with tachycardia from excessive caffeine use has a physiological intoxication, bu if this is the only symptom in the absence of maladaptive behavior, the diagnosis o Caffeine Intoxication would not apply. The maladaptive nature of a substance induced change in behavior depends on the social and environmental context. The maladaptive behavior generally places the individual at significant risk for adverse effects (e.g., accidents, general medical complications, disruption in social and family relationships, vocational or financial difficulties, legal problems). Signs and symptoms of intoxication may sometimes persist for hours or days beyond the time when the substance is detectable in body fluids. This may be due to continuing low concentrations of the substance in certain areas of the brain or to a "hit and run" effect in which the substance alters a physiological process, the recovery of which takes longer than the time for elimination of the substance. These longer-term effects of intoxication must be distinguished from withdrawal (i.e., symptoms initiated by a decline in blood or tissue concentrations of a substance).

Criteria for Substance Intoxication

A. The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. **Note:** Different substances may produce similar or identical syndromes.

B. Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgment, impaired social or occupational functioning) and develop during or shortly after use of the substance.

C. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Substance Withdrawal

Diagnostic Features

The essential feature of Substance Withdrawal is the development of a substance-specific maladaptive behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use (Criterion A). The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (Criterion C). Withdrawal is usually, but not always, associated with Substance Dependence (see p. 192). Most (perhaps all) individuals with Withdrawal have a craving to readminister the substance to reduce the symptoms. The diagnosis of Withdrawal is recognized for the following groups of substances: alcohol; amphetamines and other related substances; cocaine; nicotine; opioids; and sedatives, hypnotics, or anxiolytics. The signs and symptoms of Withdrawal vary according to the substance used, with most symptoms being the opposite of those observed in Intoxication with the same substance. The dose and duration of use and other factors such as the presence or absence of additional illnesses also affect withdrawal symptoms. Withdrawal develops when doses are reduced or stopped, whereas signs and symptoms of Intoxication improve (gradually in some cases) after dosing stops.

Specify type: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/Paranoid Type/Other Type/Combined Type/Unspecified Type

293.9 Mental Disorder NOS Due to . . . *[Indicate the General Medical Condition]* (190)

Substance-Related Disorders (191)

The following specifiers apply to Substance Dependence as noted:

[a]With Physiological Dependence/Without Physiological Dependence

[b]Early Full Remission/Early Partial Remission/Sustained Full Remission/Sustained Partial Remission

[c]In a Controlled Environment

[d]On Agonist Therapy

The following specifiers apply to Substance-Induced Disorders as noted:

[I]With Onset During Intoxication/[W]With Onset During Withdrawal

ALCOHOL-RELATED DISORDERS (212)

Alcohol Use Disorders (213)

303.90 Alcohol Dependence[a,b,c] (213)

305.00 Alcohol Abuse (214)

Alcohol-Induced Disorders (214)

303.00 Alcohol Intoxication (214)

291.81 Alcohol Withdrawal (215)
Specify if: With Perceptual Disturbances

291.0 Alcohol Intoxication Delirium (143)

291.0 Alcohol Withdrawal Delirium (143)

291.2 Alcohol-Induced Persisting Dementia (168)

291.1 Alcohol-Induced Persisting Amnestic Disorder (177)

291.x Alcohol-Induced Psychotic Disorder (338)

.5 With Delusions[I,W]

.3 With Hallucinations[I,W]

291.89 Alcohol-Induced Mood Disorder[I,W] (405)

291.89 Alcohol-Induced Anxiety Disorder[I,W] (479)

291.89 Alcohol-Induced Sexual Dysfunction[I] (562)

291.89 Alcohol-Induced Sleep Disorder[I,W] (655)

291.9 Alcohol-Related Disorder NOS (223)

AMPHETAMINE (OR AMPHETAMINE-LIKE)-RELATED DISORDERS (223)

Amphetamine Use Disorders (224)

304.40 Amphetamine Dependence[a,b,c] (224)

305.70 Amphetamine Abuse (225)

Amphetamine-Induced Disorders (226)

292.89 Amphetamine Intoxication (226)
Specify if: With Perceptual Disturbances

292.0 Amphetamine Withdrawal (227)

292.81 Amphetamine Intoxication Delirium (143)

292.xx Amphetamine-Induced Psychotic Disorder (338)

.11 With Delusions[I]

.12 With Hallucinations[I]

292.84 Amphetamine-Induced Mood Disorder[I,W] (405)

292.89 Amphetamine-Induced Anxiety Disorder[I] (479)

292.89 Amphetamine-Induced Sexual Dysfunction[I] (562)

292.89 Amphetamine-Induced Sleep Disorder[I,W] (655)

292.9 Amphetamine-Related Disorder NOS (231)

CAFFEINE-RELATED DISORDERS (231)

Caffeine-Induced Disorders (232)
305.90 Caffeine Intoxication (232)
292.89 Caffeine-Induced Anxiety Disorder[I] (479)
292.89 Caffeine-Induced Sleep Disorder[I] (655)
292.9 Caffeine-Related Disorder NOS (234)

CANNABIS-RELATED DISORDERS (234)

Cannabis Use Disorders (236)
304.30 Cannabis Dependence[a,b,c] (236)
305.20 Cannabis Abuse (236)

Cannabis-Induced Disorders (237)
292.89 Cannabis Intoxication (237)
Specify if: With Perceptual Disturbances
292.81 Cannabis Intoxication Delirium (143)
292.xx Cannabis-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.89 Cannabis-Induced Anxiety Disorder[I] (479)
292.9 Cannabis-Related Disorder NOS (241)

COCAINE-RELATED DISORDERS (241)

Cocaine Use Disorders (242)
304.20 Cocaine Dependence[a,b,c] (242)
305.60 Cocaine Abuse (243)

Cocaine-Induced Disorders (244)
292.89 Cocaine Intoxication (244)
Specify if: With Perceptual Disturbances
292.0 Cocaine Withdrawal (245)
292.81 Cocaine Intoxication Delirium (143)
292.xx Cocaine-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Cocaine-Induced Mood Disorder[I,W] (405)
292.89 Cocaine-Induced Anxiety Disorder[I,W] (479)
292.89 Cocaine-Induced Sexual Dysfunction[I] (562)
292.89 Cocaine-Induced Sleep Disorder[I,W] (655)
292.9 Cocaine-Related Disorder NOS (250)

HALLUCINOGEN-RELATED DISORDERS (250)

Hallucinogen Use Disorders (251)
304.50 Hallucinogen Dependence[b,c] (251)
305.30 Hallucinogen Abuse (252)

Hallucinogen-Induced Disorders (252)
292.89 Hallucinogen Intoxication (252)
292.89 Hallucinogen Persisting Perception Disorder (Flashbacks) (253)
292.81 Hallucinogen Intoxication Delirium (143)
292.xx Hallucinogen-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Hallucinogen-Induced Mood Disorder[I] (405)
292.89 Hallucinogen-Induced Anxiety Disorder[I] (479)
292.9 Hallucinogen-Related Disorder NOS (256)

INHALANT-RELATED DISORDERS (257)

Inhalant Use Disorders (258)
304.60 Inhalant Dependence[b,c] (258)
305.90 Inhalant Abuse (259)

Inhalant-Induced Disorders (259)
292.89 Inhalant Intoxication (259)
292.81 Inhalant Intoxication Delirium (143)

292.82 Inhalant-Induced Persisting Dementia (168)
292.xx Inhalant-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Inhalant-Induced Mood Disorder[I] (405)
292.89 Inhalant-Induced Anxiety Disorder[I] (479)
292.9 Inhalant-Related Disorder NOS (263)

NICOTINE-RELATED DISORDERS (264)

Nicotine Use Disorder (264)
305.1 Nicotine Dependence[a,b] (264)

Nicotine-Induced Disorder (265)
292.0 Nicotine Withdrawal (265)
292.9 Nicotine-Related Disorder NOS (269)

OPIOID-RELATED DISORDERS (269)

Opioid Use Disorders (270)
304.00 Opioid Dependence[a,b,c,d] (270)
305.50 Opioid Abuse (271)

Opioid-Induced Disorders (271)
292.89 Opioid Intoxication (271)
Specify if: With Perceptual Disturbances
292.0 Opioid Withdrawal (272)
292.81 Opioid Intoxication Delirium (143)
292.xx Opioid-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Opioid-Induced Mood Disorder[I] (405)
292.89 Opioid-Induced Sexual Dysfunction[I] (562)
292.89 Opioid-Induced Sleep Disorder[I,W] (655)
292.9 Opioid-Related Disorder NOS (277)

PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)–RELATED DISORDERS (278)

Phencyclidine Use Disorders (279)
304.60 Phencyclidine Dependence[b,c] (279)
305.90 Phencyclidine Abuse (279)

Phencyclidine-Induced Disorders (280)
292.89 Phencyclidine Intoxication (280)
Specify if: With Perceptual Disturbances
292.81 Phencyclidine Intoxication Delirium (143)
292.xx Phencyclidine-Induced Psychotic Disorder (338)
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Phencyclidine-Induced Mood Disorder[I] (405)
292.89 Phencyclidine-Induced Anxiety Disorder[I] (479)
292.9 Phencyclidine-Related Disorder NOS (283)

SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS (284)

Sedative, Hypnotic, or Anxiolytic Use Disorders (285)
304.10 Sedative, Hypnotic, or Anxiolytic Dependence[a,b,c] (285)
305.40 Sedative, Hypnotic, or Anxiolytic Abuse (286)

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders (286)
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication (286)
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal (287)
Specify if: With Perceptual Disturbances
292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium (143)
292.81 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (143)

92.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (168)
92.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder (177)
92.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder (338)
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
92.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder[I,W] (405)
92.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder[W] (479)
92.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[I] (562)
92.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder[I,W] (655)
92.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS (293)

'OLYSUBSTANCE-RELATED)ISORDER (293)

04.80 Polysubstance Dependence[a,b,c,d] (293)

)THER (OR UNKNOWN) SUBSTANCE-RELATED DISORDERS 294)

)ther (or Unknown) Substance Use Disorders (295)

04.90 Other (or Unknown) Substance Dependence[a,b,c,d] (192)
05.90 Other (or Unknown) Substance Abuse (198)

)ther (or Unknown) Substance-nduced Disorders (295)

92.89 Other (or Unknown) Substance Intoxication (199)
Specify if: With Perceptual Disturbances
292.0 Other (or Unknown) Substance Withdrawal (201)
Specify if: With Perceptual Disturbances
292.81 Other (or Unknown) Substance-Induced Delirium (143)
292.82 Other (or Unknown) Substance-Induced Persisting Dementia (168)
292.83 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder (177)
292.xx Other (or Unknown) Substance-Induced Psychotic Disorder (338)
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Other (or Unknown) Substance-Induced Mood Disorder[I,W] (405)
292.89 Other (or Unknown) Substance-Induced Anxiety Disorder[I,W] (479)
292.89 Other (or Unknown) Substance-Induced Sexual Dysfunction[I] (562)
292.89 Other (or Unknown) Substance-Induced Sleep Disorder[I,W] (655)
292.9 Other (or Unknown) Substance-Related Disorder NOS (295)

Schizophrenia and Other Psychotic Disorders (297)

295.xx Schizophrenia (298)
The following Classification of Longitudinal Course applies to all subtypes of Schizophrenia:

Episodic With Interepisode Residual Symptoms (*specify if:* With Prominent Negative Symptoms)/ Episodic With No Interepisode Residual Symptoms

LexisNexis® Total Research System
Switch Client | Preferences | Sign Out | Help
Search | Research Tasks | Get a Document | Shepard's® | Alerts | Total Litigator | Transactional Advisor | Counsel Selector | History

Service: **Get by LEXSTAT® - Book Browse**
TOC: United States Code Service: Code, Const, Rules, Conventions & Public Laws > /.../ > EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION > **§ 300gg-23. Preemption; State flexibility; construction**
Citation: **42 U.S.C. 300gg-11**
Section: **42 USCS § 300gg-23**

42 USCS § 300gg-23

UNITED STATES CODE SERVICE
Copyright © 2010 Matthew Bender & Company, Inc.
a member of the LexisNexis Group (TM)
All rights reserved.

*** CURRENT THROUGH PL 111-237, APPROVED 8/16/2010 ***

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A. THE PUBLIC HEALTH SERVICE
REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
INDIVIDUAL AND GROUP MARKET REFORMS
EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

Practitioner's Toolbox
History
History; Ancillary Laws and Directives
Resources & Practice Tools
Research Guide
Law Review Articles:
> Standard HIPAA Order in Civil Actions. 65 Ala Law 332, September 2004.
More...

Go to the United States Code Service Archive Directory

42 USCS § 300gg-23

§ 300gg-23. Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers.

(1) In general. Subject to paragraph (2) and except as provided in subsection (b), this part [42 USCS §§ 300gg et seq.] and part C [42 USCS §§ 300gg-91 et seq.] insofar as it relates to this part [42 USCS §§ 300gg et seq.] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part [42 USCS §§ 300gg et seq.].

(2) Continued preemption with respect to group health plans. Nothing in this part [42 USCS §§ 300gg et seq.] shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 [29 USCS § 1144] with respect to group health plans.

(b) Special rules in case of portability requirements.

(1) In general. Subject to paragraph (2), the provisions of this part [42 USCS §§ 300gg et seq.] relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) Exceptions. Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part [42 USCS §§ 300gg et seq.] do not supersede any provision of State law to the extent that such provision--

(i) substitutes for the reference to "6-month period" in section 2701(a)(1) [42 USCS § 300gg(a)(1)] a reference to any shorter period of time;

(ii) substitutes for the reference to "12 months" and "18 months" in section 2701(a)(2) [42 USCS § 300gg(a)(2)] a reference to any shorter period of time;

(iii) substitutes for the references to "63" days in sections 2701(c)(2)(A) and 2701(d)(4)(A) [42 USCS § 300gg(c)(2)(A), (d)(4)(A)] a reference to any greater number of days;

(iv) substitutes for the reference to "30-day period" in sections 2701(b)(2) and 2701(d)(1) [42 USCS § 300gg(b)(2), (d)(1)] a reference to any greater period;

(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) [42 USCS § 300gg(d)] or expands the exceptions described in such section;

(vi) requires special enrollment periods in addition to those required under section 2701(f) [42 USCS § 300gg(f)]; or

(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B) [42 USCS § 300gg(g)(1)(B)].

(c) Rules of construction. Nothing in this part [42 USCS §§ 300gg et seq.] (other than section 2704 [42 USCS §

300gg-4]) shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) Definitions. For purposes of this section--

(1) State law. The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) State. The term "State" includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

History:

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart 2[4][3], § 2724 [2737] [2723], as added Aug. 21, 1996, P.L. 104-191, Title I, Subtitle A, Part 1, § 102(a), 110 Stat. 1971; Sept. 26, 1996, P.L. 104-204, Title VI, § 604(a)(2), (b)(2), 110 Stat. 2939, 2941; March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(4), Subtitle G, § 1563(c)(14) [1562(c)(14)], Title X, Subtitle A, § 10107(b)(1), 124 Stat. 130, 269, 911.)

History; Ancillary Laws and Directives:

1. Amendments
2. Redesignation
3. Other provisions

1. Amendments:

1996. Act Sept. 26, 1996 (applicable with respect to group health plans for plan years beginning on or after 1/1/98, which appears as 42 USCS § 300gg-4 note), in subsec. (c), inserted "(other than section 2704)".

2010. Act March 23, 2010, in subsec. (a)(1), inserted "individual or".

2. Redesignation:

Subpart 3 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated Subpart 4 of such Part by Act Sept. 26, 1996, P.L. 104-204, Title VI, § 604(a)(2), 110 Stat. 2939. It was further redesignated Subpart 2 of such Part by Act March 23, 2010, P.L. 111-148, Title I, Subtitle G, § 1562(c)(11), 124 Stat. 268.

This section, enacted as § 2723 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated § 2737 of such Part by Act March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(4), 124 Stat. 130. It was further redesignated § 2724 of such Part by § 1562(c)(14)(B) of the 2010 Act.

Section 1562 of Act March 23, 2010, P.L. 111-148, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

3. Other provisions:

Applicability of section. Subject to certain exceptions, Part A of title XXVII of the Public Health Service Act (42 USCS §§ 300gg et seq.) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, pursuant to § 102(c) of Act Aug. 21, 1996, P.L. 104-191, which appears as 42 USCS § 300gg note.

Notes:

Research Guide:

Law Review Articles:

Standard HIPAA Order in Civil Actions. 65 Ala Law 332. September 2004.

Stein. What Litigators Need to Know about HIPAA. 36 J Health L 433, Summer 2003.

Remus; L'Huillier. HIPAA and lawyers: yes, lawyers! 44 NH BJ 14, March 2003.

Langer. The HIPAA Privacy Rules: Disclosures of Protected Health Information in Legal Proceedings. 78 Wis L 14, April 2005.

Service: **Get by LEXSTAT® - Book Browse**
TOC: United States Code Service: Code, Const, Rules, Conventions & Public Laws > / . . . / > EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION > **§ 300gg-23. Preemption; State flexibility; construction**
Citation: **42 U.S.C. 300gg-11**
Section: **42 USCS § 300gg-23**
View: Full
Date/Time: Tuesday, August 31, 2010 - 1:49 PM EDT

Search | Research Tasks | Get a Document | *Shepard's*® | Alerts | Total Litigator | Transactional Advisor | Counsel Selector
History | Delivery Manager | Switch Client | Preferences | Sign Out | Help

LexisNexis® About LexisNexis | Terms & Conditions | Contact Us
Copyright © 2010 LexisNexis, a division of Reed Elsevier Inc. All rights reserved.

LexisNexis® Total Research System
Switch Client | Preferences | Sign Out | Help
Search | Research Tasks | Get a Document | Shepard's® | Alerts | Total Litigator | Transactional Advisor | Counsel Selector | History

Service: Get by LEXSTAT® - Book Browse
TOC: United States Code Service: Code, Const, Rules, Conventions & Public Laws > /.../ > EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION > § 300gg-26. Parity in mental health and substance use disorder benefits
Citation: 42 U.S.C. 300gg-11
Section: 42 USCS § 300gg-26

42 USCS § 300gg-26

Practitioner's Toolbox
History
History: Ancillary Laws and Directives
Resources & Practice Tools
Research Guide
Law Review Articles:
> Standard HIPAA Order in Civil Actions. 65 Ala Law 332, September 2004.
More...

UNITED STATES CODE SERVICE
Copyright © 2010 Matthew Bender & Company, Inc.
a member of the LexisNexis Group (TM)
All rights reserved.

*** CURRENT THROUGH PL 111-237, APPROVED 8/16/2010 ***

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A. THE PUBLIC HEALTH SERVICE
REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE
INDIVIDUAL AND GROUP MARKET REFORMS
EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

Go to the United States Code Service Archive Directory

42 USCS § 300gg-26

§ 300gg-26. Parity in mental health and substance use disorder benefits

(a) In general.

(1) Aggregate lifetime limits. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits--

(A) No lifetime limit. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either--

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits--

(A) No annual limit. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either--

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the

Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations.

(A) In general. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that--

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions. In this paragraph:

(i) Financial requirement. The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information. The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers. In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(b) Construction. Nothing in this section shall be construed--

(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions.

(1) Small employer exemption. This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 2791(e)(4) [42 USCS § 300gg-91(e)(4)], except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption.

(A) In general. With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage. With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be--

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries. Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group

health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations. If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification.

(i) In general. A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement. A notification to the Secretary under clause (i) shall include--

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality. A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes--

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies. To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered. In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions. For purposes of this section--

(1) Aggregate lifetime limit. The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit. The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits. The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

(4) Mental health benefits. The term "mental health benefits" means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits. The term "substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

History:

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart 2, § 2706 [2705], as added Sept. 26, 1996, P.L. 104-204, Title VII, § 703(a), 110 Stat. 2947; Jan. 10, 2002, P.L. 107-116, Title VII, § 701(b), 115 Stat. 2228; Dec. 2, 2002, P.L. 107-313, § 2(b), 116 Stat. 2457; Dec. 19, 2003, P.L. 108-197, § 2(b), 117 Stat. 2898; Oct. 4, 2004, P.L. 108-311, Title III, § 302(c), 118 Stat. 1179; Dec. 30, 2005, P.L. 109-151, § 1(b), 119 Stat. 2886; Dec. 20, 2006, P.L. 109-432, Div A, Title I, § 115(c), 120 Stat. 2941; June 17, 2008, P.L. 110-245, Title IV, § 401(c), 122 Stat. 1650; Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(b), (g)(2), 122 Stat. 3885, 3892; March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(2), Subtitle G, § 1563(c)(4) [1562(c)(4)], Title X, Subtitle A, § 10107(b)(1), 124 Stat. 130, 265, 911.)

History; Ancillary Laws and Directives:

1. Explanatory notes
2. Amendments
3. Redesignation
4. Other provisions

∓ 1. Explanatory notes:
This section formerly appeared as 42 USCS § 300gg-5.

∓ 2. Amendments:

2002. Act Jan. 10, 2002, in subsec. (f), substituted "December 31, 2002" for "September 30, 2001".
Act Dec. 2, 2002, in subsec. (f), substituted "December 31, 2003" for "December 31, 2002".

2003. Act Dec. 19, 2003, in subsec. (f), substituted "December 31, 2004" for "December 31, 2003".

2004. Act Oct. 4, 2004 (effective on enactment, as provided by § 302(d) of such Act, which appears as 26 USCS § 9812 note), in subsec. (f), substituted "after December 31, 2005" for "on or after December 31, 2004".

2005. Act Dec. 30, 2005, in subsec. (f), substituted "December 31, 2006" for "December 31, 2005".

2006. Act Dec. 20, 2006, in subsec. (f), substituted "2007" for "2006".

2008. Act June 17, 2008, in subsec. (f), substituted "services furnished--" and paras. (1) and (2) for "services furnished after December 31, 2007".
Act Oct. 3, 2008 (effective on 1/1/2009, as provided by § 512(e) of such Act, which appears as a note to this section), deleted subsec. (f), which read:
"(f) Sunset. This section shall not apply to benefits for services furnished--
"(1) on or after January 1, 2008, and before the date of the enactment of the Heroes Earnings Assistance and Relief Tax Act of 2008, and
"(2) after December 31, 2008.[.]".
Act Oct. 3, 2008 (applicable with respect to group health plans for plan years beginning after the date that is 1 year after enactment, as provided by § 512(e) of such Act, which appears as a note to this section), substituted the section heading for one which read: "Parity in the application of certain limits to mental health benefits"; in subsec. (a), in para. (1), in the introductory matter, and, in subpara. (A), substituted "mental health or substance use disorder benefits" for "mental health benefits", in subpara. (B), in cl. (i), substituted "mental health and substance use disorder benefits" for "mental health benefits" in two places, and, in cl. (ii), substituted "mental health or substance use disorder benefits" for "mental health benefits", in subpara. (C), substituted "mental health and substance use disorder benefits" for "mental health benefits", in para. (2), in the introductory matter, and, in subpara. (A), substituted "mental health or substance use disorder benefits" for "mental health benefits", in subpara. (B), in cl. (i), substituted "mental health and substance use disorder benefits" for "mental health benefits" in two places, in cl. (ii), substituted "mental health or substance use disorder benefits" for "mental health benefits", and, in subpara. (C), substituted "mental health and substance use disorder benefits" for "mental health benefits", and added paras. (3)-(5); in subsec. (b), in para. (1), substituted "mental health or substance use disorder benefits" for "mental health benefits", substituted para. (2) for one which read: "(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits)."; in subsec. (c), in para. (1), inserted "(as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual)", substituted para. (2) for one which read: "(2) Increased cost exemption. This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent."; and, in subsec. (e), substituted paras. (4) and (5) for para. (4) which read: "(4) Mental health benefits. The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.".

2010. Act March 23, 2010, in subsecs. (a) and (b), substituted "or a health insurance issuer offering group or individual health insurance coverage" for "(or health insurance coverage offered in connection with such a plan)" wherever occurring; and in subsec. (c), in para. (1), substituted "and a health insurance issuer offering group or individual health insurance coverage" for "(and group health insurance coverage offered in connection with a group health plan)", and in para. (2)(A), substituted "or a health insurance issuer offering group or individual health insurance coverage" for "(or health insurance coverage offered in connection with such a plan)".

3. Redesignation:

This section, enacted as § 2705 of Part A of Title XXVII of Act July 1, 1944, ch 373, was redesignated § 2726 of such Part by Act March 23, 2010, P.L. 111-148, Title I, Subtitle A, § 1001(2), 124 Stat. 130.)

Section 1562 of Act March 23, 2010, P.L. 111-148, which amended this section, was redesignated § 1563 of such Act by § 10107(b)(1) of the Act.

4. Other provisions:

Applicability of section. Act Sept. 26, 1996, P.L. 104-204, Title VII, § 703(b), 110 Stat. 2950, provides: "The amendments made by this section [adding this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.".

Act Oct. 3, 2008; regulations. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(d), 122 Stat. 3891, provides: "Not later than 1 year after the date of enactment of this Act, the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c) [amending 26 USCS § 9812, 29 USCS § 1185a, and 42 USCS § 300gg-5], respectively.".

Application of Oct. 3, 2008 amendments. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(e), 122 Stat. 3891; Dec. 23, 2008, P.L. 110-460, § 1, 122 Stat. 5123, provides:

"(1) In general. The amendments made by this section [for full classification, consult USCS Tables volumes] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act, regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5) [deleting 26 USCS § 9812(f), 29 USCS § 1185a(f), and 42 USCS § 300gg-5(f)], relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

"(2) Special rule for collective bargaining agreements. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section [for full classification, consult USCS Tables volumes] shall not apply to plan years beginning before the later of--

"(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

"(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.".

Assuring coordination. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(f), 122 Stat. 3892, provides:

"The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that--

"(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section (and the amendments made by this section [for full classification, consult USCS Tables volumes]) are administered so as to have the same effect at all times; and

"(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.".

Notes:

Research Guide:

Law Review Articles:

Standard HIPAA Order in Civil Actions. 65 Ala Law 332. September 2004.

Stein. What Litigators Need to Know about HIPAA. 36 J Health L 433, Summer 2003.

Remus; L'Huillier. HIPAA and lawyers: yes, lawyers! 44 NH BJ 14, March 2003.

Langer. The HIPAA Privacy Rules: Disclosures of Protected Health Information in Legal Proceedings. 78 Wis L 14, April 2005.

Service: **Get by LEXSTAT® - Book Browse**
TOC: United States Code Service: Code. Const. Rules, Conventions & Public Laws > /.../ > EXCLUSION OF PLANS: ENFORCEMENT; PREEMPTION > **§ 300gg-26. Parity in mental health and substance use disorder benefits**
Citation: **42 U.S.C. 300gg-11**
Section: **42 USCS § 300gg-26**
View: Full
Date/Time: Tuesday, August 31, 2010 - 1:53 PM EDT

Search | Research Tasks | Get a Document | *Shepard's*® | Alerts | Total Litigator | Transactional Advisor | Counsel Selector
History | Delivery Manager | Switch Client | Preferences | Sign Out | Help

LexisNexis® About LexisNexis | Terms & Conditions | Contact Us
Copyright © 2010 LexisNexis, a division of Reed Elsevier Inc. All rights reserved.

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

GO

Issues & Research » Health » State Laws Mandating or Regulating Mental Health B Go 14352 Share Comment

State Laws Mandating or Regulating Mental Health Benefits

Updated: February 2009; reposted with additions February 11, 2010. NEW

Mental health services have been one significant part of medical care for a number of years. However, the costs, coverage and availability of such services have been the object of policy discussions and a variety of state legislation. There is not a general consensus that state government should require coverage for mental health. 49 states and D.C. currently have some type of enacted law but these laws vary considerably and can be divided roughly into three categories:[1]

1. **mental health "parity" or equal coverage laws** [definition]
2. **minimum mandated mental health benefit laws** [definition]
3. **mental health "mandated offering laws".** [definition]

Note that some laws apply primarily to "serious mental illness" and may not assure coverage for particular individual diagnoses or circumstances. Many private market health plans include some type of mental health benefits on a voluntary commercial basis, not necessarily required by state or federal laws. Note that grief counseling may not be considered a covered benefit under some state laws, although it may be offered by insurers as part of a standard mental health benefit package. Laws in at least 38 states include coverage for substance abuse, alcohol or drug addiction.

CMS Guidance Regarding Mental Health Parity Requirements in CHIPRA, Medicaid and Group Insurance NEW

The federal Centers for Medicare & Medicaid Services (CMS) issued a State Health Official letter on November 4, 2009 regarding the mental health parity requirements under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The letter provides general guidance on implementation of section 502 of CHIPRA, Public Law 111-3, which imposes mental health and substance use disorder parity requirements on all Children's Health Insurance Program (CHIP) State plans under title XXI of the Social Security Act (the Act). This letter also provides preliminary guidance to the extent that mental health and substance use disorder parity requirements apply to State Medicaid programs under title XIX of the Act.

In summary the letter addresses specific requirements in the measure as follows:

1. Qualifying financial requirements and treatment limitations applied to mental health or substance use disorder benefits may be no more restrictive than those applied to medical surgical benefits.
2. No separate qualifying criteria may be applied to mental health or substance use disorder benefits.
3. When out-of-network coverage is available for medical surgical benefits, it must also be available for mental health or substance use disorder benefits.

Medicaid and Group Health Insurance:

Requirements from the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) became effective for group health insurance plans on October 3rd of 2009. These same requirements will only apply to Medicaid insofar as the state's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs). In these cases the MCOs or PIHPs must be in compliance. A state Medicaid plan is not subject to these requirements otherwise. The MHPAEA applies to all CHIP programs and became effective April 1 of 2009. State CHIP plans are deemed in compliance if they provide coverage of Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefits.

States Requiring Legislative Action for Compliance

The letter also specifies that if a state requires legislation in order to be in compliance with the requirements, a state will not be found to be in violation before its next legislative session as long as it notifies the Secretary of HHS and she concurs that legislation is needed. They ask that states in the circumstances submit a letter to the Center for Medicaid and State Operations to that effect as soon as possible and include information as follows:

1. the provisions in question,
2. the reason the state requires legislative action for compliance, and
3. the date the state will begin implementing the provision.

Federal Law Requiring Parity in Some Circumstances - in effect 2010

On October 3, 2008, the Emergency Economic Stabilization Act (HR 1424) passed Congress and was signed into law. It included a major mental health provision - known as the "*Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act*," which was attached to the economic bill and also became law. This federal mental health law requires health insurance plans that offer mental health coverage to provide the same financial and treatment coverage offered for other physical illnesses. It does not mandate that group plans must provide mental health coverage. [Parity Section 512 full text]

This legislation expands parity by requiring equality for deductibles, co-payments, out-of-pocket expenses, coinsurance, covered hospital days, and covered out-patient visits. The measure also includes a small business exemption for companies with fewer than 50 employees, as well as a cost exemption for all businesses if it will result in a cost increase of 2% in the first year and 1% in each subsequent year. The bill builds on the current 1996 federal parity law, which already requires parity coverage for annual and lifetime dollar limits. The current HIPAA preemption standard applies. This standard is extremely protective of state law. Only a state law that "prevents the application" of this Act will be preempted, which means that stronger state parity and other consumer protection laws remain in place. It will require the Comptroller General to inform Congress on health plans' and health insurers' coverage and exclusion rates, patterns, and trends of mental health and substance use disorder diagnoses. The new law exempts businesses with 50 or fewer employees from its mental health parity requirements.

Major provisions go into effect in 2010. Now that the federal government has released their long-awaited rules for complying with the Mental Health Parity Law (Fed. Register, Feb. 2), health plans and employers must act immediately to ensure compliance. Employers have until the first plan year beginning on or after July 1, 2010, to meet the requirements. With benefit design decisions needing to be made a few short months from now, health plans and sponsors need to take immediate steps to understand what is required and prepare for this major change in health insurance.

Sources: Press Release from the Office of U.S. Senator Pete Domenici; Press Release from the Office of U.S. Senator Edward Kennedy.
News Article: "Lawful Boost to Mental Health Coverage" Los Angeles Times, October 13, 2008.

Recent State Law History

In **2002** laws were added in **Alabama, Colorado, Kentucky, New Hampshire** and **New Jersey**.

In **2003**, "barebones" laws allowing exceptions to mandated coverage, were enacted in **Colorado, Montana and Texas. Maine** expanded categories of illnesses covered; **Hawaii** and **Kansas** extended dates of existing coverage laws.

In **2005**, **Washington** enacted a full mental health parity law, applying to health insurance, but exempting policies for individuals and small group employers with 50 or fewer employees. It will take effect in phases between 2006 and 2010. **Oregon** also enacted a full parity law that took effect January 1, 2007.

In **2006-07**, four additional states passed variations of full parity laws. **Idaho's** law provides parity, but only for state employee and family insurance policies. **New York's** former Gov. George Pataki signed Timothy's Law, named for a 12-year-old boy who committed suicide in 2001. The law requires that all private insurance policies have the same deductibles, number of office visits, number of inpatient visits and co-payments for mental health disorders as for other illnesses. The statute also requires that private plans provide at least 30 days of inpatient and 20 days of outpatient mental health care per year. In **Ohio**, outgoing Gov. Bob Taft signed his state's first mental health parity law (SB 116) on Dec. 29, 2006. The Mental Health Parity Act mandates that coverage provided for seven "biologically based mental illnesses," such as schizophrenia and bipolar disorder be on par with those for physical conditions. In July 2007 The **North Carolina** legislature enacted a measure covering nine conditions. See "TWO MORE STATES ENACT PARITY LAWS," State Health Notes, 1/22/07.

State Laws and Federal Limits: The state laws noted below generally do not apply to federally funded public programs such as Medicaid, Medicare, the Veterans Administration, etc. In addition, "self-funded" health insurance plans, often sponsored by the largest employers, usually are entirely exempt from state regulation because they are preempted by the federal ERISA law.

All of the state laws listed in this report were written and applied prior to the October 2008 passage of the Mental Health Parity and Addiction Equity Act, so coordination and interpretation of how state and federal laws combine or potentially conflict is a likely task for 2009.

> See ERISA and the States, a 2008 online resource guide by NCSL.

A Comment from the Commercial Sector

"Every client that I work with will have to make some plan-design changes to conform to the [new behavioral health parity provisions signed into law on Oct. 3]."

— Chip Kirby, an employee benefits attorney with Liberte Group LLC in Washington, D.C.,

told AIS's Health Plan Week., 10/24/2008

Mental Health Parity Laws
Parity, as it relates to mental health and substance abuse, prohibits insurers or health care service plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders and diseases. In short, parity requires insurers to provide the same level of benefits for mental illness, serious mental illness or substance abuse as for other physical disorders and diseases. These benefits include visit limits, deductibles, copayments, and lifetime and annual limits.
Parity laws contain many variables that affect the level of coverage required under the law. Some state parity laws--such as Arkansas'--provide broad coverage for all mental illnesses. Other state parity laws limit the coverage to a specific list of biologically based or serious mental illnesses. The state laws labeled full parity below provide equal benefits, to varying degrees, for the treatment of mental illness, serious mental illness and biologically based mental illness, and may include treatment for substance abuse. The newly enacted federal parity law affects insurance policies that already provide some mental health coverage; there is no federal law directly mandating parity to the same extent as state laws; also see background on unsuccessful federal parity legislation below the state table.

Minimum Mandated Benefit Laws
Many state laws require that some level of coverage be provided for mental illness, serious mental illness, substance abuse or a combination thereof. They are not considered full parity because they allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses. These discrepancies can be in the form of different visit limits, copayments, deductibles, and annual and lifetime limits. Some mental health advocates believe these laws offer a compromise to full parity that at least provides some level of care. Others feel that anything other than full parity is discrimination against the mentally ill. Some of these laws specify that copayments and deductibles must be equal to those for physical illness up to the required level of benefits provided. If a law does not specify, the copayment could be as much as 50 percent of the cost of the visit and require a separate deductible to be met before mental health visits will be covered.

Mandated Offering Laws
Mandated offering laws differ from the other two types of laws in that they do not require (or mandate) benefits be provided at all. A mandated offering law can do two things. First, it can require that an option of coverage for mental illness, serious mental illness, substance abuse or a combination thereof, be provided to the insured. This option of coverage can be accepted or rejected and, if accepted, will usually require an additional or higher premium. Second, a mandated offering law can require that **if** benefits are offered **then** they must be equal.

Full Parity, Mandated Benefit and Mandated Offering State Laws

State	Eff. Date Law citation/ web link.	Insurance Policies Affected by Law.	Illnesses Covered. (1)	Type of Benefit/	Co-pays and Co-insurance
AL	2001: H.677 of 2000	Individual and group with a small employer exemption of 50 or less.	Mental illness.	Mandated offering.	Must be equal.
AL	2002: S. 293	Adds health care service plans and health maintenance organizations (signed 4/26/02)	Mental illness	Mandated offering	Must be equal
AK	1997 ----- 2006 HB 289 ----- 2009 H 222 (Ch. 55 of 2009)	Group - 5 employees or less exempt; 20 or less must offer coverage. ------ Limited to large employer group markets, and does not apply if it would result in an increase in the cost of the plan of 1% or more. ----- Requires health care insurers in the group market to provide parity in the application of mental health and substance abuse benefits that comply with federal requirements	Alcoholism and Drug Use. ------ Mental Illness. ------ Mental health and substance abuse (effective 10/1/09)	Minimum Mandated ------- Mandated Benefit. ----- Mandated benefit	Must be equal ------ Must be equal.
AZ	1998: Ariz. Rev. Stat. Ann. 20-2322	Group with small employer exemption 50 or less, or cost increase of 1% or more.	Mental illness.	Mandate for plans that offer benefits.	Can be different.
AR	1987 ------ 1997: §23-00-506	Group and HMO. ------ Group: small employer exemption 50 or less; cost increase 1.5% or	Alcoholism and drug dependency. ------- Mental illnesses and	Mandated Offering ------ Full parity.	Not less favorable generally. ------ Must be equal.

	[Act 1020 of '97] --- 2001 HB 1562	more exempted. --- Not applicable to employers with 50 or fewer employees and to plans covering state employees. Exempts health benefit plans if it will result in cost increase of 1.5% or more.	developmental disorders. --- Mental Illness.	--- Minimum Mandated	--- Must be equal.
CA	1974: Cal. Ins. Code § 10125	Group.	Mental or nervous disorders.	Mandated offering.	Not specified.
CA	2000: Cal. Ins. Code § 10144.5	Group, individual and HMO.	Severe mental illness.	Full parity.	Must be equal.
CO	1992: Colo. Rev. Stat. § 10-16-104(5) --- 1994	Group. --- Group	Mental illness excluding autism. --- Alcoholism	Mandated benefits. --- Mandated Offering	Shall not exceed 50% of the payment. Deductible shall not differ. --- Shall not exceed 50% of the payment. Deductible shall not differ.
CO	1998: §10-16-104(5.5)	Group.	Biologically based mental illness.	Full parity.	Must be equal.
CO	2002: Chapter 208 of 2002	Provide coverage for substance abuse treatment regardless of whether the treatment is voluntary or court-ordered. (signed 5/28/02)	Substance abuse	Clarification of earlier laws	
CO	2003: H 1164	Allows exceptions for barebones policies		Exceptions	
CT	2000: Conn. Gen. Stat. §38a-488a; §38a-514a	Group and individual.	Mental or nervous conditions; alcoholism and drug addiction.	Full parity.	Must be equal.
DE	1999: Del. Code Ann. Tit. 18 § 3343 Tit. 18 § 3566 --- 2001 H 100	Group and individual. --- Group, HMO, individual and state employee plans.	Serious mental illnesses. --- Drug and Alcohol Dependencies.	Full parity. --- Parity	Must be equal. --- Must be equal.
FL	1992: Fla. Stat. § 627.668 --- 1993	Group and HMO. --- Group and HMO.	Mental and nervous disorders. --- Substance Abuse.	Mandated offering. --- Mandated offering.	May be different after minimum benefits are met. --- Not Specified.
GA	1998: Ga. Code §33-24-29; §33-24-28.1 (SB 620, 1998)	Group and individual.	Mental disorders including substance abuse.	Mandated offering.	Must be equal.
HI	1999: Hawaii Rev. Stat. §431M-5 --- 2000 HB 2392	Group and individual with small employer exemption- 25 or less employees. --- Deletes exemptions for employers with 25 or fewer employees & for government employee health benefit plans.	Serious mental illness. ---	Full parity. ---	Must be equal. ---

HI	1988: Hawaii Rev. Stat. §431M-1 ~7	Individual, group and HMO.	Mental illness.	Mandated benefits.	Must be comparable.
HI	2003: HB 1321 ------ 2005: SB 761	Makes law permanent, deleting sunset dates. ------ Expands definition of 'serious mental disorders' in current law to include delusional disorders, major depression, obsessive-compulsive disorders, and dissociative disorders.	Mental illness. --------	Full parity --------	 -------
ID	2006 HB 615 (ID Stat.: §67-5761A)	Health Insurance Plans for State Employees and their family members only.	Serious Mental Illness as defined in the APA's DSM-IV-TR.	Parity	Must be Equal.
IL	1991: Ill. Rev. Stat. Ch. 215 §5/370c ------ 1995 ----- 2001 SB 1341 ----- 2005 HB 59 ------- 2006 HB 4125	Group. ------ Group ------ Exempts employers with 50 or fewer employees. ------ Eliminates sunset provision in existing mental health parity law. ------ Makes HMOs subject to existing mental health coverage requirements.	Mental, emotional or nervous disorders. ------ Alcoholism ----- Serious Mental Illness ------ N/A ------- Increased number of visits for treatment of pervasive developmental disorders.	Full parity 2005 [See co-payment exceptions] Mandated offering, 1991-2004 ------- Mandated benefits ------ Parity for Serious mental illness; Mandated offering for other mental illness. ------ N/A ------- N/A	Insured may be required to pay up to 50% of the expenses incurred. ------- Not Specified. ------ Must be equal for serious illness. ------ N/A ------ N/A
IN	1997 HB 1400 ------ 2000: *H.1108 of '99*; Ind. Code § 27-13-7-14.8 Ind. Code § 5-10-8-9 (state)	Private Insurance Policies offering mental health benefits. Exempts employers with fewer than 50 employees and any business whose rates would increase over 1% as a result of legislation. ------ Group, individual and state employees with a small employer exemption 50 or less, or cost increase of 4% or more.	Mental Illness ------ Mental illness.	Parity ------- Mandate for plans that offer benefits. Full parity for state employee plans.	Not specified. ------ Must be equal for plans that offer coverage. Full parity for state employee plans.
IN	2003: H 1135	Adds substance abuse benefit for those with mental illnesses	Substance abuse	Mandate for those with mental illnesses	
IA	2005 HF 420; IA Code 514C.22 (2005)	Group policies to companies with more than 50 employees, public employees and small businesses that currently have mental health coverage.	Substance abuse, eating disorders, ADD not included.	Mandated Benefit.	Must be Equal.
KS	1998: § 40-2.105 2001: *H.2033 of '01* H 2071 of 2003 ------	Group, individual, HMO and state employee plans. H. 2071 extended sunset to Dec. 31, 2003.	Alcoholism or drug abuse or mental conditions.	Mandated benefits. ------	Not specified. ------

	2006 HB 2691	------ Group. If a policy does not have aggregate lifetime or annual limits on other medical benefits, then it may not impose them on mental health benefits.	------- Mental Illness	Minimum Mandated Benefits.	Not Specified.
KY	1980 ------ 1986: Ky. Rev. Stat. §§ 304.17-318 [group] §§304.38-193 [HMO]	Group ------ Group.	Alcoholism ------- Mental illness.	Mandated Offering. ------- Mandated offering.	Not Specified. ------ To the same extent as coverage for physical illness.
KY	2000: HB 268	Group with small employer exemption of 50 or less.	Mental illness and alcohol and other drug abuse.	Mandate for plans that offer benefits.	Equal if offered.
KY	2002: H 391 of '02	Small employer exemption raised to 51.			
LA	2000: La. Rev. Stat. Ann. § 22:669(1)	Group, HMO and state employee benefit plans.	Serious mental illness.	Mandated benefits.	Must be equal.
LA	1982: § 22:669(2)	Group, self-insured and state employee plans.	Mental illness.	Mandated offering.	Must be equal.
LA	1982: §22:215.5	Group.	Alcoholism and drug abuse.	Mandated offering.	Not specified.
ME	1984 ------ 1996: Me. Rev. Stat. Tit. 24 § 2325-A	Group with a small employer exemption for 20 employees or less. ------ Group with a small employer exemption for 20 or less.	Alcoholism and drug dependency. ------ Mental illness.	Mandated Benefit. ------ Full parity.	May place a maximum limit on benefits as long as they are consistent with the law. ----- Must be equal.
ME	1996: Me. Rev. Stat. tit. 24 § 2325-A(5-D)	Individual plans must offer coverage.	Mental illness.	Mandated offering.	Must be equal.
ME	2003: H 973	Group of 21 or more, including HMOs, adds substance abuse-related disorders and other illness categories.	Substance abuse, etc.	Full parity	
MD	1994: Md. Ins. Code Ann. § 15-802 (click 'code folder', then 'insurance', title 15, section 802)	Individual and group.	Mental illness, emotional disorder, drug abuse or alcohol abuse disorder.	Full parity [See co-payment exceptions]	Must be equal. Except outpatient: 80% -visits 1-5; 65% - visits 6-30; 50% visits over 30.
MD	2002: Chapter 394 of '02 (eff. 10/1/02)	Requires individual and group insurers, nonprofit health service plans, and HMOs to provide coverage for medically necessary residential crisis services.	Residential crisis services		
MA	1991 ------ 1996: Mass. Gen. Laws Ch. 175:47B	Individual, group, HMO. ------ Individual, group and HMO.	Alcoholism. ------ Mental or nervous conditions.	Mandated Benefits. ------ Mandated benefits.	Not specified. ------ Not specified.
MA	2001: *S.2036/ Ch. 80 of '00*	Individual, group and HMO. [Pro and Con testimony on costs of expansion]	Biologically-based mental illness.	Full Parity for bio -based; mandated benefits of mental illness and substance abuse.	Must be equal.

MI	1988 --- 2001: *S.1209 of '00, see §3501*	Group for Inpatient; Group and Individual for other levels. Exemption for cost increases of 3% or more. --- HMO's only, group and individual contracts, with a cost exemption of 3%.	Mental health and substance abuse --- Mental health and substance abuse	Minimum mandated benefits. --- Minimum mandated benefits.	Charges, conditions for services shall not be less favorable than the maximum for any other comparable service. --- Charges, conditions for services shall not be less favorable than the maximum for any other comparable service.
MN	1986 --- 1995; 2000: Minn. Stat. § 62A.152	Group and Individual. --- Group, individual and HMO's (full parity for HMO's).	Alcoholism, chemical dependency, or drug addiction. --- Mental health and chemical dependency.	Mandated Benefit. --- Full parity for plans that offer coverage and HMO's.	Not Specified. --- Must be equal.
MS	1975: Miss. Code Ann. § 83-9-39 to 41	Group.	Alcoholism.	Mandated benefit.	Not specified.
MS	2002: Miss. Code Ann. § 83-9-41; H667 of '01	Group and individual with an exemption if costs of implementation are 1% or more of overall costs.	Mental illness.	Mandated offering for small employers of 100 or less. Minimum mandated benefits for others.	Must be equal for inpatient and partial, however, payment for outpatient visits shall be a minimum of fifty percent (50%) of covered expenses.
MO	1997: §§ 376.825; § 376.811	Group, individual and HMO.	Mental disorders and chemical dependency.	Mandated offering.	Must be equal.
MO	2000: § 376.825 *H.191 of '99* --- *2004*	Group and individual. --- Group	Mental illness including alcohol and drug abuse. --- Mental Illness	Mandate for plans that offer benefits. --- Parity	Shall not be unreason-able in relation to the cost of services provided for mental illness. --- Must be equal.
MT	2000: Mont. Code Ann. § 33-22-706	Group and individual.	Severe mental illness.	Full parity.	Must be equal.
MT	1997; 2001 Mont. Code Ann. § 33-22-701 to 705	Group.	Mental illness alcoholism and drug addiction.	Mandated benefits.	No less favorable up to maximums.
MT	2003: H 384	12 month pilot allows exceptions for barebones policies.		Exceptions	
NE	1989 --- 2000:	Group and HMO --- Group and HMO with a small employer exemption of 15 or less.	Alcoholism --- Serious mental illness.	Mandated Offering. --- Mandate for	No less favorable generally than for physical illness. --- May be different.

	§§ 44-791 to 44-795			plans that offer coverage.	
NV	1997 ------- 2000: Nev. Rev. Stat. §§ 689A.0455; 689B.0359; 695B.1938; 695C.1738	Group, individual, and HMO. ------ Group and individual with a small employer exemption 25 or less, or cost increases of 2% or more.	Abuse of alcohol or drugs. ------- Severe mental illness.	Mandated benefits. ------- Mandated benefits.	Must be paid in the same manner. ------- Not more than 150% of out-of-pocket expenses required for medical and surgical.
NH	1993: N.H. Rev. Stat. Ann. §§ 415:18-a	Group, individual and HMO. Specifies different benefits for mental illness under major medical and non-major medical plans.	Mental or nervous conditions.	Mandated benefits.	Ratio of benefits shall be substantially the same as benefits for other illnesses.
NH	1995: § 417:E-1	Group.	Biologically- based mental illnesses	Full parity.	Must be equal.
NH	2002: H 762; Chapter 204 of 2002	Any policy of group or blanket accident or health insurance.	Parity for bio-based illnesses, mandated benefits for other MI's and substance abuse		
NJ	1985 ------ 1999: §§ 17:48-6v; 17-48A-7u; 17B:26-2.1s ------- 2000 ------ 2002	Group and individual. ------ Group and individual ------ State Employee Plans. ------ Individual Health Plans.	Alcoholism ------- Biologically based mental illness. ------- Biologically based mental illness. ------ Biologically based mental illness; alcohol and substance abuse.	Mandated benefits for care prescribed by a doctor. ------ Full parity. ------ Parity. ------ Mandated Offering.	Must be equal. ------ Must be equal. ------ Must be equal. ------ Bio based mental illness: No coinsurance but $500 copayment per inpatient stay. 30% coinsurance for outpatient stay. Alcohol and substance abuse: 30% coinsurance.
NM	1987 ----- 2000: N.M. Stat. Ann. §59A-23E-18	Group. ----- Group with different exemptions for small and large employers.	Alcoholism ----- Mental health benefits.	Mandated Offering. ----- Full parity.	Consistent with those imposed on other benefits. ----- Must be equal.
NY	1998: Ins. Law § 3221 (1)(5)(A) ---------- 2004 --------- 2006	Group. -------- Group ------- All private insurance policies. See: Timothy's Law web site, 2007.	Mental, nervous, or emotional disorders and alcoholism and substance abuse. ------- Eating Disorders -------- Mental health disorders	Mandated Offering. -------- Minimum Mandated Benefit. -------- Full parity	As deemed appropriate and are consistent with those for other benefits ------- Not Specified. ------- Must be equal. State to foot the

					bill for additional costs incurred by businesses with fewer than 50 employees; the Legislature allocated some $50 million to cover those costs
NC	1985 --- 1991 HB 279 --- 1997: N.C. Gen. Stat. § 58-51-55 --- 2007	Group --- State Employees Health Plan. --- State Employees Health Plan --- Health Insurers	Chemical Dependency. --- Mental Illness --- Mental illness and chemical dependency. --- Mental Illness	Mandated Offering. --- Parity --- Full parity. --- Parity	$8,000 per year and $16,000 per lifetime. --- Must be equal --- Must be equal. --- Must be equal.
ND	1995: N.D. Cent. Code § 26.1-36-09 *[page 431]*	Group and HMO.	Mental disorders, alcoholism and drug addiction.	Mandated benefits.	No deductible or copay for first 5 hours not to exceed 20% for remaining hours.
ND	2003: H 2210	Adds that inpatient treatment and partial hospitalization, or alternative treatment must be provided by an addiction treatment program licensed under chapter 50-31.	Substance abuse	Clarification	
OH	2006: SB 116 --- 1985: Ohio Rev. Code Ann.§ 3923.30	Law signed 12/29/06; effective --- Group and self-insured.	7 "biologically based mental illnesses," such as schizophrenia and bipolar disorder --- Mental or nervous disorders and alcoholism.	Full Parity --- Mandate for plans that offer mental health coverage. Mandated benefits for alcoholism.	--- Subject to reasonable deductibles and coinsurance.
OK	2000: Okla. Stat. tit. 36 §6060.11 to §6060.12 (SB 2, 1999)	Group with a small employer exemption 50 or less, or cost increase of 2% or more.	Severe mental illness.	Full parity.	Must be equal.
OR	1981 --- 2000: Or. Rev. Stat § 743.556 --- 2005: SB 913	Individual --- Group and HMO. --- Group.	Alcoholism --- Mental or nervous conditions including alcoholism and chemical dependency. --- Mental, nervous conditions including alcoholism and chemical dependency.	Mandated Offering. --- Mandated benefits. --- 2007: Full parity NEW	Coverage must be no less than 80% of total. --- Shall be no greater than those for other illnesses. ---
PA	1989	Group and HMO.	Alcoholism or drug addiction.	Mandated benefits.	For the first course of treatment shall be no greater

	------ 1999 H.366 of 1998. (see § 634)	------ Group and HMO-small employer exemption 50 or less.	------ Serious mental illness.	------ Mandated benefits.	than those for other illnesses. ------ Must not prohibit access to care.
RI	1995 ----- 1995 R.I. Gen. Laws § 27-38-2.1	Individual, group, self-insured and HMO. ----- Individual, group, self-insured and HMO. *(in effect through 12/31/2001)*	Substance dependency and abuse. ------ Serious mental illness.	Mandated benefits. ------ Full parity.	Not Specified. ----- Must be equal.
RI	1/1/2002 H.5478/ S.832 of 2001	Expands the state mental health parity law to include coverage for all mental illnesses and substance abuse disorders. *(replaces § 27-38.2-1 above)*	All mental illnesses & substance abuse disorders.	Full parity	Must be equal
SC	1994 S.C. Code Ann. § 38-71-737	Group.	Psychiatric conditions, including substance abuse.	Mandated offering.	May be different.
SC	2000 SB 1041 (repealed Jan 1, 2005) ------ 2005 SB 49	State employee insurance plan with cost increase exemptions. ------ Health Plan Insurers. Individual and small group policies are exempt.	Mental health condition or alcohol or substance abuse. ------ Psychiatric illnesses as defined by DSM-IV published by the APA.	Full parity. ------ Parity.	Must be equal. ------ Must be equal.
SD	1979 ------ 1998 § 58-17-98 (HB 1262, 1998) ------ 1999 HB 1264 ------ 2003 HB 1236	Group, individual and HMO. ------ Group, individual and HMO. ------ Group, individual and HMO. ------ Group, individual and HMO.	Alcoholism. ------- Biologically- based mental illness. ------- Clarifies biologically based mental illness as: schizophrenia, other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder. ------- Offers exclusion of coverage for specified mental illness.	Mandated Offering. ------- Full parity. ------- Parity ------- n/a	Must be equal. ------- Must be equal. ------ Must be equal. ------ n/a
TN	1982 ------ 2000 § 56-7-2360; § 56-7-2601	Groups with exemptions for employers with 50 or fewer employees or it plan results in cost increases of 1% or more. ------ Group with a small employer exemption 25 or less, or cost increase of 1% or more.	Alcohol and Drug Dependency. ------ Mental or nervous conditions.	Mandated Offering. ------ Mandated benefits.	Must be equal. ------ Must be equal.
TX	1981 ------ 1991	Group and self-insured with an exemption for self-insured plans of 250 or less. ----- State employee plans.	Chemical Dependency. ------	Mandated Benefit. ------ Full parity.	Must be sufficient to provide appropriate care. ------ Must be equal.

			Biologically-based mental illness.		
TX	1997 Ins. art. 3.51-14	Group and HMO, with a small employer exemption of 50 or less.	Serious mental illness.	Mandated benefits with a mandated offering for small groups of 50 or less.	Must be equal.
TX	2003: SB 541	Allows insurers and HMOs to offer policies without mandates for the treatment of mental illness and chemical dependency, with an exception for serious mental illnesses.		Exceptions	
UT	2001 Utah Code Ann. 31A-22-625 (HB 35, 2000)	Group (as of 7/1/01) and HMO's (as of 1/1/01)	Mental illness as defined by the DSM.	Mandated offering.	May include a restriction.
VT	1997 Vt. Stat. Ann. tit. 8 §4089b (HB 57, 1997) ------- 2006 HB 40.	Group and individual. ------- Amends the 1998 statute to add an "any willing provider" amendment. The law prohibits an insurer from excluding from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer.	Mental health condition including alcohol and substance abuse. --------	Full parity. --------	Must be equal. --------
VA	2000 thru 7/1/2004 & indefinitely. Va. Code. § 38.2-3412.1	Group and individual with a small group exemption 25 or less. (Note: Extended without sunset date by S 44, see below)	Biologically-based mental illness including drug and alcohol addiction.	Full parity.	Must be equal to achieve the same outcome as treatment for any other illness.
VA	Effective 7/1/2004. § 38.2-3412.1	Group, individual and HMO. (See 2004 change, below)	Mental health and substance abuse.	Mandated benefits.	Co-insurance for outpatient can be no more than 50% after 5th visit. All others must be equal.
VA	S 44 of '04	Repeals sunset date of 7/1/04, above. (enacted 3/19/04)	Mental health and substance abuse.		
VA	S 212 of '04 *§§ 37.1-255*	Establishes Inspector General for Mental Health	Mental health & substance abuse		
WA	1987 Wash. Rev. Code § 48.21.241 -------- 2005 HB 1154 (effective 2006-10) --------

	2006 HB 2501	coverage applies to all group health plans for groups other than small groups as defined in existing state law. Provides that the copayment or coinsurance for mental health services be no more than the co-payment or coinsurance for medical and surgical services otherwise provided under the health benefit plan.	allowed if deemed medically necessary. ------- Requires prescription drugs to treat mental illness be covered as are other prescription drugs.		
WV	1998 § 33-16-3a	Group and individual with a cost increase exemption of 1%.	Mental or nervous conditions.	Mandated offering.	Not specified.
WV	2002 HB 4039 ------ 2004 HB 4286	Insurance plans and HMOs. Law allows insurer to apply "whatever cost containment measures may be necessary" to maintain costs below 2% of the total costs for the plan. ------- Repeals a section in previous statute relating to coverage for alcohol dependency since it is superseded by a section that explicitly mentions substance abuse treatment.	Serious Mental Illness as defined in the APA DSM. ---------	Full parity ----------	Not specified. ---------
WI	Wis. Stat. § 632.89 ------ 2004 SB 71	Group (with "at least specified minimum benefits in every group contract") ------ Group Insurance	Mental or nervous disorders ------ Exempts prescription drugs and diagnostic tests from minimum coverage limits.	Mandated offering ----- Mandated Offering.	Comparable deductibles and copays ------ Not specified.
D.C.	D.C. Code §31-3102			Mandated mental health coverage; specified minimum benefits	

NOTES for state mental health statute table:
A) The *Diagnostic and Statistics Manual of the American Psychiatric Association* (DSM) includes universally accepted definitions and descriptions of mental illnesses and conditions. There are 13 DSM diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. Between 3 and 13 of these diagnoses are referred to in various state parity laws. For example, in Alabama, mental illness is defined as: 1) schizophrenia, schizophrenia form disorder, schizo-affective disorder; 2) bipolar disorder; 3) panic disorder; 4) obsessive-compulsive disorder; 5) major depressive disorder; 6) anxiety disorders; 7) mood disorders; 8) Any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised.

B) **NAIC Mental Illness Treatment tally.** The National Association of Insurance Commissioners lists 46 states with mandated requirements, not mentioning AK, AZ, MI and WY, as of February 2008.

C) Examples of "Barebones" exception laws:

Colorado H 1164
Texas S 541 of 2003
Montana H 384of 2003

of 2003 allows small employers to purchase a basic health benefit plan that does not include mental health and substance abuse treatment mandates. allows insurers and HMOs to offer policies without mandates for the treatment of mental illness and chemical dependency, with an exception for serious mental illnesses if the plan is issued to a large employer. An insurer that offers such policy must also offer at least one policy with state-mandated health benefits. allows for a 12-month demonstration project that in some cases, permits a limited coverage plan or managed care plan without mandates for mental illness

Federal Parity Amendment
In 1996 a federal parity amendment was signed into law as part of the VA-HUD appropriations bill. The law, otherwise

known as the Mental Health Parity Act of 1996 (Public Law 104-204, see text online), prohibits group health plans that offer mental health benefits from imposing more restrictive annual or lifetime limits on spending for mental illness than are imposed on coverage of physical illnesses. This law expired on September 30, 2001 due to a "sunset" provision, but was extended through December 31, 2002 when President Bush signed Public Law 107-116. The Mental Health Parity Act of 1996 offers limited parity for the treatment of mental health disorders. The statute does not require insurers to offer mental health benefits, but states that if mental health coverage is offered, the benefits must be equal to the annual or lifetime limits offered for physical health care. It also does not apply to substance use disorders, and businesses with fewer than 26 employees are exempt..

On October 30, 2001 the U.S. Senate passed a broader parity bill, which was sent to the House. On December 18, in a House-Senate negotiating meeting, the House members rejected the Senate bill by a 10n-7y vote. The *New York Times* reported that sponsors Senators Domenici and Wellstone "said they wanted to requires health plans and insurance companies to provide equivalent coverage, or parity for mental and physical illness. House Republicans, employers and insurance companies objected to the proposal, saying it would increase costs for employers in a recession, when many businesses are already cutting health benefits because of a resurgence in medical inflation."[6]

9-11: Terrorism Impacts on Mental Health

The events of September 11, 2001 and related bio-terrorism scares had a profound effect on Americans in every part of the United States. In 2003, the war with Iraq brought the potential for new psychological and mental health concerns, according to the American Psychological Association. Yet the issues raised have been a part of health policy for more than two decades.

The nation, through the actions of federal, state and local governments, and citizens in innumerable roles, united and moved forward. However, the medical traumatic effects of those events impacted many people, for months or even years. *USA Today* reported it this way: "The terrorist strikes and their devastating aftermath are triggering the largest mental health challenge ever faced by employers and straining the USA's army of grief counselors, not just at the attack sites but in workplaces across the country. The emotional fallout was expected to be so widespread that some health insurers are loosening restrictions on employees' use of mental health services." [1] The impact could be far larger than the numbers directly affected. For example, just in Arlington County, Virginia, "some 20,000 to 40,000 of the county's 200,000 residents could experience a traumatic stress reaction from the attacks, officials estimate, pointing to an earlier Surgeon General's report on mental health and disasters." [2]

Mental Health Benefits and Hurricane Katrina Victims

The widespread harm inflicted by Hurricane Katrina includes health impacts and longer-term mental and emotional harm. People who are displaced, injured, have lost loved ones, homes, property, belongings, jobs, family stability, pets, and those with friends, relatives or coworkers affected, may need or seek counseling and medical help. Some, but not all, of the varying state health insurance mandate laws may require coverage of either emergency or longer-term mental health services.

The list below is a general survey of these laws. It provides a quick comparison among states, but it is not intended as a consumer guide to services, since coverage varies even further based on employer and individual contracts, including services offered above or beyond the minimum required by state law. Also public programs including Medicaid, Medicare, local health departments have separate standards of coverage - sometimes more extensive -- than private market health policies.

Expert Sources and Reports

1. U.S. General Accounting Office, *"Mental Health Parity Act: Despite Federal Standards, Mental Health Benefits Remain Limited"* GAO/HEHS-00-95 (Washington, D.C., May 2000) [includes state charts]
2. U.S. General Accounting Office, "*Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS-96-161 (Washington, D.C: August 1996).
3. U.S. Department of Health and Human Services, Public Health Service, "The Costs and Effects of Parity for Mental Health" (Merrille Sing, Mathematica, 2001)
4. National Center for Policy Analysis, *An Easy Way to Make Health Insurance More Expensive,* February 21, 1997. (Obtained from http://www.ncpa.org/pub/ba/pdf/ba224.pdf; Internet.)
5. Gail A. Jensen and Dr. Michael A. Morrisey, *Mandated Benefit Laws and Employer- Sponsored Health Insurance,* (Health Insurance Association of America: January 1999).
6. "*Drive for More Mental Health Coverage Fails in Congress*", New York Times, December 18, 2001.

For related news stories and resources see:

"Hurricane Katrina Survivors Lack Access to Mental Health Services" The majority of Hurricane Katrina survivors who developed mental disorders after the disaster are not receiving the mental health services they need, and many who were receiving mental health care prior to the hurricane were not able to continue with treatment, according to an NIMH-funded study published online in the American Journal of Psychiatry. National Institutes of Health (NIH) 12/17/07.

"TWO MORE STATES ENACT PARITY LAWS," State Health Notes, 1/22/07

Resilience in the Time of War - articles by American Psychological Association (APA) including tips for assisting children and adults. - March 2003.

Communities Gear Up for Long-Term Effects of Disaster - Health Intelligence Network- October 8, 2001 [2]

Psychiatric Dimensions of Disaster a resource list by The American Psychiatric Association, Sept. 2001

Resources for Responding to Trauma and Terrorism - web page by the National Assoc. Mental Illness

Disaster Mental Health: Dealing with the Aftereffects of Terrorism - resources from the National Center for Post Traumatic Stress Disorder (PTSD)

What are the Traumatic Stress Effects of Terrorism? - fact sheet from NCPTSD, September 2001

Recommendations for Pharmaceutical Treatment of Acute Stress Reactions - Sept. 26. 2001

HHS Makes $35 M in Emergency Funds Available to Entities that Suffered Losses from September Attacks - competitive grants for public and not-for-profit health entities. These grants target NY, CT, NJ, VA, PA and D.C. - news release October 9, 2001

Nation in shock seeks counseling, consoling - USA Today, September 20, 2001 [1]

Public Health Preparedness - web updates from CDC, August 2002

Mental Health menu page - NCSL resources, updated regularly, 2004

Mental Health Parity: A State Lawmaker's Digest, NCSL, 2001

Authors: Richard Cauchi, Program Director & Andrew Thangasamy, staff researcher, NCSL Health Program, Denver.

NCSL Health Home Page

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

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

©2011 National Conference of State Legislatures. All Rights Reserved.

NFIB

The Voice of Small Business®

ALASKA

SB 52

February 28, 2011

The Honorable Bettye Davis
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 52

Dear Senator Davis,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 52. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, SB 52 mandates specified coverage of mental health, alcoholism and substance abuse that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices

to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

Estimates from the *Health Insurance Mandates in the States 2010* by the Council for Affordable Health Insurance, suggest that this mandate will increase premium by 5% t0 10%. With such a premium increase, clearly many small businesses will be forced to drop health insurance coverage for their employees.

SB 52 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

SB

55

<TARGET><BILL>SB 55</BILL><SUBJECT>SB
55</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SB 55 -"An Act relating to a mental health patient rights, notifications, and grievance procedures."

SPONSOR STATEMENT

SB 55 amends the one-paragraph mental health grievance procedure provided under AS 47.30.847. This bill governs due process and grievance procedures in all state and private mental health hospitals, clinics, and units which receive public funds. Prompted by the 8,000-10,000 admissions to mental health facilities and units in Alaska each year where there are relatively few formal grievances filed, this bill requires adequate notice, forms, advocate assistance, rapid written administrative response, right to appeal, and telephonic access to a state monitored call center to lodge a complaint immediately.

Mental health patients are among the most vulnerable in Alaska. Among the thousands of individuals civilly committed or brought into locked hospital psychiatric units for forced evaluations each year, some are in handcuffs, shackles or strapped to a gurney, involuntarily medicated without consent of family or legal representative, or court ordered to receive or continue psychiatric treatment in public, private, or non-profit psychiatric clinics. There are hundreds of patient assaults and staff injuries each year. There are also thousands of children who are voluntarily committed each year usually in private facilities. Although sometimes treated with psychotropic drugs, children are considered better protected by the state, family members, legal representatives, and attorney advocates.

Current statutes and regulations do little to protect psychiatric patients civilly committed 30 to 60 days, individuals detained for forced evaluation up to 7 days, or individuals detained in a jail or in a psychiatric emergency room or private unit while waiting for space in a psychiatric hospital. State and federal courts have consistently ruled that individuals who have not committed a crime and are locked up for psychiatric evaluation and treatment should not be treated like criminals and their rights are to remain intact to the greatest extent possible. Ironically, prisoners in Alaska's correctional system are afforded a much more comprehensive grievance procedure with due process rights and protections under the law than mental health patients.

Upon admission to a mental health facility patients often experience an immediate loss of liberty and freedom, arbitrary exercise of authority, and may be institutionally traumatized in the process. Because of the exceptional circumstances under which mental health patients are admitted and treated, due process requires special safeguards in transparent, readily available grievance procedures and more state oversight. This bill will reduce unnecessary patient trauma, assaults, unintentional injury or death, and attendant liability and litigation experienced in other states before statutory reform.

New grievance procedures under SB 5 require detailed complaint forms, three levels of administrative review requiring written answers by within 5 days by supervisory and executive staff at levels one and two, including response to urgent grievances within 24 hours. A level three final administrative appeal to the commissioner must be answered within 14 days after filing or by default is denied. A commissioner's final decision may be appealed to Superior Court within 30 days. A grievance may be filed at any time, but there is a statutory limitation of one year after being discharged from the facility or unit. All grievances filed shall become part of the patient's permanent record. Mental health facilities and units must file periodic reports of the number and type of grievances and resolutions, including litigation. The bill allows for a personal representative to act in the interest of the patient in the grievance process, as well as providing a patient advocate appointed in the mental health facility or unit.

Although it is counterintuitive that more verbal and written complaints are not reported to the state or documented each year, including an estimated 250 at the Alaska Psychiatric Institute which may treat an estimated 1200 to 1500 patients per year, many facilities in this rapidly growing area of mental health are privately held and not presently compelled to report to the state Division of Behavioral Health. Private hospitals presently may only report mental health complaints to the Joint Commission for the Accreditation of Hospital Organizations (JCAHO), not the state. Furthermore, JCAHO reportedly may only review grievance procedures in participating hospitals every 2-3 years. Also, many grievances in the past have been handled verbally without creating a patient record and in-patient stays are often very short from a couple of days up to a week or two. Passage of SB 55 will improve mental health treatment, grievance reporting, and state oversight.

27-LS0082\T
Mischel
12/8/11

CS FOR SENATE BILL NO. 55( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to mental health patient rights, notifications, and grievance procedures."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.30.840(a) is amended to read:

(a) A person undergoing evaluation or treatment under AS 47.30.660 - 47.30.915

(1) may not be photographed without the person's consent and that of the person's guardian if a minor, except that the person may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or the patient's designee unless a court orders otherwise;

(2) at the time of admission to an evaluation or treatment facility, shall have reasonable precautions taken by the staff to inventory and safeguard the patient's personal property; a copy of the inventory signed by the staff member making it shall

be given to the patient and made available to the patient's attorney and any other person authorized by the patient to inspect the document;

(3) shall have access to an individual storage space for the patient's private use while undergoing evaluation or treatment;

(4) shall be permitted to wear personal clothing, to keep and use personal possessions including toilet articles if they are not considered unsafe for the patient or other patients who might have access to them, and to keep and be allowed to spend a reasonable sum of the patient's own money for the patient's needs and comfort;

(5) shall be allowed to have visitors at reasonable times;

(6) shall have ready access to letter writing materials, including stamps, and have the right to send and receive unopened mail;

(7) shall have reasonable access to a telephone, both to make and receive confidential calls;

(8) has the right to be free of corporal punishment;

(9) has the right to reasonable opportunity for indoor and outdoor exercise and recreation;

(10) has the right, at any time, to have a telephone conversation with or be visited by an attorney;

(11) may not be retaliated against or subjected to any adverse change of conditions or treatment solely because of assertion of rights under this section;

(12) has the right to be treated with dignity and respect;

(13) has the right to confidentiality of and access to the person's evaluation and treatment records maintained by the facility;

(14) has the right to an individualized treatment plan, and the right to be involved in developing the treatment plan, while residing at the facility;

(15) has the right to informed consent by the person or the person's legal representative;

(16) has the right to freedom from seclusion and restraint;

(17) has the right to file a grievance under AS 47.30.847;

(18) has the right to a designated staff member clearly identified by a treatment facility to act as a patient advocate and to assist in the filing of a grievance under AS 47.30.847;

(19) has the right to consult with a patient advocate or representative of the patient's choosing.

* **Sec. 2.** AS 47.30.847 is repealed and reenacted to read:

Sec. 47.30.847. Patient grievance procedure. (a) A person undergoing evaluation or treatment at a public or private evaluation facility or unit or designated treatment facility or unit under AS 47.30.660 - 47.30.915 has the right to bring a grievance concerning the patient's treatment, care, or rights.

(b) The department shall establish one or more impartial call centers for the purpose of receiving, referring, and tracking grievances filed under this section. The call center shall maintain an electronic database and hard copies of all grievances filed under this section. The call center shall be made available to a grievant at no charge and at all times and shall process a grievance immediately as provided in this section. The call center shall assist a grievant in filing a grievance and shall provide procedural information but may not advise a grievant.

(c) A facility or unit shall provide a formal grievance procedure, which must include referral to a call center established under (b) of this section, for all patient grievances on any subject brought under (a) of this section, regardless of the availability of a less formal procedure for comments and suggestions. Once filed to the best of the grievant's knowledge and ability, all grievances shall be processed on a single form. The grievance procedure must include

(1) written notice on admission to the facility of the availability of the formal grievance procedure and facility rules pertaining to the grievance procedure;

(2) a form for submission of a grievance, access to a call center, and a secure box for deposit of grievance reporting forms; the contents of the box must be reviewed each day patients are being treated or evaluated; the form must be readily accessible to the patient and understood by the patient or easily explained by a staff member in a language and method understandable to the patient; the original of a completed form submitted to the facility must be kept in the patient's record; the form

must contain the heading "Alaska Department of Health and Social Services, Mental Health Grievance Reporting Form," and include

(A) the name of the grievant and the grievant's contact information, including the grievant's address and telephone number;

(B) the date and time of the completion of the grievance form;

(C) the name and physical location of the service provider;

(D) the date on which the event giving rise to the grievance took place;

(E) the names of persons involved in the event giving rise to the grievance, if known;

(F) a narrative description of the event giving rise to the grievance;

(G) the specific issue to be addressed;

(H) the grievant's suggested resolution of the grievance;

(I) the investigative steps taken to formulate the facility's or unit's response;

(J) the response and date of response by the facility or unit;

(K) the signature of the grievant at each level, including the initial grievance;

(L) the signature of the reviewer and date of review for each level of review; and

(M) options for the grievant to check following each response by the facility or unit, as follows:

(i) I agree;

(ii) I do not agree;

(iii) submit to level two review;

(iv) submit to level three review;

(3) a written list showing contact information for available advocacy agencies, including the department, facility accrediting bodies, the ombudsman, and the Disability Law Center of Alaska;

(4) three levels of review, as follows:

(A) level one, an initial review and written decision by a supervisory staff member to determine whether a grievant's treatment, care, or rights have been adversely affected, a written record of that determination, and, if the grievant's rights have been aversely affected, implementation of a mutually agreed upon resolution of the grievance;

(B) level two, if a resolution is not agreed upon or implemented under a level one review, a grievant may initiate a review within 20 calendar days after the determination is made under level one; a chief executive officer or the commissioner's designee for a facility shall make written findings and issue a decision within five business days after initiation of a level two review; if the level two review results in a finding of no adverse effect, no additional review is necessary, but the decision may be appealed under (C) of this paragraph by a grievant, and the written decision must include notice of the availability of a level three appeal;

(C) level three, a grievant may appeal the final written decision made under level two to the commissioner within 30 calendar days after receipt of the findings of the level two review; the commissioner shall make a final written decision on or before the 14th calendar day after the appeal is filed; if the commissioner fails to enter a timely decision, the appeal shall be considered denied; the commissioner may deny an appeal for substantial failure to follow the procedures set out in this section; a denial or decision by the commissioner may be appealed to the superior court within 30 calendar days;

(5) maintenance of a complete and confidential record, available on request by the grievant or the grievant's designated representative, of all documents, including the grievance and appeals and responses to the grievance and appeals;

(6) delivery, within 24 hours, of a copy of the initial grievance and of all documents maintained under (5) of this subsection to the call center established under (b) of this section, which shall promptly provide all necessary information to

(A) the grievant or the grievant's representative;

(B) the department; the department shall maintain

confidentiality over the grievant's health and personal information;

(C) the person responsible for the next level of review; and

(D) the person in charge of the facility or unit; and

(7) in addition to the three levels of review and procedures available under criminal and other laws provided under (4) of this subsection, an urgent level of review and expedited decision, available at all times to a current patient of a facility or unit, to be conducted immediately by the chief executive officer at the facility and referred to a call center and reviewed by the department not later than 24 hours after receipt of a grievance that alleges

(A) sexual abuse;

(B) physical abuse; or

(C) denial of

(i) lifesaving treatment or procedures;

(ii) lifesaving medications; or

(iii) basic care or human rights, as defined by the commissioner.

(d) Except as provided in (c)(7) of this section, unless an extension of time of not more than five business days is agreed upon by a patient or the patient's representative, an evaluation facility or unit or a designated treatment facility or unit shall mail or hand deliver a written response to a call center within five business days after receipt of a grievance or request for additional review. The response must include the reasons for the decision and a description of the appeal process. The grievant may request review at the next level if a written response is not timely.

(e) An evaluation facility or unit and a designated treatment facility or unit shall have a designated staff member who is trained in mental health consumer advocacy who shall, on a patient's request, serve as an advocate to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights.

(f) A grievant may not file a grievance later than one year after the incident giving rise to the grievance. The facility or unit shall make a good faith effort to mail a response to a grievant who has been discharged from the facility.

(g) The burden of proof required for all grievance reviews shall be on the facility or unit against which a grievance is filed to prove, by substantial evidence, compliance or remedial action with applicable laws and procedures.

(h) The department shall review all grievances and responses to grievances for compliance with this section.

(i) A facility or unit shall prepare and file a quarterly report with the department that describes the

(1) number of grievances submitted;

(2) general issue raised in each grievance; and

(3) resolution, including litigation, of all grievances submitted.

(j) The department shall compile the information provided under (i) of this section and provide a quarterly report to be posted for public review that describes the number and types of grievances filed against each facility in the previous quarter.

(k) Nothing in this section shall be interpreted to prohibit informal dispute resolution or mediation by the written agreement of the grievant, the facility or unit, and the department at any time during the grievance process but before a lawsuit concerning the subject of the grievance is filed by a grievant.

(*l*) A facility may not discourage or delay a patient's access to an advocate or representative of the patient's choosing.

(m) In this section,

(1) "facility" has the meaning given to "designated treatment facility" or "evaluation facility" in AS 47.30.915; and means a unit of a hospital in which patients receive mental health evaluation or treatment and for which public funds are provided;

(2) "grievance" means a complaint made by a grievant concerning a patient's treatment, care, or rights at a facility;

(3) "grievant" means a patient of a public or private mental health treatment or evaluation facility or unit or the patient's representative;

(4) "unit" means a discrete portion of a facility dedicated to the treatment or evaluation of mental health patients.

* **Sec. 3.** AS 47.30.855 is amended by adding new subsections to read:

(b) The department shall provide to a facility for posting and distribution a standardized notice that is designed to be easily understood and that separately describes patient rights, available assistance, and the grievance procedure provided under AS 47.30.847.

(c) A person in charge of a facility shall ensure that each patient or patient's representative receives a written copy of the standardized notice provided by the department under (b) of this section and of the formal grievance procedure described in AS 47.30.847(c).

(d) In this section, "facility" has the meaning given in AS 47.30.847.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 11, 2012

SUBJECT: Sectional Summary for CSSB 55( )
(Work Order No. 27-LS0082\T)

TO: Senator Bettye Davis
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds eight rights to the list of rights of a person undergoing mental health evaluation or treatment in the state under specified provisions of state law, including involuntary commitments. The additional rights include the right to be treated with dignity and respect and the right to file a grievance under the procedures established by sec. 2 of the bill.

Section 2. Establishes a grievance procedure, including varying levels of review and appeal, for a person undergoing evaluation or treatment at a public or private evaluation facility or unit or at a designated treatment facility or unit. Defines "grievance" to mean a complaint concerning a patient's treatment, care, or rights at a mental health evaluation or treatment facility or unit in the state.

Section 3. Requires the Department of Health and Social Services to provide to mental health evaluation and treatment facilities and units in the state a standardized notice of patient rights, assistance, and grievance procedures. Also requires the person in charge of the facility or unit to provide a written copy of the notice to each patient or their representative.

JMM:ljw
12-120.ljw

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version: **SB055**
Fiscal Note Number:
Publish Date:

Identifier (file name): SB055-DOA-OAH-12-1-11
Title: Mental health patient rights and grievance
Sponsor: Senator Davis
Requester: Senate Health and Social Services

Dept. Affected: Administration
Appropriation: Centralized Administrative Services
Allocation: Office of Administrative Hearings
OMB Component Number: 2771

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1007	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Terry L. Thurbon, Chief Administrative Law Judge — Phone: 465-1886
Division: Office of Administrative Hearings — Date/Time: 12/01/2011 3:59 p.m.
Approved by: John Cramer, Deputy Commissioner — Date: 12/1/2011
Department of Administration

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2 LEGISLATIVE SESSION

BILL NO. SB055

Analysis

This bill would provide mental health patients with a grievance process concerning patient treatment, care or rights. The process would include a right to an administrative appeal heard on behalf of the Commissioner of Health and Social Services by the Office of Administrative Hearings (OAH). OAH does not anticipate that addition of this licensure category would increase the office's caseload beyond OAH's capacity to provide the hearing-related services with existing authorized personnel. The cost to OAH of performing the services would be recovered from the Department of Health and Social Services through interagency receipts, based on the time commitment required for the necessary proceedings.

Senator Bettye Davis **February 7, 2012**
Chair—Hess Committee

Re: Senate Hess Committee—Sen. Bill 55 needs to pass

Approximately 1000 complaints are filed verbally or in writing by psychiatric patients each year in Alaska. The current state rules do very little to protect these patients.

Over the last 50 years state and Federal courts have consistently ruled that any individuals who have not committed a crime and are locked up for psychiatric treatment cannot be treated like a criminal and their rights are to remain intact to the greatest extent possible.

As a state we are failing miserably. We give psychiatric patients a right by law to file a complaint but we don't give the right to due process or the right to file an appeal within the psychiatric facilities or to a state agency or an agency authorized by the state; Alaska may be the only state that does not protect psychiatric patients in that respect.

Most psychiatric patients need the protection a state can give, specifically psychiatric patients civilly committed 30 or 60 days, individuals detained for forced evaluation up to 7 days, individuals detained in a jail or in a Psychiatric Emergency Room while waiting for space in a psychiatric hospital.

As a state we don't keep readily available statistics of the number of complaints filed by psychiatric patients. We don't give patients a state office they can file an appeal to with due process, etc. On the other hand, individuals in prison are given all of those rights.

As a state we should be embarrassed for not protecting psychiatric patients in the grievance appeal process as numerous courts have suggested—Maine, Georgia, etc. We can fix that by giving Sen. Bill a hearing and passing the bill.

Cc: Senate HESS Committee
Co-Sponsor Sen.Bill Wielechowski
Co-Sponsor Sen. Johnny Ellis
David Fleurant
Open Letter

Mental Health Advocates
Faith Myers / Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508
(907) 929-0532

Faith Myers
Dorrance Collins

Reference Information

Senate Bill 55

Approximately 250 complaints are filed by patients at state-run Alaska Psychiatric Institute each year according to public records. That is from a patient population of approximately 1,200 per year.

The other hospitals that do forced evaluations and civil commitments do not make their numbers of psychiatric patient complaints available to the general public and those statistics are not kept separately by the state.

Providence Hospital and its satellites treat approximately 3000 psychiatric patients per year. A large number are forced evaluations—they may arrive in handcuffs, they are detained, etc.

North Star treats approximately 4,000 patients per year, some of them in locked facilities.

Fairbanks and Juneau hospitals do forced evaluations and civil commitments—combined, approximately 800 per year.

Numerous other hospitals do forced evaluations—Ketchikan and Kodiak, Also, patients are detained in jails, Psych ER's waiting for transfer, etc.

Psychiatric patients are court ordered to continue psychiatric treatment in private clinics through Mental Health Diversionary Court, etc.

Estimated number of complaints—1,000. Subject matter, anything from sexual assault, denial of rights to going outdoors, medication errors, mistreatment, physical assault, denied medical treatment, conflicts with staff, inability to file a complaint or an appeal in a fair way, etc.

<u>Psychiatric patients are complaining about the grievance appeal process.</u>

Faith Myers / Dorrance Collins
(907) 929-0532
faith.myers@gci.net

Letter to the Editor or Comment Piece **1/28/2012**

In January it was reported that the State Senate held a "Crime Summit." The Committee goal: identify issues and offer solutions.

Conspicuously absent from the Senate Committee's review was a serious, in-depth assessment of individuals with a severe mental illness who commit crimes or have crimes committed against them and how the state can make improvements.

Ninety percent of females with a mental illness who live on the street (shelters, tents, etc.) will or have at some point become a victim of sexual assault which will in itself damage the individual and will also hinder or prevent recovery from the underlying mental illness.

Men and women with a severe mental illness commit crimes or become victims in higher numbers than the average public. The costs of transportation and one day in a Psych ER can be upwards of a thousand dollars.

Approximately 10,000 individuals in Alaska because of a mental illness will come in contact with law enforcement or a locked psychiatric facility in the next 12 months. Many will be forcibly transported to Psych ER's in handcuffs for forced evaluations, civil commitment or diversionary mental health court.

When a state improves psychiatric patient rights it translates to better care and better recovery. In our opinion, Alaska as a young state has some of the worst patient rights and government oversight of psychiatric patient rights and care in the nation.

Psychiatric patient rights in Alaska need to be improved. If we had the opportunity that is the message we would convey to the state Senate "Crime Summit" Committee.

Faith Myers
Dorrance Collins

Mental Health Advocates,
Faith Myers / Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508
(907) 929-0532
faith.myers@gci.net

1/20/2012

Give / Send to:

Sen. Bettye Davis,
Attn: Tom Obermeyer,

Please give Sen. Bill 55 a hearing in the HESS Committee this year.

Detained psychiatric patients have a right to file a grievance, but as of now do not have a right to file an appeal by law, state regulations or JCAHO rules. (Alaska may be the only state that does not give that right to detained psychiatric patients.)

Detained psychiatric patients must be given a state right to file an appeal with due process within a psychiatric facility or unit and to the state.

Thank you,

Faith Myers
Dorrance Collins

Mental Health Advocates, Faith Myers / Dorrance Collins,
3240 Penland Pkwy, Sp.35, Anchorage, AK. 99508 (907) 929-0532

Senator Hollis French, **January 13, 2012**

We read your letter 1/13/2012 in the Anchorage Daily News. The questions you raise have a large scope—We would like to add a small piece to the puzzle. Writing new laws is important, but just as important "society must change how it deals with individuals who need help."

One Society needs to change how money, support and spare time is given to any individual with a drug or alcohol problem, i.e.—payee, oversight, work or school program, etc.

Two A large number of individuals in prison have a severe mental illness. The assessment is they cannot receive proper treatment that promotes recovery in a prison setting. Detained individuals should be given at least a small amount of time in a forensic unit in a psychiatric hospital so they have a better chance for recovery. Forty years ago, state-run Alaska Psychiatric Institute (API) had a 10 bed forensic unit. API still has a 10 bed forensic unit in 2012.

Three Thousands of individuals who have not broken any laws are transported to locked psychiatric units each year for forced evaluation or commitment, many in handcuffs. Too often, individuals who may not have broken any laws are treated like criminals, both when they are transported to a psychiatric unit, or when they are in a psychiatric unit. When society treats an honest person like a criminal, sometimes they become a criminal.

Four Too often individuals with psychiatric disorders who may not have broken any laws are held in jails and hospital ER's while waiting for space at state-run API. Disability Law Center filed a law suit against DHSS concerning that issue.

Five Almost without exception, when society improves the quality of psychiatric patient rights, the quality of patient care improves and the opportunity for recovery. Sen. Bill 55 when passed will improve the psychiatric patient grievance procedures and needs to be supported and passed by the Senators.

We would be willing to testify telephonically to your committee on these issues.

Mental Health Advocates,
Faith Myers / Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

(907) 929-0532
faith.myers@gci.net

Faith Myers
Dorrance Collins

Cc: Open Letter

Testimony to the HESS Committee **January 1, 2012**

Chairperson, Committee members,

My name is Faith Myers. I volunteer as a psychiatric patient advocate. I support the passage of Senate Bill 55.

Psychiatric patients are complaining about the current grievance procedure laws. In 2009 I performed a survey of 30 former psychiatric patients. In 2011, Disability Law Center produced a 9-page report which showed 3 patients at state-run Alaska Psychiatric Institute (API) were unsatisfied with the grievance procedure process. Also, I have personally reviewed the grievance procedures from numerous hospitals with psychiatric units from Fairbanks, to Juneau, to Kodiak. The reviewed grievance procedures are inadequate to protect an individual detained in a psychiatric unit.

In 2003, I spent 4 months in Alaska Psychiatric Institute (API) which is run by the Department of Health and Social Services (DHSS). I was never allowed to file a grievance. A grievance must be answered in writing. I never could receive a written response to my complaints or file an appeal.

In 2006 as an advocate I received records from API which showed no patient in the middle of 2005/2006 was allowed to file a grievance and receive a written response. (And possibly for years.)

The current psychiatric patient grievance procedure law (AS47.30.847) is poorly written and does not properly protect detained psychiatric patients that file a complaint. Also, the current law does not cover all detained psychiatric patients according to DHSS.

Currently the only due process rules for a detained patient's complaint come from the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) and hospital policy. JCAHO gives psychiatric hospitals and units 14 days to resolve a patient's complaint and there is no appeal process mandated. Most psychiatric patients are detained less than 14 days. There is nothing in state law and very little in state regulations concerning due process for a patient's complaint or appeals.

If Sen. Bill 55 does not pass, then psychiatric institutions can go back to business as usual. When psychiatric institutions have a right to say when psychiatric patients can file a grievance and set due process rights, eventually institutions will say that no patient has a right to file a grievance.

In closing, I am asking you to pass Sen. Bill 55 which will improve in law a psychiatric patient's right to file a grievance.

Faith Myers
(907) 929-0532

Faith Myers

Cc: Open Letter

Testimony to the Senate HESS Committee **January 1, 2012**

Chairperson, Committee members,

My name is Dorrance Collins. I volunteer as a psychiatric patient advocate. I support the passage of Sen. Bill 55.

I would like to establish who will be protected by Sen. Bill 55.—thousands of individuals civilly committed or brought into locked hospital psychiatric units for forced evaluations each year, sometimes in handcuffs, shackles or strapped to a gurney and individuals court-ordered to receive or continue psychiatric treatment in private or non-profit psychiatric clinics.

Over the last 20 years, the state of Alaska has authorized private hospitals and units to detain psychiatric patients, but the state has never established a sufficient grievance procedure law or regulation for detained patients in those private hospitals.

As of now, Alaska may be the only state that does not give by law or state regulations appeal process rights and due process rights to detained psychiatric patients when they file a complaint. And that needs to change.

Several state agencies are required by law to investigate psychiatric patient complaints. Psychiatric patients are not given their number and there is now no requirement to do so.

Psychiatric patients are one of the most vulnerable groups in our society and need a grievance procedure law that will provide protection. Patients need to be given appeal process rights, due process rights and an appeal process to the state.

In closing, I am asking that you pass Sen. Bill 55.

Thank you,

Mental Health Advocate,
Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508

929-0532

Dorrance Collins

Cc: Open Letter

Tom Obermeyer,
Sen. Bettye Davis's Office,

December 15, 2011

Re: Concerning current draft of Sen. Bill 55

Our concern is to close the loopholes in the proposed bill—loopholes that are all too often used to deny patients a reasonable opportunity to file a grievance.

We have underlined our suggested additions:

Page 2, line 31—it should be stated "patients have a right to file a grievance at any time."

Page 2, line 32—Add have the right to due process with regard to grievances.

Page 3, line 4—"Patient has a right any day to consult with a patient advocate or representative of a patient's choosing during reasonable hours.

Page 3, line 9—"has a right anytime to bring a grievance."

Page 3, line 25—"formal grievance procedure and appeal process."

Add to page 6, line 6—"review, such grievances must be reviewed by the chief administrative officer, the Director or designee, who shall either arrange to hear the grievance within one working day or immediately refer the grievance to Level 1 for response."

Dorrance Collins / Faith Myers
929-0532

Dorrance Collins

Faith Myers

Cc: Open Letter

David Fleurant, **September 28, 2011**
Exe. Dir.—Disability Law Center,

It was not that long ago when not a single patient at state-run Alaska Psychiatric Institute could file a formal grievance or appeal and receive a written response. A written response to a patient's grievance in a timely manner is a Federal / JCAHO requirement, but the requirement is not in state law.

Approximately 250 detained (locked-up) patients voice a complaint about treatment or care each year at API. In 2005 we found out patients could not file a grievance or appeal at API in a fair way. We pushed API management to improve their one page patient grievance procedure and they did in 2007.

Several months later we asked API's patient advocate how the new 6 page patient grievance procedure was working. We were told API management in practice had not changed in any significant way how patient complaints or appeals were handled.

A recent 9 page report by your organization, at least by inductive reasoning, also shows API has not improved how patient grievances and appeals are resolved.

Numerous psychiatric facilities and units in Alaska detain psychiatric patients. (Approximately 10) After reviewing their grievance procedures and appeal process it is easy to conclude they are not doing any better than API at letting psychiatric patients file a grievance or appeal in a fair way.

Psychiatric institutions and units tend to operate in self-interest so much so it can present a clear danger to patients. The Alaska Supreme Court reminded all of us of that fact in '06. But as a state, we are still giving the job of writing the psychiatric patient appeal process to the institutions, time frame for completion, etc.

AS47.30.847, psychiatric patient grievance procedure law needs to be revised: a patient appeal process needs to be added, time frame for completion of grievance and appeals, reasonable oversight, all necessary to protect psychiatric patients and currently not in state law.

We are asking Disability Law Center to help improve the grievance procedure law and also to provide a report outlining why the law needs to be improved. Please contact us.

Cc: Sen. Bettye Davis
James Gottstein, Esq.
Jeff Jesse, Trust Authority
William Streur, DHSS
Gov. Sean Parnell
Open Letter

Mental Health Advocates,
Faith Myers / Dorrance Collins
3240 Penland Pkwy, Sp. 35
Anchorage, AK. 99508
(907) 929-0532

faith.myers@gci.net

Faith Myers
Dorrance Collins

State of Alaska
Department of Health and Social Services
Behavioral Health

Policy & Procedure

Topic: State Behavioral Health Requirements for Grantee Grievance Procedures

Policy: All Behavioral Health (BH) grantee treatment organizations are required to develop grievance procedures by which all clients, without regard to services used or funding source, including those clients denied services, may seek redress of grievances. The procedures, written in plain language, should be developed with meaningful consumer participation utilizing the general guidelines established by State Behavioral Health. A copy of the procedures must be filed with BH and should also be posted at the grantee organization's facility(s).[1]

Intent: The Department of Health and Social Services (DHSS) by law is required to adopt regulations to assure patient rights[2], to establish standards for treatment facilities and to keep related records[3], and to investigate complaints made by a patient[4]. This policy outlines the DHSS BH guidelines for grantee grievance procedures, explains BH's role in response to grievances, and lists relevant policy clarifications and all related references of the Alaska Statutes and the Alaska Administrative Code.

Grievance Procedure Guidelines: Grantee consumer grievance procedures must, at a minimum, meet the following criteria:

1. Provision(s) that ensure the right of consumers to file a grievance without intimidation
2. Provision(s) that ensure there is NO retaliation perpetrated against consumers who have filed a grievance
3. Provision(s) that outline a process by which consumers may easily file a grievance, to include:

[1] 7 AAC 13.135 Grievance procedures; 7 AAC 71.220 Grievance procedures
[2] AS 47.30.590 Comprehensive services
[3] AS 47.37.030 Powers of Department; AS 47.37.140 Public and Private Treatment Facilities
[4] AS 47.30.660 (b) (12) Powers and duties of department

a. A simple form written in plain language that also provides for an optional waiver of confidentiality which consumers may complete and submit,
b. Procedure(s) that allow consumers to submit a grievance orally
c. Procedure(s) that allow consumers to submit a grievance over the phone or via email

4. Explanation of agency's grievance procedure / policy provided to ALL consumers upon entry to services, to include the following:
   a. Copy of agency procedure / policy
   b. A form for consumers to sign, which shall be maintained in the consumer's clinical record, that declares their receipt and understanding of the agency procedure / policy
5. Provision(s) for consumers to designate a representative or advocate to assist them with all steps of the grievance process
6. Procedure(s) for the agency, upon consumers request, to assist the consumer with filing a grievance, which should include either:
   a. Identifying specific agency staff to provide assistance
   b. Written referral to other consumer advocacy resources such as the Disability Law Center and NAMI-Alaska
7. Step-wise procedures, limited to the following, for resolving ALL grievances:
   a. **Resource and means for commonly resolving consumer disputes to minimize the need to invoke the grievance process**
   b. Communication with consumer upon receipt of grievance that the agency has begun the process to resolve the grievance
   c. Direct resolution through dialogue with the agency staff member involved or with the staff member's supervisor, or with both as consumer requests
   d. Resolution through the agency Executive Director
   e. Resolution through the agency Governing or Advisory Board
   f. Referral of grievances unresolved at the agency's highest level to DHSS Behavioral Health for technical assistance
8. Established time frames to include the following that ensure prompt hearing of grievances:
   a. Initiation of resolution (according to the procedures noted in # 7 above) within 5 days of receiving a grievance
   b. If agency is unable to adequately initiate resolution within 5 days, a written notification shall be sent to the consumer by the end of 5 days from receipt of grievance explaining why and identifying when the grievance process will initiate
   c. Satisfactory resolution to grievances within 30 days of receipt of grievance
   d. Referral to BH, within 5 business days, for technical assistance with grievances that remain unresolved after 30 days.
9. Provision(s) for immediately elevating to the Governing or Advisory Board level any grievances that involve abuse, neglect or unnecessary seclusion or restraint.
10. Procedure(s) that provide for the creation, maintenance and storage of files for each individual grievance which shall contain all related documents, records, actions and communications.

11. Provision(s) that address maintenance of consumer confidentiality throughout the grievance process

BH Role & Responsibility:

DHSS BH shall initially represent the Department of Health and Social Services for any grievance referred for technical assistance involving BH grantee treatment organizations. BH shall take the following steps to assist with these grievances:

1. **Exercise the primary responsibility of DHSS BH to orient consumers, or other individuals calling on behalf of consumers, to the grievance process and procedures available thru the involved grantee organization**
2. For questions regarding grievances which have been heard according to the involved grantee organization's grievance procedures, BH may:
   a. Review any written response from the involved grantee organization regarding their findings and resolution to the grievance.
   b. Investigate whether the involved grantee organization complied with the following, as indicated, in regards to processing the consumer grievance:
      i. Alaska Statute / Behavioral Health Regulations
      ii. Medicaid Regulations
      iii. Special Conditions of Grant Award
   c. Determine if resolution of the grievance is reasonable based on resources available to the grantee organization
   d. Share BH findings with both the consumer and the involved grantee organization
3. In the course of providing technical assistance for any consumer grievance BH may:
   a. Communicate with any involved party to seek clarification of information, or to obtain access to supporting documents
   b. Consult with other Department or division resource
   c. Refer case to other Department or division resource for continued technical assistance or action
   d. Take any other action deemed prudent or necessary to assist consumer and / or grantee organization

Policy Clarifications:

1) The Department of Health and Social Services is authorized to review, obtain, and copy confidential and other records and information about clients, including services requested or furnished, to evaluate a grantee organization's compliance with statutes (AS 47.30.520 – 47.30.620)[5]

2) For substance abuse treatment facilities and programs, DHSS has adopted by reference the standards contained in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *Standards for*

[5] AS 47.30.590 (b) Patient rights and the confidential nature of records and information

Behavioral Health Care, 2004 – 2005.[6] The Department also provides for exemption from the provisions regarding substance abuse facilities or programs established by the State of Alaska Administrative Code for those private and public treatment facilities currently certified by JCAHO or the Commission on Accreditation of Rehabilitation Facilities (CARF).[7] Therefore:

a. All substance abuse grantee organizations are also obligated to comply with JCAHO standards regarding client Ethics, Rights, and Responsibilities (RI.2.120 – RI.2.130)[8] OR
b. If certified by CARF are obligated to also comply with the CARF standards for rights of persons served (Section 1. Business Practices: Criterion D. Rights of Persons Served)[9]

References:

Alaska Statutes (Authority)

Title 47. Welfare, Social Services and Institutions
Chapter 30. Mental Health
Section 520 - 620. Community Mental Health Services Act
Chapter 37, Uniform Alcoholism and Intoxication Treatment Act
Section 30, Powers of Department
Section 140, Public and Private Treatment Facilities

Alaska Administrative Code

Title 7. Health and Social Services
Chapter 13, Assistance for Community Health Facilities
Section 135. Grievance procedures
Chapter 29, Uniform Substance Abuse Treatment
Section 10. Application of standards
Section 30. Adoption of standards by reference
Chapter 71, Community Mental Health Services
Section 220. Grievance procedures

[6] 7 AAC 29.030 Adoption of standards by reference
[7] 7 AAC 29.010 Application of standards
[8] Comprehensive Accreditation Manual for Behavioral Health Care, 2004 – 2005
[9] 2007 Behavioral Health Standards Manual, CARF International

North Star
Behavioral Health

2530 DeBarr Road • Anchorage, Alaska 99508
(907) 258-7575 • Fax (907) 277-7844
1-800-478-7575

February 14, 2011

The Honorable Bette Davis
State Capitol Building
Juneau, AK 99801

Dear Senator Davis,

I appreciated your meeting with me to discuss issues related to North Star Behavioral Health. You hear thousands of different issues during the course of the year related to the needs of many constituents. I thank you for your time and consideration of issues related to the mental health needs of our community.

One such issue related to Senate Bill 66. As in our conversation, I support the need to protect client rights. Currently, we have many such avenues, both internal and external, to ensure such rights are protected. Our facility has patient advocates who accept complaints and grievances that can be resolved on the units and/or taken to senior leaders for resolution. Our medical staff and senior leadership review all grievances each month for systemic issues and individual staff trends that need to be addressed. External agency phone numbers are posted for patients and families to make complaints to numerous organizations if they desire (The Joint Commission, the Department of Health, the Office of Children's Services, the Center for Medicaid and Medicare Services, the Disability Law Center and others). Additionally, we are surveyed by many of these organizations at least annually. Clearly, patient and families have numerous avenues to address issues as they arise.

I have several concerns about adding to this level of oversight:

1.) The impetus of this bill was not related to children and adolescents. Children and adolescents have numerous adults (i.e., parents, step-parents, grandparents, custodians, and agencies) who ensure proper care and thus have advocates who make many primary decisions on their behalf.

2.) This population, by its nature, often exhibits poor judgment and boundaries (some of the reasons for admission). Adolescents in particular, would use such a system to distract from care and tie up staff time with unfounded complaints. This related to another concern: What makes a valid complaint to be addressed by such a group? Children and adolescents complain about such things as healthy food, phone privileges (the right to talk with peers with whom they have numerous

unhealthy boundaries) and whom we restrict visitation (previously agreed upon with guardians). This population in particular would not appear appropriate for such regulation. The amount of staff time alone would be prohibitive, both to our facility and on the part of the state.

3.) As a private psychiatric facility, we are not holding committed patients such as in the state facility. Our patients can be discharged by the guardian at any time and thereby represent no ability for involuntary commitment or confinement. Thus any grievance that would be seen by the patient or family as infringing on patient rights could be addressed simply by refusing care or treatment (in addition to external and internal reporting mentioned above).

4.) The Federal Health Care Quality Improvement Act allows certain information to be protected in order to protect privacy, promote honest disclosure and encourage facilities to address systemic issues that lead to improved outcomes. There are several issues with this. One, grievances that involve multiple patients would not be allowed to be discussed. For example: If the grievance involves one patient being treated differently than another or another patient committing an unwanted act. This prevents the facility from defending itself. Also, grievances associated with unfounded complaints could lead to potential frivolous lawsuits.

I would appreciate your consideration of these issues, either by considering removal of your support or by limiting the scope of the bill to patient populations and/or organizations in which you feel need such a system to protect clients. The bill could be limited to those patients above 18.

Sincerely,

Dr. Andrew Mayo, CEO
North Star Behavioral Health

North Star
Behavioral Health System

2530 DeBarr Road • Anchorage, Alaska 99508
(907) 258-7575 • Fax (907) 277-7844
1-800-478-7575

August 24, 2011

Senator Davis
State Capitol Room 30
Juneau AK, 99801

Re: SB 55 Draft Version 27-LS0082\D

Dear Senator Davis:

In response to your request to offer feedback on SB 55 Draft Version 27-LS0082\D, I offer the following comments. Some of these comments are a repetition of my initial concerns sent on August 3, 2009 to your attention.

As in our conversation, I support the need to protect client rights. Currently, we have many such avenues, both internal and external, to ensure such rights are protected. Our facility has patient advocates who accept complaints and grievances that can be resolved on the units and/or taken to senior leaders, for resolution. Our medical staff and senior leadership review all grievances each month for systemic issues and individual staff trends that need to be addressed. External agency phone numbers are posted for patients and families to make complaints to numerous organizations if they desire (The Joint Commission, the Department of Health, the Office of Children's Services, the Center for Medicaid and Medicare Services, the Department of Licensure, the Disability Law Center and others). Additionally, we are surveyed by some of these organizations annually and the others routinely or upon patient complaint. Clearly, patient and families have numerous avenues to address issues as they arise. I believe this bill will add to the cost of healthcare without adding an improved benefit. At times healthcare facilities have to respond to several of these agencies concerning one complaint, often with differing opinions. This will add another such group in which agencies must allocate resources.

As a private psychiatric facility, we are not holding committed patients such as in the state facility. Our patients can be discharged by the guardian at any time and thus represent no ability for involuntary commitment (patients for which commitment would be initiated are transferred to the state facility. The vast majority grievances that would be seen by the patient or family as infringing on patient rights could be addressed simply by refusing care or treatment (in addition to external and internal reporting mentioned above).

North Star
Behavioral Health System

2530 DeBarr Road • Anchorage, Alaska 99508
(907) 258-7575 • Fax (907) 277-7844
1-800-478-7575

The impetus of this bill was not related to children and adolescents. Children and adolescents have numerous adults (i.e., parents, step parents, grandparents, custodians, and agencies) who ensure proper care and thus have advocates who make many primary decisions on their behalf. Further, these parents and guardians have access to the child through visits, family therapy and phone calls. Such guardians have time and access to file complaints with any of the agencies mentioned above. This population, by its nature, often exhibits poor judgment and boundaries (some of the reasons for admission). Adolescents in particular, would use such a system to distract from care, avoid dealing with issues that precipitated admission and tie up staff time with unfounded complaints. It would be unrealistic to believe that this population would not over whelm the agency with grievances. Youth often make complaints about food (due to dietary requirements that limit unhealthy foods), inability to visit/phone with peers (often peers who may be unhealthy due to age differences, drug using partners, dealers, etc…), not wanting to attend therapy (to avoid dealing with painful issues or to avoid responsibility) which detract from effective treatment. Allowing three tiers of grievance levels, unless the youth believe it fair, in reality should be described as dealing with each grievance three times as well as with multiple agencies in some cases. This population in particular would not appear appropriate for such regulation. The amount of staff time alone would be prohibitive, both to our facility and on the part of the state.

The Federal Health Care Quality Improvement Act allows certain information to be protected in order to protect privacy, promote honest disclosure and encourage facilities to address systemic issues that lead to improved outcomes. There are several issues with this. One, grievances that involve multiple patients would not be allowed to be discussed with identifiers or necessarily outcome of the issue with that patient.. For example: If the grievance involves one patient being treated differently than another or another patient committing an unwanted act. This prevents the facility from defending itself. Also, grievances associated with unfounded complaints could lead to potential frivolous law suits. Item 7 (g) notes that the burden of proof shall be on the facility. Often grievances result in false accusations that cannot be disproven as it is difficult to prove something did not occur.

I would appreciate your consideration of these issues, either by considering removal of your support or by limiting the scope of the bill to patient populations and/or organizations in which you feel need such a system to protect clients. The bill could be limited to those patients above 18.

Sincerely,

Dr. Andrew Mayo, CEO
North Star Behavioral Health

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
and ALASKA MENTAL HEALTH BOARD

SEAN PARNELL, GOVERNOR

P.O. BOX 110608
431 N. Franklin Street, Suite 200
JUNEAU, ALASKA 99811-0608
PHONE: (907) 465-8920
FAX: (907) 465-4410
TOLL FREE: (888) 464-8920

November 4, 2011

Thomas Obermeyer, Legislative Aide
Office of Senator Bettye Davis
716 West 4th Avenue, Suite 400
Anchorage, Alaska 99501

BY FIRST CLASS MAIL, EMAIL

Re: Mental Health Patient Grievance Procedure Bill, Work Draft 10/10/11

Dear Mr. Obermeyer,

Thank you for requesting written comment on the current draft of a bill Senator Davis is considering regarding psychiatric patient grievances. The members of the Alaska Mental Health Board are committed to ensuring that mental health consumers have access to a fair and equitable patient grievance process. **We are grateful for your commitment to protecting mental health consumers' security and dignity.**

We agree that patients who have lost the right to make health care decisions themselves and who are forced to accept mental health treatment under Title 47 require additional protections to ensure their dignity and safety. We do not support the imposition of a single grievance procedure on both hospital based involuntary psychiatric treatment and community based voluntary mental health services. The treatment environments are unique, as are the levels of patients' personal authority. This draft of the bill continues to impose the same statutory grievance procedure on community mental health providers as on involuntary hospital services.

As we have commented on all the previous drafts, we again recommend that the bill be amended to state: "**Sec 47.30.847. Patient grievance procedure.** (a) A person undergoing evaluation or treatment at a designated treatment facility has the right at any time to. . ." (page 2 line 31) or that the application to patients receiving services pursuant to AS 47.30.700 – A.S. 47.30.795 be explicit in the language of the bill.

The definition of "facility" (page 7 line 22) is better, but we still advise that, to be very clear about the scope and applicability of the bill, it be clarified to state "'designated treatment facility' is defined as a hospital, clinic, institution, center or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670 - 47.30.915 but does not include correctional institutions."

I. Grievances Defined

Thank you for defining a "grievance" (page 7 line 24) as a "complaint" and removing the language including "concerns" and "suggestions." This definition limits grievances to complaints made via a "form."

As with previous versions, this draft bill goes into great detail about what must be in the form. This leads to the construction that the statute prohibits a patient from making a grievance in person, by telephone, by email, or through a family member or designated representative/advocate. As we commented on earlier drafts, this actually narrows the procedure from what currently exists. This section contains so many specific requirements, it seems to contradict the earlier requirement that a grievance be processed on "a single form" (page 3 line 24). We recommend that this discrepancy be corrected so the law, if enacted, can be applied appropriately by treatment providers.

II. Crimes Against the Disabled

We renew our concern that, as proposed, AS 47.30.847(c)(8) (page 6 lines 6-17) minimizes serious crimes committed against our constituents. This section provides an "urgent level of review" for grievances involving sexual or physical abuse, denial of "lifesaving" medical care, or denial of "basic care or human rights." Were these acts to be committed against a patient by anyone (including a mental health treatment provider), they would be criminal acts. As such, they should not be minimized or reduced to "grievances." They should be considered crimes and reported to law enforcement immediately for investigation and prosecution if appropriate. Crimes against persons with disabilities often go unaddressed. Either the victim is blamed or they are undervalued to the point where crimes committed against them no longer matter. To codify this attitude in statute is unacceptable.

III. The Impact of Duplication

Providers of Medicaid-reimbursed services must comply with the grievance procedure requirements established by CMS. Hospitals accredited by the Joint Commission must also comply with grievance procedure standards. It is important that legislation address gaps without adding complexity. We recommend that the bill be reviewed in the context of these other requirements, and amended to provide uniformity across the grievance procedure requirements. The cross walk previously prepared for you and your staff is again attached for your reference.

IV. Call Center

The Alaska Mental Health Board does not support the creation of a "call center." This is an added level of complexity for patients and cost to the system. Trained patient advocates as called for by AS 47.30.847(d) provide this support and assistance to patients.

V. Hearing and Decision

AS 47.30.847(c)(5)(B) (page 5 line 11 *et seq.*) refers to review of a grievance by the "commissioner's designee" (line 14). The Commissioner of Health and Social Services cannot designate a hearing officer within a private hospital or other designated treatment facility – and since all of the providers of involuntary psychiatric treatment are private non-profit organizations except for API, this does not make sense.

We also again point out that administrative review of grievances against non-state entities, such as the private non-profit hospitals providing psychiatric treatment to Title 47 patients, is not possible. The administrative appeal process is limited to review of administrative actions – actions taken by

governmental agencies. Thus, the third level of review (page 5 lines 20-26) is irrelevant to all but API patients.

Having had no additional information about whether a third level of review by an administrative hearing officer results in additional burden on the attorneys appointed to represent individuals in Title 47 commitment hearings, we renew our concerns/questions on this section:

1. Are patients who are receiving care involuntarily (and therefore have been found unable to make important decisions for themselves) able to represent themselves at these hearings?
2. Must counsel be appointed to ensure that the individual has meaningful access to the administrative appeal process?

Since the bill requires the Department of Health and Social Services to intervene in all grievances that reach this level of review (page 7 line 6), there will be an assistant attorney general appearing on the agency's behalf. There will be either an administrator or attorney appearing on the hospital's behalf. So it would only seem fair that the patient have counsel.

1. If that counsel is required, who pays for it?
2. How is counsel appointed?
3. Can an administrative hearing officer even appoint counsel?

On the issue of the required intervention in level three grievance reviews by the Department of Health and Social Services, it is patently unfair to require (or even permit) such intervention in those instances involving grievances against API. That would create an imbalanced proceeding where two parties – represented by attorneys -- stand against a (potentially *pro se*) patient.

As with previous versions, this draft of AS 47.30.847(g) shifts the burden of proof to the treatment provider. This contradicts the usual course of these sorts of proceedings. This draft still denies the treatment providers due process, by limiting them to proving "compliance or remedial action" (page 7 lines 3-4) — presupposing that the facts alleged in all grievances are true.

We remind you of our caution that the financial ramifications of having patient grievances (at least as so broadly defined in the current draft) heard by the office of administrative hearings will require a DHSS fiscal note of not inconsequential size, and potentially a fiscal note for Public Defender and/or Office of Public Advocacy services. That should in no way prevent attempts to improve the grievance process for psychiatric patients, but should be something for which the sponsor is prepared.

VI. Timelines

We appreciate the effort to alter the grievance process in AS 47.30.847(c)(5)(A) to create a timeline to better fit the context of a treatment model that is designed to stabilize the patient and either transition him home or to a more appropriate acute care setting within a very short timeframe. However, the five (5) day deadline set by AS 47.30.847(d) for a response to a grievance conflicts with the former sections requirement of "immediate" review (page 5 line 6). This conflict should be resolved to ensure that patient grievances are resolved prior to discharge.

VII. Errata

The draft bill still refers to a "Alaska Department of Health and Social Services, Division of Mental Health, Grievance Reporting Form." As we have commented in the past, there is no such division. Page 4, lines 3-4 should be amended to state "Alaska Department of Health and Social Services, Division of Behavioral Health, Grievance Reporting Form."

AS 47.30.847 does not define a mental health "facility," so the reference in the draft AS 47.30.855(d) to this section as a source of clarification of what a facility is under this statute is not helpful. I think a more appropriate reference is AS 47.30.915(4).

VIII. Conclusion

We thank you again for the opportunity to continue to work with you and Senator Davis on this issue. This draft bill has been improved greatly, thanks to your hard work, and we look forward to continuing dialogue on the aspects we have identified herein.

Sincerely,

J. Kate Burkhart
Executive Director

Enclosure: Procedural Crosswalk

cc: members, Alaska Mental Health Board (by email)
Melissa Stone, Director Division of Behavioral Health (by email)
Kimberli Poppe-Smart, Deputy Commissioner DHSS (by email)
Wilda Laughlin, Special Assistant to the Commissioner of DHSS (by email)

A Cross-Walk of Patient Grievance Procedure Requirements in Alaska
prepared by the Alaska Mental Health Board, February 2009

	API (policy)	JCAHO	CMS (CFR)
Notice of patient rights	Provided at admission/intake P& P PRE030-03 Policy ¶ II Written copies posted and available in each program area P& P PRE 030-03 Policy ¶ II. A. Notice communicated in manner best understood by patient P&P PRE 030-03 Policy ¶ II.B. Notice provided at new patient orientation, community meetings, individual meetings P&P 030-03 Procedure ¶ I.C.	Provided upon admission RI 2.10, EP 1-4	Hospital must inform of rights before providing care (when possible) 42 CFR §482.13(a) Rights must be communicated in a language/manner patient can understand *Interpretative Guidelines* §482.13(a)(1)
Procedure required	Yes (subject to federal/state law and accrediting requirements)	Yes RI 2.120, EP 1-5	Hospital must establish a process for prompt resolution of patients grievances 42 CFR §482.13 (a)(2)
Grievance defined			Written or oral complaint (when not resolved at the time complaint is made by staff person present) re: "patient's care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital CoP, or a Medicare beneficiary billing

	API (policy)	JCAHO	CMS (CFR)
			complaint" *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification) All written complaints re: care, abuse/neglect, compliance or Medicare billing are formal grievances *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification)
Other complaints, concerns, suggestions	Complaints of abuse, harassment, unlawful conduct by employees reported to authorities for investigation P&P 030-03 Procedure ¶ II. B.	Complaints of abuse should be referred to proper authority for investigation RI 2.150, EP 2	"change in bedding, housekeeping of a room, and serving preferred food and beverages may be made relatively quickly and would not usually be considered a 'grievance'" *Interpretive Guidelines* 42 CFR 482.13(a)(2) Complaints not related to patient care or within definition above are not grievances *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification)
Patient Advocate Required	Yes, assists with grievances & other complaints P&P 030-03 ¶ III. Notice given of outside advocates (DLC, etc.) P&P 030-03 ¶ II.		

	API (policy)	JCAHO	CMS (CFR)
Resolution defined			Patient is satisfied with remedial action *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification) If hospital has taken appropriate & reasonable action and patient remains unsatisfied, hospital may close grievance but must maintain documentation of efforts to resolve and compliance with CMS requirements *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification)
Records/ data re: grievances	Tracking, trending, and continuous performance improvement by Patient Rights and Ethics Team P& P PRE030-03 Procedure ¶ VI. D.	Data is collected, analyzed, displayed and compared, internally and externally, using statistical techniques. PI 2.10, EP1-5 Data collection and monitoring areas include patient satisfaction and quality control. PI 1.10, EP1-8, 10, 12-18, 29	Must be maintained, incorporated in Quality Assessment and Performance Improvement Program *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification)

Grievance Procedure Requirements

	API (policy)	JCAHO	CMS (CFR)
Notice of Procedure	Provided at admission/intake P& P PRE030-03 Policy ¶ II Written copies posted and available in each program area P& P PRE 030-03 Policy ¶ II. A. Notice communicated in manner best understood by patient P&P PRE 030-03 Policy ¶ II.B. Notice provided at new patient orientation, community meetings, individual meetings P&P 030-03 Procedure ¶ I.C.	Provided upon admission RI 2.10, EP 1-4	Hospital must inform of rights before providing care (when possible) 42 CFR §482.13(a)
Notice of Advocate or Contact for Grievances	Provided at admission/intake P& P PRE030-03 Policy ¶ II		Notice required 42 CFR §482.13(a)(2)
Form of Grievance	Grievance form (assistance available from advocate) P&P PRE 030-03 Policy ¶ IV.		Written or oral 42 CFR §482.13 (a)(2)(i)
Timeframe	Level 1: 5 days Level II: 5 days Urgent: review day of receipt, resolved in 3 days P&P PRE 030-03 Procedure ¶IV.		Required 42 CFR §482.13(a)(2)(ii)

	API (policy)	JCAHO	CMS (CFR)
			Grievances re: neglect/abuse reviewed immediately *Interpretative Guidelines* §482.13(a)(2)(iii) For others, "7 days for the provision of a response would be considered appropriate." Response can be that grievance investigation or remedial action is ongoing. *Interpretative Guidelines* §482.13(a)(2)(iii) "The expectation is that the facility will have a process to comply with a relatively minor request in a more timely manner" (i.e. less than 7 days) *Interpretive Guidelines* §482.13(a)(2)
Resolution Process	Level 1: discussion between advocate and patient; proposed resolution to patient in writing by 5th day P&P PRE 030-03 Procedure ¶ III. Level 2: CEO investigates grievance or delegates to member of Sr. Management; written response within 5 days P&P PRE 030-03 Procedure ¶ V.		Governing body or committee must review and resolve grievances *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification) If delegated to grievance committee, must be more than 1 person *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision

	API (policy)	JCAHO	CMS (CFR)
	Urgent grievances are reviewed by patient advocate the day of receipt and immediately referred to CEO/Medical Director or designee P&P PRE030-03 Procedure ¶ IV. Patients not satisfied with resolution can file a grievance with DLC, JCAHO, or Court P&P PRE 030-03 Procedure ¶ VI.		and clarification)
Written Decision Required	Yes (all levels) P&P 030-03 ¶ V. P&P PRE 030-03 Procedure ¶III-V.		For formal grievance, with name of contact person, steps taken to investigate, resolution, and date 42 CFR §482.13 (a)(2)(iii) Response must include adequate information to address each item required by 42 CFR §482.13 (a)(2)(iii) *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification) In language patient understands *Interpretative Guidelines* §482.13(a)(2)(iii) If grievance is made by email, response can be provided by

	API (policy)	JCAHO	CMS (CFR)
			email *Interpretive Guidelines* §482.13(a)(2) (8/18/05 revision and clarification) Not for informal complaints (see above) *Interpretive Guidelines* §482.13(a)(2)
Oversight	Patient Rights and Ethics Team P& P PRE030-03 Procedure ¶ VI. D.	Governing body oversees quality and patient safety LD 1.20, EP6	Hospital governing body (or grievance committee) 42 CFR §482.13(a)(2)

Give / Send to: Tom Obermeyer,

Follow-up to our conversation. (Sen. Bill 55)

Attached are 2 pages of criticism of North Stars patient grievance procedure.

Regretably their grievance procedure does not properly protect psychiatric patients.

Thank you,

Dorrance Collins/
Faith Myers
929-0532

Mental Health Advocates, Faith Myers / Dorrance Collins,
3240 Penland Pkwy, Sp.35, Anchorage, AK. 99508 (907) 929-0532

+ Attn: Tom Obermeyer

North Star—Behavioral Health System

Treats approximately 4,000 or more psychiatric patients per year—Operates locked psychiatric facilities.

Criticism:
Grievance procedure not sufficient to protect a vulnerable population.

Patients, family are asked to go through an informal complaint process, but there is no time frame of how long that will take.

It is not clear that patients or family members can file a grievance at the time of their choosing.

There is only one level to the grievance procedure—there is no appeal process for patients to use.

There is no clear way for patients to appeal an adverse resolution to a grievance past the walls of the institution (to the state, etc.)

Con.

There is no impartial body to hear a patient's grievance. (An impartial body with the authority to reverse or influence the resolution of a patient's grievance.)

Hospital can request open-ended extensions of time before resolving a patient's grievance.

Dorrance Collins/
Faith Myers
929-0532

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator Bettye Davis

Senate Bill 55 – Mental Health Grievance Procedure

****

Explanation of Changes in CSSB 55( ) Version "R"

(Compares Committee Substitute "R" vs T with blue/red line changes)

---

1. **Page 1, lines 2-3: Title was changed to reflect amendment of Alaska Court Rules limiting attorney fees in certain cases.**
2. **Page 3, line 1: Allows filing a grievance at any time during operating hours.**
3. **Page 3, line 7: Allows consulting a patient advocate on "any day during reasonable hours."**
4. **Page 6, line 6: Clarifies that there are "parallel" procedures available under administrative decisions and criminal and other laws.**
5. **Page 6, line 8: The urgent level of review requires an expedited "administrative" decision.**
6. **Page 6, lines 11-12: Limits an urgent grievance to "an immediate threat to the health or welfare of a grievant," removing specific language previously limited to sexual abuse, physical abuse, denial of lifesaving treatment, procedures, or medications; and basic care or human rights.**
7. **Page 7, lines 4-6: Removes the burden of proof previously shifted to mental health facilities or units which had to prove by substantial evidence compliance or remedial action with applicable laws and procedures.**
8. **Page 7, lines 23-25: Creates a presumption that if a grievance is appealed to a court under this section, the imposition of attorney's fees on a grievant would inflict a substantial hardship.**
9. **Page 8, lines 16-21: Section 4 limits the court's discretion in awarding attorney's fees in certain cases by amending court rules, and rules of civil and appellate procedure**
10. **Page 8, lines 22-26: Section 5 requires a 2/3 vote of each house to change the court and procedural rules in Section 4.**

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 20, 2012

SUBJECT: Sectional Summary CSSB 55( ) (Work Order No. 27-LS0082\R)

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds eight rights to the list of rights of a person undergoing mental health evaluation or treatment in the state under specified provisions of state law, including involuntary commitments. The additional rights include the right to be treated with dignity and respect and the right to file a grievance under the procedures established by sec. 2 of the bill.

Section 2. Establishes a grievance procedure, including varying levels of review and appeal, for a person undergoing evaluation or treatment at a public or private evaluation facility or unit or at a designated treatment facility or unit. Defines "grievance" to mean a complaint concerning a patient's treatment, care, or rights at a mental health evaluation or treatment facility or unit in the state. Includes a presumption that imposition of attorney's fees on a grievant for an appeal under this section would inflict an undue hardship.

Section 3. Requires the Department of Health and Social Services to provide to mental health evaluation and treatment facilities and units in the state a standardized notice of patient rights, assistance, and grievance procedures. Also requires the person in charge of the facility or unit to provide a written copy of the notice to each patient or their representative.

Section 4. Provides that the presumption added in sec. 2 of this version has an indirect effect on Rule 82, Alaska Rules of Civil Procedure.

Section 5. Provides a conditional effect of the presumption added in sec. 2 regarding attorney's fees takes effect only if sec. 4 receives a two-thirds majority vote.

JMM:ljw
12-219.ljw

27-LS0082\~~T~~R
Mischel
2/21/12~~/8/11~~

CS FOR SENATE BILL NO. 55( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): ~~SENATOR~~SENATORS DAVIS, Wielechowski, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act relating to mental health patient rights, notifications, and grievance procedures; and amending Rule 82, Alaska Rules of Civil Procedure and Rule 508, Alaska Rules of Appellate Procedure."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.30.840(a) is amended to read:

(a) A person undergoing evaluation or treatment under AS 47.30.660 - 47.30.915

(1) may not be photographed without the person's consent and that of the person's guardian if a minor, except that the person may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or the patient's designee unless a court orders otherwise;

(2) at the time of admission to an evaluation or treatment facility, shall have reasonable precautions taken by the staff to inventory and safeguard the patient's

personal property; a copy of the inventory signed by the staff member making it shall be given to the patient and made available to the patient's attorney and any other person authorized by the patient to inspect the document;

(3) shall have access to an individual storage space for the patient's private use while undergoing evaluation or treatment;

(4) shall be permitted to wear personal clothing, to keep and use personal possessions including toilet articles if they are not considered unsafe for the patient or other patients who might have access to them, and to keep and be allowed to spend a reasonable sum of the patient's own money for the patient's needs and comfort;

(5) shall be allowed to have visitors at reasonable times;

(6) shall have ready access to letter writing materials, including stamps, and have the right to send and receive unopened mail;

(7) shall have reasonable access to a telephone, both to make and receive confidential calls;

(8) has the right to be free of corporal punishment;

(9) has the right to reasonable opportunity for indoor and outdoor exercise and recreation;

(10) has the right, at any time, to have a telephone conversation with or be visited by an attorney;

(11) may not be retaliated against or subjected to any adverse change of conditions or treatment solely because of assertion of rights under this section;

(12) has the right to be treated with dignity and respect;

(13) has the right to confidentiality of and access to the person's evaluation and treatment records maintained by the facility;

(14) has the right to an individualized treatment plan, and the right to be involved in developing the treatment plan, while residing at the facility;

(15) has the right to informed consent by the person or the person's legal representative;

(16) has the right to freedom from seclusion and restraint;

(17) has the right to file a grievance any time during operating hours under AS 47.30.847;

(18) has the right to a designated staff member clearly identified by a treatment facility to act as a patient advocate and to assist in the filing of a grievance under AS 47.30.847;

(19) has the right to consult with a patient advocate or representative of the patient's choosing, on any day during reasonable hours.

*** Sec. 2.** AS 47.30.847 is repealed and reenacted to read:

Sec. 47.30.847. Patient grievance procedure. (a) A person undergoing evaluation or treatment at a public or private evaluation facility or unit or designated treatment facility or unit under AS 47.30.660 - 47.30.915 has the right to bring a grievance concerning the patient's treatment, care, or rights.

(b) The department shall establish one or more impartial call centers for the purpose of receiving, referring, and tracking grievances filed under this section. The call center shall maintain an electronic database and hard copies of all grievances filed under this section. The call center shall be made available to a grievant at no charge and at all times and shall process a grievance immediately as provided in this section. The call center shall assist a grievant in filing a grievance and shall provide procedural information but may not advise a grievant.

(c) A facility or unit shall provide a formal grievance procedure, which must include referral to a call center established under (b) of this section, for all patient grievances on any subject brought under (a) of this section, regardless of the availability of a less formal procedure for comments and suggestions. Once filed to the best of the grievant's knowledge and ability, all grievances shall be processed on a single form. The grievance procedure must include

(1) written notice on admission to the facility of the availability of the formal grievance procedure and facility rules pertaining to the grievance procedure;

(2) a form for submission of a grievance, access to a call center, and a secure box for deposit of grievance reporting forms; the contents of the box must be reviewed each day patients are being treated or evaluated; the form must be readily accessible to the patient and understood by the patient or easily explained by a staff

member in a language and method understandable to the patient; the original of a completed form submitted to the facility must be kept in the patient's record; the form must contain the heading "Alaska Department of Health and Social Services, Mental Health Grievance Reporting Form," and include

(A) the name of the grievant and the grievant's contact information, including the grievant's address and telephone number;

(B) the date and time of the completion of the grievance form;

(C) the name and physical location of the service provider;

(D) the date on which the event giving rise to the grievance took place;

(E) the names of persons involved in the event giving rise to the grievance, if known;

(F) a narrative description of the event giving rise to the grievance;

(G) the specific issue to be addressed;

(H) the grievant's suggested resolution of the grievance;

(I) the investigative steps taken to formulate the facility's or unit's response;

(J) the response and date of response by the facility or unit;

(K) the signature of the grievant at each level, including the initial grievance;

(L) the signature of the reviewer and date of review for each level of review; and

(M) options for the grievant to check following each response by the facility or unit, as follows:

(i) I agree;

(ii) I do not agree;

(iii) submit to level two review;

(iv) submit to level three review;

(3) a written list showing contact information for available advocacy agencies, including the department, facility accrediting bodies, the ombudsman, and

the Disability Law Center of Alaska;

(4) three levels of review, as follows:

(A) level one, an initial review and written decision by a supervisory staff member to determine whether a grievant's treatment, care, or rights have been adversely affected, a written record of that determination, and, if the grievant's rights have been aversely affected, implementation of a mutually agreed upon resolution of the grievance;

(B) level two, if a resolution is not agreed upon or implemented under a level one review, a grievant may initiate a review within 20 calendar days after the determination is made under level one; a chief executive officer or the commissioner's designee for a facility shall make written findings and issue a decision within five business days after initiation of a level two review; if the level two review results in a finding of no adverse effect, no additional review is necessary, but the decision may be appealed under (C) of this paragraph by a grievant, and the written decision must include notice of the availability of a level three appeal;

(C) level three, a grievant may appeal the final written decision made under level two to the commissioner within 30 calendar days after receipt of the findings of the level two review; the commissioner shall make a final written decision on or before the 14th calendar day after the appeal is filed; if the commissioner fails to enter a timely decision, the appeal shall be considered denied; the commissioner may deny an appeal for substantial failure to follow the procedures set out in this section; a denial or decision by the commissioner may be appealed to the superior court within 30 calendar days;

(5) maintenance of a complete and confidential record, available on request by the grievant or the grievant's designated representative, of all documents, including the grievance and appeals and responses to the grievance and appeals;

(6) delivery, within 24 hours, of a copy of the initial grievance and of all documents maintained under (5) of this subsection to the call center established under (b) of this section, which shall promptly provide all necessary information to

(A) the grievant or the grievant's representative;

(B) the department; the department shall maintain confidentiality over the grievant's health and personal information;

(C) the person responsible for the next level of review; and

(D) the person in charge of the facility or unit; and

(7) in addition to the three levels of review and parallel procedures available under criminal and other laws provided under (4) of this subsection, an urgent level of review and expedited administrative decision, available at all times to a current patient of a facility or unit, to be conducted immediately by the chief executive officer at the facility and referred to a call center and reviewed by the department not later than 24 hours after receipt of a grievance that alleges an immediate threat to the health or welfare of a grievant.

~~(A) sexual abuse;~~

~~(B) physical abuse; or~~

~~(C) denial of~~

~~(i) lifesaving treatment or procedures;~~

~~(ii) lifesaving medications; or~~

~~(iii) basic care or human rights, as defined by the commissioner.~~

(d) Except as provided in (c)(7) of this section, unless an extension of time of not more than five business days is agreed upon by a patient or the patient's representative, an evaluation facility or unit or a designated treatment facility or unit shall mail or hand deliver a written response to a call center within five business days after receipt of a grievance or request for additional review. The response must include the reasons for the decision and a description of the appeal process. The grievant may request review at the next level if a written response is not timely.

(e) An evaluation facility or unit and a designated treatment facility or unit shall have a designated staff member who is trained in mental health consumer advocacy who shall, on a patient's request, serve as an advocate to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights.

(f) A grievant may not file a grievance later than one year after the incident giving rise to the grievance. The facility or unit shall make a good faith effort to mail a response to a grievant who has been discharged from the facility.

~~(g) The burden of proof required for all grievance reviews shall be on the facility or unit against which a grievance is filed to prove, by substantial evidence, compliance or remedial action with applicable laws and procedures.~~

(~~h~~g) The department shall review all grievances and responses to grievances for compliance with this section.

(~~i~~h) A facility or unit shall prepare and file a quarterly report with the department that describes the

(1) number of grievances submitted;

(2) general issue raised in each grievance; and

(3) resolution, including litigation, of all grievances submitted.

(~~j~~i) The department shall compile the information provided under (~~i~~h) of this section and provide a quarterly report to be posted for public review that describes the number and types of grievances filed against each facility in the previous quarter.

(~~k~~j) Nothing in this section shall be interpreted to prohibit informal dispute resolution or mediation by the written agreement of the grievant, the facility or unit, and the department at any time during the grievance process but before a lawsuit concerning the subject of the grievance is filed by a grievant.

(~~l~~k) A facility may not discourage or delay a patient's access to an advocate or representative of the patient's choosing.

(*l*) If a grievance decision made under this section is appealed to a court, the court shall presume that the imposition of attorney's fees on a grievant would inflict a substantial and undue hardship on the grievant under AS 09.60.010(e).

(m) In this section,

(1) "facility" has the meaning given to "designated treatment facility" or "evaluation facility" in AS 47.30.915; and means a unit of a hospital in which patients receive mental health evaluation or treatment and for which public funds are provided;

(2) "grievance" means a complaint made by a grievant concerning a

patient's treatment, care, or rights at a facility;

(3) "grievant" means a patient of a public or private mental health treatment or evaluation facility or unit or the patient's representative;

(4) "unit" means a discrete portion of a facility dedicated to the treatment or evaluation of mental health patients.

* **Sec. 3.** AS 47.30.855 is amended by adding new subsections to read:

(b) The department shall provide to a facility for posting and distribution a standardized notice that is designed to be easily understood and that separately describes patient rights, available assistance, and the grievance procedure provided under AS 47.30.847.

(c) A person in charge of a facility shall ensure that each patient or patient's representative receives a written copy of the standardized notice provided by the department under (b) of this section and of the formal grievance procedure described in AS 47.30.847(c).

(d) In this section, "facility" has the meaning given in AS 47.30.847.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT COURT RULE AMENDMENT. AS 47.30.847(*l*), added by sec. 2 of this Act, has the effect of changing Rule 82, Alaska Rules of Civil Procedure, and Rule 508, Alaska Rules of Appellate Procedure, by limiting the court's discretion in awarding attorney's fees in certain cases.

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. AS 47.30.847(*l*), added by sec. 2 of this Act, takes effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

CS FOR SENATE BILL NO. 55(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DAVIS, Wielechowski, Ellis

A BILL

FOR AN ACT ENTITLED

"An Act relating to mental health patient rights, notifications, and grievance procedures; and amending Rule 82, Alaska Rules of Civil Procedure, and Rule 508, Alaska Rules of Appellate Procedure."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.30.840(a) is amended to read:

(a) A person undergoing evaluation or treatment under AS 47.30.660 - 47.30.915

(1) may not be photographed without the person's consent and that of the person's guardian if a minor, except that the person may be photographed upon admission to a facility for identification and for administrative purposes of the facility; all photographs shall be confidential and may only be released by the facility to the patient or the patient's designee unless a court orders otherwise;

(2) at the time of admission to an evaluation or treatment facility, shall have reasonable precautions taken by the staff to inventory and safeguard the patient's

personal property; a copy of the inventory signed by the staff member making it shall be given to the patient and made available to the patient's attorney and any other person authorized by the patient to inspect the document;

(3) shall have access to an individual storage space for the patient's private use while undergoing evaluation or treatment;

(4) shall be permitted to wear personal clothing, to keep and use personal possessions including toilet articles if they are not considered unsafe for the patient or other patients who might have access to them, and to keep and be allowed to spend a reasonable sum of the patient's own money for the patient's needs and comfort;

(5) shall be allowed to have visitors at reasonable times;

(6) shall have ready access to letter writing materials, including stamps, and have the right to send and receive unopened mail;

(7) shall have reasonable access to a telephone, both to make and receive confidential calls;

(8) has the right to be free of corporal punishment;

(9) has the right to reasonable opportunity for indoor and outdoor exercise and recreation;

(10) has the right, at any time, to have a telephone conversation with or be visited by an attorney;

(11) may not be retaliated against or subjected to any adverse change of conditions or treatment solely because of assertion of rights under this section;

(12) has the right to be treated with dignity and respect;

(13) has the right to confidentiality of and access to the person's evaluation and treatment records maintained by the facility;

(14) has the right to an individualized treatment plan, and the right to be involved in developing the treatment plan, while residing at the facility;

(15) has the right to informed consent by the person or the person's legal representative;

(16) has the right to freedom from seclusion and restraint;

(17) has the right to file a grievance any time during operating hours under AS 47.30.847;

(18) has the right to a designated staff member clearly identified by a treatment facility to act as a patient advocate and to assist in the filing of a grievance under AS 47.30.847;

(19) has the right to consult with a patient advocate or representative of the patient's choosing on any day during reasonable hours.

*** Sec. 2.** AS 47.30.847 is repealed and reenacted to read:

Sec. 47.30.847. Patient grievance procedure. (a) A person undergoing evaluation or treatment at a public or private evaluation facility or unit or designated treatment facility or unit under AS 47.30.660 - 47.30.915 has the right to bring a grievance concerning the patient's treatment, care, or rights.

(b) The department shall establish one or more impartial call centers for the purpose of receiving, referring, and tracking grievances filed under this section. The call center shall maintain an electronic database and hard copies of all grievances filed under this section. The call center shall be made available to a grievant at no charge and at all times and shall process a grievance immediately as provided in this section. The call center shall assist a grievant in filing a grievance and shall provide procedural information but may not advise a grievant.

(c) A facility or unit shall provide a formal grievance procedure, which must include referral to a call center established under (b) of this section, for all patient grievances on any subject brought under (a) of this section, regardless of the availability of a less formal procedure for comments and suggestions. Once filed to the best of the grievant's knowledge and ability, all grievances shall be processed on a single form. The grievance procedure must include

(1) written notice on admission to the facility of the availability of the formal grievance procedure and facility rules pertaining to the grievance procedure;

(2) a form for submission of a grievance, access to a call center, and a secure box for deposit of grievance reporting forms; the contents of the box must be reviewed each day patients are being treated or evaluated; the form must be readily accessible to the patient and understood by the patient or easily explained by a staff

member in a language and method understandable to the patient; the original of a completed form submitted to the facility must be kept in the patient's record; the form must contain the heading "Alaska Department of Health and Social Services, Mental Health Grievance Reporting Form," and include

(A) the name of the grievant and the grievant's contact information, including the grievant's address and telephone number;

(B) the date and time of the completion of the grievance form;

(C) the name and physical location of the service provider;

(D) the date on which the event giving rise to the grievance took place;

(E) the names of persons involved in the event giving rise to the grievance, if known;

(F) a narrative description of the event giving rise to the grievance;

(G) the specific issue to be addressed;

(H) the grievant's suggested resolution of the grievance;

(I) the investigative steps taken to formulate the facility's or unit's response;

(J) the response and date of response by the facility or unit;

(K) the signature of the grievant at each level, including the initial grievance;

(L) the signature of the reviewer and date of review for each level of review; and

(M) options for the grievant to check following each response by the facility or unit, as follows:

(i) I agree;

(ii) I do not agree;

(iii) submit to level two review;

(iv) submit to level three review;

(3) a written list showing contact information for available advocacy agencies, including the department, facility accrediting bodies, the ombudsman, and

the Disability Law Center of Alaska;

(4) three levels of review, as follows:

(A) level one, an initial review and written decision by a supervisory staff member to determine whether a grievant's treatment, care, or rights have been adversely affected, a written record of that determination, and, if the grievant's rights have been aversely affected, implementation of a mutually agreed upon resolution of the grievance;

(B) level two, if a resolution is not agreed upon or implemented under a level one review, a grievant may initiate a review within 20 calendar days after the determination is made under level one; a chief executive officer or the commissioner's designee for a facility shall make written findings and issue a decision within five business days after initiation of a level two review; if the level two review results in a finding of no adverse effect, no additional review is necessary, but the decision may be appealed under (C) of this paragraph by a grievant, and the written decision must include notice of the availability of a level three appeal;

(C) level three, a grievant may appeal the final written decision made under level two to the commissioner within 30 calendar days after receipt of the findings of the level two review; the commissioner shall make a final written decision on or before the 14th calendar day after the appeal is filed; if the commissioner fails to enter a timely decision, the appeal shall be considered denied; the commissioner may deny an appeal for substantial failure to follow the procedures set out in this section; a denial or decision by the commissioner may be appealed to the superior court within 30 calendar days;

(5) maintenance of a complete and confidential record, available on request by the grievant or the grievant's designated representative, of all documents, including the grievance and appeals and responses to the grievance and appeals;

(6) delivery, within 24 hours, of a copy of the initial grievance and of all documents maintained under (5) of this subsection to the call center established under (b) of this section, which shall promptly provide all necessary information to

(A) the grievant or the grievant's representative;

(B) the department; the department shall maintain confidentiality over the grievant's health and personal information;

(C) the person responsible for the next level of review; and

(D) the person in charge of the facility or unit; and

(7) in addition to the three levels of review and parallel procedures available under criminal and other laws provided under (4) of this subsection, an urgent level of review and expedited administrative decision, available at all times to a current patient of a facility or unit, to be conducted immediately by the chief executive officer at the facility and referred to a call center and reviewed by the department not later than 24 hours after receipt of a grievance that alleges an immediate threat to the health or welfare of a grievant.

(d) Except as provided in (c)(7) of this section, unless an extension of time of not more than five business days is agreed upon by a patient or the patient's representative, an evaluation facility or unit or a designated treatment facility or unit shall mail or hand deliver a written response to a call center within five business days after receipt of a grievance or request for additional review. The response must include the reasons for the decision and a description of the appeal process. The grievant may request review at the next level if a written response is not timely.

(e) An evaluation facility or unit and a designated treatment facility or unit shall have a designated staff member who is trained in mental health consumer advocacy who shall, on a patient's request, serve as an advocate to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights.

(f) A grievant may not file a grievance later than one year after the incident giving rise to the grievance. The facility or unit shall make a good faith effort to mail a response to a grievant who has been discharged from the facility.

(g) The department shall review all grievances and responses to grievances for compliance with this section.

(h) A facility or unit shall prepare and file a quarterly report with the department that describes the

(1) number of grievances submitted;

(2) general issue raised in each grievance; and

(3) resolution, including litigation, of all grievances submitted.

(i) The department shall compile the information provided under (h) of this section and provide a quarterly report to be posted for public review that describes the number and types of grievances filed against each facility in the previous quarter.

(j) Nothing in this section shall be interpreted to prohibit informal dispute resolution or mediation by the written agreement of the grievant, the facility or unit, and the department at any time during the grievance process but before a lawsuit concerning the subject of the grievance is filed by a grievant.

(k) A facility may not discourage or delay a patient's access to an advocate or representative of the patient's choosing.

(l) If a grievance decision made under this section is appealed to a court, the court shall presume that the imposition of attorney fees on a grievant would inflict a substantial and undue hardship on the grievant under AS 09.60.010(e).

(m) In this section,

(1) "facility" has the meaning given to "designated treatment facility" or "evaluation facility" in AS 47.30.915; and means a unit of a hospital in which patients receive mental health evaluation or treatment and for which public funds are provided;

(2) "grievance" means a complaint made by a grievant concerning a patient's treatment, care, or rights at a facility;

(3) "grievant" means a patient of a public or private mental health treatment or evaluation facility or unit or the patient's representative;

(4) "unit" means a discrete portion of a facility dedicated to the treatment or evaluation of mental health patients.

*** Sec. 3.** AS 47.30.855 is amended by adding new subsections to read:

(b) The department shall provide to a facility for posting and distribution a standardized notice that is designed to be easily understood and that separately describes patient rights, available assistance, and the grievance procedure provided under AS 47.30.847.

(c) A person in charge of a facility shall ensure that each patient or patient's representative receives a written copy of the standardized notice provided by the department under (b) of this section and of the formal grievance procedure described in AS 47.30.847(c).

(d) In this section, "facility" has the meaning given in AS 47.30.847.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT COURT RULE AMENDMENT. AS 47.30.847(*l*), added by sec. 2 of this Act, has the effect of changing Rule 82, Alaska Rules of Civil Procedure, and Rule 508, Alaska Rules of Appellate Procedure, by limiting the court's discretion in awarding attorney fees in certain cases.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. AS 47.30.847(*l*), added by sec. 2 of this Act, takes effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

SB

74

<TARGET><BILL>SB 74</BILL><SUBJECT>SB
74</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/28/11

FURTHER: Labor and Commerce

Date of 5-Day Notice: 3/24/11
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/30/11

Health and Social Services Committee considered SENATE BILL NO. 74

SB 74-INS. COVERAGE: AUTISM SPECTRUM DISORDER

"An Act requiring insurance coverage for autism spectrum disorders, describing the method for establishing a covered treatment plan for those disorders, and defining the covered treatment for those disorders; and providing for an effective date."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	**Fiscal**	**Indet.**	**Zero**	**FN #**
DEC			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	**Fiscal**	**Indet.**	**Zero**	**FN #**

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Meyer	X			
	Ellis	X			
		X			
	Dyson				X
CHAIR:	DAVIS	X			

Sponsored by:

AUTISM SOCIETY

Improving the Lives of All Affected by Autism

Alaska

Juneau, Alaska
Saturday, April 2, 2011
Dimond Field House Track
11a-1p

Alaska Walk for Autism

asagoldenheart.org

REGISTER ON-LINE NOW!

Free water bottle for everyone!
First 100 registered participants will receive an event T-Shirt.

For more information please visit:
www.asagoldenheart.org ** 1-888-374-4421

Rules Committee
•
Senate Finance Committee
•
Health & Social Services Committee
•
Community & Regional Affairs Committee
•
World Trade Special Committee
•
Committee on Committees

ALASKA STATE LEGISLATURE

While in Session
State Capitol, Rm. 119
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529
•
While in Anchorage
716 W. 4th Ave, Rm. 500
Anchorage, AK 99501
(907) 269-0169
Fax: (907) 269-0172

SENATOR JOHNNY ELLIS
RULES COMMITTEE CHAIR

SPONSOR STATEMENT – SENATE BILL 74

SB 74 – An act requiring insurance coverage for autism spectrum disorders

Autism is a devastating disorder affecting at least 1 in 110 American children. Despite being treatable, many children diagnosed with an Autism Spectrum Disorder (ASD) never receive the treatment they need. In fact, most insurance plans explicitly exclude treatment of ASDs, even when the service is otherwise covered by the health plan.

SB 74 would require insurance coverage for autism spectrum disorders, including the behavior therapies that after 30 years of study have shown to be the only effective treatment of these disorders. One of the nation's foremost actuarial firms has studied the cost of providing insurance coverage for autism spectrum disorders, and concluded that the cost to policy holders in Alaska would be minimal (estimated at between 0.28% and 0.68%, or $2.58 per month). This legislation allows Alaska to start this process on our own terms, without a federal mandate, and gives the state the needed time to build capacity to meet the demands created by SB 74.

Treatment has been shown to improve, often significantly, the symptoms of ASD. In some cases, effective treatment eliminates the need for special education services for a child with ASD. The cost savings in special education alone amounts to approximately $208,500 per capita while the child is in school. This number rises to over $1.08 million over the autistic person's lifespan. Furthermore, the incremental societal cost of not treating autism has been estimated to be approximately $3.2 million per capita.

Coverage of ASDs by insurers would not only provide a needed service to those families suffering directly from the affects of a child with autism, but saves the state and taxpayers exponentially over the lifespan of those diagnosed with autism. Though there is no cure for ASDs, this legislation would help significantly to treat individuals and families suffering from these disorders. Prompt passage of this legislation would allow the state to reap the health and economic benefits that would result from covering ASDs.

I respectfully ask for your careful consideration and support of SB 74.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 28, 2011

SUBJECT: Sectional summary; insurance for autism spectrum disorders (SB 74, Work Order No. 27-LS0443\A)

TO: Senator Johnny Ellis
Chair of the Senate Rules Committee
Attn: Amory Lelake

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Requires a health care insurer to provide coverage for the costs of the diagnosis and treatment of autism spectrum disorder under a treatment plan prescribed by a physician or psychologist. Coverage is required only for individuals under 21 years of age; must not limit the number of visits for treatment; is subject to the same copayment, deductible and coinsurance terms applicable to other health care services; and may be coordinated with an education program. The health care insurer may not refuse to cover an individual or terminate coverage because the individual is diagnosed with autism spectrum disorder.

Section 2. The Act applies to a health care insurance policy effective after January 1, 2012.

Section 3. Provides for an immediate effective date.

DCB:ljw
11-199.ljw

Rules Committee
•
Senate Finance Committee
•
Health & Social Services Committee
•
Community & Regional Affairs Committee
•
World Trade Special Committee
•
Committee on Committees

ALASKA STATE LEGISLATURE

While in Session
State Capitol, Rm. 119
Juneau, AK 99801
(907) 465-3704
Fax: (907) 465-2529
•
While in Anchorage
716 W. 4th Ave, Rm. 500
Anchorage, AK 99501
(907) 269-0169
Fax: (907) 269-0172

SENATOR JOHNNY ELLIS
RULES COMMITTEE CHAIR

SB 74
Insurance Coverage for Autism Spectrum Disorders

Sectional Analysis

Section 1 of this bill amends AS 21.42 by creating a new section AS 21.42.397 relating to insurance coverage for autism spectrum disorders.

Subsection (a) requires insurance plans to cover medically necessary treatment for autism spectrum disorders, and exempts plans offered by fraternal benefit societies.

Subsection (b) further defines the coverage that must be provided.

Subsection (c) establishes that this section does not limit coverage already provided.

Subsection (d) prohibits an insurance company from denying coverage to someone because they have an autism spectrum disorder

Subsection (e) defines "autism service provider," "autism spectrum disorders," health care insurance plan", "health care insurance," and "medically necessary."

Section 2 of the bill establishes that the provisions of section 1 only apply to insurance policies issued after January 1st, 2012.

Section 3 of this bill establishes an immediate effective date for this act.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB 74**
() Publish Date

Identifier (file name) SB074-CCED-INS-03-25-11
Title: Insurance Coverage: Autism Spectrum Disorder
Sponsor: Senator Ellis
Requester: Senate Health and Social Services

Dept. Affected: DCCED
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
1178 Micro-Loan Fund (RLF)							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by: Linda Hall, Division Director — Phone: 465-2560
Division: Division of Insurance — Date/Time: 3/25/11 12:30 PM
Approved by: Susan Bell, Commissioner — Date: 3/26/2011
Commerce, Community, and Economic Development

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 74

Analysis

This legislation mandates coverage for the diagnosis and treatment of autism spectrum disorders in any plan offered by health care insurer.

The Department does not expect a fiscal impact as a result of this legislation.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version **SB 74**
() Publish Date

Identifier (file name) SB074-CCED-INS-03-25-11
Title Insurance Coverage: Autism Spectrum Disorder
Sponsor Senator Ellis
Requester Senate Health and Social Services

Dept. Affected DCCED
Appropriation Insurance Operations
Allocation Insurance Operations
OMB Component Number 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
1178 Micro-Loan Fund (RLF)							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by Linda Hall, Division Director
Division Division of Insurance
Approved by Susan Bell, Commissioner
Commerce, Community, and Economic Development

Phone 465-2560
Date/Time 3/25/11 12:30 PM
Date 3/26/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 74

Analysis

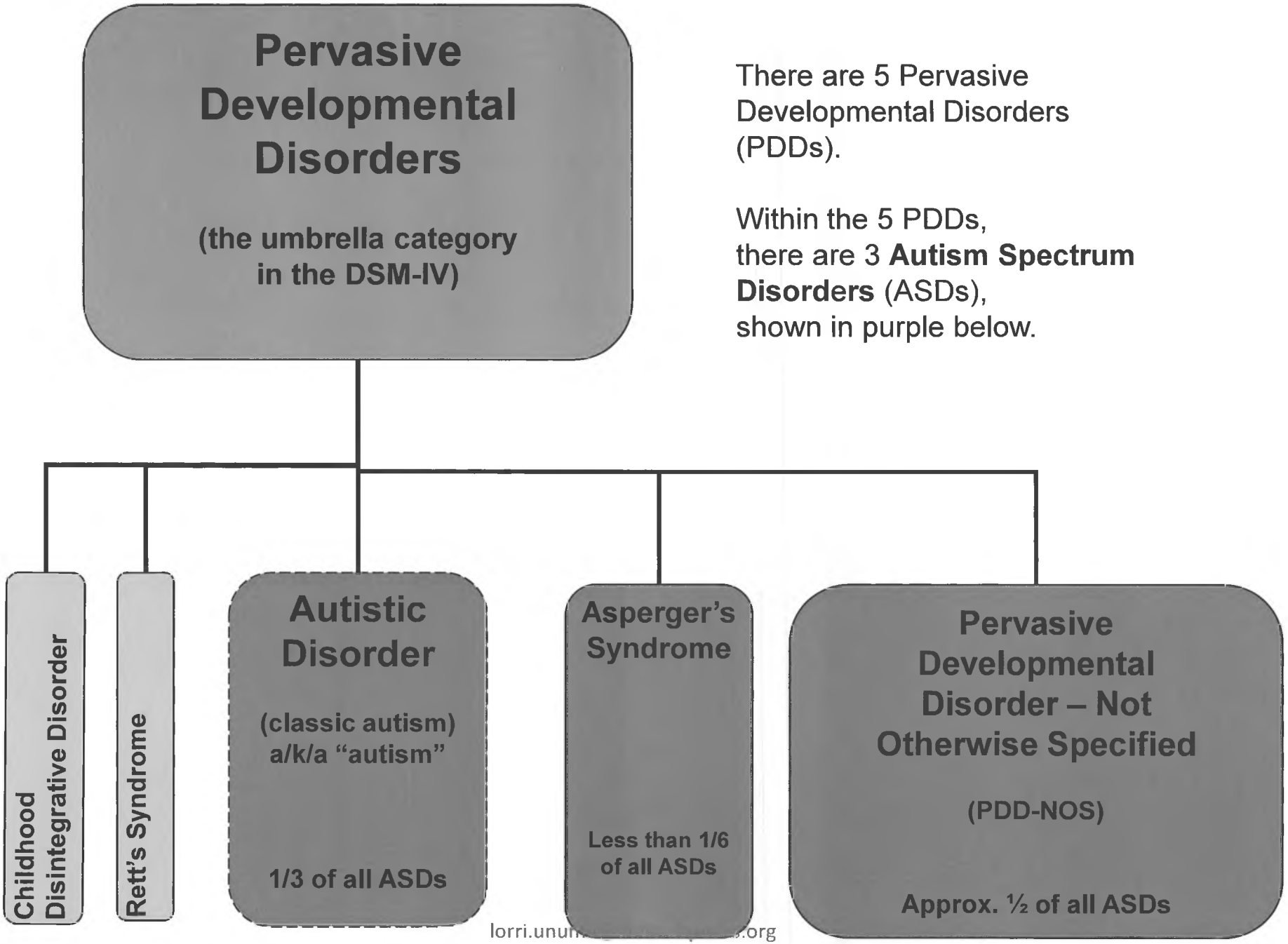
This legislation mandates coverage for the diagnosis and treatment of autism spectrum disorders in any plan offered by health care insurer.

The Department does not expect a fiscal impact as a result of this legislation.

Insurance Coverage for Autism in Alaska

Lorri Unumb, Esq.
Autism Speaks

lorri.unumb@autismspeaks.org



lorri.unum .org

Autism Spectrum Disorder

- Curable? No
- Treatable? Yes

- Impaired Communication
- Impaired Social Interaction
- Repetitive or Stereotyped Patterns of Behavior
- Narrow Range of Interests

- Four times more common in boys than girls
- Average age of diagnosis: 5-1/2

Applied Behavior Analysis (ABA Therapy)

- One-on-one therapy based on principles of repetition, reinforcement, and extinction.

- When an environment supports a set of behaviors, they increase. When an environment does not support behaviors, they tend to extinguish and fade away.

ABA Therapy Is Not Experimental

- "Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."

  Report of the Surgeon General of the United States, 1999

- "ABA therapy is not experimental or investigational in nature."

  McHenry v. PacificSource Health Plans (D. Oregon, Jan. 5, 2010)

- "The effectiveness of ABA-based intervention in ASDs has been well documented through 5 decades of research . . . . Children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups."

  American Academy of Pediatrics

Applied Behavior Analysis: Sample Therapy Structure

- Consultant
  - Highly educated and trained
  - Board certified
  - Evaluates, designs, trains
  - 3-6 hours per month

- Mid-level supervisor (lead therapist)
  - Highly educated and trained
  - Updates programming; trains; oversees
  - 6 hours per week

- Line therapists
  - Trained & supervised by above
  - Provide 40 hours per week of direct therapy, usually in 3-hour shifts

Applied Behavior Analysis: Cost of a Sample Therapy Program

- Consultant
  - 3-6 hours per month
  - $100-$150/hour
  - 6 hours x $150 = $900/month
  - $900 x 12 months = **$10,800**

- Mid-level supervisor (lead therapist)
  - 6 hours per week
  - $30-$60/hour
  - 6 hours x $60 = $360/week
  - $360/week x 52 weeks = **$18,720**

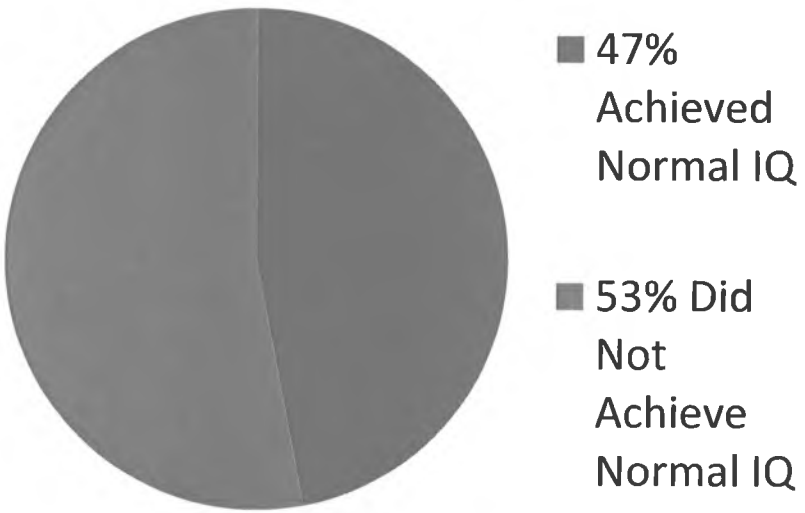
- Line therapists
  - 40 hours per week
  - $10 - $30/hour
  - 40 hours x $20 = $800/week
  - $800/week x 52 weeks = **$41,600**

- $10,800 + $18,720 + $41,600 = **$71,120**

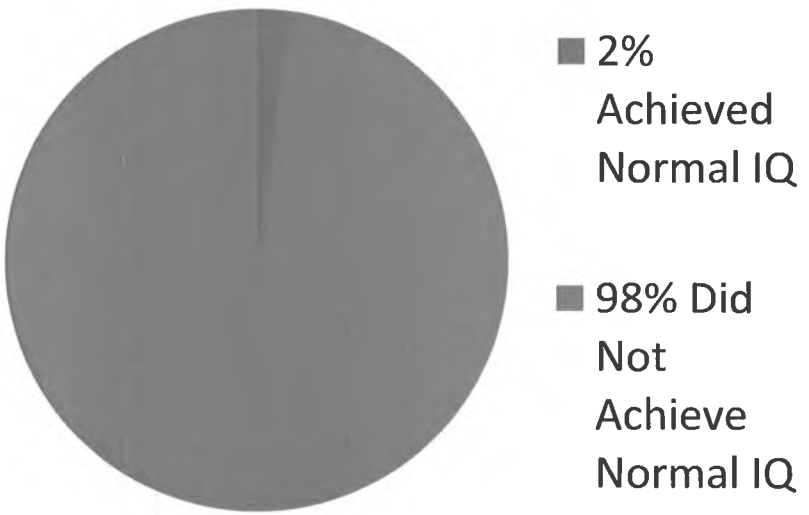
Savings to the State: Special Education

Outcome of 1987 UCLA Study on Efficacy of ABA

ABA Group



Other Intervention (Control) Group



Societal Costs of Autism

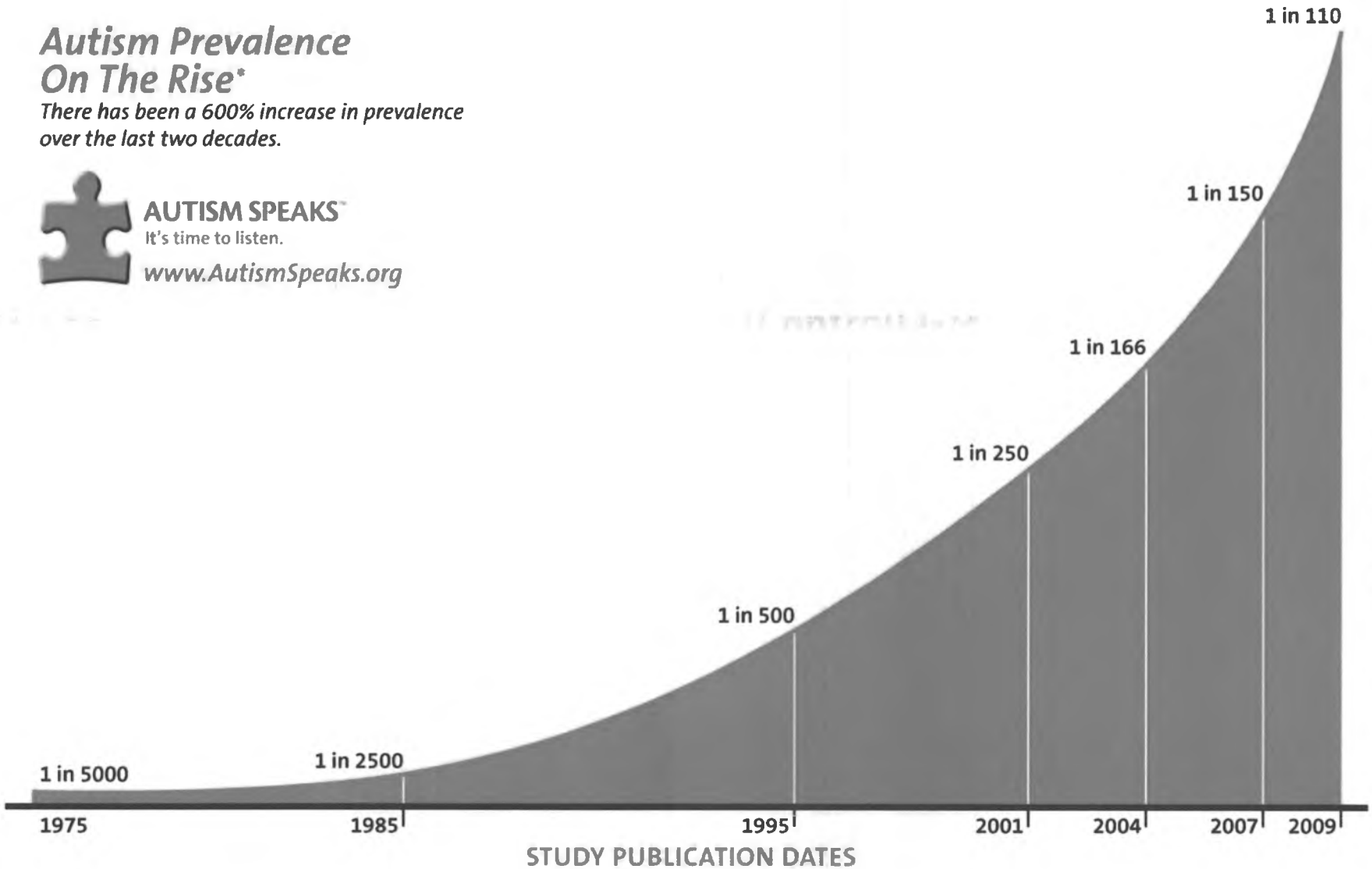
- Harvard School of Public Health (Ganz, 2006)
- $3.2 million per person over lifetime
  - Includes direct and indirect costs, such as lost productivity

- Pennsylvania (Green, Jacobson & Mulick, 1998)
- Over $1 million per person

Autism Prevalence On The Rise*

There has been a 600% increase in prevalence over the last two decades.

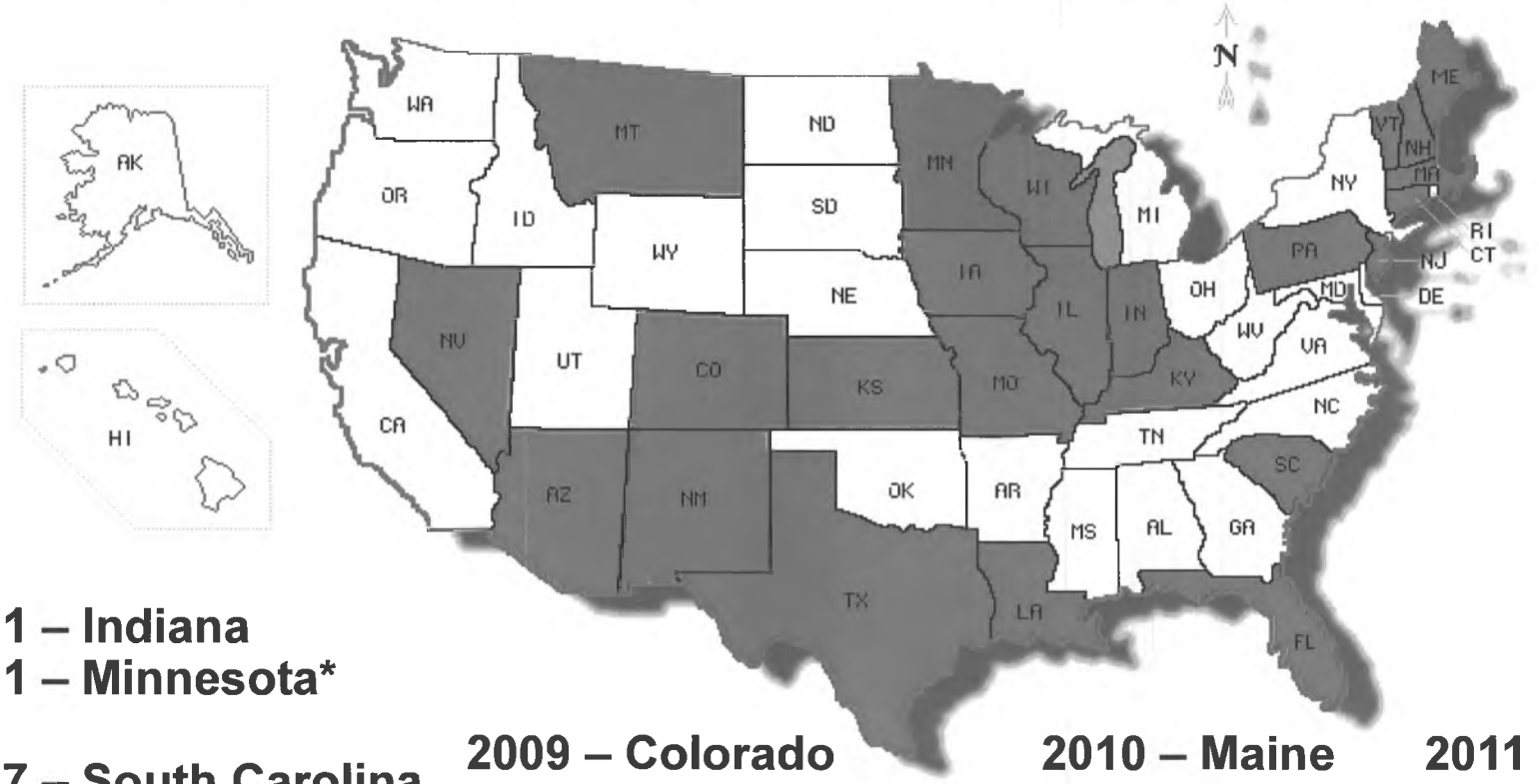
AUTISM SPEAKS™
It's time to listen.
www.AutismSpeaks.org



*Recent research has indicated that changes in diagnostic practices may account for at least 25% of the increase in prevalence over time, however much of the increase is still unaccounted for and may be influenced by certain unidentified factors.

© 2009 Autism Speaks Inc. Autism Speaks and Autism Speaks It's Time To Listen & Design are trade marks owned by Autism Speaks Inc. All rights reserved

States with Autism Insurance Reform



2001 – Indiana
2001 – Minnesota*

2007 – South Carolina
2007 – Texas

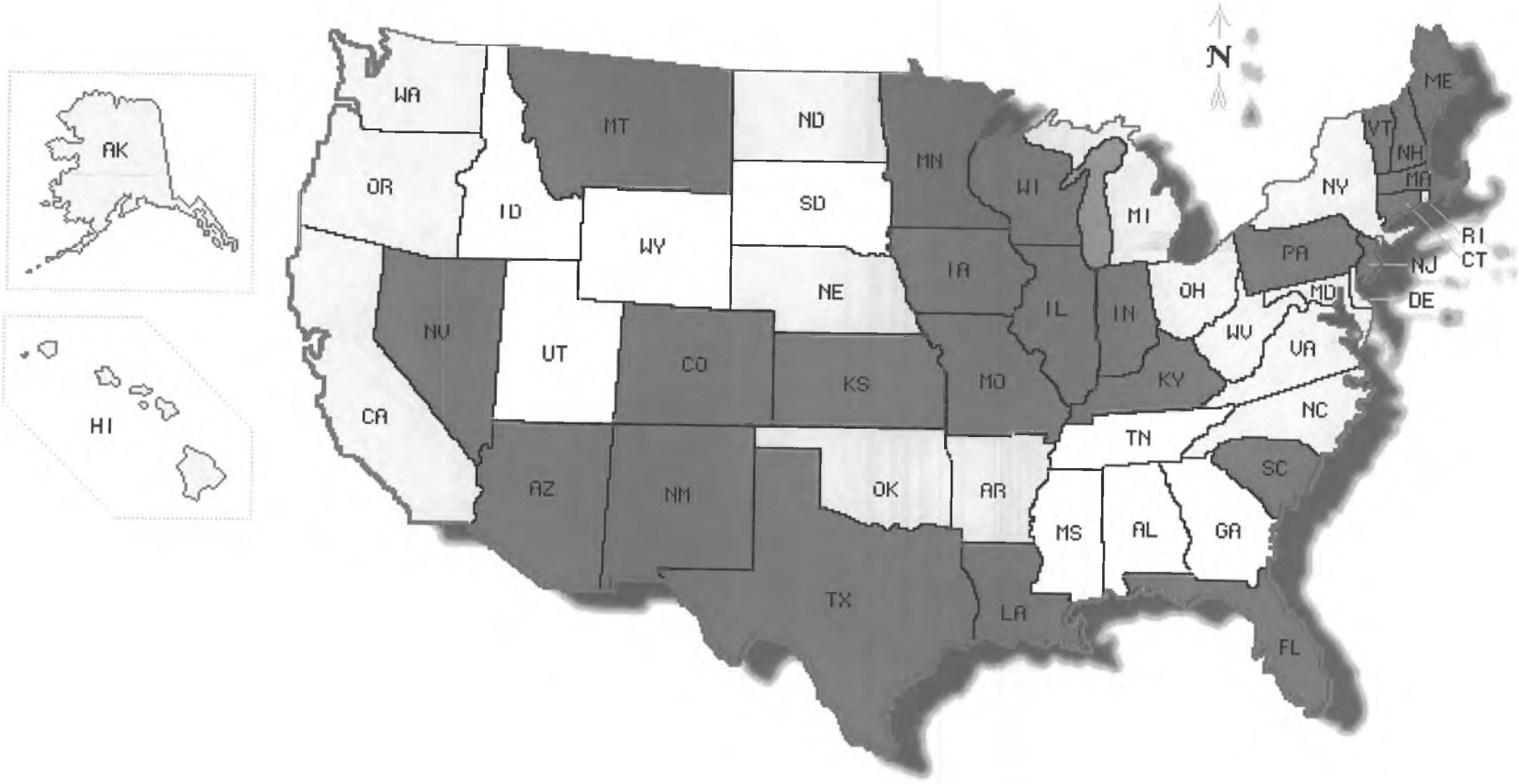
2008 – Arizona
2008 – Florida
2008 – Louisiana
2008 – Pennsylvania
2008 -- Illinois

2009 – Colorado
2009 – Nevada
2009 – Connecticut[1-19-11]
2009 – Wisconsin
2009 – Montana
2009 – New Jersey
2009 – New Mexico

2010 – Maine
2010 – Kentucky
2010 -- Kansas
2010 -- Iowa
2010 -- Vermont
2010 – Missouri
2010 – New Hampshire
2010 -- Massachusetts

2011 – Arkansas

+ States with Bills Pending



1-19-11

lorri.unumb@autismspeaks.org

Comparison of Autism Benefits

State	Annual Cap	Age Cap
Indiana	None	None
Minnesota**	None	None
South Carolina	$50,000 - ABA	16
Texas	None	11
Pennsylvania	$36,000	21
Montana	$50,000/$20,000 at 10	18
Arizona	$50,000/$25,000 at 9	17
Missouri	$40,000	18
New Hampshire	$36,000/$27,000 at 13	21
Kansas*	$36,000/$27.000 at 7	19
Massachusetts	None	None
Vermont	None	6, or 1st grade***
Iowa*	$36,000	21

lorri.unumb@autismspeaks.org

Behavioral Therapy Benefits for Autism

Major Group

Student Guide

South Carolina

APS HEALTHCARE
Healthy Together

State of South Carolina
State Health Plan Autism Spectrum Disorder Benefit

Effective with the 2009 Plan Year, the State Health Plan began covering Applied Behavior Analysis (ABA) for children diagnosed with an Autism Spectrum Disorder. The Employee Insurance Program (EIP) asked APS Healthcare to develop guidelines for administering the new benefit. Just like other services covered by APS for behavioral health diagnoses, the new Autism Spectrum Disorder (ASD) benefit services must be pre-authorized as medically necessary by APS, and providers must be contracted with APS as in-network providers. Only ABA providers fully certified by the Behavior Analyst Certification Board will be part of the network and be able to file claims for ABA services. All reimbursements for ABA services will be made by APS directly to ABA providers.

Board Certified Behavior Analysts (BCBA's) contracted with APS must provide direct supervision to their staff, including Board Certified Associate Behavior Analysts and/or any non-certified ABA therapists. Direct supervision includes the observation and oversight of the delivery of "hands on" ABA therapy by behavioral therapy staff.

The new benefit became effective on **January 1, 2009.** Following is a summary of requirements for coverage under the new benefit.

Eligibility Requirements:

1) Member must be covered by the State Health Plan and under sixteen (16) years of age with no pre-existing condition exclusions.

2) Member must be diagnosed by age eight (8) with Autistic Disorder, Asperger's Disorder or Pervasive Developmental Disorder Not Otherwise Specified by a Physician or Certified Registered Nurse Practitioner.

3) Diagnosis by age 8 must be confirmed by the following diagnosis-specific tests/screening tools:
   a. Autistic Disorder using one of the following:
      1. Checklist for Autism in Toddlers (CHAT); or
      2. Modified Checklist for Autism in Toddlers (M-CHAT); or
      3. Screening Tool for Autism in Two-Year Olds (STAT); or
      4. Social Communication Questionnaire (SCQ) (recommended for children four-years of age or older)
   b. Asperger's Syndrome using one of the following (recommended for school-age children):
      1. Autism Spectrum Screening Questionnaire (ASSQ); or
      2. Childhood Asperger Syndrome Test (CAST); or
      3. Krug Asperger's Disorder Index (KADI)
   c. Pervasive Development Disorder, NOS using the following:
      1. One of the previously mentioned tools to rule out Autism and Asperger's; and
      2. DSM-IV Diagnostic Criteria/Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS)

4) Member must be evaluated by an appropriate diagnostician to rule out the following as a sole explanation for symptoms of Autism Spectrum Disorder:
   a. Neurological Disorder (must be by an MD)
   b. Lead Poisoning (must be by an MD),
   c. Primary Speech Disorder, and
   d. Primary Hearing Disorder.

5) Member must be evaluated by a licensed Psychologist within the last 6 months for current validation of the ASD Diagnosis, using:
   a. Autism Diagnostic Observation Schedule (ADOS); or
   b. Autism Diagnostic Interview (ADI-R); or
   c. Childhood Autism Rating Scale (CARS); or
   d. A DSM-IV Diagnostic Criteria which validates one of the three ASD diagnoses

Excerpt from 2009 Report of Council of Affordable Health Insurance: "Health Insurance Mandates in the States"

BENEFITS:	Est. Cost	#
Alcoholism	1-3%	45
Autism	<1%	23
Contraceptives	1-3%	29
In Vitro Fert.	3-5%	15
Prescriptions	5-10%	3

Actual Claims Data
BCBS of Minnesota (2007)

- Dates
  - In effect 2001
- Population
  - State has population of 5.3M
  - BCBS has 2100 members with ASD
- Terms
  - No dollar cap
  - No age cap

- Cost
  - Total claims = $12M
  - 315 of the 2100 members accounted for $9.7M of the $12M cost
- Premium impact PMPM (per member per month)
  - $0.83 commercial mrkt
  - $0.79 public programs
- Average annual cost for behavioral health treatment = $30,000

South Carolina State Employee Plan

APS HEALTHCARE
Healthy Together

- Dates
  - Statute passed in 2007
  - Applicable to state health plan as of 1-1-09
- Population
  - State has 4.5 M
  - State health plan has 350-390,000 members
- Terms
  - $50,000 cap on ABA
  - To age 16

- Projected Cost

  Original: $18.9 million

  Revised: $9 million
- Actual cost

  2009: $856,371

  PMPM - 20 cents

  2010: $2,042,392

  PMPM - 44 cents

  PEPM – 75 cents

  (228,048 employees/subscribers; 79 kids accessing coverage)

lorri.unumb@autismspeaks.org

Alaska Fiscal Impact Worksheet

- Number of *employees* in state plan _____
- X
- Per *employee* per month (PEPM) cost 75 cents

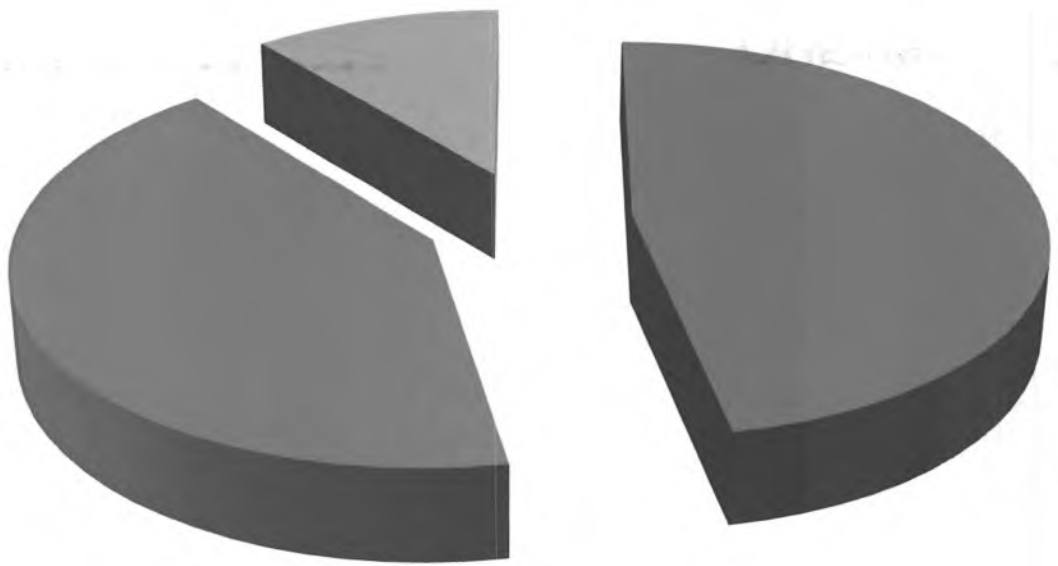
  (using 2010 South Carolina actual claims data; SC has age 16 & $50,000 cap on ABA)
- =

  _____
- X
- Number of months in year 12 months

  =
- Total annual cost _____
- (To determine total cost to state's general fund, discount the above total by percent of health insurance premium that a state employee pays, if any.)

Outcome of 1987 UCLA Study

Educational Placements for Group That Received ABA



- 47% = Mainstreamed with No Support
- 42% = Low-Intensity Special Education Placement (for language delay)
- 11% = High-Intensity Special Education Placement (for autism or intellectual disability)

Savings to the State: Special Education

"A study published in a national journal found that Pennsylvania could save an average of $187,000 to $203,000 on each child who received three years of EIBI relative to one who received special education services until age 22. The Pennsylvania study also suggested that cost savings would likely continue to accrue after children exit the school system. The study found that the state could save from $656,000 to $1.1 million per child if expenditures up to age 55 are included.

Another study published in a national journal found that Texas could save an average of $208,500 in education costs for each student who received three years of EIBI relative to a student who received 18 years of special education from ages four to 22. Applied to the estimated 10,000 children with ASDs in Texas, it was estimated that the state could save almost $2.1 billion by implementing intensive treatment programs."

Source: 2009 Report of the Joint Legislative Audit and Review Commission to the Governor and General Assembly of Virginia (JLARC Report)

"Educational in Nature"?

- False choice
- What does "educational in nature" mean?
- *Schools provide?*
- *Schools would provide if adequate resources?*
  - No obligation under IDEA or state law to <u>treat</u> medical condition
    - Schools are required to accommodate the disabling condition, not remedy it.
- Is speech therapy "educational in nature"? AAP report.
- *Provided by school personnel?*
- Academic goals
- ASD is diagnosed by a doctor, not a principal
- Argument du jour
  - Rejected in 23 states
  - Rejected in federal court

"Educational in Nature"?

- *McHenry v. PacificSource Health Plans (D. Oregon, Jan. 5, 2010)*
- "While ABA therapy may have beneficial effects on an autistic child's social and academic skills, its defining characteristic is application of techniques to modify behavior in every area of an autistic child's life. In this regard, a sports analogy is instructive. While participation in sports can benefit a student's academic and social skills, no one would classify sports as academic or social skills training.
- Similarly, the incidental benefits in these areas resulting from ABA therapy, while real, do not dictate that it be classified as either academic or social skills training.
- . . . While aimed at improving social and academic functioning, it does this by specifically addressing behavioral deficits possessed by autistic children that interfere with every area of their life, not by educating kids on social norms or teaching study skills or other tools specific to academic success."

Impact of Federal Health Care Reform

- 2009 Amendments by Rep. Doyle (Pa.) & Sen. Menendez (NJ)
- Changed "**Mental health and substance use disorder services**", one of ten required benefits, to "**Mental health and substance use disorder services*, including behavioral health treatments***".
- Applies to plans issued through Exchanges as well as small group and individual plans.
- N/A to existing coverage, large groups, self-funded
- Starts in 2014.
- http://www.autismvotes.org/site/apps/nlnet/content2.aspx?c=frKNI3PCImE&b=3930723&ct=7522291

The Essential Benefits Package

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

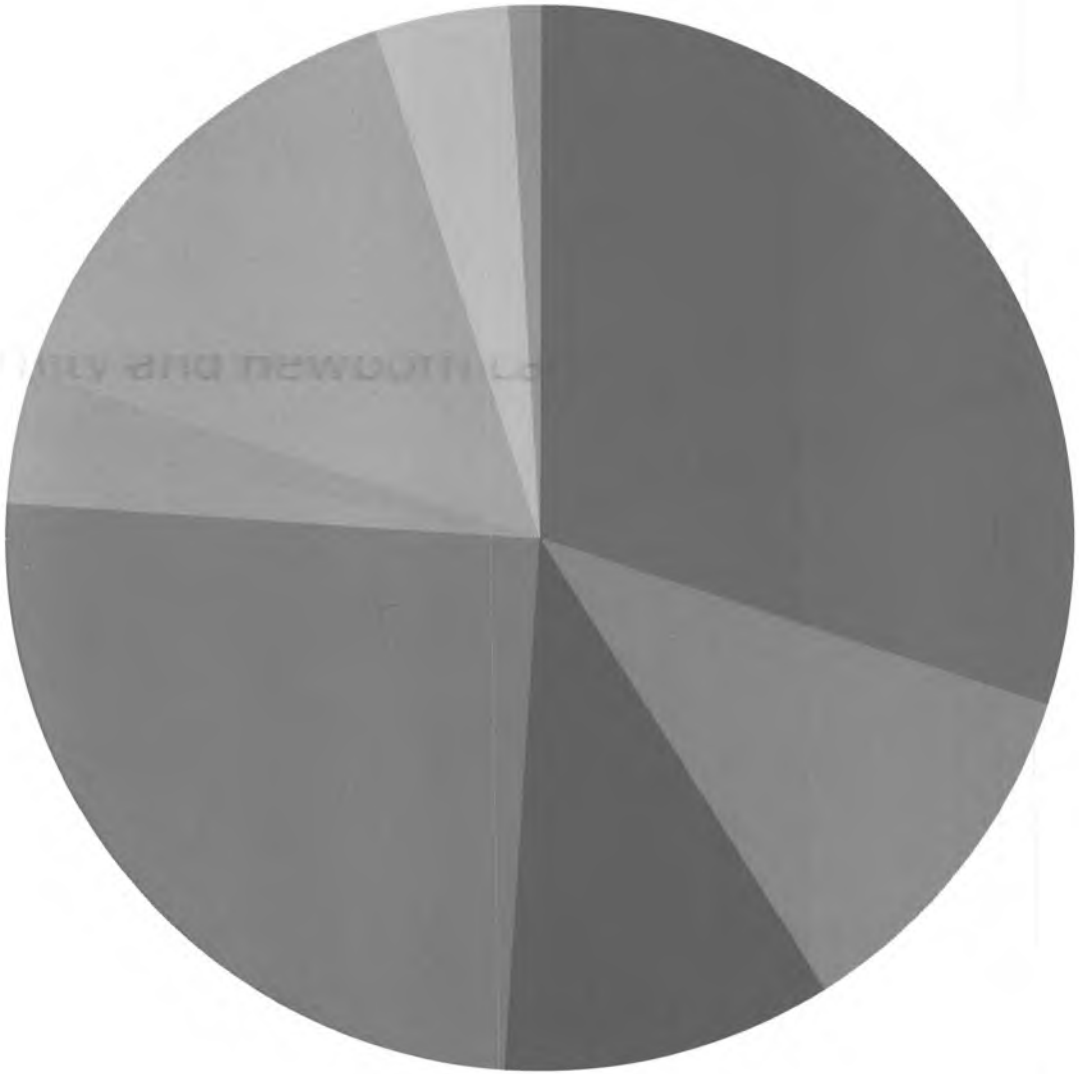
Impact of 2008 Federal Mental Health Parity Law

- 2008 Wellstone-Domenici Act prohibits **treatment limitations** and **financial requirements** on "mental health benefits" if not on physical health benefits.

- Wellstone MHP law applies only to large group fully-funded and self-funded policies.

- Illinois, Iowa, Maine, Montana, New Hampshire, New Jersey explicitly and Connecticut, Florida, Kansas, Kentucky, Missouri implicitly include autism within their state definition of mental illness.
- All of these states except Florida have passed capped autism mandates since the passage of the Wellstone federal MHP law.

Sources of Health Care Coverage



- Medicaid - 20%
- Medicare - 10%
- Uninsured - 11%
- State Health Plan - 10%
- ERISA - ASO - 25%
- Federal Tricare - 2%
- Federal Civilian - 2%
- Other Insured - Large Group - 15%
- Other Insured - Small Group - 4%
- Other Insured - Individual - 1%

Self-Funded ERISA Plans

- "Overall, self-funded plans voluntarily cover 86% of the cost of mandated services."
- 2008 Report of Maryland Health Care Commission

Self-Funded ERISA Plans That Cover Autism Treatments

- Microsoft
- Home Depot
- Intel
- Arnold & Porter
- Halliburton
- Eli Lilly
- Deloitte
- Ohio State University
- Time Warner
- Blackbaud
- Lahey Clinic
- Partners Healthcare
- Wells Fargo
- Lexington Medical Center
- University of Minnesota
- Progressive Group
- Greenville Hospital System
- Symantec
- DTE Energy
- Cerner
- State Street Financial
- Children's Mercy
- EMC
- Yahoo
- Sisters of Mercy
- Princeton University
- And many more . . .

Provider Credentials

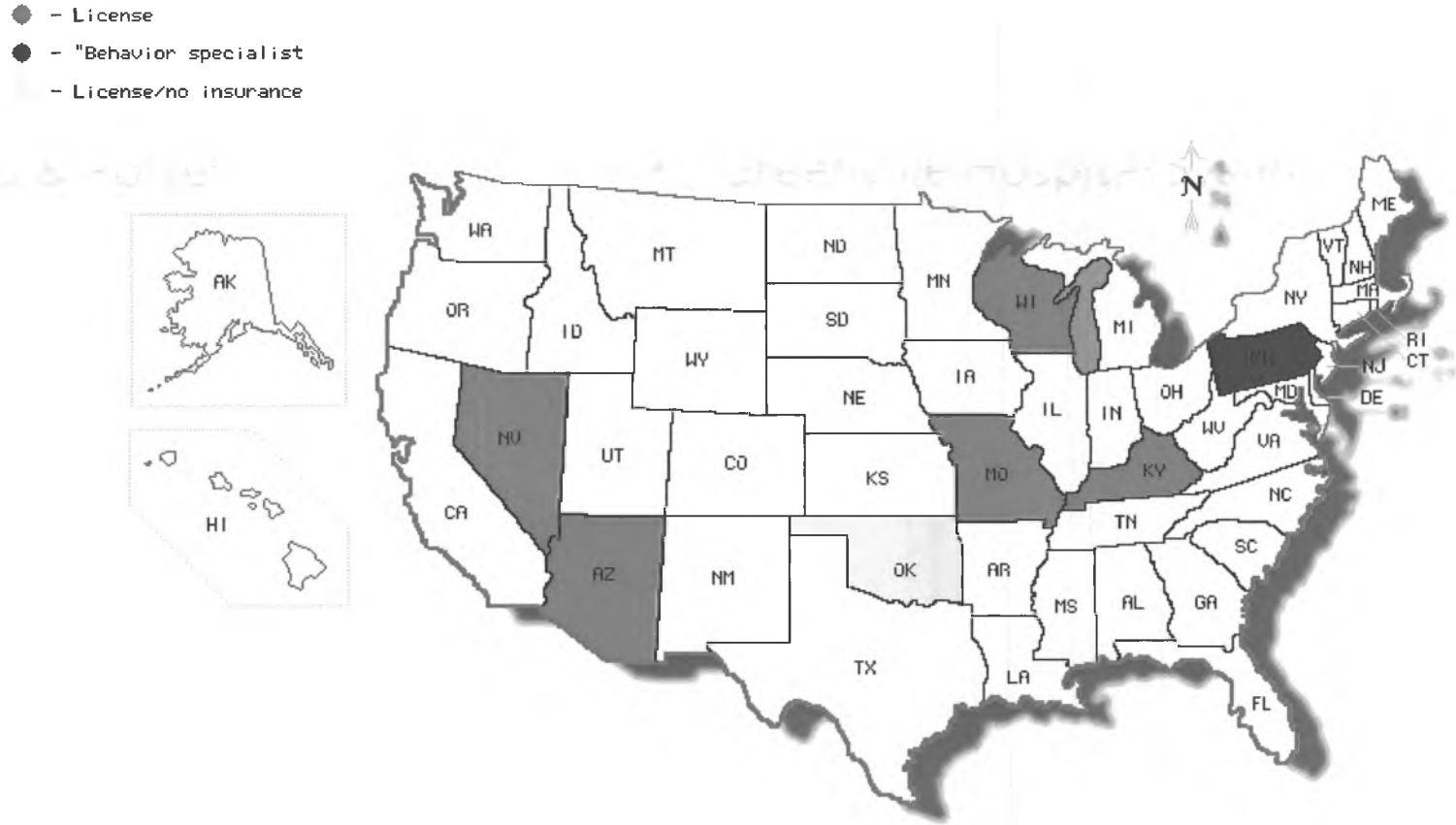
www.BACB.com

The Behavior Analyst Certification Board, Inc.® (BACB®) is a nonprofit corporation established as a result of credentialing needs identified by behavior analysts, state governments, and consumers of behavior analysis services.

The BACB's mission is to develop, promote, and implement a voluntary international certification program for behavior analyst practitioners. The BACB credentials Board Certified Behavior Analyst® BCBA®) and Board Certified Assistant Behavior Analyst® (BCaBA®).

lorri.unumb@autismspeaks.org

Insurance States that License Behavior Analysts



5-29-10

Neurology

January 2007 Issue

Table 3 Summary of evidence: Incidence and prevalence of 12 neurologic disorders

Disorder	Class of evidence	Range of ages included (y)	Median estimates: Annual incidence Rate/ 100,000	Annual incidence No.*	Prevalence Rate/ 1,000	Prevalence No.*	Rate ratio, M/F†	Age(s), y, of peak incidence
Autism spectrum disorders	I, II	2–15	—	—	6.8	500,000‡	4.2	—
Cerebral palsy	I, II	3–13	—	—	2.4	207,000‡	1.3	—
Tourette syndrome	II	7–17	—	—	3.5§	301,000	4.8	—
Migraine	I, II	12–65	—	—	121	35,461,000	0.4	—
Epilepsy	I, II	All	48	142,000	7.1	2,098,000	1	<1, ≥80
Multiple sclerosis	I	All	4.2	12,000	0.9	266,000	0.5	30
Traumatic brain injury	I	All	101	298,000	—	—	2.1	20, ≥80
Spinal cord injury	I,II	All	4.5	13,000	—	—	4.2	20
ALS	I, II	All	1.6	5,000	0.04	12,000	1.3	≥60
Stroke	I, II	All	183	541,000	10	2,956,000	1.1	≥80
		≥65	1,093	401,000	—	—	—	
Alzheimer disease	I,II	≥65	1,275	468,000	67	2,459,000	0.5	≥80
Parkinson disease	I,II	≥65	160	59,000	9.5	349,000	1.8	≥70

* Estimated number of cases in United States in 2005, rounded to nearest 1,000.
† Ratio of rates among males to rates among females.
‡ Estimated number of cases among children younger than 21 years of age only.
§ Data inadequate for firm estimate.

Why Our Job Is Not Done

- May 27, 2010 at 5:08pm
- Subject: thanks
- I just wanted to say thank you for accomplishing what many people would not have attempted. I live in Charleston, SC. My husbands insurance is self funded so we are having to give up custody of our autistic 2 year old to my parents because their insurance is better. ABA is really helping and there is nothing I wouldn't do for him. You are inspirational to me and a hero. God bless you.

"[N]o disability claims more parental time and energy than autism."

New York Times, 12/20/04

Autism Speaks

Arguments in Support of Private Insurance Coverage of Autism-Related Services

AUTISM SPEAKS™
It's time to listen.

AUTISM VOTES™
AN AUTISM SPEAKS™ INITIATIVE
It's time for lawmakers to listen.

Eight arguments defining the justification for autism insurance reform legislation

February 2009

1990 K Street NW, Washington, DC 20006 Tel 202.955.3114 Fax 202.955.3115

WWW.AUTISMVOTES.ORG

Contents

Page 4	**Executive Summary**
Page 5	**About Autism Speaks**
Page 5	**About Autism**

Arguments in favor of a legislative mandate for coverage of autism:

Page 6	***Argument 1:*** **Mandated private health insurance coverage will provide services that are desperately needed by children with autism, who have greater health care needs than children without autism.**
Page 7	***Argument 2:*** **Treatments for autism are difficult to access, often inadequate, and frequently delayed. Denied coverage by private group health insurance companies, parents are often forced either to pay out-of-pocket or forego the treatments their children need.**
Page 10	***Argument 3:*** **Mandated private insurance coverage will bring effective autism services within the reach of children who need them. The efficacy of Applied Behavior Analysis (ABA), the centerpiece of this legislative mandate's benefits, has been established repeatedly.**
Page 12	***Argument 4:*** **Government and scientific organizations have endorsed Applied Behavior Analysis (ABA) and other structured behavioral therapies.**
Page 14	***Argument 5:*** **To combat the difficulty many families face in accessing Applied Behavior Analysis (ABA) and other structured behavioral treatments through public insurance, three states have passed autism insurance mandates that specifically require private insurance companies to provide coverage of these therapies, thus creating a public-private partnership for the provision of care.**
Page 16	***Argument 6:*** **The costs of this insurance reform are small and will have very little impact on the cost of health insurance premiums for the individual consumer.**

Page 17	***Argument 7:*** **By improving outcomes for children with autism, mandated private insurance coverage will decrease the lifetime costs of treating and providing services and will actually result in an overall cost savings in the long-run.**
Page 19	***Argument 8:*** **Without passage of legislation requiring private health insurance coverage for autism, the costs associated with autism will continue not only to affect families, but will have far reaching social effects as well.**
Page 21	**Conclusion**
Page 22	**References**

Executive Summary

Autism is a complex neurobiological disorder and is the fastest-growing serious developmental disability in the U.S. The Centers for Disease Control estimates that 1 in 150 children have autism. These children require extensive services from medical professionals. Early intervention is critical to gain maximum benefit from existing therapies. Most private health insurance plans do not provide coverage for Applied Behavioral Analysis (ABA) and other autism-related services.

This document contains eight arguments in favor of requiring private health insurance policies to cover the diagnosis and treatment of autism spectrum disorders for individuals under the age of 21. These arguments are based on epidemiological, social, and economic studies of the children and families affected by autism and prove the significant long-term financial and public health benefits of this requirement.

We first point out that children with autism have substantial medical needs and have a difficult time accessing necessary treatments through Medicaid and private health insurance. Most insurance policies contain specific exclusions for autism. This is a hardship for many families, who are often forced to cope with delayed, inadequate, and fragmented care through the Medicaid system. Often, families must pay for costly treatments out-of pocket or forego them.

We then review some of the many studies and reports that document the effectiveness of intensive behavioral therapies in the treatment of autism. An autism insurance mandate should specifically target coverage of Applied Behavior Analysis (ABA) and other structured behavioral therapies, which are the most effective forms of treatment and have the best outcomes, both in human costs and in long-term economic benefits.

We then comment on the experiences of several states with insurance reform. Their experiences show that the policy holder costs resulting from the passage of legislation requiring comprehensive autism services have been relatively small.

Finally, we point out that the mandate offers hope that children with autism will need less intensive care in the future. They will, in short, have a better chance at a normal life.

What is Autism Speaks?

Autism Speaks is an organization dedicated to increasing awareness of autism spectrum disorders, to funding research into the causes, prevention, treatments, and cure for autism, and to advocating for the needs of affected families. The organization was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Bob Wright is Vice Chairman, General Electric, and served as chief executive officer of NBC for more than twenty years. Autism Speaks has merged with both the National Alliance for Autism Research (NAAR) and Cure Autism Now (CAN), bringing together the nation's three leading autism advocacy organizations.

What is Autism?

Autism is a complex neurobiological disorder that typically lasts throughout a person's lifetime. It is part of a group of disorders known as autism spectrum disorders (ASD). Today, 1 in 150 individuals is diagnosed with ASD, making it more common than pediatric cancer, diabetes, and AIDS combined. It occurs in all racial, ethnic, and social groups and is four times more likely to strike boys than girls. Autism impairs a person's ability to communicate and relate to others. It is also associated with rigid routines and repetitive behaviors, such as obsessively arranging objects or following very specific routines. Symptoms can range from very mild to quite severe.

***Argument 1*: Mandated private health insurance coverage will provide services that are desperately needed by children with autism, who have greater health care needs than children without autism.**

Children with autism have a tremendous need for services from trained medical professionals. These children are at risk for a range of other medical conditions, including behavioral or conduct problems, attention-deficit disorder or attention-deficit/hyperactivity disorder, stuttering, stammering, and other speech problems, depression and anxiety problems, bone, joint, or muscle problems, ear infections, hearing and vision problems, allergies (especially food allergies), and frequent and severe headaches. These problems greatly affect their overall health and their need for and use of health care services.

A recent study by James G. Guerney and others[1] highlights the broad medical needs of children with autism. Using data from the National Survey of Children's Health, Guerney showed that relative to children without autism, children with autism require more services for physical, occupational, and speech therapy. Children with autism are also much more likely to have poor health, to require medically necessary care for behavioral problems, and to be using medications. As evidenced in the chart below taken from the study, parents of children with autism were more likely to report the presence of a variety of concurrent medical conditions and the need for more visits to a range of medical service providers than parents of children without autism.

Table 2. Parental Description of Health Status and Therapy and Services Use, From the National Survey of Children's Health

Variable	Children With Autism (n = 324 000)*	Children Without Autism (n = 61 100 000)*	OR (95% CI)†
Would you say your child's health is			
Excellent	33.7	60.2	1.0
Very good	22.8	23.5	1.9 (1.2-2.7)
Good	32.7	13.0	5.0 (3.0-8.1)
Fair	7.4	2.0	7.7 (4.3-13.8)
Poor	3.5	0.4	21.1 (10.3-47.9)
Does the child use more medical care, mental health or educational services than is usual for most children of the same age?	90.6	11.8	52.8 (34.7-80.4)
Is the child limited or prevented in the ability to do the things most children the same age can do?	68.5	5.7	36.2 (24.0-52.6)
Does the child get special therapy, such as physical, occupational, or speech therapy?	76.0	6.3	44.4 (31.0-61.9)
Does the child have any emotional, developmental, or behavioral problem for which she needs treatment or counseling?	75.4	7.0	36.0 (25.7-53.1)
Does the child currently need or use medicine prescribed by a doctor, other than vitamins?	54.7	21.1	3.5 (2.6-4.7)
If yes, is this for a condition expected to last 12 mo or longer?	51.4	14.5	11.0 (1.6-76.0)

Abbreviations: CI, confidence interval; OR, odds ratio.
*Data are given as the percentage of each group and are based on sampling fractions and weighted extrapolation from parent report of 483 children with autism and 64 789 children without autism.
†Data are adjusted for sex, primary language, age, insurance, and household educational attainment.

This reform of private health insurance coverage will address the broad medical needs of children with autism. It will ensure that these children will receive the full range of therapies necessary to ameliorate their condition.

***Argument 2*: Treatments for autism are difficult to access, often inadequate, and frequently delayed. Denied coverage by private group health insurance companies, parents are often forced either to pay out-of-pocket or forego the treatments their children need.**

Children with autism face barriers in accessing early intensive behavioral treatments and other therapies. According to the Institute of Medicine, the term "access" is defined as "the timely use of personal health services to achieve the best possible health outcomes."[2] For a child with autism, lack of access to services can be the cause of inconsistent and uncoordinated care. Children with autism often experience barriers to access with even greater frequency than children with other special health care needs. In fact, one study found that "over one-third of the children with autism were reported to have experienced an access problem with respect to specialty care from a medical doctor in the preceding 12 months." [3] A study of the Tennessee Medicaid system, TennCare, found that for children with autism, "the rate of service use was only one tenth what should be expected based on prevalence rates." The chart below illustrates these results and the significantly lower rates of service access for children with autism.

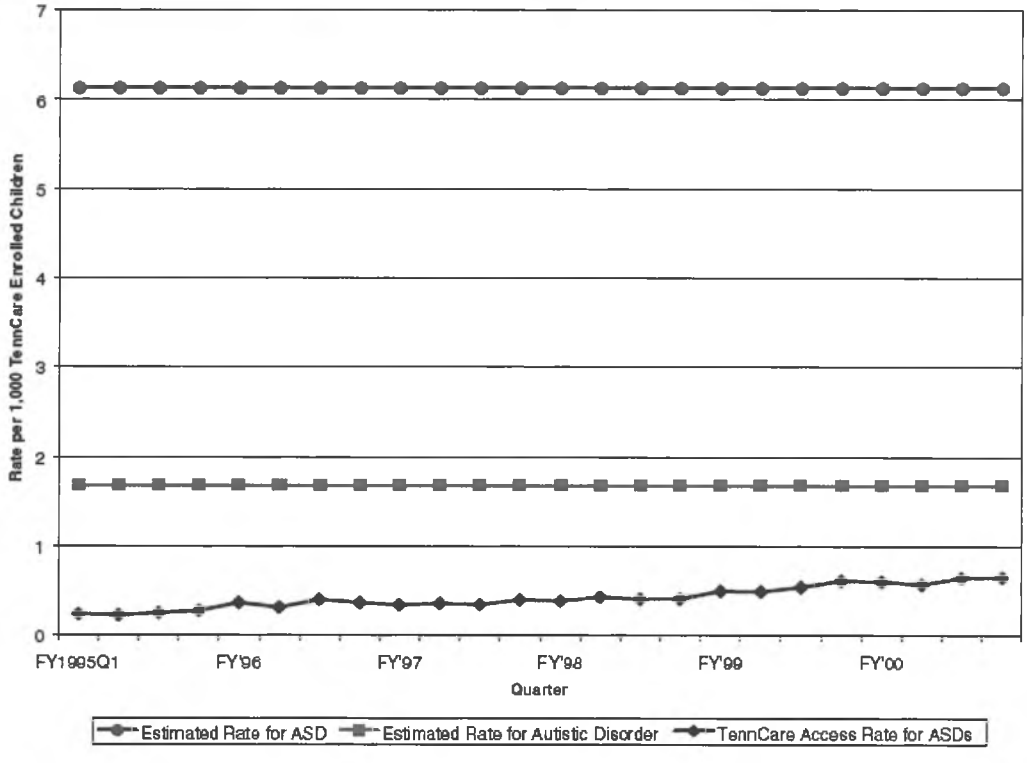


Fig. 1. Estimated incidence rates vs. service rates of autism spectrum disorders (ASDs) in TennCare for children ages 0–17 years, by quarter.

Within the Medicaid system, the amount of public money spent for services for developmental disabilities including autism is now eight times the rate of spending just a few decades ago.[4] Medicaid accounts for 75% of all funding for services for the developmentally disabled, making it the largest single public payer of behavioral health services.[5] Children with disabilities comprise a significant portion (15%) of all Medicaid recipients, and an even more significant portion (31%) of disabled children use the Medicaid system as their primary insurer.

Medicaid suffers from very low reimbursement rates that make it difficult for many locations to retain service providers. Moreover, services that can be accessed through the Medicaid system are often inadequate at meeting the specific needs of a child with autism. The system operates as a short-term service provider, tending to push children through treatment as quickly as possible. The success of the Applied Behavior Analysis, however, depends in part, on the amount of time the child with autism spends with the provider of the therapy.[6]

The failings of Medicaid point to the importance of the private health care system in providing services to children with autism. But nationwide there are very few private insurance companies or other employee benefit plans that cover Applied Behavior Analysis and other behavioral therapies. Most insurance companies designate autism as a diagnostic exclusion, "meaning that any services rendered explicitly for the treatment of autism are not covered by the plan, even if those services would be covered if used to treat a different condition."[7] A 2002 study by Pamela B. Peele and others of 128 behavioral health plans administered by one of two large managed behavioral health organizations found that all the plans had some type of limit on benefits for behavioral therapies – over half of the plans had limits on the number of annual outpatient sessions and 65 percent of the plans imposed limits on the number of inpatient days covered per year. [8]

Families that refuse to allow their children to suffer through the inadequate Medicaid system and are denied coverage by their private health insurance carriers often end up paying for therapies out of their own pockets. For these families, the financial burden is immense. Without the negotiating powers of an insurance company behind them, out-of-pocket prices are extremely high. Parents can often spend upwards of $50,000 per year on autism-related therapies, often being forced to wager their own futures and the futures of their non-autistic children to pay for necessary autism-related therapies. Children whose parents cannot afford to pay for behavioral and other therapies and who cannot access adequate therapies through the Medicaid system simply go without these interventions.

***Argument 3*: Mandated private insurance coverage will bring effective autism services within the reach of the children who need them. The efficacy of Applied Behavior Analysis (ABA), the centerpiece of this legislative mandate's benefits, has been established repeatedly.**

Private health insurance coverage of autism services will allow children with autism to access Applied Behavior Analysis (ABA), a proven treatment for their condition. Several studies have shown that as many as 47 percent of the children that undergo early intensive behavioral therapies achieve higher education placement and increased IQ levels. A significant portion of children who receive ABA are placed into mainstream educational settings. Children who begin their treatment with minimal IQ levels end treatment with substantially higher levels of intellectual functioning. These results have been shown to last well beyond the end of treatment. As such, the effectiveness of ABA therapy has allowed many children to forego costly intensive special education in the future.

Lovaas:

The most famous study of the effectiveness of behavioral modification treatments was conducted in 1987 by O. Ivar Lovaas. [9] Lovaas's study showed that when compared with other treatment programs that provide minimal therapy, Applied Behavior Analysis is extremely effective in helping many children struggling with autism, providing gained capacity for intellectual functioning and allowing a child to progress educationally.

Lovaas conducted his study of the effectiveness of behavioral modification treatments on very young children affected by autism. For his study, Lovaas split his 38 subjects into two groups: 19 subjects were put into an intensive-treatment experimental group that received more than 40 hours of one-to-one treatment per week, and 19 subjects were place in a minimal-treatment control group that received 10 hours or less of one-to-one treatment per week. Both groups were identical at intake in terms of intellectual functioning abilities, and both received their assigned treatment for 2 or more years.

Upon follow-up at age 7, the experimental group attained significantly higher results on education placement and IQ levels than the control group. According to the results of Lovaas's study, the 19-subject experimental group showed nine children (47%) who successfully passed through normal first grade in a public school and obtained an average or above average score on IQ tests.

McEachin:

Lovaas's landmark 1987 study was followed in 1993 by another study of these same 38 subjects. The objective of John J. McEachin's study was to discover the long-term effects of Lovaas's early intensive behavioral treatment and to find out if the results of the experimental group were preserved over time. [10]

For this study, Lovaas's original subjects were evaluated at a mean age of eleven-and-a-half years. The study was presented in two parts: the first examined whether the experimental group had maintained its treatment gains, the second part focused on the nine subjects who had achieved the greatest gain in the original study and examined the extent to which they "could be considered free of autistic symptomology."

McEachin's follow-up resulted in findings in three different categories: school placement, intellectual functioning, and presence of adaptive and maladaptive behaviors. In terms of class placement, the study found that "the proportion of experimental subjects in regular classes did not change from the age 7 evaluation (9 of 19, or 47%). In the control group, none of the 19 children were in a regular class, as had been true at the age 7 evaluation." (McEachin, *supra* note 10) In terms of intellectual functioning, the study found that "the experimental group at follow-up had a significantly higher mean IQ than did the control group… indicating that the experimental group had maintained its gains in intellectual functioning between age 7 and the time of the current evaluation." Finally, in terms of presence of adaptive and maladaptive behaviors, "the findings indicate that the experimental group showed more adaptive behaviors and fewer maladaptive behaviors than did the control group." (McEachin, *supra* note 10)

Based on these findings, the effectiveness of ABA and other structured behavioral programs, as provided by the proposed benefit, would be experienced in the short-term as well as the long-term.

Argument 4: **Government and scientific organizations have endorsed Applied Behavior Analysis (ABA) and other structured behavioral therapies.**

ABA is the treatment of choice for autism. Its efficacy has been recognized in a number of prominent reports, including the following:

- **The 2001 U.S. Surgeon General's Report on Mental Health**, which states, "Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment. Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior." [11]

- **The New York State Department of Health** assessed interventions for children ages 0-3 with autism, and recommended that "behavioral interventions for reducing maladaptive behaviors be used for young children with autism when such behaviors interfere with the child's learning or socialization or present a hazard to the child or others." [12]

- **The Maine Administrators of Services for Children with Disabilities** notes in their report that "There is a wealth of validated and peer-reviewed studies supporting the efficacy of ABA methods to improve and sustain socially significant behaviors in every domain, in individuals with autism. Importantly, results reported include 'meaningful' outcomes such as increased social skills, communication skills academic performance, and overall cognitive functioning. These reflect clinically-significant quality of life improvements. While studies varied as to the magnitude of gains, all have demonstrated long term retention of gains made." [13]

- **The National Institute of Mental Health** reports, "The basic research done by Ivar Lovaas and his colleagues at the University of California, Los Angeles, calling for an intensive, one-on-one child-teacher interaction for 40 hours a week, laid a foundation for other educators and researchers in the search for further effective early interventions to help those with ASD attain their potential. The goal of behavioral management is to reinforce desirable behaviors and reduce undesirable ones." [14]

- **The National Institute of Child Health and Human Development** lists Applied Behavior Analysis among the recommended treatment methods for Autism Spectrum Disorders. [15]

- **The National Research Council's** 2001 report on Educating Children with Autism acknowledged, "There is now a large body of empirical support for more contemporary behavioral approaches using naturalistic teaching methods that demonstrate efficacy for teaching not only speech and language, but also communication." [16]

- **The Association for Science in Autism Treatment** recommends ABA-based therapies, stating, "ABA is an effective intervention for many individuals with autism spectrum disorders." [17]

Argument 5: **To combat the difficulty many families face in accessing Applied Behavior Analysis (ABA) and other structured behavioral treatments through public insurance, three states have passed autism insurance mandates that specifically require private insurance companies to provide coverage of these therapies, thus creating a public-private partnership for the provision of care.**

While there are several states that have passed autism specific private insurance mandates, very few states specifically mandate coverage for ABA and other structured behavioral therapy programs. Without coverage of these crucial, medically necessary, evidence based therapies, the effectiveness of most mandates is severely diminished. For this reason, we have concluded that only the following states have passed autism insurance legislation:

South Carolina:

Senate Bill 20, better known as Ryan's Law, was passed by both the South Carolina House of Representatives and Senate on May 31, 2007. [18] The bill was then vetoed by Governor Mark Sanford on June 6. On June 7, the bill was brought back to the House and Senate floors, and unanimous votes in both chambers overrode the Governor's veto. This law goes into effect in July 2008.

> **Coverage Includes:** Treatments, including behavioral therapies, which are prescribed by the individual's treating medical doctor in accordance with a treatment plan.
>
> **Age Range:** An individual must be diagnosed with autistic spectrum disorder at age eight or younger. The coverage must be provided to any eligible person less than sixteen years of age.
>
> **Dollar Cap:** Coverage for behavioral therapy is subject to a $50,000 maximum benefit per year.

Texas:

On June 15, 2007, Texas enacted House Bill 1919, effective September 1, 2007. [19] While the Texas bill limits the ages for children who can benefit from coverage, it goes further than some other states in spelling out exactly what kinds of services are covered. The bill's text specifically cites which kinds of autism-related services are examples of treatments that must be covered.

> **Coverage Includes:** Evaluation and assessment services, A BA, behavior training and behavior management, speech therapy, occupational therapy, physical therapy, medication or nutritional supplements used to address symptoms of autism spectrum disorder.
>
> **Age Range:** An individual must be between ages three and five to receive this

coverage.

Dollar Cap: Same as afforded to physical illnesses

Indiana:

In 2001, the Indiana enacted House Bill 1122, requiring insurers that issue accident and sickness insurance policies on an individual basis to provide coverage for the treatment of autism spectrum disorders. [20]

Coverage Includes: Treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. The statute thus allows many different professionally accepted therapies, such as ABA, speech therapy, occupational therapy, physical therapy, and medications to address symptoms of autism.

Age Range: All ages are allowed coverage

Dollar Cap: Same as afforded to physical illnesses

Argument 6: **The costs of the proposed benefit are small and will have very little impact on the cost of health insurance premiums for the individual consumer.**

Earlier this year, The Council for Affordable Health Insurance, a research and advocacy association of insurance carriers, released its annual report on state health insurance mandates, *Health Insurance Mandates in the States 2007*. [21] The report defined a mandate as "a requirement that an insurance company or health plan cover (or offer coverage for) common – but sometimes not so common – health care providers, benefits and patient populations." (Bunce, *supra* note 21) Using this definition, the report identified legislative mandates for autism benefits in ten states: Colorado, Delaware, Georgia, Iowa, Indiana (which, as we have noted, provides comprehensive benefits), Kentucky, Maryland, New Jersey, New York, and Tennessee. The report assessed the incremental cost of state mandated benefits for autism in these ten states *as less than one percent.*

The Council's modest estimate of incremental premium costs is consistent with state government estimates across the country. Prior to enactment of Indiana's sweeping legislation, the Indiana Legislative Services Agency estimated additional premium costs as ranging from $.44 per contract per month to $1.67 per contract per month. [22] In vetoing Ryan's Law in South Carolina, Governor Mark Sanford estimated that the bill, with its $50,000 maximum yearly benefit for behavioral therapy, would add $48 annually to insurance policies.[23] And in Wisconsin, where pending Assembly Bill 417 would provide the same broad coverage Indiana's statute mandates, the Department of Administration estimates policy increments of between $3.45 and $4.10 per month – about the same as Governor Sanford's estimate for Ryan's Law. [24]

The cost estimates for Indiana, South Carolina, and Wisconsin – all states whose legislation allows a maximum benefit that can be considered high – suggest that an average autism insurance coverage mandate will cost approximately $50 annually per policy holder. For only a modest effect on premium cost, this insurance reform holds the promise of significantly improving the lives of thousands of children.

Argument 7: **By improving outcomes for children with autism, mandated private insurance coverage will decrease the lifetime costs of treating and providing services and will actually result in an overall cost savings in the long-run.**

A 1998 study by John W. Jacobson and others titled, *Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case,* examined the cost/benefit relationship of early intensive behavioral intervention treatment at varying levels of treatment success.[25] The study used estimates of costs for early intensive behavioral interventions (EIBI) from childhood (age three) through adulthood (age 55) based on prices in the Commonwealth of Pennsylvania and compared these costs with the expected amount of income the child would earn later in life to arrive at an estimated cost savings.

With a success rate of 47 percent for early intensive behavioral intervention therapy (as determined by Lovaas), Jacobson's study found that cost savings per child served are estimated to be from $2,439,710 to $2,816,535 to age 55.

Table 6. Financial benefits at different levels of effectiveness, age 3–55 years, per 100 children served and per child served—Pennsylvania model

	Inflated total	*1996 $ total*	*Inflated/ student*	*1996 $/ student*
At 20% normal range				
20 norm range vs. partial effect	96,085,200	36,654,400	4,804,260	1,832,720
70 partial vs. minimal effect	72,520,910	28,984,130	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	168,606,110	65,638,530	1,686,061	656,385
At 30% normal range				
30 norm range vs. partial effect	144,127,800	54,981,600	4,804,260	1,832,720
60 partial vs minimal effect	62,160,780	24,843,540	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	206,288,580	79,825,140	2,062,886	798,251
At 40% normal range				
40 norm range vs. partial effect	192,170,400	73,308,800	4,804,260	1,832,720
50 partial vs. minimal effect	51,800,650	20,702,950	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	243,971,050	94,011,750	2,439,710	940,118
At 50% normal range				
50 norm range vs. partial effect	240,213,000	91,636,000	4,804,260	1,832,720
40 partial vs. minimal effect	41,440,520	16,562,360	1,036,013	414,059
10 minimal effect	0	0	0	0
Net	281,653,520	108,198,360	2,816,535	1,081,984

Note: This table presents a comparison of financial benefits at different levels or rates of achievement of normal skills or functioning achieved by EIBI, for people ages 3–55 years, ranging from 20% of children achieving normal range skills or functioning (an assumed minimal rate) to 50% of children. At each level of effectiveness, differing rates of normal range functioning, as well as partial benefit are estimated. Costs are shown in terms of the aggregate of 100 children served, and averages per person served, with inflation and in 1996 dollars.

The study also accounts for the initial investment in early intervention by concluding that, with an initial annual cost of $32,820, the total cost-benefit savings of EIBI services per

child with autism or PDD for ages 3-55 years averages from $1,686,061 to $2,816,535 with inflation.

According to a 2005 Government Accounting Office (GAO) report, "the average per pupil expenditure for educating a child with autism was more than $18,000 in the 1999-2000 school year. This amount was almost three times the average per pupil expenditure of educating a child who does not receive any special education services."[26] With this insurance reform in place, more children would be able to access the early intervention services they need. That investment will, in the long run pay benefits, both economic and social, to the greater population.

Argument 8: **Without passage of legislation requiring private health insurance coverage for autism, the costs associated with autism will continue not only to affect families, but will have far reaching social effects as well.**

The cost of autism is borne by everyone. Michael L. Ganz's study of the societal costs of autism, *The Lifetime Distribution of the Incremental Societal Costs of Autism*, examined how the large financial burdens of autism affect not only families with an autistic child but society in general. [27]

Ganz broke down the costs associated with autism into two distinct categories, direct costs and indirect costs. Direct costs include direct medical costs, such as physician, outpatient, clinic services, dental care, prescription medications, complementary and alternative therapies, behavioral therapies, hospital and emergency services, allied health, equipment and supplies, home health, and medically related travel, as well as direct nonmedical costs, such as child care, adult care, respite and family care, home and care modification, special education, and supported employment. Indirect costs include productivity losses for people with autism (calculated by combining standard average work-life expectancies for all men and women with average income and benefits and estimated age and sex specific labor force participation rates).

According to Ganz's study, direct medical costs reach their maximum during the first five years of life, averaging around $35,000. As the child ages, direct medical costs begin to decline substantially and continue to decline through the end of life to around $1,000. Ganz goes on to report, "The large direct medical costs early in life are driven primarily by behavioral therapies that cost around $32,000 during the first 5-year age group and decline from about $4,000 in the 8-to 12-year age group to around $1,250 for the 18- to 22-year age group." (Ganz, *supra* note 27)

In terms of direct medical costs "the typical American spends about $317,000 over his or her lifetime in direct medical costs, incurring 60% of those costs after the age of 65 years. In contrast, people with autism incur about $306,000 in incremental direct medical costs, which suggests that people with autism spend twice as much as the typical American over their lifetimes and spend 60% of those incremental direct medical costs after age 21 years." (Ganz, *supra* note 27)[27]

The study also found the indirect costs of autism to be significant as well. While in the first 22 years of life, indirect costs are mostly associated with lost productivity for the parents of a child with autism, the costs from age 23 on are associated with lost productivity of the actual individual with autism as depicted in the chart below taken from the study. The impact of this lost productivity can have enormous ramifications for the tax base of an entire society and the future of the older generation as their children with autism transition into adult care.

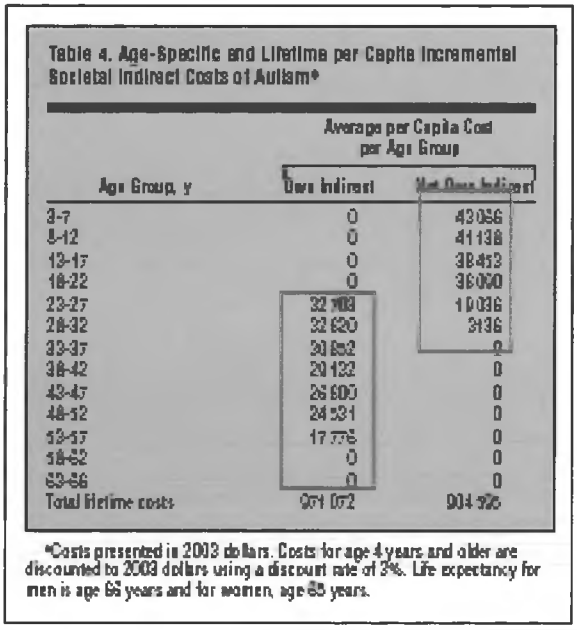


Table 4. Age-Specific and Lifetime per Capita Incremental Societal Indirect Costs of Autism*

Age Group, y	Average per Capita Cost per Age Group	
	Own Indirect	Net Own Indirect
3-7	0	42 056
8-12	0	41 138
13-17	0	38 453
18-22	0	36 060
23-27	32 703	19 036
28-32	32 620	3136
33-37	30 852	0
38-42	29 122	0
43-47	26 600	0
48-52	24 531	0
53-57	17 776	0
58-62	0	0
63-66	0	0
Total lifetime costs	971 072	904 926

*Costs presented in 2003 dollars. Costs for age 4 years and older are discounted to 2003 dollars using a discount rate of 3%. Life expectancy for men is age 68 years and for women, age 85 years.

Ganz posited that direct medical costs "combined with very limited to non-existent income for their adult children with autism combined with potentially lower levels of savings because of decreased income and benefits while employed, may create a large financial burden affecting not only those families but potentially society in general."(Ganz, *supra* note 27)

Without the help of private insurance coverage, families affected by autism may never be able to pull their heads above water and provide their children with the medically necessary, evidence- based treatments that they need. It is to the advantage of these families, to the 1 in 150 children affected by autism, and to all of society that private health insurance coverage is provided for these services.

Conclusion

A legislative mandate for coverage of autism asks private insurance companies to make a limited, but significant, contribution to help pay for medically necessary, evidence- based treatments that have been established to be of the greatest impact in fighting this terrible disorder.

Unbelievably, it is not uncommon for insurance carriers to have line- item exclusions for treatment of individuals diagnosed with autism. Across the nation, children with autism are routinely denied insurance benefits for treatment of their disorder. We believe that private insurance companies must contribute their fair share and partner in the financial burdens with these families.

With every new child diagnosed with autism costing an estimated $3 million over his or her lifetime, the current practices are both unfair and not cost effective in the long run for states and their citizens. Autism Speaks is confident that many more state governments will recognize the significant long-term cost benefits found in these legislative measures, will do what is right for their constituents, and will pass legislation requiring private health insurance coverage of autism services.

References

[1] James G. Gurney, Melissa L. McPheeters, Matthew M. Davis, Parental Report of Health Conditions and Health Care Use Among Children With and Without Autism, 160 *Archives of Pediatric and Adolescent Medicine*, 825-30 (2006).

[2] Institute of Medicine, Access to Health Care in America (Michael Millman ed.) (1993)

[3] Marty W. Krauss, Stephen Gulley, Mark Sciegaj, Nora Wells, Access to Specialty Medical Care for Children with Mental Retardation, Autism, and Other Special Health Care Needs, 41 *Mental Retardation*, 329-39 (2003).

[4] David S. Mandell, Jun Cao, Richard Ittenbach, Jennifer Pinto-Martin, Medicaid Expenditures for Children with Autistic Spectrum Disorders: 1994 to 1999, 36 *Journal of Autism and Developmental Disorders*, 475-85 (2006).

[5] Lisa A. Ruble, Craig A. Heflinger, J. William Renfrew, Robert C. Saunders, Access and Service Use by Children with Autism Spectrum Disorders in Medicaid Managed Care, 35 *Journal of Autism and Developmental Disorders*, 3-13 (2005).

[6] Department of Public Welfare, Commonwealth of Pennsylvania: Autism Task Force Final Report (2004) Retrieved from www.dpw.state.pa.us.

[7] Douglas L. Leslie, Andres Martin, Health Care Expenditures Associated with Autism Spectrum Disorders, 161 *Archives of Pediatric and Adolescent Medicine*, 350-55 (2007).

[8] Pamela B. Peele, Judith R. Lave, Kelly J. Kelleher, Exclusions and Limitations in Children's Behavioral Health Care Coverage, 53 *Psychiatric Services*, 591-94 (2002).

[9] O. Ivar Lovaas, Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children, 55 *Journal of Consulting and Clinical Psychology*, 3-9 (1987).

[10] J. J. McEachin, T. Smith, O. Ivar Lovaas, Long-term Outcome for Children with Autism Who Received Early Intensive Behavioral Treatment, 97 *American Journal on Mental Retardation,* 359-72 (1993).

[11] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, 163-64 (1999).

[12]New York Department of Health, Clinical Practice Guideline: Report of the Recommendations, Autism/Pervasive Developmental Disorders, Assessment and Intervention for Young Children (Age 0-3 Years) (1999) Retrieved from http://www.health.state.ny.us/community/infants_children/early_intervention/autism/index.htm

[13] Maine Administrators of Services for Children with Disabilities, Report of the MADSEC Autism Task Force. (2000). Retrieved from http://www.madsec.org/docs/ATFReport.pdf .

[14] National Institute of Mental Health, Autism Spectrum Disorders, Pervasive Developmental Disorders. (2007) Retrieved from http://www.nimh.nih.gov/health/publications/autism/complete-publication.shtml .

[15] National Institute of Child Health and Human Development website: Questions and Answers (2006). Retrieved from http://www.nichd.nih.gov/publications/pubs/autism/QA/sub18.cfm .

[16] National Research Council, Educating Children with Autism.(Catherine Lord & James P. McGee eds2001). Retrieved from http://www.nap.edu/openbook.php?isbn=0309072697.

[17] Association for Science in Autism Treatment website: http://www.asatonline.org/resources/resources.htm. .

[18] S. 20, 2007 Gen. Assem.,117th Sess. (S.C. 2007)

[19] H.B. 1919, 2007 Leg., 80 (R) Sess. (Tex. 2007)

[20]H.B. 1122, 112th Gen. Assem., 1st Reg. Sess. (Ind. 2001)

[21] Victoria C. Bunce, J.P. Wieske, Vlasta Prikazsky, Health Insurance Mandates in the States 2007. Council for Affordable Health Insurance, (2007). Retrieved from www.cahi.org .

[22] Legislative Services Agency,, Fiscal Impact Statement for HB 1122 (Apr. 5, 2001). Retrieved from http://www.in.gov/legislative/bills/2001/PDF/FISCAL/HB1122.006.pdf .

[23] Governor Mark Sanford, Veto Message for S.B. 20 to the South Carolina Senate President, (2007). Retrieved from http://www.scgovernor.com/uploads/upload/S.20.pdf .

[24] Wisconsin Department of Administration, Fiscal Estimate for Assembly Bill 417 (July 23, 2007). Retrieved from http://www.legis.state.wi.us/2007/data/fe/AB-417fe.pdf.

[25] John W. Jacobson, James A. Mulick, Gina Green, Cost-Benefit Estimates for Early Intensive Behavioral Intervention for Young Children with Autism – General Model and Single State Case. 13 *Behavioral Interventions*, 201-26 (1998).

[26] United States Government Accountability Office, , Special Education: Children with Autism(GAO-05-220 (2005)).

[27] Michael L. Ganz, The Lifetime Distribution of the Incremental Societal Costs of Autism. 161 *Archives of Pediatric and Adolescent Medicine*, 343-49 (2007). Retrieved from www.archpediatrics.com .

Autism's origins lie hidden in a perplexing maze of behaviors and biology. Step by step, researchers are finding their way inside.

Breaking Through

Ricardo Dolmetsch was studying the basic biology of nerve cells when two events propelled him into autism research. In 2004, a mutation in one of the proteins he specialized in was pinpointed as the cause of Timothy syndrome, a rare ▶

by Kristin Sainani

Illustrations by Timothy Archibald

Eli Archibald, photographed by his father, from the book *Echolilia*.

genetic disorder associated with autism. Then in 2006, Dolmetsch's oldest son, who was 4, was diagnosed with autism.

"At the time, we were very worried. We didn't know what was happening," says Dolmetsch, PhD '97, assistant professor of neurobiology. "So I went home and sat down with my wife, [Asha Nigh, '93,] who is also a scientist, to try to figure out what we could do."

There was solid research in psychology and behavioral treatments for autistic patients. But except for some progress in genetics, the biology of autism was virtually unknown, Dolmetsch says. "It was a little bit shocking that there was very little in the way of really good basic research."

Dolmetsch was in a unique position to do something about this gap. "I decided to shift the focus of my lab completely."

He is among a group of researchers at Stanford who are trying to untangle the root causes of autism. Some have been in the field for decades; others, like Dolmetsch, are newcomers, spurred by personal and professional motivations to understand a disorder that affects 1 in every 110 kids. (The rate is 1 in 70 for boys and 1 in 315 for girls.)

Autism is a spectrum of disorders that share three core features—language deficits, social deficits, and repetitive interests and movements. On one end of the spectrum are people with Asperger's syndrome, who are socially awkward but who often have above-average intelligence. Dolmetsch's son has this diagnosis: He was late to speak and when he did speak, he talked in a stilted and peculiar way—more like a little adult than a child; and he has problems socializing. The most serious autism cases involve severe mental disabilities (about 40 percent of children with autism have IQs below 70) and behavioral problems. Between these two extremes, children may have normal intelligence but pronounced language and social impairments.

J.C. Flores, '87, has 15-year-old identical twins with autism. Lomasi can speak, but she avoids talking and gives mostly one-word answers. Marielle can say only a few words and has no functional communication system. "They're sweet and they like to hang around people," Flores says. "But they don't really feel the need to communicate. They don't see why you have to."

In about 10 percent of cases, autism is secondary to a more pervasive genetic disorder, such as fragile-X syndrome or another chromosomal abnormality. But the vast majority of cases are unexplained, or idiopathic. Awareness about autism is at an all-time high, but public discussion has largely been dominated by questions such as: What accounts for the rapid increase in cases? Or is something in the environment causing autism? Though these questions are important (see sidebar), Dolmetsch and others at Stanford and elsewhere are trying to answer a more fundamental question: What is the underlying biology of autism? It's only by answering this question that they believe they can achieve real breakthroughs—the kinds that lead to cures.

A GENETIC PUZZLE: Flores's identical twin daughters both have autism but have different capabilities.

COURTESY J.C. FLORES

Autism is a CATCH-ALL DIAGNOSIS that likely includes a host of DISTINCT DISORDERS.

One of the biggest challenges is that autism is not one thing: It's a catchall diagnosis that likely includes a host of biologically distinct disorders. Though children with autism share a set of symptoms, these symptoms are quite varied and may have many, diverse biological origins. "Autism is incredibly heterogeneous. We've been lumping everyone together under this name autism, and unfortunately it makes it very difficult to study the biological features when we are treating multiple groups as one," says Sophia Colamarino, '90, vice president of research for Autism Speaks—a science and advocacy group—

and consulting associate professor of psychiatry and behavioral science. To get a toehold into the biology, researchers will need to identify unique subgroups of autism, she says. Researchers across the globe are defining subgroups based on genes, molecular pathways, or signatures in the brain and blood.

Another impediment: access to the brain. Scientists can slice cancer cells out of a tumor and study them directly, but they can't just scoop cells out of the brain. Stanford is on the forefront of solving this problem—in fact, Dolmetsch's solution seems straight out of a science fiction novel.

Although much remains unknown, these efforts are giving the world its first glimpses into the biology of autism.

JOACHIM HALLMAYER describes himself as a "grandfather in the field of autism." He's been chasing down the genes for the disorder for 20 years, beginning as a postdoctoral fellow in genetics at Stanford. At that time, the disease was considered rare (4 out of 10,000 kids). "I knew in a snap everybody in the Bay Area who ever diagnosed a child with autism," says Hallmayer, associate professor of psychiatry and behavioral science.

Hallmayer joined the field because of a parent: Carmen Pingree, the mother of an autistic boy in Utah, who approached his mentors at Stanford, urging them to study the disease. Hallmayer collaborated with Pingree, who used her ties in the Mormon community to assemble pedigrees for 146 families with multiple cases of autism. It was the largest genetic study of the disease at the time. The parents of children with autism continue to motivate him, he says.

Autism is particularly heartbreaking because it colors the most fundamental social bond—that between a parent and a child. Even children with milder forms of autism may have trouble displaying or returning affection. "Autistic children are as emotional as other children; I'm very convinced of this. But they don't show it," Hallmayer says. "They show it in a different way. And it's a very, very hard learning process for most parents."

Studies of twins have shown that autism has a large genetic component, but it's not all genes. Identical twins have the same DNA, but sometimes only one twin gets autism. In other cases, as with Flores's daughters, Lomasi and Marielle, the severity of the disorder differs. The genetics are also complex. Different genes may be involved in different people; and, in

Why the Increase? (No, it's not vaccines.)

Twenty years ago, people diagnosed with autism were relatively rare, and the public's awareness of the disorder was chiefly limited to Hollywood depictions such as that in the 1988 Academy Award-winning movie *Rain Man*. Today, many people know a neighbor, friend or classmate who is dealing with autism—prevalence has risen about twenty-fold since 1990. But what's behind this startling increase? Scientists agree that some of it is due to changes in diagnosis and awareness, but just how much is hotly debated.

"The best papers I've seen suggest that there is a genuine increase," Ricardo Dolmetsch says. "But it's not as big as it seems. A big, big contribution is societal awareness and changes in diagnostic criteria."

There have been at least two shifts in diagnosis, Dolmetsch says. First, some kids who might have once been diagnosed as mentally retarded now are recognized as autistic. Second, children with autism display some of the same characteristics as those who have attention-deficit hyperactivity disorder (ADHD). When the diagnosis is ambiguous, doctors in California tend to diagnose autism rather than ADHD, because the state pays for services (such as behavioral therapy) for autism but not ADHD, Dolmetsch says.

Moreover, the medical establishment's thinking about what constitutes abnormal behavior has shifted, Joachim Hallmayer says. "There's no doubt that what we diagnose as autism is different than what we diagnosed 20 years ago." Autism has been on the rise globally, but the explosion of cases occurs at different times in different countries, which points to a large role for societal awareness, Hallmayer says.

Some of the increase is definitely real, though, according to Antonio Hardan. He cites two contributors. More premature babies are surviving, and preemies are at high risk of autism (about 10 percent will develop it), and more couples are having babies when they're older, which increases the risk of genetic errors that can lead to autism.

Could something in the environment also be a factor? Maybe, the researchers say, but there is little scientific evidence to back any such claim. Despite widespread concerns about a link between pediatric vaccinations and autism, vaccines have been soundly exonerated, they say.

Paula Gani, '91, says her 4-year-old son Marcus, who has a milder form of autism, "is one of those kids who would not have been diagnosed 20 years ago." But the diagnosis and early intervention he's received are likely rewriting his future. He made limited eye contact and didn't engage socially when he was diagnosed two years ago, but "yesterday, we were going out to pizza with another mom and her kid. And he took the other little boy's hand and started singing 'The more we get together, together, together . . . '," she recounts. "It's a huge difference."

Dolmetsch is using an astonishing NEW TISSUE MODEL. 'We're making little pieces of BRAIN IN A DISH.'

any given individual, the disease may arise from changes in one gene, changes in several genes, or a combination of genetic and environmental factors. (Though no specific environmental triggers have been identified, researchers are testing everything from exposure to heavy metals and pesticides to TV watching.) Tackling this complexity requires large studies.

Hallmayer has spearheaded several massive, multisite collaborations. He chairs the committee of senior investigators for the Autism Genome Project, an international consortium of more than 50 universities that has collected data on 2,000 families with multiple cases. He also has assembled a study of 220 pairs of twins from California in which at least one twin has autism.

In the past decade, geneticists have discovered a handful of genes that when mutated or missing can cause autism. Though rare, these genes have given scientists some of their best clues about the disease's biological underpinnings. "I think it's very exciting, even if it's rare cases. We can at least get a better understanding of one piece of the puzzle and then we can branch out from there," Hallmayer says. For example, several of these genes are involved in communication between neurons. In a 2010 paper in *Nature*, Hallmayer and his colleagues from the Autism Genome Project greatly expanded this list of genes—reporting hundreds of rare genetic events that may be involved in autism.

It's long been known that about 5 percent of autistic kids have a chromosomal abnormality that can be seen under a microscope—part of a chromosome is missing, duplicated or in the wrong place. Because these changes affect a large number of genes, the children often have many problems in addition to autism. What wasn't known until recently is that we all have slight imperfections in our chromosomes—small regions of DNA that are duplicated or deleted. When these stretches of DNA contain genes, people can end up with one or three copies of the genes instead of the standard two. Technological advances have made it possible to detect these "copy-number variants," or CNVs. And it turns out they're important in autism and some psychiatric disorders. For example, a region of chromosome 16—containing about 25 genes, some involved in brain function and development—is deleted or duplicated in 1 to 2 percent of people with autism (and some with schizophrenia). Scientists are beginning to study these patients as an autism subgroup.

Hallmayer and his colleagues scanned the genomes of thousands of people with autism and 2,000 healthy individuals looking for rare CNVs. They found that children with autism had more rare CNVs that overlapped genes, including genes previously implicated in autism. Some CNVs were inherited from a parent, but some arose spontaneously in the child, likely due to a genetic error in the sperm or egg. They identified disruptions in hundreds of genes that occurred only in autism cases, never in controls. Not all of the genes will turn out to be relevant to autism, but the ones that are could explain maybe 10 to 15 percent of cases, Hallmayer says.

DOLMETSCH IS STUDYING several subtypes of autism defined by genes, including Timothy syndrome and the chromosome 16 CNV, using an astonishing new tissue model. Essentially, he says, "We're making little pieces of brain in a dish."

In 2007, scientists in Japan figured out how to genetically reprogram adult cells into pluripotent stem cells—which, like embryonic stem cells, can give rise to any other cell type in the body. Using this technology, Dolmetsch's team recreates human neural development. They take skin cells from patients with autism, turn them into stem cells, and then, using a cocktail of proteins, coax these cells to form a neural tube. A neural tube is the earliest neural structure to form and later grows into the brain at one end and the spinal cord on the other. The researchers then take slices of cells from the neural tube and direct them to become specific parts of the brain, such as the cortex. "It sounds like science fiction. It's kind of incredible this even works," Dolmetsch says. "Nobody had ever actually made neurons from autistic people before."

Timothy syndrome is caused by a defect in calcium channels, which play a critical role in electrical activity in the brain and heart. Because Timothy patients often have life-threatening heart arrhythmias, Dolmetsch's team is also making "little pieces of heart."

Sitting in his office on the second floor of the Fairchild Research Building, Dolmetsch shows movies of the hearts on his computer. The ball of cells looks like one chamber of a fetal heart beating on an ultrasound. Those laboratory hearts--

FROM TOP: PHOTOS COURTESY STANFORD SCHOOL OF MEDICINE (4); JENNY PEGG

developed from the cells of a healthy subject—beat just like the real thing, 60 times per minute. When grown from the cells of Timothy patients, however, the hearts beat erratically—they miss a beat, or have a double beat. Dolmetsch's team has already used the models in a practical way: They screened 20 different drugs that correct heart arrhythmias and found the one that works best for Timothy patients. "You can't give a child 50 drugs and see which one works, but you can do that with these cells," Dolmetsch says.

He also shows movies of thousands of lab-created neurons firing. When given an electric pulse, the blue-colored cells light up in a sudden flash of green, like fireworks going off, and then they flicker and shimmer in a fallout of electrical activity. He is studying these neurons to figure out what is different in the autistic brain, starting with Timothy patients. The results so far: In addition to abnormal calcium signaling, kids with Timothy syndrome have too many cells that produce the neurotransmitters dopamine and norepinephrine. They also have too few cells that form long-distance connections and too many that form local connections.

"This may help to explain why children with autism often have problems integrating lots of different classes of information, but they can often perform quite well in one domain," Dolmetsch says. (In other words, the wiring that impairs, say, the ability to discern symbolism in Shakespeare, might enable an extraordinary ability to memorize a scene from *Hamlet*.) "This is the first time that anybody has ever seen any cellular defects associated with any psychiatric disease, much less autism." A group from UC-San Diego also has adopted this technology—they recently reported specific defects in neurons created from patients with Rett syndrome, another genetic anomaly that can cause autism.

Dolmetsch's team has grown brain cells from 20 patients with Timothy syndrome or other known mutations. Their ultimate goal, however, is to grow brain cells from patients with autism who have no known genetic defect and then to classify these patients according to their cellular and molecular defects—such as problems with neural communication or problems with calcium channels.

Dolmetsch plans to use these models to screen for treatments that can reverse or overcome the biological defects. He also could use them to screen potential environmental contributors to autism. Some environmental agents may injure developing neurons in ways that mimic known genetic hits, he says.

LIKE DOLMETSCH, Thomas Südhof was a basic biologist working on fundamental questions about the brain when he was drawn into autism research a few years ago. Südhof is an expert in synapses, the junctions between neurons. He played an instrumental role in working out the molecular details of how messages travel across synapses—work for which he shared the $1 million Kavli Prize in neuroscience in 2010. Serendipity brought Südhof, professor of molecular and cellular physiology, to autism research. A number of autism cases were traced to rare mutations in synapse pro-

Solution Set?

RICARDO DOLMETSCH
Uses human tissue to simulate a developing autistic brain in lab-grown models.

JOACHIM HALLMAYER
Helps oversee the Autism Genome Project, collecting data on thousands of families.

THOMAS SÜDHOF
Rare mutations in brain proteins offer insights about autism's effects on synapses.

ANTONIO HARDAN
MRIs of children with autism show differences in neural connections.

KAREN PARKER
Defects in the hormone oxytocin may play a role in social deficiencies.

FROM TOP: PHOTOS COURTESY STANFORD SCHOOL OF MEDICINE (4); JENNY PEGG

teins, including two that Südhof discovered in the 1990s—neurexins and neuroligins.

These proteins bind to each other across the synapse to help neurons connect and communicate; they also are believed to play a role in "synaptic plasticity"—changes in the ability of the synapse's chemistry and structure that underlie learning and memory. What's interesting about autism, Südhof says, is that the brain is not globally impaired—for example, kids who are unable to speak have normal motor skills. "You really need a pretty good brain for that," he says. Thus, autism is likely due to subtle changes in the brain's wiring, such as how neurons connect physically, or how they communicate.

In a 2007 paper in *Science*, Südhof and his colleagues reported the first mouse model of idiopathic autism. They took a mutated form of the neuroligin gene that was discovered in two brothers, one with autism and the other Asperger's, and inserted it into mice. The mice showed some features of both autism and Asperger's. (They were less inclined to hang out with other mice, but faster at learning a water maze.) In 2009, Südhof engineered mice to have a neurexin deletion that, in humans, is associated with 1 in 200 autism cases. The mice had increased repetitive behaviors, such as excessive self-grooming, but no obvious changes in social behavior. The neurons of both sets of mice had altered synaptic signaling.

The mice aren't a perfect replica of human autism (animal models are inherently limited—after all, mice don't have language), but they have yielded important insights. Südhof's team has begun testing many other genes that have been implicated in autism in mouse models to see if they also affect synapse function. "One thing is clear: Anything in the brain involves the synapse, so the synapse is a good bet," he says.

Once you pinpoint molecular pathways that underlie autism, such as problems with calcium channels or problems with synapses, then you can develop targeted treatments. Recent advances in fragile-X syndrome are a perfect example, Colamarino says. Patients with fragile-X (about one-third of whom also have autism) are missing a protein that helps regulate synaptic function. Without this protein, there is an excess of synaptic signaling, which scientists believe could lead to intellectual disabilities. Several companies have begun testing drugs that dampen the noise. In mice with fragile-X, the drugs can reverse some neurological symptoms. It's too early to say if the drugs can reverse mental disabilities in people with fragile-X, but they have eased behavioral symptoms in short-term trials of affected adults.

No one thought it was possible to reverse symptoms of a neurodevelopmental disorder in adulthood, Colamarino says. "The idea that you can do this has completely reinvigorated the field of autism treatment research."

AT 10 P.M. on a Friday night at the Lucas Center, postdoctoral fellow Kari Berquist, doctoral student Grace Lee and senior research assistant Sweta Patnaik are waiting in a darkened MRI control room. The silhouettes on the other side of the glass window finally appear motionless. There's a moment of breathless anticipation as the father sneaks away from his sleeping son on the MRI table. Then 4-year-old Joshua (patients' names have been changed) wakes up again. They won't be able to get the scan done tonight. The father emerges from the MRI room; Joshua, who cannot yet speak, cries, kicks and clings to his dad, making *bbb* and *mmm* sounds. Joshua's mother buckles her other son—a healthy 11-month-old who already says

The 'cuddle hormone' may yield important clues

Oxytocin is the hormone that promotes social bonding, so it makes sense that defects in oxytocin might play a role in some cases of autism. Karen Parker is exploring whether changes in oxytocin levels in the blood or cerebrospinal fluid could be a marker of the disorder. "My work is thinking about the biology of social functioning," says Parker, an assistant professor of psychiatry and behavioral sciences. Oxytocin is sometimes called the cuddle hormone or the love hormone, because it's released during physical contact and sex; it also plays a role in social interaction, trust and empathy, as well as monogamy in certain animals. A behavioral neuroscientist, Parker studied the role of oxytocin in voles and monkeys before moving to autism research.

Parker has collected blood from children with autism, their healthy siblings (who sometimes show more subtle social deficits) and normal controls to try to detect differences in their oxytocin levels. She also is setting up one of the first studies in the cerebrospinal fluid (CSF). Studies in monkeys show that blood oxytocin may be normal even when brain levels, reflected in the CSF, are low. It's difficult to obtain CSF because it requires a spinal tap. Her team is investigating genetic variation in the oxytocin receptor and other genes involved in the oxytocin pathway. If Parker's and Hardan's studies show an oxytocin deficiency, patients could receive replacement oxytocin.

It's promising research because low oxytocin is treatable, Parker says. In a recent study, when 13 autistic adults were given an oxytocin nasal spray (which delivers the drug straight to the brain), they had significant improvements in reading social cues and in making eye contact. "I think it's actually fascinating that you can apply oxytocin once and see these pretty acute social changes," Parker says. "Oxytocin is the only drug that's been shown to alter social functioning. There's nothing else that touches the social deficits."

The wiring that impairs, say, the ability to DISCERN SYMBOLISM in Shakespeare, might enable an extraordinary ability to MEMORIZE A SCENE FROM *HAMLET*

"bubble" and "mama"—into his car seat for the ride home.

MRI machines are noisy and require the patient to lie perfectly still for several minutes at a time, so most children—especially those with autism—cannot tolerate them while awake. So the idea is to bring them in already sleeping. However, the next study participant also arrives awake. But 4-year-old Padma, who has autism but is high-functioning, surprises everyone by agreeing to be scanned, enticed by the promise that she will get pictures of her brain. It's a partial success: The team gets one usable scan before they finally give up at 11:30 p.m. Padma proudly tells the researchers that she is going to post her brain pictures on Facebook.

Antonio Hardan is studying these brain pictures looking for signatures of autism and of subgroups of autism. Unlike others on campus who are working from the genes up, Hardan is working backward from the brain to the underlying biology. Hardan, who sees patients in addition to conducting research, has been involved with autism since he began volunteering to work with autistic patients in medical school. "And 27 years later, that's my life in a way, my research life," says Hardan, associate professor of psychiatry and behavioral science. "When you connect with something emotionally, then that's what you want to do."

It's long been known that children with autism have larger-than-normal brains early in their development. Hardan has refined this observation, showing that some (but not all) children with autism have an increase in the thickness of the cortex—the part of the brain responsible for complex functions such as language and social behavior—that disappears as they grow. It might be possible to link this back to genetics, says Hardan, who frequently collaborates with Hallmayer. We know some of the genes that contribute to cortical thickness, he says.

Hardan is exploring new brain imaging technologies that offer an unprecedented level of detail. For example, diffusion tensor imaging (DTI) shows the individual axons (the elongated parts of neurons) that connect different parts of the brain. And MRI spectroscopy measures the levels of specific chemicals in various parts of the brain. DTI studies from several universities suggest that autistic children have abnormal long-distance brain connections, an observation that dovetails with Dolmetsch's studies in neurons. Using MRI spectroscopy, Hardan also has detected specific chemical imbalances in the brains of children with autism. He's looking for treatments that can normalize these imbalances.

Hardan's team is involved in about 15 different clinical studies. Whenever possible, he tries to link treatment responses to changes in brain images and to a subgroup of people with autism. For example, Joshua and Padma were being re-scanned after they'd received a behavioral intervention that can improve language. These images may give clues as to how the treatment is working in the brain and what subgroups of patients are likely to respond. Hardan also is collaborating with Karen Parker, who is looking for biomarkers of autism in the blood and cerebraospinal fluid. (See sidebar, page 52.)

The commitment of parents keeps him going, Hardan says. "It's amazing what they would do for their kids. My admiration of these parents fuels what I do."

WHILE AUTISM remains largely a mystery, scientists are making inroads, bit by bit.

As a parent, Dolmetsch says he's been very fortunate. When faced with his son's diagnosis, there was something concrete he could do. Thanks in part to behavioral therapy, his son, now 8, is doing well. "He's at the edge between character and dysfunction. And some days it's very dysfunctional; other days it's just character."

Having a child with autism has changed the way he thinks about science. "You always want to publish findings that are correct, but the bar is higher when your own child is involved, he says. "You don't want to do anything to mislead the field when they are trying to find a cure for your kid."

He also cares less about doing things first. "I just want somebody to do it," he says. "I just want somebody to come up with some plausible biological explanations, so we can convince people that it's worth developing treatments." ■

KRISTIN SAINANI, MS '94, PhD '02, *is a freelance writer and a clinical assistant professor in the department of health research and policy.*

ARTICLE

The Lifetime Distribution of the Incremental Societal Costs of Autism

Michael L. Ganz, MS, PhD

Objective: To describe the age-specific and lifetime incremental societal costs of autism in the United States.

Design: Estimates of use and costs of direct medical and nonmedical care were obtained from a literature review and database analysis. A human capital approach was used to estimate lost productivity. These costs were projected across the life span, and discounted incremental age-specific costs were computed.

Setting: United States.

Participants: Hypothetical incident autism cohort born in 2000 and diagnosed in 2003.

Main Outcome Measures: Discounted per capita incremental societal costs.

Results: The lifetime per capita incremental societal cost of autism is $3.2 million. Lost productivity and adult care are the largest components of costs. The distribution of costs over the life span varies by cost category.

Conclusions: Although autism is typically thought of as a disorder of childhood, its costs can be felt well into adulthood. The substantial costs resulting from adult care and lost productivity of both individuals with autism and their parents have important implications for those aging members of the baby boom generation approaching retirement, including large financial burdens affecting not only those families but also potentially society in general. These results may imply that physicians and other care professionals should consider recommending that parents of children with autism seek financial counseling to help plan for the transition into adulthood.

Arch Pediatr Adolesc Med. 2007;161:343-349

AUTISM IS A VERY EXPENSIVE disorder costing our society upwards of $35 billion in direct (both medical and nonmedical) and indirect costs to care for all individuals diagnosed each year over their lifetimes.[1] Given the financial and nonfinancial costs we face and given increasingly more options for treatment and possibly for prevention, information on the distribution of costs is needed to help us decide on how to best allocate scarce resources to support individuals with autism and their families. Because the complementary (or competing) treatment and prevention strategies currently available, or yet to be developed, vary in effectiveness or implementation costs, understanding how total costs due to autism are distributed across the life cycle is important to make better decisions.

Relatively little is known about the societal costs of autism, in total and at different points across the life cycle. In earlier work, the per capita and total societal costs for individuals with autism were described.[1] Although the per capita and societal costs were described overall and across 17 components of direct medical, direct nonmedical, and indirect costs, age-specific costs were not. Because certain categories are more relevant and more costly and because these costs are borne by different parties at different ages, presenting the age distribution of the costs of autism can provide policy makers information that is helpful for cost-utility analyses and for current and future resource planning activities. The focus of this study is to present estimates of the costs of autism along with some detail on how the estimates were constructed. Although no clinical data are presented, these data should be useful to health care professionals, families, and agencies in planning for future care, especially with respect to nonmedical costs.

Author Affiliations: Abt Associates Inc, Lexington, and Harvard School of Public Health, Boston, Mass.

METHODS

A detailed description of the sources of data and computational methods used to compile the costs of autism has been presented elsewhere.[1] Briefly, cross-sectional cost data from different age groups were used to create prevalence-based cost estimates that approximate incidence-based estimates (ie, those constructed by longitudinally tracking an incident cohort over time). A prevalence-based cohort, also known as a synthetic, or hypothetical, cohort,[2] allows us to approximate the lifetime experiences of a single incident cohort by using the prevalence-based cost patterns as if

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

they were observed longitudinally from an incident cohort. Although an incidence-based cost-of-illness approach is more appropriate because it captures the full experience of autism, including any comorbid conditions, formidable data requirements preclude it.[3]

The total costs of autism equal the sum of its direct and indirect costs. Direct costs measure the value of goods and services used and indirect costs measure the value of lost productivity due to autism. These direct and indirect costs represent the value of other activities that these resources could have purchased (ie, opportunity costs).[4,5] Physician and other professional services, hospital and emergency department services, drugs, equipment and other supplies, and medically related travel and time costs are typical components of direct medical costs. Direct medical costs were obtained either from the literature or from an analysis of the Medical Expenditure Panel Survey (MEPS)[6] and the National Health Interview Survey (NHIS).[7] Special education, transportation, child care and babysitting, respite care, out-of-home placement, home and vehicle modifications, and supported employment services are typical components of direct nonmedical costs. Nonmedical costs were obtained from the literature. Multiple cost estimates within categories were averaged to obtain a single cost estimate for each category. Indirect costs are the value of lost or impaired work time (income), benefits, and household services of individuals with autism and their caregivers because of missed time at work, reduced work hours, switching to a lower-paying but more flexible job, or leaving the workforce. Indirect costs were computed using a human capital approach[3,8] that combines average earnings, benefits, and household services with information on average work-life expectancies and labor force participation rates for men and women at different ages.

In the analyses that follow, the incremental costs of autism are presented, which are defined as those additional costs that are due exclusively to autism. For example, costs due to use of medical services for periodic well-child preventive care or care related to the common cold are not considered herein because those costs are common to children with and without autism; however, costs specifically due to autism are considered herein. When incremental costs were not available or otherwise specifically presented in the source materials, they were computed by subtracting national average costs calculated from the MEPS from the costs reported in the source documents. For example, if a source document presented an average cost of $\$X$ for all children with autism and the national average for all children for that same category was $\$Y$, then the incremental cost was computed as $\$(Y-X)$. Because of the broad impact of autism on families, insurers, taxpayers, and society and because of the considerable public autism funding, a societal perspective was used, as recommended by the Panel on Cost-effectiveness in Health and Medicine.[8]

The Harvard School of Public Health Human Subjects Committee had previously exempted this study from institutional approval.

DIRECT COSTS

Literature Review

An in-depth targeted literature review concentrating on US-based studies was conducted to obtain data on use and costs. British and Canadian studies were also used when data were otherwise unavailable. Data on physician, outpatient, clinic services, dental care,[9] prescription medications,[9-11] complementary and alternative therapies,[12-18] behavioral therapies,[19-22] hospital and emergency services,[9,23] allied health, equipment and supplies, home health,[9] and medically related travel[9] were classified as direct medical. Data on child care,[9,19] adult care,[19,20] respite and family care,[9,19,20] home and care modifications,[9,24] special education,[19,20,25-27] supported employment,[20,28-34] and other costs[9,24] were classified as direct nonmedical. Although some dimensions of care may be misclassified between direct medical and direct nonmedical (for example, many special education programs provide behavioral therapies), because the degree of misclassification is not known, no corrections were made. Costs, as reported in the source materials, were inflated to 2003 US dollars using the all-item consumer price index.[35] State-specific costs were transformed to national averages[36] and foreign costs were converted to US costs using the latest available Federal Reserve exchange rates.[37] Use measures were translated to costs by multiplying the use measures by age group–specific survey-adjusted average costs from the MEPS.[6] More in-depth information on how the cost estimates were constructed from these sources is available elsewhere[1] and in a technical appendix available on request.

Survey Analysis

Data from the NHIS[7] and the MEPS[6] were also used to supplement data on costs of autism and to also compute average costs for use in deriving the incremental costs of autism. Because confidentiality concerns constrain the MEPS to only report the first 3 digits of diagnosis codes, individuals with an *International Classification of Diseases, Ninth Revision* (*ICD-9*) diagnosis code of 299, which includes autism diagnoses (299.0*x*) as well as disintegrative psychoses (299.1*x*) and early childhood psychoses (299.8*x*/299.9*x*), were used as proxies for individuals with autism. Specific autism questions were available in the NHIS during 1997-2000. Information from those questions was combined with an *ICD-9* diagnosis code of 299 in the NHIS and was linked to the MEPS to increase the number of usable cases. Survey-adjusted means for expenditures were then computed as described earlier. Further information is available elsewhere[1] and from the technical appendix.

INDIRECT COSTS

Productivity losses for people with autism were estimated by combining standard average work-life expectancies for all men and women taken from the economics literature (ages 23-57 years for men and 23-53 years for women),[34] with average income and benefits (from Tables 696 and 628 of the *Statistical Abstract of the United States*[36]) and estimates of age- and sex-specific labor force participation rates.[38] Average incomes are projected for future years based on estimated productivity growth rates[35] to estimate average total earnings and benefits at each age. These estimates are adjusted for the fact that while some adults with autism are unable to work, others are (35% of adults with lower levels of disability and 10% of adults with higher levels of disability work in supported work environments). Finally, the lost value of sex-specific household services is added.[3,39] These estimates do not account for the effects of taxes or lost leisure time. Similar methods were used to estimate productivity for parents. Fathers of children with lower levels of disability were assumed to be unemployed 10% of the time (and working full-time during the remaining 90%) and mothers were assumed to be unemployed 55% of time (and were working half-time 25% of the time and full-time, 20%).[40,41] Fathers of children with higher levels of disability were assumed to be unemployed 20% of the time and mothers were assumed to be unemployed 60% of time (and were working half-time 30% of the time and full-time, 10%). These assumptions were combined with the same average earnings, benefits, productivity growth, labor force participation rates as used for individuals with autism, and the appropriate work-life expectances. These estimates assumed households in which both a mother and a father care for 1 child with autism. These estimates will differ based on different family configurations.

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

Table 1. Age-Specific and Lifetime per Capita Incremental Societal Costs of Autism*

Age Group, y	Average Per Capita Cost per Age Group			Total Per Capita Cost
	Direct Medical	Direct Nonmedical	Indirect	
3-7	35 370	10 805	43 066	446 203
8-12	6013	15 708	41 138	314 297
13-17	5014	13 550	38 453	285 082
18-22	2879	10 720	36 090	248 446
23-27	1574	27 539	51 740	404 260
28-32	1454	23 755	35 757	304 828
33-37	1389	20 492	30 852	263 662
38-42	1283	17 676	29 132	240 457
43-47	1440	15 248	26 600	216 439
48-52	1447	13 152	24 531	195 650
53-57	1290	11 292	17 776	151 790
58-62	1218	9489	0	53 535
63-66	1027	7908	0	35 738
Total lifetime costs	305 956	978 761	1 875 667	3 160 384

*Costs presented in 2003 dollars. Costs for age 4 years and older are discounted to 2003 dollars using a discount rate of 3%. Life expectancy for men is age 66 years and for women, age 65 years.

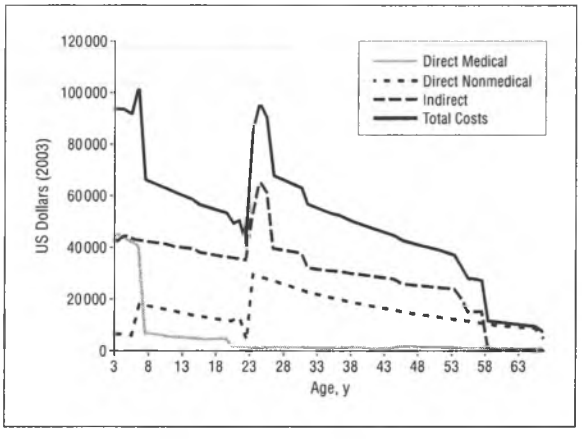


Figure 1. Age distribution of incremental societal costs of autism (present value).

CALCULATING COSTS

To the extent possible, cost estimates were derived for higher- and lower-functioning individuals as they were presented in the literature. Semidependent, independent, or those individuals described as having high-functioning autism were classified in the higher-functioning category. Dependent individuals or those not described as having high-functioning autism were classified in the lower-functioning category. Based on data presented in Fombonne,[42] the prevalence of higher-functioning autism is assumed to be 54%. The male-female ratio is assumed to be 4:1. Weighted average per capita costs were computed based on the assumed distribution of lower- and higher-functioning status and the male-female ratio. Age 3 years was considered to be the baseline age (age at diagnosis) and 2003 was the baseline year. Because there is some evidence that people with autism have reduced life expectancies,[43-46] costs were tabulated through age 66 years for males and through age 65 years for females. Costs were discounted to present value (to age 3 years) using a discount rate of 3% as recommended by the Panel on Cost-effectiveness in Health and Medicine.[8] Costs in future years were discounted, or deflated, to reflect the time value of money: a dollar today is worth more than a dollar in the future. In doing so, all costs were adjusted for the different periods in which they were incurred. In other words, dollars at different ages become comparable. Because health care resource investments, such as in the case of autism research and treatment budgets, incur costs in the present and potentially realize the benefits in the future, it is common to discount future flows of costs (and benefits) to present value. Although 3% is the currently used standard for a discount rate, this rate is varied in the sensitivity analyses described in the next subsection.

SENSITIVITY ANALYSES

In previous work, the robustness of the overall cost estimates was assessed using 1-way sensitivity analyses and conclusions were mostly robust to changes in many key parameters.[1] However, the total costs were found to be most sensitive to changes in the discount rate and to changes in the assumed level of indirect costs. Because variations in indirect costs will not substantially change the pattern of costs over the life cycle, herein focus is placed on the discount rate.[8] The discount rate is varied between 2% and 5% as suggested by Gold et al.[8]

DEFINITION OF AUTISM

Many of the sources of data simply used the term *autism* and did not differentiate between the different autism spectrum disorders. Reflecting the literature, the term *autism* herein is used in an inclusive manner to mean all disorders in the spectrum. Given the nature of many of the nonmedical and indirect costs, it is likely that those costs are more representative of more disabled individuals. Older sources[9] may have only included lower-functioning children and individuals in their definitions of autism. However, varying the proportions of lower- and higher-functioning individuals does not substantially change conclusions about overall lifetime costs.[1]

RESULTS

In the Tables that follow, the average per capita costs by category are presented in 5-year intervals (the full Tables

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

Table 2. Age-Specific and Lifetime per Capita Incremental Societal Direct Costs of Autism*

Age Group, y	Average per Capita Cost per Age Group						
	Physician and Dental	Drugs	CAM Therapies	Behavioral Therapies	Emergency and Hospital	Home Health	Travel
3-7	1147	147	198	32 501	828	467	81
8-12	577	153	109	4033	768	303	70
13-17	435	131	50	3479	591	267	60
18-22	426	129	33	1254	852	132	52
23-27	496	124	28	0	774	106	45
28-32	507	114	25	0	682	87	39
33-37	547	98	21	0	598	93	33
38-42	540	84	18	0	522	90	29
43-47	765	72	16	0	426	137	25
48-52	845	61	14	0	352	154	21
53-57	851	52	12	0	292	65	18
58-62	810	44	10	0	323	14	16
63-66	632	34	9	0	301	39	14
Total lifetime costs	42 259	6180	2704	206 337	36 235	9738	2503

Abbreviation: CAM, complementary and alternative medicine.
*Costs presented in 2003 dollars. Costs for age 4 years and older are discounted to 2003 dollars using a discount rate of 3%. Life expectancy for men is age 66 years and for women, age 65 years.

Table 3. Age-Specific and Lifetime per Capita Incremental Societal Direct Nonmedical Costs of Autism*

Age Group, y	Average per Capita Cost per Age Group						
	Child Care	Adult Care	Respite Care	Home Improvements	Special Education	Supported Work	Other
3-7	4636	0	1100	161	4585	0	323
8-12	3999	0	948	139	10 343	0	278
13-17	3450	0	818	120	8922	0	240
18-22	2907	0	706	10	6247	0	851
23-27	0	25 064	0	9	0	836	1630
28-32	0	21 620	0	8	0	721	1406
33-37	0	18 650	0	7	0	622	1213
38-42	0	16 087	0	6	0	537	1046
43-47	0	13 877	0	5	0	463	903
48-52	0	11 970	0	4	0	399	778
53-57	0	10 326	0	4	0	291	672
58-62	0	8907	0	3	0	0	579
63-66	0	7423	0	3	0	0	483
Total lifetime costs	74 963	662 192	17 858	2388	150 483	19 349	51 528

*Costs presented in 2003 dollars. Costs for age 4 years and older are discounted to 2003 dollars using a discount rate of 3%. Life expectancy for men is age 66 years and for women, age 65 years.

are available as eTables 1-4 at http://archpediatrics.com). **Table 1** and **Figure 1** display the incremental societal direct medical, direct nonmedical, and indirect costs. Direct medical costs are quite high for the first 5 years of life (average of around $35 000), start to decline substantially by age 8 years (around $6000), and continue to decline through the end of life to around $1000. Direct nonmedical costs vary around $10 000 to approximately $16 000 during the first 20 years of life, peak in the 23- to 27-year age range (around $27 500), and then steadily decline to the end of life to around $8000 in the last age group. Indirect costs also display a similar pattern, decreasing from around $43 000 in early life, peaking at ages 23 to 27 years (around $52 000), and declining through the end of life to $0.

Table 2 displays the individual components of the incremental societal direct medical costs. Considered over the entire life span, direct medical costs make up 9.7% of total discounted lifetime costs. Behavioral therapies, which are the largest component of direct medical costs, make up 6.5% of total discounted lifetime costs.[1] However, behavioral therapies, as presented herein, are only relevant for children 19 years or younger. The large direct medical costs early in life are driven primarily by behavioral therapies that cost around $32 000 during the first 5-year age group and decline from about $4000 in the 8- to 12-year age group to around $1250 for the 18- to 22-year age group. Physician and dental costs are initially high, then decrease, but increase again in later life. Prescription drugs, complementary and alternative therapies, and hospital and emergency services are also relatively

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

Table 4. Age-Specific and Lifetime per Capita Incremental Societal Indirect Costs of Autism*

Age Group, y	Average per Capita Cost per Age Group	
	Own Indirect	Not Own Indirect
3-7	0	43 066
8-12	0	41 138
13-17	0	38 453
18-22	0	36 090
23-27	32 703	19 036
28-32	32 620	3136
33-37	30 852	0
38-42	29 132	0
43-47	26 600	0
48-52	24 531	0
53-57	17 776	0
58-62	0	0
63-66	0	0
Total lifetime costs	971 072	904 595

*Costs presented in 2003 dollars. Costs for age 4 years and older are discounted to 2003 dollars using a discount rate of 3%. Life expectancy for men is age 66 years and for women, age 65 years.

high initially but steadily decline. Some costs decline less smoothly than others because of different availability of cost-by-age estimates in the literature.

Table 3 displays the individual components of the incremental societal direct nonmedical costs. Nonmedical costs, except during ages 3 to 7 years, are more expensive than direct medical costs and make up 31% of total discounted lifetime costs.[1] Different costs become relevant at different ages, which contributes to the dips and spikes in the direct nonmedical line in Figure 1. Child care and respite costs, which average about $5700 in early ages to around $3600 at ages 18 to 22 years, contribute far less (3% of total discounted lifetime costs) than adult care costs (21% of total discounted lifetime costs), which range from around $25 000 at ages 23 to 27 years to around $7400 at ages 63 to 66 years. Special education costs, which make up 4.8% of total discounted lifetime costs, range from around $12 000 at age 6 years (costs for ages 3-5 years are assumed to be zero) to around $6200 at ages 18 to 22 years, and supported employment costs range from around $800 at ages 23 to 37 years to around $300 at ages 53 to 57 years (age 57 years is the assumed end of working life).

Table 4 displays the components of the incremental societal indirect costs. Indirect costs are by far the largest component of the total incremental societal costs of autism (59.3% of total discounted lifetime costs).[1] Own indirect costs, which make up 30.7% of total discounted lifetime costs, range from around $33 000 at ages 23 to 27 years to around $18 000 at ages 53 to 57 years. Not own (assumed herein to be parents') indirect costs, which make up 28.6% of total discounted lifetime costs, range from around $43 000 at ages 3 to 7 years, when parents are assumed to be about 33 to 37 years of age, to around $19 000 at ages 23 to 27 years, when parents are assumed to be 53 to 57 years of age, to around $3000 per year for the next 5 years until the end of the average work life. Although total indirect costs spike at ages 23 to 27 years, because of the overlapping own and not own indirect costs, as **Figure 2** indicates, at any given time from age 3 years through age 57 years, there is a substantial and smoothly declining level of indirect costs. Figure 2 also dramatically illustrates, at least for this model, the transition from exclusive parental lost productivity almost immediately to lost own productivity.

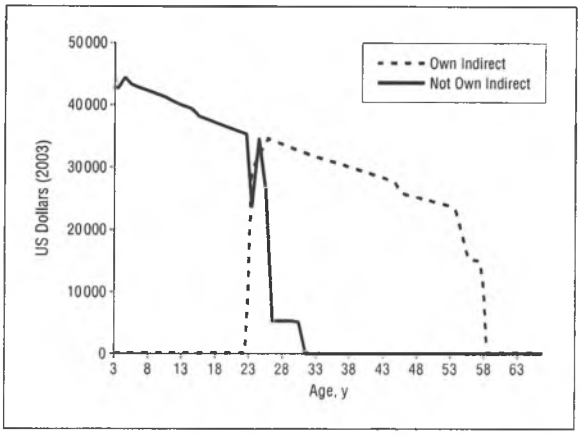


Figure 2. Age distribution of own and not own indirect incremental costs (present value).

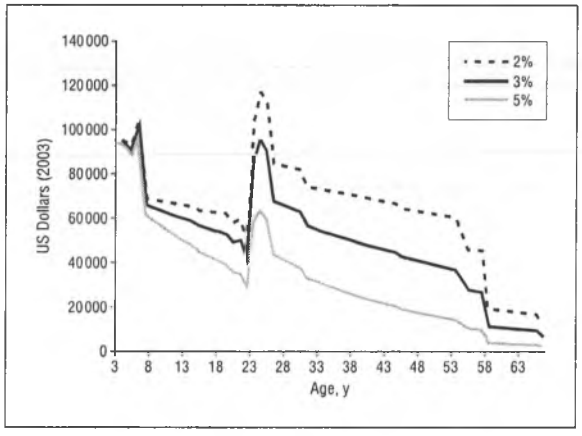


Figure 3. Age distribution of total incremental societal costs of autism computed at different discount rates.

SENSITIVITY ANALYSES

Sensitivity analyses using 2% and 5%, which are common upper and lower bounds, reveal that the patterns of age-specific expenditures are similarly shaped. **Figure 3** displays total costs using 2%, 3%, and 5% as the discount rates. There is an inverse relationship between the discount rate and the weight placed on future costs: lower discount rates place greater weight on future costs and higher rates place less weight on future costs. As a result, total present value costs will be larger the smaller the discount rate. The maximum difference in total costs between the 5% scenario and the 2% scenario (about $53 000) occurs at age 24 years and the average difference in costs between the 5% and 2% scenarios is about $31 000.

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

COMMENT

This article presents the first description, to my knowledge, of the societal costs of autism in the United States across all ages of the life span and contributes not only to the literature on the costs of autism but also to the literature on age-specific health care costs in general. As was previously reported, the total annual societal per capita cost of caring for and treating a person with autism in the United States was estimated to be $3.2 million and about $35 billion for an entire birth cohort of people with autism.[1] Sensitivity analyses revealed that these lifetime costs could range from $13 billion to $76 billion depending on the underlying assumptions of the model. Although those estimates are highly conservative because they exclude a number of important elements (such as legal costs that families incur to secure services[47,48]; lost productivity of those other than parents; the costs of genetic testing; the full costs of alternative therapies, including diets; the costs of adverse outcomes of potentially dangerous treatment modalities; and costs associated with immunization-avoidance behaviors[48]), they are valuable because they add information to a relatively underdeveloped literature. As treatment and, perhaps prevention, strategies are developed, knowledge of when costs are incurred relative to when benefits are expected is important for clinical decision-making and cost-effectiveness analysis efforts.

Knowledge about age-specific per capita incremental societal costs is particularly important because, as opposed to the summary lifetime data presented previously,[1,25,47] age-specific data illuminate the relative magnitudes of different types of costs at different ages. Given that at different ages different segments of society are responsible for absorbing these costs, this detailed disaggregation of costs can provide even more valuable information to planners, policy makers, and even to families making decisions that can affect current and future financial health, especially as they consider the fact that at various points in the life cycle different costs are more germane than others.

Although autism is typically thought of as a disorder of childhood, its costs can be felt well into adulthood. Adult care, which has the largest lifetime cost of all direct costs, is typically more than 5 times larger than the next 3 largest costs, which include care incurred during childhood (behavioral therapies, child/respite care, and special education). Alemayehu and Warner[49] reported that the typical American spends about $317 000 over his or her lifetime in direct medical costs, incurring 60% of those costs after age 65 years. In contrast, people with autism incur about $306 000 in incremental direct medical costs, implying that people with autism spend twice as much as the typical American over their lifetimes and spend 60% of those incremental direct medical costs after age 21 years.

These results, especially on the substantial costs resulting from lost productivity of both individuals with autism and their parents and from rather large adult care costs, have important implications for those aging members of the baby boom generation approaching retirement. As those individuals retire, many of their adult children with autism will be transitioning into adult care settings. Those costs, combined with very limited to nonexistent income for their adult children with autism combined with potentially lower levels of savings because of decreased income and benefits while employed, may create a large financial burden affecting not only those families but potentially society in general. Perhaps physicians and other care professionals should consider recommending that parents of children with autism seek financial counseling to help plan for the transition into adulthood.

Although this study is limited by a number of factors, it is the first of its kind, to my knowledge, and can shed insight into the lifetime distribution of autism costs and also motivate future, more rigorous studies. The cost model presented herein is based on a number of simplifying assumptions and relies on sometimes incomplete and old information. These caveats should be kept in mind when using these estimates for policy or practice decision making. The results presented herein for direct medical costs are consistent with recently published data on health care use and costs for children with autism. Gurney et al[50] reported that, relative to children without autism, children with autism, as reported by their parents, experience a significantly higher number of preventive visits and emergency and nonemergency hospital visits. Croen et al[51] reported, based on administrative data from the Northern California Kaiser Permanente Medical Care program, that children with autism incurred 2.5 times as much outpatient costs, 2.9 times as much inpatient costs, and 7.6 times as much medication costs as randomly selected children without autism. Pursuing a research agenda of both carefully and systematically documenting the costs of autism in the United States can be helpful in improving these estimates. Prospectively tracking the life experiences of individuals with autism and their families and obtaining a wide variety of data on the different sources of services for people with autism can provide this more complete picture. Prospectively collected clinical and quality-of-life data combined with cost data will be even more useful for understanding the societal costs, both financial and nonfinancial, of caring for those members of our society with autism at every age of the life course.

Accepted for Publication: November 16, 2006.
Correspondence: Michael L. Ganz, MS, PhD, Abt Associates Inc, 181 Spring St, Lexington, MA 02421 (mganz@hsph.harvard.edu).
Financial Disclosure: None reported.
Additional Information: eTables 1-4 are available at http://archpediatrics.com.

REFERENCES

1. Ganz ML. The costs of autism. In: Moldin SO, Rubenstein JLR, eds. *Understanding Autism: From Basic Neuroscience to Treatment*. Boca Raton, Fla: Taylor and Francis Group; 2006.
2. National Center for Health Statistics. NCHS definitions: synthetic cohort. December 16, 2004. http://www.cdc.gov/nchs/datawh/nchsdefs/syntheticcohort.htm. Accessed January 5, 2005.

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

3. Waitzman NJ, Scheffler RM, Romano PS. *The Costs of Birth Defects: Estimates of the Value of Prevention*. Lanham, Md: University Press of America, Inc; 1996.
4. Pindyck RS, Rubinfeld DL. *Microeconomics*. 5th ed. Upper Saddle River, NJ: Prentice Hall; 2000.
5. Rice DP, Hodgson TA, Kopstein AN. The economic costs of illness: a replication and update. *Health Care Financ Rev*. 1985;7:61-80.
6. Agency for Healthcare Research and Quality. The Medical Expenditure Panel Survey. http://www.ahrq.gov/data/mepsix.htm. Accessed January 3, 2005.
7. Centers for Disease Control and Prevention. The National Health Interview Survey. December 16, 2004. http://www.cdc.gov/nchs/nhis.htm. Accessed January 3, 2005.
8. Gold MR, Siegel JE, Russell LB, Weinstein MC, eds. *Cost-Effectiveness in Health and Medicine*. New York, NY: Oxford University Press; 1996.
9. Birenbaum A, Guyot D, Cohen HJ. *Health Care Financing for Severe Developmental Disabilities*. Washington, DC: American Association on Mental Retardation; 1990.
10. Aman MG, Van Bourgondien ME, Wolford PL, Sarphare G. Psychotropic and anticonvulsant drugs in subjects with autism: prevalence and patterns of use. *J Am Acad Child Adolesc Psychiatry*. 1995;34:1672-1681.
11. Martin A, Scahill L, Klin A, Volkmar FR. Higher-functioning pervasive developmental disorders: rates and patterns of psychotropic drug use. *J Am Acad Child Adolesc Psychiatry*. 1999;38:923-931.
12. Aman MG, Lam KS, Collier-Crespin A. Prevalence and patterns of use of psychoactive medicines among individuals with autism in the Autism Society of Ohio. *J Autism Dev Disord*. 2003;33:527-534.
13. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL. Unconventional medicine in the United States: prevalence, costs, and patterns of use. *N Engl J Med*. 1993;328:246-252.
14. Green VA, Pituch KA, Itchon J, Choi A, O'Reilly M, Sigafoos J. Internet survey of treatments used by parents of children with autism. *Res Dev Disabil*. 2006; 27:70-84.
15. Langworthy-Lam KS, Aman MG, Van Bourgondien ME. Prevalence and patterns of use of psychoactive medicines in individuals with autism in the Autism Society of North Carolina. *J Child Adolesc Psychopharmacol*. 2002;12: 311-321.
16. Levy SE, Mandell DS, Merhar S, Ittenbach RF, Pinto-Martin JA. Use of complementary and alternative medicine among children recently diagnosed with autistic spectrum disorder. *J Dev Behav Pediatr*. 2003;24:418-423.
17. Nickel RE. Controversial therapies for young children with developmental disabilities. *Infants Young Child*. 1996;8:29-40.
18. Yussman SM, Ryan SA, Auinger P, Weitzman M. Visits to complementary and alternative medicine providers by children and adolescents in the United States. *Ambul Pediatr*. 2004;4:429-435.
19. Hildebrand DG. *Cost-Benefit Analysis of Lovaas Treatment for Autism and Autism Spectrum Disorder (ASD)*. Vancouver, British Columbia: Columbia Pacific Consulting; 1999.
20. Jacobson JW, Mulick JA, Green G. Cost-benefit estimates for early intensive behavioral intervention for young children with autism—general model and single state case. *Behav Intervent*. 1998;13:201-226.
21. Lovaas OI. Behavioral treatment and normal educational and intellectual functioning in young autistic children. *J Consult Clin Psychol*. 1987;55:3-9.
22. McEachin JJ, Smith T, Lovaas OI. Long-term outcome for children with autism who received early intensive behavioral treatment. *Am J Ment Retard*. 1993; 97:359-372.
23. Walsh KK, Kastner T, Criscione T. Characteristics of hospitalizations for people with developmental disabilities: utilization, costs, and impact of care coordination. *Am J Ment Retard*. 1997;101:505-520.
24. Fujiura GT, Roccoforte JA, Braddock D. Costs of family care for adults with mental retardation and related developmental disabilities. *Am J Ment Retard*. 1994; 99:250-261.
25. Järbrink K, Knapp M. The economic impact of autism in Britain. *Autism*. 2001;5: 7-22.
26. Parrish T, Harr J, Wolman J, Anthony J, Merickel A, Esra P. *State Special Education Finance Systems, 1999–2000. Part II: Special Education Revenues and Expenditures*. Palo Alto, Calif: Center for Special Education Finance; 2004.
27. Yeargin-Allsopp M, Rice C, Karapurkar T, Doernberg N, Boyle C, Murphy C. Prevalence of autism in a US metropolitan area. *JAMA*. 2003;289:49-55.
28. Bureau of Labor Statistics. *Occupational Outlook Handbook, 2004-05 Edition*. Washington, DC: US Dept of Labor; 2004.
29. Capo LC. Autism, employment, and the role of occupational therapy. *Work*. 2001; 16:201-207.
30. Heal LW, McCaughrin WB, Tines JJ. Methodological nuances and pitfalls of benefit-cost analysis: a critique. *Res Dev Disabil*. 1989;10:201-212.
31. Keel JH, Mesibov GB, Woods AV. TEACCH-supported employment program. *J Autism Dev Disord*. 1997;27:3-9.
32. Mawhood L, Howlin P. The outcome of a supported employment scheme for high functioning adults with autism or Asperger syndrome. *Autism*. 1999;3:229-254.
33. Rusch FR, Conley RW, McCaughrin B. Benefit-cost analysis of supported employment in Illinois: a statewide evaluation. *Am J Ment Retard*. 1990;95: 44-54.
34. Skoog GR, Ciecka JE. The Markov (increment-decrement) model of labor force activity: extended tables of central tendency, variation, and probability intervals. *J Legal Econ*. 2001;11:23-87.
35. Congressional Budget Office. The budget and economic outlook: an update. August 2003. http://www.cbo.gov/showdoc.cfm?index=4493&sequence=3. Accessed January 4, 2005.
36. US Department of Commerce. *Statistical Abstract of the United States*. Washington, DC: Bureau of the Census; 2004.
37. Board of Governors of the Federal Reserve System. Foreign Exchange Rates Historical Data Series H.10. http://www.federalreserve.gov/releases/H10/hist/. Accessed January 4, 2005.
38. Congressional Budget Office. CBO's projections of the labor force. September 2004. http://www.cbo.gov/showdoc.cfm?index=5803&sequence=0. Accessed January 4, 2005.
39. American Academy of Pediatrics. The pediatrician's role in the diagnosis and management of autistic spectrum disorder in children. *Pediatrics*. 2001;107:1221-1226.
40. Butter EM, Wynn J, Mulick JA. Early intervention critical to autism treatment. *Pediatr Ann*. 2003;32:677-684.
41. Population Division. *Annual Estimates of the Population by Sex and Five-Year Age Groups for the United States: April 1, 2000 to July 1, 2003*. Washington, DC: US Census Bureau; 2004. www.census.gov/popest/national/asrh/NCEST2003/NC-EST2003-01.pdf. Accessed January 4, 2005.
42. Fombonne E. Epidemiological surveys of autism and other pervasive developmental disorders: an update. *J Autism Dev Disord*. 2003;33:365-382.
43. Fombonne E. The life expectancy of children diagnosed with a pervasive developmental disorder. *J Autism Dev Disord*. 2003;33:361.
44. Gillberg C. Outcome in autism and autistic-like conditions. *J Am Acad Child Adolesc Psychiatry*. 1991;30:375-382.
45. Shavelle RM, Strauss D. Comparative mortality of persons with autism in California, 1980-1996. *J Insur Med*. 1998;30:220-225.
46. Shavelle RM, Strauss DJ, Pickett J. Causes of death in autism. *J Autism Dev Disord*. 2001;31:569-576.
47. Maltby J. The costs of autism: more than meets the eye. *Advocate*. 2000;33(6): 12-16. http://www.autisminfo.com/Advocate.pdf. Accessed December 24, 2004.
48. Folstein SE, Rosen-Sheidley B. Genetics of autism: complex aetiology for a heterogeneous disorder. *Nat Rev Genet*. 2001;2:943-955.
49. Alemayehu B, Warner KE. The lifetime distribution of health care costs. *Health Serv Res*. 2004;39:627-642.
50. Gurney JG, McPheeters ML, Davis MM. Parental report of health conditions and health care use among children with and without autism: National Survey of Children's Health. *Arch Pediatr Adolesc Med*. 2006;160:825-830.
51. Croen LA, Najjar DV, Ray GT, Lotspeich L, Bernal P. A comparison of health care utilization and costs of children with and without autism spectrum disorders in a large group-model health plan. *Pediatrics*. 2006;118:e1203-e1211 http://pediatrics.aappublications.org/cgi/content/full/118/4/e1203.

Downloaded from www.archpediatrics.com on March 22, 2011
©2007 American Medical Association. All rights reserved.

March 4, 2011

Actuarial Cost Estimate: Alaska House Bill 79 and Senate Bill 74

An Act requiring insurance coverage for autism spectrum disorders, describing the method for establishing a covered treatment plan for those disorders, and defining the covered treatment for those disorders; and providing for an effective date

OLIVER WYMAN

Prepared By:

Marc Lambright, FSA, MAAA

Contents

1. Executive Summary 1

2. Background 3

3. Scope and Limitations 4

4. Description of Key HB 79 / SB 74 Provisions and their Impact on Covered Benefits .5

5. Modeling Methodology 7
   - Modeling Perspective 7
   - Emerging Cost Experience for Autism Coverage 8
   - General Modeling Process 9

6. Summary of Key Assumptions 10
   - Treated Prevalence and Age at Diagnosis 10
   - ABA Program Utilization and Cost 12
   - Other (than ABA) Medical Costs 15
   - Administrative Costs 15
   - Alaska Market Data 15

7. Cost Estimates 17
   - Long-Term Cost Estimates - "Middle" Cost Scenario 17
   - Scenario Estimates 18
   - Short-Term Cost Estimates by Scenario 18
   - Individual Market Comment 18

8. Cost – Benefit Analysis for ASD Treatments 19
   - Societal Costs of Autism- Ganz Report 19
   - Cost Savings to State and Local Governments 20

Appendix

Cost Assumptions – Illustrative Exhibits, and 22

HB 79 / SB 74 Text 22

1

Executive Summary

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of insurance benefits for autism spectrum disorders (ASD) under Alaska House Bill 79 and Senate Bill 74, which are identical bills that will be referred to as "HB 79 / SB 74" throughout this report.

The most significant class of treatments covered under HB 79 / SB 74 are behavioral health treatments, which are referred to as applied behavior analysis, or "ABA" throughout this document since ABA is one of the most common behavioral health treatments and the general approach and costs for ABA are assumed to be similar to those of other behavioral health treatments. The key provisions of HB 79 / SB 74 are explained further in Section 4 of this report.

Our analysis involved developing a robust model that reflects the likely behavior of consumers, providers and insurers of ABA services, and includes Alaska demographic and insurance market information. Key assumptions, including the treated prevalence of ASD, the age of diagnosis, ABA program utilization by age, ABA annual costs by age, and additional other (i.e., not ABA) medical costs, as well as the modeling methodology are explained in detail in Sections 5 and 6 of this report and summarized through graphs in the Appendix.

Our analysis included scenario testing to develop cost estimates under a range of assumptions. Our "Middle" estimate is that, in the long-term, costs would increase by about 0.39% of premiums and premiums would increase about 0.45% should HB 79 / SB 74 be enacted. Our estimated range of long-term premium increases is 0.28% to 0.68% based on our "Low" and "High" estimates.

We expect that premium increases would be lower in the years immediately following the passage of a law consistent with the provisions of HB 79 / SB 74, with first year cost increases in the range of 0.09% to 0.45% percent of premiums. Our expectation of lower first year costs is based on experiences in other states that have seen low initial costs when

ASD benefits are first covered. These lower costs can be expected due to the lags typically seen in accessing new benefits and the limited supply of ABA providers.

The estimated cost increases for our "Middle" scenario, along with some statistics for the individual, small, and large group markets, are shown in the table below.

Long-Term Cost Estimates - "Middle" Cost Scenario

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	25,000	39,000	52,000	116,000
Average Premium per Person	$2,800	$5,500	$4,700	$4,559
Annual Claim Cost per Covered Person	$17.60	$17.60	$17.60	$17.60
Claim Cost as a Percentage of Premium	0.63%	0.32%	0.37%	0.39%
Estimated Premium Increase with Admin @ 15%	$20.70	$20.70	$20.70	$20.70
Premium Increase as a Percentage of Premium	0.74%	0.38%	0.44%	0.45%

For our scenario testing we varied the assumptions that drive cost estimates. The assumptions under the "Low," "Middle," and "High" scenarios and premium increase estimates are summarized in the table below.

Scenario	% Autistic Disorder Diagnosed Under Age 6 Starting ABA	Program Cost - Autistic Disorder (Ages 0-6)	Avg. Annual non-ABA Cost	Premium Increase per Covered	Premium Increase (% of Premium)
Low	50.0%	$50,000	$2,350	$12.80	0.28%
Middle	65.0%	$65,000	$3,525	$20.70	0.45%
High	80.0%	$83,718	$4,700	$30.90	0.68%

While this analysis focused primarily on estimating the insured costs of covered medical benefits associated with HB 79 / SB 74, in Section 8 we summarize information related to the lifetime costs of ASD, which include the costs associated with medical services, education, custodial care and the lost productivity and wages of individuals affected by ASD, as well as their family caregivers.

Based on the results of several studies, we expect that the costs of ABA treatments covered under HB 79 / SB 74 could be recovered through reductions in educational and medical expenditures alone. We also expect that benefits associated with successful treatments would reduce future costs of caring for individuals with ASD, and improve both the productivity and the quality of life for individuals with ASD, as well as their family caregivers.

2

Background

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of legislation providing for additional insurance benefits for autism spectrum disorders (ASD) on insurance premiums. As part of this work, Oliver Wyman has developed a range of independent estimates of the impact of HB 79 / SB 74 on insurance premiums, which provides coverage for the diagnosis and treatment of autism spectrum disorders.

Oliver Wyman is a part of the Marsh & McLennan family of companies. With over 60 members of the American Academy of Actuaries, Oliver Wyman is one of the largest actuarial practices in North America. Oliver Wyman's health practice, which has fourteen credentialed actuaries, advises insurers, regulators, governments, interest groups, and others.

This report, along with its supporting analysis, was developed by Marc Lambright, a Principal and consulting actuary in Oliver Wyman's Philadelphia office. Marc is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and is professionally qualified to analyze the cost impact of HB 79 / SB 74 and provide the estimates shown in this report. As part of Oliver Wyman's quality assurance process, the underlying analysis and this report were independently peer reviewed by another credentialed Oliver Wyman actuary.

3

Scope and Limitations

The intent of this analysis is to provide a reasonable range of estimates for the incremental insured costs of the ASD benefits provided for in HB 79 / SB 74 and the associated premium impact on the individual, small group, and large group markets affected by HB 79 / SB 74. This analysis also identifies and partially quantifies identified offsetting cost savings associated with successful ASD treatment.

We note that cost estimates associated with autism coverage legislation have varied widely state to state based on state specific differences in legislation and the methods and assumptions used in estimating costs, though typically independent estimates show premium increases due to legislation covering additional autism benefits of less than 1%. A March 2009 report by The Council for Affordable Health Insurance (CAHI) states: "CAHI's actuarial working team estimates that an autism mandate increases the cost of health insurance by about 1 percent."[1] The reason for this variability is that the largest component of the increase in costs under HB 79 / SB 74 is due to the coverage of behavioral therapies, including applied behavior analysis (ABA), which is almost universally excluded from health coverage, and therefore very little mature insured data exists for use in developing credible utilization and unit cost estimates for ABA.

The reader is further cautioned that the ultimate cost of covering ABA benefits is uncertain; however, this analysis reflects the likely behavior of consumers, providers and insurers of ABA services in developing the assumptions underlying the cost estimates. Likewise, the additional costs for medical services other than ABA are uncertain. Insurance policies often cover some services for children diagnosed with an ASD, although the legislation could cause the insured costs for certain services to increase because ASD exclusions or limitations are common, and certain services that may have been initially denied or terminated following utilization review or benefit limitations might be covered due to HB 79 / SB 74.

[1] The Council for Affordable Health Insurance. "The Growing Trend Towards Autism Coverage." March 2009.

4

Description of Key HB 79 / SB 74 Provisions and their Impact on Covered Benefits

Insurance Markets Covered by HB 79 / SB 74

The Bills state: *"Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in this state shall provide coverage for the costs of the diagnosis and treatment of autism spectrum disorders."*

In our modeling we are assuming that this means that HB 79 / SB 74 applies to health insurance contracts in the individual, small group, and large group markets.

Covered Benefits

HB 79 / SB 74 provides for the diagnosis and treatment for autism spectrum disorders, where covered services are outlined in the following language:

"*Covered treatment may include medically necessary pharmacy care, psychiatric care, psychological care, habilitative or rehabilitative care, and therapeutic care.*"

"'habilitative or rehabilitative care' means professional counseling, guidance services, and treatment programs, including applied behavior analysis or other structured behavioral therapies necessary to develop, restore, and maintain the functioning of an individual to the maximum extent practicable; in this paragraph, 'applied behavior analysis' means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function"

The inclusion of applied behavior analysis (ABA), and other behavioral therapies is especially important, and the coverage of these types of programs has the most significant impact on the cost of covered benefits under HB 79 / SB 74.

ABA may include 30-40 hours of therapy a week, though many programs would not utilize that level of resources. Key assumptions underlying our ABA cost estimates which also consider costs of other intensive programs are outlined in Section 6.

5

Modeling Methodology

The following discussion outlines the general modeling methodology used to develop our cost estimates. Estimates were developed both on a per covered person per year basis and as a percentage of average annual premiums, as shown in Section 7. Details of key assumptions are discussed in Section 6 and illustrated graphically in the exhibits shown in the Appendix.

Modeling Perspective

Our model was developed to produce costs under a range of assumptions, but generally assumes that a sufficient supply of providers would be available to meet the demand for autism services, especially with regard to ABA services. It also assumes that there would be sufficient awareness of autism and motivation (primarily by parents) to seek treatment so that the diagnosis and treatment of ASDs would be more in line with CDC diagnosed prevalence estimates. We would expect that it would take a minimum of several years for both the supply of providers to meet the demand for ASD services and for parents of autistic children to aggressively seek treatment of their children's disorders.

In spite of these real limitations that will likely limit short-term costs associated with autism benefits covered due to HB 79 / SB 74, we feel that it is appropriate from a public policy perspective to look at the costs over a longer term and assume that both awareness of ASDs will increase and that supply and demand for ASD services would eventually be in balance. We have developed our estimates with this in mind.

Acknowledging that short-term costs are also important to policymakers, in the following discussion outlining our cost estimates, we have included illustrative exhibits showing the possible progression of costs for additional covered benefits by assuming that initial costs would be roughly one-half of the long-term estimates. We also assumed that it would take five years for costs to reach their ultimate levels, although these assumptions varied by cost scenario.

Emerging Cost Experience for Autism Coverage

While actual cost experience is limited, there have been some examples of emerging experience reported in various forums that are indicative of the costs of autism insurance laws being modest. These examples of emerging experience are not inconsistent with the cost estimates in this report.

South Carolina State Health Plan – Calendar year 2010 costs of approximately $2 million for 350,000 to 390,000 members. This represents an increase of about 0.1% to 0.2% in medical costs.[2]

The Ohio State University[3]
Percentage of Claim Cost Experienced by OSU Managed Health Care Systems Inc. (MHCS) for Autism Treatment:

2006 0.15%
2007 0.15%
2008 0.12%

Aetna Texas- Comments to press indicated increased costs equal to approximately 0.1% of premium in the year after the Texas autism law was enacted. Aetna noted in December 2008 that it had tracked the cost of the autism coverage legislation in Texas for its first year of existence and found that it increased costs for policyholders who filed autism-related claims by $379 a month. A total of 235 policyholders had filed autism claims in the state as of the time the data was released. At that time, the company had not decided whether to pass those costs on to the policyholders because the cost of the legislation might change after the first year.[4] While this is only first year experience for a single insurer, it illustrates that initial costs after the passage of autism insurance legislation are likely low. Aetna's Texas block of business is quite large (approximately $1.5 - 2.0 billion in premium[5]), so the statistics provided indicate a cost of less than 0.1% of premium.

---

[2] APS Healthcare South Carolina state employees' plan experience.

[3] Robert Meier Ohio legislature testimony submitted March 17, 2009.

[4] Associated Press. *Lawmaker: Oklahoma autism bill has momentum.* December 4, 2008. http://newsok.com/article/3327594. Accessed January 2009.

[5] NAIC Annual Statements for 2007.

General Modeling Process

The modeling process employed to develop our cost estimates was as follows:

1. A treated prevalence estimate for Alaska was developed based on the Center for Disease Control and Prevention's (CDC) Mortality and Morbidity Weekly Report (MMWR) on autism prevalence dated December 18, 2009.
2. Prevalence rates by diagnostic subtype (Autistic Disorder, PDD-NOS, and Asperger's Syndrome) were estimated separately, since diagnosis patterns and service utilization could reasonably be expected to vary by how severely affected an individual with ASD is and by diagnostic subtype.
3. The percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average ages of diagnosis implicit in the modeling are consistent with publicly available age at diagnosis statistics.[6]
4. The percentage of diagnosed children who could be expected to have an ABA program was estimated for each age based on assumptions regarding the percentage of children that would start a program and typical program continuance.
5. A distribution of the number of annual hours for ABA by age was developed based on ABA provider input and an assumption that utilization review by insurers would impact utilization to some degree.
6. Based on the assumed treatment prevalence, likelihood of having an ABA program, assumed distribution of ABA program hours, and estimated ABA program cost per hour of therapy, ABA cost estimates by age were developed.
7. Non-ABA costs were estimated based upon studies of medical costs for children diagnosed with ASD, and the potential increase in costs that could be expected due to HB 79 / SB 74 benefits.
8. Based on Census demographic data and the cost estimates associated with HB 79 / SB 74's coverage of ASD services by age as outlined in 1-7 above, an annual cost per covered person was developed.
9. The cost of services was increased to reflect administrative and other insurer costs or profit charges.
10. The estimated size of the covered market was developed based on Census, Medical Expenditure Panel Survey (MEPS) enrollment and premium information for Alaska, and Kaiser Family Foundation coverage data. These assumptions are further explained and documented in Section 6.
11. The incremental costs of the ASD services per covered person and as a percentage of premiums were calculated based on the model cost estimates and market data under a range of assumptions to develop "Low," "Middle," and "High" cost scenario estimates.

[6] IAN database. http://dashboard.ianexchange.org/StateStatsAdvanced.aspx?A1=OR&ADU=T. Accessed January 2011.

6

Summary of Key Assumptions

Key assumptions underlying the cost estimates for the proposed HB 79 / SB 74 covered benefits are summarized in this section. In order to better illustrate the sensitivity of costs to various assumptions, we developed assumptions for "Low," "Middle," and "High" cost scenarios. Appendix 1 further illustrates these assumptions for the "Middle" scenario.

Treated Prevalence and Age at Diagnosis

The December 18, 2009 CDC MMWR[7] report included the following information related to the prevalence of ASD:

1. *Children aged 8 years with a notation of an ASD or descriptions consistent with an ASD were identified through screening and abstraction of existing health and education records containing professional assessments of the child's developmental progress at health-care or education facilities. Children aged 8 years whose parent(s) or legal guardian(s) resided in the respective areas in 2006 met the case definition for an ASD if their records documented behaviors consistent with the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR) criteria for autistic disorder, pervasive developmental disorder–not otherwise specified (PDD NOS), or Asperger disorder. Presence of an identified ASD was determined through a review of data abstracted from developmental evaluation records by trained clinician reviewers.*[8]

2. *In 2006, the overall identified ASD prevalence per 1,000 children aged 8 years varied across ADDM sites ...The average across all 11 sites was 9.0 (CI = 8.6–9.3) per 1,000 children.*[9] A prevalence rate of 9 per 1,000 is approximately 1 in 110.

[7] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. December 18, 2009. http://www.cdc.gov/mmwr/PDF/ss/ss5810.pdf. Accessed February 2011.

[8] Ibid, p. 1.

[9] Ibid, p. 7.

3. *In general, estimated ASD prevalence was lower in ADDM sites that relied solely on health sources to identify cases (mean: 7.5 per 1,000 population; CI = 7.0 – 7.9) compared with sites that also had access to education sources.*[10]

4. *Among all children meeting the ADDM ASD surveillance case definition, approximately 77% had a documented ASD classification in their records.*[11]

5. *All children initially identified for screening were first stratified by two factors highly associated with final case status: information source (education only, health only, or both types of sources) and the presence or absence of either an ASD ICD-9 code (299.0 or 299.8) or an autism special education eligibility. The potential number of cases missed because of missing records, and the impact on prevalence, was estimated on the assumption that within each of the strata, the proportion of children with missing records who ultimately would be confirmed as having ASD cases would have been similar to that of children for whom no records were missing.*[12]

In estimating treated prevalence, which drives medical services utilization and costs, we used the population prevalence as a starting point, and then made adjustments based on details in the MMWR study which would indicate that treated prevalence could be expected to be lower than population prevalence. Treated prevalence rates would be expected to be lower than population prevalence rates for several reasons:

1. As noted in 4. above, approximately 77% of children meeting the ADDM ASD surveillance case definition had documented ASD classification in their records. Without a documented ASD diagnosis, it is not likely that someone would receive treatments for ASD covered by insurance. Note 77% of the 9.0/1,000 population prevalence means a documented diagnosis prevalence rate of approximately 1 in 144.

2. There is a reasonable expectation that covered medical ASD services would be supported by documentation in health records. Based on a review of health records only, the population prevalence of ASD is approximately 7.5/1,000, or 1 in 133.

3. The CDC methodology assumed that where records and information were missing, the proportion of children with missing records who ultimately would be confirmed as having ASD would have been similar to that of children for whom no records were missing. There is a reasonable likelihood that records would be less likely to be missing for children with documented ASD diagnoses who would seek treatment.

4. With ASD, as with any other disease or disorder, there will be some subset of the diagnosed population that will not seek treatment for any number of reasons.

Based on our analysis of the CDC report, including the key items from the report noted above, a reasonable assumption for the treated prevalence of ASD is 1 in 150.

[10] Ibid, p. 7.

[11] Ibid, p. 9.

[12] Ibid, p.7.

Prevalence by diagnostic subtype was estimated based on an academic study published in the American Journal of Psychiatry.[13] As noted in the previous section, the percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average age of diagnosis implicit in the modeling is consistent with publicly available age at diagnosis statistics.

The treated prevalence and age at diagnosis assumptions for Alaska are shown below:

Alaska Treated Prevalence

Diagnostic Subtype	Ultimate Prevalence	Average Age of Diagnosis
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	**1 in 150**	

The average age of diagnosis stated in the 2009 CDC MMWR report is 53 months,[14] which is higher than the average age used in our cost modeling of about 42 months. We believe that this difference is reasonable and explainable in that we are using parent reported data that is likely provided by the same parents who would most likely utilize insured benefits. Note, a lower age of diagnosis results in higher cost estimates, all other things being equal.

ABA Program Utilization and Cost

ABA Program Utilization by Age

ABA programs require a significant commitment from affected children, as well as their families. It is likely that a significant number of ASD children will not have an ABA program regardless of the availability of a provider, and many others diagnosed with ASD may have difficulty accessing a provider. We also note that the most severely affected children with the diagnostic subtype of Autistic Disorder will be more likely to have behavioral programs than those with PDD-NOS or Asperger's and will also, on the whole, have more intensive programs.

For this reason, we have assumed that 50% to 80% of children with Autistic Disorder (50% for "Low" scenario, 65% for "Middle" and 80% for "High") diagnosed under age six will begin an ABA program. Based on discussions with ABA providers and researchers, actual utilization of ABA programs has been lower in many cases due to the lack of providers, the lack of coverage, and to some extent the limited understanding of ABA programs and their efficacy. As noted later, we make an adjustment to reflect lower cost estimates for PDD-NOS and Asperger's. Implicit in that adjustment is an expectation of lower ABA utilization for these two diagnostic subtypes.

[13] Fombonne, E. and S. Chakrabarti. American Journal of Psychiatry. June 2005.

[14] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. December 18, 2009. p. 9.

In Minnesota, a state that is widely regarded as having some of the most extensive ABA coverage and services in the nation, provider data indicates ABA utilization of approximately 20% of diagnosed three to six year olds[15], which is lower than assumed in each of the scenarios in our modeling. While our range of assumptions for ABA utilization may appear conservative, and likely is conservative in the near-term, we feel that the range is reasonable since insurers will likely have some conservatism in their cost estimates and premium rates. Private insurance utilization will also likely be higher than under the public/private programs in Minnesota, and utilization could increase over time due to increased awareness of ASD, and potentially, an increased supply of ABA providers.

In addition to the likelihood of starting a program, program continuance assumptions have a very significant impact on overall ABA utilization and cost estimates. ABA programs are generally geared towards addressing deficits in younger children and are not intended to be continued indefinitely. For this reason, we have assumed that no programs would terminate prior to school age, that a large percentage of ABA programs would terminate at ages six and seven, when an autistic child could be expected to enter elementary school, and annually thereafter a large percentage of remaining programs would terminate until only a very small percentage of children have ABA programs by the time they reach their teenage years. Programs would be expected to terminate if a child has experienced sufficient progress such that a program is no longer necessary or if the insurer or family sees no progress, as well as for other reasons.

The assumed percentage of children diagnosed with Autistic Disorder that have an ABA program by age for our "Middle" scenario is shown in the table below:

	% of Diagnosed Children with Autistic Disorder with ABA
Under 6	65.0%
6	48.8%
7	32.5%
8	21.7%
9	14.4%
10	9.6%
11	6.4%
12	4.3%
13 to 21	3.3%

ABA Program Annual Number of Hours

In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and reviewed benefit materials from one of the large self-insured employer who offers ABA benefits.[16] We developed a distribution of expected hours for a child with Autistic Disorder that resulted in the annual averages shown in the following table:

[15] Discussion with Dr. Eric Larsson Executive Director, Clinical Services, The Lovaas Institute for Early Intervention. Midwest Headquarters regarding ABA utilization research in Minnesota. February 2009.
[16] Autism Therapy Reference- Microsoft Corporation (administered by Premera Blue Cross).

Average Annual ABA Program Hours for a child with Autistic Disorder	
Ages Under 8	1,500
Ages 8 to 12	671
Ages 13 to 21	401

The general assumption is that pre-school aged children will have programs for 20 to 40 hours a week, averaging about 30 hours a week. This time will be reduced by over half by age eight, when children would be expected to be in school and the school system would be required to provide services during the school day. It would then again be reduced significantly at age 13, as the child ages and ABA programs would be expected to be less time consuming and address a smaller number of behavioral deficits.

Cost per Hour of ABA Service

In developing the costs per hour, we reviewed ABA program staffing information and ABA provider wage and overhead cost assumptions. We developed an average cost for the entire United States and then adjusted this for Alaska, based on Bureau of Labor Statistics[17] health care wage data. The resulting average cost per hour of ABA therapy in Alaska is about $56 for a program based on the assumption that staffing will be in line with what best practices might recommend. This is the cost underlying our "High" assumption, though we note that costs would vary based on the mix of professionals and technicians providing the services, and likely would be lower if less experienced ABA practitioners need to be employed to meet the increasing demands for services. Costs will vary, as well, depending upon the degree of care management employed by a given payer.

Range of Annual ABA Program Costs for Scenario Estimates

Given the actual cost of an ABA program could vary significantly for many reasons, we have assumed annual average program costs by scenario for a child with Autistic Disorder being treated with an intensive ABA program as follows:

"Low" cost scenario - assumes average ABA program cost is $50,000 per year.
"Middle" cost scenario - assumes average ABA program cost is $65,500 per year.
"High" cost scenario - based on the assumptions outlined in this section for the continuance of ABA programming, 1,500 annual hours for ABA programming for children younger than age 8, and an hourly rate of slightly under $56, the calculated average annual cost for an ABA program for all ages is $83,718.

After developing cost estimates for ABA for children diagnosed with Autistic Disorder, we assumed that for children diagnosed with PDD-NOS or Asperger's, ABA costs would be one-third of the Autistic Disorder costs. The basis for this adjustment is that children with these two diagnoses can be expected to utilize ABA programs at a significantly lower rate than those with Autistic Disorder, and have less intensive programs (i.e., programs with fewer weekly and annual therapy hours). The one-third factor applied to overall costs reflects the combination of lower utilization and fewer therapy hours.

[17] BLS wage data. http://www.bls.gov/guide/geography/wages.htm. Accessed January 2011.

Other (than ABA) Medical Costs

Based on several studies[18], we estimated that children with ASDs had costs covered by insurers of approximately three times the average for non-inpatient medical services under current benefit programs. It is also clear that under HB 79 / SB 74 some services that an insurer could currently deny or exclude would now be covered. In our range of estimates, we assumed that this additional coverage would result in increased insured medical costs of 50% to 100% of the current level of estimated covered non-inpatient costs for services to all children diagnosed with an ASD, which we assumed are currently three times higher than the population costs in the absence of the benefits under HB 79 / SB 74 for children/dependents under age 21 diagnosed with an ASD.

The estimated annual cost for additional non-ABA services (note many non-ABA medical services are already provided to individuals with ASD) that would be covered as a result of HB 79 / SB 74 are shown for each scenario in the table below:

Scenario	Non-ABA Costs
Low	$2,350
Middle	$3,525
High	$4,700

(Amounts in 2011 dollars)

Administrative Costs

Typically, medical claim costs could be expected to be 80% to 90% of premiums, meaning 10% to 20% of premiums are available for administration, profit, or other costs, often collectively referred to as "retention." We have estimated the incremental retention charge to be 15% of premium.

Alaska Market Data

The MEPS survey provides average premiums, enrollees, offer rates, take-up rates, and self-insured percentages by employer size for healthcare coverage sponsored by privately insured employers. From this data we can estimate the size of the privately insured small group, insured large group, and self-insured markets. State-specific premium data for Alaska was available for 2009[19], so we trended this data based on average recent employer premium increases provided in the Kaiser Family Foundation HRET[20] survey to estimate the 2011 average annual premium per member necessary to compute the cost of HB 79 / SB 74 benefits as a percentage of annual premiums.

To estimate average premiums for the individual market, we reviewed the 2009 individual premium and membership experience found in the regulatory filings for insurers in Alaska.

---

[18] Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

[19] MEPS state survey data. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=-1&year=2009. Accessed January 2011.

[20] Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2010 Annual Survey.

We calculated the average individual premium for 2009 in Alaska, and again trended this amount to estimate 2011 premiums.

As part of our development of premiums and membership estimates, we completed reasonableness tests by reviewing Alaska insurer regulatory filings to ensure that the premium estimates were not unreasonable.

7

Cost Estimates

Long-Term Cost Estimates - "Middle" Cost Scenario

The table below summarizes our "Middle" scenario average annual cost estimates and premium increases on a per covered person basis, and as a percentage of the annual premiums. Our "Middle" estimate is that, in the long-term, the premium increase associated with the additional benefits provided by HB 79 / SB 74 would be about 0.45% of insured premiums across all markets. However, we expect that costs would be lower in the years immediately following the passage of HB 79 / SB 74 based on experiences in other states that have passed legislation providing for the coverage of additional ASD benefits, lags typically seen in accessing new benefits, and the limited supply of ABA providers.

The estimated cost increases by market are shown in the table below. The annual claim cost per covered person estimate of $17.60 and premium increase estimate of $20.70 are in 2011 dollars.

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	25,000	39,000	52,000	116,000
Average Premium per Person	$2,800	$5,500	$4,700	$4,559
Annual Claim Cost per Covered Person	$17.60	$17.60	$17.60	$17.60
Claim Cost as a Percentage of Premium	0.63%	0.32%	0.37%	0.39%
Estimated Premium Increase with Admin @ 15%	$20.70	$20.70	$20.70	$20.70
Premium Increase as a Percentage of Premium	0.74%	0.38%	0.44%	0.45%

We expect that state government programs covering state employees would have claims costs and claims cost increases comparable to insured large groups.

Scenario Estimates

As discussed in Section 3, limited insurance data exists that can be used to directly estimate the costs of ABA benefits under HB 79 / SB 74. This causes uncertainty in developing actuarial assumptions and cost estimates. Due to this uncertainty, it is useful to develop cost estimates for scenarios using optimistic and pessimistic assumptions.

Cost estimates are very sensitive to various assumptions, especially those related to ABA utilization and costs. Therefore, we varied our assumptions to develop estimated costs for ASD services under "Low," "Middle," and "High" cost scenarios, as shown in the table below:

Scenario	% Autistic Disorder Diagnosed Under Age 6 Starting ABA	Program Cost - Autistic Disorder (Ages 0-6)	Avg. Annual non-ABA Cost	Premium Increase per Covered	Premium Increase (% of Premium)
Low	50.0%	$50,000	$2,350	$12.80	0.28%
Middle	65.0%	$65,000	$3,525	$20.70	0.45%
High	80.0%	$83,718	$4,700	$30.90	0.68%

Short-Term Cost Estimates by Scenario

In addition to the uncertainty associated with long-term cost estimates, how quickly costs could reach their ultimate level is also uncertain. We have provided the table below to illustrate the potential short-term increases in premiums, and how they could grade into the long-term estimates over time.

Estimated Increase in Premiums due to HB 79 / SB 74						
Scenario	Year 1	Year 2	Year 3	Year 4	Year 5	Years 6 and Beyond
Low	0.09%	0.13%	0.17%	0.21%	0.24%	0.28%
Middle	0.23%	0.27%	0.32%	0.36%	0.41%	0.45%
High	0.45%	0.50%	0.54%	0.59%	0.63%	0.68%

Individual Market Comment

Completing an assessment of the potential for anti-selection to increase premium rates in the individual market under HB 79 / SB 74 is complicated for several reasons. Notably, the recent passage of Federal health care reform legislation has guaranteed issue provisions that would impact the coverage of individuals with ASD in the individual market. Therefore, a detailed analysis of the individual market is complicated by several matters, and is beyond the scope of this review.

8

Cost – Benefit Analysis for ASD Treatments

There have been several studies related to the efficacy of ABA treatment programs, and the costs associated with ASD treatments, care, and supports. In this section, we summarize some of these studies.

Societal Costs of Autism- Ganz Report

One of the most often cited reports explaining the financial costs of ASD is *The Lifetime Distribution of the Incremental Societal Costs of Autism* by Michael Ganz, MS, PhD which was published in 2007. This report summarized the modeled costs of a hypothetical cohort of children born in 2000 and diagnosed with autism in 2003. A study result is that the incremental societal cost of autism is $3.2 million per capita in 2003 dollars.[21] The report is very helpful in identifying specific costs of ASD, and in providing a framework for quantifying these costs, as well as providing actual cost estimates.

Direct Medical

- Physician and Dental
- Drugs
- Complementary and Alternative Therapies
- Behavioral Therapies
- Emergency and Hospital
- Home Health Care
- Travel

[21] Ganz, Michael L. *The Lifetime Distribution of the Incremental Societal Costs of Autism.* Archives of Pediatrics & Adolescent Medicine. April 2007. Volume 161.

Direct Nonmedical

- Child Care
- Adult Care
- Respite Care
- Home Improvements
- Special Education
- Supported Work
- Other

Indirect

- Own Indirect- lost productivity and lower wages
- Not Own Indirect - lost productivity and lower wages of others (typically family)

Cost Savings to State and Local Governments

The Ganz study is probably the most comprehensive in terms of assessing the breadth of the financial costs associated with caring for individuals with ASD. Several other studies have attempted more limited quantifications of costs and savings to governments associated with providing early intensive behavioral interventions (EIBI) or ABA programs for young children. In summary, the studies quantify the costs of EIBI, assume success rates associated with EIBI based on efficacy studies, and then assume cost savings to educational and other government financed programs, like Medicaid, associated with these treatments.

Virginia's independent Joint Legislative Audit and Review Commission (JLARC) issued a report in August 2009: *Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders.* As part of this report, JLARC reviewed several studies related to the efficacy of EIBI, and potential cost savings to State and Local governments associated with effective EIBI treatments. The JLARC report outlines their assessment of the cost savings associated with EIBI as follows[22]:

"A study published in a national journal found that Pennsylvania could save an average of $187,000 to $203,000 on each child who received three years of EIBI relative to one who received special education services until age 22. The Pennsylvania study also suggested that cost savings would likely continue to accrue after children exit the school system. The study found that the state could save from $656,000 to $1.1 million per child if expenditures up to age 55 are included. Another study published in a national journal found that Texas could save an average of $208,500 in education costs for each student who received three years of EIBI relative to a student who received 18 years of special education from ages four to 22. Applied to the estimated 10,000 children with ASDs in Texas, it was estimated that the state could save almost $2.1 billion by implementing intensive treatment programs.

By applying the methodology used in the Pennsylvania and Texas studies to Virginia-related data, JLARC staff estimate that the Commonwealth could save approximately $137,400 in special education costs per student with an ASD if EIBI was consistently provided. In fact, the analysis

[22] Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders, p. 15. http://jlarc.virginia.gov/reports/Rpt388.pdf. Accessed December 2009.

indicates that Virginia could realize savings as long as at least 42 percent of students with ASDs who received EIBI make moderate improvements (require less intensive services and fewer supports), which is a substantially more conservative outcome than the outcomes reported in the research literature."

The actual success rates of EIBI treatments will drive the benefits derived from these treatments. Also, as noted in the JLARC report, moderate improvements in functioning could also lead to significant financial savings. The JLARC report also discusses various studies of the efficacy of EIBI and Table 3 on page 15 of the report summarizes the findings on the efficacy of EIBI of three research studies. This table is reproduced below:

Table 3: Multiple Studies Demonstrate Children Who Receive Intensive Treatment Fare Better Than Those Who Receive Less Intensive Services

	Outcomes	
Group	**Average Change in IQ Points**	**Educational Placement**
EIBI compared to less intensive public school special education (2006 study)		
Treatment	+25	• 29% in general class without supports • 52% in general class with supports
Comparison	+14	• 5% in general class
EIBI compared to less intensive parent-training model (2000 study)		
Treatment	+16	• 27% in general class without supports
Comparison	-1	• No children in general class without supports
EIBI compared to less intensive treatment (1987 study)		
Treatment	• 47% achieved IQ in normal range (94-120)	• 47% in general class without supports • 42% in less intensive special education class for language delayed • 11% in intensive special education class for children with autism or intellectual disability (ID)
Comparison	• 2% achieved IQ in normal range	• 2% in general class without supports • 45% in less intensive special education class for language delayed • 53% in intensive special education class for children with autism or ID

Note: A more detailed table on the results of these studies can be found in Appendix C.

While a complete cost-benefit analysis is beyond the scope of this review, under the assumption that the costs of ASD services and efficacy of EIBI are in line with those indicated in the studies noted, we expect that the costs of ABA treatments covered under HB 79 / SB 74 could be recovered through reductions in educational and medical expenditures, alone.

We also expect that benefits associated with successful treatments would be realized in the areas noted in the beginning of this section through reducing other costs of care and improving the productivity of individuals with ASD and their caregivers, in addition to non-economic or quality of life benefits.

Appendix

Cost Assumptions – Illustrative Exhibits and HB 79 / SB 74 Text

EXHIBIT I - SUMMARY OF House Bill 79/Senate Bill 74 "MIDDLE" SCENARIO ASSUMPTIONS AND COSTS

State Alaska

Age Limits for Autism Benefits

Minimum	None
Maximum	20

Additional Annual Medical Costs for Non ABA Services

Up to age 21 $ 3,525 per person w/ ASD

Annual Limits by Covered Service

	Hours Limit	Max Hours	Dollar Limit	Max $s
ABA	No	-	No	No Cap

Key Assumptions:

United States Treated Prevalence

Diagnostic Subtype	Ultimate Prevalence	Average Age of Diagnosis
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	**1 in 150**	

Alaska Treated Prevalence

Diagnostic Subtype	Ultimate Prevalence	Average Age of Diagnosis
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	**1 in 150**	

% of Diagnosed Children with Autistic Disorder with ABA

Under 6	65.0%
6	48.8%
7	32.5%
8	21.7%
9	14.4%
10	9.6%
11	6.4%
12	4.3%
13 to 21	3.3%

Average Annual ABA Program Hours for a child with Autistic Disorder

Ages Under 8	1,500
Ages 8 to 12	671
Ages 13 to 21	401

Average cost of ABA Program (0-6 Year Olds): $65,000

Market	Coverage Estimates: Number of Persons Covered	Premium (Per Person)	Total Premium	Costs Excluding Administrative Expense: Costs	Costs (% of Premium)	Cost (Per Covered Person)	Premium Increase including Admin @ 15%: Incremental Premium	Premium Increase %	Annual Increase per Covered Person
Individual	25,000	$ 2,800	$ 70,000,000	$ 440,000	0.63%	$ 17.60	$ 518,000	0.74%	$ 20.70
Small Group	39,000	$ 5,500	$ 214,500,000	$ 686,400	0.32%	$ 17.60	$ 808,000	0.38%	$ 20.70
Large Group	52,000	$ 4,700	$ 244,400,000	$ 915,200	0.37%	$ 17.60	$ 1,077,000	0.44%	$ 20.70
Total	116,000	$ 4,559	$ 528,900,000	$ 2,041,600	0.39%	$ 17.60	$ 2,402,000	0.45%	$ 20.70

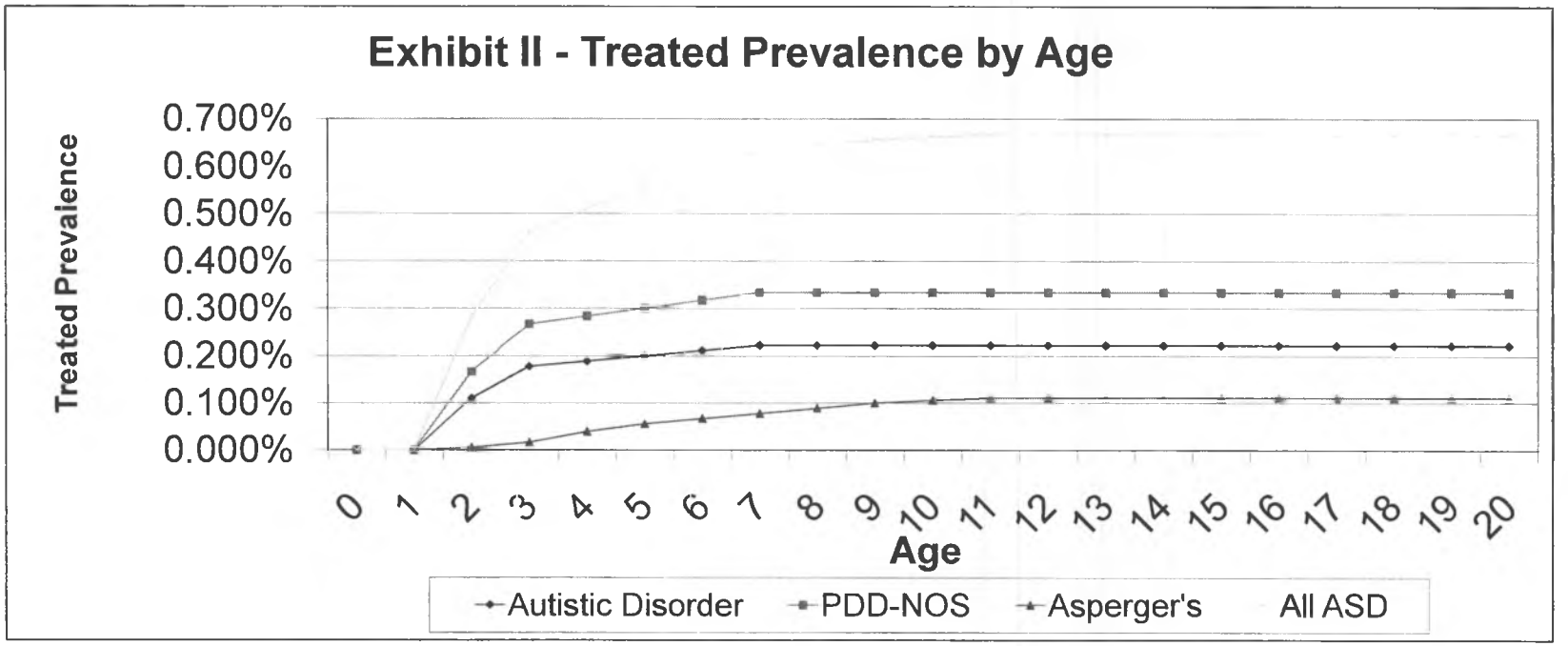


Exhibit II - Treated Prevalence by Age
Treated Prevalence
0.700%
0.600%
0.500%
0.400%
0.300%
0.200%
0.100%
0.000%
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
Autistic Disorder
PDD-NOS
Asperger's
All ASD

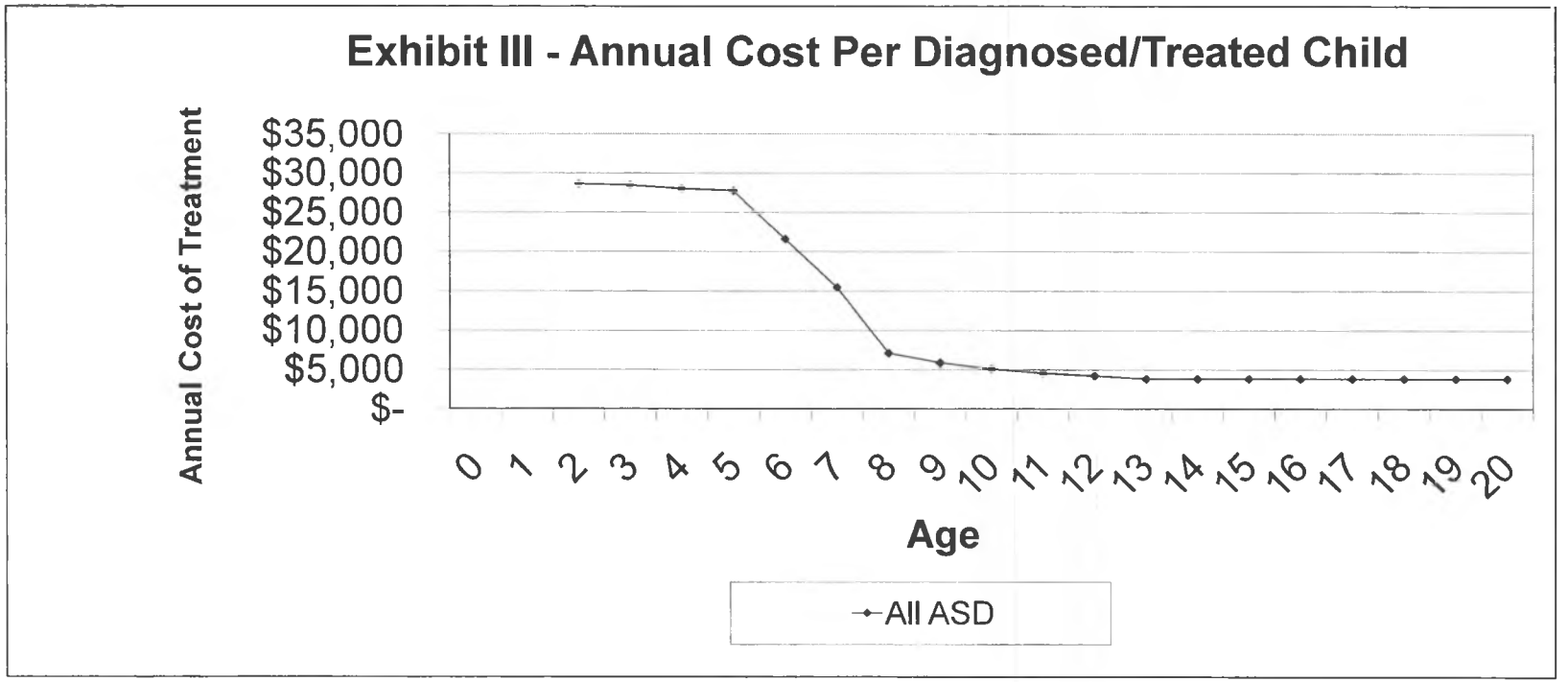


Exhibit III - Annual Cost Per Diagnosed/Treated Child
Annual Cost of Treatment
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$-
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
All ASD

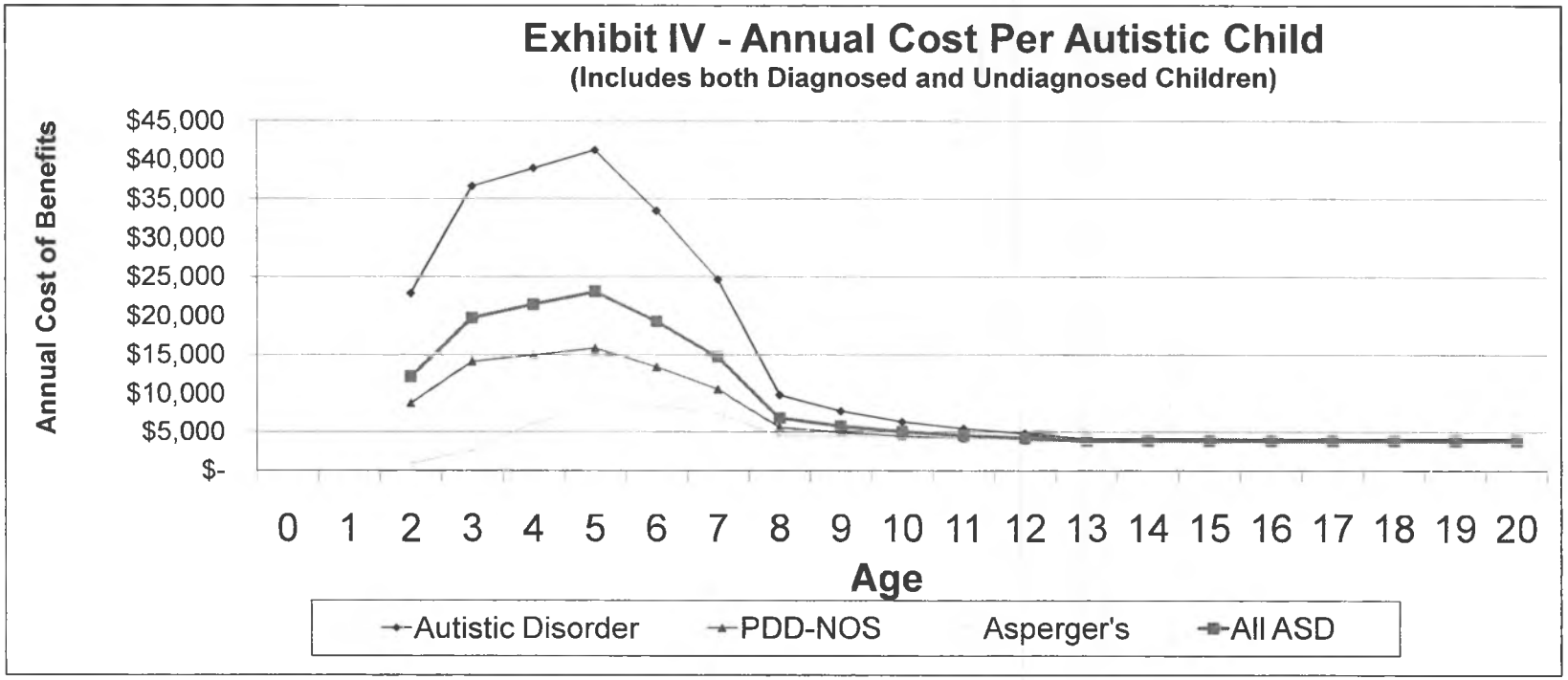


Exhibit IV - Annual Cost Per Autistic Child
(Includes both Diagnosed and Undiagnosed Children)
Annual Cost of Benefits
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$-
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
Autistic Disorder
PDD-NOS
Asperger's
All ASD

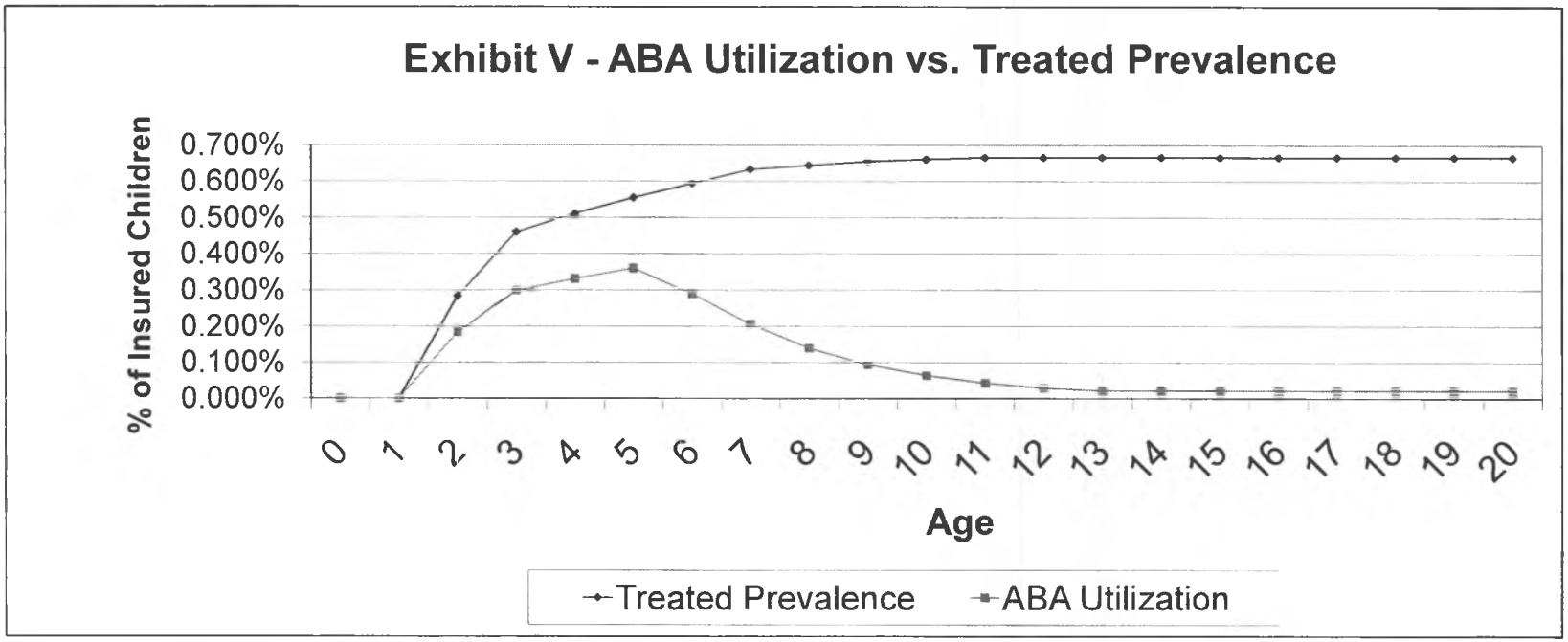


Exhibit V - ABA Utilization vs. Treated Prevalence
% of Insured Children
0.700%
0.600%
0.500%
0.400%
0.300%
0.200%
0.100%
0.000%
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
Treated Prevalence
ABA Utilization

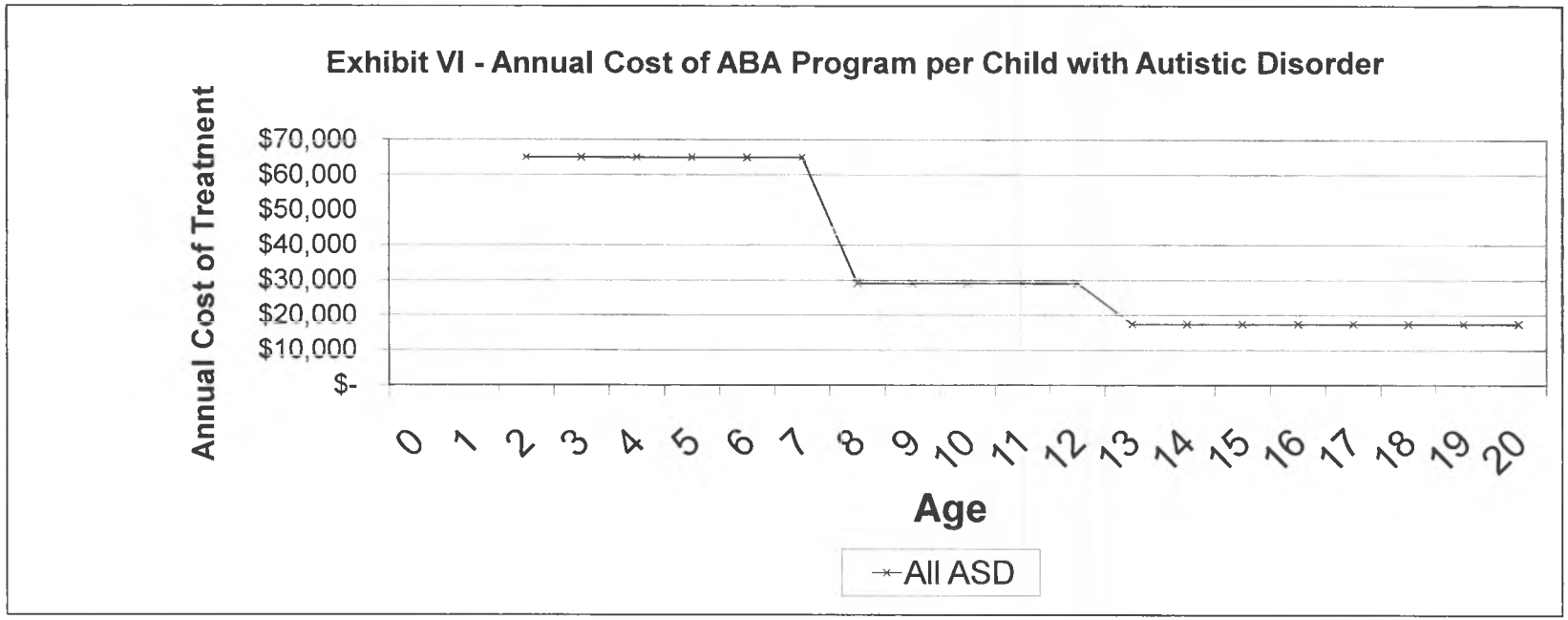


Exhibit VI - Annual Cost of ABA Program per Child with Autistic Disorder
Annual Cost of Treatment
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$-
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Age
All ASD

HOUSE BILL NO. 79

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES PETERSEN AND KAWASAKI, Gruenberg, Gara, Kerttula, Holmes

Introduced: 1/18/11
Referred: Health and Social Services, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act requiring insurance coverage for autism spectrum disorders, describing the method for establishing a covered treatment plan for those disorders, and defining the covered treatment for those disorders; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.397. Coverage for autism spectrum disorders. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in this state shall provide coverage for the costs of the diagnosis and treatment of autism spectrum disorders. Coverage required by this subsection must include treatment prescribed by a licensed physician or psychologist, provided by or supervised by an autism service provider, and as identified in a treatment plan developed following a comprehensive evaluation. Covered treatment may include medically necessary pharmacy care, psychiatric care, psychological care, habilitative or rehabilitative care, and therapeutic care. In this subsection,

(1) "habilitative or rehabilitative care" means professional counseling, guidance services, and treatment programs, including applied behavior analysis or other structured behavioral therapies necessary to develop, restore, and maintain the functioning of an individual to the maximum extent practicable; in this paragraph, "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function;

(2) "therapeutic care" means services provided by or under the supervision of a speech-language pathologist licensed under AS 08.11 or an occupational therapist or physical therapist licensed under AS 08.84.

(b) Coverage under this section

(1) is required to be provided only to individuals under 21 years of age;

(2) may not limit the number of visits to an autism service provider for treatment;

(3) is subject to copayment, deductible, and coinsurance provisions, and other general exclusions or limitations included in a health insurance policy to the same extent as other health care services covered by the policy; and

(4) must cover medically necessary treatment that is coordinated with an education program, but may not be contingent on the coordination of treatment with an education program.

(c) This section does not limit benefits that are otherwise available to an individual under a health care insurance plan.

(d) A health care insurer may not refuse to deliver, execute, issue, amend, or renew coverage to an individual or terminate coverage because the individual is diagnosed with or received treatment for autism spectrum disorders.

(e) In this section,

(1) "autism service provider" means an individual who is licensed, certified, or registered by the applicable state licensing board or by a nationally

recognized certifying organization and who provides direct services to an individual with an autism spectrum disorder;

(2) "autism spectrum disorders" means pervasive developmental disorders, or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-IV-TR, as amended or reissued from time to time;

(3) "health care insurance plan" has the meaning given in AS 21.54.500;

(4) "health care insurer" has the meaning given in AS 21.54.500;

(5) "medically necessary" means any care, treatment, intervention, service, or item prescribed by a licensed physician or psychologist in accordance with accepted standards of practice that will, or is reasonably expected to,

(A) prevent the onset of an illness, condition, injury, or disability;

(B) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;

(C) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacity of other persons of the individual's age.

*** Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 21.42.397, enacted by sec. 1 of this Act, applies to a health insurance policy that is offered, issued for delivery, delivered, or renewed on or after January 1, 2012.

*** Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

From: **AUTISM SPEAKS**

Rebecca Shaffer Stelzner -- 202.955.3114; rshaffer@autismspeaks.org

Rubenstein Communications, Inc.
Adam Pockriss – 212.843.8286; apockriss@rubenstein.com

FOR IMMEDIATE RELEASE

AUTISM SPEAKS ENDORSES ALASKA AUTISM INSURANCE REFORM BILL

House Bill 79 Would End Health Care Discrimination Against Children with Autism by Requiring Coverage of Diagnosis and Treatment

NEW YORK, NY (January 27, 2011) – Autism Speaks, the nation's largest autism advocacy organization, today announced its support for House Bill 79, the autism insurance reform bill. The legislation would require private health insurance companies to cover the diagnosis, testing, and treatment of autism spectrum disorder (ASD).

Sponsored in the Alaska State House by State Representative Pete Petersen, HB 79 includes coverage of behavioral health treatments, such as Applied Behavior Analysis (ABA), an evidence-based, medically-necessary autism therapy, for individuals with autism under the age of 21. HB 79 has been referred to the House Health & Social Services Committee, which may hear the bill next month.

"We applaud and thank Representative Petersen for his leadership again this year on this issue of critical concern to thousands of Alaska's families," said Peter Bell, Autism Speaks executive vice president for programs and services. "Autism Speaks joins Alaska's autism community in calling on the legislature to pass HB 79 and join the growing number of states that have ended healthcare discrimination against children with autism."

Many states do not require private insurance companies to cover even essential autism treatments and services. In the absence of coverage, families often pay as much as they can out-of-pocket for services that can cost upwards of $50,000 per year. In the process, many risk their homes and the educations of their unaffected children – essentially mortgaging their entire futures.

To date, twenty-three states – Arizona, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Pennsylvania, South Carolina, Texas, Vermont, and Wisconsin – have enacted autism insurance reform legislation. Several other state legislatures will introduce similar legislation during the current 2011 session.

To learn more about Autism Votes, an initiative of Autism Speaks focused on federal and state legislative advocacy, please visit **www.autismvotes.org**.

About Autism
Autism is a complex neurobiological disorder that inhibits a person's ability to communicate and develop social relationships, and is often accompanied by behavioral challenges. Autism spectrum disorders are diagnosed in one in 110 children in the United States, affecting four times as many boys as girls. The prevalence of autism increased 57 percent from 2002 to 2006. The Centers for Disease Control and Prevention have called autism a national public health crisis whose cause and cure remain unknown.

About Autism Speaks
Autism Speaks is North America's largest autism science and advocacy organization. Since its inception only five short years ago, Autism Speaks has made enormous strides, committing over $142.5 million to research and developing innovative new resources for families through 2014. The organization is dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families. In addition to funding research, Autism Speaks also supports the Autism Treatment Network, Autism Genetic Resource Exchange and several other scientific and clinical programs. Notable awareness initiatives include the establishment of the annual United Nations-sanctioned World Autism Awareness Day on April 2 and an award-winning "Learn the Signs" campaign with the Ad Council which has received over $210 million in donated media. Autism Speaks' family resources include the Autism Video Glossary, a 100 Day Kit for newly-diagnosed families, a School Community Tool Kit, a community grant program and much more. Autism Speaks has played a critical role in securing federal legislation to advance the government's response to autism, and has successfully advocated for insurance reform to cover behavioral treatments. Each year *Walk Now for Autism Speaks* events are held in more than 80 cities across North America. To learn more about Autism Speaks, please visit www.autismspeaks.org.

About the Co-Founders
Autism Speaks was founded in February 2005 by Suzanne and Bob Wright, the grandparents of a child with autism. Bob Wright is Senior Advisor at Lee Equity Partners and served as vice chairman, General Electric, and chief executive officer of NBC and NBC Universal for more than twenty years. He also serves on the boards of the Polo Ralph Lauren Corporation, RAND Corporation and the New York Presbyterian Hospital. Suzanne Wright has an extensive history of active involvement in community and philanthropic endeavors, mostly directed toward helping children. She serves on the boards of several non-profit organizations and is also Trustee Emeritus of Sarah Lawrence College, her alma mater. Suzanne has received numerous awards such as

the CHILD Magazine Children's Champions Award, Luella Bennack Volunteer Award, Spirit of Achievement award by the Albert Einstein College of Medicine's National Women's Division and the Weizmann Institute of Science. In 2008, the Wrights were named to the *Time* 100 list of the most influential people in the world for their commitment to global autism advocacy.

###

Sean Parnell, Governor
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

P.O. Box 240249 • Anchorage, Alaska 99524-0249 • Phone: 907-269-8990 • Fax: 907-269-8995 • Toll Free 888-269-8990

March 24, 2011

Senator Johnny Ellis
State of Alaska
Alaska State Legislature
State Capitol, Room 119
Juneau, AK 99801

Re: SB 74 Insurance Coverage for Autism Spectrum Disorders

Dear Senator Ellis:

Thank you for sponsoring SB 74, which provides private insurance coverage for Autism Spectrum Disorders. The Governor's Council on Disabilities and Special Education strongly supports SB 74, which will provide coverage for the diagnosis and treatment of autism spectrum disorders, including but not limited to applied behavioral analysis, the leading evidence-based intervention for autism.

As you know, many families struggle when their child is diagnosed as being on the spectrum, because many insurance policies specifically exclude treatments for Autism Spectrum Disorders (even if those treatments are routinely covered otherwise). This bill would put services for people with autism on the same footing as other health issues when it comes to insurance coverage of treatment and prevention services. Otherwise, families often go into debt in order to secure needed services, or go without them.

In addition, 40 years of research clearly shows that 50 percent of children with severe autism who receive early intervention and treatment do not require lifelong services and supports. According to a study conducted by Michael Ganz, a Harvard University Economist, with treatment, the state will see savings of $208,500 per person in avoided or reduced special education costs and lifetime savings of $1.8 million. Without treatment it is estimated lifetime costs to the State of Alaska will exceed $3.2 million per person.

Thank you again for your support on this important issue.

Respectfully,

Donna Swihart

Donna Swihart, Chair

Key Campaign XXIV Priority IV:

Autism Insurance Reform

BACKGROUND:

Autism is a disorder affecting at least 1 in 110 children with approximately 1 in 500 requiring significant clinical treatment. Alaska currently has around 1,512 children and youth under the age of 21 who have autism; approximately 454 need significant clinical treatment.

It is recommended that private, state employee and university employee insurance policies provide coverage for the diagnosis and treatment of autism spectrum disorders, including, but not limited to applied behavior analysis, the leading evidence-based intervention for autism.

URGENCY:

- Most insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan.
- Because Alaska law does not require insurance coverage for autism services, families that do not qualify for DHSS services pay out-of-pocket, often as j\much as $50,000 per year or more; in some instances, bearing this burden results in divorce or bankruptcy.
- Autism is treatable. Ro years of research shows that with treatment, many children overcome the severe symptoms of their disorder.
- The earlier the diagnosis, the more effective the treatment.
- Treatment equals savings. Without treatment it is estimated that it will cost the state $3.2 million per capita.
- Coverage of medically necessary autism treatment in Alaska will enable many children to access the services they need and live more productive lives.
- The costs of this insurance reform are small and will have very little impact on the cost of health insurance premiums for the individual consumer.

ACTION REQUESTED

The Key Coalition of Alaska asks the Alaska State Legislature to:

Pass HB79 and SB94 requiring insurance coverage for autism spectrum disorders.

From: David Flynn <dflynn@tdxpower.com>
Date: March 25, 2011 4:03:20 PM AKDT
To: "Sen. Bettye Davis" <Senator_Bettye_Davis@legis.state.ak.us>
Cc: "Sen. Dennis Egan" <Senator_Dennis_Egan@legis.state.ak.us>, "Sen. Johnny Ellis" <Senator_Johnny_Ellis@legis.state.ak.us>, "Sen. Kevin Meyer" <Senator_Kevin_Meyer@legis.state.ak.us>, "Sen. Fred Dyson" <Senator_Fred_Dyson@legis.state.ak.us>
Subject: SB 74: Autism Insurance Coverage

My family and I live in Delta Junction , AK.

Our 3.5yr old son has autism and it is a struggle for him...and our family...to cope with the challenges of this condition.

I can be contacted as an advocate for these children and families and believe that anything that we can do to assist these special people and their families is worth doing. This bill's passing would be one way to help.

Please do what you can to see that this Bill passes.

Much appreciation in advance for your efforts in this regard...

David J. Flynn, P.Eng
TDX Project Engineer
907-865-4806 TDX
907-590-7775 cell

On Mar 27, 2011, at 5:26 PM, "Joanne Healy" <jhealy7@alaska.edu> wrote:

By supporting this now you will be saving the states millions over the long run. Early Intervention WORKS!!!!

The Council supports this bill with the intent to better support and treat Alaskans experiencing autism. The Centers for Disease Control estimates that one in every 110 children, with one in every 70 boys, are diagnosed annually. These children require extensive services from medical professionals and other providers. Most insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan.

--

Joanne Healy
Assistant Professor Special Education
714A Gruening Building
University of Alaska Fairbanks
P.O. Box 756480
Fairbanks, AK 99775-6480
(907) 474-1557 (907) 474-5451 fax
jhealy7@alaska.edu * www.uaf.edu

On Mar 27, 2011, at 1:12 PM, "Paul & Robin Barrett" <robinbarrett@gci.net> wrote:

Please support this bill. Money spent for early autism treatment will be a mere drop in the bucket when compared to the later cost of lifetime institutionalism. Our son is age 10 and severely autistic. Our insurance does not pay for the therapy he desperately needs. We have been selling our retirement assets to pay for his treatment. In the past 5 years we are out-of-pocket more than $136,000.00. Most families cannot afford such expenses (nor can we, over time) so their children are untreated and likely doomed to a lifetime of dependence on society. Again, please support this bill.

Paul and Robin Barrett

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

Autism Insurance Reform

(The Council supports HB 79, Requiring Insurance Coverage for Autism Spectrum Disorders)

- **The earlier the diagnosis, the more effective treatment is.** The diagnostic process involves a comprehensive assessment (neuro-developmental pediatrics, psychology, speech, occupational and physical therapy, ophthalmology, audiology) by a multidisciplinary team. Only those children who meet specific medical criteria are diagnosed with autism.

- **Treatment equals savings.** With treatment, Alaska will see savings of $208,500 per capita in avoided special education costs and lifetime savings of $1.08 million per capita. Treatment may include the following medically necessary services.
  - ✓ Pharmacy, psychiatric, psychological, rehabilitative and therapeutic care.
  - ✓ Habilitative care includes applied behavior analysis (the design, implementation and evaluation of environmental modifications to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

- **Without treatment it is estimated that it will cost the state $3.2 million per capita.** (Michael Ganz, Harvard economist)

- **Coverage of medically necessary autism treatment in Alaska will enable many children to access the services they need and live more productive lives.**

- **The costs of this insurance reform are small and will have very little impact on the cost of health insurance premiums for the individual consumer.**
  - ✓ **According to a February 9, 2010 actuarial study conducted by Oliver Wyman Actuarial Consulting, Inc.** the "Middle" estimate is that, in the long-term, the premium increase associated with the mandated benefits for private insurance plans would be about 0.39% of insured premiums across all markets or $1.34 per policyholder per month. **Note:** the original estimate was 0.02% or $3.60 per policyholder per month; it was revised based on the actual experiences of states that have enacted autism insurance reform.
  - ✓ **The Council estimates** government programs such as the State of Alaska and/or the university system would have cost increases comparable to large insured groups. This would translate into an increased cost to the State of Alaska of $1.34 per state employee per month. **Note:** the Division of Insurance's actuarial consultants, Buck Consultants, estimated a rate of 1-3% or $3.20 per member per month based on the nationwide trends of children being diagnosed with autism over the past 10 years. However, the actual experiences of government insurance programs that implemented autism insurance reform were closer to the $1.34 per member per month figure cited above.
  - ✓ South Carolina's State Employee Health Plan experience has been far less than $1.34. In year one it was 20 cents per member per month and in year two it was 44 cents per member per month.

PO Box 240249, Anchorage, AK 99524-0249
Phone (907) 269-8990 · Toll Free (888) 269-8990 · Fax (907) 269-8995

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

Autism Insurance Reform

(The Council supports HB 79, Requiring Insurance Coverage for Autism Spectrum Disorders)

WHAT:

- **Autism is a disorder affecting at least 1 in 110 children with approximately 1 in 500 requiring significant clinical treatment.** Alaska currently has around 1,512 children and youth under the age of 21 who have autism; approximately 454 need significant clinical treatment.

RECOMMENDED INSURANCE REFORM

- **The Governor's Council on Disabilities and Special Education recommends that private, state employee and university employee insurance policies provide coverage for the diagnosis and treatment of autism spectrum disorders, including but not limited to applied behavior analysis, the leading evidence-based intervention for autism.**
  - ✓ Must be prescribed by a licensed physician, psychologist or advanced nurse practitioner.
  - ✓ Must be provided by an autism service provider as identified in a treatment plan developed following a comprehensive evaluation.
  - ✓ Must identify the medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care and therapeutic care.

WHY:

- **Most insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan.**

- **Because Alaska law does not require insurance coverage for autism services, families that do not qualify for DHSS services pay out of pocket, often as much as $50,000 per year or more; in some instances, bearing this burden results in divorce or bankruptcy.** Families that cannot afford to do so, go without crucial intervention.

- **Autism is treatable.** 40 years of research shows that with treatment, many children overcome the severe symptoms of their disorder.
  - ✓ About half the children who receive intensive early intervention achieve normal functioning after 2-3 years of treatment
  - ✓ There is an average gain of 22 IQ points
  - ✓ 1/3 gained 45 IQ points
  - ✓ Nearly 50% of those receiving intensive early intervention do not require lifelong services and supports

(Continued on back side)

PO Box 240249, Anchorage, AK 99524-0249
Phone (907) 269-8990 · Toll Free (888) 269-8990 · Fax (907) 269-8995

APPLIED BEHAVIOR ANALYSIS (ABA)-BASED INTERVENTIONS FOR YOUNG CHILDREN WITH AUTISM SPECTRUM DISORDERS

As research and services are evolving relative to understanding and meeting the needs of young children with autism, several practices have emerged as being key to success. First, rarely do methods other than those that are evidence-based work with these children (i.e., shown effective with this population of children and then replicated through additional rigorous research). Second, when one examines the body of strategies that have been scientifically validated, one sees that the vast majority of these interventions have one common characteristic – each has been designed on, and to later adhere to, core principles of Applied Behavior Analysis, or ABA. A large number of ABA-based strategies have been developed, tested and employed, with some designed to have a generalized impact on the child's functioning, while other methods intended to address specific language, social or behavioral needs of these children. Lastly, evidenced-based methods have generally been shown to be far more effective the sooner and more intensively they are employed.

ABA is a scientifically-driven and validated approach to learning and/or change of behavior. The core ABA principles are based on Operant Learning Theory, which states that new behaviors will happen more frequently if they are regularly reinforced, while previously demonstrated behaviors or skills will diminish if they are not. Applied Behavior Analysis is often employed within a highly structured context and in a systematic manner, relying heavily on the regular observation of overt behaviors as a first step to individualization of intervention. Key to the child's success is s/he developing the ability to discriminate (recognize) when and how to respond (behave). For a young child with ASD, this typically first means responding consistently and quickly to simple cues and directions provided by an adult. This requires teaching the child, on a 1:1 basis, to attend or jointly attend with the adult, to specific objects or actions. The interventionist chooses and delivers cues, directions or actions precisely, and consistently uses positive reinforcement to strengthen and shape the child's correct responses. Doing so increases the child's ability to participate in typical social, home, and school settings as a function of his/her regular demonstration of those skills or behaviors that are contextually applicable or appropriate there. Progress is monitored through data collected on each target skill or behavior, with performance graphed over time.

While a Behavior Analyst who uses ABA tends not to speculate on the non-overt, internalized changes taking place with children with autism, the fact is that successful intervention often results in increased fluency and duration of responding to both verbal and visual cues (i.e., natural characteristics of an object, item or setting such as the shape of a letter, color of a ball, or correspondence of a top button to a top button hole). Doing so increases the probability of independent performance by the child in the future (maintenance of acquired skills), and tends to promote his/her use of these acquired skills in new and different settings (generalization).

There are a large number of tested interventions based on the principles of Applied Behavioral Analysis. While many have been validated for use with children with challenging behaviors and/or autism, others have been developed for behavior change by different populations, such as for parenting, weight loss, cessation of smoking, and the such. An effective Behavior Analyst systematically selects from different ABA assessment, data analysis, and planning methods as tools in the delivery of services, so as to ensure that the match between the interventions, schedule of service activities, the delivery of services and the child's home, school and community environments are optimal for learning. While many practitioners employ ABA methods, quality is controlled through a national process of certification, through the Behavior Analyst Certification Board, Inc, (BACB), an organization with roots within the Association for Behavior Analysis, International. The graduate level certification standards and credentialing from BACB is endorsed by the Association of Professional Behavior Analysts, the Association for Behavior Analysis International and Division 25 (Behavior Analysis) of the American Psychological Association.

Provided By: Millie Ryan 5 April 2009
The Governor's Council on Disabilities and Special Education

Diagnosis of Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) covers a wide range of symptoms from very mild to severe. ASD affects social skills, communication and cognitive development. ASD affects the individual's ability to convey or interpret others' emotions. Children may engage in restricted and/or repetitive play and have unusual attachments to objects. People with ASD might not seem interested in other people and prefer to be alone. People with ASD might not seem interested in other people and prefer to be alone. Some children with ASD do not like to be held or cuddled, and many do not make eye contact with others. Individuals with ASD also show varied degrees in impairment in their verbal and nonverbal communication. Some individuals with ASD may be nonverbal, while others may not have any difficulty speaking. Some repeat something previously heard or use stock phrases or learned scripts to communicate. Cognitively, individuals with ASD develop differently from others. Many people with ASD have difficulty processing sensory stimuli and verbal input, and this affects their understanding of the world around them.

It is important to note that some people without an ASD might also have some of these symptoms. But for people with an ASD, the impairment is bad enough to make life very challenging in terms of interacting with others, communicating, learning or holding down a job.

The Governor's Council on Disabilities recommended that the state establish universal screening for ASD during well-child exams to identify children who have behaviors that could indicate a disorder. The American Academy of Neurology recommends immediate referral for a diagnostic evaluation for any of the following:

- No babbling by 12 months
- No gesturing by 12 months
- No single words by 16 months
- No 2 work spontaneous phrases by 24 months
- Any loss of any language or social skills at any age

ASD screenings identify those children who require a comprehensive assessment across developmental and physical domains. Professionals from multiple disciplines then conduct a complete assessment (i.e. neurodevelopmental pediatrics, psychology, speech, occupational and physical therapy, ophthalmology, audiology). For young children, it is especially critical to conduct a differential diagnosis to rule out any other possible genetic or medical disorders.

The diagnosis focuses on determining to what extent the child has:

- Irregularities and impairments in communication
- Engagement in repetitive activities and stereotyped movements

- Resistance to environmental change or change in daily routines
- Unusual responses to sensory experiences

In order to receive a diagnosis of ASD, the child must show qualitative impairment in reciprocal social interaction, qualitative impairment in communication and repetitive, stereotypical behaviors that interfere with his or her ability to develop, communicate and learn compared to typically developing peers.

In order to qualify for special education with an ASD, a child must

- exhibit a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age three, that adversely affects educational performance; and
- require special facilities, equipment, or methods to make the child's educational programs effective; and
- be diagnosed as having an autism spectrum disorder by a psychiatrist, physician, licensed psychologist or advanced nurse practitioner; and
- be certified by a group consisting of qualified professional and a parent of the child as qualifying for and needing special education services

CENTERS FOR DISEASE CONTROL AND PREVENTION

AUTISM SPECTRUM DISORDERS

Treatment

There is no single best treatment for all children with ASDs. However, well-planned, structured teaching of specific skills is very important. Some children respond well to one type of treatment while others have a negative response or no response at all to the same treatment. Before deciding on a treatment program, it is important to talk with the child's health care providers to understand all the risks and benefits.

It is also important to remember that children with ASDs can get sick or injured just like children without ASDs. Regular medical and dental exams should be part of a child's treatment plan. Often it is hard to tell if a child's behavior is related to the ASD or is caused by a separate health condition. For instance, head banging could be a symptom of the ASD, or it could be a sign that the child is having headaches. In those cases, a thorough physical exam is needed. Monitoring healthy development means not only paying attention to symptoms related to ASDs, but also to the child's physical and mental health, as well.

Early Intervention Services

Research shows that early intervention treatment services can greatly improve a child's development.[1],[2] Early intervention services help children from birth to 3 years old (36 months) learn important skills. Services include therapy to help the child talk, walk, and interact with

others. Therefore, it is important to talk to your child's doctor as soon as possible if you think your child has an ASD or other developmental problem.

Even if your child has not been diagnosed with an ASD, he or she may be eligible for early intervention treatment services. The Individuals with Disabilities Education Act (IDEA) says that children under the age of 3 years (36 months) who are at risk of having developmental delays may be eligible for services. These services are provided through an early intervention system in your state. Through this system, you can ask for an evaluation.

In addition, treatment for particular symptoms, such as speech therapy for language delays, often does not need to wait for a formal ASD diagnosis. While early intervention is extremely important, intervention at any age can be helpful.

Types of Treatments

The National Institute of Mental Health and the Autism Society of America suggest a list of questions parents can ask when planning treatments for their child.

There are many different types of treatments available. For example, auditory training, discrete trial training, vitamin therapy, anti-yeast therapy, facilitated communication, music therapy, occupational therapy, physical therapy, and sensory integration.

The different types of treatments can generally be broken down into the following categories:

- Behavior and Communication Approaches
- Dietary Approaches
- Medication
- Complementary and Alternative Medicine

Behavior and Communication Approaches

According to reports by the American Academy of Pediatrics and the National Research Council, behavior and communication approaches that help children with ASDs are those that provide structure, direction, and organization for the child in addition to family participation.

Applied Behavior Analysis (ABA)

A notable treatment approach for people with an ASD is called applied behavior analysis (ABA). ABA has become widely accepted among health care professionals and used in many schools and treatment clinics. ABA encourages positive behaviors and discourages negative behaviors in order to improve a variety of skills. The child's progress is tracked and measured.

There are different types of ABA. Following are some examples:

- **Discrete Trial Training (DTT)**
  DTT is a style of teaching that uses a series of trials to teach each step of a desired behavior or response. Lessons are broken down into their simplest parts and positive reinforcement is used to reward correct answers and behaviors. Incorrect answers are ignored.

- **Early Intensive Behavioral Intervention (EIBI)**
  This is a type of ABA for very young children with an ASD, usually younger than five, and often younger than three.

- **Pivotal Response Training (PRT)**
  PRT aims to increase a child's motivation to learn, monitor his own behavior, and initiate communication with others. Positive changes in these behaviors should have widespread effects on other behaviors.

- **Verbal Behavior Intervention (VBI)**
  VBI is a type of ABA that focuses on teaching verbal skills.

Other therapies that can be part of a complete treatment program for a child with an ASD include:

Developmental, Individual Differences, Relationship-Based Approach (DIR; also called "Floortime")
Floortime focuses on emotional and relational development (feelings, relationships with caregivers). It also focuses on how the child deals with sights, sounds, and smells.

Treatment and Education of Autistic and related Communication-handicapped CHildren (TEACCH)

TEAACH uses visual cues to teach skills. For example, picture cards can help teach a child how to get dressed by breaking information down into small steps.

Occupational Therapy
Occupational therapy teaches skills that help the person live as independently as possible. Skills might include dressing, eating, bathing, and relating to people.

Sensory Integration Therapy
Sensory integration therapy helps the person deal with sensory information, like sights, sounds, and smells. Sensory integration therapy could help a child who is bothered by certain sounds or does not like to be touched.

Speech Therapy
Speech therapy helps to improve the person's communication skills. Some people are able to learn verbal communication skills. For others, using gestures or picture boards is more realistic.

The Picture Exchange Communication System (PECS)
PECS uses picture symbols to teach communication skills. The person is taught to use picture symbols to ask and answer questions and have a conversation.

Visit the Autism Speaks or Easter Seals website to read more about these therapies.

Dietary Approaches

Some dietary treatments have been developed by reliable therapists. But many of these treatments do not have the scientific support needed for widespread recommendation. An unproven treatment might help one child, but may not help another.

Many biomedical interventions call for changes in diet. Such changes include removing certain types of foods from a child's diet and using vitamin or mineral supplements. Dietary treatments are based on the idea that food allergies or lack of vitamins and minerals cause symptoms of ASDs. Some parents feel that dietary changes make a difference in how their child acts or feels.

If you are thinking about changing your child's diet, talk to the doctor first. Or talk with a nutritionist to be sure your child is getting important vitamins and minerals.

Medication

There are no medications that can cure ASDs or even treat the main symptoms. But there are medications that can help some people with related symptoms. For example, medication might help manage high energy levels, inability to focus, depression, or seizures. Also, the U.S. Food and Drug Administration approved the use of risperidone (an antipsychotic drug) to treat 5- to 16-year-old children with ASDs who have severe tantrums, aggression, and cause self-injury.

To learn more about medications and ASDs go to National Institute of Mental Health autism website.

Complementary and Alternative Treatments

To relieve the symptoms of ASDs, some parents and health care professionals use treatments that are outside of what is typically recommended by the pediatrician. These types of treatments are known as complementary and alternative treatments (CAM). They might include special diets, chelation (a treatment to remove heavy metals like lead from the body), biologicals (e.g., secretin), or body-based systems (like deep pressure).[3]

These types of treatments are very controversial. Current research shows that as many as one third of parents of children with an ASD may have tried complementary or alternative medicine treatments, and up to 10% may be using a potentially dangerous treatment.[4] Before starting such a treatment, check it out carefully, and talk to your child's doctor.

Additional Treatment Resources

The National Institute on Deafness and Other Communication Disorders has a website to help individuals with an ASD who have communication challenges.

The National Institute of Dental and Craniofacial Research has a website to help health professionals with the oral health care needs of patients with an ASD.

Clinical Trials.Gov lists federally funded clinical trials that are looking for participants. If you or someone you know would like to take part in an autism study, go to the website and search "autism."

The Autism Treatment Network (ATN) seeks to create standards of medical treatment that will be made broadly available to physicians, researchers, parents, policy makers, and others who want to improve the care of individuals with autism. ATN is also developing a shared national medical database to record the results of treatments and studies at any of their five established regional treatment centers.

References

1. Handleman, J.S., Harris, S., eds. Preschool Education Programs for Children with Autism (2nd ed). Austin, TX: Pro-Ed. 2000.
2. National Research Council. Educating Children with Autism. Washington, DC: National Academy Press, 2001.
3. Gupta, Vidya Bhushan. Complementary and Alternative Medicine. New York Medical College and Columbia University, 2004. Pediatric Habilitation, volume 12.
4. Levy, S. Complementary and Alternative Medicine Among Children Recently Diagnosed with Autistic Spectrum Disorder; Journal of Developmental and Behavioral Pediatrics, December 2003; vol 24: pp 418-423. News release, Health Behavior News Service.

Learn the Signs. Act Early.

State of Alaska > Health & Social Services > Autism Awareness

Overview of Autism Spectrum Disorders

- Autism spectrum disorders are a group of developmental disabilities that can cause social, communication and behavioral challenges for affected children and adults. Autism's effects vary person to person, so these challenges can be mild or significant.
- About 1 percent of all babies born in Alaska each year will develop an autism spectrum disorder, according to CDC nationwide estimates. In other words, about 11,000 Alaskans will be born this year, and 110 of them will be diagnosed with an autism disorder by the age of eight.
- In 2008, more than 600 children were receiving services related to an autism diagnosis in Alaska schools.
- Current research indicates that autism spectrum disorders are present at birth and last throughout a person's life, although symptoms can improve over time. Some children with autism disorders show hints of future problems within the first few months of life. In others, symptoms might not develop until 24 months or later. In still others, the children may develop normally until 18 months or 24 months, and then they stop gaining new skills or they lose the skills they once had.

A person with an autism spectrum disorder may exhibit some or all of the following:

- Not respond to his or her name by 12 months old
- Not point at objects to show interest by 14 months old (such as pointing at an airplane flying overhead)
- Not play "pretend" games by 18 months old (such as pretend to feed a doll)
- Avoid eye contact and want to be alone
- Have trouble understanding other people's feelings or talking about his or her own feelings
- Have delayed speech and/or language skills
- Repeat words or phrases over and over (often called "echolalia")
- Give unrelated answers to questions
- Get upset by minor changes
- Have obsessive interests
- Flap hands, rock his or her body or spin in circles
- Have unusual reactions to the way things sound, smell, taste, look or feel

Types of Autism Spectrum Disorders

There are three types of autism spectrum disorders:

Autistic Disorder

This is sometimes called "classic" autism. It is what most people think of when hearing the word "autism". People with autistic disorder usually have significant language delays, social and communication challenges, and unusual behaviors and interests. Many people with autistic disorder also have intellectual disability.

Asperger Syndrome

People with Asperger syndrome usually have milder symptoms of autistic disorder. They might have social challenges and unusual behaviors and interests. However, they typically do not have problems with language or intellectual disability.

Pervasive Developmental Disorder – Not Otherwise Specified

This is sometimes called "atypical autism," or PDD-NOS. People who meet some of the criteria for autistic disorder or Asperger syndrome, but not all, may be diagnosed with atypical autism. These people usually have fewer and milder symptoms than those with autistic disorder. The symptoms might cause only social and communication challenges

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

GO

Insurance Coverage for Autism

November 2010

The Centers for Disease Control and Prevention (CDC) estimate that an average of one in 110 children have an autism spectrum disorder (ASD). More children than ever before are being classified as having autism spectrum disorders. The CDC estimates that up to 730,000 people between the ages of 0 and 21 have an ASD.

There is no cure for autism, but it is a treatable condition. Most health professionals agree that early intervention treatment programs are important. Treatment options may include behavioral and educational interventions, complementary and alternative medicine, dietary changes or medications to manage or relieve the symptoms of autism. These treatments may be costly. Some families may spend more than $50,000 per year on autism-related therapies, such as applied behavior analysis. A study in 2006 by the Harvard School of Public Health estimated that it costs $3.2 million to take care of an individual with autism over his or her lifetime and that it costs society an estimated $35 billion each year to care for all individuals with autism.

Some states require insurers to provide coverage for the treatment of autism. However, opponents to this approach argue that care for individuals with autism is the responsibility of parents and/or the responsibility of school systems. Others have raised concerns that mandating coverage for autism will significantly increase insurance premiums. According to the Council for Affordable Health Insurance, an autism mandate increases the cost of health insurance by about 1 percent. However, if the incidence of autism continues to increase and as more services are covered, the cost of insurance may increase 1 to 3 percent. This debate has intensified in recent years and states are taking a variety of approaches to meet the needs of children and adults with autism.

Additional NCSL Resources

- NCSL's Autism Policy Issues Overview webpage
- NCSL's State Autism Legislation Database
- NCSL's Mandated Health Insurance Coverage webpage
- NCSL's State Laws Mandating or Regulating Mental Health Benefits webpages

A total of 35 states and the District of Columbia have laws related to autism and insurance coverage. At least 23 states—Arizona, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Pennsylvania, South Carolina, Texas, Vermont and Wisconsin—specifically require insurers to provide coverage for the treatment of autism. Other states may require limited coverage for autism under mental health coverage or other laws.

In the past few years, the debate over autism and insurance coverage has heated up in state legislatures. Most of the legislation to provide coverage for autism has been enacted in the last three years.

During the 2007-2008 legislative session, nine states passed legislation related to autism and insurance coverage. Arizona, Florida, Illinois, Louisiana, Pennsylvania, South Carolina and Texas enacted legislation specifically requiring coverage for autism. In addition, Massachusetts enacted legislation in 2008 to specify that autism shall be covered under mental health parity laws on a nondiscriminatory basis. Connecticut enacted legislation in 2008 that requires insurers to provide coverage for physical, speech and occupational therapy services for the treatment of autism spectrum disorders to the extent that such services are a covered benefit for other diseases and conditions under such policy. A summary of this legislation is included in the two tables below.

In 2009, Colorado, Connecticut, Montana, Nevada, New Jersey, New Mexico and Wisconsin enacted legislation requiring insurance coverage for autism. Illinois enacted legislation requiring insurance coverage for habilitative services for children with a congenital or genetic disorder, including autism.

In 2010, Iowa, Kansas, Kentucky, Maine, Massachusetts, Missouri, New Hampshire and Vermont enacted legislation requiring insurance coverage for autism. In addition, in April 2010, Oklahoma enacted legislation to specify that health insurance policies must provide the same coverage and benefits to children who have been diagnosed with autism as children who have not been diagnosed with the disorder.

In 2009, the Federal Autism Treatment Acceleration Act of 2009 (S 819 and HR 2413), was introduced which provides for enhanced treatment, support, services and research for individuals with autism spectrum disorders and their families. One component of the bill requires health insurance coverage for the diagnosis and treatment of autism spectrum disorders under group health plans.

Additional Resources:

National Association of Insurance Commissioners

The Council for Affordable Health Insurance

- Health Insurance Mandates in the States, 2010
- Mandate Benefit Definition Memo, 2009
- The Growing Trend Toward Mandating Autism Coverage, March 2009

America's Health Insurance Plans

Autism Votes: An Autism Speaks Initiative

- Actuarial Cost Estimate: Virginia House Bill No. 303 and Senate Bill 464- Bills Relating to Health Insurance Coverage for Autism Spectrum Disorder, January 15, 2010

Early Intensive Intervention Services for Alaska Children with Autism: A Policy Analysis
The Governor's Council on Disabilities and Special Education, August 2007

Statutes specifically requiring insurance coverage of autism

State	Statute Summary
Arizona	Ariz. Rev. Stat. Ann. § 20-826.04, § 20-1057.11, § 20-1402.03 and § 20-1404.03 (2008 Ariz. Sess. Laws, Chap. 4; HB 2847 of 2008) Require policies issued by certain health insurers, beginning July 1, 2009, to provide coverage for the diagnosis and treatment of autism spectrum disorders, with some limitations. Coverage for autism treatment may not be excluded or denied and dollar limits, deductibles and coinsurance cannot be imposed based solely on the diagnosis of an autism spectrum disorder. Coverage for medically necessary behavioral therapy services may not be excluded or denied and is subject to a $50,000 maximum benefit per year for an eligible person up to the age of 9 and a $25,000 maximum benefit per year for an eligible person who is between the ages of 9 and 16 years.
Colorado	Colo. Rev. Stat. § 10-16-104 (1.3)(q), § 10-16-104 (1.4) and § 25.-5-8-107 (a)(IV) (2009 Colo., Sess. Laws, Chap. 391; SB 244 of 2009, Fiscal Note, Commission on Mandated Health Insurance Benefits Review of SB 244) Require that all health benefit plans provide coverage for the assessment, diagnosis and treatment of autism spectrum disorders for a child. Treatment for autism spectrum disorders is defined to include treatments that are medically necessary, appropriate, effective or efficient and shall include evaluation and assessment services; behavior training and management and applied behavior analysis; habilitative or rehabilitative care, including occupational, physical or speech therapy; pharmacy care and medication; psychiatric care; psychological care; and therapeutic care. Colo. Rev. Stat. §10-16-104.5 (1993 Colo., Sess. Laws, Chap. 211, amended by 2009 Colo., Sess. Laws, Chap. 391; SB 244 of 2009) Specified sickness and accident insurance policies providing indemnity for disability due to sickness and specified individual policies that provide coverage for autism shall provide such coverage in the same manner as for any other accident or sickness, other than mental illness, otherwise covered under such policy.
Connecticut	Conn. Gen. Stat. § 38a-514b (2009 Conn. Acts, P.A. 115; SB 301 of 2009, Summary, Fiscal Note) Requires specified group health insurance policies to provide coverage for the diagnosis and treatment of autism spectrum disorders. Treatments shall be medically necessary and identified and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan. Treatments may include behavioral therapy, prescription drugs, psychiatric services, psychological services, physical therapy, speech and language pathology services and occupational therapy. This law repealed the previous version of § 38a-514b (2008 Conn. Acts, P.A. 132; HB 5696, Fiscal Note), which specified that each individual and group health insurance policy is required to provide coverage for physical, speech and occupational therapy services for the treatment of autism spectrum disorders to the extent such services are a covered benefit for other diseases and conditions under such policy.
Florida	Fla. Stat. § 627.6686 and § 641.31098 (2008 Fla. Laws, Chap. 30; SB 2654 of 2008, Bill Analyses) Requires health insurance plans and health maintenance contracts to provide coverage to eligible individuals for well-baby and well-child screening for diagnosing the presence of autism spectrum

Statutes specifically requiring insurance coverage of autism	
State	**Statute Summary**
	disorders, treatment of autism spectrum disorders through speech, occupational and physical therapy and applied behavior analysis. Coverage is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan and is limited to $36,000 annual and may not exceed $200,000 in total lifetime benefits.
Illinois	Ill. Rev. Stat. ch. 215, § 5/356z.14 (2008 Ill. Laws, P.A. 95-1005, SB 934 of 2008; and 2009 Ill. Laws, P.A. 95-1049, SB 101 of 2008) Requires all individual and group accident and health insurance or managed care plans to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals less than 21 years of age. Coverage is to include applied behavioral analysis and other treatments with a maximum benefit of $36,000 per year. The law was amended in 2009 by 2009 Ill. Laws, P.A. 95-1049 (SB 101 of 2008) to require insurance coverage for habilitative services for children less than 19 years of age with a congenital, genetic or early acquired disorder, including autism spectrum disorders. Habilitative services includes occupational therapy, physical therapy, speech therapy and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic or early acquired disorder. ► For more information, please see Illinois' fact sheet on insurance coverage for autism.
Indiana	Ind. Code § 27-8-14.2-1 et seq. and § 27-13-7-14.7 (HB 1122 of 2001; Fiscal Impact Statement) Requires an accident and sickness insurance policy that is issued on a group basis and a group contract with a health maintenance organization to provide coverage for the treatment of a pervasive developmental disorder. Coverage is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with a pervasive developmental disorder. An insurer that issues an accident and sickness insurance policy on an individual basis or a health maintenance organization that enters into an individual contract that provides basic health care services must offer to provide coverage for the treatment of a pervasive developmental disorder of an enrollee. ► For additional information about the law, please visit the Indiana Resource Center for Autism's webpage.
Iowa	Iowa House File 2531 of 2010 (Fiscal Analysis) Requires state employee health care plans to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals under 21 years of age. Treatment is defined as pharmacy care, psychiatric care, psychological care, rehabilitative care and therapeutic care. The law also establishes a $36,000 annual maximum benefit on coverage for children with autism spectrum disorder. The coverage plan cannot limit the number of visits to an autism service provider for treatment. Coverage must be provided in coordination with requirements established in Iowa Code § 514c.22. Iowa Code § 514c.22 (2005 Iowa Acts, Chap. 91; HF 420 of 2005) Requires specified insurers to provide coverage benefits for treatment of a biologically based mental illness, including pervasive developmental disorders and autistic disorders.
Kansas	2010 Kan. Sess. Laws, Chap. 120 (HB 2160 of 2010; Supplemental Note) Requires state employee health insurance plans to provide coverage for the diagnosis and treatment of autism spectrum disorder for any covered individual up to 19 years old. Covered services are defined to include applied behavioral analysis and evidence-based services. The annual benefit cap for children up to age 7 is $36,000 and for children at least 7 years old and up to age 19, the annual cap is $27,000. The law also requires the state employees health care commissioner to submit a report to the legislature that includes information on the impact of the mandated coverage for autism spectrum disorder on the state health care benefits program, data on the utilization of coverage and the cost of providing such coverage, and recommendations for whether such coverage should continue. 2009 Kan. Sess. Laws, Chap. 136 (HB 2214 of 2009) The law amends Kan. Stat. Ann. § 40-2,105a (HB 2033 of 2001) to require any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization, which provides medical, surgical or hospital expense coverage to include coverage for the diagnosis and treatment of mental illness. The law re-defines mental illness to include any disorder defined in the DSM-IV.

Statutes specifically requiring insurance coverage of autism	
State	**Statute Summary**
Kentucky	2010 Ky. Acts, Chap. 150; (HB 159 of 2010) Requires large group health benefit plans to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals between the ages of one through 21 years of age. For individuals between the ages of one through their seventh birthday, the maximum annual benefit amount is $50,000, and the maximum benefit for individuals between the ages of seven through 21 is $1,000 per month. Coverage may not be subject to any limits on the number of visits an individual may make to an autism services provider. Treatment of autism spectrum disorders is defined to include medical care, pharmacy care (if covered by the plan), psychiatric care, psychological care, therapeutic care, applied behavior analysis, and rehabilitative and habilitative care. This law also amends Ky. Rev. Stat. § 304.17A-143 (1998 Ky. Acts, Chap. 106; SB 63 of 1998), to require individual and small group market health benefit plans to provide coverage for pharmacy care (if covered by the plan), psychiatric care, psychological care, applied behavioral analysis, and habilitative care for the treatment of autism spectrum disorders, in addition to the law's existing coverage for therapeutic and rehabilitative care. The law increases the maximum benefit per month from $500 to $1000. Additional definitions related to this law are included in Kentucky Regulations 806 KAR 17:460. The law also amends Ky. Rev. Stat. § 18A.225 to require state employee health benefit plans to provide coverage for the diagnosis and treatment of autism spectrum disorder consistent with the requirement for coverage under large group health benefit plans.
Louisiana	La. Rev. Stat. Ann. § 22:1050 (2008 La. Acts. P.A. 648; HB 958 of 2008: Fiscal Note) Requires health insurance policies, including health maintenance organizations, to provide coverage for the diagnosis and treatment of autism spectrum disorders in individuals less than 17 years of age. Coverage is subject to a maximum benefit of $36,000 per year and a lifetime maximum benefit of $140,000. Treatment of autism spectrum disorders is defined to include habilitative or rehabilitative care (including applied behavior analysis), pharmacy, psychiatric, psychological and therapeutic care. 2009 House Bill 406 amended the statute (La. Acts, P.A. 419) to exclude individually, underwritten, guaranteed renewable limited benefit health insurance policies from the provisions in this law.
Maine	2010 Me. Laws, Chap. 635 (LD 1198; SB 446 of 2010; Fiscal Note) Requires all individual health insurance policies and contracts, group health insurance policies, and all individual and group health maintenance organization contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age and under. Treatment is defined as habilitative or rehabilitative care, applied behavior analysis, counseling services and therapy services, including speech, occupational and physical therapy. The policy or contract may limit coverage for applied behavior analysis to $36,000 per year, and the insurance policy or contract may not include any limits on the number of visits. The law also requires the Department of Professional and Financial Regulation, Bureau of Insurance to review and evaluate the financial and social impact and medical efficacy of this mandated health insurance benefit, and submit a report to the Legislature by February 1, 2015. Me. Rev. Stat. Ann. tit. 24 § 2325-A; tit. 24-A § 2749-C, § 2843 and § 4234-A Requires specified group contracts to provide, at a minimum, benefits for a person receiving medical treatment for specified mental illnesses, including pervasive developmental disorders. Other specified individual and group insurance contracts or policies must make available benefits for the treatment and diagnosis of specified mental illnesses, including pervasive developmental disorder or autism, under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses. 2009 Me. Acts, Chap. 33 (SB 226 of 2009) Requires the Department of Health and Human Services to amend the rules of reimbursement for the provision of supervisory services by board-certified behavior analysts in the MaineCare programs for home and community benefits for persons with mental retardation or autistic disorders, developmental and behavioral clinical services, day habilitation services for persons with mental retardation, early intervention services, community support benefits for persons with mental retardation or autistic disorders, day treatment services, intermediate care facilities for persons with mental retardation and school-based rehabilitative services. The law also requires the Department of Health and Human Services to pursue amendment to the federally approved Medicaid state plan on a timely basis and, after approval, amend the MaineCare rules to provide for reimbursement of board-certified behavior analysts for supervision only.

Statutes specifically requiring insurance coverage of autism	
State	**Statute Summary**
Massachusetts	2010 Mass. Acts, Chap. 207 (HB 4935 of 2010) Requires specified individual, group and state employee health plans and health maintenance contracts to provide benefits on a nondiscriminatory basis for the diagnosis and treatment of autism spectrum disorder. Treatment is defined to include habilitative or rehabilitative, pharmacy, psychiatric, psychological and therapeutic care. The health plan may not contain an annual or lifetime dollar or unit of service limitation on coverage for autism which is less than the limitations imposed on coverage for physical conditions. The plan may not limit the number of visits an individual may make to an autism services provider. The law allows for exemptions from providing coverage under certain circumstances. Mass. Gen. Laws Ann. ch. IV § 32A-22 (2008 Mass. Acts, Chap. 256; HB 4423) Requires an individual policy and a group blanket or general policy of accident and sickness insurance or a health maintenance contract that provides hospital and surgical insurance to provide mental health benefits on a nondiscriminatory basis for the diagnosis and treatment of specified biologically-based mental disorders, including autism. Requires the group insurance commission to provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage on a nondiscriminatory basis for the diagnosis of treatment of specified biologically-based mental disorders, including autism.
Missouri	Missouri House Bill 1311 and House Bill 1341 of 2010 (HB 1311 Fiscal Note) Requires all group health benefit plans to provide coverage for the diagnosis and treatment of autism spectrum disorders. Coverage is limited to medically necessary treatment that is ordered by the insured's treating physician or psychologist, in accordance with a treatment plan. Treatment for autism spectrum disorder is defined to include psychiatric, psychological, habilitative or rehabilitative care, applied behavior analysis, therapeutic care and pharmacy care. Coverage for applied behavior analysis is subject to a maximum benefit of $40,000 per year for individuals through 18 years of age. However, this limit may be exceeded, with approval by the health benefit plan, if the applied behavior analysis services are medically necessary for an individual. The health benefit plan may not place limits on the number of visits an individual makes to an autism service provider. The law requires the department of insurance and other institutions to submit a report to the legislature regarding the implementation of this coverage, including specified costs of this coverage.
Montana	Mont. Code Ann. § 33-22-515 (2009 Mont. Laws, Chap. 359, SB 234 of 2009, Fiscal Note) Requires specified disability policies, certificates of insurance and membership contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger. Coverage must include habilitative or rehabilitative care, medications, psychiatric or psychological care, therapeutic care and other specified care. Coverage for treatment of autism spectrum disorders may be limited to a maximum benefit for $50,000 per year for a child 8 years of age and younger and to $20,000 per year for a child 9 years of age through 19 years of age. Mont. Code Ann. § 33-22-706 Requires a policy or certificate for health insurance or disability insurance to provide a level of benefits for the necessary care and treatment of severe mental illness, including autism, that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness include but are not limited to inpatient services, outpatient services, rehabilitative services, medication and other specified treatments. The law was amended in 2009 by Mont. Laws, Chapter 359 to specify that coverage for a child with autism who is 18 years of age or younger must comply with § 33-22-515.
Nevada	Nev. Rev. Stat. § 689A.0435 (2009 Nev. Stats., Chap. 331, AB 162 of 2009, Health and Human Services Fiscal Note | Public Employees' Benefits Program Fiscal Note) Requires an individual health benefit plan to provide the option of coverage for screening, diagnosis, and treatment of autism spectrum disorders for persons covered by the policy under the age of 18, or if enrolled in high school, until the person reaches the age of 22. Requires health insurance for small employers and group and blank health insurance benefit plans and health care plans issued by a health maintenance organization to provide coverage for screening, diagnosis and treatment of autism spectrum disorders to persons covered by the policy of group health insurance under the age of 18, or if enrolled in high school until the person reaches the age of 22. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care or behavior therapy.

Statutes specifically requiring insurance coverage of autism	
State	**Statute Summary**
New Hampshire	2010 N.H. Laws, Chap. 363 (House Bill 569 of 2010) Clarifies and defines treatment of pervasive developmental disorder or autism, as required under N.H. Rev. Stat. Ann. § 417-E:1, to include professional services and treatment programs, including applied behavioral analysis, prescribed pharmaceuticals (subject to the terms and conditions of the policy), direct or consultative services provided by specified licensed professionals, and services provided by licensed speech, occupation or physical therapists. The policy, contract or certificate may limit coverage for applied behavior analysis to $36,000 per year for children 0 to 12 years of age, and $27,000 from ages 13 to 21. N.H. Rev. Stat. Ann. § 417-E:1 Requires specified insurers that provide benefits for disease or sickness to provide benefits for treatment and diagnosis of certain biologically-based mental illness, including pervasive developmental disorder or autism, under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness.
New Jersey	N.J. Rev. Stat. § 17:48-6ii, § 17:48A-7ff, § 17:48E-35.33, § 17B:26-2.1cc, § 17B:27-46.1ii, § 17B:27A-7.16, § 17B:27A-19.20, § 26:2J-4.34, § 52:14-17.29p and § 52:14-17.46.6b (2009 N.J. Laws, Chap. 115, AB 2238 of 2009) Require specified health insurance policies and health benefit plans to provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability. When the covered person's primary diagnosis is autism or another developmental disability, coverage must be provided for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. When the covered person is under 21 years of age and the person's primary diagnosis is autism, coverage must be provided for expenses incurred for medically necessary behavioral interventions based on the principles of applied behavioral analysis and related programs, as prescribed through a treatment plan. N.J. Rev. Stat. § 17:48-6v, § 17:48A-7u, § 17:48E-35.20, § 17B:26-2.1s, § 17B:27-46.1v, § 17B:27A-7.5, § 17B:27A-19.7 and § 26:2J-4.20 Require specified insurers that provide hospital or medical expense benefits to provide coverage for biologically-based mental illness, including pervasive developmental disorder or autism, under the same terms and conditions as provided for any other sickness under contract.
New Mexico	N.M. Stat. Ann. § 59A-22-49, § 59A-23-7.9, § 59A-46-50 and § 59A-47-45 (2009 N.M. Laws, Chap. 74, SB 39 of 2009, Fiscal Impact Report) Requires specified insurance policies, health care plans, certificates of health insurance or contracts to provide coverage to an eligible individual who is 19 years of age or younger, or an individual who is 22 years of age or younger and is enrolled in high school for well-baby and well-child screening for diagnosing the presence of autism spectrum disorder and the treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Coverage is limited to $36,000 annually and shall not exceed $200,000 in total lifetime benefits.
Pennsylvania	Pa. Cons. Stat. tit. 40, § 764h (Pa. Laws, Act 2008-62; HB 1150 of 2008; Mandated Benefits Review by the Pennsylvania Health Care Cost Containment Council; Autism Spectrum Disorders Mandated Benefits Review Panel Report by Abt Associates Inc.; Pennsylvania Department of Public Welfare "Where to Get Help with PA's Autism Insurance Law" webpage) Requires a health insurance policy or government program to provide coverage for individuals less than 21 years of age for the diagnostic assessment and treatment of autism spectrum disorders. Maximum benefit of $36,000 per year.
South Carolina	S.C. Code Ann. § 38-71-280 (2007 S.C. Acts, Act 65; SB 20 of 2007: Fiscal Impact Statement) Requires a health insurance plan to provide coverage for the treatment of autism spectrum disorders. Coverage is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan. To be eligible for coverage, an individual must be diagnosed with autism spectrum disorder at age eight or younger and be less than 16 years of age.
Texas	Tex. Insurance Code § 1355.015 (2007 Tex. Gen. Laws, Chap. 877; HB 1919 of 2007:, Fiscal Note) Requires a health benefit plan to provide coverage for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by the physician. The law defines "generally recognized services" to include applied

Statutes specifically requiring insurance coverage of autism	
State	**Statute Summary**
	behavior analysis; speech, occupational and physical therapy; medications or nutritional supplements; and other treatments. This coverage may be subject to annual deductibles, copayments and coinsurance that are consistent with annual deductibles, copayments and coinsurance required for other coverage under the health benefit plan. 2009 Tex. Gen. Laws, Chap. 1107 (House Bill 451) amended the law to specify that a health benefit plan must provide coverage to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age. The law previously required coverage to an enrollee older than two years of age and younger than six years of age.
Vermont	2010 Vt. Acts, Act 127 (SB 262 of 2010, Vermont Legislative Joint Fiscal Office Analysis) Requires health insurance plans to provide coverage for the diagnosis and treatment of autism spectrum disorders, including applied behavior analysis for children beginning at 18 months of age and continuing until the child reaches age six or enters first grade, whichever occurs first. Treatment of autism spectrum disorders is defined to include habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care and therapeutic care. A plan may not limit the number of visits an individual may have with an autism services provider. The law requires specified agencies to evaluate the feasibility and budget impacts of requiring health insurance plans, including Medicaid and the Vermont health access plan, to provide coverage for autism spectrum disorders for children under the age of 18.
Wisconsin	Wis. Stat. § 632.895(12m) and Wis. Stat. § 609.87 (Assembly Bill 75 of 2009; 2009 Wis. Laws. Act 28) Requires specified disability insurance policies and self-insured health plans to provide coverage for treatment for autism spectrum disorder if the treatment is prescribed by a physician, including specified therapies. The statute defines intensive-level and nonintensive-level services. The law was amended in 2010 by Wis. Laws. Act 282 (SB 667) to create Wis. Stat. § 632.895 (12m) (b) 3m. which adds behavior analysts licensed under § 440.312 to the list of professionals qualified to provide intensive-level and nonintensive-level services. Wis. Stat. § 51.01(5a) Defines autism as a developmental disability. Admin. Code, Insurance Commissioner 6.54(3)(a) et seq. specifies that no insurance company may refuse, cancel or deny insurance coverage solely on the basis of the applicant's or insured's physical condition or developmental disability.

Statutes that may require limited insurance coverage of autism	
State	**Statute Summary**
California	Cal. Insurance Code § 10144.5 Requires every policy of disability insurance that covers hospital, medical, or surgical expenses in this state to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, including autism, for a person of any age under the same terms and conditions applied to other medical conditions. A March 2009 letter issued by the California Department of Managed Health Care clarifies that health plans must cover all basic health care services required under the Knox-Keene Act, including speech, physical and occupational therapies for persons with autism spectrum disorders, when those health care services are medically necessary.
District of Columbia	D.C. Code Ann. § 31-3271 and § 31-3272 (2007 D.C. Stat., Act 16-0493; B16-711 of 2007) Defines habilitative services as occupational, physical and speech therapy for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. Congenital or genetic birth defect is defined as a defect existing at or from birth, including a hereditary defect; includes autism or an autism spectrum disorder. Requires health insurers to provide habilitative services for children less than 21 years of age. The coverage shall not be more restrictive than coverage provided for any other illness, condition or disorder. A health insurer shall not be required to provide reimbursement for habilitative services delivered through early intervention or school services.

Statutes that may require limited insurance coverage of autism	
State	**Statute Summary**
Georgia	Ga. Code § 33-24-59.10 (HB 565 of 2001) An insurer that provides benefits for neurological disorders shall not deny providing benefits for neurological disorders because of a diagnosis of autism.
Maryland	Md. Insurance Code Ann. § 15-835 (2002 Md. Laws, Chap. 382; HB 692) Requires insurers, nonprofit health service plans and health maintenance organizations to provide coverage of habilitative services for children less than 19 years of age. Habilitative services include occupational, physical and speech therapy for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. The definition of congenital or genetic birth defect includes autism spectrum disorder.
New York	N.Y. Insurance Law § 3216 Requires every policy that provides coverage for hospital, surgical or medical care coverage to not exclude coverage for the diagnosis and treatment of medical conditions otherwise covered by the policy solely because the treatment is provided to diagnose or treat autism spectrum disorder.
Oklahoma	2010 Okla. Sess. Laws, Chap. 166 (SB 2045 of 2010) Requires all individual and group health insurance policies that provide medical and surgical benefits to provide the same coverage and benefits to any individual under the age of 18 years who has been diagnosed with an autistic disorder as it would provide coverage and benefits to an individual who has not been diagnosed with an autistic disorder.
Oregon	Or. Rev. Stat. § 743A.190 (2007 Or. Laws, Chap. 872; HB 2918) Requires specified health benefit plans to provide coverage for an enrolled child less than 18 years of age who is diagnosed with a pervasive developmental disorder or autism all medical services, including medical and rehabilitative services, that are medically necessary and are otherwise covered under the plan. Rehabilitative services include physical, occupational or speech therapy services to restore or improve function.
Tennessee	Tenn. Code Ann. § 56-7-2367 (2006 Tenn. Pub. Acts, Chap. 894; SB 2719) Defines autism spectrum disorder as a neurological disorder. Requires that contracts and policies that provide benefits for neurological disorders to provide benefits and coverage for treatment of children less than 12 years of age with autism.
Virginia	Va. Code § 38.2-3412.1:01 (1999 Va. Acts, Chap. 941; SB 430) Requires specified insurers that provide coverage for health care services to provide coverage for biologically based mental illnesses, including autism. Va. Code § 2.2-2818 and § 2.2-2818.2 (2009 Va. Acts, Chap. 317, SB 1351, Fiscal Impact Statement and 2009 Va. Acts, Chap. 247, HB 2557, Fiscal Impact Statement) Require the Department of Human Resource Management to establish a plan for providing health insurance coverage for state employees and retired state employees. The plan is required to include coverage for biologically based mental illness, including autism.

Sources: Health Insurance Mandates in the States 2009, The Council for Affordable Health Insurance; The National Association of Insurance Commissioners, 2006; State Autism Profiles, Easter Seals, 2008; The National Conference of State Legislatures, 2010.

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

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

©2011 National Conference of State Legislatures. All Rights Reserved.

The TRUST

The Alaska Mental Health Trust Authority

February 7, 2011

Senator Johnny Ellis
Room #119
State Capitol
Juneau, AK 99801

RE: SB 74 – Private Autism Insurance Coverage

Dear Senator Ellis,

I am writing in support of **SB 74 – Private Autism Insurance Coverage**

The Alaska Mental Health Trust Authority (The Trust) appreciates your efforts to ensure that children in Alaska who experience autism receive the supports they need to be active members of our Alaskan communities. The Trust supports SB 74, which mandates that private insurance companies include coverage for treatment of autism spectrum disorders.

The Trust advocates for a robust continuum of healthcare opportunities for its beneficiaries, those experiencing developmental disabilities, mental illness, Alzheimer's disease and other related dementias and chronic alcoholics with psychosis. In Alaska today 1,512 children and young people have autism, approximately 454 of whom need significant clinical treatment. In response to these numbers, The Trust has partnered with the *Governor's Council on Disabilities and Special Education* to identify and develop treatment options for persons diagnosed with a disorder on the autism spectrum.

Thirty years of research demonstrates that with intensive early intervention, children on the autism spectrum could gain a significant number of IQ points, and half of them could achieve normal functioning within 2-3 years of treatment. With early intervention and treatment, Alaska will see a savings of $208,500 per capita in avoided special education costs and a lifetime savings of $1.08 million per capita. According to economists, without treatment it is estimated it will cost the state $3.2 million per capita. Requiring that private insurance policies include coverage for treating autism, we can help many children access the services they need, and live more productive lives.

We appreciate your advocacy on behalf of Trust beneficiaries; specifically, beneficiaries diagnosed with autism and their families, and look forward to continuing to work with you on this issue.

Sincerely,

Jeff Jessee, CEO

3745 Community Park Loop, Suite 200 Anchorage, Alaska 99508 **Tel:** 907-269-7960 **Fax:** 907-269-7966 www.mhtrust.org

ALASKA
PRIMARY CARE ASSOCIATION

The Honorable Johnny Ellis
State Capitol, Room 119
Juneau, Alaska 99801

March 28, 2011

RE: SB 74 Insurance Coverage: Autism Spectrum Disorder

Dear Senator Ellis:

The Alaska Primary Care Association (APCA) recognizes that insurance coverage often dictates access to health care for individuals. And because access greatly increases the likelihood of positive health outcomes, the APCA is supportive of efforts to expand access. In fact, the mission of the APCA is to work to promote access to health care for all Alaskans. With this goal in mind, the APCA supports access to services for Alaskans experiencing autism. SB 74 would empower these Alaskans to receive services and help ensure early identification of challenges and appropriate intervention. As a result, SB 74 would promote both a higher quality of life for these individuals and a savings to the State of Alaska and to families.

While it is difficult to predict the long term costs or consequences of the bill to the overall health system in Alaska, the positive impact the bill would have on individual Alaskans with autism and on the costs specific to these individuals is clear. The Alaska Primary Care Association thus supports SB 74 as it pertains to access to care and services for Alaskans with autism.

The Centers for Disease Control estimates that one in every 110 children is diagnosed with autism annually, and estimates a higher rate for boys at one in 70. Although these children require services from medical professionals and other providers specific to this condition, most insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan. SB 74 would help to address this disparity in coverage and help ensure that these Alaskans receive necessary services.

Thank you for your work on behalf of Alaskans and your work on this specific issue.

Sincerely,

Marilyn Kasmar
Executive Director

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 *fax:* 907.929.2734 www.alaskapca.org
supporting Alaskans' health care homes

March 29, 2010

Alaska Senators and Representatives,

Please add my support for the Autism Insurance Coverage Bill. I have a 16 year old son with autism who was diagnosed when he was 4 years old by Dr. Brennan in Anchorage. When he was little my pediatrician told me to expect nothing from him, he would never be functional. Fortunately, a mother does not always listen to such advice.

He started receiving services before he was three at the Infant Learning Program. They gently guided me to the special ed preschool program at the school district. They set me up with a private speech therapist who came to the house twice a week. Speech therapy cost $150/hour and occupational therapy (we used it for sensory therapy) cost $57.50/15 minutes. Our private insurance had a maximum lifetime limit of $10,000 for these therapies. Caleb was maxed out by age 5 on our insurance.

We were able to gain coverage through TEFRA which is a part of Medicaid that covers autism if they have another physical disability. It was always iffy if he was going to qualify because he was a healthy child, other than the autism. I appealed several times through TEFRA to keep his services. At times in his young life he received therapy almost daily. The bill would have been over $500/week without state help.

With the help of Fairbanks Resource Agency (respite care, who because my part time therapists), TEFRA help, family help, school help, church help, adaptive rec help, speech and OT help, my son now goes to Lathrop High School on his own. He has one special ed class – study skills. We are approaching the end of his high school life and we have so much more to go.

Autism is a medical disability. It should be covered by insurance. The state can no longer afford to shoulder the entire bill for autism. This disability affects all of us. We should all pay.

Sincerely,

Amber Cheney
1015 Galena St.
Fairbanks, AK 99709
907-452-7294
cheneyamber@yahoo.com

Stone Soup GROUP

Supporting families who care for children with special needs

March 7, 2011

Senator Johnny Ellis
Alaska State Legislature
State Capitol Room 119
Juneau AK, 99801

Dear Sen. Ellis,
I'm writing on behalf of families served by Stone Soup Group to thank you for your leadership in sponsoring Senate Bill 74, the Autism Insurance Reform Bill. Stone Soup Group is a nonprofit agency that provides support services to families caring for children and youth with special health care needs and disabilities. With the increased incidents of autism and related disorders in the past decade, Stone Soup Group has grappled with how to assist families in accessing therapeutic interventions not covered by private insurance programs. The ability to use private insurance to access those services opens doors for thousands of families.

Autism is a complex neurobiological disorder and is the fastest-growing serious developmental disability in the U.S. The Centers for Disease Control estimates that one in every 110 children, with one in every 70 boys are diagnosed annually. These children require extensive services from medical professionals. Early intervention is critical to gain maximum benefit from existing therapies. Most private health insurance plans do not provide coverage for Applied Behavioral Analysis (ABA) and other autism-related services.

Stone Soup Group full supports Senate Bill 74 and the companion House Bill 79 sponsored by Rep. Petersen. Thank you for all of your hard work for Alaska's families.

Respectfully,

K Donnelly

Kelly Donnelly
Executive Director

March 30, 2011

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

Senator Bettye Davis
State Capitol Room 30
Juneau, AK 99801-1182

Dear Senator Davis:

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our concerns with SB 74 which mandates coverage for autism spectrum disorders (ASD) for children up to age 21.

We are concerned with the challenges faced by children with autism and want to approach this issue in a manner that is in their best interest balanced by the interests of all the members we serve. Our concerns relate to the coverage of predominantly educational therapies under health insurance and increased costs, particularly for specific segments of health insurance purchasers- individuals and small employers.

Coverage for Educational and Unproven Therapies under a Medical Plan
Health insurance is a means to pay for effective healthcare services and treatments, not educational therapies or unproven interventions. Under SB 74, applied behavior analysis (ABA) treatment would be required to be covered under the medical plan. The outcomes expected from ABA therapy more closely mirror social programs than medical coverage and may be considered investigational when applied to the treatment of autism.

Coverage for autism services should be considered in a comprehensive manner that accounts for the responsibilities of the public education system and should not shift the cost burden to purchasers of private health coverage. Provisions in the federal Individuals with Disabilities in Education Act (IDEA) which guarantees "free and appropriate public education" require school districts to conduct outreach to pre-school children who may be disabled and need special services. IDEA requires districts to establish individual education programs for disabled children ages 3-21 and provide special services to such children. Insurance coverage should not duplicate services that are provided through such programs, and any private coverage should not result in schools shifting responsibilities under federal and state laws to insurers.

Increased Costs for Members
Of serious concern to us is the cost impact of this benefit mandate on employers and families who are struggling to afford coverage. Our analysis of this mandate projects a premium increase of at least 3% to Alaska consumers. Excluded from this are children of employees in a self-funded plan as these plans are exempt from state mandates.

A very similar bill to mandate autism benefits was before the Washington State Legislature this session. The fiscal impact to the state as prepared by the Office of Financial Management was estimated at over $140 million for the biennium, growing to over $200 million in subsequent years. The bill has not advanced this session.

Every benefit mandate adds to the overall cost of healthcare and insurance premiums. We believe employers should have the flexibility to choose their own benefit plans without the burden of additional state mandates. An increasing load of mandates may force employers to drop health insurance altogether. We urge you to strongly consider the financial impacts for this benefit mandate proposal, especially given the current economic conditions, and in light of additional benefit requirements resulting from federal healthcare reform.

P.O. Box 327
Seattle, WA 98111

tel 425.918.5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association

While this proposed mandate would provide some financial relief to families impacted by ASD, whose employers can continue to afford coverage, there will be an unfortunate tradeoff for those families who would no longer be able to afford medical coverage at all, including families with ASD affected children.

Children with a diagnosis of autism spectrum disorder receive the same comprehensive medical coverage under Premera plans available to any other member. This proposal will add to the overall cost of healthcare and would be borne by insured members.

Thank you for considering our concerns on this issue.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

Sen. Bettye Davis

m: Joanne Healy [marshallhealy@gmail.com]
nt: Wednesday, March 30, 2011 8:24 AM
To: Sen. Bettye Davis; Sen. Dennis Egan; Sen. Johnny Ellis; Sen. Kevin Meyer; Sen. Fred Dyson
Subject: SB 74

I urge you to support SB 74 This is a classic example of pay a little now and save a millions in the future for our state. Early intervention works for children who are affected by autism and helps them become contributing members of our community. 37 other states support autism insurance bills for a reason it saves them money it is fiscally responsible and makes a huge difference in the lives of the families involved.

Thanks for your support,

Joanne Healy
1280 Jones Road
Fairbanks, AK 99709

Sen. Bettye Davis

From: Linda Robertson [stepinbcba@yahoo.com]
Sent: Wednesday, March 30, 2011 6:05 AM
To: Sen. Bettye Davis
Subject: Autism Insurance Bill

Dear Senator Davis:

I am a Board Certified Behavior Analyst, recently retired special educator (after over 35 years teaching preschool, infant learning, resource, intensive resource and admininistrative work), and half owner of a new business, "Step-In Autism Services of Alaska". While we are a for-profit business, since my young partner (a Board-Certified Assistant Behavior Analyst working on her Masters and BCBA) and I, need to pay our bills and support or help support our families, we are primarily concerned about providing effective, and quality services that can make a real difference to children with autism and their families.

We know, as evidenced by many, many, years of research, that behavior based programs can truly make a difference in the lives of both families and their autistic children. We are working with a number of children referred to us through Tri-West, military insurance. We have several children referred by local service agencies who currently work with us to provide services paid for through Medicaid. This is a lengthy, and sometimes fruitless process for families who are already stressed beyond what most of us would consider our "stress capacity" despite the best intentions of our local non-profit service providers.

Please, please do anything you can to support the services these families so desperately need. They need to more easily access the Medicaid funding or private insurance necessary to provide the services that their children and young adults require to allow them to become independent or as independent as possible. This is absolutely a case where if we pay early up front we will pay much less later as these individuals will be able to assume all or more of their own care and are allowed to become contributing members of society.

Thank you so much for your attention to this very important matter,

Linda Robertson, M.Ed, BCBA
Step-In Autism Services of Alaska, LLC
3504 Industrial Avenue
Fairbanks, Alaska, 99709
Phone: (907) 378-8411
www.stepinautismalaska

Sen. Bettye Davis

m: JayeKeener [jaye.keener@gmail.com]
nt: Monday, March 28, 2011 9:31 AM
To: Sen. Bettye Davis
Subject: Please support SB 74: Autism Insurance Coverage

Dear Senator Davis,

Please support SB 74 with the intent to better support and treat Alaskans experiencing autism. The Centers for Disease Control estimates that one in every 110 children, with one in every 70 boys, are diagnosed annually. These children require extensive services from medical professionals and other providers. Most insurance policies specifically exclude coverage for treating autism, even when the services are otherwise covered by the health plan. Thank you for you time and consideration. Sincerely,

Jaye Keener

726-1001
16510 Centerfield Dr. # B-202
Eagle River, AK 99577
jaye.keener@gmail.com

Sen. Bettye Davis

From: Paul & Robin Barrett [robinbarrett@gci.net]
Sent: Sunday, March 27, 2011 1:12 PM
To: Sen. Bettye Davis
Subject: SB 74

Please support this bill. Money spent for early autism treatment will be a mere drop in the bucket when compared to the later cost of lifetime institutionalism. Our son is age 10 and severely autistic. Our insurance does not pay for the therapy he desperately needs. We have been selling our retirement assets to pay for his treatment. In the past 5 years we are out-of-pocket more than $136,000.00. Most families cannot afford such expenses (nor can we, over time) so their children are untreated and likely doomed to a lifetime of dependence on society. Again, please support this bill.

Paul and Robin Barrett

Sen. Bettye Davis

From: David Flynn [dflynn@tdxpower.com]
Sent: Friday, March 25, 2011 4:03 PM
To: Sen. Bettye Davis
Cc: Sen. Dennis Egan; Sen. Johnny Ellis; Sen. Kevin Meyer; Sen. Fred Dyson
Subject: SB 74: Autism Insurance Coverage

My family and I live in Delta Junction , AK.

Our 3.5yr old son has autism and it is a struggle for him...and our family...to cope with the challenges of this condition.

I can be contacted as an advocate for these children and families and believe that anything that we can do to assist these special people and their families is worth doing. This bill's passing would be one way to help.

Please do what you can to see that this Bill passes.

Much appreciation in advance for your efforts in this regard...

David J. Flynn, P.Eng
TDX Project Engineer
907-865-4806 TDX
907-590-7775 cell

SB

82

<TARGET><BILL>SB 82</BILL><SUBJECT>SB
82</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Senate
Health & Social
Committee
Chair
•
Senate
Education Committee
Vice-Chair

Legislative Council
Vice-Chair
•
Senate
Transportation
Committee
•
Senate
Labor & Commerce
Committee

Senator_Bettye_Davis@legis.state.ak.us
http://www.aksenate.org/

Senator Bettye Davis

Senate Bill 82 "An Act relating to the procedures and jurisdiction of the Department of Health and Social Services for the care of children who are in state custody; relating to court jurisdiction and findings pertaining to children who are in state custody; and modifying the licensing requirements for foster care."

SPONSOR STATEMENT

Senate Bill 82 modifies various provisions in Title 47 by making small, but very significant changes that better prioritize the needs of foster children. This legislation seeks to:

1. **Achieve Permanency for Older Children in Foster Care** – Permanency for children in OCS custody is best achieved through reunification with the child's parent, or failing that option, through adoption or guardianship. If these three options are not available, another form of permanency is through APPLA ("Another Planned Permanent Living Arrangement"). This bill seeks to make sure the APPLA option is not chosen unnecessarily by providing guidelines for both OCS and the court as to when APPLA should be used.
2. **Presumption to Keep Siblings Together** – Although OCS attempts to keep siblings together when they enter foster care, this bill creates a statutory presumption that siblings be placed in the same home when possible and when such a placement is in the siblings' best interest. When the children cannot be in the same home, this bill requires an OCS supervisor to document in the file the efforts made and the reason for the separation.
3. **Early Release of Custody** - When OCS files a motion to release a child from state custody before the custody order expires, this bill requires OCS and the court to take extra steps to ensure the child and Guardian ad Litem have ample notice of the motion and that the release is in the child's best interest.
4. **Foster Home Licensing Variance Process** - If a potential foster home cannot meet the building codes required to be a licensed foster home, this bill allows a variance to be granted if the home is consistent with construction of other homes in the community and is otherwise a safe environment for the child.
5. **Streamlining Application Process for Foster Parents**
   This bill requires that paperwork required for foster parent licensing be streamlined as much as possible.
6. **Housekeeping** – The bill includes some minor changes to a statute to make it consistent with last year's legislation to extend foster care to age 21.

Session: (January – April)
[illegible]
Interim: (April – December)
[illegible]

CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 82(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to the procedures and jurisdiction of the Department of Health and Social Services for the care of children who are in state custody; relating to court jurisdiction and findings pertaining to children who are in state custody; and modifying the licensing requirements for foster care."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the Alaska Foster Family Protection Act.

*** Sec. 2.** AS 47.10.080(*l*) is amended to read:

(*l*) Within 12 months after the date a child enters foster care as calculated under AS 47.10.088(f), the court shall hold a permanency hearing. The hearing and permanent plan developed in the hearing are governed by the following provisions:

(1) the persons entitled to be heard under AS 47.10.070 or under (f) of this section are also entitled to be heard at the hearing held under this subsection;

(2) when establishing the permanent plan for the child, the court shall make appropriate written findings, including findings related to whether

(A) and when the child should be returned to the parent or guardian;

(B) the child should be placed for adoption or legal guardianship and whether a petition for termination of parental rights should be filed by the department; and

(C) **there is a compelling reason that the most appropriate placement for** the child **is** [SHOULD BE PLACED] in another planned, permanent living arrangement **and the department has recommended the arrangement under AS 47.14.100(p); the findings under this paragraph must include the steps that** [AND WHAT STEPS] are necessary to achieve the new arrangement;

(3) if the court is unable to make a finding required under (2) of this subsection, the court shall hold another hearing within a reasonable period of time;

(4) in addition to the findings required by (2) of this subsection, the court shall also make appropriate written findings related to

(A) whether the department has made the reasonable efforts required under AS 47.10.086 to offer appropriate family support services to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(B) whether the parent or guardian has made substantial progress to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(C) if the permanent plan is for the child to remain in out-of-home-care, whether the child's out-of-home placement continues to be appropriate and in the best interests of the child; and

(D) whether the department has made reasonable efforts to finalize the permanent plan for the child;

(5) the court shall hold a hearing to review the permanent plan at least annually until successful implementation of the plan; if the plan approved by the court

changes after the hearing, the department shall promptly apply to the court for another permanency hearing, and the court shall conduct the hearing within 30 days after application by the department.

*** Sec. 3.** AS 47.10.080 is amended by adding a new subsection to read:

(w) The court shall recognize a presumption that maintenance of a sibling relationship, including with a sibling who is related by blood, marriage, or adoption through one parent, is in a child's best interest.

*** Sec. 4.** AS 47.10.100 is amended to read:

Sec. 47.10.100. Retention of jurisdiction over child [MINOR]. (a) The court retains jurisdiction over the case and may at any time stay execution, modify, set aside, revoke, or enlarge a judgment or order, or grant a new hearing, in the exercise of its power of protection over the **child** [MINOR] and for the **child's** [MINOR'S] best interest, for a period of time not to exceed two years or in any event extend past the day the **child reaches** [MINOR BECOMES] 19 **years of age**, unless sooner discharged by the court, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it. An application for any of these purposes may be made by the parent, guardian, or custodian acting in behalf of the minor, or the court may, on its own motion, and after reasonable notice to interested parties and the appropriate department, take action that it considers appropriate.

(b) If the court determines at a hearing authorized by (a) of this section that **the department has complied with the requirements for release of a child under AS 47.14.100(q) and that** it is **in** [FOR] the best interests of the **child** [MINOR] to be released to the **child's own custody, or to the** care or custody of the **child's** [MINOR'S] parent, guardian, or custodian, it **shall** [MAY] enter an order to that effect and the **child** [MINOR] is discharged from the control of the department.

(c) If a **child** [MINOR] is adjudicated a child in need of aid before the **child's** [MINOR'S] 18th birthday, the court may retain jurisdiction over the **child** [MINOR] after the **child's** [MINOR'S] 18th birthday for the purpose of supervising the **child**

[MINOR], but the court's jurisdiction over the minor under this chapter never extends beyond the **child's** [MINOR'S] 19th birthday, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it. The department may retain jurisdiction over a child [BETWEEN THE CHILD'S 18TH AND 19TH BIRTHDAYS FOR THE PURPOSE OF SUPERVISING THE CHILD,] if the child has been placed under the supervision of the department before the child's 18th birthday, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it.

*** Sec. 5.** AS 47.14.100(m) is amended to read:

(m) Prima facie evidence of good cause not to place a child with an adult family member or family friend under AS 47.10.088(i) or under (e) of this section includes the failure to meet the requirements for a foster care license under AS 47.32 and regulations adopted under AS 47.32**, taking into account a waiver, variance, or exemption allowed under AS 47.32.030(a)(3) and 47.32.032**. Prima facie evidence of good cause not to place a child with an adult family member or adult family friend does not include poverty or inadequate or crowded housing. If the department denies a request for placement with an adult family member or a family friend, the department shall inform the adult family member or family friend of the basis for the denial and the right to request a hearing to review the decision. A non-party adult family member or family friend requesting a review hearing under AS 47.10.088(i) or under (e) of this section is not eligible for publicly appointed legal counsel.

*** Sec. 6.** AS 47.14.100 is amended by adding new subsections to read:

(o) Except as provided in (p) and (q) of this section, the department shall continue to search for a suitable adoptive or permanent legal guardianship for a child who is in the custody of the state and who is under 18 years of age.

(p) The department may recommend to the court another planned permanent

living arrangement for a child who is in state custody only if

(1) the child is 16 years of age or older;

(2) the department has unsuccessfully made intensive efforts to find a permanent placement for the child; and

(3) the department, after considering reunification, adoption, legal guardianship, or permanent placement with a fit and willing relative, determines that there is a compelling reason that the most appropriate permanency plan for the child is placement in another planned permanent living arrangement, and the department documents for the court the compelling reason for the alternate plan.

(q) Unless the child, department, and guardian ad litem agree to a release from custody without a motion and with less than 30 days' notice, the department may release from state custody a child who is under 19 years of age who has been committed to the custody of the department only if

(1) the child, if the child is available, and the guardian ad litem are notified not less than 30 days before a motion for release is filed;

(2) the department files a motion with the court for release of state custody that describes the reasons the release is in the best interest of the child; and

(3) a court makes a written finding that release from state custody is in the best interest of the child.

(r) The department shall make reasonable efforts to place siblings in the same placement if the siblings are residing in the same home when taken into the custody of the department. If siblings are not placed together after reasonable efforts have been made, the case supervisor for the division with responsibility over the custody of children shall document in the file the efforts that were made and the reason separating the siblings for placement purposes is in the best interest of the children. In this subsection, "sibling" means two or more persons who are related by blood, adoption, or marriage as a child of one or both parents.

(s) As used in (p) of this section, "compelling reason" may include circumstances in which

(1) the child has specifically requested that emancipation be established;

(2) a parent and child have a significant bond, but the parent is unable to care for the child because of an emotional or physical disability, and the child's foster parents have committed to raising the child to the age of majority and to facilitating visitation with the disabled parent.

(t) In this section, "another planned permanent living arrangement" means a permanent living arrangement for a child who is committed to the custody of the department under AS 47.10.080(c)(1) that is an alternative to permanent placement with an adult family member, and to reunification, adoption, and legal guardianship.

* **Sec. 7.** AS 47.32 is amended by adding a new section to read:

Sec. 47.32.032. Foster care license; variance. (a) The department shall streamline the application and licensing paperwork necessary for a person to be approved as a foster parent or relative placement to the extent consistent with federal law.

(b) The department shall approve a variance of the applicable building code requirements for licensure of a foster care home to the extent permitted by federal law if an applicant does not meet the requirements at the time of inspection and

(1) the home design and construction is consistent with homes located in the community; and

(2) the home is otherwise a safe environment for a child.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **CSSSSB082(HSS)**
() Publish Date:

Identifier (file name): SSSB082CS(HSS)-DHSS-FLSW-03-18-11
Title: Foster Care Licensing/State Custody
Sponsor: Sen. Davis
Requester: Senate JUD Committee

Dept. Affected: Health and Social Services
Appropriation: Children's Services
Allocation: Front Line Social Workers
OMB Component Number: 2305

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable.

Prepared by: Christy Lawton, Acting Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/18/11 12:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 3/18/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. CSSSSB082(HSS)

Analysis:

CSSSSB082 has zero fiscal impact on DHSS. This bills addresses permanent planning for children in custody under "Another Planned, Permanent Living Arrangement (APPLA)"; modifies licensing procedures; outlines court requirements for release or termination of custody by the courts; outlines "compelling reason" standards for youth with APPLA permanency goals; and provides a provision to support placement of siblings into the same foster home.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SSSB082**
() Publish Date:

Identifier (file name): SSSB082-DHSS-FLSW-03-11-11
Title: Foster Care Licensing/State Custody
Sponsor: Sen. Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Children's Services
Allocation: Front Line Social Workers
OMB Component Number: 2305

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Christy Lawton, Acting Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/11/11 5:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 3/11/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SSSB082

Analysis:

SSB082 has zero fiscal impact on DHSS. This bill addresses permanent planning for children in custody under "Another Planned, Permanent Living Arrangement (APPLA)"; modifies licensing procedures; outlines court requirements for release or termination of custody by the courts; outlines "compelling reason" standards for youth with APPLA permanency goals; provides a provision to support placement of siblings into the same foster home; and establishes a requirement that the Department will enroll children 6 years of age and younger into a "reading enhancement program" where available. No additional costs are anticipated.

27-LS0500\I.1
Mischel
3/15/11

AMENDMENT

OFFERED IN THE SENATE BY SENATOR DAVIS

TO: CSSSSB 82( ), Draft Version "I"

Page 5, line 10:

Delete "The"

Insert "Unless the child, department, and guardian ad litem agree to a release from custody without a motion and with less than 30 days' notice, the"

Page 6, following line 2:

Insert a new subsection to read:

"(t) In this section, "another planned permanent living arrangement" means a permanent living arrangement for a child who is committed to the custody of the department under AS 47.10.080(c)(1) that is an alternative to permanent placement with an adult family member, and to reunification, adoption, and legal guardianship."

Page 6, lines 11 - 13:

Delete all material.

Renumber the following paragraphs accordingly.

27-LS0500\I
Mischel
3/14/11

CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 82( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"An Act relating to the procedures and jurisdiction of the Department of Health and Social Services for the care of children who are in state custody; relating to court jurisdiction and findings pertaining to children who are in state custody; and modifying the licensing requirements for foster care."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the Alaska Foster Family Protection Act.

*** Sec. 2.** AS 47.10.080(*l*) is amended to read:

(*l*) Within 12 months after the date a child enters foster care as calculated under AS 47.10.088(f), the court shall hold a permanency hearing. The hearing and permanent plan developed in the hearing are governed by the following provisions:

(1) the persons entitled to be heard under AS 47.10.070 or under (f) of this section are also entitled to be heard at the hearing held under this subsection;

(2) when establishing the permanent plan for the child, the court shall make appropriate written findings, including findings related to whether

(A) and when the child should be returned to the parent or guardian;

(B) the child should be placed for adoption or legal guardianship and whether a petition for termination of parental rights should be filed by the department; and

(C) **there is a compelling reason that the most appropriate placement for** the child **is** [SHOULD BE PLACED] in another planned, permanent living arrangement **and the department has recommended the arrangement under AS 47.14.100(p); the findings under this paragraph must include the steps that** [AND WHAT STEPS] are necessary to achieve the new arrangement;

(3) if the court is unable to make a finding required under (2) of this subsection, the court shall hold another hearing within a reasonable period of time;

(4) in addition to the findings required by (2) of this subsection, the court shall also make appropriate written findings related to

(A) whether the department has made the reasonable efforts required under AS 47.10.086 to offer appropriate family support services to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(B) whether the parent or guardian has made substantial progress to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(C) if the permanent plan is for the child to remain in out-of-home-care, whether the child's out-of-home placement continues to be appropriate and in the best interests of the child; and

(D) whether the department has made reasonable efforts to finalize the permanent plan for the child;

(5) the court shall hold a hearing to review the permanent plan at least annually until successful implementation of the plan; if the plan approved by the court

changes after the hearing, the department shall promptly apply to the court for another permanency hearing, and the court shall conduct the hearing within 30 days after application by the department.

*** Sec. 3.** AS 47.10.080 is amended by adding a new subsection to read:

(w) The court shall recognize a presumption that maintenance of a sibling relationship, including with a sibling who is related by blood, marriage, or adoption through one parent, is in a child's best interest.

*** Sec. 4.** AS 47.10.100 is amended to read:

Sec. 47.10.100. Retention of jurisdiction over child [MINOR]. (a) The court retains jurisdiction over the case and may at any time stay execution, modify, set aside, revoke, or enlarge a judgment or order, or grant a new hearing, in the exercise of its power of protection over the **child** [MINOR] and for the **child's** [MINOR'S] best interest, for a period of time not to exceed two years or in any event extend past the day the **child reaches** [MINOR BECOMES] 19 **years of age**, unless sooner discharged by the court, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it. An application for any of these purposes may be made by the parent, guardian, or custodian acting in behalf of the minor, or the court may, on its own motion, and after reasonable notice to interested parties and the appropriate department, take action that it considers appropriate.

(b) If the court determines at a hearing authorized by (a) of this section that **the department has complied with the requirements for release of a child under AS 47.14.100(q) and that** it is **in** [FOR] the best interests of the **child** [MINOR] to be released to the **child's own custody, or to the** care or custody of the **child's** [MINOR'S] parent, guardian, or custodian, it **shall** [MAY] enter an order to that effect and the **child** [MINOR] is discharged from the control of the department.

(c) If a **child** [MINOR] is adjudicated a child in need of aid before the **child's** [MINOR'S] 18th birthday, the court may retain jurisdiction over the **child** [MINOR] after the **child's** [MINOR'S] 18th birthday for the purpose of supervising the **child**

[MINOR], but the court's jurisdiction over the minor under this chapter never extends beyond the **child's** [MINOR'S] 19th birthday, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it. The department may retain jurisdiction over a child [BETWEEN THE CHILD'S 18TH AND 19TH BIRTHDAYS FOR THE PURPOSE OF SUPERVISING THE CHILD,] if the child has been placed under the supervision of the department before the child's 18th birthday, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it.

* **Sec. 5.** AS 47.14.100(m) is amended to read:

(m) Prima facie evidence of good cause not to place a child with an adult family member or family friend under AS 47.10.088(i) or under (e) of this section includes the failure to meet the requirements for a foster care license under AS 47.32 and regulations adopted under AS 47.32**, taking into account a waiver, variance, or exemption allowed under AS 47.32.030(a)(3) and 47.32.032**. Prima facie evidence of good cause not to place a child with an adult family member or adult family friend does not include poverty or inadequate or crowded housing. If the department denies a request for placement with an adult family member or a family friend, the department shall inform the adult family member or family friend of the basis for the denial and the right to request a hearing to review the decision. A non-party adult family member or family friend requesting a review hearing under AS 47.10.088(i) or under (e) of this section is not eligible for publicly appointed legal counsel.

* **Sec. 6.** AS 47.14.100 is amended by adding new subsections to read:

(o) Except as provided in (p) and (q) of this section, the department shall continue to search for a suitable adoptive or permanent legal guardianship for a child who is in the custody of the state and who is under 18 years of age.

(p) The department may recommend to the court another planned permanent

living arrangement for a child who is in state custody only if

(1) the child is 16 years of age or older;

(2) the department has unsuccessfully made intensive efforts to find a permanent placement for the child; and

(3) the department, after considering reunification, adoption, legal guardianship, or permanent placement with a fit and willing relative, determines that there is a compelling reason that the most appropriate permanency plan for the child is placement in another planned permanent living arrangement, and the department documents for the court the compelling reason for the alternate plan.

(q) ~~The~~ Unless the Child ... department may release from state custody a child who is under 19 years of age who has been committed to the custody of the department only if

(1) the child, if the child is available, and the guardian ad litem are notified not less than 30 days before a motion for release is filed;

(2) the department files a motion with the court for release of state custody that describes the reasons the release is in the best interest of the child; and

(3) a court makes a written finding that release from state custody is in the best interest of the child.

(r) The department shall make reasonable efforts to place siblings in the same placement if the siblings are residing in the same home when taken into the custody of the department. If siblings are not placed together after reasonable efforts have been made, the case supervisor for the division with responsibility over the custody of children shall document in the file the efforts that were made and the reason separating the siblings for placement purposes is in the best interest of the children. In this subsection, "sibling" means two or more persons who are related by blood, adoption, or marriage as a child of one or both parents.

(s) As used in (p) of this section, "compelling reason" may include circumstances in which

(1) the child has specifically requested that emancipation be established;

(2) a parent and child have a significant bond, but the parent is unable to care for the child because of an emotional or physical disability, and the child's

foster parents have committed to raising the child to the age of majority and to facilitating visitation with the disabled parent.

(c) In this section, "another..."

* **Sec. 7.** AS 47.32 is amended by adding a new section to read:

Sec. 47.32.032. Foster care license; variance. (a) The department shall streamline the application and licensing paperwork necessary for a person to be approved as a foster parent or relative placement to the extent consistent with federal law.

(b) The department shall approve a variance of the applicable building code requirements for licensure of a foster care home to the extent permitted by federal law if an applicant does not meet the requirements at the time of inspection and

~~(1) the variance serves the best interest of a child intended to be placed in that home;~~

~~(2) the placement is preferable to other placement options;~~

(1) the home design and construction is consistent with homes located in the community; and

~~(3)~~ (2) the home is otherwise a safe environment for a child.

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 82

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY SENATOR DAVIS

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to the procedures and jurisdiction of the Department of Health and Social Services for the care of children who are in state custody; relating to court jurisdiction and findings pertaining to children who are in state custody; and modifying the licensing requirements for foster care."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the Alaska Foster Family Protection Act.

*** Sec. 2.** AS 47.10.080(*l*) is amended to read:

(*l*) Within 12 months after the date a child enters foster care as calculated under AS 47.10.088(f), the court shall hold a permanency hearing. The hearing and permanent plan developed in the hearing are governed by the following provisions:

(1) the persons entitled to be heard under AS 47.10.070 or under (f) of this section are also entitled to be heard at the hearing held under this subsection;

(2) when establishing the permanent plan for the child, the court shall make appropriate written findings, including findings related to whether

(A) and when the child should be returned to the parent or guardian;

(B) the child should be placed for adoption or legal guardianship and whether a petition for termination of parental rights should be filed by the department; and

(C) **there is a compelling reason that the most appropriate placement for** the child **is** [SHOULD BE PLACED] in another planned, permanent living arrangement **and the department has recommended the arrangement under AS 47.14.100(p); the findings under this paragraph must include the steps that** [AND WHAT STEPS] are necessary to achieve the new arrangement;

(3) if the court is unable to make a finding required under (2) of this subsection, the court shall hold another hearing within a reasonable period of time;

(4) in addition to the findings required by (2) of this subsection, the court shall also make appropriate written findings related to

(A) whether the department has made the reasonable efforts required under AS 47.10.086 to offer appropriate family support services to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(B) whether the parent or guardian has made substantial progress to remedy the parent's or guardian's conduct or conditions in the home that made the child a child in need of aid under this chapter;

(C) if the permanent plan is for the child to remain in out-of-home-care, whether the child's out-of-home placement continues to be appropriate and in the best interests of the child; and

(D) whether the department has made reasonable efforts to finalize the permanent plan for the child;

(5) the court shall hold a hearing to review the permanent plan at least annually until successful implementation of the plan; if the plan approved by the court

changes after the hearing, the department shall promptly apply to the court for another permanency hearing, and the court shall conduct the hearing within 30 days after application by the department.

* **Sec. 3.** AS 47.10.080 is amended by adding a new subsection to read:

(w) The court shall recognize a presumption that maintenance of a sibling relationship, including with a sibling who is related by blood through one parent, is in a child's best interest.

* **Sec. 4.** AS 47.10.100 is amended to read:

Sec. 47.10.100. Retention of jurisdiction over child [MINOR]. (a) The court retains jurisdiction over the case and may at any time stay execution, modify, set aside, revoke, or enlarge a judgment or order, or grant a new hearing, in the exercise of its power of protection over the **child** [MINOR] and for the **child's** [MINOR'S] best interest, for a period of time not to exceed two years or in any event extend past the day the **child reaches** [MINOR BECOMES] 19 **years of age**, unless sooner discharged by the court, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it. An application for any of these purposes may be made by the parent, guardian, or custodian acting in behalf of the minor, or the court may, on its own motion, and after reasonable notice to interested parties and the appropriate department, take action that it considers appropriate.

(b) If the court determines at a hearing authorized by (a) of this section that **the department has complied with the requirements for release of a child under AS 47.14.100(q) and that** it is **in** [FOR] the best interests of the **child** [MINOR] to be released to the **child's own custody, or to the** care or custody of the **child's** [MINOR'S] parent, guardian, or custodian, it **shall** [MAY] enter an order to that effect and the **child** [MINOR] is discharged from the control of the department.

(c) If a **child** [MINOR] *is adjudicated a child in need of aid before the* **child's** [MINOR'S] 18th birthday, the court may retain jurisdiction over the **child** [MINOR] after the **child's** [MINOR'S] 18th birthday for the purpose of supervising the **child**

[MINOR], but the court's jurisdiction over the minor under this chapter never extends beyond the **child's** [MINOR'S] 19th birthday, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it. The department may retain jurisdiction over a child [BETWEEN THE CHILD'S 18TH AND 19TH BIRTHDAYS FOR THE PURPOSE OF SUPERVISING THE CHILD,] if the child has been placed under the supervision of the department before the child's 18th birthday, except that the department may apply for and the court may grant [AN] additional one-year **periods** [PERIOD] of supervision past [AGE] 19 **years of age that do not extend beyond the person's 21st birthday** if continued supervision is in the best interests of the person and the person consents to it.

*** Sec. 5.** AS 47.14.100(m) is amended to read:

(m) Prima facie evidence of good cause not to place a child with an adult family member or family friend under AS 47.10.088(i) or under (e) of this section includes the failure to meet the requirements for a foster care license under AS 47.32 and regulations adopted under AS 47.32**, taking into account a waiver, variance, or exemption allowed under AS 47.32.030(a)(3) and 47.32.032**. Prima facie evidence of good cause not to place a child with an adult family member or adult family friend does not include poverty or inadequate or crowded housing. If the department denies a request for placement with an adult family member or a family friend, the department shall inform the adult family member or family friend of the basis for the denial and the right to request a hearing to review the decision. A non-party adult family member or family friend requesting a review hearing under AS 47.10.088(i) or under (e) of this section is not eligible for publicly appointed legal counsel.

*** Sec. 6.** AS 47.14.100 is amended by adding new subsections to read:

(o) Except as provided in (p) and (q) of this section, the department shall continue to search for a suitable adoptive or permanent legal guardianship for a child who is in the custody of the state and who is under 18 years of age.

(p) The department may recommend another planned permanent living

arrangement for a child who is in state custody only if

(1) the department has unsuccessfully made intensive efforts to find a permanent placement for the child;

(2) the department, after considering reunification, adoption, legal guardianship, or permanent placement with a fit and willing relative, determines that there is a compelling reason that the most appropriate permanency plan for the child is placement in another planned permanent living arrangement, and the department documents for the court the compelling reason for the alternate plan; and

(3) the court, at a permanency hearing under AS 47.10.080(*l*), has approved the placement of the child to another permanent planned living arrangement.

(q) The department may release from state custody a child who is under 19 years of age who has been committed to the custody of the department only if

(1) the child and the guardian ad litem are notified not less than 30 days before a petition for release is filed;

(2) the department files a petition with the court for termination of state custody and release that describes the reasons the release is in the best interest of the child; and

(3) a court makes a written finding that release from state custody is in the best interest of the child.

(r) The department shall make all reasonable efforts to place siblings who are in the custody of the department in the same placement. If siblings are not placed together after reasonable efforts have been made, the state or regional director of the division with responsibility over the custody of children shall provide a written explanation in the file of the efforts that were made and the reason separating the siblings for placement purposes is in the best interest of the children. In this subsection, "sibling" means two or more persons who are related by blood or marriage as a child of one or both parents.

(s) As used in (p) of this section, "compelling reason" may include circumstances in which

(1) the child is more than 15 years of age and has specifically requested that emancipation be established;

(2) a parent and child have a significant bond, but the parent is unable to care for the child because of an emotional or physical disability, and the child's foster parents have committed to raising the child to the age of majority and to facilitating visitation with the disabled parent;

(3) a tribe has identified another planned permanent living arrangement for the child.

* **Sec. 7.** AS 47.32 is amended by adding a new section to read:

Sec. 47.32.032. Foster care license; variance. (a) The department shall ensure that the application and licensing paperwork necessary for a person to be approved as a foster parent or relative placement is not unduly complex and is as short and straightforward as necessary to protect a child's best interests.

(b) The department shall approve a variance of the applicable building code requirements for licensure of a foster care home if an applicant does not meet the requirements at the time of inspection and

(1) the variance serves the best interest of a child intended to be placed in that home;

(2) the placement is preferable to other placement options;

(3) the home design and construction is consistent with homes located in the community; and

(4) the home is otherwise a safe environment for a child.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 10, 2011

SUBJECT: Comparison of versions "A" and "M" (SSSB 82 (Work Order No. 27-LS0500\M))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Tom Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have asked for an outline of the differences in the sponsor substitute and the original version of SB 82. The sponsor substitute, version "M", enclosed, modifies the authority and duties of the Department of Health and Social Services when another planned permanent living arrangement for or release of a child in the custody of the department is recommended. The sponsor substitute also deletes the enrollment in a reading program requirement for low income children.

JMM:plm
11-135.plm

Enclosure

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSSSB082(HSS)
() Publish Date:

Identifier (file name): SSSB082CS(HSS)-DHSS-FLSW-03-18-11
Dept. Affected: Health and Social Services
Title: Foster Care Licensing/State Custody
Appropriation: Children's Services
Allocation: Front Line Social Workers
Sponsor: Sen. Davis
Requester: Senate JUD Committee
OMB Component Number: 2305

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable.

Prepared by: Christy Lawton, Acting Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/18/11 12:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 3/18/2011
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. CSSSSB082(HSS)

Analysis:

CSSSSB082 has zero fiscal impact on DHSS. This bills addresses permanent planning for children in custody under "Another Planned, Permanent Living Arrangement (APPLA)"; modifies licensing procedures; outlines court requirements for release or termination of custody by the courts; outlines "compelling reason" standards for youth with APPLA permanency goals; and provides a provision to support placement of siblings into the same foster home.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SSSB082**
() Publish Date:

Identifier (file name): SSSB082-DHSS-FLSW-03-11-11
Title: Foster Care Licensing/State Custody
Sponsor: Sen. Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Children's Services
Allocation: Front Line Social Workers
OMB Component Number: 2305

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Christy Lawton, Acting Director — Phone 465-3191
Division: Office of Children's Services — Date/Time 3/11/11 5:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 3/11/2011
DHSS Finance & Management Services

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SSSB082

Analysis:

SSB082 has zero fiscal impact on DHSS. This bill addresses permanent planning for children in custody under "Another Planned, Permanent Living Arrangement (APPLA)"; modifies licensing procedures; outlines court requirements for release or termination of custody by the courts; outlines "compelling reason" standards for youth with APPLA permanency goals; provides a provision to support placement of siblings into the same foster home; and establishes a requirement that the Department will enroll children 6 years of age and younger into a "reading enhancement program" where available. No additional costs are anticipated.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/11/11

FURTHER: Judiciary

Date of 5-Day Notice: 3/10/11
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/11/11

Health and Social Services Committee considered SPONSOR SUBSTITUTE FOR SENATE BILL NO. 82

SB 82-FOSTER CARE LICENSING/STATE CUSTODY

"An Act relating to the procedures and jurisdiction of the Department of Health and Social Services for the care of children who are in state custody; relating to court jurisdiction and findings pertaining to children who are in state custody; and modifying the licensing requirements for foster care."

and recommends:

[X] be **replaced** with **CS** SB82 (HSS) [X] *Same Title* [ ] *New Title*

[X] adopt **previous CS** _____ (_____) [ ] *Same Title* [ ] *New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
HSS			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
K Meyer	Meyer	X			
Ellis	Ellis	X			
ECha	ECha	X			
Dyson	Dyson	X			
CHAIR: Bettye Davis	DAVIS	X			

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

Richard Moore
Senator
Massachusetts Senate
President, NCSL

Tim Rice
Executive Director
Illinois Legislative Information System
Staff Chair, NCSL

William Pound
Executive Director

To: Amanda Metivier, Aide to Alaska Rep. Les Gara

From: Amy Taylor, NCSL Intern and Kelly Crane, NCSL

Date: November 17, 2010

Subject: Another Planned Permanent Living Arrangement

Following is information on state legislation around Another Permanent Planned Living Arrangement as a permanency goal for children in foster care. Also, below is information on states that allow for the reinstatement of parental rights (a strategy states may use to reduce the use of APPLA as a permanency option).

- **State Legislation**

New York:

2005 N.Y. Laws, SB 5805, Chap. 3: Specifies the required contents of permanency hearing reports to the court. Describes acceptable permanency goals. Provides that the permanency goal of "another planned permanent living arrangement" must include a significant connection to an adult who is willing to be a permanency resource for the child.

2007 N.Y. Laws, SB 4551, Chap. 327: Clarifies that the plan of "another planned permanent living arrangement" must include documentation of the child's significant connection to an adult who is willing to be a permanency resource for the child.
New York FCA §§1089(c)(1)(v), 1089(d)(2)(i)(E) can be retrieved at:

Alabama:

Section 12-15-315 of the Alabama Code: States that if the juvenile court determines the permanent plan shall be placement in another planned permanent living arrangement, the Department of Human Resources must document to the juvenile court a compelling reason for determining that it would not be in the best interests of the child to return home, be placed for adoption with no identified resource or with the current foster parent, or be permanently placed with a relative, with a transfer of legal and physical custody to the relative or with a transfer of physical custody to the relative but with the Department of Human Resources retaining legal custody, be placed with a kinship guardian, or be placed in adult custodial care.

Denver
7700 East First Place
Denver, Colorado 80230-7143
Phone 303.364.7700 Fax 303.364.7800

Washington
444 North Capitol Street, N.W. Suite 515
Washington, D.C. 20001
Phone 202.624.5400 Fax 202.737.1069

Website www.ncsl.org
Email info@ncsl.org

Connecticut:

Sec. 4. Section 46b-129 of the Connecticut Code: Orders that at a permanency hearing the court shall approve a permanency plan that is in the best interests of the child or youth and takes into consideration the child's or youth's need for permanency. Another Planned living arrangement can be ordered by the court, provided the Commissioner of Children and Families has documented a compelling reason why it would not be in the best interest of the child or youth for the permanency plan to include a different permanency goal. (Sec. 4. Section 46b-129 of the 2010 supplement to the general statutes)

West Virginia:

Section 49-6-5 of West Virginia Code: Orders that a child may be placed in another planned permanent living arrangement, but only in cases where the department has documented to the circuit court a compelling reason for determining that it would not be in the best interests of the child to follow one of the other permanency options. (Section 49-6-5. Disposition of neglected or abused children)

- **Reinstatement of Parental Rights**

Several states have also passed legislation that allows for the reinstatement of parental rights following termination of parental rights. The laws were developed in response to children who were aging out of the foster care system and re-establishing ties with parents and family members.

Legislation for Reinstatement following Termination of Parental Rights

State	Statute or Code	Who Can File Motion or Petition	Who Must Be Notified
Alaska	Alaska Stat. § 47.10.089	A person who has voluntarily relinquished the child.	
California	Cal. Welfare and Institutions Code § 366.26	Child for whom court has determined that adoption is no longer the permanent plan.	Social worker or probation officer, child's attorney, child's tribe, if applicable, former parent
Hawaii	Act 135, 2010 Session Laws	Child who is 14 or older; child's GAL; department	Former parent; child's GAL; department; child's resource family
Illinois	705 Ill. Comp. Stat. 405/2-28 and 705 Ill. Comp. Stat. 405/2-34	Dept of Child and Family Services on behalf of 13 years or older child	Parties to the Juvenile Court proceeding

Louisiana	La. Child. Code Ann. art. 1051	Child in foster care over the age of 15.	Parents, foster parents, CASA volunteer.
Nevada	Nev. Rev. Stat. Ann. § 128.160, 128.170	Child or legal custodian or guardian of child	Parents, child's legal custodian or guardian, person or entity that petitioned for TPR, child's attorney
New York	N.Y. Fam. Ct. Act, §§ 635-637	Attorney, Guardian of child age 14 or older	Court may issue summons to child, guardian and custodian, respondent in TPR proceeding.
Oklahoma	Okla. Stat. Ann. tit. 10 A, § 1-4-909	Child 15 or older	Department, child's attorney, child, former parent, foster parent or relative guardian, GAL, child's tribe
Washington	Wash. Rev. Code Ann §13.34.215	Child 12 or older, or younger if good cause is shown	Department, child's attorney, child, former parent, existing parent, current caregiver, child's tribe.

Please let us know if we can be of further assistance!

Amy Taylor
National Conference of State Legislatures
Children and Families Program

aahc
ALASKA ASSOCIATION OF
Homes for Children

Alaska Baptist Family Services
Anchorage, AK

Alaska Children's Services
Anchorage, AK

Alaska Family Services
Palmer, AK

Covenant House of Alaska
Anchorage, AK

Family Centered Services of Alaska
Fairbanks, AK

Juneau Youth Services
Juneau, AK

Kenai Peninsula Community Care Center
Kenai, AK

Maniilaq Association
Kotzebue, AK

Nome Children's Home
Nome, AK

North Slope Borough Children's Services
Barrow, AK

North Star Behavioral Health
Anchorage & Palmer, AK

Presbyterian Hospitality House
Fairbanks, AK

Providence Behavioral Health Systems
Anchorage, AK

Residential Youth Care
Ketchikan, AK

Searhc
Sitka, AK

The Boys and Girls Home of Alaska
Fairbanks, AK

The Salvation Army Booth Memorial Home
Anchorage, AK

Youth Advocates of Sitka
Sitka, AK

March 7, 2011

Senator Bettye Davis
Alaska Senate
State Capitol
Juneau, Alaska 99801

RE: SB 82: Stability and Opportunity for Foster Youth

Dear Senator Davis,

Alaska Association of Homes for Children (AAHC) thanks you for introducing legislation to improve the service delivery of foster care. Several agencies within our association provide foster care and many of the youth we serve benefit from this critical service.

Unfortunately, we all have witnessed children on long waiting lists for a viable foster care placement for various reasons. The intent of SB 82 provides concrete solutions to streamline the process for foster parents, develop resources for children, and reinforce the goals related to permanency planning.

Placing children in rural areas poses additional challenges related to numerous licensing issues. It can be extremely difficult finding foster homes that meet state licensing requirements. Licensing variances for homes failing to meet specific codes when indicated would provide opportunities for families to open up their homes to provide care for foster children.

Foster care provides for a very cost effective way of helping children. Allowing more families to commit to the many Alaskan children waiting for a quality home creates a win win opportunity for all. AAHC truly appreciates your continued efforts to assist with the foster care system in Alaska.

The provisions within your bill would provide a wise investment in the health and wellbeing of Alaska's children.

Thank you,

Brad Ohs
AAHC President

cc: Representative Les Gara

Advisory Board on Alcoholism
and Drug Abuse

abada
amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

February 23, 2011

Representative Les Gara
Alaska State Legislature
State Capitol, Room 500
Juneau, Alaska 99801

Re: Support for HB 33

Dear Representative Gara,

On behalf of the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse, I would like to express our thanks and appreciation for the commitment that you and your co-sponsors have made to improving the lives of Alaskan children in foster care. HB 33 continues that process of system improvement, and we support the small but very significant changes that better prioritize the needs of foster children.

Being removed from your home, even when that home is not a safe or healthy environment, is traumatic. Being removed from your home and then separated from your brothers and sisters compounds the initial harm caused by abuse or neglect exponentially. While we know this from research and study, the Boards recognized fully the devastating effect this separation has on foster children when we heard from youth involved in the 2011 Youth Policy Summit. No child should have to beg, plead and fight for years to see a brother or sister, and yet we heard how this is the case for far too many youth who grow up in foster care.

HB 33 also prioritizes family connections as an important source of strength, support and resiliency for children and youth who experience abuse or neglect by making family placements easier in rural Alaska. Too often children in rural Alaska are placed with foster parents in urban communities rather than with relatives in villages, with the justification that the rural homes fail to meet foster care licensing standards. How can an aunt in a village where no one has running water ever hope to care for a niece or nephew who is in need, if there is no reasonableness standard in determining a safe physical environment for placement? HB 33 provides that element of reason to family placement decisions.

We are grateful for your continued advocacy for Alaska's children and are glad to be able to support HB 33.

Sincerely,

J. Kate Burkhart
Executive Director

cc: Representative Bill Thomas
Representative Bob Herron
Representative Berta Gardner

NASW ALASKA CHAPTER
National Association of Social Workers

401 E. Northern Lights Blvd., Suite 205
Anchorage, Alaska 99503
907-332-NASW (6279) Fax: 907-332-6270
1-800-478-NASW (6279)
director@naswak.org
http://www.naswak.org

January 2nd, 2011

Representative Les Gara
State of Alaska
State Capitol, Room 500
Juneau, Alaska 99801-1182

Dear Representative Gara:
The National Association of Social Workers (NASW) – Alaska Chapter, a membership organization that represents over 500 social workers across the State of Alaska, supports The Alaska Foster Family Protection Act.

The mission of NASW is to enhance the effective functioning and well-being of individuals, families, and communities through its work and through its advocacy. The Alaska Foster Family Projection act upholds this mission by ensuring that Alaska's most vulnerable children can more easily transition into safe and permanent homes. The increase in the number of rural foster care placements is especially crucial so youth in rural Alaska can continue to live in their home communities. Research demonstrates that youth from rural communities, and specifically Alaska Native youth, have more promising futures when they are able to maintain connection with their communities and tribes.

Thank you for your consistent attention to child welfare issues in Alaska. We look forward to working with you on behalf of children and families in our state.

Sincerely,

M. Loomis

Meg Loomis, MSW
Executive Director

January 26, 2011

The Honorable Les Gara
Alaska House of Representatives
State Capital
Juneau, AK. 99801-1181

RE: HB 33: Stability and Opportunity for Foster Youth

Dear Representative Gara,

The members of the Alaska Behavioral Health Association would like to inform you of their support for this legislation. It's intent is consistent with the goals and values of the members that provide services in our state and also provides opportunities to expand a system that is currently incapable of meeting the needs of youth.

Our providers have experienced tremendous difficulties in placing children and youth back in their home communities when a foster home is required due to the home situation of the biological parents. Frequently, homes may be available but they don't meet the more ridged codes and standards that govern construction in metropolitan areas. While no one would ever want a child placed in an unsafe environment, we are aware that minor code violations can be prohibitively expensive to repair and a foster home can be lost.

We hear reports from providers that it often takes up to six months or more from the time a family begins the application process and they are finally able to accept a child in their home. We appreciate the careful attention to ensure that a child is placed in a safe environment; however, redundancy and over-attention can become a barrier rather than a safe guard.

Thank you for your commitment to foster children and working to make their lives better.

Sincerely,

Donn Bennice

Donn Bennice, Ph.D.
President

Alaska Children's Services

The Honorable Les Gara
Alaska House of Representatives
State Capitol
Juneau, AK 99801-1182

RE: HB 33: Stability and Opportunity for Foster Youth

Dear Representative Gara:

This letter is to inform you of the strong support the Administration and Board of Directors have for the above-mentioned bill. It's intent is consistent with the goals and values of the Treatment Foster Care Program operated by Alaska Children's Services and provides opportunities to expand a system that is currently incapable of meeting the needs of youth.

We are particularly appreciative of the section regarding permanency placement. As you have stated the ultimate goal in foster care is to place a child in a good, stable, permanent home through adoption, guardianship, or reunification. Frequently, however, in our haste to find a child a bed or a roof over their head, we lose sight of this goal. By adding additional oversight to the permanency planning process, this goal can be reached.

Alaska Children's Services has experienced tremendous difficulties in placing children and youth back in their home communities when a foster home is required due to the home situation of the biological parents. Frequently, homes may be available but don't meet the more rigid codes and standards that govern construction in metropolitan areas. While no one would ever want to place a child in an unsafe environment, we are aware that minor code violations can be prohibitively expensive to repair and a foster home can be lost.

Alaska Children's Services has three full-time professional staff who comprise the treatment foster care licensing department. They report that it frequently takes up to six months or more from the time a family begins the application process and they are finally able to accept a child in their home. We appreciate the careful attention to ensure that a child is placed in a safe environment; however, redundancy and over-attention can become a barrier rather than a safeguard.

Overall, thank you very much for your continued commitment to one of our most vulnerable populations, our foster children, and please advise if there is more we can do to support this legislation.

Regards,

Jim Maley,
President & CEO

Denali Family Services
For Children For Families For Alaska

4600 DeBarr Rd., Suite 301 • Anchorage, Alaska 99508
Phone: (907) 274-8281 • Fax (907) 274-4055
www.denalifs.org

COA

February 8, 2011

Representative Les Gara
Alaska State Legislature
Juneau, Alaska 99801

Dear Representative Gara:

I am writing in support of HB33, the legislation you have proposed relating to foster care in Alaska. Denali Family Services (DFS) is a community mental health agency that provides therapeutic foster care to many children in the custody of the State / Office of Children's Services. DFS is also a child placement agency and in that role, processes foster home applications and licenses foster home in cooperation with OCS (i.e., the license is still a State foster care license). As an agency licensing foster homes, we support using the variance for homes in rural communities as long as the home is a safe environment and there are adequate ways to exit the home in case of a fire.

Denali Family Services serves many adolescents who are moving from care to independence and I am especially pleased to see the language changes that will make extending foster care to age 21 easily accessible for youth who want to take advantage of that opportunity. For youth who do not have a support system in place, those additional three years can make a huge difference in their maturity and readiness to survive on their own.

With regard to the application process for foster parents, DFS has significantly reduced our paperwork requirements in the last two years. In addition, effective this fiscal year, DFS will be utilizing a new foster parent training curricula (Presley Ridge). This curricula offers foster care providers in-depth, specialized training and OCS has agreed that DFS' foster parents who complete the Presley Ridge training will not have to take the OCS CORE training. This change will provide foster parents with more specialized training while maintaining the total hours at a number (per year) that is manageable.

On behalf of Denali Family Services, I am writing in support of HB33. Should you need additional information, please feel free to contact me at 907-222-2322.

Sincerely,

Yvonne M. Chase, PhD, LCSW
President / CEO

SEAN PARNELL, GOVERNOR

350 Main Street, Room 412
P.O. Box 110660
JUNEAU, AK 99811-0660
PHONE: (907) 465-5829
FAX: (907) 465-2204

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH CARE SERVICES

November 19, 2010

The Honorable Les Gara
Alaska House of Representatives
716 W. 4th Ave. Suite 310
Anchorage AK, 99501-2133

Dear Representative Gara,

In light of the postponement of our scheduled meeting regarding the status of 2010 foster care reform efforts I wanted to update you on the issues. I look forward to meeting with you in the near future, and to working with you to further improve the lives of Alaska's children and youth in foster care.

In advance of a meeting, I want to touch on some of the points you raised and inform you of some of the progress that has been achieved since your letter of October 12.

Regarding the implementation of the provisions of HB 126, a small number of youth in the past have been released from foster care when continued care would have been to their benefit. Changes in our IL procedures, effective October 1, 2010 have made Regional Independent Living Specialists (RILS) responsible for developing transition plans for all youth age 17 and older. In light of HB 126, transition plans will be revised to include a thorough review of continued support and future requirements if the youth chooses to re-enter custody at a later date.

Recent federal changes to the Fostering Connections Act, allows states to pursue federal reimbursements for foster care for youth to age 21. However, the federal requirements indicate that should states choose to accept reimbursement for youth to age 21, the states must also open this option to youth to age 21 for the adoption and guardianship subsidy programs as well. HB 126 is currently funded with general fund and anticipated federal reimbursement amounts. OCS will implement HB 126 extended foster care using only general funds until it can be determined whether or not existing general fund will adequately support the program or extended adoption and guardianship subsidies will be pursued.

It has been, and continues to be the policy of OCS to utilize transportation funds to allow foster youth who move between placements to stay in their original school for the remainder of the school term. The additional $80,000 for FY 11 will assist us in implementing this policy further.

SEAN PARNELL, GOVERNOR

350 Main Street, Room 412
P.O. Box 110660
JUNEAU, AK 99811-0660
PHONE: (907) 465-5829
FAX: (907) 465-2204

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH CARE SERVICES

Since we received your letter an RFP, *Mentoring for Independent Living* was posted on November 4, 2010. Although the service area is statewide, the proposal evaluation committee will favor those proposing to serve two or more population centers. The deadline for proposals has been extended to December 10, 2010.

In the Fall, 2010 40 youth received funding to attend the University of Alaska, AVTEC and other colleges out of state. Through coordination with the University of Alaska, nine supplemental tuition waivers were issued to youth attending the University of Alaska. This was in addition to the 10 Presidential Tuition Waivers, for a grand total of 19 tuition waivers.

Additional waivers will be issued for the Spring, 2011 semester. Regional Independent Living Specialists contacted all youth who received a waiver and are providing case management services. The RILS are utilizing the additional funds to provide occupational and post secondary training opportunities to youth both in and out of custody. We currently have youth utilizing these funds at UAF Community & Technical College and in UAF's Nurse Aide Program. Meetings have taken place with the Department of Labor and Workforce Development to create coordination of services to utilize funds for Career Exploration and to provide for Apprenticeship and On-the-Job training opportunities for foster care youth.

I understand your concern with the case load of the four RILS and share your belief that two additional staff will positively impact the outcomes of youth coming out of care. Posting of these jobs is anticipated to take place in the near future.

Regarding the housing assistance funds, to date a total seven youth have utilized these funds for a total of 28 months of housing assistance. We are continuing to make efforts to promote this assistance and are contacting all youth out of care, in each region of the state.

With respect to the formal *FosterWear* cards, they have been printed and sent out to all licensed providers. Cards for unlicensed providers have been sent to the field offices as well. We regularly print *FosterWear* information in the Alaska Center For Resource Families (ACRF) newsletter and Izabel Bower's is currently working on a "print mailer" that will be sent out after the holidays.

I am also looking forward to working with you on the new initiatives you outlined in your letter. Dee Pearson and Mike Sobosinski of UAA have discuss peer mentorship in general and will be meeting again to discuss this service delivery more in depth. Dee is exploring a pilot project for peer mentorships for youth attending the University Fall, 2011.

SEAN PARNELL, GOVERNOR

350 Main Street, Room 412
P.O. Box 110660
JUNEAU, AK 99811-0660
PHONE: (907) 465-5829
FAX: (907) 465-2204

DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH CARE SERVICES

The above is a brief update on the status of some of the initiatives and programs that OCS is working on. I greatly look forward to exploring in more depth at our next meeting these subjects and any others you would like to talk about in our efforts to improve the lives and futures of Alaska's children and young people.

Sincerely,

Christy Lawton
Acting Director

Cc: Tracy Spartz Campbell, Deputy Director
Dee Pearson, Independent Living Coordinator

SB 118

<TARGET><BILL>SB 118</BILL><SUBJECT>SB 118</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SPONSOR STATEMENT

SENATE BILL 118-*"An Act providing medical assistance reimbursement for the services of licensed marital and family therapists."*

SB118 adds counseling services provided by a licensed marital and family therapist to the list of optional services covered by the medical assistance program in the state.

Currently, licensed marriage and family therapists are only allowed to provide Medicaid services in community mental health clinics or physician mental health clinics. Including licensed marital family therapists to the provider list of independent licensed practitioners avails more licensed behavioral health professionals to help address the shortage of Medicaid eligible mental health providers in the state.

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version **SB118**
Fiscal Note Number
Publish Date

Identifier (file name) SB118-DHSS-BHA-12-16-11
Title Medicaid Reimbursement for Family Therapy
Sponsor Sen. Davis
Requester Senate HSS Committee

Dept. Affected Health and Social Services
Appropriation Behavioral Health
Allocation Behavioral Health Administration
OMB Component Number 2665

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel	24.0		20.0	20.0			
Services	100.0		100.0	100.0			
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**124.0**	**0.0**	**120.0**	**120.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	62.0		60.0	60.0			
1003	GF Match	62.0		60.0	60.0			
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**124.0**	**0.0**	**120.0**	**120.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

No change.

Prepared by Melissa W. Stone
Division Behavioral Health
Approved by Nancy Rolfzen, Assistant Commissioner
DHSS Finance & Management Services

Phone 269-3410
Date/Time 11/17/11 5:00 PM
Date 12/16/2011

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB118

Analysis

If enacted, this bill would amend AS 47.07.030(b) to include Licensed Marriage and Family Therapists (LMFT) as providers eligible to render and bill for Medicaid funded services as independent practitioners.

Assumptions and Cost Analysis
Whenever a program expansion or redesign occurs the State must assign staff to oversee the program design, development, and implementation, and to maintain on-going operations. Initial efforts involved are primarily directed at training new Medicaid eligible providers regarding the billing and documentation requirements for proper Medicaid claiming.

No additional salary is requested. Behavioral Health staff will provide coordination, support, and oversight as part of their normal and usual duties.

Travel
It is expected that additional travel will be required to meet the goals of this project. Travel will be required for training purposes and for oversight of provider billing processes until the group becomes comfortable with the program requirements. Inadequate training of new providers often results in denied claims or audit exceptions requiring repayment of federal funds.

Year One: A planning team will hold at least two, 2-day meetings in Anchorage to talk about the needs and expectations for the project, review existing training modules, and begin formulating initial ideas and strategies. The second meetingswill provide an opportunity to make final recommendations and training strategies.
$4,000

Year One through Three: Additional travel costs are expected to be incurred for the training phases of this project. Six on-site trainings throughout Alaska are assumed per year.
$20,000

Training - Year one through Three:
Funding will support technical assistance and training from contractors. Duties would include: activities related to the design, planning, and implementation of the program; developing a comprehensive plan for related provider training; developing and conducting evaluations to assess effectiveness of project initiatives; and, developing program, policy or system changes to improve overall program performance. The contract will cover travel costs for the trainers.
$100,000

50% FMAP is assumed.

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version **SB118**
Fiscal Note Number
Publish Date

Identifier (file name) SB118-DHSS-MS-12-16-11
Title Medicaid Reimbursement for Family Therapy
Sponsor Sen. Davis
Requester Senate HSS Committee

Dept. Affected Health and Social Services
Appropriation Medicaid Services
Allocation Behavioral Health Medicaid Services
OMB Component Number 2660

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits	4,650.0		4,650.0	4,650.0	4,650.0	4,650.0	4,650.0
Miscellaneous							
TOTAL OPERATING	**4,650.0**	**0.0**	**4,650.0**	**4,650.0**	**4,650.0**	**4,650.0**	**4,650.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	2,325.0		2,325.0	2,325.0	2,325.0	2,325.0	2,325.0
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)	2,325.0		2,325.0	2,325.0	2,325.0	2,325.0	2,325.0
1178	temp code (UGF)							
TOTAL		**4,650.0**	**0.0**	**4,650.0**	**4,650.0**	**4,650.0**	**4,650.0**	**4,650.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

No change.

Prepared by Kimberlie Poppe-Smart, Deputy Commissioner
Division Health Care Services
Approved by Nancy Rolfzen, Assistant Commissioer
DHSS Finance and Management Services

Phone 307-334-2520
Date/Time 12/16/11 5:00 PM
Date 12/16/2011

(Revised 8/17/2011 OMB)

Analysis

If enacted, this bill would amend AS 47.07.030(b) to include Licensed Marriage and Family Therapists (LMFT) as providers eligible to render and bill for Medicaid funded services as independent practitioners.

Independent licensed practitioners currently eligible by Statute to provide behavioral health services and directly bill Medicaid are:

- Physicians and advanced nurse practitioners - current regulations mandate that all services must be provided directly by the licensed professional
- PhD psychologists - services limited to testing and assessment services based on appropriate referrals
- Licensed clinical social workers (LCSW) - although included in Statute since 1991, funding has never been authorized; currently not a State Plan service

Clinic providers approved to provide behavioral health services and bill Medicaid are:

- Community mental health centers (CMHC) - must be approved grantees of the Division of Behavioral Health
- Physician mental health clinics - require the supervision of an on-site psychiatrist
- Rural health clinics and federally qualified health centers (FQHC) - allowed to bill for services provided by the federally mandated professionals: physicians, nurse practitioners, physician assistants, PhD psychologists, and LCSWs.
- Designated tribal outpatient clinics - limited to services provided directly by physicians, nurse practitioners and physician assistants.

Licensed Marriage and Family Therapists are allowed to provide Medicaid services only in Community Mental Health Clinics or Physician Mental Health Clinics.

Assumptions and Cost Analysis:

- DBH has established a prevalence rate of 25% of the population that has a need for a behavioral health service under the current "medical necessity" definition.
- In FY2010 approximately 120,000 individuals were eligible for Medicaid and approximately 23,000 Medicaid recipients received at least one behavioral health service.
- Based on the prevalence rate, about 30,000 Medicaid clients (25% of 120,000) are actually in need of behavioral health services which indicates approximately 7,000 recipients (30,000 less 23,000) have an unmet need.
- Based on current CMHS rates, the cost would be approximately $1,000 per client per year.
- There are currently 93 Licensed Marriage & Family Therapists. If all 93 licensed LMFTs enrolled and increased their case load to serve 50 clients per year, they would serve 4,650 clients (93 x 50). At a rate of $1000 per recipient the increase in program costs would be $4,650,000 annually.

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version: **SB118**
Fiscal Note Number:
Publish Date:

Identifier (file name): SB118-DHSS-MAA-12-16-11
Title: Medicaid Reimbursement for Family Therapy
Sponsor: Sen. Davis
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Health Care Services
Allocation: Medical Assistance Administration
OMB Component Number: 242

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services	275.0						
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**275.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	206.2						
1003	GF Match	68.8						
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**275.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Updated fiscal note to reflect current fiscal year.

Prepared by: Kim Poppe-Smart, Deputy Commissioner — Phone: 269-7827
Division: Health Care Services — Date/Time: 12/1/11 12:00 AM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date: 12/16/2011
DHSS Finance & Management Services

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB118

Analysis

The Division of Health Care Services projects a one time only cost of $275.0 to cover programming costs in the legacy Medicaid Management Information System (MMIS) associated with providing medical assistance reimbursement for the services of licensed marital and family therapists. The division plans to use programming staff of Affiliated Computer Services (ACS), the current State of Alaska MMIS Medicaid contractor responsible for the disbursement of Medicaid payments. The programming staff of ACS have extensive experience making programming adjustments to the legacy MMIS.

AAMFT
American Association for Marriage and Family Therapy
Advancing the Professional Interests of Marriage and Family Therapists

112 South Alfred Street
Alexandria, VA 22314
Telephone: (703) 838-9808
Fax: (703) 838-9805
Website: www.aamft.org

Medicare Coverage of Marriage and Family Therapists

Issue

Improving access to Medicare-covered mental health benefits by recognizing state licensed Marriage and Family Therapists.

Background

In order for a mental health service to be covered by Medicare, the service must be for the diagnosis and treatment of mental illness. In addition, the mental health service must be delivered by a "covered" practitioner who is legally authorized to perform that service under state law. The covered mental health professionals recognized by Medicare presently include psychiatrists, psychologists, mental health clinical nurse specialists and Clinical Social Workers (CSWs). Marriage and Family Therapists (MFTs) are not listed as Medicare-covered providers despite the fact that MFTs have education, training and practice rights equivalent to or greater than existing covered providers.

Several recent reports have indicated that limited access to mental health services is a serious problem in the Medicare program. This is particularly true in rural areas, which have historically had difficulty attracting and retaining health professionals. According to a recent Surgeon General's report, 37% of seniors display symptoms of depression in a primary care environment. Equally striking is that fact that this depression often goes unrecognized and therefore untreated. The failure to treat depression often leads to more primary care visits and higher Medicare expenditures. The unavailability of qualified mental health professionals compounds the mental health crisis among the elderly population and increases the costs to the program.

Currently, the federal government recognizes five mental health disciplines as core mental health professionals. These are psychiatrists, psychologists, mental health clinical nurse specialists, clinical social workers and marriage and family therapists. Of these five groups, only marriage and family therapists are not recognized by Medicare.

The cost of adding MFTs to Medicare is modest. According to the Congressional Budget Office (CBO), the cost of adding both MFTs and Licensed Professional Counselors (LPCs) to the Medicare program would be 18 million dollars per year. Assuming generously that MFTs account for half those costs, the total outlay will still be a nominal 9 million dollars per year for recognition of MFTs in Medicare.

The U.S. Senate has twice approved legislation recognizing MFTs under Medicare, in 2003 (S. 1) and 2005 (S. 1932). Further, there is bipartisan legislation in the House and Senate to expand Medicare to include MFTs as covered mental health professionals.

Discussion

MFTs are legally authorized through state licensing laws to treat mental illness. MFTs are required to obtain a master's degree in a mental health discipline and two years post-graduate supervised clinical experience, much like existing covered mental health providers, such as clinical social workers. This legislation will not change the mental health benefit or modify the MFT scope of practice, but will merely allow Medicare beneficiaries who need medically necessary covered mental health services to obtain those services from a marriage and family therapist. In essence, our proposal increases the pool of qualified providers that Medicare beneficiaries can choose from without change the services.

Significant shortages of mental health professionals continue to exist in many areas of the country, and rural counties suffer disproportionately. Among 1253 rural counties with 2,500 to 20,000 people, nearly three-fourths lack a psychiatrist, 58 percent have no clinical social worker, and 50 percent are missing a master's or doctoral psychologist. The supply of all these professionals is far lower in the 769 counties with fewer than 2,500 people. Further, the Health Resources Services Administration indicated that 90% of psychiatric and mental health nurses with graduate degrees were in metropolitan areas. There are many counties where only a marriage and family therapist may be present to serve the elderly population. A targeted study of licensed professionals in a sampling of states found many counties with no Medicare mental health providers, but with a marriage and family therapist: including Clayton, Iowa; Hamilton, Florida; Hutchinson, Texas; and Brunswick, Virginia; to name a few.

Federal government agencies also understand the valuable role MFTs play in increasing access to mental health services. The advisory committee to the Secretary of Health and Human Services recently encouraged inclusion of MFTs in the Medicare program. **The National Advisory Committee on Rural Health and Human Services specifically recommended "that the Secretary expand the range of certified mental health providers under Medicare to include marriage and family therapists" in its 2004 report.**

The Health Resources and Services Administration (HRSA) further recognizes MFT's participation in caring for underserved populations. One of HRSA's responsibilities is to identify areas of the country with mental health shortages. The purpose of this designation is to identify communities with unmet mental health service needs and pursue opportunities to recruit qualified mental health professionals to those communities.

Ironically, HRSA counts marriage and family therapists among the "core" providers qualified to deliver necessary mental health services. The failure of the Medicare program to recognize marriage and family therapists leaves many elderly beneficiaries without access to care and creates a conflict in federal law. For example, in communities where the only mental health professional available is a marriage and family therapist, the Health Resources and Services Administration may count that MFT and consider the community well-served. In fact, the elderly of that community have no access to the MFT because Medicare will not recognize the provider. Consequently, the government doesn't even know that there is an access problem because the two federal programs don't have consistent criteria.

Marriage and family therapists are not seeking to expand the scope of mental health services covered by Medicare, nor are they seeking to expand their own scope of practice. Instead, MFTs are simply trying to correct an inequity that restricts beneficiaries' access to a particular type of qualified mental health provider.

Furthermore, MFTs are not seeking higher payments for their services than are currently paid to clinical social workers. Under our proposal, marriage and family therapists would be paid at the same rate as clinical social workers (75% of the psychologists rate) for mental health services already covered by Medicare, which the MFT is legally authorized to provide in the state in which the service was delivered.

The importance of increasing the number of qualified Medicare mental health professionals by including MFTs is supported by many health organizations, including but not limited to the Depression and Bipolar Support Alliance, the National Council for Community Behavioral Healthcare, the National Rural Health Association and the California Primary Care Association.

Recommendation

Improve access to Medicare-covered mental health services by including marriage and family therapists among the list of providers who can deliver covered mental health services and pay for those services at the same rate as clinical social workers.

If you have any questions or need additional information, please contact:
Brian Rasmussen or Melissa Stamps
AAMFT Government Affairs Managers
112 S. Alfred St.
Alexandria, VA 22314
703-253-0463 / 703-253-0445

Share |

Share |

Forgot your password?

Login

Public Professionals Trainees

Home About Press Directories Education and Training Events MFT Resources Advocacy Membership AAMFT Community

Medicaid

Overview

While the majority of health care is provided through the private market, and the largest programs are administered by the federal government, state governments also play a critical role in how healthcare is delivered. There are many health programs that are common across the states, and ensuring MFT recognition and participation by these programs is key to the success of the profession. AAMFT and our divisions have been advocating for MFT inclusion in these critical programs for many years and have made great progress, but there is much work to be done. The following are some of the largest and most influential state healthcare programs and the status of MFT reimbursement. read more (pdf) >

Medicaid is the largest provider of mental health services in the United States. Medicaid is the primary source of health care for low-income families with children, the low-income elderly, and people with disabilities. In 2006, 45 million people were enrolled in Medicaid. Excluding prescription drugs, behavioral healthcare costs amount to 10% of all Medicaid spending.

Medicaid is a joint federal-state partnership in both funding and administration. The federal government funds a majority of all Medicaid spending in almost each state, with poorer states receiving a higher percentage of federal funding. On average, state spending on Medicaid accounts in 2008 accounted for approximately 22% of total spending by the states. Medicaid provides coverage for more than 40% of non-elderly persons living in poverty and 25% of all children.

Medicaid is overseen by the Centers for Medicare and Medicaid Services (CMS), an agency within the United States Department of Health and Human Services. Although federal guidelines require all states to cover specific categories of people and types of benefits, each state administers its own Medicaid program. In each state, the program is administered by an agency designated by the governor as the state Medicaid agency. Most states have a traditional Medicaid program, as well as managed care plans.

Some people confuse the Medicaid program with Medicare, because both were established by federal statute and because there is some overlap in their purpose and beneficiary populations. Both Medicaid and Medicare provide health insurance to the low-income elderly and people with disabilities. Approximately 1 in 6 Medicare beneficiaries are "dual eligibles" who are enrolled in both programs. However, Medicare is purely a federal program, funded and administered at the federal level, in contrast to Medicaid's federal-state partnership.

Medicaid covers a variety of services. State Medicaid programs are required to cover mandatory services, such as physician and hospital services. Additionally, states may cover certain optional services, such as family therapy. Medicaid mental health benefits are covered through several mandatory and optional service categories, such as physician and psychologist services, outpatient services provided in hospitals and clinics, rehabilitation services, and personal care services. Although the states are required to provide mandatory services, the states have discretion in determining the duration and scope of coverage for services.

MFT Recognition in Medicaid

Federal rules allow for the use of MFTs as providers, but do not mandate recognition of MFTs. After many years of advocacy, approximately thirty-eight states now have at least some reimbursement or recognition of Family Therapists in their Medicaid programs. As the largest provider of mental health benefits in a state, comprehensive Medicaid recognition of MFTs is crucial to the success of the profession. The level of recognition is currently varied as many states have multiple Medicaid products and MFTs are covered by some Medicaid products and not others. In some states, MFTs and other Master's level providers can only receive Medicaid reimbursement if their services are performed in a clinic or other institutional setting.

Most states describe the details of their Medicaid services and provider qualifications in a Medicaid provider manual. An examination of this manual is usually the easiest way to determine which mental health benefits are offered and within which service category, and whether MFTs may provide these benefits. Most of these manuals are now available online. Since mental health and substance abuse benefits are provided through several service categories and different provider settings, it is important to examine the entire manual to determine if MFTs are eligible providers in all of the relevant service categories.

State Chart

MFT Recognition in State Medicaid Plans

Community Health Clinics
Physician Mental Health Clinics

State	MFTs included in Medicaid plans?	State	MFTs included in Medicaid plans?
Alaska	Partly	Montana	No
Alabama	Partly	North Carolina	Yes
Arkansas	Yes	North Dakota	No
Arizona	Partly	Nebraska	Yes
California	Yes	New Hampshire	Yes
Colorado	No	New Jersey	Yes
Connecticut	Yes	New Mexico	Yes
District of Columbia	No	Nevada	Yes
Delaware	Yes	New York	No
Florida	Yes	Ohio	Yes

Bookmark this page

Share |

Georgia	Yes	Oklahoma	Yes
Hawaii	Yes	Oregon	Yes
Iowa	Yes	Pennsylvania	No
Idaho	Yes	Rhode Island	Partly
Illinois	Yes	South Carolina	Yes
Indiana	Partly	South Dakota	No
Kansas	Yes	Tennessee	Yes
Kentucky	Partly	Texas	Partly
Louisiana	No	Utah	Yes
Massachusetts	Partly	Virginia	Yes
Maryland	Partly	Vermont	Yes
Maine	Yes	Washington	No
Michigan	No	Wisconsin	Yes
Minnesota	Yes	West Virginia	No
Missouri	No	Wyoming	Yes
Mississippi	No		

Based on data collected by AAMFT staff and reports from AAMFT division leaders. Data represents AAMFT's best estimate of the status of MFT recognition in Medicaid plans for each state. "Partly" means that some, but not all, Medicaid mental health programs, or Medicaid managed care plans recognize MFTs. Even plans that appear to broadly recognize MFTs might not recognize MFTs as providers in each service category or health plan. Since MFT status with these plans is subject to change, AAMFT does not guarantee that these plans will recognize MFTs.

SEHP Fact Sheet

All states offer some form of health benefits for eligible state employees and their dependents. Approximately 3.4 million state employees and retirees are covered by a state employee health plan. The AAMFT has developed the following fact sheet concerning these plans and the role of MFTs within these plans.

read more >

TherapistLocator

Over 15,000 marriage and family therapists are listed in TherapistLocator.net. The therapists are Clinical Members of the AAMFT, and as such must meet stringent training and education requirements established by the AAMFT. All AAMFT Clinical Members have agreed to abide by the AAMFT Code of Ethics. This Directory will assist you in locating a marriage and family therapist in your area. When seeking the services of a marriage and family therapist be sure to ask if your potential therapist is a Clinical Member of the AAMFT or look for the following logo identifying a Clinical Member of the AAMFT.

Visit the AAMFT TherapistLocator.net, a public service of the AAMFT. There you will find information about a range of problems facing today's families, and you can search for a qualified family therapist in your area.

read more >

Vendorship Fact Sheet

In a majority of states, MFTs have achieved recognition under state Freedom of Choice (Vendorship) and Any Willing Provider laws. These laws require certain health plans to reimburse MFTs for providing mental health services covered by the plan. The following fact sheet developed by AAMFT provides an overview of MFT recognition under these laws in each state.

read more >

American Association for Marriage and Family Therapy
112 South Alfred Street Alexandria, VA 22314-3061
Phone: (703) 838-9808 | Fax: (703) 838-9805

© 2002 - 2011 American Association for Marriage and Family Therapy Terms of Use | Privacy Statement

Bookmark this page

Alaska Association of Marriage and Family Therapists

Linda R. King, President

Phone: 907 862-2352 • Fax: 907 522-7088 • E-Mail: lrking@hotmail.com
www.akamft.org

February 9, 2011

Governor Sean Parnell
Governor of the State of Alaska
Juneau, Alaska

Dear Governor Sean Parnell,

I am writing to you on behalf of the Board of the Alaska Division of the American Association for Marriage and Family Therapy.

We have been a part of the Alaska Mental, Behavioral, and Family Health system for many years. Our profession is recognized throughout the United States and in Alaska. Alaska has its own licensing Board of Marriage and Family Therapy in the Division of Professional Licensing. Our scope of practice includes most all mental health issues with a specialized perspective involving relationships (AS 08.63.900(5)(A) (B)). From this perspective, our colleagues are trained and treat all manner of mental health issues from a systems approach/awareness.

It has come to our attention through colleagues and Department of Health and Human Services publications that Alaska has a significant decrease in mental health providers. It appears that the State paradigm overlooks available and capable therapists already within the State. This can easily be corrected by amending AS47.07.030 to include licensed marriage and family therapists (LMFTs) and by changing the Medicaid regulations to pay fee for services to those professionals acknowledged on AS47.07.030.

We implore you to support the necessary changes to include LMFTs. The following is based on our research and analysis of the issues:

- Psychologists and licensed clinical social workers (LCSWs) are already acknowledged.
- The reimbursement rate for LMFTs would be the same as LCSWs.
- If there was an increase of beneficiary services by LCSWs the fiscal impact would be the same as if LMFTs were added to the State Medicaid Provider List.
- There are already LMFTs in State granted programs that currently bill Medicaid for acknowledged services rendered. This margin appears to represent two-thirds of current LMFTs.

- Of the total number of LMFTs in Alaska, many would not elect to become providers for a variety of reasons. It could be due to low reimbursement rates, a large number of existing clients, paperwork hassle, etc. It would be good to know the percentage of total LCSWs who are Medicaid eligible. For instance, in one state that I looked at last month, only 24% of the total number of licensed professional counselors (LPCs), who are Medicaid eligible in this state, elected to participate in Medicaid. Many LMFTs will elect not to participate in Medicaid.

- Almost all of the LMFTs would be treating clients who would receive treatment anyway even if LMFTs were not in the plan. In other words, most MFT services would merely be in substitution for the services of another provider type. Russell Crane, Ph.D. at Brigham Young University describes this "substitution effect" in terms of MFT access to Medicare (see supplemental attachment). This study conservatively estimates the substitution effect at 50%. I could argue that this percentage would actually be higher than 50%.

- The administrative cost of adding LMFTs would be zero or very minimal. LMFTs would be performing the same services as LCSWs. There would not be expansion of Medicaid services, but merely the addition of a new profession that enrollees would be allowed to access.

- Also, according to State Statute AS21.36.090(d) it is unfair discrimination to a beneficiary of a group health insurance policy to exclude providers who are recognized State licensed providers, which includes LMFTs.

- In addition, the Governor's office has taken a stance against domestic violence (DV). The etiology of DV is complex, involving more than the issue of anger. The common thread in DV is relational conflict learned through multi-generational patterns. What professional therapist is better equipped to help with mental health/relational issues of DV than a LMFT.

Now is the time to fix this dilemma. The need is current, the problem is real, the desire to change is echoed throughout the State, and the fiscal impact is minimal compared to other more intrusive interventions that result without inclusion (e.g., law enforcement, hospitalization, court involvement, etc). Therefore, we of the Board of the Alaska Association for Marriage and Family Therapy encourage supporting any Bills or Regulation changes to avail all LMFTs to serve Medicaid Beneficiaries whether it be in an agency or private practice setting.

Linda R. King, LMFT

Linda R. King, LMFT
President of AK AMFT

Board Members: John Pagan, President Elect : Cynthia Boliver, Treasurer: Richard Kurtz, Secretary, Ken McCarty, Markie Blummer, Michael Murray, Members at large

Bruce Bardwell, LMFT
PO Box 3343
Homer, AK 99603
bruce.bardwell@gmail.com
907-235-9241

Re: SB118

To Senator Davis

I am a licensed Marriage and Family Therapist in the state of Alaska (Lic#- 235), and I have been a practicing therapist for 30 years both in Alaska and in Washington State. I am writing in support of SB118 which would reimburse LMFTs in Alaska for serving Medicaid clients. I currently work as an outpatient therapist at The Center in Homer with therapists who have MSW, LPA, LPC, designations, and I have found that we all have had a similar level of training and supervision. There isn't one type of therapy degree that is better, more rigorous, or more competent than another. By granting reimbursement to LMFTs, citizens of Alaska will be given a greater selection of competent therapists to choose from which will lead to better outcomes for all. Thank you for your support of this legislation.

Sincerely,

Bruce Bardwell, LMFT

Bruce Bardwell, LMFT

Human Relations Center

1600 A Street, Suite 104
Anchorage, Alaska 99501

Phone: (907) 272-5500
Fax: (907) 277-0985

Val Anderson
Office Manager

Sandy Bhargava, LPC
Licensed Professional Counselor

Vicki Heinz, LMFT
Licensed Marriage & Family Therapist

Karen Senzig, Psy. D.
Licensed Clinical Psychologist

Glen Williams, Ph. D.
Licensed Clinical Psychologist

March 3, 2011

Dear Senator Davis,

I am a licensed marriage and family therapist practicing in the Anchorage area for over 20 y ears. I am writing for your support to include me and my fellow marriage and family therapists in AS47.07.030. I feel that this will give the Medicaid recipients in Alaska seeking behavioral health services more choice and availability when their need is greatest. I also feel that it expresses parity among the licensed mental health providers.

Thank you so much for you interest and attention to this important legislation.

Vicki Heinz, LMFT

Vicki Heinz, LMFT
Past President AKAMFT

Human Relations Center

1600 A Street, Suite 104
Anchorage, Alaska 99501

Phone: (907) 272-5500
Fax: (907) 277-0985

Val Anderson
Office Manager

Sandy Bhargava, LPC
Licensed Professional Counselor

Vicki Heinz, LMFT
Licensed Marriage & Family Therapist

Karen Senzig, Psy. D.
Licensed Clinical Psychologist

Glen Williams, Ph. D.
Licensed Clinical Psychologist

April 4, 2011

Dear Senator Bettye Davis,

It was nice to meet you and thank you personally for your sponsorship and support of HB118 recently at Baxter Elementary. We feel that it is important that our profession is recognized as one of the key providers of family therapy in Alaska. It is also important that our clientele who have Medicaid insurance have options when they are in need of mental health care. Due to the shortage of Medicaid providers available, they are often met with long waiting lists or in some cases fly to other locations in the state to receive care at an even greater cost.

Thank you for your support of HB118.

Sincerely,

Vicki Heinz LMFT

Vicki Heinz, LMFT
Past President AKAMFT

Sen. Bettye Davis

From: Mike Magowan [mmagowan@gci.net]
Sent: Monday, April 04, 2011 9:56 PM
To: Sen. Bettye Davis
Subject: SB118

RECEIVED
APR 05 2011

Senator Davis. I support SB118. Thank you very much for your efforts. Michael Magowan, LMFT

Bruce Bardwell, LMFT
PO Box 3343
Homer, AK 99603
bruce.bardwell@gmail.com
907-235-9241

Re: SB118

To Senator Davis

I am a licensed Marriage and Family Therapist in the state of Alaska (Lic#- 235), and I have been a practicing therapist for 30 years both in Alaska and in Washington State. I am writing in support of SB118 which would reimburse LMFTs in Alaska for serving Medicaid clients. I currently work as an outpatient therapist at The Center in Homer with therapists who have MSW, LPA, LPC, designations, and I have found that we all have had a similar level of training and supervision. There isn't one type of therapy degree that is better, more rigorous, or more competent than another. By granting reimbursement to LMFTs, citizens of Alaska will be given a greater selection of competent therapists to choose from which will lead to better outcomes for all. Thank you for your support of this legislation.

Sincerely,

Bruce Bardwell, LMFT

Bruce Bardwell, LMFT

RECEIVED

MAR 24 2011

Mercy Dennis M.A., L.M.F.T.

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

March 23, 2011

Attention: Senator Davis

Regarding: AS47.07.030.

First I want to thank you for authoring legislation that incorporates Licensed Marriage and Family Therapists As Eligible Medicaid Providers under Statute AS47.07.030. It is important that consumers have the right to choose from those Alaska licensed professionals who are qualified to provide the services they need.

Licensed Marriage and Family Therapists have been a part of the Alaska Mental Health System for many years. Our scope of practice includes treating most all mental health issues, as do Licensed Clinical Social Workers and Psychologists, who are already acknowledged in AS47.07.030.

From my experience of talking with prospective clients there is a shortage of Medicaid Eligible Mental Health Providers in the state. Since I am not authorized to see Medicaid clients I always try to refer those folks to qualified professionals who are authorized. I find this pool of available providers to be very small and I hear the frustration of those inquiring clients. Including LMFTs to the list of eligible Medicaid providers will help correct this shortage and better serve our Alaskan Mental Health Consumers.

Sincerely,

Mercy Dennis

Mercy Dennis, LMFT

1010 West Tenth Avenue Anchorage, Alaska 99501 (mailing address)
2605 Denali, Suite 203 Anchorage Alaska 99503 (office address)
907-278-5522 phone / 907-258-6613 fax / info@mercydennis.com

Sen. Bettye Davis

m: Michael Weingarten [michaelweingarten@yahoo.com]
nt: Wednesday, March 16, 2011 12:03 PM
To: Sen. Bettye Davis
Subject: LMFT Support

RECEIVED
MAR 16 2011

I am a Licensed Marriage and Family Therapist. I have been an Anchorage resident since 1979.

LMFT's are well trained to treat many types of mental health problems, including many issues that arise in the Medicaid population.

I understand that you are moving forward to assist us with legislation which incorporates Licensed Marriage and Family Therapists As Eligible Medicaid Providers under AS47.07.030

I appreciate your efforts!

Sincerely,
Michael Weingarten, MA, LMFT
Anchorage, AK

Michael Weingarten
3705 Arctic Blvd. # 1516
(District 22) 99503

Therapists Bill

Sen. Bettye Davis

From: Vicki Heinz [vickiheinz@hotmail.com]
Sent: Monday, March 21, 2011 6:51 PM
To: Celeste Hodge; Ken McCarty; Linda King; Leon Weber; joann.young@premera.com
Cc: Sen. Bettye Davis
Subject: RE: An Act providing medical assistance reimbursement for the services of licensed marriage & family therapists

Celeste,
I am past president of AKAMFT and a board member. I am in support of the draft legislation. I would like to thank Senator Davis again for her support of our occupation and this legislation.
Vicki Heinz, LMFT

From: Celeste_Hodge@legis.state.ak.us
To: discoverycove@alaska.net; vickiheinz@hotmail.com; lrking@hotmail.com; ltw@alaska.net; joAnn.Young@PREMERA.com
CC: Senator_Bettye_Davis@legis.state.ak.us
Date: Mon, 21 Mar 2011 15:08:45 -0800
Subject: An Act providing medical assistance reimbursement for the services of licensed marriage & family therapists

Senator Davis would like you to review the attached draft legislation "An Act providing medical assistance reimbursement for the services of licensed marriage and family therapists" and email if you support or have concerns with the legislation. Please call me if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide
Senate Health & Social Services Committee
Office of Senator Bettye Davis
716 W. 4th Avenue #400
Anchorage, Alaska 99501
(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)
State Capitol
Juneau, Alaska 99801
(907) 465-4906; (907) 465-3756 (Fax)
Toll Free: 1-800-770-3822
Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Celeste Hodge

From: Linda King [lrking@hotmail.com]
Sent: Monday, March 21, 2011 7:32 PM
To: Celeste Hodge
Subject: Re: An Act providing medical assistance reimbursement for the services of licensed marriage & family therapists

Celeste
I am the president of the AKAMFT. I regret I was out of town and couldn't personally tell senator Davis thank you! It looks great please accept our appreciation for all your work.
With regards,
Linda King,LMFT

Sent from Linda's iPhone

On Mar 21, 2011, at 4:08 PM, Celeste Hodge <Celeste_Hodge@legis.state.ak.us> wrote:

> Senator Davis would like you to review the attached draft legislation "An Act providing medical assistance reimbursement for the services of licensed marriage and family therapists" and email if you support or have concerns with the legislation. Please call me if you have questions. Thanks.

Celeste Graham-Hodge, Committee Aide

Senate Health & Social Services Committee

Office of Senator Bettye Davis

716 W. 4th Avenue #400

Anchorage, Alaska 99501

(907) 269-4049; (907) 269-0148 (Fax)

(While in Session)

State Capitol

Juneau, Alaska 99801

(907) 465-4906; (907) 465-3756 (Fax)

Toll Free: 1-800-770-3822

Celeste_Hodge@legis.state.ak.us

Confidentiality Notice: This e-mail message including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

<Providing Medical Assistance Reimb LMFT.pdf>

Alaska Association of Marriage and Family Therapists

Linda R. King, President

Phone: 907 862-2352 • Fax: 907 522-7088 • E-Mail: lrking@hotmail.com
www.akamft.org

March 3, 2011

Dear Senator Davis,

I am writing to you on behalf of the Board of the Alaska Division of the American Association for Marriage and Family Therapy and as a clinician.

I am the clinical supervisor for Cornerstone Clinic in Anchorage. For years we have been fighting the battle of not being able to see Medicaid clinics. We have pursued several psychiatrists with no success. We are unique clinic that includes family practice medical facility and a counseling center. Two years ago equipped a play therapy room to better serve children. We have two therapists who have received extra training in play therapy. Every week we turn away children who desperately could use our services because we cannot take Medicaid. These children are referred to agencies with waiting list and are eventually seen. The Medicaid dollar is being spent on many of these children, but unfortunately it takes our qualified therapists out of the loop because they don't choose to work for one the few agencies available to these clients.

Please seriously consider putting Marriage and Family Therapist on the Statute AS47.07.030.

Sincerely,

Linda R. King, LMFT

Linda R. King, LMFT
President of AK AMFT

Sen. Bettye Davis

From: Karla Gelhar [karlamarie507@gmail.com]
Sent: Monday, April 11, 2011 10:04 AM
To: Sen. Bettye Davis
Subject: Include MFTs in SB118

Dear Senator Davis,

I am writing to support including Marriage and Family Therapists (MFTs) in the SB118 bill. I live in Ketchikan and am in graduate school to become a licensed marriage and family therapist in Alaska. There is such a need for holistic care of children, parents and couples here in Ketchikan and all over the state. Please include MFTs in the bill so everyone has the opportunity to access support for their family and relationships. Often times a child will be referred for services and progress will occur, however, the child is sent right back to the hurting environment of the family. Children, parents and couples need support as a group as well as individually. Please include MFTs in the SB118 bill to support Alaska's families.

On a side note. When choosing marriage and family therapy I was shocked that the masters program was 92 credit hours versus a masters in counseling psychology was only 52 credits. MFTs are the 'newest kid on the block' and have extensive training and supervision and have earned equal status within licensed mental health professionals.

Thank you for the work you do on behalf of Alaskan families,

Karla M Gelhar
Ketchikan, AK
karlamarie507@gmail.com
907.821.1543

LAURA PATIN LMFT, LPC

11517 Old Glenn Highway Suite 204
Eagle River, AK 99577
(907) 694-2314
laurapatin@~~gci.net~~ yahoo

April 4, 2011

Attention: Senator Dyson
Regarding: AS47.07.030.

First I want to thank you for authoring legislation that incorporates Licensed Marriage and Family Therapists As Eligible Medicaid Providers under Statute AS47.07.030. It is important that consumers have the right to choose from those Alaska licensed professionals who are qualified to provide the services they need.

Licensed Marriage and Family Therapists have been a part of the Alaska Mental Health System for many years. Our scope of practice includes treating most all mental health issues, as do Licensed Clinical Social Workers and Psychologists, who are already acknowledged in AS47.07.030.

From my experience of talking with prospective clients there is a shortage of Medicaid Eligible Mental Health Providers in the state. Since I am not authorized to see Medicaid clients I always try to refer those folks to qualified professionals who are authorized. I find this pool of available providers to be very small and I hear the frustration of those inquiring clients. Including LMFTs to the list of eligible Medicaid providers will help correct this shortage and better serve our Alaskan Mental Health Consumers.

Sincerely,

L. Patin LMFT. LPC

Laura Patin, LMFT, LPC

Ken McCarty, LMFT
Licensed Marriage Family Therapist
Discovery Cove Recovery and Wellness Center
2975 Mill Bay Rd. Suite B - Kodiak, AK 99615
Phone: (907) 487-2223 * Fax (907) 487-2229

3/10/11

Bettye Davis
Senator
Juneau, Alaska

Dear Senator Betty Davis,

Thank you for serving our community in Anchorage and this Great State of Alaska. Senator Stevens knows about this issue. Senator Stevens is informed and interested in this issue but as the President of the Senate does not believe that it is his role to present a bill at this time. The proposal is amending AS 47.07.030 to include Licensed Marriage Family Therapists to the list of eligible, viable professionals to serve Alaskans who are beneficiaries of Medicaid.

The problem is Medicaid and the current State Statutes and Regulations that avail Medicaid benefits. The problem is providers and not having enough of them who are willing to take Medicaid payments and demands. The problem is State Statutes that currently disqualify licensed professional therapist because of their license, though such licenses are recognized by the State of Alaska, but not recognized on a Statute "role call." The problem is State regulations that inhibit professional therapists from even being a candidate to serve Medicaid beneficiaries even if their name is on the "Statute role call list."

In October 2010, according a representative of the Department of Behavioral Health (D.B.H.) that there is a 28% decline in therapists throughout the State. When asked if that decline is due to funding the answer was no, rather due to the inability to find qualified therapists. The current system with the D.B.H. appears to exclusively serve agency recipients who qualify under their selective criteria. This process eliminates providers throughout the State that can fill the need.

I am a licensed Marriage Family Therapist in Kodiak. I came to Kodiak to direct / team lead a D.B.H. authorized agency. I was asked to come to integrate mental health and substance treatments. In March of 2009 I departed the agency and was led to start a private practice named Discovery Cove. Over the nearly two years I had multiple requests from constituents in Kodiak if I could see them for counseling. Their funding source was Medicaid. The consistent theme was these individuals did not want to go to the "only Medicaid service center in town." I explored avenues to be a Medicaid provider but to no avail. I was told on several occasions by D.B.H. that these constituents do have options...the single service center in town. To have only one place to be served is not an option.

In February 2010 Discovery Cove began the medicated assisted treatment (Suboxone) for those addicted to opiates. The efficacy of the program is in the collaboration of medication and psycho-social group / individual treatment. We are the only provider in Kodiak that is doing this treatment. The psychiatrist who serves Discovery Cove flies in monthly to serve these clients. The psycho-social groups occur twice a week for beginning clients and once a month for those in continuing care clients. To date we have served 23 clients. Discovery Cove can bill Medicaid for services with the psychiatrist but we cannot bill for services for the psycho-social groups and individual sessions, as they are conducted by licensed professionals not on the "roll call list." The D.B.H. approved agency refuses to do this treatment and even proclaims the treatment ineffective. The D.B.H. endorses the treatment and this year the State of Alaska Annual School of Addiction Conference theme is Rx Treatment, which I have been honored again as a guest speaker. Therefore, those constituents who are Medicaid beneficiaries who cannot afford "out-of-pocket" treatment are flown to Anchorage by Medicaid for their treatment.

The D.B.H. has informed me that Discovery Cove is the only private practice agency in the State of Alaska that is offering a comprehensive (physician / mental health) program for clients. I have tried to help other private practice facilities and agencies establish similar programs but they have not been able to duplicate what we have created. The week of Thanksgiving 2010 I received a telephone call from the Anchorage Neighborhood Health Clinic informing me that they were shutting down their Suboxone program for various reasons, none of which was the ineffectiveness of the treatment. I have been asked by several entities in Anchorage if I could come and create a treatment center, like Kodiak's Discovery Cove. I am courting the idea. The problem again is with treating the Medicaid beneficiaries. I already have a Licensed Professional Counseling (LPC) who is experienced in substance treatment, who is eager to help. I have been looking for offices near The People Mover stops. The need is great. There are few treatment providers and those in existence are already at their maximum capacity to receive clients. The Anchorage Neighborhood Health Clinic just let go of some 70 people this past year who were in their program. Opportunity to serve exists but the Statute and Regulation guidelines are thwarting that service. Even this week as we move forward to establishing another office in Alaska in the Anchorage area I have been receiving call throughout Alaska of people willing to fly in for services.

The issue that I am present does not exclusively affect Ken McCarty and Discovery Cove. I know of providers in Fairbanks, Talkeetna, Nome, Anchorage, and Juneau who are willing to be Medicaid providers but because of D.B.H. rules of being a private practice provider and/or having the "wrong" professional license they cannot serve. I believe that the 28% void of therapist can be easily filled without soliciting outside of Alaska. Over 2,000 years ago a saying was made of "the harvest is plentiful the workers are few, pray to the Lord of the harvest for more workers." It is my belief that just as in the case then as it is now that the issue is not that there are an insufficient amount of workers to help in the harvest rather restrictive paradigms that inhibit. I implore you to change the paradigm and unleash the workers.

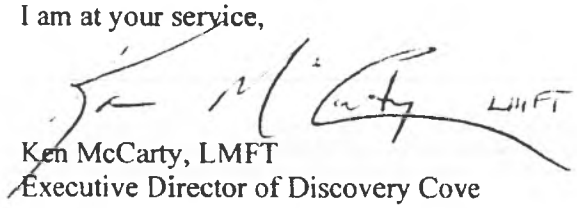
Necessity to resolve the lack of licensed mental health professionals:

- Amend Statute AS 47.07.030 to include licensed Marriage Family Therapists (LMFT) and Licensed Professional Counselors (LPC)
- Amend State of Alaska Medicaid Regulations to pay private providers who are acknowledged in the amended State Statute
- Amend the Department of Behavioral Health to acknowledge and be more provider friendly with private providers who are willing to receive Medicaid

- Allow for Fee for Service paradigms with allowance of multiple available providers in a given area thus availing true options and stimulation of healthy professionalism.

I have been blessed with a thriving private practice to serve and bring healing to the community of Kodiak. I am a provider for many managed care insurance programs. I am frequently solicited by the military to come provider services in Anchorage and Fairbanks. I am honored to serve those who have the means to pay and have done pro-bono work for those who cannot. I am honored to serve on the Governor Board of Marriage Family Therapists. And, as you have read, I am grieved by those Medicaid beneficiaries who are restricted to receive appropriate health services whether it be for mental health or substance treatment.

I am at your service,



Ken McCarty, LMFT
Executive Director of Discovery Cove
(9070) 487-2223

APR 08 2011

MAUREEN CHRISTENSEN, M.ED.

Licensed Marital and Family Therapist

April 7, 2011

Attention: Senator Davis
Senator Egan
Senator Ellis
Senator Meyer
Senator Dyson

Regarding: SB1118

Thank you for your support of SB118. Licensed Marriage and Family Therapists are qualified to be providers of mental health services for individuals and families who are Medicaid eligible.

I appreciate your support for this legislation.

Sincerely,

Maureen Christensen

Maureen Christensen LMFT

4235 Laurel, Suite #230 · Anchorage, Alaska 99508 · Ph. (907)-561-3210

04/07/2011 11:02 9075620780 TUDOR PROF BLDG #5690 P.001 /001

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

January 31, 2011

Briefing: Consideration for Adding Licensed Marriage and Family Therapists As Eligible Medicaid Providers

Introduction

The Department of Health & Social Services is providing this brief in response to an inquiry received asking for the inclusion of Licensed Marriage and Family Therapists as providers eligible to render and bill for Medicaid funded services as independent practitioners.

Background

Currently, the **independent licensed** practitioners eligible by Statute to provide behavioral health services and directly bill Medicaid are:

- Physicians and advanced nurse practitioners - current regulations mandate that all services must be provided directly by the licensed professional
- PhD psychologists - services limited to testing and assessment services based on appropriate referrals
- Licensed clinical social workers (LCSW) - although included in Statute since 1991, funding has never been authorized; currently not a State Plan service.

Clinic providers approved to provide behavioral health services and bill Medicaid for are:

- Community mental health centers (CMHC) - must be approved grantees of the Division of Behavioral Health
- Physician mental health clinics - require the supervision of an on-site psychiatrist
- Rural health clinics and federally qualified health centers (FQHC) - allowed to bill for services provided by the federally mandated professionals: physicians, nurse practitioners, physician assistants, PhD psychologists, and LCSW's.
- Designated tribal outpatient clinics - limited to services provided directly by physicians, nurse practitioners and physician assistants.

Within the clinic categories listed above, Licensed Marriage and Family therapists are allowed to provide Medicaid services only in Community Mental Health Clinics or Physician Mental Health Clinics.

Issues

For years, the department has received requests to expand the scope of behavioral health services from individual practitioners, professional organizations and advocacy groups. These requests and the related issues below should be considered in this program expansion discussion:

1. Cost. Initial service cost projections and numbers of people served are included below.

2. Medicaid State Plan. Changes to the Medicaid program require submission of an Amendment to the State Plan for consideration and approval by CMS.

3. Program Coverage. When a new eligible provider group is added, regulations must be developed which outline scope of services, service definitions and documentation requirements, place of service requirements, service limits, service authorization requirements and rates.

4. Access to care. Addition of new or revised Medicaid benefits improves access to care for beneficiaries who have more options for care or more available service providers.

5. Medical Necessity. Coverage and services descriptions must support "medical necessity". The practice of marital and family therapy is defined as: "the diagnosis and treatment of mental and emotional disorders that are referenced in the standard diagnostic nomenclature for marital and family therapy, whether cognitive, affective, or behavioral, within the context of human relationships, particularly marital and family systems"[1]. Very often, the diagnostic codes referenced are the V-Codes[2] which describe factors influencing health status and are generally not approved diagnoses for Medicaid coverage. If the State were to revise the "medical necessity" definition to account for the scope of practice of LMFT's all other qualified behavioral health providers would also be eligible to similarly expand services. This would allow for the provision of services to recipients who do not currently qualify for services.

6. Medicaid Management Information System (MMIS). The MMIS must be redesigned.

7. Rates. The development of a rate methodology including a concurrent rate review is required.

8. Service Authorization/Service limits. If program coverage guidelines include service limits or the need for service authorization, the department must develop the clinical guidelines for use in approving services.

9. Staff. Whenever a program expansion or redesign occurs the State must assign staff to oversee the program design, development, and implementation, and to maintain on-going operations.

10. Workforce. One possible effect of adding a new provider group is the potential migration of employees from grant funded non-profit agencies to the private sector

[1] AS 08.63.900(5)
[2] Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., Text Revision; Relational Problems (pg.736 – 743)

11. Eligible providers. A primary concern regarding the addition of a new provider type is the consequent inclusion of other licensed providers. As noted above, LCSW's have not been included as providers though they have requested coverage. Likewise psychologists have requested to expand the type of services they may provide. Independent physicians have requested the ability to bill for services provided under their direction by psychologists, LCSW's, LMFT's and licensed professional counselors (LPC). FQHC's have also requested the ability to add both LMFT's and LPC's as eligible practitioners. In general, approving one or more new licensed professional groups would in all likelihood stimulate other licensed professional groups to question why they were not considered.

12. Impacts to other initiatives. Any modifications to the State Medicaid Plan will affect and be affected by system related projects

13. Transportation/telemedicine. Changes in program coverage always have some impact on Medicaid transportation costs. Because savings in the transportation budget historically have not offset costs associated with new programs, transportation has generally not been used as a primary factor in support of new services. Medicaid coverage (with few exceptions) allows practitioner services to be provided via telemedicine. The department continues to support the use of telemedicine as an alternative to transportation whenever possible.

Impact and Cost Analysis

- DBH has established a prevalence rate of 25% of the population that has a need for a behavioral health service under the current "medical necessity" definition.
- In FY 10 approximately 120,000 individuals were eligible for Medicaid and approximately 23,000 Medicaid recipients received at least one behavioral health service.
- Based on the prevalence rate, about 30,000 Medicaid clients are actually in need of behavioral health services which indicates approximately 7,000 recipients have an unmet need.
- **If all licensed LMFT's (93) enrolled and increased their case load to serve 50 clients per year, they would serve 4,650 clients. At a rate of $1000 per recipient the increase in program costs would be $4,650,000.**

Conclusion

Based on the complicating factors listed and budget impact the department is not proposing the addition of LMFT's at this time.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

January 31, 2011

Briefing: Consideration for Adding Licensed Marriage and Family Therapists As Eligible Medicaid Providers

Introduction

The Department of Health & Social Services is providing this brief in response to an inquiry received asking for the inclusion of Licensed Marriage and Family Therapists as providers eligible to render and bill for Medicaid funded services as independent practitioners.

Background

Currently, the **independent licensed** practitioners eligible by Statute to provide behavioral health services and directly bill Medicaid are:

- Physicians and advanced nurse practitioners - current regulations mandate that all services must be provided directly by the licensed professional
- PhD psychologists - services limited to testing and assessment services based on appropriate referrals
- Licensed clinical social workers (LCSW) - although included in Statute since 1991, funding has never been authorized; currently not a State Plan service.

Ken McCarty 1/31/11 7:22 PM
Comment: I hear from the psychologists in the State that currently they are being denied acknowledgement from Alaska Medicaid

Clinic providers approved to provide behavioral health services and bill Medicaid for are:

- Community mental health centers (CMHC) - must be approved grantees of the Division of Behavioral Health
- Physician mental health clinics - require the supervision of an on-site psychiatrist
- Rural health clinics and federally qualified health centers (FQHC) - allowed to bill for services provided by the federally mandated professionals: physicians, nurse practitioners, physician assistants, PhD psychologists, and LCSW's.
- Designated tribal outpatient clinics - limited to services provided directly by physicians, nurse practitioners and physician assistants.

Within the clinic categories listed above, Licensed Marriage and Family therapists are allowed to provide Medicaid services only in Community Mental Health Clinics or Physician Mental Health Clinics.

Issues

For years, the department has received requests to expand the scope of behavioral health services from individual practitioners, professional organizations and advocacy groups. These requests and the related issues below should be considered in this program expansion discussion:

1. Cost. Initial service cost projections and numbers of people served are included below.

2. Medicaid State Plan. Changes to the Medicaid program require submission of an Amendment to the State Plan for consideration and approval by CMS.

3. Program Coverage. When a new eligible provider group is added, regulations must be developed which outline scope of services, service definitions and documentation requirements, place of service requirements, service limits, service authorization requirements and rates.

4. Access to care. Addition of new or revised Medicaid benefits improves access to care for beneficiaries who have more options for care or more available service providers.

5. Medical Necessity. Coverage and services descriptions must support "medical necessity". The practice of marital and family therapy is defined as: "the diagnosis and treatment of mental and emotional disorders that are referenced in the standard diagnostic nomenclature for marital and family therapy, whether cognitive, affective, or behavioral, within the context of human relationships, particularly marital and family systems"[1]. Very often, the diagnostic codes referenced are the V-Codes[2] which describe factors influencing health status and are generally not approved diagnoses for Medicaid coverage. If the State were to revise the "medical necessity" definition to account for the scope of practice of LMFT's all other qualified behavioral health providers would also be eligible to similarly expand services. This would allow for the provision of services to recipients who do not currently qualify for services.

6. Medicaid Management Information System (MMIS). The MMIS must be redesigned.

7. Rates. The development of a rate methodology including a concurrent rate review is required.

8. Service Authorization/Service limits. If program coverage guidelines include service limits or the need for service authorization, the department must develop the clinical guidelines for use in approving services.

9. Staff. Whenever a program expansion or redesign occurs the State must assign staff to oversee the program design, development, and implementation, and to maintain on-going operations.

Ken McCarty ..., 1/31/11 7:35 PM
Comment: This is already in existence.

Ken McCarty ..., 1/31/11 7:23 PM
Comment: This statement is inaccurate. MFT's can diagnose most all DSM nomenclature. V-Codes are not acceptable for Medicaid but they are not the only diagnostic code MFT's use. In fact I rarely use them for my clients, as many are not V-code clients. There is no desire to change the "Medical Necessity." This comment is a distractive statement with the appearance to illicit fear and confusion rather then truth!

Ken McCarty ..., 1/31/11 5:31 PM
Comment: This comment too seems with error as new providers do not alter a data base. If it is referring to AKAIMS that data base system is considered a joke in the provider community and is a waste of tax payers money. Those who support it are the ones who are getting paid by the State.

Ken McCarty ..., 1/31/11 7:25 PM
Comment: There is no need for a special rate review. A CPT code of 90806 is the same for all providers / clinicians

Ken McCarty ..., 1/31/11 7:30 PM
Comment: This is another inaccurate statement. Current Medicaid leaves an open ended number of client sessions for Community Mental Health Centers and does not question the potential gouging of the system. For a private provider referral is based on success and success is based on healing and limited time needed for counseling.

Ken McCarty ..., 1/31/11 7:34 PM
Comment: The State already has people doing these things. This is not requiring a major development of a bureaucratic agency

[1] AS 08.63.900(5)
[2] Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., Text Revision; Relational Problems (pg.736 – 743)

10. Workforce. One possible effect of adding a new provider group is the potential migration of employees from grant funded non-profit agencies to the private sector

11. Eligible providers. A primary concern regarding the addition of a new provider type is the consequent inclusion of other licensed providers. As noted above, LCSW's have not been included as providers though they have requested coverage. Likewise psychologists have requested to expand the type of services they may provide. Independent physicians have requested the ability to bill for services provided under their direction by psychologists, LCSW's, LMFT's and licensed professional counselors (LPC). FQHC's have also requested the ability to add both LMFT's and LPC's as eligible practitioners. In general, approving one or more new licensed professional groups would in all likelihood stimulate other licensed professional groups to question why they were not considered.

12. Impacts to other initiatives. Any modifications to the State Medicaid Plan will affect and be affected by system related projects

13. Transportation/telemedicine. Changes in program coverage always have some impact on Medicaid transportation costs. Because savings in the transportation budget historically have not offset costs associated with new programs, transportation has generally not been used as a primary factor in support of new services. Medicaid coverage (with few exceptions) allows practitioner services to be provided via telemedicine. The department continues to support the use of telemedicine as an alternative to transportation whenever possible.

Ken McCarty 1/31/11 7:42 PM
Comment: Is this statement suggesting that the State's Medicaid is trying to control employee choices through fiscal threats? There are State supported agencies who are refusing to do State of the Industry treatment and keep therapists from providing those services that are Evidenced Based; and the employee compromises client treatment and their ethics due to a State assured paycheck. Availing Fee for Service places competency into competition which is a win / win with the loser being the agency who doesn't want to change and is expecting the entitlement of the State.

Ken McCarty 1/31/11 7:44 PM
Comment: This is a "Baby with the Bathwater Statement." LCSW's, LMFT's, and LPC's are already recognized to be paid by Medicaid when in an State authorized agency. The proposal is to recognize them in private practice settings too.

Ken McCarty 1/31/11 7:48 PM
Comment: Physicians are under scrutiny and value their privileged license. Telemedicine is a too as exception but behavioral health / substance client care has been best accomplished through one-on-one evaluation and update. I do telemedicine with my clients and the psychiatrist when he is not available, but there are things he cannot assess on a screen compared to in person.

Ken McCarty 2/1/11 9:00 PM
Comment: MFT's are already working for Medicaid accepted agencies. There are currently 78 licensed MFT's, which is a reduction of 17 from last year...due to license fee increase. Not all private practice MFT's are interested in the bureaucratic paperwork of Medicaid. Therefore, the calculation suggested are greatly exaggerated. I am doing a data search to determine how many current private practice MFT's exist to suggest a calculation.

Impact and Cost Analysis

- DBH has established a prevalence rate of 25% of the population that has a need for a behavioral health service under the current "medical necessity" definition.
- In FY 10 approximately 120,000 individuals were eligible for Medicaid and approximately 23,000 Medicaid recipients received at least one behavioral health service.
- Based on the prevalence rate, about 30,000 Medicaid clients are actually in need of behavioral health services which indicates approximately 7,000 recipients have an unmet need.
- **If all licensed LMFT's (93) enrolled and increased their case load to serve 50 clients per year, they would serve 4,650 clients. At a rate of $1000 per recipient the increase in program costs would be $4,650,000.**

Conclusion

Based on the complicating factors listed and budget impact the department is not proposing the addition of LMFT's at this time.

SB 119

<TARGET><BILL>SB 119</BILL><SUBJECT>SB 119</SUBJECT><COMM>SHSS27</COMM></TARGET>

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB 119**
() Publish Date

Identifier (file name) SB119-CCED-CBPL-04-08-11
Dept. Affected: DCCED

Title: Athletic Trainer Licensing
Appropriation: Corporations, Business and Professional Licensing
Allocation: Corporations, Business and Professional Licensing

Sponsor: Senator Meyer
Requester: Senate Health and Social Services
OMB Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	29.9		29.9	29.9	29.9	29.9	29.9
Travel	0.0		0.0	0.0	0.0	0.0	0.0
Services	38.8		1.8	1.8	1.8	1.8	1.8
Commodities	1.0		1.0	1.0	1.0	1.0	1.0
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**69.7**	**0.0**	**32.7**	**32.7**	**32.7**	**32.7**	**32.7**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES	**4.5**			**4.5**		**4.5**	

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
1156 Other RSS	69.7		32.7	32.7	32.7	32.7	32.7
TOTAL	**69.7**	**0.0**	**32.7**	**32.7**	**32.7**	**32.7**	**32.7**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time							
Part-time	1		1	1	1	1	1
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by: Don Habeger, Director — Phone: 465-2536
Division: Corporations, Business and Professional Licensing — Date/Time: 4/9/11 9:00 PM
Approved by: Susan K. Bell, Commissioner — Date: 4/9/2011
Commerce, Community, and Economic Development

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 119

Analysis

SB 119 creates a new program within the Department of Commerce, Community and Economic Development for the professional licensing of Athletic Trainers.

Current language in the bill states that the biennial fee for a license may not exceed $100. According to the sponsor, about 45 Athletic Trainers will require licensing which calculates to $4,500 biennially. However, under AS 08.01.065, the program will be required to cover its costs with licensing fees. This will result in fees that are substantially higher than the $100 limit cited in the bill. The costs identified in this fiscal note will result in an initial biennial fee of $2,276 with subsequent biennial fees at $1,450.

The work of implementing and maintaining this program cannot be absorbed by the current licensing staff that are already 100 % allocated and saturated with the work of licensing other occupations. This fiscal note requests a part time Occupational Licensing Examiner (OLE) Range 13 to assist in developing and maintaining regulations, procedures and providing other licensing services. This fiscal note also includes Services costs for printing of applications, communications, advertising, legal and the initial IT costs to configure, program and implement the licensing program. Commodities costs consist of standard operating supplies.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: **SB 119\M**
() Publish Date

SB119-DOA-OAH-04-07-11
Title: An Act relating to the licensing and regulation of athletic trainers
Sponsor: Senators Meyer, McGuire, Ellis and Menard
Requester: Senate Health and Social Services

Dept. Affected: Administration
Appropriation: Centralized Administrative Services
Allocation: Office of Administrative Hearings
OMB Component Number: 2771

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Commodities	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Outlay	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
FUND SOURCE		(Thousands of Dollars)					
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other (please identify)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost 0.0

POSITIONS

Full-time	**0.0**	0.00	0	0	0	0	0
Part-time	0.0	0	0	0	0	0	0
Temporary	0.0	0	0	0	0	0	0

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial version.

Prepared by: Terry L. Thurbon, Chief Administrative Law Judge — Phone 465-1886
Division: Office of Administrative Hearings — Date/Time 04/05/2011 6:02 p.m.
Approved by: John Cramer, Deputy Commissioner — Date 4/7/2011
Department of Administration

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. SB 119\M

Analysis

This bill provides for regulation and licensure of athletic trainers by the Department of Commerce, Community and Economic Development under a new chapter in AS title 8. Under AS 44.64.030(a)(6), the office of administrative hearings (OAH) conducts hearings in licensing matters, including disciplinary actions, arising under AS title 8, and in some cases provides administrative law judges to serve as mediators in the cases. OAH does not anticipate that addition of this licensure category would increase the office's caseload or the cost of providing hearings for this function beyond OAH's capacity to handle the cases at currently approved staffing levels. The cost to OAH of performing the services would be recovered from the department through interagency receipts, based on the time commitment required for hearings and mediations.

27-LS0732\B
Kirsch
4/11/11

CS FOR SENATE BILL NO. 119( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS MEYER, McGuire, Ellis, Menard

A BILL

FOR AN ACT ENTITLED

"An Act relating to athletic trainers."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.01.010 is amended by adding a new paragraph to read:

(39) regulation of athletic trainers under AS 08.07.

*** Sec. 2.** AS 08 is amended by adding a new chapter to read:

Chapter 07. Athletic Trainers.

Sec. 08.07.010. License required. (a) An individual may not practice or offer to practice athletic training, or allow another person to offer athletic training by the individual, in the state without being licensed under this chapter, unless the individual

(1) is a student in an accredited athletic trainer program;

(2) is present in the state for not more than 90 days for a specific athletic event or series of athletic events with an individual or group not based in the state; or

(3) is authorized to practice athletic training under another provision of Alaska law.

(b) This section does not prohibit a person licensed under another chapter of this title from performing functions defined as athletic training if those functions are within the scope of that person's license and the person does not use a title listed in (c) of this section.

(c) Unless licensed under this chapter, an individual may not use the titles "athletic trainer," "licensed athletic trainer," "A.T.," or any combination of those terms to indicate that the individual is a licensed athletic trainer.

Sec. 08.07.020. Qualifications for license; fee; renewal. (a) The department shall issue an athletic trainer license to an individual who

(1) applies to the department on a form provided by the department;

(2) pays the fees established by the department; and

(3) provides proof of certification by the National Athletic Trainers' Association Board of Certification, Inc.

(b) Notwithstanding AS 08.01.065, the biennial fee for a license may not exceed $100.

(c) An athletic trainer license may be renewed on proof of certification by the National Athletic Trainers' Association Board of Certification, Inc., and as provided in AS 08.01.100.

Sec. 08.07.030. Definition. In this chapter, "athletic training" means the treatment of an individual under the direction of a physician licensed under AS 08.64 to manage risk of injury and prevent injury, evaluate clinically, assess, and treat an individual's injury or illness, and rehabilitate and recondition that individual.

*** Sec. 3.** AS 09.65.300(c) is amended to read:

(c) In this section,

(1) "health care provider" means a state licensed physician, physician assistant, dentist, dental hygienist, osteopath, optometrist, chiropractor, registered nurse, practical nurse, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, licensed clinical social worker, **athletic trainer,** or certified direct-entry midwife;

(2) "health care services" means services received by an individual in

order to treat or to prevent illness or injury;

(3) "nonprofit organization" means an organization that qualifies for exemption from taxation under 26 U.S.C. 501(c)(3) or (4) (Internal Revenue Code).

Alaska State Legislature

Interim:
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0199

Session:
State Capitol Building
Juneau, Alaska 99801-1182
(907) 465-4945

Senator Kevin Meyer
Senate District O

SPONSOR STATEMENT FOR SB 119

"An Act relating to the licensing and regulation of athletic trainers"

SB 119 would amend current statutes to establish licensing and regulation of athletic trainers in the State of Alaska.

Athletic Trainers are certified, health care professionals who practice in the field of sports medicine. This profession plays a significant role in the management, prevention, recognition and rehabilitation of injured athletes under the supervision of a licensed physician. As people become increasingly more active, athletic trainers are a vital resource in administering immediate emergency care as well as injury prevention and treatment programs.

The National Athletic Trainer's Association (NATA), which was founded in 1950, is the professional membership association for certified athletic trainers. According to NATA, Alaska is one of the few states that do not currently license athletic trainers. Should SB 119 pass, athletic trainers would be required to have a license to practice in the State of Alaska.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 9, 2011

SUBJECT: Sectional summary of SB 119: licensing of athletic trainers (Work Order No. 27-LS0732\M)

TO: Senator Kevin Meyer
Attn: Christine Marasigan

FROM: Lisa Moritz Kirsch
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1 Adds athletic trainers to the list of occupations subject to regulation under chapter AS 08.01.

Section 2
Sec. 08.07.010 Requires a license to practice athletic training in Alaska unless you are a student in a training program, temporarily in state for an athletic event, or authorized to practice athletic training under another Alaska law. This section also limits the use of titles containing the terms "athletic trainer" or the abbreviation "A.T."

Sec 08.07.020 Sets out the general qualifications for a license, establishes a $100 cap on the biennial license fee, and invokes the procedure for renewal in AS 08.01.100.

Sec. 08.07.030 Authorizes the Department of Commerce, Community, and Economic Development to adopt regulations setting specific standards for licensing as an athletic trainer based on nationally recognized professional standards.

Sec. 08.07.040 Defines "athletic training."

Section 3 Adds athletic trainers to the list of practitioners who are immune to liability for civil damages when they provide free health care services, so long as the practitioner complies with the requirements of AS 09.65.300, and does not commit gross negligence, reckless misconduct, or intentional misconduct.

LMK:ljw
11-240.ljw

National Athletic Trainers' Association®

Health Care for Life & Sport

ATHLETIC TRAINING EDUCATION OVERVIEW

This document provides a brief overview of the education and credentialing process for entry-level athletic trainers. Athletic Training programs typically fall into three categories: a baccalaureate degree in Athletic Training; a baccalaureate degree with a major in athletic training; or graduate-level program with a major in athletic training. Academic programs are accredited by the Commission on Accreditation of Athletic Training Education (CAATE). The minimum entry point into the profession of Athletic Training is at the baccalaureate level; by 2014-2015, all accredited education programs in Athletic Training will lead to a degree in Athletic Training. Upon completion of a CAATE-accredited Athletic Training education program, students become eligible to obtain national certification granted by the NATA Board of Certification, Inc. (BOC).

ENTRY-LEVEL EDUCATION

Entry-level athletic training education uses a competency-based approach in both the classroom and clinical settings. Using a medical-based education model, Athletic Training students are educated to provide comprehensive preventive services and care in six domains of clinical practice: prevention; clinical evaluation and diagnosis; immediate care; treatment, rehabilitation and reconditioning; organization and administration; and professional responsibility. The educational requirements for CAATE-accredited Athletic Training Education Programs include not only cognitive (knowledge) and psychomotor (skill) content, but also a broad scope of foundational behaviors of professional practice, as well as a comprehensive clinical learning requirement that is embodied in the clinical proficiencies (professional, practice-oriented outcomes) as identified in the *Athletic Training Educational Competencies and Clinical Proficiencies*.

Students must receive formal instruction in the following specific subjects

Basic and Applied Sciences	Professional Content
• Human anatomy • Human physiology • Biology • Statistics and research design Rehabilitation • Exercise Physiology • Kinesiology/Biomechanics • Chemistry* • Physics* **Recommended but not required by some ATEP*	• Risk Management and Injury Prevention • Pathology of Injuries and Illnesses • Orthopedic Clinical Examination and Diagnosis • Medical Conditions and Disabilities • Acute Care of Injuries and Illnesses • Therapeutic Modalities • Conditioning, Rehabilitative Exercise & Pharmacology • Psychosocial Intervention and Referral • Nutritional Aspects of Injuries & Illnesses • Health Care Administration

CLINICAL EDUCATION

Students are required to participate in a minimum of two years of academic clinical education. Through these experiences, students gain clinical experiences associated with a variety of different patient populations defined but not limited to: gender, varying levels of risk, utilization of protective equipment, and general medical conditions (e.g. diabetes, asthma) that address the continuum of care.

Clinical experiences provide students with opportunities to practice, under the direct supervision of qualified Clinical Instructors (i.e., Certified Athletic Trainer [ATC®] or other credentialed health care professionals).

THE ATC® CREDENTIAL

The ATC® credential and the BOC requirements are currently recognized by 46 states for eligibility and/or regulation of the practice of athletic trainers. The credibility of the BOC program and the ATC® credential it awards are supported by three pillars: (1) the BOC certification examination; (2) the BOC Standards of Professional Practice, and Disciplinary Guidelines and Procedures; and (3) continuing competence (education) requirements.

BOC certification is recognized by the National Commission for Certifying Agencies and is the only accredited certification program for athletic trainers. To be certified, an individual must demonstrate that he/she is an athletic trainer capable of performing the required duties without threat of harm to the public. The BOC traditionally conducts annual examination development meetings during which certified athletic trainers and recognized experts in the science of athletic training develop, review and validate examination items and problems. The knowledge, skills, and abilities required for competent performance as an entry-level athletic trainer fall into three categories:

1. Understanding, applying, and analyzing;
2. Knowledge and decision-making;
3. Special performance abilities.

BOC certified athletic trainers are educated, trained and evaluated in six major practice domains:

1. Prevention
2. Clinical Evaluation and Diagnosis
3. Immediate Care
4. Treatment, Rehabilitation and Reconditioning
5. Organization and Administration
6. Professional Responsibility

For more information regarding the educational, certification, and licensure requirements for athletic trainers visit:

The National Athletic Trainers' Association – www.nata.org
The National Athletic Trainers' Association Education Council – www.nataec.org
The Board of Certification – www.bocatc.org
The Commission on the Accreditation of Athletic Training Education Programs–www.caate.net

SYNOPSIS OF ATHLETIC TRAINER STATUTORY REGULATION BY STATE
(DOES NOT INCLUDE REGULATIONS)
July 2010

ST	DATE	TYPE	DEF.	SUPERVISION	TITLE PROT.	EXAMINATION	REGULATORY AGENCY	EXEMPTIONS	RECI-PROCITY
AL	1993	License	Std*	Direction or referral of physician	YES	NATABOC	Board of AT	PT Grandfather until 1996	YES
AK									
AZ	2000	License	1	Physician	YES	Nat'l exam approved by Board (Regs specify BOC)	Board of AT	NATABOCs grandfathered til 1/1/2004	NO
AR	2000	License	Std*	Non-clinic: physician direction; Clinic: direct supervision of PT & referral of physician	YES	Exam (BOC per Regs)	Board of AT		YES
CA									
CO	2009	Registration	Std*	Physician, dentist, or other Health Care Provider	YES	NO	Department of Regulatory Agencies	Licensed Health professionals	NO
CT	2000	License[2]	Std*	Direction of Health Care Provider	YES	NATABOC	Comm. of Public Health		YES
DE	1989	License	Std*	Physician referral; Non-athletic injury requires PT supervision every 5th Tx	YES	NATABOC	Board of PT & AT		YES
DC									
FL	1988	License	Std*	Written protocol with physician	YES	Approved by Board (Regs specify BOC)	Board of AT	Provider of first aid	N/A

1 AZ includes athletic illness in its definition; athletic injuries is any injury that is of the type tha occurs during participation in sports, recreation, or physical fitness regardless of circumstances.

[2] Though statutorily mandated, no funding has been allotted in CT to implement this law.

ST	DATE	TYPE	DEF.	SUPERVISION	TITLE PROT.	EXAMINATION	REGULATORY AGENCY	EXEMPTIONS	RECI-PROCITY
GA	1977	License	Std*	Physician	YES	Approved by Board (Regs allow BOC)	Board of AT		YES
HI	1985	Exemption	Std[3]						
ID	2003	License	Std*	Physician or Chiropractor	YES	NATABOC or approved by Board	Board of AT (advises Board of Medicine)	Free care; Good Samaritan	YES
IL	1995	License	Std*	Physician	YES	NATABOC	Board of AT	Grandfathers Pre-1985	YES
IN	1993	License	Std*	Physician referral or direction	YES	NATABOC	Board of AT		YES
IA	1994	License	Std*	Physician	YES	By Department (Regs specify BOC)	Board of AT	Licensed health professionals	YES
KS	1995	License	Std*	N/A	YES	Approved by Board (Regs specify BOC)	Board of Healing Arts	Pre-7/04 ATC registrants grandfathered	YES
KY	1978	Certification	Std*	Physician approves modalities to be used	YES	Board approved (BOC per Regs)	Medical Board w/advice of AT Advisory Cmte.		YES
LA	1985	Certification	Std*	Physician approves modalities to be used	YES	Board administered (BOC accepted)	Medical Board	Licensed health professionals	YES with exam
ME	1995	License	Std*	No referral w/ certain restrictions; otherwise, referral to professional incl. PT	YES	NATABOC (BOC per Regs)	Commissioner of Professions; AT Advisory Comm...		N/A

3 Scope defined as that of AT certified by the NATABOC

ST	DATE	TYPE	DEF.	SUPERVISION	TITLE PROT.	EXAMINATION	REGULATORY AGENCY	EXEMPTIONS	RECI-PROCITY
MD	2009	License eff. 8/15/09	Std*	Protocol of physician	YES	NATABOC plus oral/written competency in English	Athletic Training Committee of Medical Board	Licensed Health Professionals	NO
MA	1982	License	[4]	Physician or DDS	YES	NATABOC	Board of Allied Health Prof.		YES
MI	2006	License	[5]	Physician	YES	Board approved (Regs pending; BOC proposed)	Athletic Trainer Board		
MN	1993	Registration	Std*	Protocol of physician	YES	NATABOC	AT Advisory Council		YES
MS	1991	License	Std[6]	Direction of physician, nurse practitioner or physician assistant.	YES	NATABOC	Council of Advisors in Athletic Training (State Board of Health)	Coaches/instr-uctors "in the line of duties"	YES
MO	2004	License	Std*	Team and/or consulting physician	YES	NATABOC	AT Advisory to Board of Healing Arts	Pre-1983 Grandfathers	YES
MT	2007	License	Std*	None specified	YES	Approved by the Board	AT Board	Coaches/teachers; other professionals; personal trainers; massage therapists	YES
NE	1987	License	Std*	Guidelines or referral from physician	YES	Approved by the Board (BOC approved per Regs)	Board of AT	Licensed health care professionals	
NV	2003	License	Std*	Protocol of physician	YES	NATABOC	Board of AT		YES

[4] Practice limited to schools, teams or organizations with whom AT is associated and under the direction of a physician or dentist duly registered in the commonwealth.

[5] Does not specify that treatment is limited to athletes or athletics; speaks to treatment of an "individual;" includes clinical evaluation and treatment for "injury or illness, or both" within rules promulgated by the Board.

[6] Includes injury or illness; injury is that sustained as a result of participation in sports, games or recreation, or a comparable injury.

ST	DATE	TYPE	DEF	SUPERVISION	TITLE PROT.	EXAMINATION	REGULATORY AGENCY	EXEMPTIONS	RECI-PROCITY
NJ	1984	License	[7]	Treatment under direction of physician	YES	NATABOC or equivalent app. by Board	AT Advisory to Board of Medical Examiners	Licensed health care professionals	YES
NM	1983	License	Std*	Prescription or protocol	YES	Nat'l certifying exam approved by Bd (BOC per web); jurisprudence; CPR; AED	AT Practice Board	Licensed health care professionals	
NY	1992	Certification	[8]	Clinical settings require physician	Only ATC	Direction of Commissioner (BOC per regs)	AT Advisory to Board of Medicine		
NC	1997	License	Std*	Protocol of physician	YES	NATABOC	Board of AT		YES
ND	1983	License	Std*	Written authorization of physician	YES	Board approved nat'l exam (BOC per regs)	Board of AT		
OH	1990	License	Std*	Referral of physician, DPM, DDS, DC, or PT	YES	NATABOC plus jurisprudence		Licensed health care professionals	YES
OK	1986	License	Std*	Protocol from physician	YES	NATABOC	AT Advisory Comm. to Medical Board	Good Samaritan; licensed health care professionals	
OR	1996	Registration	Std*	Consultation or referral with physician	YES	NATABOC	Board of AT		YES
PA	1987	Certification	Std*	Direction of physician, dentist, or podiatrist	YES	NATABOC	State Board of Medicine		YES

[7] Physical conditioning and reconditioning of athletes and prevention of injuries…and application of physical treatment modalities as recommended by the advisory committee.
[8] Limits practice to schools and professional athletic organizations and, under the supervision of a physician, comparable functions on orthopedic athletic injuries excluding spinal cord. Athletic Training is the application of principles, methods and procedures for managing athletic injuries, including the preconditioning, conditioning and reconditioning of an individual through the use of appropriate preventive and supportive devices, under the supervision of a physician.

ST	DATE	TYPE	DEF.	SUPERVISION	TITLE PROT.	EXAMINATION	REGULATORY AGENCY	EXEMPTIONS	RECI-PROCITY
RI	1986	License	[9]	Direction of physician	YES	Board approved (BOC per Regs)	Board of AT, reporting to state department		YES
SC	1976	Certification	Std*	Advice and consent of physician	YES	NATABOC	Board of Health & Environmental Control		YES
SD	1984	License	Std*[10]	Written authorization of physician	NO	Directed by Board or NATABOC			
TN	1985	License	Std*	Advice and consent or written order of physician	YES	NATABOC + jurisprudence	Board of Athletic Training (7/1/06)	Licensed professionals	YES
TX	1971	License	Std*	Direction of treating physician	YES	Board administered or NATABOC	Advisory Board of AT (to Dept. of Health)	Licensed health care professionals	YES
UT	2006	License	Std*	Directing Physician	YES	BOC or equivalent	Athletic Trainers Licensing Board	Licensed health care professionals	
VT	1998	License	Std*	SEE [11]	YES	NATABOC	Office of Professional Regulation	Licensed health care professionals	YES
VA	2004	License	Std*	PT & patient's physician, or direction of any MD, DO, DC, DPM, or DDS	YES	State administered, NATABOC, or Board approved	Advisory Board on AT to Board of Medicine	Coaches or others in line with duties; grandfathers	

[9] Practice limited to "only those athletes participating in the athletic program being conducted by the educational institution, professional athletic organization, or board sanctioned amateur athletic organization employing the athletic trainer."

[10] It is grounds for revocation of license to continue treatment or rehabilitation on individuals other than those associated with the employing institution or athletic organization

[11] For athletes participating at any organized level, no supervision but athlete must first have been examined by a physician; for treating injuries, referral from physician or DC required

ST	DATE	TYPE	DEF.	SUPERVISION	TITLE PROT.	EXAMINATION	REGULATORY AGENCY	EXEMPTIONS	RECI-PROCITY
WA	2007	License	Std*	Consultation, referral or guidelines of licensed health care provider	YES	Approved by Secretary of Health	Advisory Board to Secretary	Licensed health care professionals; personal trainers; teachers/coaches	YES
WI	1999	License	Std*[12]	Protocol established by AT and approved by physician	YES	NATABOC or state administered	AT Affiliated Credentialing Board of Medical Board		YES
WV	2010 eff. 6/11/10	Registration	None specified	None specified	YES	BOC	Board of Physical Therapy		
WY	2009	Licensure	Std*	Direction of physician	YES	Nationally recognized exam approved by Board	State Board of Athletic Training	Licensed health care professionals; credentialed coaches	YES

***Standard** Definition includes prevention, education, recognition, evaluation, treatment and rehabilitation of an athletic injury or illness, and organization and administration of exercise, conditioning, and athletic training programs

States in **BOLD** have no statutory language.

F:data/governmentaffairs/StatesGovernmentAffairs Activity/

[12] Includes illness ("injuries or illnesses") and adds "sustained while participating in physical activity." Rehabilitating and physically reconditioning that 'impede or prevent the individual from returning to participation in physical acvitiiy, if the individual recently participated in, and intends to return to participating in, physical activity.'

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

W L Wickham DO

(Print Name)

907-264-2044

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Callie Wilson
(Print Name)

(907) 212-6309
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law).* This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Jeffrey S. Moore
(Print Name)

279-2663
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

T Oesterle
(Signature)

VASILEFF
(Print Name)

907 563 3145
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Rick M. Clark ATC
(Print Name)

568-3145
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

Peter Schaab
(Signature)

P. SCHAAB
(Print Name)

272-0095
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

John Ardaly, MD
(Print Name)

907 278 8141 (office)
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

LESLIE P. DEAN
(Print Name)

907-563-3145
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Curt D. Mentzer
(Print Name)

580-1572
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Todd Paris

(Print Name)

745-2663

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law).* This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

MARK FLANN
(Print Name)

907-562-2277
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

Jarod Crawford AT-C
(Signature)

Jarod Crawford
(Print Name)

230-3722
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

David Wonchala
(Print Name)

563-3145
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

J.W. Joosse

(Print Name)

456 5803

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Donna Klecka
(Print Name)

223-3900
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

John Lapkass
(Signature)

John Lapkass
(Print Name)

563-3145
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

DOUG VERMILLION
(Print Name)

644-6055
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

(Print Name)

907-279-5589

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Jim Tamai

(Print Name)

907 374 4463

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

R. McEvoy
(Print Name)

907 261 7125
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law).* This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Mike McNamara
(Print Name)

907-227-5667
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Gary Benedetti MD
(Print Name)

745-2663
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

(Print Name)

729-1666
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

_____
(Signature)

Dana Murphy PA-C
(Print Name)

562 2277
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

Elisha T. Powell, MD

(Signature)

Elisha T. Powell, MD

(Print Name)

907-279-2663

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

James Ent

(Print Name)

562-2277

(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

Duane Heath
(Print Name)

907-562-2277
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

MICHAEL GEITZ, MD
(Print Name)

563-6272
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature)

(Print Name)

694-8085
(Phone Number)

Please fax this document to: (907)586-1061

ALASKA ATHLETIC TRAINERS ASSOCIATION

April 1st, 2011

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

The Alaska Athletic Trainers Association, on behalf of Alaska athletic trainers, is working toward professional licensure in Alaska. Legislation will be introduced in the 2011 session with sponsorship by Senator Kevin Meyer.

- The language of the bill states that anyone calling themselves *an athletic trainer* must be licensed by the state of Alaska Division of Occupational Licensing.
- The requirements for licensure are exactly the same as those required by the Board of Certification. The BOC is the postgraduate certification program for the National Athletic Trainers Association. The state of Alaska will not add to the already rigorous requirements of the BOC.
- The fees imposed by the Alaska Division of Occupational Licensing are not cost prohibitive. They have given us a quote of $100.00 bi-annually ($50.00 a year to be licensed in Alaska).
- Alaska is one of only 3 states that does not license athletic trainers.
- Presently, athletic trainers are not covered by the Alaska Statue 09.65.300 *Immunity for Providing Free Health Care Services* (Alaska's version of *the Good Samaritan Law)*. This prevents athletic trainers from volunteering their services at schools, community or nonprofit events.

I support the role of the athletic trainer in Alaska and sign this document in support of licensure.

(Signature) Gary H. Wilson 344-2155

(Print Name)

(Phone Number)

Please fax this document to: (907)586-1061

SB 127

<TARGET><BILL>SB 127</BILL><SUBJECT>SB 127</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Interim:
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0199

Session:
State Capitol Building
Juneau, Alaska 99801-1182
(907) 465-4945

Senator Kevin Meyer
Senate District O

SPONSOR STATEMENT FOR SB 127

"An Act establishing September 9th each year as Fetal Alcohol Spectrum Disorders Awareness Day."

SB 127 would proclaim September 9th each year as Fetal Alcohol Spectrum Disorders Awareness Day (FASD).

Alaska has the highest known incidence of FASD in the United States. This is a condition caused by prenatal exposure to alcohol, which can result in permanent brain damage, birth defects, learning disabilities, behavioral problems and most tragically, the loss of individual potential.

While FASD affects all racial and socioeconomic groups, it is a 100% preventable condition. FASD Awareness Day is observed internationally on September 9th. This serves as a reminder on the ninth day of the ninth month of the year that during the nine months of pregnancy a woman should abstain from alcohol.

SB 127 would observe FASD Awareness Day by promoting the awareness of the effects of prenatal exposure to alcohol.

SB82

TEN THINGS YOU SHOULD KNOW ABOUT FAS

1. Drinking during pregnancy can cause permanent damage to a developing fetus.

2. FAS is one of the most common causes of mental retardation, and is the only cause that is entirely preventable.

3. According to recent State of Alaska DHSS surveillance data, more than 126 children are born at risk for FASD each year in Alaska.

4. Prenatal exposure to alcohol can cause brain damage and other permanent birth defects.

5. Obtaining an FAS diagnosis can improve an individual's ability to function in the world, and may reduce secondary disabilities like depression and school failure.

6. FASD is found in all races and all socio-economic groups – wherever women drink alcohol FASD exists.

7. There is no safe level of alcohol consumption during pregnancy.

8. Women should stop drinking prior to trying to conceive – alcohol can cause damage to a developing fetus even before a woman knows she is pregnant.

9. FASD is 100 percent preventable.

10. With the right diagnosis, support and understanding, many individuals with FASD are living happy and full lives.

From State of Alaska, Office of Fetal Alcohol Syndrome FAQ
http://www.hss.state.ak.us/fas/info/faqs.htm

Advisory Board on Alcoholism
and Drug Abuse

abada
amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

February 13, 2012

Senator Kevin Meyer
Alaska State Capitol Room 103
Juneau, Alaska 99801

Re: SB 127 — Fetal Alcohol Spectrum Disorders Awareness Day

Dear Senator Meyer,

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board express their appreciation and support for SB 127 permanently establishing September 9 as Fetal Alcohol Spectrum Disorders Awareness Day each year. As you know, fetal alcohol spectrum disorders are 100% preventable. Raising awareness and recognition of this fact will help prevent more Alaskan children from being born affected by prenatal alcohol exposure.

Even more importantly, an annual day of FASD awareness and prevention will increase understanding of the special, and often very individual, needs of individuals diagnosed with fetal spectrum disorders. Too often the services and supports they need to thrive – at home, at school, and in their communities – are not available. By designating a day to focus on the unique issues of fetal alcohol spectrum disorders and their impact on Alaska, we can not only support Alaskans with FASD but also prevent future Alaskans from experiencing FASD.

Thank you for your continued work on this important issue.

Sincerely,

J. Kate Burkhart
Executive Director

cc: Robert Coghill, Jr., Chairman ABADA
Dan Meddleton, Chairman AMHB

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB127**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB127-DOA-FAC-2-10-12
Title: Fetal Alcohol Spectrum Disorders Awareness Day
Sponsor: Senator Meyer
Requester: Senate Health & Social Services

Dept. Affected: Administration
Appropriation: General Services
Allocation: Facilities
OMB Component Number: 2429

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
[illegible]3	temp code (UGF)							
	TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by: Vern Jones — Phone: 465-5684
Division: Division of General Services — Date/Time: 2/10/12 6:45 PM
Approved by: John Cramer, Deputy Commissioner — Date: 2/10/2012
Department of Administration

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB127

Analysis

This bill establishes September 9th as Fetal Alcohol Spectrum Disorders Awareness Day. It is anticipated that there will be no fiscal impact.

SB 134

<TARGET><BILL>SB 134</BILL><SUBJECT>SB 134</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATOR ALBERT M. KOOKESH

ALASKA STATE LEGISLATURE SENATE DISTRICT C

E-mail: Senator.Albert.Kookesh@legis.state.ak.us

State Capitol, Room 11

Juneau AK, 99801-1182

907-465-3473

888-288-3473

FAX 907-465-2827

Sponsor Statement

SB 134

SB 134 puts the Child Support Civil Rule 90.3 guidelines into statute. In 1987, the Alaska Supreme Court enacted Civil Rule 90.3. The Supreme Court admitted this was a substantive law that the Legislature could replace at any time. In the 25 years since then, the Legislature has not replaced civil rule 90.3 with an actual law. This bill proposes to correct that long-standing deficiency.

One of the major problems with having the child support guidelines set by a court rule is the people affected by current guidelines have not had the opportunity to speak to the individuals with the power to make changes. Instead every four years they are encouraged to write letters or testify before a review committee made up of lawyers and judges who then submit their recommendations to the Supreme Court Justices who make the final decisions. With the rule in statute, individuals will have the opportunity to speak to lawmakers who have the power to make changes. Proposals to amend can be made in the future through the legislative process.

The bill proposes enactment of the current rule into statute with the exception of how the child support obligation is calculated. Currently the non-custodial parent's support obligation is based solely on his or her income, without regard to what the other parent makes. With this bill it will be changed to an income shares model which calculates support as the share of each parent's income estimated allocation to the child, if the original household were intact.

According to 2005 statistics (Legislative Research Report, November 2010)

- Twenty four (24) states establish their child support guidelines statutorily through their legislature while 16 states use court rule only, and 11 states use a combination of rule, commission and or agency.
- Thirty five (35) states consider the income of both parents in determining child support payments.

35 States

SB 134 changes the word court to tribunal in some cases back to court and adds number (6) to definition in Sec. 25.28.300 (page 18) to read "tribunal" means the superior court or the child support services agency created in AS 25.27.010. It also includes changes made by SB 96 addressing medical support.

The Child Support Services Division has no objections to the bill. I would appreciate your prompt and favorable action on this bill.

27-LS0671\B
Mischel
2/9/12

CS FOR SENATE BILL NO. 134( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR KOOKESH

A BILL

FOR AN ACT ENTITLED

"An Act relating to child support awards; repealing Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 25 is amended by adding a new chapter to read:

Chapter 28. Child Support Awards.

Sec. 25.28.010. Guidelines; primary physical custody. (a) A tribunal shall calculate a child support award in a case in which one parent is awarded primary physical custody as an amount equal to the presumptive support obligation calculated under (d) of this section multiplied by the noncustodial parent's proportionate income share of combined monthly net income.

(b) To calculate the basic support obligation, the tribunal shall add together the monthly net income of both parents and determine the basic support obligation from the economic table as follows:

ECONOMIC TABLE

MONTHLY BASIC SUPPORT OBLIGATION
FOR EACH CHILD
KEY: A = AGE 0-11 B = AGE 12-18

COMBINED MONTHLY NET INCOME	ONE CHILD FAMILY		TWO CHILDREN FAMILY	
	A	B	A	B
For income less than $1,000, the obligation is based on the resources and living expenses of each household				
1,000	220	272	171	211
1,100	242	299	188	232
1,200	264	326	205	253
1,300	285	352	221	274
1,400	307	379	238	294
1,500	327	404	254	313
1,600	347	428	269	333
1,700	367	453	285	352
1,800	387	478	300	371
1,900	407	503	316	390
2,000	427	527	331	409
2,100	447	552	347	429
2,200	467	577	362	448
2,300	487	601	378	467
2,400	506	626	393	486
2,500	526	650	408	505
2,600	534	661	416	513
2,700	542	670	421	520
2,800	549	679	427	527
2,900	556	686	431	533
3,000	561	693	436	538

1	3,100	566	699	439	543
2	3,200	569	704	442	546
3	3,300	573	708	445	549
4	3,400	574	710	446	551
5	3,500	575	711	447	552
6	3,600	577	712	448	553
7	3,700	578	713	449	554
8	3,800	581	719	452	558
9	3,900	596	736	463	572
10	4,000	609	753	473	584
11	4,100	623	770	484	598
12	4,200	638	788	495	611
13	4,300	651	805	506	625
14	4,400	664	821	516	637
15	4,500	677	836	525	649
16	4,600	689	851	535	661
17	4,700	701	866	545	673
18	4,800	713	882	554	685
19	4,900	726	897	564	697
20	5,000	738	912	574	708
21	5,100	751	928	584	720
22	5,200	763	943	593	732
23	5,300	776	959	602	744
24	5,400	788	974	612	756
25	5,500	800	989	622	768
26	5,600	812	1,004	632	779
27	5,700	825	1,019	641	791
28	5,800	837	1,035	650	803
29	5,900	850	1,050	660	815
30	6,000	862	1,065	670	827
31	6,100	875	1,081	680	839

1	6,200	887	1,096	689	851
2	6,300	899	1,112	699	863
3	6,400	911	1,127	709	875
4	6,500	924	1,142	718	887
5	6,600	936	1,157	728	899
6	6,700	949	1,172	737	911
7	6,800	961	1,188	747	923
8	6,900	974	1,203	757	935
9	7,000	986	1,218	767	946
10	7,100	998	1,233	776	958
11	7,200	1,009	1,248	785	971
12	7,300	1,021	1,262	794	982
13	7,400	1,033	1,276	803	993
14	7,500	1,044	1,290	812	1,004
15	7,600	1,055	1,305	821	1,015
16	7,700	1,067	1,319	830	1,026
17	7,800	1,078	1,333	839	1,037
18	7,900	1,089	1,346	848	1,048
19	8,000	1,100	1,360	857	1,059
20	8,100	1,112	1,374	865	1,069
21	8,200	1,123	1,387	874	1,080
22	8,300	1,134	1,401	882	1,091
23	8,400	1,144	1,414	891	1,101
24	8,500	1,155	1,428	899	1,112
25	8,600	1,166	1,441	908	1,122
26	8,700	1,177	1,454	916	1,133
27	8,800	1,187	1,467	925	1,143
28	8,900	1,198	1,481	933	1,153
29	9,000	1,208	1,493	941	1,163
30	9,100	1,219	1,506	949	1,173
31	9,200	1,229	1,519	957	1,183

9,300	1,239	1,532	966	1,193
9,400	1,250	1,545	974	1,203
9,500	1,260	1,557	982	1,213
9,600	1,270	1,570	989	1,223
9,700	1,280	1,582	997	1,233
9,800	1,290	1,594	1,005	1,242
9,900	1,300	1,606	1,013	1,252
10,000	1,310	1,619	1,021	1,262
10,100	1,319	1,631	1,028	1,271
10,200	1,329	1,643	1,036	1,281
10,300	1,339	1,655	1,044	1,290
10,400	1,348	1,666	1,051	1,299
10,500	1,358	1,678	1,059	1,308
10,600	1,367	1,690	1,066	1,318
10,700	1,377	1,701	1,073	1,327
10,800	1,386	1,713	1,081	1,336
10,900	1,395	1,724	1,088	1,345
11,000	1,404	1,736	1,095	1,354
11,100	1,413	1,747	1,102	1,363
11,200	1,422	1,758	1,110	1,371
11,300	1,431	1,769	1,117	1,380
11,400	1,440	1,780	1,124	1,389
11,500	1,449	1,791	1,131	1,398
11,600	1,458	1,802	1,138	1,406
11,700	1,467	1,813	1,145	1,415
11,800	1,475	1,823	1,151	1,423
11,900	1,484	1,834	1,158	1,431
12,000	1,492	1,844	1,165	1,440

COMBINED MONTHLY NET	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN

INCOME	FAMILY A	FAMILY B	FAMILY A	FAMILY B	FAMILY A	FAMILY B
For income less than $1,000, the obligation is based on the resources and living expenses of each household						
1,000	143	177	121	149	105	130
1,100	157	194	133	164	116	143
1,200	171	211	144	179	126	156
1,300	185	228	156	193	136	168
1,400	199	246	168	208	147	181
1,500	212	262	179	221	156	193
1,600	225	278	190	235	166	205
1,700	238	294	201	248	175	217
1,800	251	310	212	262	185	228
1,900	264	326	223	275	194	240
2,000	277	342	234	289	204	252
2,100	289	358	245	303	213	264
2,200	302	374	256	316	223	276
2,300	315	390	267	330	233	288
2,400	328	406	278	343	242	299
2,500	341	421	288	356	251	311
2,600	346	428	293	362	256	316
2,700	351	435	298	368	259	321
2,800	356	440	301	372	262	324
2,900	360	445	305	376	266	328
3,000	364	449	308	380	268	331
3,100	367	453	310	383	270	334
3,200	369	457	312	386	272	336
3,300	371	459	314	388	273	339
3,400	372	460	315	389	274	340
3,500	373	461	316	390	275	341
3,600	374	462	317	391	276	342

1	3,700	375	463	318	392	277	343
2	3,800	377	466	319	394	278	344
3	3,900	386	477	326	404	284	352
4	4,000	395	488	334	413	291	360
5	4,100	404	500	341	422	298	368
6	4,200	413	511	350	431	305	377
7	4,300	422	522	357	441	311	385
8	4,400	431	532	364	449	317	392
9	4,500	438	542	371	458	323	400
10	4,600	446	552	377	467	329	407
11	4,700	455	562	384	475	335	414
12	4,800	463	572	391	483	341	422
13	4,900	470	581	398	491	347	429
14	5,000	479	592	404	500	353	437
15	5,100	487	602	411	509	359	443
16	5,200	494	611	418	517	365	451
17	5,300	503	621	425	525	371	458
18	5,400	511	632	432	533	377	466
19	5,500	518	641	439	542	383	473
20	5,600	527	651	446	551	389	480
21	5,700	535	661	452	559	395	488
22	5,800	543	671	459	567	401	495
23	5,900	551	681	466	575	407	502
24	6,000	559	691	473	584	413	509
25	6,100	567	701	479	593	418	517
26	6,200	575	710	486	601	424	524
27	6,300	583	721	493	609	430	532
28	6,400	591	731	500	617	436	539
29	6,500	599	740	506	626	442	546
30	6,600	607	750	513	635	448	554
31	6,700	615	761	520	643	454	561

1	6,800	623	770	527	651	460	568
2	6,900	631	780	533	659	466	575
3	7,000	639	790	540	668	472	583
4	7,100	647	800	547	677	478	591
5	7,200	654	809	554	684	484	598
6	7,300	662	818	560	693	490	605
7	7,400	670	828	567	701	496	613
8	7,500	677	837	574	709	502	620
9	7,600	685	846	581	718	507	627
10	7,700	692	855	587	726	513	634
11	7,800	700	865	594	734	519	642
12	7,900	707	874	601	742	525	649
13	8,000	714	883	607	750	531	656
14	8,100	722	892	614	759	536	663
15	8,200	729	901	620	767	542	670
16	8,300	736	910	627	775	548	677
17	8,400	743	919	633	783	553	684
18	8,500	750	928	640	791	559	691
19	8,600	758	936	646	799	565	698
20	8,700	765	945	653	807	570	705
21	8,800	772	954	659	815	576	712
22	8,900	779	962	665	822	582	719
23	9,000	786	971	672	830	587	726
24	9,100	792	980	678	838	593	732
25	9,200	799	988	684	846	598	739
26	9,300	806	996	691	854	604	746
27	9,400	813	1,005	697	861	609	753
28	9,500	820	1,013	703	869	614	759
29	9,600	826	1,021	709	877	620	766
30	9,700	833	1,030	716	884	625	773
31	9,800	840	1,038	722	892	631	779

9,900	846	1,046	728	900	636	786
10,000	853	1,054	734	907	641	793
10,100	859	1,062	740	915	647	799
10,200	866	1,070	746	922	652	806
10,300	872	1,078	752	930	657	812
10,400	879	1,086	758	937	662	819
10,500	885	1,094	764	944	668	825
10,600	891	1,102	770	952	673	832
10,700	898	1,109	776	959	678	838
10,800	904	1,117	782	966	683	844
10,900	910	1,125	788	974	688	851
11,000	916	1,132	794	981	693	857
11,100	922	1,140	799	988	698	863
11,200	928	1,147	805	995	703	869
11,300	934	1,155	811	1,002	708	876
11,400	940	1,162	817	1,009	714	882
11,500	946	1,170	822	1,017	719	888
11,600	952	1,177	828	1,024	723	894
11,700	958	1,184	834	1,031	728	900
11,800	964	1,191	839	1,038	733	906
11,900	970	1,199	845	1,045	738	912
12,000	975	1,206	851	1,051	743	919.

(c) The economic table in (b) of this section is presumptive for up to five children and for combined monthly net incomes up to and including $12,000. When support is awarded for more than five children in the physical custody of one parent, the tribunal shall add the column for five children to the column equal to the additional children over five. When combined monthly net income exceeds $12,000, on written findings of fact, the tribunal may exceed the presumptive amount of support set for combined monthly net incomes of $12,000.

(d) The tribunal shall calculate a presumptive support obligation by adding average monthly expenditures for child health care expenses allowable under

AS 25.28.040 to the basic support obligation in (b) of this section.

(e) The tribunal may allow the obligor parent to reduce child support payments by up to 75 percent for a period in which the obligor parent has extended visitation of more than 27 consecutive days. The order must specify the amount of the reduction that is allowable if the extended visitation is exercised.

(f) The tribunal may calculate child support based on a determination of the potential income of a parent who voluntarily and unreasonably is unemployed or underemployed. A determination of potential income may not be made for a parent who is physically or mentally incapacitated or who is caring for a child under two years of age to whom the parents owe a joint legal responsibility. Potential income shall be based on the parent's work history, qualifications, and job opportunities. The tribunal may also consider potential income from assets that are not producing income or are producing low income.

(g) In this section, "monthly net income" means one-twelfth of the parent's total annual income from all sources less

(1) mandatory deductions, including

(A) federal, state, and local income tax;

(B) social security tax or the equivalent contribution to an alternate plan established by a public employer, and self-employment tax;

(C) Medicare tax;

(D) mandatory union dues;

(E) mandatory contributions to a retirement or pension plan;

(2) voluntary contributions to a retirement or pension plan or account in which the earnings are tax-free or tax-deferred, except that the total amount of these voluntary contributions plus any mandatory contributions under (1)(E) of this subsection may not exceed 7.5 percent of the parent's gross wages and self-employment income;

(3) child support and alimony payments arising from previous relationships that are required by another tribunal and actually paid;

(4) child support for children from prior relationships living with the parent, calculated by using the formula under this chapter; and

(5) work-related child care expenses for the child who is the subject of the child support order.

Sec. 25.28.020. Child support guidelines for shared, divided, and hybrid custody awards. (a) The tribunal shall calculate shared, divided, and hybrid physical custody awards as provided in this section.

(b) The tribunal shall calculate a child support award in a case in which the parents are awarded shared physical custody by

(1) calculating the annual amount each parent would pay to the other parent under AS 25.28.010 assuming the other parent had primary custody; in this calculation, the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d) apply;

(2) multiplying the amount determined under (1) of this subsection for each parent by the percentage of time the other parent has physical custody of the child; however, if the tribunal finds that the percentage of time each parent will have physical custody does not accurately reflect the ratio of funds each parent will directly spend on supporting the child, the tribunal shall vary this percentage to reflect its findings;

(3) determining which parent has the greater amount under (2) of this subsection; the parent with the greater amount under (2) of this subsection is the obligor parent, and the annual award is equal to the difference between the two amounts under (2) of this subsection; however, if the amount is greater than the amount of support calculated under AS 25.28.010 assuming the obligor parent has primary custody, the annual support is the amount calculated under AS 25.28.010.

(c) The child support award for shared custody under (b) of this section must be paid in 12 equal monthly installments, except that if

(1) shared custody is based on the obligor parent's having physical custody for periods of 30 consecutive days or more, the total annual award may be paid in equal installments over those months in which the obligor parent does not have physical custody; or

(2) the obligor parent's income is seasonal, the tribunal may order unequal monthly support payments as provided in AS 25.28.030(e) and (f).

(d) The child support order must state that failure to exercise sufficient physical custody to qualify for shared physical custody under (b) or (c) of this section is grounds for modification of the child support order. Denial of visitation by the custodial parent is not cause to increase a child support award.

(e) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded divided custody by determining the amount each parent would pay to the other parent for support of a child for whom that parent has primary physical custody under AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), and offsetting those amounts; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

(f) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded hybrid custody by

(A) applying AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), to determine support for a child in the primary physical custody of each parent;

(B) applying (b) of this section to determine support for a child in the shared physical custody of the parents;

(C) adjusting pro rata the percentages provided in AS 25.28.010(b) based on the number of children to which each type of custody applies; and

(D) combining the amounts to determine the net obligation; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

Sec. 25.28.030. Exceptions to support awards. (a) Notwithstanding the requirements in AS 25.28.010 and 25.28.020, the tribunal may vary the award for the reasons stated in this section.

(b) The tribunal may vary the child support award as calculated under the

other provisions of this chapter for good cause on proof by a preponderance of the evidence that manifest injustice would result if the support award were not varied. The tribunal shall specify in writing the reason for the variation, the amount of support that would have been required but for the variation, and the estimated value of any property conveyed instead of support calculated under the other provisions of this chapter. Good cause may include a finding that unusual circumstances exist that require variation of the award in order to award an amount of support that is just and proper for the parties to contribute toward the nurture and education of their children. The tribunal shall consider the custodial parent's income in this determination.

(c) The calculation for primary physical custody under AS 25.28.010 does not apply to the extent that the supporting parent has an annual net income of more than $105,000. The tribunal may make an additional award only if it is just and proper, taking into account the needs of the child, the standard of living of the child, and the extent to which that standard should reflect the supporting parent's ability to pay.

(d) Except as provided in AS 25.28.010(d) and 25.28.020, the minimum child support amount that may be ordered is $75 a month or $900 a year for one child and, for each additional child, $50 a month.

(e) If the noncustodial parent's income is seasonal, the tribunal may order that the annual support amount be paid in unequal monthly payments, with higher payments during the months the parent expects to receive higher income and lower payments in other months; the tribunal may not make an unequal payment order unless

(1) the tribunal finds that the burden of budgeting for periods of unequal income should be placed on the obligee rather than the obligor; and

(2) the obligee agrees.

(f) An order of the tribunal for unequal payments under (e) of this section must specify the annual support amount, the average monthly support amount, and the amount due for each month. The order must provide that variations from the average monthly amount begin with monthly payments in excess of the average monthly amount so that a deficit situation cannot occur. Until the excess payments begin, the tribunal shall order payment of the average monthly amount.

Sec. 25.28.040. Health care expenses. (a) The tribunal shall include in the

order coverage of the child's health care needs and require health insurance for the child if insurance is available to either parent or both parents at a reasonable cost. The tribunal shall consider whether the child is eligible for services through the Indian Health Service, any other entity, or other insurance coverage before ordering either parent or both parents to provide health care coverage through insurance, cash medical support, or other means. A court shall find that health insurance is available only if the dependent child has reasonable geographic access to the covered services or the insurance includes the coverage of transportation needed for the services.

(b) The tribunal shall allocate equally the cost of insurance between the parents unless the tribunal orders otherwise for good cause. An obligor's child support obligation shall be decreased by the amount of the obligee's portion of health insurance payments ordered by the tribunal and actually paid by the obligor. The tribunal shall increase a child support award by the obligor's portion of health insurance if the obligee is ordered to, and actually does, obtain and pay for insurance.

(c) The cost of insurance is the cost attributable to the child for whom support is paid. If the cost to the employee of covering the employee alone is the same as the cost to the employee of covering the employee and dependents, then there is no additional cost to the employee for adding the child and no portion of the cost of coverage may be allocated to the child. If dependent coverage can be added for a single cost, rather than for each dependent, and the dependent coverage covers dependents in addition to the child subject to the order, the cost of the dependent coverage shall be allocated equally among the dependents covered. If there is reason to believe that there is an incremental cost to the employee for insuring dependents but evidence of that incremental cost is unavailable, the cost of insurance is determined by dividing the total cost of coverage by the number of family members covered and multiplying that amount by the number of children subject to the order.

(d) The tribunal shall allocate equally between the parties the cost of reasonable health care expenses not covered by insurance unless the tribunal orders otherwise for good cause. A party shall reimburse the other party for the party's share of the uncovered health care expenses within 30 days after receipt of the bill for the health care, payment verification, and, if applicable, a health insurance statement

indicating what portion of the cost is uncovered. The tribunal shall allocate the reasonable, uncovered health care expenses exceeding $5,000 in a calendar year based on the parties' relative financial circumstances when the expenses occur.

(e) For the purpose of establishing a monthly support obligation for monthly health care expenses, a tribunal shall apply a rebuttable presumption that the cost of health insurance is reasonable under this section if the cost of purchasing health insurance does not exceed five percent of the responsible parent's net income.

(f) In this section,

(1) "cash medical support" means an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise, or for other health care expenses not covered by insurance;

(2) "health care expenses" includes medical, dental, vision, and mental health counseling expenses.

Sec. 25.28.050. Child support affidavit and documentation. (a) Subject to the confidentiality requirements of Rule 90.1(f), Alaska Rules of Civil Procedure, each parent in a proceeding of a tribunal at which child support is involved shall file a statement under oath, accompanied by documentation verifying the statement, that states the parent's monthly net income and the components of monthly net income as defined in AS 25.28.010. This statement and documentation must be filed with a party's initial pleading in superior court, including the dissolution petition, divorce complaint or answer, motion to modify, and any response to a motion to modify. The documents must be redacted to delete social security numbers and to provide only partial financial account information as provided in Rule 90.1(f), Alaska Rules of Civil Procedure. The statement must state whether the parent has access to health insurance for the children and, if so, the additional cost to the parent of the children's health insurance.

(b) While there is an ongoing monthly support obligation, each party shall provide to the other party, within 30 days after a written request, documents such as tax returns and pay stubs showing the party's income for the prior calendar year. The party making the request shall provide documentation of the party's annual income for the same period at the time the request is made. A request under this section may not

be made more than once a year. This section does not preclude discovery under the Alaska Rules of Civil Procedure.

(c) Unless the information has already been provided to the tribunal under Rule 90.1(f), Alaska Rules of Civil Procedure, a statement under (a) of this section must be accompanied by a confidential information sheet as described in Rule 90.1, Alaska Rules of Civil Procedure. Once a complete confidential information sheet has been submitted to the tribunal listing names, dates of birth, and social security numbers as required, the parties shall omit or redact social security numbers from documents subsequently filed in the action unless otherwise ordered by the tribunal.

(d) The tribunal may withhold or assess costs or attorney fees for a violation of this section as the circumstances and discouragement of like conduct in the future may require. Costs and attorney fees may be imposed on offending attorneys or parties.

Sec. 25.28.060. Travel expenses. After determining an award of child support under this chapter, the court shall allocate between the parties reasonable travel expenses that are necessary to exercise visitation as may be just and proper for the parties to contribute.

Sec. 25.28.070. Modification; defense against arrearages. (a) A tribunal may modify a final child support award on a showing of a material change of circumstances as provided by state law. A material change of circumstances shall be presumed if support as calculated under this chapter is more than 15 percent greater or less than the outstanding support order. An award may be modified to require cash medical support regardless of whether insurance is available to either parent if neither parent has purchased health insurance. In this subsection, "support" includes health insurance payments or cash medical support made under AS 25.28.040.

(b) A tribunal may not modify a child support arrearage retroactively, except as authorized by AS 25.27.166(d). A modification that is effective on or after the date that a motion for modification, or a notice of petition for modification by the child support services agency, is served on the opposing party is not considered a retroactive modification.

(c) The tribunal may find that a parent and a parent's assignee are precluded

from collecting arrearages for support of a child that accumulated during a time period exceeding two months for which the parent agreed or acquiesced to the obligor exercising primary custody of the child. A finding that preclusion is a defense must be based on clear and convincing evidence.

Sec. 25.28.080. Third-party custody. (a) When the state, or another third party entitled to child support, has custody of all children of a parent, the parent's support obligation to the third party is an amount equal to the parent's prorated presumptive support obligation specified in AS 25.28.010(d). If the third party has custody of some but not all children, the parent's support obligation to the third party is an amount equal to the parent's prorated presumptive support obligation specified in AS 25.28.010(d) for the total number of the parent's children in third-party custody and divided by the total number of the parent's children. In this subsection, the number of the parent's children includes only children of the parent who live with the parent, are substantially supported by the parent, or are in custody of the third party entitled to support.

(b) If, in addition to a support obligation to a third party, one or both parents retain primary or shared physical custody of at least one of their children, the support obligation between the parents is calculated under the other provisions of this chapter, without consideration of the third-party custodian or any children in the custody of the third-party custodian, except that the parent's prorated presumptive support obligation under AS 25.28.010(d) must be adjusted pro rata for the number of children in the primary custody of a parent, or shared custody of the parents, compared to the total number of children. After that calculation is completed, any support owed may be offset with support owed to a third-party custodian under (a) of this section in order to minimize transactions.

Sec. 25.28.090. Dependent tax deduction. The court may allocate the dependent tax deduction for each child between the parties as is just and proper and in the child's best interests. The allocation must be consistent with AS 25.24.152 and federal law.

Sec. 25.28.095. Review of guidelines. The child support services agency established in AS 25.27.010 shall notify the legislative committees with jurisdiction

over matters involving child support awards of the need for a compliance review of the guidelines established in this chapter every four years as provided in federal law. The compliance review must include a determination of whether the application of the guidelines consistently results in a determination of appropriate child support awards in the state.

Sec. 25.28.300. Definitions. In this chapter,

(1) "child support" and "child support obligation" have the meaning given "duty of support" in AS 25.27.900;

(2) "divided custody" means that one parent has primary physical custody of one or more children of the relationship and the other parent has primary custody of one or more other children of the relationship, and the parents do not share physical custody of any of their children;

(3) "hybrid custody" means that at least one parent has primary physical custody of one or more children of the relationship, and the parents have shared physical custody of at least one child of the relationship;

(4) "primary physical custody" or "primary custody" means that a child resides with the other parent for a period, specified in the custody order, of less than 25 percent of the year;

(5) "shared physical custody" or "shared custody" means that a child resides with one parent for a period, specified in writing in the custody order, of at least 25 percent but not more than 75 percent of the year, regardless of the status of legal custody;

(6) "tribunal" means the superior court or the child support services agency created in AS 25.27.010.

*** Sec. 2.** AS 47.10.120(a) is amended to read:

(a) When a child in need of aid is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the child. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL

PROCEDURE].

*** Sec. 3.** AS 47.12.230(a) is amended to read:

(a) When a delinquent minor is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the minor. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPEAL OF COURT RULE. Rule 90.3, Alaska Rules of Civil Procedure, is repealed.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

NONAPPLICABILITY OF TWO-THIRDS VOTE REQUIREMENT. Because the rule repealed in sec. 4 of this Act is a substantive rule rather than a rule of practice or procedure, the repeal of the rule takes effect even if sec. 4 of this Act does not receive the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION; CHILD SUPPORT SERVICES AGENCY. The child support services agency established in AS 25.27.010 may proceed to adopt regulations necessary to implement the changes made by AS 25.28, enacted by sec. 1 of this Act, but the regulations may not take effect before the effective date of sec. 1 of this Act.

*** Sec. 7.** Section 6 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 8.** Except as provided in sec. 7 of this Act, this Act takes effect July 1, 2013.

27-LS0671\~~A~~B
Mischel
~~3/14/11~~

2/9/12

CS FOR SENATE BILL NO. 134( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY ~~SENATOR KOOKESH~~

~~Introduced~~Offered:
Referred:

Sponsor(s): SENATOR KOOKESH

A BILL

FOR AN ACT ENTITLED

"An Act relating to child support awards; ~~and~~ repealing Rule 90.3, Alaska Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 25 is amended by adding a new chapter to read:

Chapter 28. Child Support Awards.

Sec. 25.28.010. Guidelines; primary physical custody. (a) A tribunal shall calculate a child support award in a case in which one parent is awarded primary physical custody as an amount equal to the presumptive support obligation calculated under (d) of this section multiplied by the noncustodial parent's proportionate income share of combined monthly net income.

(b) To calculate the basic support obligation, the tribunal shall add together the monthly net income of both parents and determine the basic support obligation from the economic table as follows:

ECONOMIC TABLE

MONTHLY BASIC SUPPORT OBLIGATION
FOR EACH CHILD
KEY: A = AGE 0-11 B = AGE 12-18

COMBINED MONTHLY NET INCOME	ONE CHILD FAMILY		TWO CHILDREN FAMILY	
	A	B	A	B
For income less than $1,000, the obligation is based on the resources and living expenses of each household				
1,000	220	272	171	211
1,100	242	299	188	232
1,200	264	326	205	253
1,300	285	352	221	274
1,400	307	379	238	294
1,500	327	404	254	313
1,600	347	428	269	333
1,700	367	453	285	352
1,800	387	478	300	371
1,900	407	503	316	390
2,000	427	527	331	409
2,100	447	552	347	429
2,200	467	577	362	448
2,300	487	601	378	467
2,400	506	626	393	486
2,500	526	650	408	505
2,600	534	661	416	513
2,700	542	670	421	520
2,800	549	679	427	527
2,900	556	686	431	533
3,000	561	693	436	538

3,100	566	699	439	543
3,200	569	704	442	546
3,300	573	708	445	549
3,400	574	710	446	551
3,500	575	711	447	552
3,600	577	712	448	553
3,700	578	713	449	554
3,800	581	719	452	558
3,900	596	736	463	572
4,000	609	753	473	584
4,100	623	770	484	598
4,200	638	788	495	611
4,300	651	805	506	625
4,400	664	821	516	637
4,500	677	836	525	649
4,600	689	851	535	661
4,700	701	866	545	673
4,800	713	882	554	685
4,900	726	897	564	697
5,000	738	912	574	708
5,100	751	928	584	720
5,200	763	943	593	732
5,300	776	959	602	744
5,400	788	974	612	756
5,500	800	989	622	768
5,600	812	1,004	632	779
5,700	825	1,019	641	791
5,800	837	1,035	650	803
5,900	850	1,050	660	815
6,000	862	1,065	670	827
6,100	875	1,081	680	839

1	6,200	887	1,096	689	851
2	6,300	899	1,112	699	863
3	6,400	911	1,127	709	875
4	6,500	924	1,142	718	887
5	6,600	936	1,157	728	899
6	6,700	949	1,172	737	911
7	6,800	961	1,188	747	923
8	6,900	974	1,203	757	935
9	7,000	986	1,218	767	946
10	7,100	998	1,233	776	958
11	7,200	1,009	1,248	785	971
12	7,300	1,021	1,262	794	982
13	7,400	1,033	1,276	803	993
14	7,500	1,044	1,290	812	1,004
15	7,600	1,055	1,305	821	1,015
16	7,700	1,067	1,319	830	1,026
17	7,800	1,078	1,333	839	1,037
18	7,900	1,089	1,346	848	1,048
19	8,000	1,100	1,360	857	1,059
20	8,100	1,112	1,374	865	1,069
21	8,200	1,123	1,387	874	1,080
22	8,300	1,134	1,401	882	1,091
23	8,400	1,144	1,414	891	1,101
24	8,500	1,155	1,428	899	1,112
25	8,600	1,166	1,441	908	1,122
26	8,700	1,177	1,454	916	1,133
27	8,800	1,187	1,467	925	1,143
28	8,900	1,198	1,481	933	1,153
29	9,000	1,208	1,493	941	1,163
30	9,100	1,219	1,506	949	1,173
31	9,200	1,229	1,519	957	1,183

9,300	1,239	1,532	966	1,193
9,400	1,250	1,545	974	1,203
9,500	1,260	1,557	982	1,213
9,600	1,270	1,570	989	1,223
9,700	1,280	1,582	997	1,233
9,800	1,290	1,594	1,005	1,242
9,900	1,300	1,606	1,013	1,252
10,000	1,310	1,619	1,021	1,262
10,100	1,319	1,631	1,028	1,271
10,200	1,329	1,643	1,036	1,281
10,300	1,339	1,655	1,044	1,290
10,400	1,348	1,666	1,051	1,299
10,500	1,358	1,678	1,059	1,308
10,600	1,367	1,690	1,066	1,318
10,700	1,377	1,701	1,073	1,327
10,800	1,386	1,713	1,081	1,336
10,900	1,395	1,724	1,088	1,345
11,000	1,404	1,736	1,095	1,354
11,100	1,413	1,747	1,102	1,363
11,200	1,422	1,758	1,110	1,371
11,300	1,431	1,769	1,117	1,380
11,400	1,440	1,780	1,124	1,389
11,500	1,449	1,791	1,131	1,398
11,600	1,458	1,802	1,138	1,406
11,700	1,467	1,813	1,145	1,415
11,800	1,475	1,823	1,151	1,423
11,900	1,484	1,834	1,158	1,431
12,000	1,492	1,844	1,165	1,440

COMBINED MONTHLY NET	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN

INCOME	FAMILY		FAMILY		FAMILY	
	A	B	A	B	A	B
For income less than $1,000, the obligation is based on the resources and living expenses of each household						
1,000	143	177	121	149	105	130
1,100	157	194	133	164	116	143
1,200	171	211	144	179	126	156
1,300	185	228	156	193	136	168
1,400	199	246	168	208	147	181
1,500	212	262	179	221	156	193
1,600	225	278	190	235	166	205
1,700	238	294	201	248	175	217
1,800	251	310	212	262	185	228
1,900	264	326	223	275	194	240
2,000	277	342	234	289	204	252
2,100	289	358	245	303	213	264
2,200	302	374	256	316	223	276
2,300	315	390	267	330	233	288
2,400	328	406	278	343	242	299
2,500	341	421	288	356	251	311
2,600	346	428	293	362	256	316
2,700	351	435	298	368	259	321
2,800	356	440	301	372	262	324
2,900	360	445	305	376	266	328
3,000	364	449	308	380	268	331
3,100	367	453	310	383	270	334
3,200	369	457	312	386	272	336
3,300	371	459	314	388	273	339
3,400	372	460	315	389	274	340
3,500	373	461	316	390	275	341
3,600	374	462	317	391	276	342

1	3,700	375	463	318	392	277	343
2	3,800	377	466	319	394	278	344
3	3,900	386	477	326	404	284	352
4	4,000	395	488	334	413	291	360
5	4,100	404	500	341	422	298	368
6	4,200	413	511	350	431	305	377
7	4,300	422	522	357	441	311	385
8	4,400	431	532	364	449	317	392
9	4,500	438	542	371	458	323	400
10	4,600	446	552	377	467	329	407
11	4,700	455	562	384	475	335	414
12	4,800	463	572	391	483	341	422
13	4,900	470	581	398	491	347	429
14	5,000	479	592	404	500	353	437
15	5,100	487	602	411	509	359	443
16	5,200	494	611	418	517	365	451
17	5,300	503	621	425	525	371	458
18	5,400	511	632	432	533	377	466
19	5,500	518	641	439	542	383	473
20	5,600	527	651	446	551	389	480
21	5,700	535	661	452	559	395	488
22	5,800	543	671	459	567	401	495
23	5,900	551	681	466	575	407	502
24	6,000	559	691	473	584	413	509
25	6,100	567	701	479	593	418	517
26	6,200	575	710	486	601	424	524
27	6,300	583	721	493	609	430	532
28	6,400	591	731	500	617	436	539
29	6,500	599	740	506	626	442	546
30	6,600	607	750	513	635	448	554
31	6,700	615	761	520	643	454	561

1	6,800	623	770	527	651	460	568
2	6,900	631	780	533	659	466	575
3	7,000	639	790	540	668	472	583
4	7,100	647	800	547	677	478	591
5	7,200	654	809	554	684	484	598
6	7,300	662	818	560	693	490	605
7	7,400	670	828	567	701	496	613
8	7,500	677	837	574	709	502	620
9	7,600	685	846	581	718	507	627
10	7,700	692	855	587	726	513	634
11	7,800	700	865	594	734	519	642
12	7,900	707	874	601	742	525	649
13	8,000	714	883	607	750	531	656
14	8,100	722	892	614	759	536	663
15	8,200	729	901	620	767	542	670
16	8,300	736	910	627	775	548	677
17	8,400	743	919	633	783	553	684
18	8,500	750	928	640	791	559	691
19	8,600	758	936	646	799	565	698
20	8,700	765	945	653	807	570	705
21	8,800	772	954	659	815	576	712
22	8,900	779	962	665	822	582	719
23	9,000	786	971	672	830	587	726
24	9,100	792	980	678	838	593	732
25	9,200	799	988	684	846	598	739
26	9,300	806	996	691	854	604	746
27	9,400	813	1,005	697	861	609	753
28	9,500	820	1,013	703	869	614	759
29	9,600	826	1,021	709	877	620	766
30	9,700	833	1,030	716	884	625	773
31	9,800	840	1,038	722	892	631	779

9,900	846	1,046	728	900	636	786
10,000	853	1,054	734	907	641	793
10,100	859	1,062	740	915	647	799
10,200	866	1,070	746	922	652	806
10,300	872	1,078	752	930	657	812
10,400	879	1,086	758	937	662	819
10,500	885	1,094	764	944	668	825
10,600	891	1,102	770	952	673	832
10,700	898	1,109	776	959	678	838
10,800	904	1,117	782	966	683	844
10,900	910	1,125	788	974	688	851
11,000	916	1,132	794	981	693	857
11,100	922	1,140	799	988	698	863
11,200	928	1,147	805	995	703	869
11,300	934	1,155	811	1,002	708	876
11,400	940	1,162	817	1,009	714	882
11,500	946	1,170	822	1,017	719	888
11,600	952	1,177	828	1,024	723	894
11,700	958	1,184	834	1,031	728	900
11,800	964	1,191	839	1,038	733	906
11,900	970	1,199	845	1,045	738	912
12,000	975	1,206	851	1,051	743	919.

(c) The economic table in (b) of this section is presumptive for up to five children and for combined monthly net incomes up to and including $12,000. When support is awarded for more than five children in the physical custody of one parent, the tribunal shall add the column for five children to the column equal to the additional children over five. When combined monthly net income exceeds $12,000, on written findings of fact, the tribunal may exceed the presumptive amount of support set for combined monthly net incomes of $12,000.

(d) The tribunal shall calculate a presumptive support obligation by adding average monthly expenditures for child health care expenses allowable under

AS 25.28.040 to the basic support obligation in (b) of this section.

(e) The tribunal may allow the obligor parent to reduce child support payments by up to 75 percent for a period in which the obligor parent has extended visitation of more than 27 consecutive days. The order must specify the amount of the reduction that is allowable if the extended visitation is exercised.

(f) The tribunal may calculate child support based on a determination of the potential income of a parent who voluntarily and unreasonably is unemployed or underemployed. A determination of potential income may not be made for a parent who is physically or mentally incapacitated or who is caring for a child under two years of age to whom the parents owe a joint legal responsibility. Potential income shall be based on the parent's work history, qualifications, and job opportunities. The tribunal may also consider potential income from assets that are not producing income or are producing low income.

(g) In this section, "monthly net income" means one-twelfth of the parent's total annual income from all sources less

(1) mandatory deductions, including

(A) federal, state, and local income tax;

(B) social security tax or the equivalent contribution to an alternate plan established by a public employer, and self-employment tax;

(C) Medicare tax;

(D) mandatory union dues;

(E) mandatory contributions to a retirement or pension plan;

(2) voluntary contributions to a retirement or pension plan or account in which the earnings are tax-free or tax-deferred, except that the total amount of these voluntary contributions plus any mandatory contributions under (1)(E) of this subsection may not exceed 7.5 percent of the parent's gross wages and self-employment income;

(3) child support and alimony payments arising from previous relationships that are required by another tribunal and actually paid;

(4) child support for children from prior relationships living with the parent, calculated by using the formula under this chapter; and

(5) work-related child care expenses for the child who is the subject of the child support order.

Sec. 25.28.020. Child support guidelines for shared, divided, and hybrid custody awards. (a) The tribunal shall calculate shared, divided, and hybrid physical custody awards as provided in this section.

(b) The tribunal shall calculate a child support award in a case in which the parents are awarded shared physical custody by

(1) calculating the annual amount each parent would pay to the other parent under AS 25.28.010 assuming the other parent had primary custody; in this calculation, the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d) apply;

(2) multiplying the amount determined under (1) of this subsection for each parent by the percentage of time the other parent has physical custody of the child; however, if the tribunal finds that the percentage of time each parent will have physical custody does not accurately reflect the ratio of funds each parent will directly spend on supporting the child, the tribunal shall vary this percentage to reflect its findings;

(3) determining which parent has the greater amount under (2) of this subsection; the parent with the greater amount under (2) of this subsection is the obligor parent, and the annual award is equal to the difference between the two amounts under (2) of this subsection; however, if the amount is greater than the amount of support calculated under AS 25.28.010 assuming the obligor parent has primary custody, the annual support is the amount calculated under AS 25.28.010.

(c) The child support award for shared custody under (b) of this section must be paid in 12 equal monthly installments, except that if

(1) shared custody is based on the obligor parent's having physical custody for periods of 30 consecutive days or more, the total annual award may be paid in equal installments over those months in which the obligor parent does not have physical custody; or

(2) the obligor parent's income is seasonal, the tribunal may order unequal monthly support payments as provided in AS 25.28.030(e) and (f).

(d) The child support order must state that failure to exercise sufficient physical custody to qualify for shared physical custody under (b) or (c) of this section is grounds for modification of the child support order. Denial of visitation by the custodial parent is not cause to increase a child support award.

(e) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded divided custody by determining the amount each parent would pay to the other parent for support of a child for whom that parent has primary physical custody under AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), and offsetting those amounts; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

(f) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded hybrid custody by

(A) applying AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), to determine support for a child in the primary physical custody of each parent;

(B) applying (b) of this section to determine support for a child in the shared physical custody of the parents;

(C) adjusting pro rata the percentages provided in AS 25.28.010(b) based on the number of children to which each type of custody applies; and

(D) combining the amounts to determine the net obligation; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

Sec. 25.28.030. Exceptions to support awards. (a) Notwithstanding the requirements in AS 25.28.010 and 25.28.020, the tribunal may vary the award for the reasons stated in this section.

(b) The tribunal may vary the child support award as calculated under the

other provisions of this chapter for good cause on proof by a preponderance of the evidence that manifest injustice would result if the support award were not varied. The tribunal shall specify in writing the reason for the variation, the amount of support that would have been required but for the variation, and the estimated value of any property conveyed instead of support calculated under the other provisions of this chapter. Good cause may include a finding that unusual circumstances exist that require variation of the award in order to award an amount of support that is just and proper for the parties to contribute toward the nurture and education of their children. The tribunal shall consider the custodial parent's income in this determination.

(c) The calculation for primary physical custody under AS 25.28.010 does not apply to the extent that the supporting parent has an annual net income of more than $105,000. The tribunal may make an additional award only if it is just and proper, taking into account the needs of the child, the standard of living of the child, and the extent to which that standard should reflect the supporting parent's ability to pay.

(d) Except as provided in AS 25.28.010(d) and 25.28.020, the minimum child support amount that may be ordered is $75 a month or $900 a year for one child and, for each additional child, $50 a month.

(e) If the noncustodial parent's income is seasonal, the tribunal may order that the annual support amount be paid in unequal monthly payments, with higher payments during the months the parent expects to receive higher income and lower payments in other months; the tribunal may not make an unequal payment order unless

(1) the tribunal finds that the burden of budgeting for periods of unequal income should be placed on the obligee rather than the obligor; and

(2) the obligee agrees.

(f) An order of the tribunal for unequal payments under (e) of this section must specify the annual support amount, the average monthly support amount, and the amount due for each month. The order must provide that variations from the average monthly amount begin with monthly payments in excess of the average monthly amount so that a deficit situation cannot occur. Until the excess payments begin, the tribunal shall order payment of the average monthly amount.

Sec. 25.28.040. Health care expenses. (a) The tribunal shall include in the

order coverage of the child's health care needs and require health insurance for the child if insurance is available to either parent or both parents at a reasonable cost. The tribunal shall consider whether the child is eligible for services through the Indian Health Service, any other entity, or other insurance coverage before ordering either parent or both parents to provide health care coverage through insurance, cash medical support, or other means. A court shall find that health insurance is available only if the dependent child has reasonable geographic access to the covered services or the insurance includes the coverage of transportation needed for the services.

(b) The tribunal shall allocate equally the cost of insurance between the parents unless the tribunal orders otherwise for good cause. An obligor's child support obligation shall be decreased by the amount of the obligee's portion of health insurance payments ordered by the tribunal and actually paid by the obligor. The tribunal shall increase a child support award by the obligor's portion of health insurance if the obligee is ordered to, and actually does, obtain and pay for insurance.

(c) The cost of insurance is the cost attributable to the child for whom support is paid. If the cost to the employee of covering the employee alone is the same as the cost to the employee of covering the employee and dependents, then there is no additional cost to the employee for adding the child and no portion of the cost of coverage may be allocated to the child. If dependent coverage can be added for a single cost, rather than for each dependent, and the dependent coverage covers dependents in addition to the child subject to the order, the cost of the dependent coverage shall be allocated equally among the dependents covered. If there is reason to believe that there is an incremental cost to the employee for insuring dependents but evidence of that incremental cost is unavailable, the cost of insurance is determined by dividing the total cost of coverage by the number of family members covered and multiplying that amount by the number of children subject to the order.

(d) The tribunal shall allocate equally between the parties the cost of reasonable health care expenses not covered by insurance unless the tribunal orders otherwise for good cause. A party shall reimburse the other party for the party's share of the uncovered health care expenses within 30 days after receipt of the bill for the health care, payment verification, and, if applicable, a health insurance statement

indicating what portion of the cost is uncovered. The tribunal shall allocate the reasonable, uncovered health care expenses exceeding $5,000 in a calendar year based on the parties' relative financial circumstances when the expenses occur.

~~(~~e(e) For the purpose of establishing a monthly support obligation for monthly health care expenses, a tribunal shall apply a rebuttable presumption that the cost of health insurance is reasonable under this section if the cost of purchasing health insurance does not exceed five percent of the responsible parent's net income.

(f) In this section,

(1) "cash medical support" means an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise, or for other health care expenses not covered by insurance;

(2) "health care expenses" includes medical, dental, vision, and mental health counseling expenses.

Sec. 25.28.050. Child support affidavit and documentation. (a) Subject to the confidentiality requirements of Rule 90.1(f), Alaska Rules of Civil Procedure, each parent in a proceeding of a tribunal at which child support is involved shall file a statement under oath, accompanied by documentation verifying the statement, that states the parent's monthly net income and the components of monthly net income as defined in AS 25.28.010. This statement and documentation must be filed with a party's initial pleading in superior court, including the dissolution petition, divorce complaint or answer, motion to modify, and any response to a motion to modify. The documents must be redacted to delete social security numbers and to provide only partial financial account information as provided in Rule 90.1(f), Alaska Rules of Civil Procedure. The statement must state whether the parent has access to health insurance for the children and, if so, the additional cost to the parent of the children's health insurance.

(b) While there is an ongoing monthly support obligation, each party shall provide to the other party, within 30 days after a written request, documents such as tax returns and pay stubs showing the party's income for the prior calendar year. The party making the request shall provide documentation of the party's annual income for the same period at the time the request is made. A request under this section may not

be made more than once a year. This section does not preclude discovery under the Alaska Rules of Civil Procedure. ~~If a party has made a reasonable demand for documentation under this subsection, a tribunal may modify a child support arrearage retroactively.~~

(c) Unless the information has already been provided to the tribunal under Rule 90.1(f), Alaska Rules of Civil Procedure, a statement under (a) of this section must be accompanied by a confidential information sheet as described in Rule 90.1, Alaska Rules of Civil Procedure. Once a complete confidential information sheet has been submitted to the tribunal listing names, dates of birth, and social security numbers as required, the parties shall omit or redact social security numbers from documents subsequently filed in the action unless otherwise ordered by the tribunal.

(d) The tribunal may withhold or assess costs or attorney fees for a violation of this section as the circumstances and discouragement of like conduct in the future may require. Costs and attorney fees may be imposed on offending attorneys or parties.

Sec. 25.28.060. Travel expenses. After determining an award of child support under this chapter, the court shall allocate between the parties reasonable travel expenses that are necessary to exercise visitation as may be just and proper for the parties to contribute.

Sec. 25.28.070. Modification; defense against arrearages. (a) A tribunal may modify a final child support award on a showing of a material change of circumstances as provided by state law. A material change of circumstances shall be presumed if support as calculated under this chapter is more than 15 percent greater or less than the outstanding support order. An award may be modified to require cash medical support regardless of whether insurance is available to either parent if neither parent has purchased health insurance. In this subsection, "support" includes health insurance payments or cash medical support made under AS 25.28.040.

(b) A tribunal may not modify a child support arrearage retroactively, except as authorized by AS 25.27.166(d~~) and AS 25.28.050(b).~~). A modification that is effective on or after the date that a motion for modification, or a notice of petition for modification by the child support services agency, is served on the opposing party is

not considered a retroactive modification.

(c) The tribunal may find that a parent and a parent's assignee are precluded from collecting arrearages for support of a child that accumulated during a time period exceeding two months for which the parent agreed or acquiesced to the obligor exercising primary custody of the child. A finding that preclusion is a defense must be based on clear and convincing evidence.

Sec. 25.28.080. Third-party custody. (a) When the state, or another third party entitled to child support, has custody of all children of a parent, the parent's support obligation to the third party is an amount equal to the parent's prorated presumptive support obligation specified in AS 25.28.010(d). If the third party has custody of some but not all children, the parent's support obligation to the third party is an amount equal to the parent's prorated presumptive support obligation specified in AS 25.28.010(d) for the total number of the parent's children in third-party custody and divided by the total number of the parent's children. In this subsection, the number of the parent's children includes only children of the parent who live with the parent, are substantially supported by the parent, or are in custody of the third party entitled to support.

(b) If, in addition to a support obligation to a third party, one or both parents retain primary or shared physical custody of at least one of their children, the support obligation between the parents is calculated under the other provisions of this chapter, without consideration of the third-party custodian or any children in the custody of the third-party custodian, except that the parent's prorated presumptive support obligation under AS 25.28.010(d) must be adjusted pro rata for the number of children in the primary custody of a parent, or shared custody of the parents, compared to the total number of children. After that calculation is completed, any support owed may be offset with support owed to a third-party custodian under (a) of this section in order to minimize transactions.

Sec. 25.28.090. Dependent tax deduction. The court may allocate the dependent tax deduction for each child between the parties as is just and proper and in the child's best interests. The allocation must be consistent with AS 25.24.152 and federal law.

Sec. 25.28.095. Review of guidelines. The child support services agency established in AS 25.27.010 shall notify the legislative committees with jurisdiction over matters involving child support awards of the need for a compliance review of the guidelines established in this chapter every four years as provided in federal law. The compliance review must include a determination of whether the application of the guidelines consistently results in a determination of appropriate child support awards in the state.

Sec. 25.28.300. Definitions. In this chapter,

(1) "child support" and "child support obligation" have the meaning given "duty of support" in AS 25.27.900;

(2) "divided custody" means that one parent has primary physical custody of one or more children of the relationship and the other parent has primary custody of one or more other children of the relationship, and the parents do not share physical custody of any of their children;

(3) "hybrid custody" means that at least one parent has primary physical custody of one or more children of the relationship, and the parents have shared physical custody of at least one child of the relationship;

(4) "primary physical custody" or "primary custody" means that a child resides with the other parent for a period, specified in the custody order, of less than 25 percent of the year;

(5) "shared physical custody" or "shared custody" means that a child resides with one parent for a period, specified in writing in the custody order, of at least 25 percent but not more than 75 percent of the year, regardless of the status of legal custody;

(6) "tribunal" means the superior court or the child support services agency created in AS 25.27.010.

*** Sec. 2.** AS 47.10.120(a) is amended to read:

(a) When a child in need of aid is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in

full or in part the maintenance and care of the child. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 3.** AS 47.12.230(a) is amended to read:

(a) When a delinquent minor is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the minor. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPEAL OF COURT RULE. Rule 90.3, Alaska Rules of Civil Procedure, is repealed.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

NONAPPLICABILITY OF TWO-THIRDS VOTE REQUIREMENT. Because the rule repealed in sec. 4 of this Act is a substantive rule rather than a rule of practice or procedure, the repeal of the rule takes effect even if sec. 4 of this Act does not receive the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: CHILD SUPPORT SERVICES AGENCY. The child support services agency established in AS 25.27.010 may proceed to adopt regulations necessary to implement the changes made by AS 25.28, enacted by sec. 1 of this Act, but the regulations may not take effect before the effective date of sec. 1 of this Act.

*** Sec. 7.** Section 6 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 8.** Except as provided in sec. 7 of this Act, this Act takes effect July 1, 2013.

SENATE BILL NO. 134

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY SENATOR KOOKESH

Introduced: 1/17/12
Referred: Health and Social Services, Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act relating to child support awards; and repealing Rule 90.3, Alaska Rules of Civil Procedure."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 25 is amended by adding a new chapter to read:

Chapter 28. Child Support Awards.

Sec. 25.28.010. Guidelines; primary physical custody. (a) A tribunal shall calculate a child support award in a case in which one parent is awarded primary physical custody as an amount equal to the presumptive support obligation calculated under (d) of this section multiplied by the noncustodial parent's proportionate income share of combined monthly net income.

(b) To calculate the basic support obligation, the tribunal shall add together the monthly net income of both parents and determine the basic support obligation from the economic table as follows:

ECONOMIC TABLE

MONTHLY BASIC SUPPORT OBLIGATION
FOR EACH CHILD
KEY: A = AGE 0-11 B = AGE 12-18

COMBINED MONTHLY NET INCOME	ONE CHILD FAMILY		TWO CHILDREN FAMILY	
	A	B	A	B
For income less than $1,000, the obligation is based on the resources and living expenses of each household				
1,000	220	272	171	211
1,100	242	299	188	232
1,200	264	326	205	253
1,300	285	352	221	274
1,400	307	379	238	294
1,500	327	404	254	313
1,600	347	428	269	333
1,700	367	453	285	352
1,800	387	478	300	371
1,900	407	503	316	390
2,000	427	527	331	409
2,100	447	552	347	429
2,200	467	577	362	448
2,300	487	601	378	467
2,400	506	626	393	486
2,500	526	650	408	505
2,600	534	661	416	513
2,700	542	670	421	520
2,800	549	679	427	527
2,900	556	686	431	533
3,000	561	693	436	538

1	3,100	566	699	439	543
2	3,200	569	704	442	546
3	3,300	573	708	445	549
4	3,400	574	710	446	551
5	3,500	575	711	447	552
6	3,600	577	712	448	553
7	3,700	578	713	449	554
8	3,800	581	719	452	558
9	3,900	596	736	463	572
10	4,000	609	753	473	584
11	4,100	623	770	484	598
12	4,200	638	788	495	611
13	4,300	651	805	506	625
14	4,400	664	821	516	637
15	4,500	677	836	525	649
16	4,600	689	851	535	661
17	4,700	701	866	545	673
18	4,800	713	882	554	685
19	4,900	726	897	564	697
20	5,000	738	912	574	708
21	5,100	751	928	584	720
22	5,200	763	943	593	732
23	5,300	776	959	602	744
24	5,400	788	974	612	756
25	5,500	800	989	622	768
26	5,600	812	1,004	632	779
27	5,700	825	1,019	641	791
28	5,800	837	1,035	650	803
29	5,900	850	1,050	660	815
30	6,000	862	1,065	670	827
31	6,100	875	1,081	680	839

1	6,200	887	1,096	689	851
2	6,300	899	1,112	699	863
3	6,400	911	1,127	709	875
4	6,500	924	1,142	718	887
5	6,600	936	1,157	728	899
6	6,700	949	1,172	737	911
7	6,800	961	1,188	747	923
8	6,900	974	1,203	757	935
9	7,000	986	1,218	767	946
10	7,100	998	1,233	776	958
11	7,200	1,009	1,248	785	971
12	7,300	1,021	1,262	794	982
13	7,400	1,033	1,276	803	993
14	7,500	1,044	1,290	812	1,004
15	7,600	1,055	1,305	821	1,015
16	7,700	1,067	1,319	830	1,026
17	7,800	1,078	1,333	839	1,037
18	7,900	1,089	1,346	848	1,048
19	8,000	1,100	1,360	857	1,059
20	8,100	1,112	1,374	865	1,069
21	8,200	1,123	1,387	874	1,080
22	8,300	1,134	1,401	882	1,091
23	8,400	1,144	1,414	891	1,101
24	8,500	1,155	1,428	899	1,112
25	8,600	1,166	1,441	908	1,122
26	8,700	1,177	1,454	916	1,133
27	8,800	1,187	1,467	925	1,143
28	8,900	1,198	1,481	933	1,153
29	9,000	1,208	1,493	941	1,163
30	9,100	1,219	1,506	949	1,173
31	9,200	1,229	1,519	957	1,183

9,300	1,239	1,532	966	1,193
9,400	1,250	1,545	974	1,203
9,500	1,260	1,557	982	1,213
9,600	1,270	1,570	989	1,223
9,700	1,280	1,582	997	1,233
9,800	1,290	1,594	1,005	1,242
9,900	1,300	1,606	1,013	1,252
10,000	1,310	1,619	1,021	1,262
10,100	1,319	1,631	1,028	1,271
10,200	1,329	1,643	1,036	1,281
10,300	1,339	1,655	1,044	1,290
10,400	1,348	1,666	1,051	1,299
10,500	1,358	1,678	1,059	1,308
10,600	1,367	1,690	1,066	1,318
10,700	1,377	1,701	1,073	1,327
10,800	1,386	1,713	1,081	1,336
10,900	1,395	1,724	1,088	1,345
11,000	1,404	1,736	1,095	1,354
11,100	1,413	1,747	1,102	1,363
11,200	1,422	1,758	1,110	1,371
11,300	1,431	1,769	1,117	1,380
11,400	1,440	1,780	1,124	1,389
11,500	1,449	1,791	1,131	1,398
11,600	1,458	1,802	1,138	1,406
11,700	1,467	1,813	1,145	1,415
11,800	1,475	1,823	1,151	1,423
11,900	1,484	1,834	1,158	1,431
12,000	1,492	1,844	1,165	1,440

COMBINED MONTHLY NET	THREE CHILDREN	FOUR CHILDREN	FIVE CHILDREN

INCOME	FAMILY		FAMILY		FAMILY	
	A	B	A	B	A	B
For income less than $1,000, the obligation is based on the resources and living expenses of each household						
1,000	143	177	121	149	105	130
1,100	157	194	133	164	116	143
1,200	171	211	144	179	126	156
1,300	185	228	156	193	136	168
1,400	199	246	168	208	147	181
1,500	212	262	179	221	156	193
1,600	225	278	190	235	166	205
1,700	238	294	201	248	175	217
1,800	251	310	212	262	185	228
1,900	264	326	223	275	194	240
2,000	277	342	234	289	204	252
2,100	289	358	245	303	213	264
2,200	302	374	256	316	223	276
2,300	315	390	267	330	233	288
2,400	328	406	278	343	242	299
2,500	341	421	288	356	251	311
2,600	346	428	293	362	256	316
2,700	351	435	298	368	259	321
2,800	356	440	301	372	262	324
2,900	360	445	305	376	266	328
3,000	364	449	308	380	268	331
3,100	367	453	310	383	270	334
3,200	369	457	312	386	272	336
3,300	371	459	314	388	273	339
3,400	372	460	315	389	274	340
3,500	373	461	316	390	275	341
3,600	374	462	317	391	276	342

1	3,700	375	463	318	392	277	343
2	3,800	377	466	319	394	278	344
3	3,900	386	477	326	404	284	352
4	4,000	395	488	334	413	291	360
5	4,100	404	500	341	422	298	368
6	4,200	413	511	350	431	305	377
7	4,300	422	522	357	441	311	385
8	4,400	431	532	364	449	317	392
9	4,500	438	542	371	458	323	400
10	4,600	446	552	377	467	329	407
11	4,700	455	562	384	475	335	414
12	4,800	463	572	391	483	341	422
13	4,900	470	581	398	491	347	429
14	5,000	479	592	404	500	353	437
15	5,100	487	602	411	509	359	443
16	5,200	494	611	418	517	365	451
17	5,300	503	621	425	525	371	458
18	5,400	511	632	432	533	377	466
19	5,500	518	641	439	542	383	473
20	5,600	527	651	446	551	389	480
21	5,700	535	661	452	559	395	488
22	5,800	543	671	459	567	401	495
23	5,900	551	681	466	575	407	502
24	6,000	559	691	473	584	413	509
25	6,100	567	701	479	593	418	517
26	6,200	575	710	486	601	424	524
27	6,300	583	721	493	609	430	532
28	6,400	591	731	500	617	436	539
29	6,500	599	740	506	626	442	546
30	6,600	607	750	513	635	448	554
31	6,700	615	761	520	643	454	561

1	6,800	623	770	527	651	460	568
2	6,900	631	780	533	659	466	575
3	7,000	639	790	540	668	472	583
4	7,100	647	800	547	677	478	591
5	7,200	654	809	554	684	484	598
6	7,300	662	818	560	693	490	605
7	7,400	670	828	567	701	496	613
8	7,500	677	837	574	709	502	620
9	7,600	685	846	581	718	507	627
10	7,700	692	855	587	726	513	634
11	7,800	700	865	594	734	519	642
12	7,900	707	874	601	742	525	649
13	8,000	714	883	607	750	531	656
14	8,100	722	892	614	759	536	663
15	8,200	729	901	620	767	542	670
16	8,300	736	910	627	775	548	677
17	8,400	743	919	633	783	553	684
18	8,500	750	928	640	791	559	691
19	8,600	758	936	646	799	565	698
20	8,700	765	945	653	807	570	705
21	8,800	772	954	659	815	576	712
22	8,900	779	962	665	822	582	719
23	9,000	786	971	672	830	587	726
24	9,100	792	980	678	838	593	732
25	9,200	799	988	684	846	598	739
26	9,300	806	996	691	854	604	746
27	9,400	813	1,005	697	861	609	753
28	9,500	820	1,013	703	869	614	759
29	9,600	826	1,021	709	877	620	766
30	9,700	833	1,030	716	884	625	773
31	9,800	840	1,038	722	892	631	779

9,900	846	1,046	728	900	636	786
10,000	853	1,054	734	907	641	793
10,100	859	1,062	740	915	647	799
10,200	866	1,070	746	922	652	806
10,300	872	1,078	752	930	657	812
10,400	879	1,086	758	937	662	819
10,500	885	1,094	764	944	668	825
10,600	891	1,102	770	952	673	832
10,700	898	1,109	776	959	678	838
10,800	904	1,117	782	966	683	844
10,900	910	1,125	788	974	688	851
11,000	916	1,132	794	981	693	857
11,100	922	1,140	799	988	698	863
11,200	928	1,147	805	995	703	869
11,300	934	1,155	811	1,002	708	876
11,400	940	1,162	817	1,009	714	882
11,500	946	1,170	822	1,017	719	888
11,600	952	1,177	828	1,024	723	894
11,700	958	1,184	834	1,031	728	900
11,800	964	1,191	839	1,038	733	906
11,900	970	1,199	845	1,045	738	912
12,000	975	1,206	851	1,051	743	919.

(c) The economic table in (b) of this section is presumptive for up to five children and for combined monthly net incomes up to and including $12,000. When support is awarded for more than five children in the physical custody of one parent, the tribunal shall add the column for five children to the column equal to the additional children over five. When combined monthly net income exceeds $12,000, on written findings of fact, the tribunal may exceed the presumptive amount of support set for combined monthly net incomes of $12,000.

(d) The tribunal shall calculate a presumptive support obligation by adding average monthly expenditures for child health care expenses allowable under

AS 25.28.040 to the basic support obligation in (b) of this section.

(e) The tribunal may allow the obligor parent to reduce child support payments by up to 75 percent for a period in which the obligor parent has extended visitation of more than 27 consecutive days. The order must specify the amount of the reduction that is allowable if the extended visitation is exercised.

(f) The tribunal may calculate child support based on a determination of the potential income of a parent who voluntarily and unreasonably is unemployed or underemployed. A determination of potential income may not be made for a parent who is physically or mentally incapacitated or who is caring for a child under two years of age to whom the parents owe a joint legal responsibility. Potential income shall be based on the parent's work history, qualifications, and job opportunities. The tribunal may also consider potential income from assets that are not producing income or are producing low income.

(g) In this section, "monthly net income" means one-twelfth of the parent's total annual income from all sources less

(1) mandatory deductions, including

(A) federal, state, and local income tax;

(B) social security tax or the equivalent contribution to an alternate plan established by a public employer, and self-employment tax;

(C) Medicare tax;

(D) mandatory union dues;

(E) mandatory contributions to a retirement or pension plan;

(2) voluntary contributions to a retirement or pension plan or account in which the earnings are tax-free or tax-deferred, except that the total amount of these voluntary contributions plus any mandatory contributions under (1)(E) of this subsection may not exceed 7.5 percent of the parent's gross wages and self-employment income;

(3) child support and alimony payments arising from previous relationships that are required by another tribunal and actually paid;

(4) child support for children from prior relationships living with the parent, calculated by using the formula under this chapter; and

(5) work-related child care expenses for the child who is the subject of the child support order.

Sec. 25.28.020. Child support guidelines for shared, divided, and hybrid custody awards. (a) The tribunal shall calculate shared, divided, and hybrid physical custody awards as provided in this section.

(b) The tribunal shall calculate a child support award in a case in which the parents are awarded shared physical custody by

(1) calculating the annual amount each parent would pay to the other parent under AS 25.28.010 assuming the other parent had primary custody; in this calculation, the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d) apply;

(2) multiplying the amount determined under (1) of this subsection for each parent by the percentage of time the other parent has physical custody of the child; however, if the tribunal finds that the percentage of time each parent will have physical custody does not accurately reflect the ratio of funds each parent will directly spend on supporting the child, the tribunal shall vary this percentage to reflect its findings;

(3) determining which parent has the greater amount under (2) of this subsection; the parent with the greater amount under (2) of this subsection is the obligor parent, and the annual award is equal to the difference between the two amounts under (2) of this subsection; however, if the amount is greater than the amount of support calculated under AS 25.28.010 assuming the obligor parent has primary custody, the annual support is the amount calculated under AS 25.28.010.

(c) The child support award for shared custody under (b) of this section must be paid in 12 equal monthly installments, except that if

(1) shared custody is based on the obligor parent's having physical custody for periods of 30 consecutive days or more, the total annual award may be paid in equal installments over those months in which the obligor parent does not have physical custody; or

(2) the obligor parent's income is seasonal, the tribunal may order unequal monthly support payments as provided in AS 25.28.030(e) and (f).

(d) The child support order must state that failure to exercise sufficient physical custody to qualify for shared physical custody under (b) or (c) of this section is grounds for modification of the child support order. Denial of visitation by the custodial parent is not cause to increase a child support award.

(e) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded divided custody by determining the amount each parent would pay to the other parent for support of a child for whom that parent has primary physical custody under AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), and offsetting those amounts; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

(f) The tribunal shall

(1) calculate a child support award in a case in which the parents are awarded hybrid custody by

(A) applying AS 25.28.010, taking into account the income limit in AS 25.28.030(c) and the minimum support amount in AS 25.28.030(d), to determine support for a child in the primary physical custody of each parent;

(B) applying (b) of this section to determine support for a child in the shared physical custody of the parents;

(C) adjusting pro rata the percentages provided in AS 25.28.010(b) based on the number of children to which each type of custody applies; and

(D) combining the amounts to determine the net obligation; and

(2) consider whether the amount determined under (1) of this subsection should be varied under AS 25.28.030(b).

Sec. 25.28.030. Exceptions to support awards. (a) Notwithstanding the requirements in AS 25.28.010 and 25.28.020, the tribunal may vary the award for the reasons stated in this section.

(b) The tribunal may vary the child support award as calculated under the

other provisions of this chapter for good cause on proof by a preponderance of the evidence that manifest injustice would result if the support award were not varied. The tribunal shall specify in writing the reason for the variation, the amount of support that would have been required but for the variation, and the estimated value of any property conveyed instead of support calculated under the other provisions of this chapter. Good cause may include a finding that unusual circumstances exist that require variation of the award in order to award an amount of support that is just and proper for the parties to contribute toward the nurture and education of their children. The tribunal shall consider the custodial parent's income in this determination.

(c) The calculation for primary physical custody under AS 25.28.010 does not apply to the extent that the supporting parent has an annual net income of more than $105,000. The tribunal may make an additional award only if it is just and proper, taking into account the needs of the child, the standard of living of the child, and the extent to which that standard should reflect the supporting parent's ability to pay.

(d) Except as provided in AS 25.28.010(d) and 25.28.020, the minimum child support amount that may be ordered is $75 a month or $900 a year for one child and, for each additional child, $50 a month.

(e) If the noncustodial parent's income is seasonal, the tribunal may order that the annual support amount be paid in unequal monthly payments, with higher payments during the months the parent expects to receive higher income and lower payments in other months; the tribunal may not make an unequal payment order unless

(1) the tribunal finds that the burden of budgeting for periods of unequal income should be placed on the obligee rather than the obligor; and

(2) the obligee agrees.

(f) An order of the tribunal for unequal payments under (e) of this section must specify the annual support amount, the average monthly support amount, and the amount due for each month. The order must provide that variations from the average monthly amount begin with monthly payments in excess of the average monthly amount so that a deficit situation cannot occur. Until the excess payments begin, the tribunal shall order payment of the average monthly amount.

Sec. 25.28.040. Health care expenses. (a) The tribunal shall include in the

order coverage of the child's health care needs and require health insurance for the child if insurance is available to either parent or both parents at a reasonable cost. The tribunal shall consider whether the child is eligible for services through the Indian Health Service, any other entity, or other insurance coverage before ordering either parent or both parents to provide health care coverage through insurance, cash medical support, or other means. A court shall find that health insurance is available only if the dependent child has reasonable geographic access to the covered services or the insurance includes the coverage of transportation needed for the services.

(b) The tribunal shall allocate equally the cost of insurance between the parents unless the tribunal orders otherwise for good cause. An obligor's child support obligation shall be decreased by the amount of the obligee's portion of health insurance payments ordered by the tribunal and actually paid by the obligor. The tribunal shall increase a child support award by the obligor's portion of health insurance if the obligee is ordered to, and actually does, obtain and pay for insurance.

(c) The cost of insurance is the cost attributable to the child for whom support is paid. If the cost to the employee of covering the employee alone is the same as the cost to the employee of covering the employee and dependents, then there is no additional cost to the employee for adding the child and no portion of the cost of coverage may be allocated to the child. If dependent coverage can be added for a single cost, rather than for each dependent, and the dependent coverage covers dependents in addition to the child subject to the order, the cost of the dependent coverage shall be allocated equally among the dependents covered. If there is reason to believe that there is an incremental cost to the employee for insuring dependents but evidence of that incremental cost is unavailable, the cost of insurance is determined by dividing the total cost of coverage by the number of family members covered and multiplying that amount by the number of children subject to the order.

(d) The tribunal shall allocate equally between the parties the cost of reasonable health care expenses not covered by insurance unless the tribunal orders otherwise for good cause. A party shall reimburse the other party for the party's share of the uncovered health care expenses within 30 days after receipt of the bill for the health care, payment verification, and, if applicable, a health insurance statement

indicating what portion of the cost is uncovered. The tribunal shall allocate the reasonable, uncovered health care expenses exceeding $5,000 in a calendar year based on the parties' relative financial circumstances when the expenses occur.

(e) In this section,

(1) "cash medical support" means an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise, or for other health care expenses not covered by insurance;

(2) "health care expenses" includes medical, dental, vision, and mental health counseling expenses.

Sec. 25.28.050. Child support affidavit and documentation. (a) Subject to the confidentiality requirements of Rule 90.1(f), Alaska Rules of Civil Procedure, each parent in a proceeding of a tribunal at which child support is involved shall file a statement under oath, accompanied by documentation verifying the statement, that states the parent's monthly net income and the components of monthly net income as defined in AS 25.28.010. This statement and documentation must be filed with a party's initial pleading in superior court, including the dissolution petition, divorce complaint or answer, motion to modify, and any response to a motion to modify. The documents must be redacted to delete social security numbers and to provide only partial financial account information as provided in Rule 90.1(f), Alaska Rules of Civil Procedure. The statement must state whether the parent has access to health insurance for the children and, if so, the additional cost to the parent of the children's health insurance.

(b) While there is an ongoing monthly support obligation, each party shall provide to the other party, within 30 days after a written request, documents such as tax returns and pay stubs showing the party's income for the prior calendar year. The party making the request shall provide documentation of the party's annual income for the same period at the time the request is made. A request under this section may not be made more than once a year. This section does not preclude discovery under the Alaska Rules of Civil Procedure. If a party has made a reasonable demand for documentation under this subsection, a tribunal may modify a child support arrearage retroactively.

(c) Unless the information has already been provided to the tribunal under Rule 90.1(f), Alaska Rules of Civil Procedure, a statement under (a) of this section must be accompanied by a confidential information sheet as described in Rule 90.1, Alaska Rules of Civil Procedure. Once a complete confidential information sheet has been submitted to the tribunal listing names, dates of birth, and social security numbers as required, the parties shall omit or redact social security numbers from documents subsequently filed in the action unless otherwise ordered by the tribunal.

(d) The tribunal may withhold or assess costs or attorney fees for a violation of this section as the circumstances and discouragement of like conduct in the future may require. Costs and attorney fees may be imposed on offending attorneys or parties.

Sec. 25.28.060. Travel expenses. After determining an award of child support under this chapter, the court shall allocate between the parties reasonable travel expenses that are necessary to exercise visitation as may be just and proper for the parties to contribute.

Sec. 25.28.070. Modification; defense against arrearages. (a) A tribunal may modify a final child support award on a showing of a material change of circumstances as provided by state law. A material change of circumstances shall be presumed if support as calculated under this chapter is more than 15 percent greater or less than the outstanding support order. An award may be modified to require cash medical support regardless of whether insurance is available to either parent if neither parent has purchased health insurance. In this subsection, "support" includes health insurance payments or cash medical support made under AS 25.28.040.

(b) A tribunal may not modify a child support arrearage retroactively, except as authorized by AS 25.27.166(d) and AS 25.28.050(b). A modification that is effective on or after the date that a motion for modification, or a notice of petition for modification by the child support services agency, is served on the opposing party is not considered a retroactive modification.

(c) The tribunal may find that a parent and a parent's assignee are precluded from collecting arrearages for support of a child that accumulated during a time period exceeding two months for which the parent agreed or acquiesced to the obligor

exercising primary custody of the child. A finding that preclusion is a defense must be based on clear and convincing evidence.

Sec. 25.28.080. Third-party custody. (a) When the state, or another third party entitled to child support, has custody of all children of a parent, the parent's support obligation to the third party is an amount equal to the parent's prorated presumptive support obligation specified in AS 25.28.010(d). If the third party has custody of some but not all children, the parent's support obligation to the third party is an amount equal to the parent's prorated presumptive support obligation specified in AS 25.28.010(d) for the total number of the parent's children in third-party custody and divided by the total number of the parent's children. In this subsection, the number of the parent's children includes only children of the parent who live with the parent, are substantially supported by the parent, or are in custody of the third party entitled to support.

(b) If, in addition to a support obligation to a third party, one or both parents retain primary or shared physical custody of at least one of their children, the support obligation between the parents is calculated under the other provisions of this chapter, without consideration of the third-party custodian or any children in the custody of the third-party custodian, except that the parent's prorated presumptive support obligation under AS 25.28.010(d) must be adjusted pro rata for the number of children in the primary custody of a parent, or shared custody of the parents, compared to the total number of children. After that calculation is completed, any support owed may be offset with support owed to a third-party custodian under (a) of this section in order to minimize transactions.

Sec. 25.28.090. Dependent tax deduction. The court may allocate the dependent tax deduction for each child between the parties as is just and proper and in the child's best interests. The allocation must be consistent with AS 25.24.152 and federal law.

Sec. 25.28.300. Definitions. In this chapter,

(1) "child support" and "child support obligation" have the meaning given "duty of support" in AS 25.27.900;

(2) "divided custody" means that one parent has primary physical

custody of one or more children of the relationship and the other parent has primary custody of one or more other children of the relationship, and the parents do not share physical custody of any of their children;

(3) "hybrid custody" means that at least one parent has primary physical custody of one or more children of the relationship, and the parents have shared physical custody of at least one child of the relationship;

(4) "primary physical custody" or "primary custody" means that a child resides with the other parent for a period, specified in the custody order, of less than 25 percent of the year;

(5) "shared physical custody" or "shared custody" means that a child resides with one parent for a period, specified in writing in the custody order, of at least 25 percent but not more than 75 percent of the year, regardless of the status of legal custody;

(6) "tribunal" means the superior court or the child support services agency created in AS 25.27.010.

* **Sec. 2.** AS 47.10.120(a) is amended to read:

(a) When a child in need of aid is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the child. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

* **Sec. 3.** AS 47.12.230(a) is amended to read:

(a) When a delinquent minor is committed under this chapter, the court or the child support services agency created in AS 25.27.010 shall, after giving the parent a reasonable opportunity to be heard, require that the parent pay to the department in a manner that the court or the child support services agency directs a sum to cover in full or in part the maintenance and care of the minor. The support obligation shall be calculated under **AS 25.28** [RULE 90.3(i) OF THE ALASKA RULES OF CIVIL PROCEDURE].

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REPEAL OF COURT RULE. Rule 90.3, Alaska Rules of Civil Procedure, is repealed.

*** Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

NONAPPLICABILITY OF TWO-THIRDS VOTE REQUIREMENT. Because the rule repealed in sec. 4 of this Act is a substantive rule rather than a rule of practice or procedure, the repeal of the rule takes effect even if sec. 4 of this Act does not receive the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

How will you get the Revised Prose done

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version: **SB134-ACS-TRC-2-9-12**
Fiscal Note Number:
Publish Date:

Identifier (file name): SB134-ACS-TRC-2-9-2012
Title: Child Support Awards
Sponsor: Senator Kookesh
Requester:

Dept. Affected: Alaska Court System
Appropriation: Trial Courts
Allocation:
OMB Component Number: 768

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services	1,009.8		1,009.8				
Travel	63.0		63.0				
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**1,072.8**	**0.0**	**1,072.8**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF	1,072.8		1,072.8				
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
	TOTAL	**1,072.8**	**0.0**	**1,072.8**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary	10.0		10.0				

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by: Nancy Meade, General Counsel — Phone: 907-463-4736
Division: Alaska Court System — Date/Time: 2/09/2012 11:00 A.M.
Approved by: Nancy Meade for Christine Johnson, Administrative Director — Date: 2/9/2012
Alaska Court System

(Revised 11/17/2011 OMB)

Analysis

SB 134 will repeal Civil Rule 90.3, the court rule that contains the current child support guidelines, and replace it with a new chapter in the statutes setting out the method for calculating child support awards. The formula for calculating the amount to be awarded will change from the current "percentage of income" approach, in which a set percentage of the non-custodial parent's income is presumed to be the appropriate support amount, to an "income shares" approach, in which a set dollar amount that depends on the parents' incomes is the presumptive support obligation. The bill also makes other changes to the current method for establishing the appropriate support amounts.

Under AS 25.14.170(b), the adoption of child support award guidelines or a significant amendment to guidelines is a material change in circumstances such that a party to an existing order would have grounds to seek modification of that order. The Child Support Services Division (CSSD) has estimated that it is enforcing about 20,000 child support orders, and an additional unknown number of court orders are in existence in which the parties opted not to use the CSSD for enforcement. It is estimated that 10,000 modification requests could be made after the bill takes effect; about half of the requests (5,000) are likely to be handled by the CSSD directly without court involvement, and about half (5,000) could come to the court for consideration and resolution.

The Court System estimates that, on average, each of the predicted 5,000 requests for modification of child support orders would require three hours of a judge's time to consider and resolve. The motions are expected to be filed by parties over a two-year period following the effective date of the bill. To handle these motions, the court will hire 3.8 temporary (pro tem) judges (NPP FTE), as well as 3.8 (NPP FTE) court clerks to assist those judges with paperwork and case management during FY 13 and FY 14. The court allocated these positions to the different court locations based on the prior two fiscal years' statistics that show where similar motions have been filed statewide. The personal service costs for these pro tem judges who will be assigned to the courts with the highest predicted number of these motions amounts to $760,000 for each of the two years, as shown on page three.

In addition, the pro tem judges and clerks will be required to travel to other courts locations to handle the motions in the courts in which the parties file them; it is estimated that travel costs would amount to $63,000 for each of the two years.

Finally, the court's Family Law Self-Help Center, which is the court's free statewide service to help people represent themselves in family law cases, anticipates that the number of requests for assistance would rise significantly, requiring two additional full-time temporary facilitators for each year over a two-year period.

FISCAL NOTE

STATE OF ALASKA

BILL NO. SB134-ACS-TRC-2-9-12

Analysis Continued

Alaska Court System Fiscal Note Calculations for SB 134	
Personal Services:	Cost
Pro Tems Superior Court Judge - Anchorage (2.2 NPP FTE)	424,700
Pro Tems Superior Court Judge - Fairbanks (.6 NPP FTE)	120,000
Pro Tems Superior Court Judge - Palmer (.4 NPP FTE)	84,200
Pro Tems Superior Court Judge - Kenai (.2 NPP FTE)	46,900
Pro Tems Superior Court Judge - Remaining Court Locations (.4 NPP FTE)	84,200
Clerical Staffing In-Court Clerks for ProTem Judges (3.8 NPP FTE)	160,100
Facilitator for Family Law Self Help Center (2.0 NPP FTE)	89,700
Subtotal Personal Services Cost	1,009,800
Travel:	
Travel to Various Court Locations:	
Estimate 25 trips X $400 Airfare for Judge and Clerk	20,000
Estimate 25 trips X $60 Per Diem X 5 Days for Judge and Clerk	15,000
Estimate 25 trips X $125 Lodging X 4 Days for Judge and Clerk	25,000
Estimate 25 trips - Ground Transportation, Parking @ $60/Trip for Judge and Clerk	3,000
Subtotal Travel Cost	63,000
Total Estimated Cost	1,072,800

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB134**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB134-DOR-CSSD-02-02-12
Title: An Act Relating to Child Support Awards
Sponsor: Senator Kookesh
Requester: (S) HSS

Dept. Affected: Revenue
Appropriation: Child Support Services
Allocation: Child Support Services
OMB Component Number: 111

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services	2,011.3		353.5	353.5	353.5	353.5	353.5
Travel							
Services	4,592.6		10.8	10.8	10.8	10.8	10.8
Commodities	166.0						
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**6,769.9**	**0.0**	**364.3**	**364.3**	**364.3**	**364.3**	**364.3**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts	4,468.1		240.4	240.4	240.4	240.4	240.4
1003	GF Match	2,301.8		123.9	123.9	123.9	123.9	123.9
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
178	temp code (UGF)							
TOTAL		**6,769.9**	**0.0**	**364.3**	**364.3**	**364.3**	**364.3**	**364.3**

POSITIONS							
Full-time	**5**		5	5	5	5	5
Part-time							
Temporary	**24**						

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial note

Prepared by: John Mallonee — Phone: 269-6801
Division: Child Support Services — Date/Time: 2/2/12 10:00am
Approved by: Jerry Burnett, Director — Date: 2/2/2012
Administrative Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB134

Analysis

SB 134 will establish Alaska child support guidelines in statute and repeal the court Civil Rule 90.3 child support guidelines. The bill changes child support calculation formulas from the current percentage approach that only takes into account the non-custodial parent's income to an income shares model that considers the income of both parents. Additionally, the bill increases the minimum support amount required of the non-custodial parent and decreases the percentage of time required for a finding of shared custody.

AS 25.24.170(b) and AS 25.27.190(e) consider the adoption, enactment or significant modification to the guidelines a material change of circumstance for the purpose of a modification of the order. This would allow the custodial or non-custodial parents to request a modification of their existing order(s). 45 CFR 303.8(e) requires a modification to be completed 180 days from receipt of the request. Failure to meet this requirement could result in the loss of federal funds. There are approximately 20,000 child support orders that would be eligible for modification. The division conservatively anticipates 10,000 modification requests will be submitted in the first six months. The modification section currently completes an estimated 3,000 modifications/year with a staff of 14. The anticipated increase in modification requests and the increased time required to perform the calculations will require 24 non-permanent staff. The five permanent staff will be needed because of the additional work required to determine the awards under the income shares approach.

Every four years as required by 45 CFR 302.56(e) the state must review the guidelines and revise if appropriate. Currently this is done by the Supreme Court. If the guidelinse are placed in statute then another process would be required to satisfy this requirement.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB 134**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB134-LAW-CIV-02-02-12
Title: An Act relating to child support awards; and repealing Rule 90.3, Alaska Rules of Civil Procedure.
Sponsor: Senator Kookesh
Requester: (S) Health & Social Services

Dept. Affected: Law
Appropriation: Civil
Allocation: Collections and Support
OMB Component Number: 2210

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services	2,660.9						
Travel	13.4						
Services	429.0						
Commodities	61.7						
Capital Outlay	12.1						
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**3,177.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)								
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1007	I/A Rcpts (Other)	3,177.1						
1037	GF/MH (UGF)							
178	temp code (UGF)							
TOTAL		**3,177.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time	**1**						
Temporary	**19**						

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version.

Prepared by: Eileen Donahue, Division Operations Manager — Phone: 465-5427
Division: Administrative Services — Date/Time: 2/3/12 8:40AM
Approved by: Michael C. Geraghty, Attorney General — Date: 2/3/2012
Department of Law

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB 134

Analysis

SB 134 will establish Alaska child support guidelines in statute and repeal the court Civil Rule 90.3 child support guidelines. The bill changes child support calculation formulas from the current percentage approach that only takes into account the non-custodial parent's income to an income shares model that considers the income of both parents. Additionally, the bill increases the minimum support amount required of the non-custodial parent and decreases the percentage of time required for a finding of shared custody.

AS 25.24.170(b) and AS 25.27.190(e) consider the adoption, enactment or significant modification to the guidelines a material change of circumstance for the purpose of a modification of the order. This would allow custodial and non-custodial parents to request a modification of their existing order(s). Federal law, 45 CFR 303.8(e), requires the Child Support Services Division (CSSD) to complete modification requests within 180 days from receipt of the request. CSSD could lose significant federal funds if it cannot meet this requirement. CSSD estimates it is enforcing approximately 20,000 child support orders that would be eligible for modification. CSSD conservatively anticipates 10,000 modification requests will be submitted in the first six months, with about ½ of the requests on court orders. The Attorney General's Office, Collections & Support Unit, represents CSSD in court when the agency requests modification of a court-issued child support order. The Collections & Support Section currently processes about 700 modification requests a year with 3.5 attorneys. The anticipated increase in modification requests from 700 to 5,000 in one year will require non-permanent positions of 12.5 attorneys, 2 paralegals, and 5 support positions to meet the anticipated initial demand.

LEGISLATIVE RESEARCH REPORT

NOVEMBER 22, 2010

REPORT NUMBER 11.076

CHILD SUPPORT GUIDELINES IN OTHER STATES

PREPARED FOR SENATOR ALBERT KOOKESH

BY TIM SPENGLER, LEGISLATIVE ANALYST

You were interested in child support guidelines in other states. Specifically, you wanted to know if other states codify their child support guidelines in statute. Additionally, you wanted to know how many states consider the income of *both* parents when deciding child support payment amounts. Briefly, about half of the states have established guidelines in statute, and most (35) states take into consideration both parents' incomes when deciding child support award amounts.[1]

Background on Federal Guidance and Mandates

Historically, the rationale and methodology behind calculating child support payments developed differently across the country's legal jurisdictions.[2] As a result, divorcing couples and their children were subject to child support award processes that were often amorphous and inconsistent, which often times led to inadequate financial support from the obligor parent (the payer of the support). In the 1930s, recognizing that federal entitlement programs for the impoverished were being burdened by the victims of insufficient support awards, the federal government began providing guidance to the states. Federal involvement through legislation increased over subsequent years, culminating in the Child Support Enforcement Amendments of 1984 (P.L. 98-378), the Family Support Act of 1988 (P.L. 100-485), and subsequent amendments to those laws, which collectively provide the child support mandates under which modern state child support guidelines have been developed.

States comply with federal mandates through the adoption of child support guidelines in statue, regulation, court rule, or some combination of the three. The federal mandates seek to address the problems of earlier child support regimes by accomplishing the following four main goals:

---

[1] Much of the background information in this report was taken from a previous report from our agency.

[2] Information in this section is summarized from Laura W. Morgan, "Child Support Guidelines," National Legal Research Group, 1999; accessed through the FindLaw online library at *http://library.findlaw.com/1999/Jan/1/241469.html#consistent*. Ms. Morgan served as the Chair of the Child Support Committee of the Family Law Section of the American Bar Association from 1997 to 2003. She maintains the website "Support Guidelines.com" (*http://www.supportguidelines.com/*), which provides extensive information on child support matters.

(1) increase the adequacy of child support awards;

(2) increase the consistency and predictability of child support awards;

(3) increase compliance through perceived fairness of child support awards; and

(4) increase the ease of administration of child support cases.

Pursuant to federal regulations, at a minimum, state guidelines must accomplish the following:

- Consider all earnings and income of the absent parent;
- Be based on specific descriptive and numeric criteria and result in the computation of the support obligation;
- Provide for the health care needs of the children, through health insurance coverage or other means; and
- Provide that in any judicial or administrative proceeding for the award of child support, there shall be a rebuttable presumption that the amount of the award, which would result from the application of the state's guideline, is the correct amount of child support to be awarded.[3]

Under federal law, the child support awards resulting from state guidelines enjoy a "rebuttable presumption" of correctness. That is, in order to deviate from the guideline amounts, the party challenging the award must establish that the application of the guideline is somehow unreasonable or unjust to their particular circumstances. Courts also must extensively record and justify deviation from the guidelines.

States with Child Support Guidelines in Statue

According to the National Conference of State Legislatures, the following 24 states establish their child support guidelines statutorily through their legislatures: California, Colorado, Florida, Georgia, Illinois, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Nevada, New Hampshire, New Mexico, New York, Ohio, Oklahoma, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.[4] Some of these states also concurrently establish guidelines in regulation (often through a child support commission).

The remaining 26 states (including Alaska) establish their child support guidelines by court rule or agency regulation. These states are Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Indiana, Iowa, Kansas, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, and Wisconsin. In Alaska, child support guidelines are provided in the Alaska Court Rules, Rules of Civil Procedure 90.3. We provide, as Attachment A, a table from the National Conference of State Legislatures that details which branch of government establishes child support guidelines in each state. The table includes relevant statutory and court rule citations from all states.

---

[3] 45 C.F.R § 302.56 and 45 C.F.R. § 302.56(f-g).

[4] We corresponded with Rochelle Finzel, children and families program manager, National Conference of State Legislators, at (303) 364-7700. The information NCSL provided on this matter was compiled in 2005, so some changes may have occurred since then.

Thirty-five (35) States Consider the Income of Both Parents in Determining Child Support Payments

In order to meet both federal requirements and the goal of providing adequate support, states have largely implemented two basic child support calculation models, respectively known as the *income shares* and the *percentage of income*. These models are used for calculating the amount of a child support award to be paid by the obligor parent.

The *income shares* model is used in 35 states and is based on the income of both parents. Alaska, along with 11 other states, employs the *percentage of income* model, which (usually) bases the award only on the non-custodial parent's income.[5] Three states (Delaware, Hawaii, and Montana) use the *Melson Formula* to calculate child support awards. This formula is generally thought to be more complex than the other models.[6]

The ***income shares*** model is based on the concept that a child should receive the same proportion of parental income that he or she would have received if the parents lived together. In an intact household, the income of both parents is generally pooled and spent for the benefit of all household members, including any children. Thus, the *income shares* model **calculates support as the share of each parent's income** estimated to have been allocated to the child if the original household were intact.

Using the *income shares* model, computation of child support is basically a four-step process:

(1) The income of the parents (gross or net) is determined and added together.[7]

(2) A "basic child support obligation" is computed based on the combined income of the parents, using a table or grid in the guidelines. The amounts in the table are derived from economic data on household expenditures on children.

(3) A "presumptive child support obligation" is then computed by adding expenditures for work-related child care expenses and extraordinary medical expenses to the basic child support obligation. Other add-ons and deductions may also be calculated.

(4) The presumptive child support obligation is prorated between each parent based on his or her proportionate share of total income. The obligor's share is payable as child support, while the obligee's share is retained and presumed to be spent directly on the child.

Distinguishing features of the income shares model include the following:

- It embodies the underlying economic assumption that as income increases, the proportion of income spent on child support decreases.
- It illustrates that both parents are sharing in the support of the child, thereby potentially increasing the perception of fairness to both parents.
- Compared to the *percentage of income* model, the *income shares* model can more easily take into consideration adjustments for shared and split custody, health care

[5] The states that the employ the *percentage of income* model are Alaska, Arkansas, Georgia, Illinois, Massachusetts, Minnesota, Mississippi, Nevada, North Dakota, Tennessee, Texas, and Wisconsin.

[6] The Melson Formula was developed by a Delaware Family Court judge; additional information on the formula can be found online at *http://courts.delaware.gov/Help/Support/SupportChapter8.pdf*.

[7] Whether the calculation is based on gross or net income varies among states.

needs, child care expenses, other children (previous or subsequent) needing support, and children's ages by the manipulation of income, add-ons and deductions and then allocating these costs between the parents. Because these factors can be built into the *income shares* formula, there is less reason for deviation from the guidelines' presumptive award. Limiting deviation meets the ideal of perceived fairness, as well as the federal requirement that the number of cases in which deviation is granted be limited. Limited deviation also meets the goals of consistency and predictability.

The ***percentage of income*** model (used in Alaska and 11 other states), stipulates that in *primary custody* arrangements—those in which the custodial parent has physical custody for over 70 percent of the year—**support amounts are based solely on the income of the non-custodial spouse** (obligor) and the number of children involved. In Alaska, and a number of other states, in *shared custody* situations—those in which each parent has custody for at least 30 percent of the year—the calculation includes the income of both parents, with the *percentage of income* model applied separately to each, then adjusted for the time each has physical custody. The parent with the higher calculation in this scenario becomes the obligor.

Proponents of the *percentage of income* model argue that both parents are assumed to contribute to the child's upbringing in the same proportion as the obligor. The custodial parent is making the contribution in the manner he or she would have made had the parties not divorced. Thus, there is no need to adopt a more complex formula. Many have argued, however, that it is inherently unfair for the custodial parent's income not to affect the presumptive amount. Typically, under this model, only a large disparity between the custodial parent's income and the non-custodial parent's income will be viewed as a justifiable factor upon which to base a deviation. Some states, including Alaska, address this concern in part by considering the income of both parents in shared custody situations. Those incomes are multiplied by the percentage of time each parent has physical custody, and, as we noted earlier, the role of obligor is assigned to the parent with the larger calculated amount.

Opponents of the *percentage of income* model also argue that it generally does not directly adjust for child care, extraordinary medical expenses, or whether other children are being supported in the obligor's household. Most states using this model have attempted to address a number of the above concerns by explicitly identifying these issues as factors for courts to consider as exceptions or deviations, or as expenses to be shared equally or reimbursed by one of the parties.

Despite their differences, child support guideline models have certain aspects in common. First, most of the guidelines incorporate a "self-support" reserve for the obligor.[8] Second, all the guidelines have a provision relating to imputed income.[9] Third, by federal regulation, all the guidelines take into consideration the health care expenses for the children, by insurance or other means. Lastly, most guidelines have incorporated into the presumptive child support formula special additions for child care expenses, special formulas for shared custody, split custody, and extraordinary visitation, and special deductions for the support of previous and subsequent children.

We hope you find this information to be useful. Please let us know if you have questions or need additional information.

---

[8] A self-support reserve means that the obligor is allowed to retain a certain amount of income below which level, support is minimal. For example, under the Washington state *income shares* model, the formula is not applied for obligors with net earnings of less than $500 per month.

[9] Imputed income is benefits that accrue even though no money is received. For example, an employee receives imputed income when an employer offers free health insurance and life insurance coverage or the use of a company car.

Attachment A

"Which Branch of Government Establishes Each States' Child Support Guidelines," a table including statutory and court rule citations, National Conference of State Legislatures, compiled in 2005

NCSL
NATIONAL CONFERENCE of STATE LEGISLATURES

GO

Issues & Research » Human Services » [Child Support] Establishment Responsibility Go 17623 Share Comment

Which Branch of Government Establishes Each States' Child Support Guidelines

State and Statute Section	Legislature	Court	Agency	Commission	Comment
Alabama Ala. R.J.A. R. 32		X			The Administrative Director of Courts reviews the guidelines and makes recommendations to the Alabama Supreme Court.
Alaska Ak. Rules of Civ. Pro. Rule 90.3(I)		X			
Arizona Ar. Rev. Stat. §25-320		X			The Chief Justice of the Arizona Supreme Court appoints a committee to review guidelines. The committee makes recommendations to the S.Ct. for approval.
Arkansas Ar. Code Ann. § 9-12-312		X			The Chief Justice of the Arkansas Supreme Court appoints a committee to review guidelines. The committee makes recommendations to the S.Ct. for approval.
California Cal. Fam. Code §4050 et seq.	X				The Legislature statutorily amends the guidelines based on the recommendations of the Judicial Council (§68500).
Colorado Colo. Rev. Stat. Ann. §14-10-115	X			X	The Legislature statutorily amends the guidelines based on the recommendations of a 17 member child support commission.
Connecticut Conn. Gen. Stat §46b-215a-c			X	X	The Legislature created the Commission for Child Support Guidelines; an 11 member commission established to promulgate child support guidelines. Such guidelines are reviewed by the legislative regulation review committee, which is responsible for approving all "agencies" rules and regulations.
Delaware Fam. Ct. Civ. R. 52		X			

Washington, D.C. D.C. Code Ann. § 16-916.2	X			X	The Council of the District of Columbia provides for the guidelines in code amending such based on the recommendations of a 15 member child support guidelines commission.
Florida Fla. Stat. Ann. §61.3	X				
Georgia Ga. Code Ann. §19-6-15	X			X	The General Assembly provides for the guidelines in code amending such based on the recommendations of a commission appointed by the Governor.
Hawaii Hawaii Rev. Stat. 576D-7		X			The Family Court establishes the guidelines in consultation with child support enforcement agency (Attorney General's Office).
Idaho Idaho Code 32-706A		X			
Illinois 305 ILCS 5/12-4.20c	X			X	The General Assembly statutorily amends the guidelines based on the recommendations of the Child Support Advisory Committee.
Indiana Ind. Stat. Ann. §33-2.1-10-1 to 9		X		X	The Indiana Supreme Court adopts amendments to the guidelines based on the recommendation of a 12 member child support advisory committee.
Iowa Iowa Code Ann. §598.21		X			
Kansas K.S.A. §20-165		X			
Kentucky Ky. Rev. Stat. Ann. §403.213	X			X	The General Assembly statutorily amends the guidelines based on the recommendation of a 10 member commission.
Louisiana La. Rev. Stat. Ann. §9:315.12	X				
Maine Me. Rev. Stat. Ann. tit. 9 §311 After October 1, 1997 tit. 19-A §2001	X				
Maryland Md. Code Ann., Fam. Law §12-202(c)	X				The General Assembly provides for the guidelines in code amending such based on the recommendations of the Child Support Enforcement Administration of the Department of Human Resources.

Massachusetts Mass. Gen. Laws Ann. ch. 208 §28		X			
Michigan Mich. Comp. Laws §552.519. Sec. 19(1) & (3)(a)(vi)		X			Michigan law creates a friend of the court bureau within the state court administrative office, under the supervision and direction of the supreme court. Such bureau is responsible for establishing and reviewing the child support guidelines.
Minnesota Minn. Stat. Ann. §518.551	X				The Legislature statutorily amend the guidelines based on the recommendation of the department of human services.
Mississippi Miss. Code Ann. §43-19-101 (5)	X				The Legislature statutorily amend the guidelines based on the recommendation of the department of human services.
Missouri Mo. Stat. Ann. §452.340(7)		X			
Montana Mont. Code Ann. §40-5-209			X		
Nebraska Neb. Rev. Stat. §42-364.16		X			
Nevada Nev. Rev. Stat. §125B.070	X				The Legislature statutorily amends the guidelines based on the recommendations of the State Bar of Nevada.
New Hampshire N.H. Rev. Stat. Ann. § 458-C:6	X				The Legislature statutorily amends the guidelines based on the recommendations of the division of human services, department of health and human services.
New Jersey N.J. Stat. Ann. §2A.:17-56.25 Admin. R. 5:6A			X		
New Mexico	X			X	The Legislature statutorily amends the guidelines based on the recommendations of "an appropriate executive or legislative commission or executive department."
New York N.Y. Soc. Serv. Law §111b(10)	X				The Legislature statutorily amends the guidelines based on the recommendations of the Department of Social Services.
North Carolina N.C. Gen. Stat. §15-13.4(c1)		X			The Conference of Chief District Judges is required to establish the guidelines. In addition, the conference must get specific input prior to amending and must report its findings to the General Assembly.
North Dakota			X		

N.D. Code Ann. §14-09-09.7					
Ohio Ohio Rev. Code Ann. §3113.21.5(G)	X			X	The General Assembly provides for the guidelines in code amending such based on the recommendations of the department of human services. The department, in turn, is required to establish a child support guideline advisory commission to assist the department in completing the review.
Oklahoma Okl. Stat. Ann. §119.1	X				The Legislature statutorily amends the guidelines based on the recommendations of the Judiciary Committees of the Senate and the House of Representatives.
Oregon Or. Rev. Stat. §25.270			X		
Pennsylvania Pa. Con. Stat. Ann. §1910.16-1 (Rules of Civic Procedure)		X			
Rhode Island R.I. Gen. Laws §15-5-16.2		X			The family court is responsible for establishing guidelines by an administrative order.
South Carolina S.C. Code of Laws §20-7-852(D)			X		
South Dakota S.D. Codified Laws Ann. §25-7-6.12	X				The Legislature statutorily amends the guidelines based on the recommendations of the department of social services. (In the year 2000, the Governor is responsible for establishing a commission to review the guidelines and report its recommended changes to the Legislature.
Tennessee Tenn. Code Ann. §36-5-101 (2) & (3)		X	X		Guidelines were originally established by the department of children's services. However, the Tenn. Supreme Court is permitted to modify the guidelines. If the court fails to review the guidelines, then the agency is required to review and make recommendations to the court.
Texas Tex. Fam. Code Ann. §111.001	X			X	The Legislature statutorily amends the guidelines based on the recommendations of a 25 member or more advisory committee appointed by the Texas Supreme Court.
Utah Utah Code Ann. §78-45-7.13	X			X	The Legislature statutorily amends the guidelines based on the recommendations of an 11 member advisory committee appointed by the Governor. [Committee reports to the Legislative Judiciary Interim Committee.]

Vermont Vt. Stat. Ann. tit.15 §654			X		
Virginia Va. Code Ann. §20-108.2 (H)	X			X	The General Assembly provides for the guidelines in code amending such based on the recommendations of a panel of representatives organized by the Secretary of Health and Human Services.
Washington Wash. Rev. Code Ann. §26.19.025	X				
West Virginia W. Va. Code §48A-1B-1	X				
Wisconsin Wis. Stat. Ann. §49.22(9)			X		
Wyoming Wyo. Stat. Ann. §20-6-305	X				The Legislature statutorily amends the guidelines based on the recommendations of the department of family services.

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

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

©2010 National Conference of State Legislatures. All Rights Reserved.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 20, 2011

SUBJECT: Child support obligation when children of obligor are living separately (Work Order No. 27-LS0671\A)

TO: Senator Albert Kookesh
Attn: Dorothy Shockely

FROM: Jean M. Mischel
Legislative Counsel

You have asked whether the above-referenced draft bill takes into account all children of an obligor, whether or not all are subject to a support order. The income share approach does account for a child or children of an obligor who may be living with the obligor and not subject to a separate order of support by inferring a portion of income for that child or children.

The calculation of child support is made by multiplying the presumptive support obligation by the noncustodial parent's proportionate income share of combined monthly net income with the other parent of the child under sec. 25.28.010(a). Monthly net income, as defined under sec. 25.28.010(g) at page 10 of the bill draft, excludes the following in relation to other children:

> (3) child support and alimony payments arising from previous relationships that are required by another tribunal and actually paid; [and]
> (4) child support for children from prior relationships living with the parent, calculated by using the formula under this chapter; . . . .

Therefore, a child not subject to an order and living with a noncustodial parent of another child, is treated as if the child were the subject of a support order under the bill draft in terms of calculating net income from which a share for the noncustodial parent's support obligation is derived. However, children from a subsequent relationship are not considered in the calculation of the parent's net income. In "unusual circumstances" a court may vary an award if the award would result in "manifest injustice" under sec. 25.28.030 at pages 12 and 13 of the bill draft.

If I may be of further assistance, please advise.

JMM:ljw
11-274.ljw

October 5, 2005

Ms. Beth Adams
Alaska court System
820 W. 4th Avenue
Anchorage, AK 99501

Dear Ms. Adams,

I am writing to make comments on the current Alaska child support guidelines (Civil Rules 90.3) I have worked for Senator Albert Kookesh for the past three years as his Legislative Aide. In the scope of my job I take calls from constituents, usually when our office is contacted people are out of options in resolving their situation(s).

First of all I would like to say I do appreciate what this department does. On the other hand we have taken many calls from frustrated obligors in the Child Support Services Division (CSSD). I have read the complex civil rule so I am somewhat aware of how it is suppose to work, unfortunately that is not the case with the people we hear from.

We have heard of peoples saving accounts zeroed out!

75% of wages deducted!

Drivers Licenses taken so the person can not drive to work!

No consideration given to present family; when 2/3 of wages deducted!

No communication, no explanation for changes and or reviews, and no call backs.

Under AS 25.24.160 (a)(1) **it requires that child support be set in an amount which is just and proper.** When someone can't go to work because he/she doesn't have a drivers license and his/her savings is wiped out and he/she can't support him or her self, little alone the family he/she has right now, that is not just and proper. Most people find they are helpless with no place to go.

I would like to suggest;

- No more than 33% percent of wages be taken, period. People are finding they cannot live on anything less, especially in rural Alaska, where the cost of living is 3 times higher than urban Alaska.
- Only two thirds of savings and other income be garnished.
- Consideration is given to ALL of the children in calculating the support payments. The 'subsequent' children have the same rights and needs as those under court order.

- The automated system is scary, the employer should have some control, like deducting only one third of ones pay.
- **Involve the parent(s) in any changes and reviews. If you involve the parent(s) in decisions, that's gives them ownership and a since of control and therefore are more cooperative**.
- A handbook in layman's terms.

Your consideration to making this Department more user friendly would benefit everyone, especially the children you are serving.

Thank you for your time.

Sincerely,

Dorothy J. Shockley
Legislative Aide to Senator Albert Kookesh

Celeste Hodge

From: John D Younce <jackruby69@hotmail.com>
Sent: Friday, January 27, 2012 11:17 AM
To: Dorothy Shockley
Subject: SB 134, 1-27-2011 John D. Younce

Dorothy,

I am relieved to hear there is a bill aiming to change the child support calculations in Alaska. I have paid child support for a number of years and recently began thinking about fairness in regards to the income differences of the parents. I am in favor of a calculation table such as the one SB 134 describes. I imagine most obligors feel the same as I do. The current system is obviously unfair, unjust, and begs for opposition in the form of class action lawsuits by groups of obligors who feel they have been cheated (and also possible retroactive payments from St. of AK). The talk of a class action lawsuit has been out there for a while now, but I was never willing to stand against this system. Thanks to you and Sen Kookesh for giving obligors such as myself the chance to "comfortably" stand against an unjust system. 35 or more other states employ the same system for good reason.

In closing, I appreciate the ease of contacting and discussing this issue with you. It's uncommon to navigate directly to a human voice these days. Although it looks as though this bill may take a few sessions to make the table, my attitude is that the sooner the state changes the language, the less they may be liable to repay later.

Sincerely,

John D. Younce

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Senate Health & Social Srv
Committee Name
Committee on SB 134 Dated 2/3/2012
Bill / Subject

Please enter the following 5 resolutions into the record as requested by Fairbanks resident Scott Calder

SIGNED: Scott Calder via Fax 40 12 pages including cover
Testifier

Representing

fm 474-0174 cell 687-5571
Address / Phone Number

By: Bonnie Williams
Introduced: 10/27/05
Adopted: 10/27/05

FAIRBANKS NORTH STAR BOROUGH

RESOLUTION NO. 2005 - 71

A RESOLUTION SUPPORTING EXTERNAL REVIEW OF THE CASE FILES OF CHILDREN WHO HAVE BEEN PLACED IN OUT-OF-HOME CARE BY STATE AGENCIES

WHEREAS, the Citizen's Review Panel for Permanency Planning Act was enacted in 1990 and required the appointment of local review panels in each judicial district; and

WHEREAS, the local panels were to have reviewed the case plans of each child placed in out-of-home state custody; and

WHEREAS, the Assembly has adopted five other resolutions on this issue asking for compliance with the Act; and

WHEREAS, public citizens are concerned about children who have been placed in out-of-home care by state agencies particularly when there is no external review of the agency's actions for the purpose of quality assurance; and

WHEREAS, efforts to develop a different and new system under the title of "Citizen Review Panel" under the Child Abuse Prevention and Treatment Act (CAPTA), which was most recently reauthorized on June 25, 2003, by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36), have not met the needs and expectations for government accountability regarding cases of children placed outside their family homes; and

WHEREAS, possible failure of state and federal governments to provide appropriate external review of case plans of children in state custody as provided in the original Citizen's Review Panel for Permanency Planning Act of 1990 needs to be reviewed; and

NOW, THEREFORE, BE IT RESOLVED that the Assembly of the Fairbanks North Star Borough urges the Honorable Governor Frank Murkowski and the Alaska State Legislature to restore and reenact the Citizen's Review Panel under Ch. 117 SLA 1990.

BE IT FURTHER RESOLVED that the Assembly encourages and supports creations of public processes to resolve grievances regarding the care of children.

BE IT FURTHER RESOLVED, that the Assembly encourages and supports legislation that would safeguard children and families.

BE IT FURTHER RESOLVED, that copies of this resolution shall be sent to the Honorable Governor Frank Murkowski, the Alaska Interior Delegation and Alaska's Congressional Delegation.

PASSED AND APPROVED THIS 27th DAY OF OCTOBER 2005.

Garry Hutchison
Presiding Officer

ATTEST:

Mona Lisa Drexler, CMC
Municipal Borough Clerk

Ayes: Romans, Bartos, Sattley, Rex, Williams, Hopkins, Aldridge, Frank, Hutchison
Noes: None
Excused:

By: Bonnie Williams
Introduced: 06/24/04
Substituted: 06/24/04
Adopted: 06/24/04

FAIRBANKS NORTH STAR BOROUGH

RESOLUTION NO. 2004 - 50

A RESOLUTION ASKING FOR COMPLIANCE WITH THE CITIZENS REVIEW PANEL FOR PERMANENCY PLANNING ACT OF 1990

WHEREAS, in 1990 the Legislature enacted Ch.117, SLA 1990, which created the Citizens' Review Panels for Permanency Planning in the Department of Administration, and required the appointment of local out-of-home care citizen review panels in each judicial district; and

WHEREAS, these local panels by law should have reviewed the case plans of each child in out of home placement under state custody, beginning fourteen years ago, to shorten the duration of state custody and encourage custody in a permanent home; and

WHEREAS, goals of the Act included the best interest of the child, either in restoration to their own family and home, or in the expeditious placement in other secure and permanent homes; and

WHEREAS, one local panel was appointed 12 years ago experimentally in Anchorage, and was not in compliance with state statute current at the time; and

WHEREAS, in some cases, the best interest of the children are not being met and in fact, harm, danger and even death have occurred involving children in state custody; and

WHEREAS, the Fairbanks North Star Borough Assembly adopted Resolution No. 96-047, requesting the Governor to appoint a local oversight panel needed in Fairbanks; adopted Resolution 97-027 requesting the same, and adopted Resolution No. 2002-94, requesting compliance with the Act; and

WHEREAS, no panel has been appointed in the Fourth Judicial District serving Fairbanks, and legislation is needed to correct the causes of this problem,; and

WHEREAS, it is in the best interests of the State of Alaska to care for its youngest and most vulnerable citizens; and

WHEREAS, quality assurance and quality care of children in state custody will benefit Alaskans and the State of Alaska in the later years of those same children and others.

NOW THEREFORE BE IT RESOLVED that the Fairbanks North Star Borough Assembly respectfully requests that Governor Frank Murkowski implement a local review panel program in compliance with Ch. 117, SLA 1990.

BE IT FURTHER RESOLVED that the Assembly urges each member of the Interior Delegation to sponsor and vote for legislation to create an external, local, citizen review panel program in Fairbanks as part of a statewide program as earlier provided in Ch. 117, SLA 1990.

BE IT FURTHER RESOLVED that copies of this resolution be sent to Governor Frank Murkowski and all members of the Interior Delegation.

PASSED AND APPROVED THIS 24th DAY OF JUNE 2004.

Hank Bartos
Presiding Officer

ATTEST:

Mona Lisa Drexler, CMC
Municipal Borough Clerk

Ayes: Romans, Sattley, Rex, Henry, Williams, Beck, Frank, Aldridge, Cummings, Bartos
Noes: None

By: Bonnie Williams
Introduced: 11/21/02
Adopted: 11/21/02

RESOLUTION 2002-94

A RESOLUTION RELATING TO THE CITIZENS REVIEW PANEL FOR PERMANENCY PLANNING ACT OF 1990 ASKING FOR COMPLIANCE

WHEREAS, in 1990 the Legislature enacted Ch.117, SLA 1990, which created the Citizens' Review Panels for Permanency Planning in the Department of Administration, and required the appointment of local out-of-home care citizen review panels in each judicial district; and

WHEREAS, these local panels by law shall review the case plan of each child in an out-of-home placement with a view to shortening state custody and encouraging custody in a permanent home; and

WHEREAS, goals of the Act included the best interests of the child, for the good of the child, either in restoration to their own family, or expeditiously into a secure, permanent home; and

WHEREAS, no local panel have ever been appointed in this judicial district; and

WHEREAS, only one local panel has ever been appointed in the past 12 years, that being experimentally in Anchorage; and

WHEREAS, the best interests of the child cannot be seen to be met; and

WHEREAS, events receiving news coverage in the past several years indicate that the best interests of the child are in fact not being met in some cases; and

WHEREAS, harm, danger and even death have occurred involving children in state custody; and

WHEREAS, a federal audit completed this year revealed serious flaws and concerns in the State's operations; and

WHEREAS, the Fairbanks North Star Borough Assembly unanimously adopted Resolution No. 96-047, requesting the Governor to appoint a local oversight panel needed in Fairbanks; and adopted Resolution 97-027 requested the same; and

WHEREAS, no panel has yet been appointed in the Fourth Judicial District serving Fairbanks; and

WHEREAS, it is in the best interests of the State of Alaska to care for its youngest and most vulnerable citizens; and

WHEREAS, quality assurance and sound care of children in custody of the State will result in far greater savings of the State in the later years of those same children.

NOW THEREFORE BE IT RESOLVED that the Fairbanks North Star Borough Assembly respectfully requests that Governor-Elect Frank Murkowski consider and appoint a local review panel in Fairbanks in compliance with a state statute passed in 1990.

BE IT FURTHER RESOLVED that copies of this resolution be sent to all members of the Interior Delegation, the Speaker of the House of the Alaska Legislature, and the respective Chairs of HESS and Judiciary in both the State House and the State Senate.

PASSED AND APPROVED THIS 21st DAY OF NOVEMBER 2002.

Richard J. Solie, Jr.
Presiding Officer

ATTEST:

Mona Lisa Drexler, CMC
Municipal Borough Clerk

Ayes: Romans, Hutchison, Sattley, Williams, Beck, Frank, Foote, Cummings, Henry, Solie
Noes: None

By: Ladd McBride
Introduced: 03/27/97
Postponed to the Call of the Chair: 03/27/97
Amended: 04/10/97
Adopted: 04/10/97

RESOLUTION NO. 97-027

A RESOLUTION RELATING TO THE CITIZENS' REVIEW PANEL FOR PERMANENCY PLANNING ACT OF 1990

WHEREAS, in 1990, the Legislature enacted Ch. 117, SLA 1990, which created the Citizens' Review Panels for Permanency Planning in the Department of Administration, and required the appointment of local out-of-home external citizen review panels in each judicial district; and

WHEREAS, the local panels, by law, must review the caseplan of each child in out-of home placement to ensure that children do not linger unnecessarily in state custody, but rather, receive the support and benefit of a permanent home; and

WHEREAS, among the goals of the Act is the goal to reunite children with their own families by ensuring that services are available and appropriate for reunification, or otherwise, to expeditiously place the child in a secure, permanent home; and

WHEREAS, although this legislative Act was effective on July 1, 1990, to date, only a "pilot project" review panel in Anchorage has been established using statewide appropriations, leaving the rest of the State unserved; and

WHEREAS, on June 13, 1996, the Fairbanks North Star Borough Assembly unanimously adopted Resolution No. 96-047, requesting the Governor to appoint a local oversight panel needed in Fairbanks however, no panel has been appointed; and

WHEREAS, the Legislature has introduced Senate Bill 73 and House Bill 100, by the request of the Governor and House Bill 127, sponsored by the Health, Education and Social Services Committee, all three would change significantly the original Act.

WHEREAS, these changes would limit local citizen oversight, reduce citizen participation, and disrupt the continuity of service of the citizen volunteers by encouraging political interference and administrative pressures upon the panel members reviewing agencies involved in state custody of children and would severely diminish the effectiveness of the Act.

NOW THEREFORE BE IT RESOLVED that the Borough Assembly respectfully urges the Governor of the State of Alaska to:

1. Without additional delays, appoint the local out-of-home care external review panels, and the state panel as required by existing state laws in effect since July 1, 1990.

BE IT FURTHER RESOLVED that the Fairbanks North Star Borough Assembly respectfully requests the Alaska State Legislature to:

1. Extend the sunset termination date for the Citizens' Review Panel For Permanency Planning Act an additional four years as provided by existing statute, with no other changes;

2. Appropriate the funds for foster care review requested by the Governor in his FY '98 Operating Budget Proposal, provided that the Governor agrees to implement the statewide program as originally enacted.

BE IT FURTHER RESOLVED that copies of this resolution shall be sent to the Honorable Tony Knowles, Governor, State of Alaska; the Honorable Karen Perdue, Commissioner, Department of Health and Social Services; the Honorable Con Bunde, Chair, House Committee on Health, Education, & Social Services; the Honorable Gary Wilken, Chair, Senate Committee on Health, Education, & Social Services; and all members of the Interior Delegation.

PASSED AND APPROVED THIS 10TH DAY OF APRIL, 1997.

Henry "Hank" Hove
Presiding Officer

ATTEST:

Maria Lisa Drexler, CMC/AAE
Municipal Borough Clerk

Ayes: Kilgore, Parr, Bartos, Quakenbush, McBride, Sonafrank, LaSota, Webb, Sattley and Hove
Noes: St. John

By: Bob Logan
Introduced: 06/13/96
Amended: 06/13/96
Adopted: 06/13/96

RESOLUTION NO. 96-047

A RESOLUTION REQUESTING THE GOVERNOR TO APPOINT A LOCAL OVERSIGHT PANEL FOR PERMANENCY PLANNING

WHEREAS, in 1990, the Legislature enacted ch. 117 SLA 1990 relating to the establishment of a Citizen's Review Panel for Permanency Planning both on the state and the local level; and

WHEREAS, provisions in ch. 117 SLA 1990 require the governor to appoint, for each judicial district, a local citizen out-of-the-home care review panel composed of five members and two alternates who are residents of the judicial district; and

WHEREAS, the local panel is required to review the case plan of each child in the custody of the department who is in a placement other than the child's own home; and

WHEREAS, members of the state panel are to be appointed by the governor from among present members of local citizen review panels established under AS 47.10.420; and

WHEREAS, to date only one local panel, operating in Anchorage, has been appointed and the department claims that this panel is a "pilot" panel to be developed as the "Model Panel"; and

WHEREAS, until all of the local panels are appointed, the state panel cannot be selected; and

WHEREAS, because of the ever-increasing juvenile problems in the state which have multiplied dramatically since 1990 and although this legislation was passed by the legislature in 1990 to address the problems that existed then, little has been accomplished to implement the program; and

WHEREAS, concerned citizens throughout the state are urging the establishment of both the state and local panels.

NOW, THEREFORE, BE IT RESOLVED that the Fairbanks North Star Borough Assembly respectfully requests and urges the governor of the State of Alaska to select the panels in each of the judicial districts in the state, not only to implement the statutes adopted by the legislature, but also to provide for the safety and protection of the juveniles of Alaska and their care providers.

BE IT FURTHER RESOLVED that the Legislature is requested to provide for full funding of the State and Local Panels.

BE IT FURTHER RESOLVED that copies of this resolution shall be sent to the Honorable Tony Knowles, Governor, State of Alaska; the Honorable Mark Boyer, Commissioner, Department of Administration, the Honorable Karen Perdue, Commissioner, Department of Health and Social Services; and all members of the Interior Delegation.

PASSED AND APPROVED THIS 13TH DAY OF JUNE, 1996.

Cheryl Kilgore
Presiding Officer

ATTEST:

Mona Lisa Drexler, CMC/AAE
Municipal Borough Clerk

Ayes: Hackenmiller, Hove, McBride, Quakenbush, LaSota, St. John, Parr, Chizmar and Kilgore
Noes: None

SB 151

<TARGET><BILL>SB 151</BILL><SUBJECT>SB 151</SUBJECT><COMM>SHSS27</COMM></TARGET>

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version: **SB 151**
Fiscal Note Number:
Publish Date:

Identifier (file name): SB151-DOC-OC-03-02-12
Title: "An Act relating to mitigation at sentencing in a criminal defendant convicted of certain sex offenses a prohibition... "
Sponsor: Senator Meyer
Requester: (S)HSS

Dept. Affected: DOC
Appropriation: Admin & Support
Allocation: Commissioner's Office
OMB Component Number: 694

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

This is the original version of the bill.

Prepared by: Leslie Houston, Director — Phone: 907-465-3339
Division: Department of Corrections - Administrative Services — Date/Time: 3/2/12 11:05 AM
Approved by: Joseph D. Schmidt, Commissioner — Date: 3/2/2012
Department of Corrections

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB 151

Analysis

This bill would add fetal alcohol spectrum disorder to the list of mitigating factors at sentencing in a criminal trial. The burden of assessment would be on the courts and therefore would have zero fiscal impact on the Department of Corrections.

FISCAL NOTE

STATE OF ALASKA cost ≠ codes
2012 LEGISLATIVE SESSION

Bill Version **SB151**
Fiscal Note Number
Publish Date

Identifier (file name) SB151-DOA-PDA-1-23-12
Title Fetal Alcohol Spec. Disorder as Mitigator
Sponsor Senators Meyer, Hoffman, Dyson, Menard
Requester Senate Health and Social Services

Dept. Affected Administration
Appropriation Legal and Advocacy Services
Allocation Public Defender Agency
OMB Component Number 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version

Prepared by Quinlan Steiner, Public Defender — Phone 907 334-4414
Division Public Defender Agency — Date/Time 1/20/12 12:15 PM
Approved by John Cramer, Deputy Commissioner — Date 1/23/2012
Department of Administration

(Revised 8/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB151

Analysis

AS 12.55.155(d) allows a sentencing court to impose a sentence less than the presumptive range where mitigating factors have been proven. This bill amends AS 12.55.155(d) by adding section 20, which allows the court to find a factor of mitigation where the defendant committed the offense while affected by fetal alcohol spectrum disorder.

The Public Defender Agency does not anticipate a fiscal impact from this change. Accordingly, the Agency submits a zero fiscal note.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB151-ACS-TRC-3-02-1**
Fiscal Note Number:
Publish Date:

Identifier (file name): SB151-ACS-TRC-3-02-2012
Title: Mitigation at sentencing for defendant with FASD
Sponsor: Senator Meyer
Requester:

Dept. Affected: Alaska Court System
Appropriation: Trial Courts
Allocation:
OMB Component Number: 768

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0..0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial version

Prepared by: Nancy Meade, General Counsel
Division: Alaska Court System
Approved by: Nancy Meade for Christine Johnson, Administrative Director
Alaska Court System

Phone: 907-463-4736
Date/Time: 3/02/2012 4:00 p.m.
Date: 3/2/2012

(Revised 11/17/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB151-ACS-TRC-3-02-12

Analysis

Senate Bill 151 adds a new factor to the list of mitigating factors in AS 12.55.155(d) that the court shall consider at sentencing; if proven, the court may then impose a sentence below the presumptive range for certain crimes. Specifically, except for defendants convicted of offenses against persons , arson, and criminal mischief, and except if the defendant has any prior felony conviction, the court may consider whether the defendant committed the offense "while affected by a fetal alcohol spectrum disorder that was insufficient to constitute a complete defense . . . but that significantly affected the defendant's conduct."

The court cannot predict the number of cases in which parties will attempt to prove this factor as a mitigator at sentencing, but believes the sentencing hearings will be held and handled in the normal course without a fiscal impact. The Alaska Court System therefore submits a zero fiscal note.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB 151**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB151-LAW-CRIM-03-02-12
Title: An Act realing to mitigation at sentencing in a criminal case for a defendant found by the court to have been...
Sponsor: Senator Meyer
Requester: (S) Health and Social Services

Dept. Affected: Law
Appropriation: Criminal
Allocation: Criminal Justice Litigation
OMB Component Number: 2202

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	***	***	***	***	***	***	***

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		***	***	***	***	***	***	***

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version.

Prepared by: Eileen Donahue, Division Operations Manager — Phone: 465-5427
Division: Administrative Services — Date/Time: 3/2/12 5:00 PM
Approved by: Michael C. Geraghty, Attorney General — Date: 3/2/2012
Department of Law

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

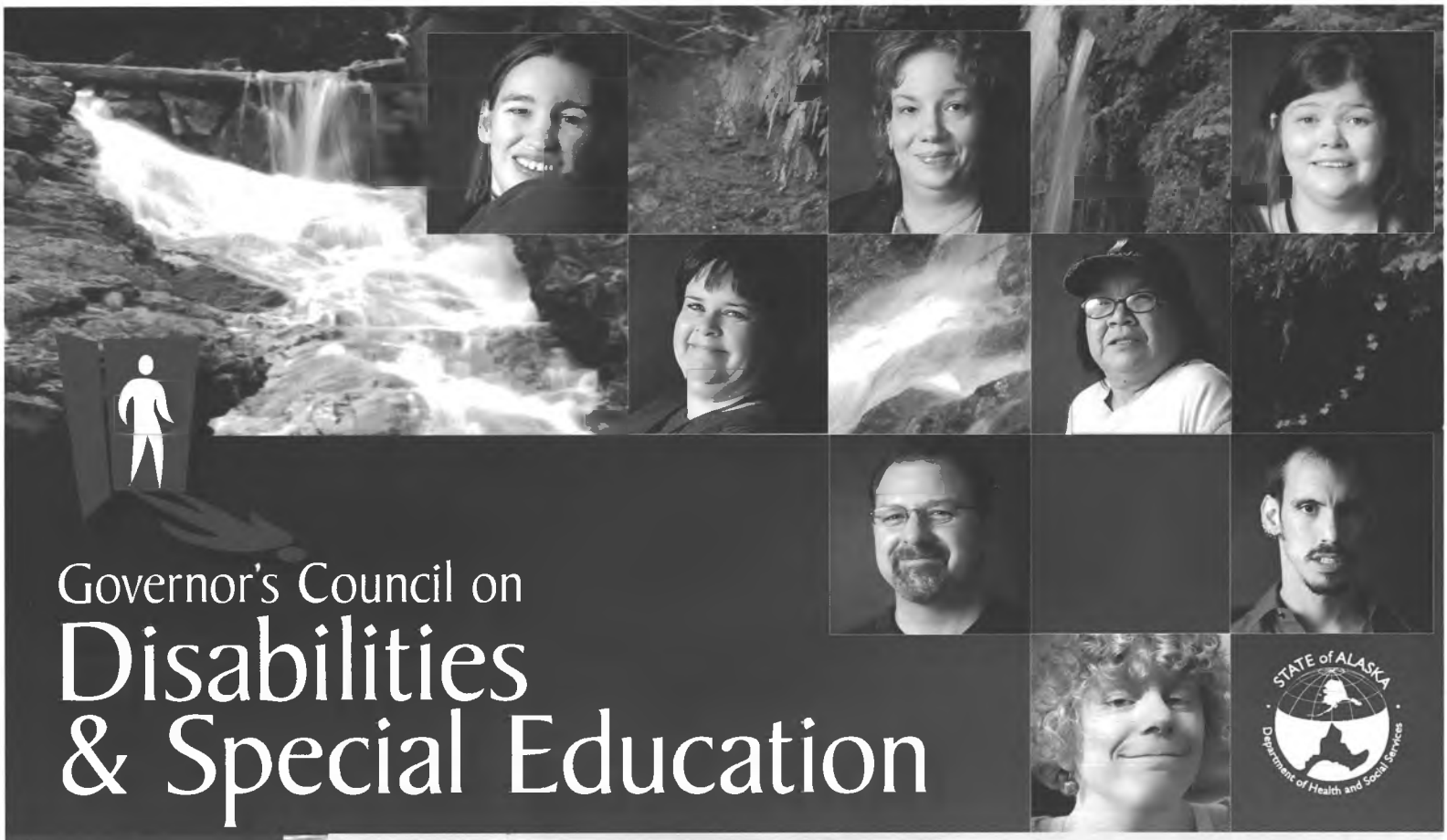
BILL NO. SB 151

Analysis

SB 151 would add as a mitigating factor at sentencing. It would allow a new mitigator if the defendant was affected by a fetal alcohol spectrum disorder that significantly affected the defendant's behavior. If proven, the court would have discretion to reduce the term of imprisonment to below the presumptive range.

The proposed new factor would not apply to persons convicted of crimes against a person (AS 11.41), arson in the first degree (AS 11.46.400), or if the person being sentenced had previously been convicted of a felony.

The fiscal impact for the Departmetn of Law is indeterminate because it will require expert testimony on the issue of whether the person suffers from such a disorder and if so, did it significantly affect his or her behavior.



Governor's Council on Disabilities & Special Education

1 Role

2 Mission

3 The Council in Action

4 Moving Towards Employment

5 Outcomes

6 Priorities

1. Role of the Council

- State Council on Developmental Disabilities
- Special Education Advisory Panel
- Interagency Coordinating Council for Infants and Toddlers with Disabilities
- Governing Board of the Special Education Service Agency
- Beneficiary Board for the Alaska Mental Health Trust Authority

2. Mission

Creating change that improves the lives of Alaskans with disabilities

3. Making Sustainable Change — An Example of the Council in Action

The Council manages the Alaska Works Initiative, a strategic effort funded by the Centers for Medicare & Medicaid Services to improve Medicaid programs and employment infrastructures. The Council works with state agencies, business & industry, service providers and the university to improve employment outcomes for Alaskans with severe disabilities. The Council also receives funding from the Alaska Mental Health Trust Authority to manage the microenterprise grant program, which helps Trust beneficiaries start their own businesses. In addition, the Council received funding from the Department of Education & Early Development to start a Project SEARCH program, which provides internship opportunities to youth with intellectual or developmental disabilities in their last year of school at a host business.

- From 2009 to 2010, there was a **5.6% *increase*** in the number of Alaskans on social security who worked (Note: nationally, there was an average ***4.8% decrease*** in the number of people on Social Security who worked).

State of Alaska • Department of Health & Social Services • Governor's Council on Disabilities & Special Education
3601 C Street, Suite 740, P.O. Box 240249, Anchorage, Alaska 99524-0249 • 907-269-8990

3. Continued … Sustainable Change

- In fiscal year 11, the number of people with developmental disabilities who were employed increased by 10.6% (358 to 396).
- In fiscal year 11, 13 Trust beneficiaries started their own businesses.
- Three Project SEARCH sites were established at Mat-Su Regional Medical Center, Providence Hospital and Fairbanks Memorial Hospital; other partners include the Division of Vocational Rehabilitation, local school districts and disability service providers.

4. Moving toward Employment: Stories of people who have benefited from the work of the Council

- Katie, age 21, was the first student to be hired by one of the host hospitals participating in Project SEARCH. Katie was in the program at Mat-su Regional Medical Center (MRMC) only five months before she was hired to work as a technician in Environmental Services. She works 20-25 hours per week, is a union member and makes over $13 an hour. One of the goals of Project SEARCH is to change the culture of a workplace into one that accepts disability in the workplace. At MRMC, Katie and the other Project SEARCH students have certainly accomplished this.
- Becca is starting Becca's Alpacas in the Mat-Su valley, thanks to start-up funding from the microenterprise grant program. Her business will primarily raise, breed, and sell alpacas. She may also collect and sell alpaca waste as fertilizer for local gardeners, and shear alpaca fleece and have it made into yarn to sell locally and/or online.

5. Other Outcomes for Alaskans with Intellectual or Developmental Disabilities in Fiscal Year 2011

As a result of the Council's work with 119 entities participating in partnerships or coalitions, the following number of people benefited:

- 627 people have needed health services.
- 3,019 people received formal or informal supports.
- 3,297 people have transportation for work, medical and personal needs.
- 81 individuals got and kept employment consistent with their interests and abilities.
- 2,301 students have the education and support they need to reach their educational goals.
- 1,821 infants and young children have services and supports needed to reach developmental goals.
- 384 individuals have homes of their choice.
- 928 people have information, skills, opportunities and supports to live independently, productively and included in all aspects of community life.

6. Fiscal Year 2012-13 Priorities

- Ensuring the continuation of complex behavior collaborative consultation and training services to meet the needs of individuals with cognitive disabilities and challenging behaviors
- Implementing autism insurance reform
- Changing the funding formula for the Special Education Service Agency (SESA) and removing its sunset clause in state statute
- Increasing the employment and self-employment rate of people with disabilities
- Improving services and supports to women with disabilities who are victims of sexual or physical assault
- Increasing access to services for people residing in rural and remote areas of the state

Bill would let judges consider fetal alcohol spectrum disorders

FETAL ALCOHOL: First, its direct role in a crime must be proved.

By AUSTIN BAIRD
Associated Press
Published: March 3rd, 2012 09:43 PM
Last Modified: March 3rd, 2012 11:54 PM

More Legislature stories »

Bill to ax tax breaks for churches hits hurdle

Bill would let judges consider fetal alcohol spectrum disorders

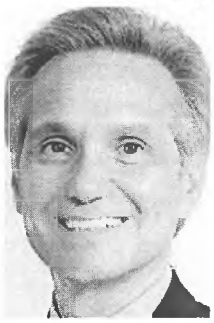
Senate oil tax reform plan advances with concessions

House committee adopts softened school intervention bill

Gatto plans to be back for last month of legislative session

JUNEAU -- A proposal before the Alaska Legislature would give judges flexibility when handing down criminal sentences to people who were born with effects caused by their mother drinking during pregnancy.

Click to enlarge



Click to enlarge

Kevin Meyer

Judges are not allowed to consider fetal alcohol spectrum disorders -- a catch-all phrase for conditions caused by prenatal exposure to alcohol -- during criminal sentencing. SB151 would change that by adding FASD to the list of mental conditions that judges can consider as a mitigating factor.

Senate Majority Leader Kevin Meyer, R-Anchorage, worked with a statewide coalition from various professions called the Alaska FASD Partnership to craft the bill in response to the large number of people affected by the fetal alcohol disorders in the criminal justice system. Meyer said a mitigating factor is not a "get out of jail free card" and only reduces punishment if it's proved that a condition played a direct role in a crime. The bill calls for proof of documentation of prenatal alcohol use as well as a convincing clinical diagnosis.

The proposal is welcomed by advocates but not touted as a cure-all.

Public understanding of the issue is lacking, according to Teri Tibbett, the partnership's coordinator, and problems are multifaceted and complex.

"Alcohol has been around for a long time and so have women," Tibbett said. "Those two have gone together about that long but we understand the impacts better now than ever."

Modern research has determined that cell death caused by exposure to alcohol in the womb is the root of damage, according to Susan Astley, an epidemiology professor at the University of Washington. The best-known result is a series of distinct facial features -- smaller eye openings, a thin upper lip and the ridges below the nose are smooth -- but other problems are also common, she said.

Morgan Fawcett is a 19-year-old getting ready to study journalism but for now he travels around the U.S. and Canada sharing the story of his struggles with prenatal alcohol exposure with clinicians, lawmakers and others interested groups.

Fawcett recently told a group in Juneau that he made it to his early teens with an array of unexplained problems. He said he couldn't focus or remember things he was just told; that he was often at a loss during class; that his jaw would lock, sometimes tightly enough that he couldn't eat or drink, and that he suffered debilitating migraines.

He was 14 when he realized those problems and others resulted from his mother's drinking during pregnancy.

"I was angry at (my mother) in the beginning but I love her and I know she didn't do this on purpose," Fawcett said. "No mother would do this intentionally. If more people understood this, mothers wouldn't be the focus."

Alaska has been somewhat of a national leader by creating a network of diagnostic clinics and treatment programs, Astley said.

Story tools
21 Comments
E-mail a friend
Print
Share on Facebook
Digg this
Seed Newsvine
Send link via AIM
Tweet this
MY YAHOO!
Font size : A | A | A

ADVERTISEMENT

findnsave Get the Deal!
Local Deals

$500 OFF Pair of NEW Wi110 or Soundless Hearing Aids
Accurate Hearing Systems, LLC
$500 off Wi110 hearing aids

0% Interest for 60 Months* Expires March 9th, 2012
Integrity Roofing & Windows
0% interest for 60 months

$500 OFF Pair of NEW Wi110 or Soundless Hearing Aids
Accurate Hearing Systems, LLC
$500 off Wi110 hearing aids

Find more great deals!
findnsave.adn.com

Top Jobs all 134 top jobs

alaskacareerbuilder find

Place an ad | Advanced search

Human/Social Services
Case Manager, 2 FT - FSS
The Arc of Anchorage

Engineering/Technical
Project Managers
Aramco

Executive/Professional
VP Operations
Ukpeagvik Inupiat Corp

Engineering/Technical
Chief Engineer and Watch Officer
Pacific Breeze Fisheries LLC

Human/Social Services
Program Director
Graf Rheeneerhaanjii Adolescent Treatment Center/Fairbanks Native Association

Top Homes by Prudential more

731 Hunt Circle
Close to schools, bases, shopping, and park. Sth facing wndws for sun and mnt views.Attractive ceiling lines,lam firs, near grnbelt areas. At end of quiet culdesac.

◄ 11 of 15 ►

HomeFinder.com find

Search ADN Real Estate | Place a homes ad
Realtor Market Place | Homefinder Magazine

Top Rentals more

Continental Apartments
Midtown: Our property features lush landscaping in a quiet, peaceful environment.

"Damage can take place throughout pregnancy, from very early to the very end," she said. "It's impossible to predict exactly what damage will take place if you drink at a certain time and you can't tell for sure when certain effects were caused."

Seven-term Rep. Beth Kerttula, D-Juneau, remembers when discussion in the Capitol started and ended with how severely mothers should be punished. Kerttula recalls a fellow legislator saying during a committee hearing a few years ago that drinking pregnant women should be taken to the wharf in downtown Juneau, latched into stockades and have tomatoes thrown at them.

Meyer said another bill would have held bartenders in Alaska criminally liable if they served alcohol to pregnant women.

"People have the right heart, even when they put up ideas like this," Meyer said. "You want an easy target and, sure, the mothers are easy targets. But if it was that simple, someone else would have fixed this already."

Judge Michael Jeffery of the Barrow District Court, which serves the North Slope, said a 1990 case that involved an 18-year-old affected by fetal alcohol syndrome brought the problem to his attention. Jeffery sympathized with a request by the young man's lawyer who wanted the condition to count as a mitigating factor but a panel of judges determined he could not add conditions at his discretion.

"Extra jail time didn't help him or anyone else and it's true for many people," Jeffery said.

Jeffery learned the problem is endemic in his community and around the state, especially so in the justice system: An estimated 27 percent of Alaska's inmate population has fetal alcohol syndrome, according to a 2006 state report.

Long before Jeffery's experience in the United States' northernmost court became the basis of SB151, he implemented a few changes of his own.

He uses plain English and large type to account for poor reading comprehension commonly associated with FASD during his court cases. Listening comprehension is another common problem, with only the last few words of sentences heard and remembered, so Jeffery repeats important points often and carefully structures sentences. Another procedure has caused tense moments, he said: He explains common effects of FASD, how it is caused and where to find treatment, often with parents and relatives in attendance.

"If someone doesn't speak the language, you give them a translator in court," Jeffery said. "What I'm doing for people with this disorder is no different. They don't understand things the same way, interpret information the same."

He said he wants to see similar changes elsewhere, and to that end the American Bar Association is working on a resolution that addresses some of the concerns about justice and FASD. Howard Davidson, who runs the ABA's Center on Children and the Law, said the resolution is modeled after a similar step taken by the Canadian Bar Association in 2010; he said the wording is still being refined but could be ready for a vote of approval in time for the group's national convention this August.

SB151 has attracted eight co-sponsors and the Senate Health and Social Services Committee will start discussion Monday.

8 of 11 ▶

apartments.com

Advanced Search | Place a rentals ad

Top Autos all autos

Harleys Auto Park

2006 Chevrolet Cobalt
$8,995
Harleys Auto Park

2 of 10 ▶

cars.com™

Search for a New or Used Car | Place an auto ad

Featured Advertisers all

Alaska Native Heritage Center
The Alaska Native Heritage Center is a nonprofit with the mission of sharing and perpetuating and preserving the unique Alaska Native cultures, languages, traditions and values through celebration and education.

Alaska Railroad
We provide scenic Alaska rail-tours and exciting vacations.

6th Avenue Outfitters
Retailer for Outdoor apparel and equipment. Exclusive Dealer for Alaskan Outfitters Inflatable Boats and the famous Alaskan Raft-A-Cat.

Best Deals more deals »

Pets
Find puppies, kittens, and all pet supplies and services here. More...

Other Transportation
Find great deals on bicycles, snowmachines, ATV's, watrcraft and airplanes. More...

Merchandise, Miscellaneous
Antiques, apparel, even the kitchen sink. Find deals on general merchandise here. More...

More great deals »

Advanced Search | Place an ad | Special Sections

Comments

NEW STORY COMMENTS: Learn about our upgrade | Create an avatar in the new system »

By submitting your comment, you are agreeing to adn.com's user agreement.

Hide comments Like

Add New Comment Login

Type your comment here.

Real-time updating is **enabled**. (Pause)

Showing 1-10 of 21 comments Sort by newest first

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 2, 2012

Senator Kevin Meyer
Alaska State Capitol, Room 103
Juneau, Alaska 99801

Re: Letter of Support for CSSB 151 – Mitigation at Sentencing for a Defendant Affected by FASD

Dear Senator Meyer,

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse support the committee substitute for SB 151 (CSSB 151). This bill recognizes the special needs presented by Alaskans experiencing fetal alcohol spectrum disorders (FASD) in the justice system.

It is an objective of Alaska's comprehensive mental health program that people with mental and cognitive disabilities are treated with dignity in all aspects of life. Our judges, prosecutors, defenders, and court staff work to ensure that everyone who appears in court is treated fairly and with respect. However, Alaskans experiencing FASD often present with special needs and situations that impede the course of justice. Low cognitive functioning, inability to understand and stay within accepted social norms, limited short term memory, impulsivity, and impaired judgment can all result in a person experiencing FASD not being able to explain his or her actions, understand why they resulted in a criminal charge, or understand the criminal justice process. Usually, these impairments do not rise to the level of legal incompetence – but they often make it hard for judges and juries to make decisions that serve our notions of fairness and justice.

Based on research in other jurisdictions, an estimated 60% of inmates experience an FASD, brain injury, or similar organic cognitive impairment. The cost of incarceration is very high and usually does not result in restoration or rehabilitation. In fact, according to a 2009 ISER Study,[1] the cost of prison far exceeds the cost of services. CSSD 151 allows judges – **at their discretion** – to modify presumptive sentences to take into account the defendant's disabilities and to provide the sort of sentence needed to prevent recidivism and ensure a just outcome for victims, defendants, and our communities.

We thank you for your work on behalf of all Alaskans.

Sincerely,

J. Kate Burkhart
Executive Director

[1] *The Cost of Crime: Could The State Reduce Future Crime and Save Money by Expanding Education and Treatment Programs?* published by Institute of Social and Economic Research (ISER), University of Alaska (January 2009). Available online at www.iser.uaa.alaska.edu.

Alaska FASD Partnership

Over 75 organizations and individuals supporting:

Advocacy ▪ Diagnosis
▪ Case Management
▪ Prevention
▪ Substance Abuse Treatment for Pregnant Women
▪ Parent Navigation
▪ Training for Parents
▪ Public Awareness
▪ Alternatives to Incarceration
▪ Court Interpreters
▪ Peer Support
▪ Training for Judges, Public Defenders, and Prosecutors
▪ Training for Educators and Medical Professionals
▪ Traditional Healing
▪ Supported Housing and Employment
▪ Family Support

March 2, 2012

Senator Kevin Meyer
Alaska State Legislature
Juneau, Alaska 99801

Dear Senator Meyer,

It is with great pleasure that the Alaska FASD Partnership supports the proposed committee substitute for SB 151 to include FASD, Traumatic and Acquired Brain Injury, and Intellectual Disability as "impaired brain function" in the definition of "mental disease or defect."

The Partnership also supports the bill's intent to include FASD and traumatic and acquired brain injury as mitigating factors related to sentencing.

Individuals diagnosed with a fetal alcohol spectrum disorder (FASD) or a traumatic or acquired brain injury (T/ABI) are disproportionately represented within Alaska's criminal justice system. However, the intent underlying Alaska's sentencing structure – that people will modify their behaviors based on the criminal justice system's response to their crimes – is not met when applied to individuals with FASD or T/ABI. These disabilities manifest as deficits in executive function resulting in impaired adaptive behavior, memory difficulties, an inability to plan, and a failure to recognize the consequences of actions. In the interest of justice, it is important to take these deficits into account during sentencing. Neither the offender nor society benefits from holding individuals with FASD or T/ABI to community standards that they cannot possibly attain given their impairments.

The cost of incarceration in Alaska's prison is about $136 per day. Over the course of five to ten years in an Alaskan prison, an inmate is expected to cost the state close to $250,000-$500,000 (not including medical, mental health or other specialized treatment while incarcerated).

According to the 2009 ISER Study, *The Cost of Crime: Could the State Reduce Future Crime and Save Money by Expanding Education and Treatment Programs?*" the cost of providing services is less than the cost of incarceration. With appropriate supports, clients with FASD, T/ABI and other brain-based disabilities can live successfully in the community as contributing citizens, ***and*** provide jobs for Alaskan case workers, clinicians, assisted living providers, mental health and substance abuse

Alaska Fetal Alcohol Spectrum Disorders (FASD) Partnership
431 N. Franklin St. Suite 203, Juneau, Alaska 99801 ▪ (907) 465-8920
Webpage: www.hss.state.ak.us/fasd.htm ▪ email: akfasdpartnership@alaska.gov

counselors, psychologists and psychiatrists. Not only does CSSB 151 further the cause of justice for a vulnerable population, it represents a better investment of our state's resources.

Additionally, the state's movement toward "Smart Justice" will promote less crime, reduced public costs, and greater rehabilitative effect on offenders. The research behind "Smart Justice" suggests that spending money on rehabilitating offenders is more cost effective than paying the high costs associated incarceration and recidivism, including public safety, courts, prisons, alcoholism and drug abuse programs.

Thank you for the time and effort you have put into supporting this important effort.

Sincerely,

Monica Charles Leinberger

Monica Charles-Leinberger, Chair
Alaska FASD Partnership

Partnership members include: *Abused Women's Aid in Crisis, Advisory Board on Alcoholism and Drug Abuse, Alaska Behavioral Health Association, Alaska Center for Children & Adults, Alaska Children's Services, Alaska Mental Health Board, Alaska Mental Health Trust Authority, Alaska Peer Support Consortium, Alaska Youth & Family Network, All-Alaska Pediatric Partnership, Anchorage Coordinated Resources Project, Anchorage School District (Anchorage), Arctic FASD Regional Training Center, Assets Inc., Association for the Education of Young Children-SEAK , Big Brothers Big Sisters of Alaska, Boys & Girls Home of Alaska, Camp Fire USA Alaska Council, Central Council of the Tlingit & Haida Indian Tribes of Alaska, Christian Health Associates, Copper Basin Neurodevelopmental Center, Deltana Community Services Partnership, Dena A Coy/Southcentral Foundation, Diocese of Juneau, Fairbanks Community Behavioral Health Center, Family Centered Services of Alaska, Frontier Community Services, Gastineau Human Services, Governor's Council on Disabilities and Special Education, Hoonah Indian Association, Hope Community Resources, Independent Living Center, Kenai Peninsula FASD Program, Ketchikan Indian Community, Kinetictions, Kobuk Valley Consulting, Kodiak Area Native Association, Juneau Family Health and Birth Center, Juneau FASD Diagnostic Clinic, Juneau Partnerships for Families and Children, Lower Kuskokwim School District, Lynn Canal Counseling Services, Nenana City School District, Nome Youth Facility, Nondalton Tribe, Regional Wellness Forum, Set Free Alaska, Inc. (Wasilla), Southcentral Foundation FAS Diagnostic Team, Southeast Regional Health Consortium, Southeast Regional Resource Center, Southern Kenai Peninsula Communities Project, Sprout Family Services, Stone Soup Group, Tongass Substance Screening, UAA Department of Health Sciences, UAA Center for Human Development, Volunteers of America-Alaska ...and many individuals.*

The TRUST

The Alaska Mental Health
Trust Authority

March 2, 2012

Senator Kevin Meyer
State Capitol Building
Juneau, Alaska 99801

Dear Senator Meyer,

The Alaska Mental Health Trust Authority is pleased to support SB 151, adding fetal alcohol spectrum disorders and traumatic and acquired brain injury as mitigating factors under "mental disease or defect" in state statute. The Trust also supports the bill's intention to use the word "intellectual disability" to describe Alaskans with developmental disabilities, rather than the archaic term "mental retardation."

This legislation is an important step in the state's recognition that people with disabilities are better served with supports and services, rather than incarceration without supports.

SB 151 fulfills a recommendation adopted by the Alaska Criminal Justice Assessment Commission that "the legislature should create a statutory mitigating factor for use at criminal sentencing, recognizing when the wrongful conduct was substantially affected by an organic brain disorder." [1]

SB 151 also supports a recommendation currently before the American Bar Association stating that the ABA "... urges lawyers and judges, as well as bar associations and law school clinical programs, to support training that includes law school law enforcement, and legal/judicial education curricula on enhanced awareness of the child and adult disability of Fetal Alcohol Spectrum Disorders (FASD) and its impact on individuals in the child welfare, juvenile justice, and adult criminal justice systems, and that they work with medical, mental health, and FASD disability experts to promote: ... (d) applying FASD as a mitigating factor in the mitigation of juvenile justice and criminal sentencing ... and consideration of alternatives to incarceration that reduce recidivism."

The Trust thanks Senator Meyer's efforts to address issues related to people with disabilities, so that the most appropriate (and cost effective) outcomes are realized.

Sincerely,

Jeff Jessee
Chief Executive Officer
Alaska Mental Health Trust Authority

[1] Alaska Criminal Justice Assessment Commission (2000). *Final Report.* Retrieved October 12, 2010 from www.hss.ajc.state.ak.us/reports/CJAC Final 2004.pdf, at p.71.

DISABILITY LAW CENTER OF ALASKA

ANCHORAGE
3330 Arctic Boulevard
Suite 103
Anchorage, AK 99503
(907) 565-1002
FAX (907) 565-1000
1-800-478-1234
www.dlcak.org

March 2, 2012

Senator Kevin Meyer
State Capitol Room 103
Juneau AK, 99801

Re: Support for SB 151

Dear Senator Meyer:

The Disability Law Center of Alaska supports the objective of SB 151, which is to allow the courts to take into consideration during sentencing whether the defendant was diagnosed with a fetal alcohol spectrum disorder, a traumatic brain injury or an acquired brain injury. If these conditions cannot be considered as mitigating factors, then as one jurist observed, these individuals are paying for their disability with their freedom.

Thank you for your efforts in correcting this manifest injustice.

Sincerely,

DISABILITY LAW CENTER OF ALASKA

David C. Fleurant
Executive Director

MEMBER OF THE NATIONAL DISABILITY RIGHTS NETWORK

CS FOR SENATE BILL NO. 151(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS MEYER, Hoffman, Dyson, Menard, Paskvan, Egan, Davis, Ellis, McGuire

A BILL

FOR AN ACT ENTITLED

"An Act relating to inclusion of fetal alcohol spectrum disorders, traumatic and acquired brain injury, and intellectual disability in the definition of 'mental disease or defect'; and relating to mitigation at sentencing in a criminal case for a defendant suffering from a mental disease or defect."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 12.47.130(5) is amended to read:

(5) "mental disease or defect" means a disorder of thought or mood **or a condition of impaired brain function** that substantially impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life; "mental disease or defect" also includes **"intellectual disability"** [MENTAL RETARDATION], which means a significantly below average general intellectual functioning that impairs a person's ability to adapt to or cope with the ordinary demands of life; **in this paragraph, "condition of impaired brain function" means fetal alcohol spectrum disorders or traumatic and acquired brain injury;**

*** Sec. 2.** AS 12.55.155(d) is amended to read:

(d) The following factors shall be considered by the sentencing court if proven in accordance with this section, and may allow imposition of a sentence below the presumptive range set out in AS 12.55.125:

(1) the offense was principally accomplished by another person, and the defendant manifested extreme caution or sincere concern for the safety or well-being of the victim;

(2) the defendant, although an accomplice, played only a minor role in the commission of the offense;

(3) the defendant committed the offense under some degree of duress, coercion, threat, or compulsion insufficient to constitute a complete defense, but that significantly affected the defendant's conduct;

(4) the conduct of a youthful defendant was substantially influenced by another person more mature than the defendant;

(5) the conduct of an aged defendant was substantially a product of physical or mental infirmities resulting from the defendant's age;

(6) in a conviction for assault under AS 11.41.200 - 11.41.220, the defendant acted with serious provocation from the victim;

(7) except in the case of a crime defined by AS 11.41.410 - 11.41.470, the victim provoked the crime to a significant degree;

(8) before the defendant knew that the criminal conduct had been discovered, the defendant fully compensated or made a good faith effort to fully compensate the victim of the defendant's criminal conduct for any damage or injury sustained;

(9) the conduct constituting the offense was among the least serious conduct included in the definition of the offense;

(10) the defendant was motivated to commit the offense solely by an overwhelming compulsion to provide for emergency necessities for the defendant's immediate family;

(11) after commission of the offense for which the defendant is being sentenced, the defendant assisted authorities to detect, apprehend, or prosecute other

persons who committed an offense;

(12) the facts surrounding the commission of the offense and any previous offenses by the defendant establish that the harm caused by the defendant's conduct is consistently minor and inconsistent with the imposition of a substantial period of imprisonment;

(13) the defendant is convicted of an offense specified in AS 11.71 and the offense involved small quantities of a controlled substance;

(14) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the distribution of a controlled substance, other than a schedule IA controlled substance, to a personal acquaintance who is 19 years of age or older for no profit;

(15) the defendant is convicted of an offense specified in AS 11.71 and the offense involved the possession of a small amount of a controlled substance for personal use in the defendant's home;

(16) in a conviction for assault or attempted assault or for homicide or attempted homicide, the defendant acted in response to domestic violence perpetrated by the victim against the defendant and the domestic violence consisted of aggravated or repeated instances of assaultive behavior;

(17) except in the case of an offense defined by AS 11.41 or AS 11.46.400, the defendant has been convicted of a class B or C felony, and, at the time of sentencing, has successfully completed a court-ordered treatment program as defined in AS 28.35.028 that was begun after the offense was committed;

(18) [EXCEPT IN THE CASE OF AN OFFENSE DEFINED UNDER AS 11.41 OR AS 11.46.400 OR A DEFENDANT WHO HAS PREVIOUSLY BEEN CONVICTED OF A FELONY,] the defendant committed the offense while suffering from a mental disease or defect as defined in AS 12.47.130 that was insufficient to constitute a complete defense but that significantly affected the defendant's conduct;

(19) the defendant is convicted of an offense under AS 11.71, and the defendant sought medical assistance for another person who was experiencing a drug overdose contemporaneously with the commission of the offense.

SB 172

<TARGET><BILL>SB 172</BILL><SUBJECT>SB 172</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/20/12

Date of 5-Day Notice: 1/24/12
(in accordance with Uniform Rule 23)

FURTHER: Judiciary

DATE TURNED IN TO OFFICE: 1/30/12

Health and Social Services Committee considered SENATE BILL NO. 172

SB 172-CARE DIRECTIVES/DO NOT RESUSCITATE ORDERS

"An Act relating to health care decisions, including do not resuscitate orders."

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Meyer	X			
	Egan	X			
	DYSON	X			
CHAIR:	Davis	X			

Senator Fred Dyson

SPONSOR STATEMENT

SB 172 – An Act Relating to Health Care Decisions, Including Do Not Resuscitate Orders

The purpose of this bill is to provide for the protection of a patient's right to prevent a physician from issuing a Do Not Resuscitate (DNR) order on the patient without the expressed consent of that patient, or if the patient lacks capacity, without the expressed consent of the authorized agent of the patient, or, if no one is available or known to be authorized to speak for the patient and the patient lacks capacity, without the concurrence of a second physician.

In 2004 and 2005 the Alaska Legislature drafted the current AS 13.52 *Health Care Decisions Act.* The Legislature included language in AS 13.52.120(a) establishing a *presumption in favor of life.* Legislative Legal states the language of the Health Care Decision Act, when read in its entirety, supports interpreting the chapter to allow a patient (or the patient's authorized representative) to prevent a physician from issuing a DNR order, but that ambiguities in the chapter could result in other interpretations.

This ambiguity in statute allows unnecessary emotional and mental anguish to Alaskan residents faced with critical end of life decisions. SB 172 clarifies the authority of DNR decisions with respect to patients and physicians, and amends the Alaska Health Care Directive form to allow patients to accept or refuse life-sustaining procedures.

Contact: Chuck Kopp, Staff to Senator Fred Dyson, (907)465-2199

SENATE BILL NO. 172

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - SECOND SESSION

BY SENATORS DYSON, Davis, Coghill, McGuire, Olson

Introduced: 1/20/12
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care decisions, including do not resuscitate orders."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 13.52.045 is amended by adding a new subsection to read:

(b) A health care institution or health care facility may not interpret the issuance of a do not resuscitate order for a patient as preventing the health care institution or health care facility from providing life-sustaining procedures to the patient.

*** Sec. 2.** AS 13.52.060(e) is amended to read:

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience, except **that a health care provider may not decline to comply with** [FOR] a do not resuscitate order **that is consistent with this chapter for reasons of conscience**. A health care institution or health care facility may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution or facility that is expressly based on reasons of conscience and if the policy was timely

communicated to the patient or to a person then authorized to make health care decisions for the patient. **Notwithstanding the other provisions of this subsection, this subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an individual instruction or a health care decision that requests that cardiopulmonary resuscitation or other resuscitative measures be provided.**

* **Sec. 3.** AS 13.52.060(f) is amended to read:

(f) A health care provider, health care institution, or health care facility may decline to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the provider, institution, or facility**, except that this subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an advance health care directive or a health care decision that requests that cardiopulmonary resuscitation or other resuscitative measures be provided**. In this subsection, "medically ineffective health care" means health care that according to reasonable medical judgment cannot cure the patient's illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress.

* **Sec. 4.** AS 13.52.065(a) is amended to read:

(a) A physician may issue a do not resuscitate order for a patient of the physician **only as provided in this section**. The physician shall document the grounds for the order in the patient's medical file.

* **Sec. 5.** AS 13.52.065(b) is amended to read:

(b) The department shall by regulation adopt a protocol, subject to the approval of the State Medical Board, for do not resuscitate orders that sets out a standardized method of procedure for the withholding of cardiopulmonary resuscitation by health care providers and health care institutions. **The protocol adopted by the department must comply with this section.**

* **Sec. 6.** AS 13.52.065 is amended by adding new subsections to read:

(g) Except as provided in (h) of this section, a physician may not issue a do not resuscitate order for a patient of the physician without the express consent of

(1) the patient, if the patient has capacity and is 18 years of age or older; under this paragraph, the consent may be provided by an advance health care directive; or

(2) a person authorized to make health care decisions for the patient.

(h) A physician may issue a do not resuscitate order for a patient of the physician without the express consent required by (g) of this section if the patient does not have capacity, no person is authorized to make health care decisions for the patient, and,

(1) if the patient has an advance health care directive, the directive indicates that the patient wants a do not resuscitate order; or

(2) if the patient has an advance health care directive, the directive is silent about the issuance of a do not resuscitate order and another physician concurs in the decision to issue a do not resuscitate order.

(i) A physician shall revoke a do not resuscitate order issued for a patient if

(1) the issuance of the do not resuscitate order violates (g) of this section;

(2) except as provided in (5) of this subsection, the patient has capacity and requests that the do not resuscitate order be revoked;

(3) the patient has an advance health care directive that indicates that the patient does not want a do not resuscitate order;

(4) the patient does not have capacity, the patient does not have an advance health care directive that indicates that the patient wants a do not resuscitate order, and a person authorized to make health care decisions for the patient requests or does not oppose the revocation of the do not resuscitate order; or

(5) the patient is under 18 years of age and the parent or guardian of the patient requests that the do not resuscitate order be revoked.

(j) A physician may revoke a do not resuscitate order issued by another physician for a patient, if the physician has a

(1) physician-patient relationship with the patient; or

(2) health care obligation to the patient arising out of the physician's

(A) individual relationship with the patient; or

(B) employment by the health care institution or health care facility where the patient is being treated.

* **Sec. 7.** AS 13.52.080(a) is amended to read:

(a) A health care provider or health care institution that acts in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for

(1) providing health care information in good faith under AS 13.52.070;

(2) complying with a health care decision of a person based on a good faith belief that the person has authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;

(3) declining to comply with a health care decision of a person based on a good faith belief that the person then lacked authority;

(4) complying with an advance health care directive and assuming in good faith that the directive was valid when made and has not been revoked or terminated;

(5) participating in the withholding or withdrawal of cardiopulmonary resuscitation under the direction or with the authorization of a physician or upon discovery of do not resuscitate identification upon an individual;

(6) causing or participating in providing cardiopulmonary resuscitation or other life-sustaining procedures

(A) under AS 13.52.065(e) when an individual has made an anatomical gift;

(B) because an individual has made a do not resuscitate order ineffective under **AS 13.52.065** [AS 13.52.065(f)] or another provision of this chapter; or

(C) because the patient is a woman of childbearing age and AS 13.52.055 applies; or

(7) acting in good faith under the terms of this chapter or the law of another state relating to anatomical gifts.

*** Sec. 8.** AS 13.52.080(c) is amended to read:

(c) A health care provider, health care institution, or health care facility is not subject to civil or criminal liability, or to discipline for unprofessional conduct, if a do not resuscitate order prevents the health care provider, health care institution, or health care facility from attempting to resuscitate a patient who requires cardiopulmonary resuscitation or other resuscitative measures because of complications arising out of health care being administered to the patient by the health care provider, health care institution, or health care facility. This subsection does not apply if

(1) the complications suffered by the patient are caused by gross negligence or reckless or intentional actions on the part of the health care provider, health care institution, or health care facility**; or**

(2) the do not resuscitate order relied on by the health care provider, health care institution, or health care facility was issued in violation of AS 13.52.065.

*** Sec. 9.** AS 13.52.120(b) is amended to read:

(b) Notwithstanding any other provision of law **except (h) of this section**, death resulting from the withholding or withdrawal of cardiopulmonary resuscitation or other life-sustaining procedures does not, for any purpose, constitute a suicide or homicide if the withholding or withdrawal is

(1) consistent with this chapter**, except that a violation of AS 13.52.065(g) - (i), does not, for any purpose, constitute a homicide**; and

(2) from an individual

(A) for whom a do not resuscitate order has not been issued;

(B) for whom a do not resuscitate order has been issued under

(i) the protocol for do not resuscitate orders established under AS 13.52.065; or

(ii) a do not resuscitate identification found on the individual.

*** Sec. 10.** AS 13.52.120 is amended by adding a new subsection to read:

(h) The provisions of (b) of this section do not apply to a person who orders or causes the withholding or withdrawal of cardiopulmonary resuscitation or other life-

sustaining procedures if the person acts intentionally, recklessly, with criminal negligence, or with gross negligence. In this subsection, "intentionally," "recklessly," and "criminal negligence" have the meanings given in AS 11.81.900.

* **Sec. 11.** AS 13.52.300 is amended to read:

Sec. 13.52.300. Optional form. The following sample form may be used to create an advance health care directive. The other sections of this chapter govern the effect of this or any other writing used to create an advance health care directive. This form may be duplicated. This form may be modified to suit the needs of the person, or a different form that complies with this chapter may be used, including the mandatory witnessing requirements:

ADVANCE HEALTH CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care to the extent allowed by law. You also have the right to name someone else to make health care decisions for you to the extent allowed by law. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form if the form complies with the requirements of AS 13.52.

Part 1 of this form is a durable power of attorney for health care. A "durable power of attorney for health care" means the designation of an agent to make health care decisions for you. Part 1 lets you name another individual as an agent to make health care decisions for you if you do not have the capacity to make your own decisions or if you want someone else to make those decisions for you now even though you still have the capacity to make those decisions. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you that you could legally make for yourself. This form has a place for you to limit the authority of your agent. You do not have to limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right, to the extent allowed by law, to

(a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration or discontinuation of psychotropic medication;

(b) select or discharge health care providers and institutions;

(c) approve or disapprove proposed diagnostic tests, surgical procedures, and programs of medication;

(d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care; and

(e) make an anatomical gift following your death.

Part 2 of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law, except you may not authorize mercy killing, assisted suicide, or euthanasia. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to make an anatomical gift following your death.

Part 4 of this form lets you make decisions in advance about certain types of mental health treatment.

Part 5 of this form lets you designate a physician to have primary

responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as your agent to make sure that the person understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time, except that you may not revoke this declaration when you are determined not to be competent by a court, by two physicians, at least one of whom shall be a psychiatrist, or by both a physician and a professional mental health clinician. In this advance health care directive, "competent" means that you have the capacity

(1) to assimilate relevant facts and to appreciate and understand your situation with regard to those facts; and

(2) to participate in treatment decisions by means of a rational thought process.

PART 1

DURABLE POWER OF ATTORNEY FOR
HEALTH CARE DECISIONS

(1) DESIGNATION OF AGENT. I designate the following individual as my agent to make health care decisions for me:

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (zip code)

_____

(home telephone) (work telephone)

OPTIONAL: If I revoke my agent's authority or if my agent is not

willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

_____

(name of individual you choose as first alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home telephone) (work telephone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent

_____

(name of individual you choose as second alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home telephone) (work telephone)

(2) AGENT'S AUTHORITY. My agent is authorized and directed to follow my individual instructions and my other wishes to the extent known to the agent in making all health care decisions for me. If these are not known, my agent is authorized to make these decisions in accordance with my best interest, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

Under this authority, "best interest" means that the benefits to you resulting from a treatment outweigh the burdens to you resulting from that treatment after assessing

(A) the effect of the treatment on your physical, emotional, and cognitive functions;

(B) the degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment;

(C) the degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;

(D) the effect of the treatment on your life expectancy;

(E) your prognosis for recovery, with and without the treatment;

(F) the risks, side effects, and benefits of the treatment or the withholding of treatment; and

(G) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. Except in the case of mental illness, my agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. In the case of mental illness, unless I mark the following box, my agent's authority becomes effective when a court determines I am unable to make my own decisions, or, in an emergency, if my primary physician or another health care provider determines I am unable to make my own decisions. If I mark this box, my agent's authority to make health care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this durable power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN. If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named under (1) above, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making health care decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want. There is a state protocol that governs the use of do not resuscitate orders by physicians and other health care providers. You may obtain a copy of the protocol from the Alaska Department of Health and Social Services. A "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to you.

(6) END-OF-LIFE DECISIONS. Except to the extent prohibited by law, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check only one box.)

(A) [ ] Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards; OR

(B) [ ] Choice Not To Prolong Life

I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician,

I have (check all choices that represent your wishes)

[ ] (i) a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of

myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

[ ] (ii) a terminal condition: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period of time, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

[ ] Additional instructions:_____

_____

(C) Artificial Nutrition and Hydration. If I am unable to safely take nutrition, fluids, or nutrition and fluids (check your choices or write your instructions),

[ ] I wish to receive artificial nutrition and hydration indefinitely;

[ ] I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest;

[ ] I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve;

[ ] In accordance with my choices in (6)(B) above, I do not wish to receive artificial nutrition and hydration.

[ ] Other instructions: _____

_____

(D) Relief from Pain.

[ ] I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort; or

[ ] I give these instructions:

_____

_____

(E) **Life-Sustaining Procedures. "Life-sustaining procedures" means any medical treatment, procedure, or intervention that may keep you alive but will not remove your terminal condition or remove permanent unconsciousness; "life-sustaining procedures" includes assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, including antibiotics, or artificial nutrition and hydration.**

[ ] I wish to receive life-sustaining procedures.

[ ] I do not wish to receive life-sustaining procedures.

(F) Should I become unconscious and I am pregnant, I direct that

_____

_____

(7) OTHER WISHES. (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that

_____

_____

Conditions or limitations: _____

_____.

(Add additional sheets if needed.)

PART 3

ANATOMICAL GIFT AT DEATH

(OPTIONAL)

If you are satisfied to allow your agent to determine whether to make an anatomical gift at your death, you do not need to fill out this part of the form.

(8) Upon my death: (mark applicable box)

(A) [ ] I give any needed organs, tissues, or other body parts, OR

(B) [ ] I give the following organs, tissues, or other body parts only

_____

_____

(C) [ ] My gift is for the following purposes (mark any of the following you want):

[ ] (i) transplant;

[ ] (ii) therapy;

[ ] (iii) research;

[ ] (iv) education.

(D) [ ] I refuse to make an anatomical gift.

PART 4

MENTAL HEALTH TREATMENT

This part of the declaration allows you to make decisions in advance about mental health treatment. The instructions that you include in this declaration will be followed only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are not competent and cannot make treatment decisions. Otherwise, you will be considered to be competent and to have the capacity to give or withhold consent for the treatments.

If you are satisfied to allow your agent to determine what is best for you in making these mental health decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(9) PSYCHOTROPIC MEDICATIONS. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

_____ I consent to the administration of the following medications:

_____ I do not consent to the administration of the following medications:

Conditions or limitations: _____

_____.

(10) ELECTROCONVULSIVE TREATMENT. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

_____ I consent to the administration of electroconvulsive treatment.

_____ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _____

_____.

(11) ADMISSION TO AND RETENTION IN FACILITY. If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding admission to and retention in a mental health facility for mental health treatment are as follows:

_____ I consent to being admitted to a mental health facility for mental health treatment for up to _____ days. (The number of days not to exceed 17.)

_____ I do not consent to being admitted to a mental health facility for mental health treatment.

Conditions or limitations: _____

_____.

OTHER WISHES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations: _____

_____.

PART 5

PRIMARY PHYSICIAN

(OPTIONAL)

(12) I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(telephone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(telephone)

(13) EFFECT OF COPY. A copy of this form has the same effect as the original.

(14) SIGNATURES. Sign and date the form here:

_____

(date) (sign your name)

_____

(print your name)

_____

(address) (city) (state) (zip code)

(15) WITNESSES. This advance care health directive will not be valid for making health care decisions unless it is

(A) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; the witnesses may not be a health care provider employed at the health care institution or health care facility where you are receiving

health care, an employee of the health care provider who is providing health care to you, an employee of the health care institution or health care facility where you are receiving health care, or the person appointed as your agent by this document; at least one of the two witnesses may not be related to you by blood, marriage, or adoption or entitled to a portion of your estate upon your death under your will or codicil; or

(B) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

Witness Who is Not Related to or a Devisee of the Principal

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care;

(4) the person appointed as agent by this document;

(5) related to the principal by blood, marriage, or adoption; or

(6) entitled to a portion of the principal's estate upon the principal's death under a will or codicil.

_____

(date) (signature of witness)

_____

(printed name of witness)

_____

(address) (city) (state) (zip code)

Witness Who May be Related to or a Devisee of the Principal

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider who is providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care; or

(4) the person appointed as agent by this document.

_____

(date) (signature of witness)

_____

(printed name of witness)

_____

(address) (city) (state) (zip code)

ALTERNATIVE NO. 2

State of Alaska

_____ Judicial District

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

Notary Seal

_____

(signature of notary public)

* **Sec. 12.** AS 13.52.390(17) is amended to read:

(17) "health care decision" means a decision made by an individual or the individual's agent, guardian, or surrogate regarding the individual's health care, including

(A) selection and discharge of health care providers and institutions;

(B) approval or disapproval of proposed diagnostic tests, surgical procedures, and programs of medication;

(C) direction to provide, withhold, or withdraw artificial nutrition and hydration if providing, withholding, or withdrawing artificial nutrition, artificial hydration, or artificial nutrition and hydration is in accord with generally accepted health care standards applicable to health care providers or institutions;

(D) the administration or withdrawal of psychotropic medications, the use of electroconvulsive treatment, and the admission to a mental health facility; [AND]

(E) making an anatomical gift at death; **and**

(F) a direction relating to the provision of cardiopulmonary resuscitation or other resuscitative measures;

* **Sec. 13.** AS 13.52.065(f) is repealed.

* **Sec. 14.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONTINUING EFFECT OF DO NOT RESUSCITATE ORDERS. A do not resuscitate order made under AS 13.52 before the effective date of this Act continues in effect under AS 13.52, unless the do not resuscitate order is revoked under AS 13.52.065(i) or (j), added by sec. 6 of this Act, or made ineffective under another provision of AS 13.52, as amended by this Act.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 23, 2012

SUBJECT: Sectional summary of SB 172 relating to health care decisions, including do not resuscitate orders
(Work Order No. 27-LS0991\B)

TO: Senator Fred Dyson
Attn: Chuck Kopp

FROM: Terry Bannister
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Amends AS 13.52.045 to prohibit a health care institution or health care facility from interpreting the issuance of a do not resuscitate order as preventing the providing of life-sustaining procedures to the patient.

Section 2. Amends 13.52.060(e) to prohibit a health care provider from declining, for reasons of conscience, to comply with a do not resuscitate order that is consistent with this chapter. Also states that the subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an individual instruction or a health care decision that requests that cardiopulmonary resuscitation or other resuscitative measures be provided.

Section 3. Amends AS 13.52.060(f) to state that the subsection does not allow a health care provider, health care institution, or health care facility to decline to comply with an advance health care directive or a health care decision that is consistent with the chapter and that requests that cardiopulmonary resuscitation or other resuscitative measures be provided. The subsection addresses declining to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards.

Section 4. Amends AS 13.52.065(a) limits a physician's right to issue a DNR order. The order may be issued only as provided in AS 13.52.065.

Section 5. Amends AS 13.52.065(b) to require that the protocol (adopted by the department) for withholding cardiopulmonary resuscitation comply with AS 13.52.065.

Section 6. Adds new subsections to AS 13.52.065.

Sec. 13.52.065(g) prohibits a physician from issuing a do not resuscitate order for a patient of the physician without the express consent described in the subsection (except as provided by (h)).

Sec. 13.52.065(h) states when a physician may issue a do not resuscitate order for a patient of the physician without the express consent required by (g) of this section.

Sec. 13.52.065(i) requires a physician to revoke a do not resuscitate order issued for a patient under certain listed circumstances.

Sec. 13.52.065(j) allows a physician to revoke a do not resuscitate order issued by another physician under certain described circumstances.

Section 7. Amends AS 13.52.080(a) to replace a citation to a subsection that is repealed by this bill.

Section 8. Amends AS 13.52.080(c) to provide that its immunity provisions do not apply if a do not resuscitate order relied on by the health care provider, health care institution, or health care facility was issued in violation of AS 13.52.065.

Section 9. Amends AS 13.52.120(b) to clarify that a violation of the new provisions (added by bill sec. 6) does not, in the context of the provision's required consistency with the chapter, constitute a homicide. Adds a cross reference to the new (h) as an exception for applying the subsection's approach to suicide or homicide.

Section 10. Adds AS 13.52.120(h) to state that the provisions in (b) about homicide and suicide do not apply to a person who orders or causes the withholding or withdrawal of life-sustaining procedures and acts intentionally, recklessly, with criminal negligence, or with gross negligence.

Section 11. Amends the optional form in AS 13.52.300 to add a wish regarding life-sustaining procedures.

Section 12. Amends AS 13.52.390 (the definition section) to change the definition of "health care decision" to state that the term includes a direction about receiving cardiopulmonary resuscitation or other resuscitative measures.

Section 13. Repeals AS 13.52.065(f), which currently addresses how DNR orders are made ineffective.

Section 14. Adds a provision to indicate how DNR orders made before the bill's effective date are to be treated in light of the bill.

If I may be of further assistance, please advise.

TLB:plm
12-040.plm

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB172**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB172-DHSS-EP-1-27-12
Title: Care Directives / Do Not Resuscitate Orders
Sponsor: Dyson
Requester: Senate Health and Social Services

Dept. Affected: Health and Social Services
Appropriation: Public Health
Allocation: Emergency Programs
OMB Component Number: 2877

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Ward B. Hurlburt, M.D. MPH / Chief Medical Officer, Director — Phone 269-6680
Division: Public Health — Date/Time 1/27/12 4:30 PM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date 1/27/2012
DHSS Finance & Management Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB172

Analysis

This bill specifies that a health care provider may not decline to comply with a do not resuscitate order that is consistent with the chapter for reasons of conscience. The bill amends the statutes specifically as it relates to requests that cardiopulmonary resuscitation or other resuscitative measures be provided. It provides that the protocol adopted by the department must comply with the amended language provided section.

Implementation of the bill as written would require the Division of Public Health's Section of Emergency Programs, Emergency Medical Services (EMS) Unit to upgrade the statewide DNR protocol in the Comfort One program.

Implementation of the bill as written would require the Division of Public Health's Section of Emergency Programs, Emergency Medical Services (EMS) Unit to upgrade the statewide Do Not Resuscitate protocol materials. While the program already budgets on-going printing costs as part of the base budget, revising these materials will have one-time costs associated that are not considered part of the base. This involves modifying already printed administrative forms and procedures that support the Comfort One program. Also, the current inventory of forms already printed and distributed will need to be replaced with the updated forms. The cost to update the forms and replace the inventory can be absorbed without reducing services elsewhere.

The Division of Public Health provides about 4500 enrollment forms and a lesser number of each of two pamphlets each year. The Comfort One enrollment forms are distributed to the three main EMS Regions (Southern, Southeast, and Interior). Southern Region is the largest user of the forms and has had an increasing number of requests for the forms. The three regions send forms out to the other four regions upon request.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM October 28, 2011

SUBJECT: Question regarding AS 13.52 (Work Order No. 27-LS0991)

TO: Senator Fred Dyson
Attn: Chuck Kopp

FROM: Terry Bannister
Legislative Counsel

You have asked whether AS 13.52 adequately protects the right of a patient, or the patient's designee, to overrule a physician's decision to issue a do not resuscitate (DNR) order. This question was prompted by a recent situation in which a physician at a hospital issued a DNR order against the express wishes and directions of both the patient and the patient's wife who held his durable power of attorney.[1] You have referred me to AS 13.52.065, which addresses DNR protocol and identification requirements, AS 13.52.100, which addresses the patient's right to make health care decisions while the patient has capacity, and AS 13.52.120, which addresses a presumption in favor of life.

AS 13.52.065(a) does allow a physician to issue a do not resuscitate order. However, that provision cannot be read in isolation from the rest of AS 13.52 (the "chapter"). AS 13.52 is fairly clear that a patient with capacity has the right to make a DNR order ineffective. However, the chapter is not as clear that an individual can prevent a doctor from placing the order or that an authorized agent of the patient may make a DNR order ineffective or prevent the doctor from placing the DNR order.

With certain exemptions for conscience or where medically ineffective standards are involved,[2] AS 13.52.060(d) requires a health care provider,[3] to comply with an individual instruction[4] of the patient, and with a health care decision made by an authorized person. The term, "individual instruction," appears to cover a DNR order, because it covers a

[1] I am presuming this was a durable power of attorney for health care.

[2] AS 13.52.060(e) - (f).

[3] The term includes a physician.

[4] Defined in AS 13.52.390 as an individual's direction concerning a health care decision for the individual.

health care decision,[5] which in turn includes any care, treatment, service, or procedure that affects an individual's physical or mental condition.[6]

The chapter's specific provisions regarding DNR orders, AS 13.52.065(f) and AS 13.52.100(c), clearly allow DNR orders to be made ineffective if a patient who is able to make the decision requests this, but these sections do not expressly address authorized agents. However, with regard to patients without capacity, AS 13.52.100(c) states that if the individual is not able to make the decision, the DNR protocol authorized by AS 13.52.065(b) be used. The sample form in AS 13.52.300 for an advance care directive states that the protocol governs the use of DNR orders by health care providers; the exact meaning of "use" is not defined in the chapter or the protocol, so it is left up to interpretation. The DNR protocol established by the Department of Health and Social Services[7] states that a DNR patient may revoke the patient's DNR status at any time and in any manner in accordance with AS 13.52,[8] but does not go into more detail or expressly address revocation by agents of the individual.

It can also be argued that in this chapter a reference to a "patient" also includes an authorized agent of an adult individual. This interpretation is supported by AS 13.52.060(d) mentioned above. It is also supported by AS 13.52.080(a)(6)(B), because that provision appears to indicate that AS 13.52.065(f) is not the only provision under which a DNR order can be made ineffective. This position is also supported by AS 13.52.010's allowing a patient to make advance health care directives and appoint agents regarding health care decisions. And, under AS 13.52.010(b), an agent may be given the authority under a durable power of attorney for health to make any health care decision the principal could have made while having capacity.[9]

---

[5] See AS 13.52.390(17).

[6] See AS 13.52.390(16).

[7] The current protocol was adopted in 1996 under AS 18.12, a chapter that was repealed when AS 13.52 was enacted in 2004 (with an effective date of January 1, 2005). Under sec. 18, ch. 83, SLA 2004, the Department of Health and Social Services was given authority to adopt regulations to implement AS 13.52, and under sec. 19, ch. 83, SLA 2004, the Department of Law's regulations attorney was directed to make certain citation changes in 7 AAC 16 to reflect the new chapter (these do not appear in the regulations) until the new regulations were adopted. Under sec. 19, ch. 83, SLA 2004, the regulations in 7 AAC 16 were to continue in effect until the Department of Health and Social services adopted regulations for the 2004 act.

[8] See 7 AAC 16.010(g).

[9] See AS 13.52.010(b).

The fact that the chapter at AS 13.52.300 contains an advance care directive form to state health care decisions and to appoint agents also supports an interpretation that individuals may indicate their wishes, and appoint agents, regarding DNR orders. The form itself contains language that the individual has the right to give instructions about the individual's own health care, although this language is qualified by making the right "to the extent allowed by law." But the form states that the DNR protocol governs the use of DNR orders. Finally, AS 13.52.120(a) states that the chapter establishes a presumption in favor of life, which would seem to support interpreting the chapter to allow a patient (or the patient's authorized representative) to prevent a physician from issuing a DNR order.

In AS 13.52 it seems clear that a patient with capacity has the right to make a DNR order ineffective. And while I would tend to conclude that the better interpretation of AS 13.52 is that a doctor's right to issue a DNR order is limited by the decision of the patient or the patient's authorized representative, and that an agent with that authority can revoke a DNR order, there are some ambiguities in the chapter that could result in other interpretations.

It would be helpful to know the exact basis for the positions taken by the physician and the hospital.

If I may be of further assistance, please advise.

TLB:ljw
11-419.ljw

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM December 30, 2011

SUBJECT: Bill relating to health care decisions, including do not resuscitate orders (Work Order No. 27-LS0991\M)

TO: Senator Fred Dyson
Attn: Chuck Kopp

FROM: Terry Bannister
Legislative Counsel

This memo accompanies the bill described above.

1. "Intervening care." After reviewing what you were requesting and the terms used in the chapter, it appears that you are referring to "life-sustaining procedures" (see the definition in AS 13.52.300). Please read the complete definition and make sure that this is what you had in mind. The new section uses that term instead of "intervening care." The provision has been moved to AS 13.52.045, which addresses the provision of life-sustaining procedures.

Contrary to what I indicated on the phone, it appears that the selection of life-sustaining procedures is not sufficiently addressed in the form provided under AS 13.52.300, so it is necessary to change the form. Unfortunately, this requires that the entire form be laid out in your bill even though the actual changes are small.

2. Use of "advance health care directive." After reviewing your question about the substitution of "advance health care directive" for "individual instruction" in AS 13.52.060(e), I decided to return to "individual instruction" because it is narrower than "advance health care directive," and a narrower term is consistent with the goal of the changes to AS 13.52.060(e) (to limit the health care provider's right to decline to comply for reasons of conscience).

3. Authorization by another physician to revoke a DNR order. Language has been added to proposed sec. 13.52.065(j) to identify which physicians may revoke another physician's DNR. Please examine sec. 13.52.065(j)(2)(B): is employment of the physician by the health care facility or institution the relationship that you had in mind?

If I may be of further assistance, please advise.

TLB:ljw
11-476.ljw
Enclosure

LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature
Division of Legal and Research Services
State Capitol, Juneau, AK 99801

(907) 465-3991 phone
(907) 465-3908 fax
research@legis.state.ak.us

Memorandum

TO: Senator Fred Dyson
FROM: Chuck Burnham, Legislative Analyst
DATE: January 19, 2012
RE: State Laws: Assuring Healthcare Provider Compliance with Advance Health Directives
LRS Report 12.142

You asked about states' laws on "do not resuscitate orders" (DNRs). Specifically, you asked how other states prevent healthcare providers from using their patient care management authority to issue DNRs against the will of patients who have terminal conditions.

Background

As you likely know, all states have laws codifying patients' control, to varying degrees, over the medical care they receive in their final days of life.[1] Such legal mechanisms are commonly known as "advanced health directives," and may include "do not resuscitate orders" (DNRs). Typically, DNRs are used by elderly individuals or those with terminal illnesses to direct healthcare providers to suspend treatment should the patient experience a medical event that, in the absence of intervention, is likely to bring about death. In the absence of a DNR, medical ethics and standards of practice generally compel physicians to attempt life-saving measures; however, this requirement is limited when, in the judgment of the attending physician, such care would not ultimately prove beneficial to the patient. This concept is embodied in the Code of Ethics of the American Medical Association (AMA), which includes the following language in AMA Opinion 2.035:

> Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in Opinion 2.03, "Allocation of Limited Medical Resources," and Opinion 2.095, "The Provision of Adequate Health Care," not on the concept of "futility," which cannot be meaningfully defined.

Recognizing the emotional and trying atmosphere that surrounds end-of-life care, the AMA provides in Opinion 2.037 a framework of considerations and actions to be taken by healthcare providers in circumstances where their prescribed treatment differs from the wishes of terminal patients. That Opinion frames the issue as follows:

> When further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what is futility in the particular instance.[2]

---

[1] Alaska's laws on advanced healthcare directives are codified at AS 13.52. For the purposes of this report, the term "patient" generally includes individuals receiving care, their families, and other proxies that may be involved in end-of-life decisions should the patient become incapacitated.

[2] The AMA Code of Medical Ethics is available online at *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?*.

The AMA recommends that healthcare institutions adopt policies that use a due process approach in determining medical futility. Opinion 2.037 outlines a seven-step approach that emphasizes fostering understanding and cooperation between patient and physician, involvement of institutional bodies such as ethics committees where disagreements remain, and the swift and orderly transfer of patients to other institutions when agreement cannot be reached.

Patient Protections in State Laws

Although the policies of the AMA generally appear to strike a reasonable balance between the wishes of patients and the medical judgment of physicians, those policies do not carry the weight of law. The concern that you contemplate—that physicians may order a DNR over the wishes of the patient at a point too early in the end-of-life process—is clearly shared by policymakers in a number of other jurisdictions.

For example, the Uniform Law Commission (ULC) includes protection against physicians superseding the wishes of patients in its Uniform Healthcare Decisions Act.[3] Section 7 of the Act, "Obligations of Healthcare Provider," includes the following:

> (d) Except as provided in subsections (e) and (f), a health-care provider or institution providing care to a patient shall:
>
> > (1) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and
> >
> > (2) comply with a health-care decision for the patient made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

The Act then allows that should a healthcare provider decline to comply with the instructions of a patient for reasons of conscience, policy, or conflict with generally accepted healthcare standards, the patient should be promptly informed and treatment should continue until transfer to another facility can be arranged.[4] The Act, in part or in total, has been adopted by a number of states including Alaska and, for example, Mississippi and New Mexico.

Although the policies of the AMA and the Uniform Act have clearly influenced policymakers' approaches to protecting patients' wishes in end-of-life circumstances, states nonetheless vary considerably in their laws on the topic. For instance, in California and Hawaii, physicians may issue orders specifying withholding end-of-life treatment, but only with the signature of a patient or legally recognized proxy. Similar orders may be issued by physicians in Tennessee and Virginia only with the "consent" of the affected patient. Medical doctors in Ohio may issue a "DNR Identification" order, but state law makes clear that the legal "declaration" of a patient regarding treatment preferences supersedes the physician's DNR.[5]

It is important to note that although the states we have mentioned, and others, have taken steps to protect patients from becoming subject to a DNR order against their will, determinations on when to discontinue efforts at life-saving interventions such as cardio pulmonary resuscitation (CPR) fall to the purview of physicians, the policies of the institutions in which they practice, and the accepted standards of medical practice. Therefore, patients' authority under the laws we've discussed necessarily extend only to whether they desire or refuse medical intervention through an advanced directive at the end of life rather than to the duration or timing of the cessation of those measures.

We hope this is helpful. If you have questions or need additional information, please let us know.

---

[3] Established in 1892, the ULC, also known as the National Conference of Commissioners on Uniform State Laws, seeks to provide states with "non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law." The ULC is comprised of lawyers, judges, legislators, and academics who have been appointed by state governments. More information is available on the Commission's website at *http://www.nccusl.org/Default.aspx*.

[4] Full text of the Act is available online at *http://www.nccusl.org/Default.aspx*.

[5] We include, as attachments, examples of relevant statutes of California, Delaware, Florida, Georgia, Hawaii, Mississippi, New Mexico, Ohio, Tennessee, and Virginia.

SENATOR FRED DYSON

January 18, 2012

Senator Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801

Re: AS 13.52 Alaska Health Care Decisions Act – Do Not Resuscitate (DNR) Orders & End of Life Decisions

Dear Senator Davis,

Thank you for your valuable support as a co-sponsor of the attached bill amending AS 13.52 *Alaska Health Care Decisions Act.* Ambiguities in the current law concerning the rights of patients and their surrogates to refuse or invalidate a DNR order have resulted in unnecessary distress of Alaskan residents facing critical end of life decisions.

In August 2011 my office was contacted by a recently discharged Anchorage area hospital patient and his wife, Mervin and Margery Mullins. The couple stated that a physician at the hospital put a Do-Not-Resuscitate order on Mervin, who has brain cancer, but doing much better than the prognosis. The DNR order was issued against the expressed wishes of both Mervin and Margery. When they protested, the physician told them that a DNR order is issued at the sole direction of a physician for his/her patient. Margery met with the hospital Chief Ethicist who confirmed their attending physician was correct. According to the Mullins, they were also told that the Durable Power of Attorney held by Margery "did not matter" because the decision was the physician's to make.

I had several conversations with the hospital Chief Operating Officer and Chief Medical Officer. They stated there is ambiguity in the law as to what a hospital (health care facility) can do with respect to overruling a DNR order placed on a patient by a physician. I explained my view - that the presumption of the law is in favor of life and of the patient's rights on end of life decisions, stated as such in AS.13.52.120(a) *In the absence of evidence to the contrary of the patient's intent, this chapter establishes a presumption in favor of life, consistent with the best interest of the patient.* The Chief Medical Officer agreed and directed that the DNR order be removed from Mr. Mervin Mullins.

I asked Legislative Legal to advise me on what the law actually says in AS 13.52 with respect to DNR orders and end of life decisions, and their opinion on whether the law adequately protects the patient (or his/her agent) right to overrule a physician's decision to issue a DNR order. I have attached to this correspondence the memos from Legal, dated October 28, 2011, and December 30, 2011.

During Session (January - May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 (fax)

During Interim (June-December): 10928 Eagle River Road, Suite 238 • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 (fax)

senator.fred.dyson@legis.state.ak.us • www.akrepublicans.org

In part, Legal states -

> *AS 13.52 is fairly clear that a patient with capacity has the right to make a DNR order ineffective. However, the chapter is not as clear that an individual can prevent a doctor from placing the order or that an authorized agent of the patient may make a DNR order ineffective or prevent the doctor from placing the DNR order. (emphasis added)*
>
> *Finally, AS 13.52.120(a) states that the chapter establishes a presumption in favor of life, which would seem to support interpreting the chapter to allow a patient (or the patient's authorized representative) to prevent a physician from a issuing a DNR order. In AS 13.52 it seems clear that a patient with capacity has the right to make a DNR order ineffective. And while I would tend to conclude that the better interpretation of AS 13.52 is that a doctor's right to issue a DNR order is limited by the decision of the patient or the patient's authorized representative, and that an agent with that authority can revoke a DNR order, there are some ambiguities in the chapter that could result in other interpretations. (emphasis added)*

Based on this review by Legal, the stated confusion in the law by an Anchorage area hospital facility, and the experience of the Mullins couple, I asked Legal to draft an amendment to AS 13.52 clarifying the ambiguities. Specifically, that a physician may not issue a DNR order without the expressed consent of the patient, or if the patient lacks capacity, without the expressed consent of the authorized agent of the patient, or, if no one is available or known to be authorized to speak for the patient, without the concurrence of a second physician.

The Advance Health Care Directive sample form provided in AS 13.52.300 is also amended to allow the patient the option of accepting or decline life-sustaining procedures (treatments that will keep you alive, but not remove your terminal condition).

If you agree with me that this is an important matter and find the amendments to AS 13.52 to be acceptable, I would very much welcome your support as a co-sponsor.

Best regards,

Fred Dyson

SB 202

<TARGET><BILL>SB 202</BILL><SUBJECT>SB 202</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATOR DENNIS EGAN

Sponsor Statement

SB 202: Resuscitation Protocol Documents

Cardiopulmonary Resuscitation (CPR) standards are updated regularly based on new research. Unfortunately, due to the slow process of changing agency regulations, current state regulations reference outdated and incorrect CPR standards.

For example, when the current resuscitation regulations were adopted in 2002, the gold standard for adult CPR was 15 chest compressions for every two breaths administered. Today, the American Heart Association recommends 30 compressions for every two breaths. Pediatric standards have also changed significantly since the time current CPR regulations were established.

The International Liaison Committee on Resuscitation (ILCOR) is an international group of scientists that reviews studies, makes treatment recommendations, and publishes its findings. The addition of the ILCOR findings to AS 47.05.012 would allow Emergency Medical Services offices and instructors to teach the most current and appropriate resuscitation standards without having to go through the lengthy process of revising agency regulations.

This bill is necessary to maintain a high standard of emergency medical care in Alaska.

ALASKA SENATE
STATE CAPITOL • JUNEAU, ALASKA 99801-1182 • (907) 465-4947 • FAX (907) 465-2108
SENATOR.DENNIS.EGAN@LEGIS.STATE.AK.US

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB202**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB202-DHSS-EP-3-2-12
Title: Resuscitation Protocol Documents
Sponsor: Senator Egan
Requester: Senate HSS Committee

Dept. Affected: Health and Social Services
Appropriation: Public Health
Allocation: Emergency Programs
OMB Component Number: 2877

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable. Initial version.

Prepared by: Ward B. Hurlburt, M.D., MPH / Chief Medical Officer-Director — Phone: 269-6680
Division: Public Health — Date/Time: 3/2/12 4:00 PM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date: 3/2/2012
DHSS Finance & Management Services

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB202

Analysis

The bill amends AS 47.05.012 by adding resuscitation protocols to the list of materials that may be incorporated by reference in regulations. This will allow Emergency Medical Services (EMS) instructors to teach the most appropriate cardiopulmonary resuscitation techniques without the delay in adopting new statutory changes when new standards are published. The state EMS office has to choose between teaching and testing EMTs on current best practices or according to current state regulations which reference outdated and incorrect medical standards.

There is no fiscal impact to the department. The cost to update training materials to the current ILCOR standards is expected to be minimal and can be absorbed with existing resources.

The International Liaison Committee on Resuscitation (ILCOR) is an international consensus group of scientists that reviews studies, makes treatment recommendations for resuscitation, and publishes its findings when appropriate, usually every five years.

ALASKA COUNCIL ON EMERGENCY MEDICAL SERVICES

ACEMS
P.O. Box 110616
Juneau, AK 99811-0616
(907) 465-3027

March 2, 2012

Senator Dennis Egan
State Capitol Room 510
Juneau AK, 99801

Dear Senator Egan,

We are deeply appreciative and excited that this bill is going forward. The Governor's Alaska Council on Emergency Medical Services (ACEMS) feels the responsibility of ensuring the most up to date information is utilized in the instruction of the state's first responders throughout Alaska. The ability to do that with cardiopulmonary resuscitation training (CPR) has been hindered by a seemingly minor road block in the state regulatory process.

We feel that SB 202 will remedy this situation.

The members of ACEMS feel there would be a significant benefit in adding the ILCOR scientific findings to the list in AS 47.05.012. This would allow the EMS Unit of the Section of Emergency Programs (the lead agency for EMS training in Alaska) and EMS instructors in the State to teach the most current, appropriate resuscitation standards as they are published, without having to go through a succession of regulatory changes to adopt new curricula for their training programs. This bill is vital to help maintain the high standards of emergency care in Alaska.

Thank you for your time and efforts of this very important matter. If you have any questions, please feel free to contact me.

Sincerely,

David Hull

David Hull, MICP
Chair, Alaska Council on Emergency Medical Services

SB 221

<TARGET><BILL>SB 221</BILL><SUBJECT>SB 221</SUBJECT><COMM>SHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE
SENATE FINANCE COMMITTEE

Senator Bert Stedman, Co-Chair
State Capitol, Room 516
Juneau, Alaska 99801-1182
(907) 465-3873 Phone
(907) 465-3922 Fax
Senator_Bert_Stedman@legis.state.ak.us

Senator Lyman Hoffman, Co-Chair
State Capitol, Room 518
Juneau, AK 99801-1182
Phone (907) 465-4453
Fax (907) 465-4523
Senator_Lyman_Hoffman@legis.state.ak.us

SPONSOR STATEMENT – SENATE BILL 221

SB 221 – An Act relating to the disposition of proceeds from the alcoholic beverage tax and to the alcohol and other drug abuse treatment and prevention fund.

The state of Alaska is projected to collect nearly $40 million dollars from the existing alcohol excise tax in FY2013. SB 221 allocates 100 percent of existing alcohol tax revenue to the Alcohol and Other Drug Abuse Treatment and Prevention Fund (ADTP). In 2002, State Representative Lisa Murkowski championed HB225 to raise the alcoholic beverage tax and establish the ADTP to "help provide revenue needed for the expanded treatment, therapeutic courts, diversion programs and other initiatives now under consideration in the Legislature." Since 2003, only 50 percent of funds collected from the existing alcohol tax have been appropriated to the ADTP. While the political reasoning for the fund was to expand treatment, decreases in general fund spending have left overall funding for substance abuse treatment and prevention reduced or stagnant.

Despite passage of HB 225, demand for residential treatment, intensive outpatient, aftercare and community treatment and prevention programs continue to dramatically exceed the substance abuse treatment system's capacity. Providers throughout the state report treatment beds are full to capacity, long waiting lists exist for services they offer, and there are numerous requests for services they can't provide.

According to the Division of Behavioral Health, when the 141,000 uninsured Alaskans living at or below 250 percent of the federal poverty index become eligible for publicly funded health insurance after 2014 under federal law, (based on 2006 prevalence estimates) at least 2,800 of these adults can be expected to experience a substance abuse disorder requiring treatment. Federal match funds (FMAP) will provide 100 percent funding for expanded populations from 2014-2016, then phase down to a 90 percent match by 2020. Failing to build adequate alcohol and drug treatment capacity for the Medicaid expansion will have a profound impact on State General Fund expenditures for the Medicaid program long into the future. Passage of SB 221 will provide supplemental funding to expand treatment capacity statewide by addressing the backlog of capital budget requests for evidence-based detox and treatment facilities, as well as reinforce and expand current substance abuse treatment programs.

Alcoholism and drug abuse are inextricably linked to Alaska's epidemic levels of domestic violence and sexual assault, suicide, child neglect cases and rising corrections costs. According to a 2005 McDowell report, costs incurred as a result of substance abuse neared $738 million annually. With a small statutory change, all monies collected from alcohol taxes can be put toward proven substance abuse treatment and prevention programs. I strongly urge you to join in support of SB 221 to allocate 100 percent of existing alcohol tax revenue for substance abuse treatment and prevention.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB221**
Fiscal Note Number:
() Publish Date:

Identifier (file name): SB221-DOA-DOF-3-16-12
Title: Alcoholic Bev Tax/Prevention Fund
Sponsor: Senate Finance Committee
Requester: Senate Health and Social Services

Dept. Affected: Administration
Appropriation: Centralized Administrative Services
Allocation: Finance
OMB Component Number: 59

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Not applicable, initial version.

Prepared by: Scot Arehart, Director — Phone: 465-3435
Division: Division of Finance — Date/Time: 3/16/2012 1:00pm
Approved by: John Cramer, Deputy Commissioner — Date: 3/16/2012
Department of Administration

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB221
2012 LEGISLATIVE SESSION

Analysis

This bill relates to the disposition of proceeds from the alcoholic beverage tax and to the alcohol and other drug abuse treatment and prevention fund.

This fund was established several years ago, and there are processes in place for the Department of Revenue to make the deposits of taxes, and the Department of Health and Social Services to expend the funds upon receiving an appropriation.

This bill will have no fiscal impact on the Department of Administration, Division of Finance.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **SB 221**
Fiscal Note Number: 1
() Publish Date:

Identifier (file name): SB221-DOR-TAX-03-15-12
Title: Alcoholic Bev. Tax/Prevention
Sponsor: Senate Finance
Requester: Senate HSS

Dept. Affected: Revenue
Appropriation: Taxation and Treasury
Allocation: Tax
OMB Component Number: 2476

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial fiscal note.

Prepared by: Johanna Bales, Deputy Director — Phone: 907-269-6628
Division: Tax — Date/Time: 03/15/2012; 3:00 pm
Approved by: Jerry Burnett, Director Administrative Services Division — Date: 3/15/2012
Department of Revenue

(Revised 1/17/2012 OMB)

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. SB 221

Analysis

Bill Language:
Under current statute, 50% of the Alcoholic Beverage Excise Tax is deposited into the alcohol and other drug abuse treatment and prevention fund , a subaccount within the general fund, and the remaining 50% is deposited directly into the general fund. This bill would require the entire proceeds of the Alcoholic Beverage Excise Tax to be deposited in the alcohol and other drug abuse treatment and prevention fund established in the general fund. In FY 2011, the Tax Division collected approximately $38.7 million in total alcoholic beverage excise tax. Approximately $19.3 million was deposited in the alcohol and other drug abuse treatment and prevention fund. Under this bill, the entire amount would be deposited in the drug abuse treatment and prevention fund.

Revenues:
The bill has no effect on total revenues.

Expenditures:
The department can implement the provisions of the bill with existing resources.

Behavioral Health Response
LegLog 870
Breakdown of Funding for SA Treatment & Prevention by Component and Fund Source
11/3/2011

Behavioral Health offers response to the following request:

- Can we provide a breakdown of our alcohol and drug treatment and prevention programs by component showing funding by fund source for FY11? FED, UGF, DGF, Other.

Based on the associated core services, Behavioral Health recognizes the expenditures and revenue in the following components as Substance Abuse related.

- AK Fetal Alcohol Syndrome Program – SA Prevention and Intervention
- Alcohol Safety Action Program (ASAP) – SA Prevention and Intervention
- Community Action Prevention & Intervention - SA Prevention and Intervention
- Rural Services & Suicide Prevention - SA Prevention and Intervention
- Behavioral Health Grants – SA Treatment

The attached spreadsheet reports actual expenditures and revenue in the above components for FY11. The expenditures and revenue reported for Substance Abuse Administration are based on an allocation proportionate to the expenditures in the substance abuse components vs. the expenditures in the mental health related components. The expenditures reported for Substance Abuse Medicaid are available at the collocation code level.

Department of Health and Social Services
Division of Behavioral Health
FY11 Substance Abuse Maintenance of Effort (MOE)
Source: FY11 Actuals from the Alaska Budget System (ABS)

The following spreadsheet shows the allocation detail for the actual expenditures and revenue during FY11. Data source Alaska Budget System. All funds are in thousands of dollars. The State of Alaska fiscal year is from July 1 to June 30.

		M	N	O	P	Q	R	S	T	U
1		Substance Abuse Medicaid	Substance Abuse Admin	Substance Abuse Prevention				Substance Abuse Treatment	Boards & Commissions	Substance Abuse TOTAL
2		SA Rehab	BH Admin	AK FAS Program	Alcohol Safety Action Program	Community Action Prevention & Intervention Grants	Rural Services & Suicide Prevention	Behavioral Health Grants	ABADA	
3	71000 Personal Services		4009.4		1,626.8				270.0	5,906.2
4	72000 Travel		244		21.3	11.0			90.6	366.9
5	73000 Services		2170.7	89.0	196.2	410.3	451.4	1,093.3	67.4	4,478.3
6	74000 Commodities		43		26.4	1.6	12.4		12.9	96.3
7	75000 Capital Outlay				0.0	0.0	0.0			-
8	77000 Grants & Benefits	12,755.0		1,274.4	1,552.8	3,119.3	2,462.0	28,024.8		49,188.3
9	78000 Misc./Debt Service				0.0					-
10		12,755.0	6,467.1	1,363.4	3,423.5	3,542.2	2,925.8	29,118.1	440.9	60,036.0
11										
12	**Funding Sources:**									
13	**1003 G/F Match**	517.4	783.6							1,301.0
14	**1004 Gen Fund**	807.7	83.2	1,363.4	875.8	947.0	313.1	9,306.0	21.3	13,717.5
15	**1005 GF/Prgm**				365.8					365.8
16	1007 I/A Rcpts		59.4		1,063.7			1,169.4	19.3	2,311.8
17	1013 Alchl/Drug									-
18	**1037 GF/MH**	2,375.7	2625.1		722.4	1,507.2	128.9		222.6	7,581.9
19	1061 CIP Receipts									-
20	1092 MHTAAR		242.7					188.7	169.3	600.7
21	1108 Stat Desig	4.9	19.8							24.7
22	**1168 Tob Ed/Ces**		859.9							859.9
23	1180 ADTP Fund				131.7		2,115.0	15,144.4		17,391.1
24	Non-Federal Subtotal	3705.7	4673.7	1,363.4	3,159.4	2,454.2	2,557.0	25,808.5	432.5	44,154.4
25	1002 Fed Rcpts	9049.3	1793.4		264.1	1,088.0	368.8	3,309.6	8.4	15,881.6
26	TOTAL	12,755.0	6,467.1	1,363.4	3,423.5	3,542.2	2,925.8	29,118.1	440.9	60,036.0
27										
28										

29	**Substance Abuse Maintenance of Effort**	FY11 Actual SA MOE
30	SA Medicaid (cell M24)	3,705.7
31	SA Admin (cell N24)	4,673.7
32	SA Prevention (cells O24-R24)	9,534.0
33	ABADA	432.5
34	SA Treatment (cells S24)	25,808.5
35	SA MOE (cell U23)	44,154.4

36
37
38 revenue detail is preliminary (submitted by DHSS Budget but not approved by OMB as of 10/31/2011)

39 [redacted]

1		Substance Abuse Medicaid	Substance Abuse Admin	Substance Abuse Prevention				Substance Abuse Treatment	Boards & Commissions	Substance Abuse TOTAL
2		SA Rehab	BH Admin	AK FAS Program	Alcohol Safety Action Program	Community Action Prevention & Intervention Grants	Rural Services & Suicide Prevention	Behavioral Health Grants	ABADA	
13	1003 G/F Match	517.4	783.6							1,301.0
14	1004 Gen Fund	807.7	83.2	1,363.4	875.8	947.0	313.1	9,306.0	21.3	13,717.5
15	1005 GF/Prgm				365.8					365.8
18	1037 GF/MH	2,375.7	2625.1		722.4	1,507.2	128.9		222.6	7,581.9
22	1168 Tob Ed/Ces		859.9							859.9
	TOTAL GENERAL FUNDS	3,700.8	4351.8	1,363.4	1,964.0	2,454.2	442.0	9,306.0	243.9	23,826.1

Department of Health and Social Services
Division of Behavioral Health
FY12 Authorized - Substance Abuse Components
Source: Alaska Budget System (ABS)

		H	I	J	K	L		M	N	O
1		Substance Abuse Prevention				Substance Abuse Treatment	Boards	**Substance Abuse Total**	Unallocated to MH & SA until Actual Expenditures are Recorded	
2		AK FAS Program	Alcohol Safety Action Program	Community Action Prevention & Intervention Grants	Rural Services & Suicide Prevention	Behavioral Health Grants	ABADA		BH Medicaid	BH Admin
3	71000 Personal Services		1,831.6				307.1	2,138.7		7,242.1
4	72000 Travel		71.7				93.1	164.8		692.9
5	73000 Services	194.1	387.8	478.0	398.6	1,579.0	114.6	3,152.1	1,551.9	3,408.8
6	74000 Commodities		120.0	30.0	10.0		22.9	182.9		202.0
7	75000 Capital Outlay						3.5	3.5		
8	77000 Grants & Benefits	1574.4	1,627.4	6,227.9	2,713.0	29,842.7		41,985.4	175,745.7	85.0
9	78000 Misc./Debt Service							-		
10		1,768.5	4,038.5	6,735.9	3,121.6	31,421.7	541.2	47,627.4	177,297.6	11,630.8
11										
12	**Funding Sources:**									
13	1003 G/F Match							-	7,518.8	947.0
14	1004 Gen Fund	1,409.0	786.2	863.7	285.9	1,678.8		5,023.6		674.7
15	1005 GF/Prgm		392.9					392.9		134.5
16	1007 I/A Rcpts		902.2	1,400.0		1,771.5	22.5	4,096.2		190.2
17	1013 Alchl/Drug (incl w fed)							-		2.0
18	1037 GF/MH	359.5	852.4	1,547.2	148.9	8,664.3	235.8	11,808.1	73,560.8	5,018.2
19	1061 CIP Receipts		638.4					638.4		352.6
20	1092 MHTAAR					275.0	234.0	509.0		666.8
21	1108 Stat Desig							-	717.5	182.5
22	1156 Rcpt Svcs							-		
23	1168 Tob Ed/Ces							-		921.0
24	1180 ADTP Fund		142.0		2,186.8	15,558.2		17,887.0	1,500.0	231.4
25	GF Subtotal	1,768.5	3,714.1	3,810.9	2,621.6	27,947.8	492.3	40,355.2	83,297.1	9,320.9
26	1002 Fed Rcpts		324.4	2,925.0	500.0	3,473.9	48.9	7,272.2	94,000.5	2,309.9
27	TOTAL	1,768.5	4,038.5	6,735.9	3,121.6	31,421.7	541.2	47,627.4	177,297.6	11,630.8
28										

Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update

Prepared for:

The Advisory Board on Alcoholism and Drug Abuse
Department of Health & Social Services

McDowell Group
Research-Based Consulting
Juneau
Anchorage

December 2005

Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update

Prepared for:

The Advisory Board on Alcoholism and Drug Abuse
Department of Health & Social Services

Prepared by:

McDowell Group

Juneau • Anchorage

December 2005

TABLE OF CONTENTS

Executive Summary **1**

Productivity Losses **5**

Summary 5
Lost Production Due to Mortality 6
Lost Production Due to Diminished Productivity 9
Lost Production Due to Incarceration 11
Lost Production Due to Alcohol/Other Drug Treatment 14

Traffic Crashes **15**

Criminal Justice and Protective Services **18**

Criminal Justice 18
Protective Services 25

Health Care **27**

Hospital Costs 28
Residential and Outpatient Alcohol and Other Drug Treatment Costs 30
Medical Outpatient Costs 31
Prescription Drugs and Nursing Home/Long-Term Care Costs 32
Fetal Alcohol Spectrum Disorders 33
AIDS and HIV Costs 36
Hepatitis B and C Costs 37

Co-Occurring Disorders **39**

Co-Occurrence of Serious Mental Illness and Substance Dependence or Abuse 39
Bring the Kids Home Initiative 41

Public Assistance and Social Services **43**

Cost of Underage Drinking in Alaska **44**

Employment and Tax Impacts of Alcohol Sales **45**

List of References **47**

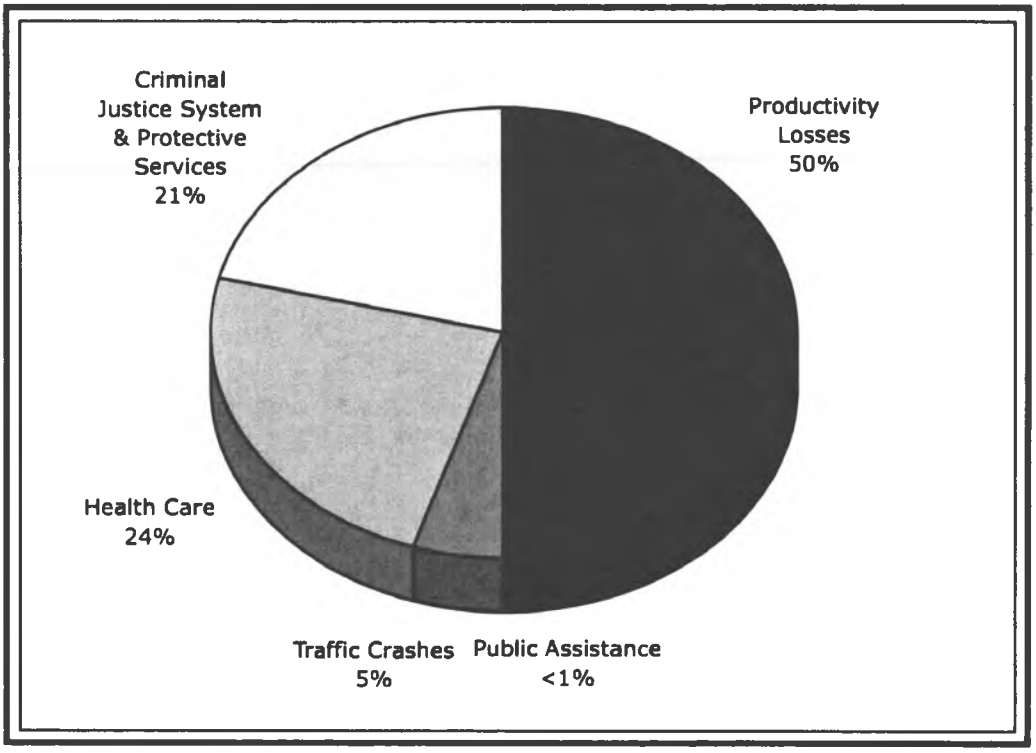
EXECUTIVE SUMMARY

The Advisory Board on Alcoholism and Drug Abuse, through the Alaska Department of Health and Social Services, contracted with McDowell Group in April 2005 to update a prior study on the economic costs of alcohol and other drug abuse in Alaska.

Alcohol and other drug abuse impacts the economy in many ways. Public safety, health care, and public assistance are among the areas impacted by alcohol and other drug abuse. The extent of these impacts is evident in the level of alcohol and other drug dependency and its associated cost on the Alaska economy. According to a 1998 study, 9.7 percent of Alaska's population is dependent upon or abuses alcohol (39,596 residents), while 1.5 percent is other drug dependent (14,238 residents). The total cost of this dependence to the Alaska economy is estimated to be $738 million during 2003. Alcohol abuse costs accounted for $525.5 million (71 percent). Other drug abuse costs were estimated at $212.5 million (29 percent). Costs by category include:

- $367 million from productivity losses.
- $154 million from criminal justice and protective services.
- $178 million from health care.
- $35 million from traffic crashes.
- $4 million from public assistance.

Percentage of Costs by Category Related to Alcohol and Other Drug Abuse in Alaska, 2003



More detailed study results for each cost category are presented below. Some of the economic benefits related to the manufacturing and sale of alcohol are also included.

Productivity Losses

Lost productivity occurs when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for criminal offense, and inpatient treatment or hospitalization. The reduced efficiency of employees, or premature death of Alaska residents, results in less production of goods and services, and is thus a cost to society.

Alcohol and other drug abuse in Alaska cost an estimated $367 million in lost productivity during 2003. Components of productivity losses and associated costs include:

- Premature death from alcohol and other drug abuse in Alaska resulted in an estimated $183 million in lost productivity in 2003. The annual average number of deaths from alcohol and other drug abuse between 1999 and 2003 was 236.
- Workers impaired by alcohol and other drug abuse had an estimated reduced productivity in Alaska of $136 million during 2003. This includes $106 million in alcohol-related impairment and $20 million in other drug-related impairment.
- Costs from alcohol and other drug-related incarcerations totaled an estimated $39 million in lost productivity during 2003. During that period, 1,193 inmate incarcerations were directly related to alcohol and other drug abuse.
- Lost productivity from Alaska residents receiving inpatient treatment for alcohol and other drug abuse cost an estimated $8.8 million in 2003.

Traffic Crashes

Alcohol and other drug abuse are a major cause of traffic crashes in Alaska. There were 1,109 traffic crashes in Alaska attributed to alcohol and other drug abuse during 2002. Of these crashes, 25 were fatal, 107 were major injury crashes, 370 were minor injury crashes, and 607 had property damage only. The estimated costs from these crashes were more than $35 million. Costs included:

- $16 million for legal costs.
- $12 million for insurance administration costs.
- $5 million for property damage costs.
- $2 million for workplace costs.

Costs by traffic accident category included:

- $26 million from major injuries.
- $5 million from fatalities.
- $2.5 million from minor injuries.
- $1 million from property damage only.

Criminal Justice

Alcohol and other drug abuse contribute to crime and child abuse. In 2003, an estimated 17,400 arrests were attributed to alcohol and other drug abuse. During this same period, 15,800 Alaska residents were victims of alcohol and other drug abuse-related crimes. Costs attributed to crime-related alcohol and other drug abuse in the state were nearly $154 million during this period. Crime costs in 2003 included:

- $43 million for law enforcement.
- $38 million for corrections.
- $12 million for legal costs and court adjudication.
- $636,000 for property damage.
- $1.9 million in economic costs to victims.
- Adult and child protective services attributed to alcohol and other drug abuse cost an estimated $59 million. These costs include foster care services, adoption care services, residential care services, and social worker services.

Health Care

Health care costs attributed to alcohol and other drug abuse result from illnesses or injuries. Examples of the kinds of health problems that can result from alcohol and drug abuse are cirrhosis of the liver, hypertension, diabetes, or stomach cancer. Health care costs related to alcohol and other drug abuse totaled an estimated $178 million in 2003. Health care costs included:

- Hospital costs from illnesses and injuries were estimated at $9.3 million. Alcohol abuse-related health care costs accounted for $84.8 million, while other drug abuse-related costs were $8.2 million.
- Alcohol and other drug residential and outpatient treatment costs were approximately $26.8 million.
- Total medical outpatient costs from illnesses and injuries totaled an estimated $25.7 million.
- Pharmaceutical costs were estimated at $23.0 million, while nursing home costs were $719,400.
- Medical care totaled $3.9 million for patients with other drug-related HIV and HIV with AIDS. Approximately 78 HIV and HIV with AIDS cases were attributed to intravenous drug abuse.
- Costs for medical treatment of hepatitis B and C caused by intravenous drug abuse was $5.1 million. Intravenous drug abuse contributed to 344 hepatitis B and C cases in Alaska in 2003.

Public Assistance and Social Services

A portion of public assistance expenditures can be attributed to alcohol and other drug abuse. Alcohol and other drug-dependent persons may qualify for public assistance because of reduced income, inability to hold a job, or disability caused by substance abuse. Costs attributed to abuse (program administration costs only) were an estimated $4.1 million in 2003.

Employment Impacts of Alcohol Sales

Although the focus of this study is centered on the cost of alcohol and other drug abuse, there are some economic benefits associated with the sale of alcoholic beverages. These economic benefits include employment, income and tax revenues. In 2003, there were approximately 3,000 jobs in alcohol-related industries in Alaska, with earnings of approximately $62 million. State excise tax revenue on alcoholic beverages, collected at the wholesale level, was approximately $33 million in FY 2004.

Actual Costs

It is critical the reader recognize that the alcohol and other drug-related costs presented in this study are estimates only. Actual costs could be 25 percent higher or lower than the total presented in this report. Very little underlying data exists regarding the monetary impact of alcohol and other drug abuse in Alaska. There is a clear need for more comprehensive research.

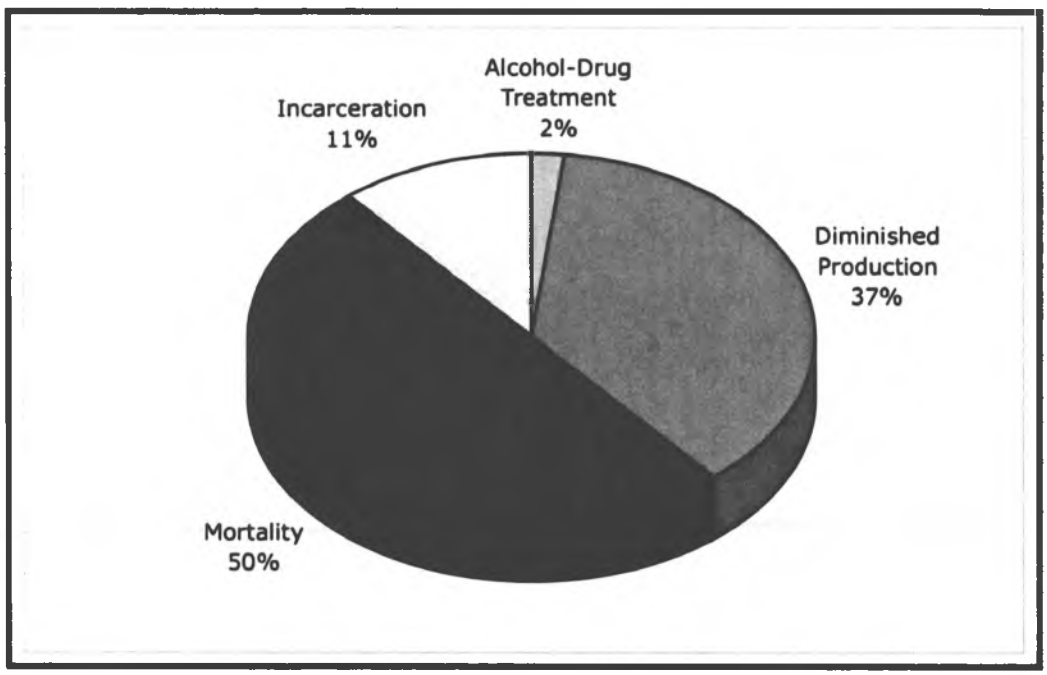
For this report, the McDowell Group study team used national data to estimate Alaska's alcohol and other drug abuse costs and then adjusted these costs for Alaska's higher cost of living. The study team relied heavily on a 1998 publication from the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (NIDA/NIAAA, 1998), and a 1999 study for the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. As exhaustive and thorough as these studies are, they do not address Alaska's higher alcohol rates or its higher cost of providing services. Alaska's alcohol-dependent population is double the national average, according to results of the Alaska Adult Household Telephone Survey conducted by the Gallup Organization. In addition, cost-of-living indicators published by American Chamber of Commerce Researchers Association (ACCRA) show Anchorage health care costs were 65 percent higher than the national average during 2003.

In nearly all cases, Alaska-specific data were not available on the amount of crime, health and medical costs, lost production, and public assistance that can be attributed to alcohol and other drug abuse. Estimates rely on national norms based on tested methodologies. National norms are based on a lower prevalence of alcohol abuse and dependence than is the case in Alaska. Comprehensive development of Alaska-specific data is recommended.

Summary

Alcohol and other drug abuse cost Alaska an estimated $367 million in lost productivity during 2003. Lost productivity occurs when alcohol and other drug abuse results in premature death, reduced efficiency of workers through physical or mental impairment, incarceration for criminal offense, and residents requiring inpatient treatment or hospitalization. Overall, the reduced efficiency of employees or premature death of Alaska residents results in less production of goods and services, and thus is a cost to society. Figure 1 illustrates the sources of lost productivity in the Alaska economy.

Figure 1
Percent of Lost Productivity for Alaska from Alcohol and Other Drug Abuse in 2003



- Premature death from alcohol and other drug abuse in Alaska resulted in an estimated $183 million in lost productivity in 2003. Males accounted for $145 million in estimated losses and females, $37.7 million. An average of 236 deaths annually can be attributed to alcohol and other drug abuse between 1999 and 2003. Alcohol and drug abuse accounted for approximately 8 percent of deaths in that period; the average annual number of deaths from all causes in Alaska was 2,964 between 1999 and 2003.
- Alcohol and other drug abuse can impair worker performance resulting in lost productivity. An estimated 39,596 Alaska residents are alcohol dependent, resulting in reduced productivity of $106 million in 2003. Another 14,238 residents were drug dependent, resulting in $30 million in diminished productivity. The male population accounted for the largest portion of lost

productivity at $111 million, while productivity losses for females were estimated at $26 million.

- Of the 3,743 Alaska residents incarcerated in 2003, an estimated 1,193 incarcerations can be attributed to alcohol and other drug abuse. Lost productivity from alcohol and drug related incarcerations was estimated at $39 million.

- Time spent by Alaska residents while receiving inpatient treatment for alcohol and other drug abuse resulted in approximately $9 million in lost productivity in 2003. These figures do not include the actual cost of treatment.

Lost Production Due to Mortality

The largest cost to Alaska residents from alcohol and other drug abuse stems from productivity losses due to premature death. Death from alcohol and other drug abuse can result from suicide, motor vehicle crashes, homicide, cirrhosis, diabetes, or other medical causes. From an economic point of view, an Alaska resident provides two types of production benefits. The first is in the form of employment. By being employed, the resident is contributing to the overall benefit of Alaska society by producing goods and services. The second production benefit is from household services. An individual spends time caring for children, cleaning and maintaining a household like any wage and salary job, though that service is generally not compensated. Combined, these production losses contribute to the largest cost from alcohol and other drug abuse in Alaska.

Methodology

To estimate productivity losses from premature death, McDowell Group relied on the same methodology used in the "The Economic Costs of Alcohol and Drug Abuse in the United States – 1992" for the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (NIDA/NIAAA) published in 1998. The research team first applied attribution factors by diagnosis supplied in the NIDA/NIAAA study to annual deaths by diagnosis reported by Alaska Vital Statistics from 1999 to 2003. Second, 2000 estimates of the present value of life earnings by age and gender were obtained from a published report by University of California Professor Dorothy Rice. These values are a combination of earnings data and estimated value of household services, which originate from U.S. Bureau of Census data. Earnings were adjusted by 5.5 percent to reflect the change in annual per capita personal income from 2000 to 2003 reported by the Bureau of Economic Analysis. Finally, the number of deaths by age and gender attributed to alcohol and other drug abuse were multiplied by the appropriate present value of life earnings in 2003 dollars.

In summary, the value of an average person's lifetime productivity is estimated and, depending on their age at the time of premature death, lost productivity is measured. It is important to note that this measure is not an estimate of "out-of-pocket" losses. Rather, it is a theoretical construct intended to reflect the fact that humans have the potential to be productive, and if life is cut short, society has suffered a loss of production potential.

Results

On average, there were 236 deaths in Alaska due to alcohol and other drug abuse between 1999 and 2003. Based on data from this period, alcohol and other drug abuse accounted for approximately 8 percent of all the deaths in the state (there was an annual average of 2,964 deaths from all causes between 1999 and 2003).

A breakdown of average annual deaths by age and gender is presented in Table 1. Of these deaths, 72 were females and 163 were males. From 1999 to 2003 the largest number of deaths was between ages 40 to 44 for females (seven alcohol and other drug-related deaths) and ages 45 to 54 for males (36 alcohol and other drug-related deaths). Table 2 shows the number of alcohol and other drug-related deaths by cause during this period. Motor vehicle crashes (41 deaths) and suicide (33 deaths) were the major causes of premature death from alcohol and other drug abuse between 1999 and 2003.

Table 1
Average Annual Number of Deaths Attributed to Alcohol and Other Drug Abuse by Age and Gender, 1999-2003

Age	Males	Females
00-04	2.9	2.0
05-09	1.4	0.2
10-14	2.9	1.4
15-19	10.8	4.0
20-24	11.4	4.0
25-29	9.7	3.5
30-34	9.9	3.3
35-39	13.3	5.9
40-44	15.6	6.9
45-49	16.7	6.5
50-54	14.1	4.7
55-59	11.9	4.2
60-64	8.7	4.6
65-69	9.5	3.8
70-74	9.1	4.1
75-79	6.1	4.2
80-84	5.4	3.5
85+	4.0	5.2
Total	**163.4**	**72.2**

Source: Alaska Bureau of Vital Statistics.

Table 2
Average Annual Number of Deaths Attributed to Alcohol and Other Drug Abuse by Diagnoses or Accident, 1999-2003

Illness or Accident	Average Deaths
Motor vehicle accidents	41.2
Intentional self-harm (suicide)	33.0
Mental and behavioral disorders due to use of alcohol	31.2
Assault (homicide)	20.0
Malignant neoplasm of esophagus	14.0
Cerebrovascular disease	11.8
Accidental drowning and submersion	9.1
Accidental poisoning by and exposure to alcohol	8.6
Fibrosis and cirrhosis of liver	8.2
Toxic liver disease	7.7
Malignant neoplasm of lip, oral cavity and pharynx	6.5
Accidental falls	5.4
Accidents caused by fire and flames	4.7
Psychoactive Substance (nondependent) abuse	4.4
Diabetes mellitus	4.2
Malignant neoplasm of stomach	4.0
Air and space transport accidents	3.3
Water transport accidents	3.1
Drug dependence	2.8
Pedal cyclist, motorcycle rider and ATV accidents	2.5
Alcoholic cardiomyopathy	2.4
Pneumonia and influenza	2.4
Acute pancreatitis	2.4
Other diseases of pancreas (including alcohol-induced and chronic)	0.9
Essential hypertension	0.8
Diseases of esophagus, stomach and duodenum	0.8
Respiratory tuberculosis	0.4
Alcoholic gastritis	0.2
Total	**235.6**

Source: Alaska Bureau of Vital Statistics.

Total economic loss from premature death of Alaska residents was $183 million during 2003. Table 3 presents estimated loss of productivity by age and gender. Males accounted for almost $145 million in lost productivity. Females accounted for approximately $38 million. The most significant costs were associated with males in two age groups, those between the ages of 20 to 24 years and 40 to 44 years, which each accounted for $18 million in lost productivity. Females age 35 to 39 years accounted for $5 million, as did those age 40 to 44.

Table 3
Mortality Costs Attributed to Alcohol and Other Drug Abuse
By Age and Gender, 2003

Age	Males	Females
1-4	$3,363,000	$1,693,000
5-9	$1,751,000	$226,000
10-14	$4,038,000	$1,382,000
15-19	$16,320,000	$4,450,000
20-24	$18,240,000	$4,602,000
25-29	$15,410,000	$3,892,000
30-34	$14,810,000	$3,348,000
35-39	$17,870,000	$5,216,000
40-44	$18,040,000	$5,054,000
45-49	$15,590,000	$3,765,000
50-54	$9,872,000	$1,951,000
55-59	$5,456,000	$1,076,000
60-64	$2,188,000	$625,000
65-69	$1,189,000	$236,000
70-79	$539,800	$115,200
75-79	$150,100	$49,440
80-84	$59,880	$16,690
85 & over	$12,000	$4,255
Total	**$144,900,000**	**$37,700,000**

Source: Alaska Bureau of Vital Statistics and Dr. Dorothy Rice, University of California.

Lost Production Due to Diminished Productivity

Alcohol and other drug abuse by Alaska residents results in reduced productivity. This loss can come in the form of high absenteeism, reduced efficiency from diminished physical and mental abilities, or limited work history because of the individual's inability to hold a job. Abuses of alcohol and other drugs may also impact a person's ability to be productive in non-employment related activities like household or parenting services. In extremely severe cases, abusers of alcohol and other drugs can be hospitalized or even institutionalized, in essence removing the individual from productive society entirely. These productivity losses from alcohol and other drug abuse have a significant cost burden to the residents of Alaska.

Methodology

The primary method for estimating economic costs from diminished productivity was to measure lost earnings. The research team relied on estimates presented in the NIDA/NIAAA (1998) study that determined the percent of lost earnings from alcohol and other drug dependence. In the study, the authors estimated the loss of earnings from alcohol-dependent males at 9.4 percent of average earnings and lost earnings from other drug dependent males at 7.7 percent of average earnings. Estimates on lost earnings for the female alcohol and other drug-dependent population came from the 1990 Rice study on the economic impacts of alcohol and other drug abuse. These estimates were used because the authors of the NIDA/NIAAA (1998) study found no impacts to female earnings from alcohol or other drug dependence. The 1990 study reports a reduction in earnings from alcohol dependence of 6.9 percent and 5.4 percent from other drug dependence.

Estimates on the number of Alaskans who are alcohol and other drug dependent came from the 2003 National Survey on Drug Use and Health by the Substance Abuse and Mental Health Services Administration (SAMHSA). In the report, SAMHSA estimated that 10.4 percent of Alaska's population is classified with alcohol or drug dependence or abuse: 8.6 percent for alcohol and 3.1 percent for other drugs. Approximately 1.3 percent of the population is dependent or abusing both alcohol and drugs. SAMHSA reports that males are almost twice as likely to be classified with substance dependence or abuse as females.

Total costs from diminished productivity for male and females were calculated by multiplying diminished productivity by the number of Alaskans who were alcohol and other drug dependent in 2003. The research team collected data from the Alaska Department of Labor and Workforce Development (ADOL) on earnings for males and females during 2003. Alaska males earned an average of $33,762 in 2003, while females earned $23,056. The research team then estimated the annual loss in earnings by multiplying the percent decline in earnings for alcohol or other drug dependence for each gender by the appropriate annual Alaska earnings for 2003.

Results

In 2003, Alaska had approximately 39,596 adult residents classified with alcohol dependence or abuse and 14,238 residents classified with drug dependence or abuse. Of those alcohol-dependent residents, 27,355 were males and 12,240 were females. The drug-dependent population consists of 9,283 adult males and 4,956 adult females. Table 4 presents computation figures for estimating diminished productivity from alcohol and other drug dependence or abuse.

Table 4
Productivity Losses from Alcohol and Other Drug Dependence or Abuse by Gender, 2003

	Alcohol		Other Drugs	
	Males	**Females**	**Males**	**Females**
Alaska population 18 years and over that is alcohol and other drug dependent	27,355	12,240	9,283	4,956
Annual average earnings for Alaska in 2003	$33,762	$23,056	$33,762	$23,056
Loss in productivity from alcohol and other drug dependence	9.4%	6.9%	7.7%	5.4%
Annual lost earnings from alcohol and other drug abuse	$3,174	$1,591	$2,600	$1,245
Estimated productivity loss from alcohol and other drug abuse	$87 million	$19 million	$24 million	$6 million

Sources: Alaska Department of Labor, Employment and Earnings report, 2003; SAMHSA *2003 National Survey on Drug Use and Health*, and *The Economic Costs of Alcohol and Drug Abuse in the United States-1992* (NIDA/NIAAA, 1998).

The typical Alaska male alcohol abuser cost society $3,174 annually in diminished productivity in 2003. The typical male drug abuser cost society $2,600 in 2003. During that same period, the average female alcohol abuser cost society $1,591 in lost production, while the typical female drug abuser cost society $1,245. Total diminished productivity for Alaska from alcohol and other drug-dependent residents was an estimated $137 million. Of those adults who abuse alcohol or are dependent, the largest portion was from the state's male population. An estimated $87 million in diminished productivity was from males who abuse or are dependent on alcohol, and another $19 million was from females. Diminished productivity from other drug dependence was estimated to cost the state economy $30 million, $24 million from males and $6 million from females.

Lost Production Due to Incarceration

Another source of lost productivity for Alaska is from residents incarcerated because of alcohol and other drugs. Residents can be incarcerated for committing an alcohol or other drug related crime or from committing a crime while under the influence of alcohol or other drugs. An example of an alcohol or other drug-related crime would be distributing alcohol without a license or selling illegal drugs. Sexual assault is an example of a crime committed under the influence, where alcohol or other drug use was a contributing factor. Without alcohol or other drugs, incarcerated Alaskans could be productive members of society producing goods and services. While incarcerated, these individuals are generally not employed and thus are not productive members of society. This loss in productivity can be measured by estimating lost earnings.

Methodology

Estimates for lost productivity from incarcerations involved two steps. The first was to determine the number of Alaska residents incarcerated due to alcohol or other drug-related crimes. The research team relied on national attribution rates published in the NIDA/NIAAA (1998) study. These rates are presented in Table 5. These national attribution rates are thought to be lower than incarceration rates for Alaska from alcohol and other drug abuse. However, no Alaska-specific research has been completed to verify this premise. Currently, only anecdotal information is available. It is speculated that alcohol and other drug abuse plays a role in 85 percent to 95 percent of all incarcerations in Alaska.[1]

Table 5
Attribution Rates for Alcohol and Other Drug-Related Incarcerations

	Alcohol	Other Drug
Homicide	30.0%	15.8%
Assault	30.0%	5.1%
Sexual assault	22.5%	5.1%
Robbery	3.4%	27.2%
Burglary	3.6%	30.0%
Larceny/theft	2.8%	29.6%
Auto theft	3.5%	6.8%
Drug laws	0.0%	100.0%
Driving under the influence	100.0%	0.0%
Liquor laws	100.0%	0.0%
Prostitution	0.0%	12.8%

Source: *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

The second step was to estimate potential loss of earnings from incarceration. The research team assumed that persons incarcerated because of alcohol and other drug abuse could be as productive as the general population. As shown above, ADOL indicates Alaska males earned $33,762 in 2003 and females earned $23,056. The earnings estimates were then applied to the alcohol and other drug-related incarcerated population for Alaska in 2003.

[1] Based on discussions with Sarah Williams, Coordinator of Substance Abuse Program, and Teri Carns, Staff Director for the Alaska Criminal Justice Assessment Commission.

Results

In 2003, there were 3,743 people incarcerated for crimes of all types (this is a count of the inmate population regardless of what year they were placed in a correctional facility, not the number of annual offenses). Of these, 1,193 incarcerations were attributed to abuse of alcohol and other drugs. Males accounted for most of the incarcerations attributed to abuse of alcohol and other drugs at 1,065 in 2003, while females accounted for 128 incarcerations.

Table 6 presents the number of people incarcerated for alcohol or drug related offenses in 2003 by offense and gender. These are not the number of incidences in a single year, but the cumulative total of those in prison as of December 31, 2003. Sexual assault, assault, and homicide were the primary offenses committed. Based on attribution rates shown in Table 5, an estimated 122 people were incarcerated for sexual assaults, 163 for assaults, and 122 for homicides attributed to alcohol abuse. Drug law violations were the primary offense associated with other drug abuse at 175 incarcerations.

Table 6
Alcohol and Other Drug-related Incarcerations in Alaska by Offense and Gender, 2003

	Alcohol		Other Drug	
Offense	**Females**	**Males**	**Females**	**Males**
Homicide	7	115	4	61
Assault	11	152	2	26
Sexual Assault	1	121	0	27
Robbery	0	4	2	32
Burglary	0	2	0	21
Larceny-Theft	1	5	11	51
Auto Theft	0	1	0	3
Drug Laws	0	0	34	141
Driving under the influence	41	259	0	0
Liquor Laws	8	49	0	0
Prostitution	0	0	0	0
Total	**70**	**708**	**54**	**360**

Source: McDowell Group based on Alaska Department of Corrections 2003 Offender Profile data and attribution rates by offense from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

Total lost productivity from incarcerations from alcohol and other drug abuse in Alaska was $39 million in 2003. Incarcerated males accounted for $36 million, while females accounted for $3 million in lost productivity.

Lost Production Due to Alcohol/Other Drug Treatment

The final source of lost productivity included in this study is from Alaska residents receiving inpatient alcohol and other drug treatment. Treatment includes long-term residential treatment, short-term hospitalization, and detoxification. While receiving treatment for alcohol and other drug abuse, patients are not productive residents in the Alaska economy, so society loses the benefit of their production of goods and services. This loss in productivity can be measured by estimating lost earnings.

Methodology

Total bed days for residential and detoxification treatment centers were used to estimate lost productivity in 2005 from time spent while undergoing alcohol and other drug treatment. Data for 2003 was not available, therefore 2005 is considered a reasonable proxy for 2003 bed days. Total bed days were then converted to work years. Work years were multiplied by average annual 2003 earnings of $37,356 for all Alaskans, as reported by ADOL.

Results

There were 85,926 total bed days for alcohol and other drug abuse in 2005.[2] These total bed days was equivalent to 235 work years. Overall, total lost production from inpatient treatment for alcohol and other drug abuse was estimated at $8.8 million. This figure does not include lost productivity from residents receiving substance abuse treatment outside the state. Although the exact number of these individuals is unknown, it is estimated that much of the private residential treatment received by Alaskans occurs outside of the state.[3]

[2] Source: Alaska Department of Health and Social Services, Mike Bellevue.
[3] Source: Finding the Answers to Tough Questions About Substance Abuse in Alaska, 1999 Annual Report, State of Alaska Advisory Board on Alcoholism and Drug Abuse.

Alcohol use is a major cause of traffic crashes in Alaska. In 2002, 1,109 traffic crashes were attributed to alcohol, costing an estimated $35 million. Of these crashes, 25 were fatal injury crashes, 107 were major injury crashes, 370 were minor injury crashes, and 607 crashes had property damage only. According to the Alaska Department of Transportation and Public Facilities (ADOTPF), a traffic crash is alcohol-related under the following conditions:

- If the blood alcohol test given to the driver, pedestrian, pedal cyclists, or recreational vehicle operator was positive.
- If a police investigation indicated that alcohol consumption was a contributing factor.
- If a citation was issued for driving while under the influence of alcohol, driving with an open container of alcohol, or public drunkenness.

Methodology

To measure the cost of traffic crashes, the research team used two sources: State of Alaska 2002 alcohol-related traffic crash statistics from ADOTPF, and cost-per-accident data from the National Highway Traffic Safety Administration (NHSTA), adjusted for inflation to 2003 dollars.[4] Crash data was divided into four categories: property damage only, minor injury, major injury, and deaths. These categories were matched to the national data, which shows unit costs from motor vehicle crashes in eight categories. McDowell Group matched minor injuries reported by ADOTPF with Maximum Abbreviated Injury Scale (MAIS) Level 1, classified as minimum injuries in the NHTSA report. Major injuries were matched to MAIS Level 5, classified as critical injuries by NHTSA. No extrapolation is needed for the remaining categories, property damage only and fatalities, which are in each study. Unit costs related to traffic crashes from the NHTSA report are presented in Table 7.

Table 7
Unit Costs of Traffic Crashes in the U.S., 2003

Type of Cost	Fatal	Major Injury (MAIS 5)	Minor Injury (MAIS 1)	Property Damage Only
Insurance administration	$37,120	$75,118	$715	$116
Workplace cost	$8,702	$8,191	$252	$51
Legal cost	$102,138	$88,753	$172	$0
Property damage	$10,273	$9,446	$3,844	$1,484
Total	**$158,233**	**$181,508**	**$4,983**	**$1,651**

Source: *The Economic Cost of Motor Vehicle Crashes, 2000*, NHSTA.

Other than knowing that other drugs are a contributing factor in traffic crashes, little is known about their significance, because only alcohol-related data is collected. In the NHTSA study, costs from traffic crashes are divided into separate expense categories. This includes medical costs, loss in productivity from mortality and morbidity, insurance administration costs, workplace costs, legal costs, and property damage costs. To avoid double counting, the research team estimated insurance

[4] *The Economic Cost of Motor Vehicle Crashes, 2000*, published by the National Highway Traffic Safety Administration (NHTSA).

administration costs, workplace, legal and property costs. Losses in productivity and medical costs are accounted for in other sections of the report.

Cost estimates for alcohol-related traffic crashes were adjusted to reflect changes in the Alaska cost-of-living and in U.S. prices from 2000 to 2003. Inflation was estimated using the Anchorage consumer price index from the Bureau of Labor Statistics (BLS). Inflation over this period was approximately 8 percent. The source for the cost-of-living data was the American Chamber of Commerce Researchers Association (ACCRA). During 2003, Anchorage's cost-of-living was approximately 25 percent higher than the average participating city in the American Chamber of Commerce.

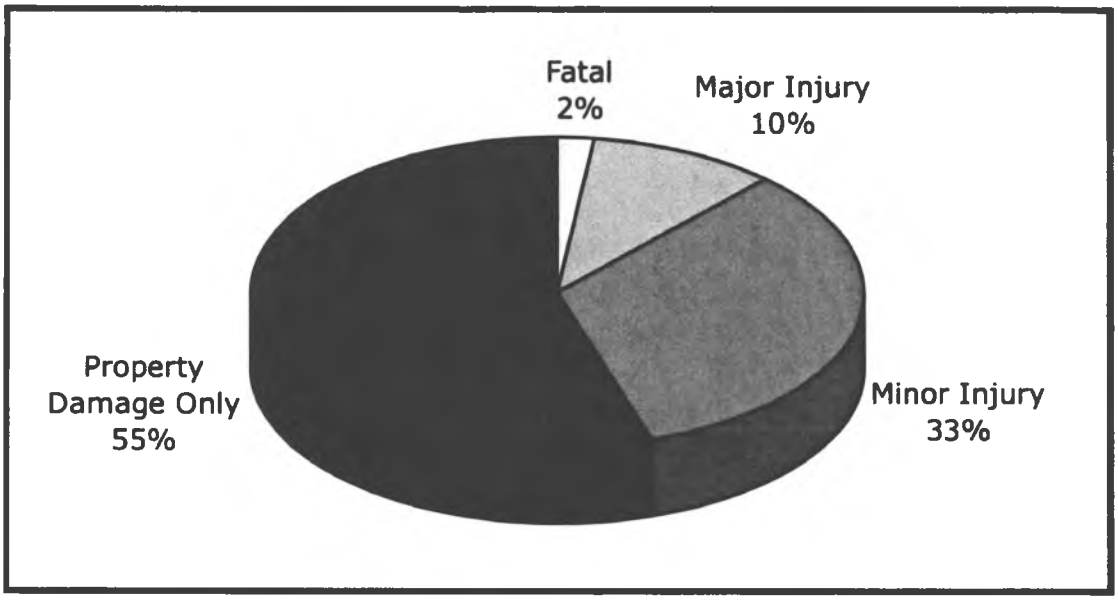
Traffic accident statistics include ATV and snowmobile crashes on roadways, but DOTPF does not collect ATV and snowmobile crashes off roadways, such as rivers, lakes, and in the backcountry. Lost productivity and health care costs associated with alcohol-related ATV and snowmobile deaths or injuries are included in the cost estimates. Property damage is not included.

Results

In 2002, 1,109 traffic crashes in Alaska were alcohol-related, about 8 percent of traffic crashes from all causes (13,325). However, the percentage of traffic fatalities caused by alcohol is much greater. About half of all U.S. fatal traffic crashes are caused by alcohol use (NHTSA, 1994). In Alaska, 32 percent of the 78 deaths from traffic crashes were attributed to alcohol in 2002. Figure 2 shows the number of alcohol-related crashes by category.

Adjusted to reflect 2003 dollars, alcohol-related traffic crashes in Alaska cost approximately $35 million in 2003. Table 7 shows the cost of alcohol-related traffic crashes by severity and expense. Legal costs of $16 million were the largest expense, followed by insurance administration costs at $12 million. By crash category, major injuries accounted for the largest costs at $26 million. Lost productivity associated with fatal crashes are not included in this estimate. (See chapter on Lost Productivity.) If these costs were included, the costs of alcohol-related traffic deaths would be far higher than other traffic crash categories.

Figure 2
Percent of Alcohol-Related Traffic Crashes by Type in Alaska, 2002



Source: Alaska Department of Transportation and Public Facilities.

Table 8
Number of Traffic Crashes and
Total Cost of Alcohol-Related Crashes in Alaska, 2003

Number of Traffic Crashes and Cost Type	Fatal	Major Injury	Minor Injury	Property Damage Only	Total Costs
Number of traffic crashes	25	107	370	607	1,109
Insurance administration cost (thousands of dollars)	$1,245	$10,787	$355	$94	$12,482
Workplace cost (thousands of dollars)	$292	$1,176	$125	$42	$1,635
Legal cost (thousands of dollars)	$3,427	$12,745	$85	$0	$16,257
Property damage cost (thousands of dollars)	$345	$1,356	$1,909	$1,209	$4,819
Total Costs (thousands of dollars)	**$5,309**	**$26,064**	**$2,474**	**$1,345**	**$35,192**

Source: McDowell Group, Note: Number of accidents is based on 2002 data from Alaska Department of Transportation and Public Facilities report, *2002 Alaska Traffic Collisions*; and *The Economic Cost of Motor Vehicle Crashes, 2000*, NHTSA, adjusted for inflation and cost-of-living in Alaska.

Alcohol and other drug abuse contribute to a majority of the criminal justice and protective services costs in Alaska. Combined, these costs totaled nearly $154 million during 2003. Costs for police protection, legal and court services, and incarceration services totaled $93.8 million in 2003. Child and adult protective services totaled nearly $60 million in Alaska during 2003. Child protective services, the largest share of protective services, includes foster care, adoption care, residential care, and social worker services.

Criminal Justice

Like all states in the U.S., Alaska suffers from alcohol and other drug abuse-related crime. Nationwide, 49 percent of 14,000 inmates surveyed reported they were under the influence of alcohol and other drugs at the time of the offense (NIDA/NIAAA, 1998). In another study, it was reported that 2.5 million arrests were made in the U.S. for alcohol offenses, while another 1.5 million arrests were for other drug offenses (Schneider Institute for Health Policy, 2001).

In Alaska there were an estimated 17,000 arrests or offenses known to law enforcement in 2003 that were attributed to alcohol and other drug abuse. During the same period, approximately 57,000 Alaska residents were victims of alcohol and other drug abuse-related crimes. All combined, costs attributed to crime-related alcohol and other drug abuse in Alaska were $93.8 million during this period.

The focus of this section is to provide estimates on the economic costs of crime-related alcohol and other drug abuse for Alaska during 2003.

Methodology

To estimate the economic costs of alcohol and other drug abuse-related crime, the research team relied on a methodology similar to that used in the NIDA/NIAAA (1998) report. Five cost measurements were used: law enforcement, legal and adjudication, corrections, victims' property damage, and victims' medical expenses. Within each category, crime-related attribution rates for alcohol and other drug abuse (NIDA/NIAAA, 1998) were applied to Alaska crime data.

To estimate enforcement and legal costs, estimates were based on data from the Alaska Department of Public Safety (DPS), and blended with attribution rates from the NIDA/NIAAA (1998) report. DPS prepares an annual report, "Crime Reported in Alaska," as part of the nationwide Unified Crime Reporting system. In 2003, law enforcement agencies reporting to DPS for the purposes of the UCR had jurisdiction over 97.5 percent of Alaska's population. The report presents data on offenses known to law enforcement for a proscribed group of offenses: murder, rape, aggravated assault, burglary, larceny-theft, and motor vehicle theft. This includes all offenses of which law enforcement is aware, whether or not an arrest was made. In addition, the report provides arrest data on a number of additional categories of offense. For the purpose of this report, data on offenses known to law enforcement were used when available. When unavailable, straight arrest data was used. Variations between the two data types are noted when appropriate.

Though not used in this study, data from the Arrestee Drug Abuse Monitoring Program (ADAM) project provides an indication of the linkage between drug abuse and crime in Alaska. For example, a survey (including drug testing) of 718 male and female arrestees in Anchorage in 1999 found that 54 percent of males and 56 percent of females tested positive for one or more drugs (including cocaine, marijuana, opiates, Methamphetamine, and PCP).[5] The ADAM project also collected arrestee data on alcohol use. The survey collected data on long-term and near-term drinking behavior prior to arrest for 1,178 males booked into Anchorage jails in 2000 and 2001. The authors of the summary report concluded that "among those that enter the criminal justice system through jails, problematic alcohol abuse is rampant."[6]

Inmate population by offense was used for correction cost estimates. Inmate counts were based on the Alaska Department of Corrections 2003 Offender Profile. The Offender Profile provides inmate counts by offense category as of December 31 of each year. Alcohol and drug abuse attribution rates from NIDA/NIAAA (1998) were applied to this data. Total expenditures by the Department of Corrections in 2003 were $179 million.

Alaska population data from ADOL and victimization rates from the Bureau of Justice Statistics were used to estimate victim property damage and medical costs. In each case, Alaska-specific data by offense was multiplied by its associated attribute rate for alcohol and other drug abuse.

Attribution rates, arrests, and incarcerations related to alcohol and other drug abuse are presented in Tables 9 and 10.[7] Victimization rates, victim numbers, and attribution rates related to alcohol and other drug abuse are shown in Table 11.

[5] "Drug Abuse Among Arrestees in Anchorage", Alaska Justice Forum 17(1), Spring 2000.
[6] "Alcohol Use Among Anchorage Arrestees", Alaska Justice Forum 19(4), Winter 2003.
[7] Specific data on drug and alcohol arrests is available from the Alaska State Troopers Alaska Bureau of Alcohol and Drug Enforcement (ABADE). For example, ABADE alcohol-related arrest/charges included 43 for distribution/sales and 237 for transport in 2003. Cocaine related arrests/charges includes 53 for distribution/sales, 28 for transport and 24 for possession in 2003. Crack related arrests/charges includes 13 for distribution/sales and 11 for possession. Source: 2003 Annual Drug Report.

Table 9
Arrests Attributed to Alcohol and Other Drug Abuse in Alaska, 2003

Type of Offense	Total Number of Arrests	Alcohol Abuse	Drug Abuse	Arrests Attributed to Alcohol Abuse	Arrests Attributed to Drug Abuse	Total Substance Related Arrests
Murder	39	30%	16%	12	6	**18**
Aggravated Assault	2,638	30%	5%	791	135	**926**
Sexual Assault	575	23%	2%	129	14	**143**
Robbery	442	3%	27%	15	120	**135**
Burglary	3,809	4%	30%	137	1,143	**1,280**
Larceny-Theft	17,626	3%	30%	494	5,217	**5,711**
Auto Theft	2,411	4%	7%	84	164	**248**
Driving While Intoxicated*	4,987	100%	0%	4,987	0	**4,987**
Liquor Laws*	1,746	100%	0%	1,746	0	**1,746**
Stolen Property*	24	0%	15%	0	4	**4**
Prostitution*	59	0%	13%	0	8	**8**
Drug Laws*	2,187	0%	100%	0	2,187	**2,187**
Total	**36,543**			**8,396**	**8,997**	**17,392**

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); and *Crime Reported in Alaska, 2003* from the Alaska Department of Public Safety.
Notes: Columns and rows may not total due to rounding.
* Categories marked with an asterisk (*) represent pure arrest data. Other categories are offenses known to law enforcement, which include arrests as well as offenses for which no arrest was made.

Table 10
Incarcerations Attributed to Alcohol and Other Drug Abuse in Alaska, 2003

Type of Offense	Alaska Inmates in 2003 by category	Percent Alcohol-related	Percent Other Drug Related	Incarcerations Attributed to Alcohol Abuse	Incarcerations Attributed to Other Drug Abuse	Total Incarcerations Related Alcohol and Other Drug Abuse
Murder	407	30.0%	15.8%	122	64	**186**
Aggravated assault	541	30.0%	5.1%	162	28	**190**
Sexual assault	543	22.5%	2.4%	122	28	**150**
Robbery	124	3.4%	27.2%	4	34	**38**
Burglary	70	3.6%	30.0%	3	21	**24**
Larceny/theft	209	2.8%	29.6%	6	62	**68**
Auto theft	40	3.5%	6.8%	1	3	**4**
Driving while intoxicated	300	100.0%	0.0%	300	0	**300**
Liquor laws	57	100.0%	0.0%	57	0	**57**
Prostitution	2	0.0%	12.8%	0	0	**0**
Drug laws	175	0.0%	100.0%	0	175	**175**
Total	**2,468**			**778**	**414**	**1,192**

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); and incarceration data from Alaska Department of Corrections. Counts do not include entire inmate population; only those offenders in the specified categories are counted. Inmates whose offense was an "attempt" at any of the specified categories are included in the counts. For example, inmates imprisoned for "attempted murder" would be grouped in the "murder" category.
Notes: Columns and rows may not total due to rounding.

Table 11
Victimizations Attributed to Alcohol and Other Drug Abuse in Alaska, 2003

Type of Crime	Victimizations per 1,000 persons age 12 or older or per 1,000 households	Total Number of Victims	Percent Alcohol-related	Percent Other Drug Related	Number of Victims Attributed to Alcohol Abuse	Number of Victims Attributed to Other Drug Abuse	Total Number of Victims Attributed to Substance Abuse
Robbery	2.5	1,309	3.4%	27.2%	45	356	**401**
Assault	19.3	10,107	30.0	5.1	3,032	515	**3,548**
Personal larceny	124.4	28,506	2.8	29.6	798	8,438	**9,236**
Burglary	29.8	6,829	3.6	30.0	246	2,049	**2,294**
Motor vehicle theft	9	2,062	3.5	6.8	72	140	**212**
Sexual Assault	0.8	419	22.5	2.4	94	10	**104**
Murder	-	39	30.0	16.0	12	6	**18**
Total		**49,232**			**4,299**	**11,514**	**15,813**

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); population data from Alaska Department of Labor, and victimization rates from Bureau of Justice Statistics.

As reported under Productivity Losses, crime rates attributed to alcohol and other drug abuse are thought to be higher in Alaska than the rest of the nation. Attribution rates from the NIDA/NIAAA (1998) study were used to estimate Alaska crime rates related to substance abuse, because no Alaska-specific data is currently available to support this premise.

To measure criminal costs attributed to alcohol and other drug abuse, the research team used NIDA/NIAAA (1998) data to estimate the economic implications of criminal activity. After adjusting for inflation and the Alaska cost-of-living differential, law enforcement costs per arrest ranged from $60 to $4,100, depending on the offense, while the average legal costs for most offenses were $1,100 per arrest. Legal costs for driving while intoxicated, liquor laws, and public drunkenness were approximately $60 per arrest. Average incarceration costs per inmate were approximately $33,500. Property damage and medical costs per victim by crime type are presented in Table 12. These unit costs were used to estimate the costs of arrests, incarcerations, and victimizations related to alcohol and other drug abuse.

Table 12
Property Damage and Medical Expenses per Victim, 2003

Type of Crime	Property Damage Expenses per Victim	Medical Expenses per Victim
Robbery	$27	$10
Assault	46	540
Rape	-	72
Murder**	-	23,816
Larceny	31	-
Burglary	58	-
Motor vehicle theft	207	-

Source: McDowell Group estimates based on NIDA, NIAAA 1992 and the Bureau of Justice Statistics.
** Medical costs for homicides include long-term costs. See NIDA/NIAAA (1998), Appendix C, Table C.6.

As noted above, costs were adjusted to reflect changes in U.S. prices from 1992 to 2003, as well as the cost-of-living in Alaska. Bureau of Labor Statistics inflation rates specific to health care were used to inflate health care and medical expenses (a 56 percent inflation rate). To adjust for Alaska's higher medical costs relative to the rest of the country, medical expenses for victims were increased by a 65 percent health care-specific cost-of-living differential. This differential was drawn from American Chamber of Commerce Research Association data for fourth quarter 2003.

Additional costs from lost productivity due to incarceration are presented in the Productivity Losses chapter to avoid double counting. Inmates are generally not employed while incarcerated, so society loses the benefit of their production of goods and services.

Drug traffic control costs were not included in this report. The U.S. budget in fiscal year 2003 for drug traffic control was $11 billion.[8] Some portion of this money was spent in Alaska for drug interdiction, international intelligence, research, and a number of other drug-related activities. However, specific information on Alaska's portion of this budget is not available.

Results

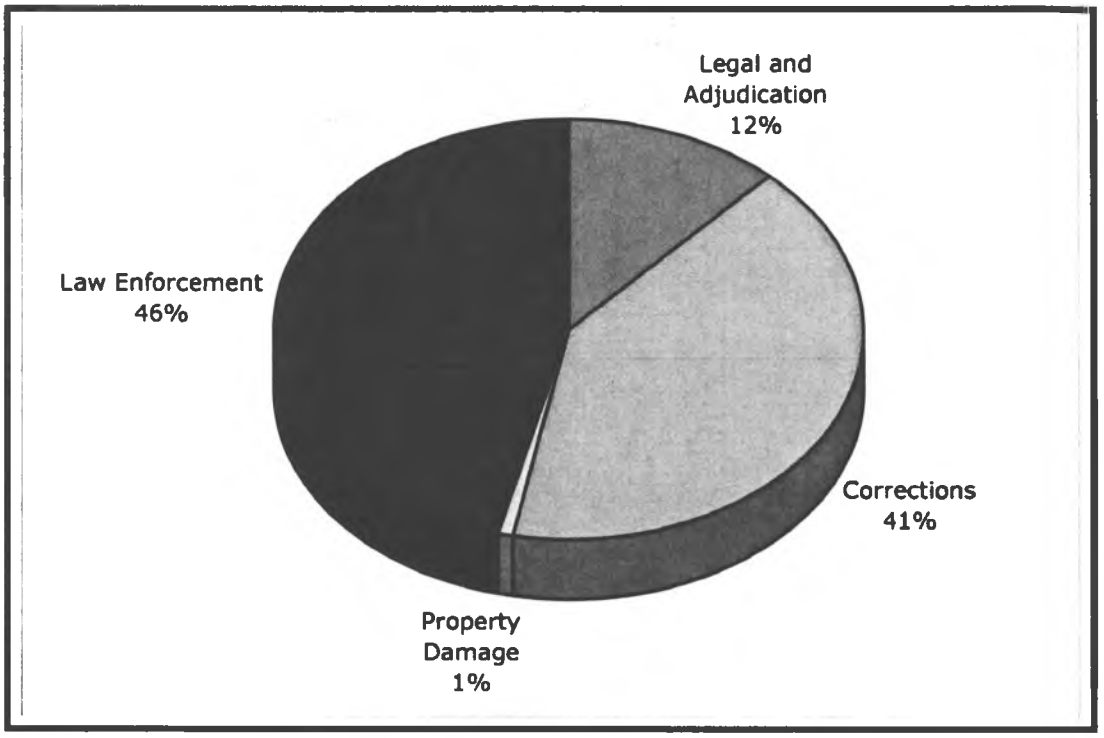
In Alaska in 2003, approximately 17,400 offenses known to law enforcement and 1,190 incarcerations were attributed to alcohol and other drug abuse. Of the 17,400 arrests, 8,400 crimes were related to alcohol abuse, while other drug abuse accounted for 9,000 crimes. Among incarcerations, 780 were alcohol-related and 410 were other drug-related.

Alaska also had an estimated 15,800 residents who were victims of alcohol or other drug abuse-related crimes. The number of victims who had property damage was 11,700, while 4,100 of the victimizations were against a person.

Figure 3 shows the distribution of alcohol and other drug-related crime by cost. Total costs for Alaska substance abuse-related crime were $93.8 million in 2003. The largest expense was law enforcement at $43.4 million, followed by correction costs at $38.2 million and legal and adjudication costs at $11.6 million. Property damage costs totaled more than $636,000 and medical costs to victims totaled $1.9 million. Medical costs are reported in this chapter for reference, but were not added to total crime-related costs to avoid double counting. Medical costs are included in the Health Care chapter.

[8] Bureau of Justice Statistics, http://www.ojp.usdoj.gov/bjs/dcf/dcb.htm, retrieved 8/17/05.

Figure 3
Distribution of Criminal Justice Costs Attributed to Alcohol and Other Drug Abuse in Alaska, 2003



Note: Figures may not add to 100% due to rounding.

Table 13 presents law enforcement costs from alcohol and other drug-related crime for Alaska during 2003. Larceny and theft accounted for the largest expense at $23 million. Burglary accounted for $5.2 million and assault for $3.7 million.

Legal costs from alcohol and other drug-related crimes for Alaska during 2003 are presented in Table 14. Larceny and theft were the largest expense at $6 million. Costs for burglary were $1.3 million, and for assault were $972,000.

Among Alaska incarceration costs in 2003, costs for inmates imprisoned for driving while intoxicated were greatest, at $10 million. This is a substantial increase from 1999, due largely to a more than doubling of the inmate population for DWI crimes. This was followed by costs for aggravated assault, at $6.4 million and homicide at $6.2 million. Drug laws were fourth, at $5.9 million, and sexual assault followed, at $4.5 million. Table 15 presents incarceration costs for Alaska during 2003 by offense.

Table 13
Law Enforcement Costs Attributed to Alcohol and Other Drug Abuse by Offense in Alaska, 2003

Type of Offense	Alcohol	Drug	Total
Homicide*	$47,000	$25,000	$71,000
Aggravated Assault*	3,196,000	544,000	3,740,000
Sexual Assault*	512,000	47,000	559,000
Robbery*	61,0600	485,000	545,000
Burglary*	555,000	4,610,000	5,165,000
Larceny-Theft*	1,986,000	21,066,000	23,051,000
Auto Theft*	348,000	657,000	1,005,000
Driving while intoxicated	311,000	-	311,000
Liquor Laws	107,000	-	107,000
Stolen Property	-	15,000	15,000
Prostitution	-	30,000	30,000
Drug Laws	-	8,831,000	8,831,000
Total	**$7,122,000**	**$36,307,000**	**$43,430,000**

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); and offense data from Alaska Department of Public Safety, *Crime in Alaska, 2003*.

* Categories marked with an asterisk (*) represent pure arrest data. Other categories are offenses known to law enforcement, which include arrests as well as offenses for which no arrest was made.

Note: Columns and rows may not total due to rounding.

Table 14
Legal and Adjudication Costs Attributed to Alcohol and Other Drug Abuse by Offense in Alaska, 2003

Type of Offense	Alcohol-Related	Drug-Related	Total
Homicide	$11,000	$5,000	$16,000
Aggravated assault	832,000	140,000	972,000
Sexual assault	140,000	23,000	163,000
Robbery	16,000	125,000	141,000
Burglary	142,000	1,195,000	1,337,000
Larceny-theft	520,000	5,494,000	6,013,000
Auto theft	97,000	174,000	271,000
Driving while intoxicated	311,000	-	311,000
Liquor laws	107,000	-	107,000
Stolen property	-	4,000	4,000
Prostitution	-	8,000	8,000
Drug laws	-	2,299,000	2,299,000
Total	**$2,176,000**	**$9,468,000**	**$11,644,000**

Source: McDowell Group, based on attribution rates from The Economic Costs of Alcohol and Drug Abuse in the United States – 1992 (NIDA/NIAAA, 1998); and offense data from Alaska Department of Public Safety, Crime in Alaska, 2003.

Note: Columns and rows may not total due to rounding.

Table 15
Incarceration Costs Attributed to
Alcohol and Other Drug Abuse by Offense in Alaska, 2003

Type of Offense	Alcohol-Related	Other Drug-Related	Total
Homicide	$ 4,163,000	$2,195,000	$6,358,000
Aggravated assault	5,540,000	936,000	6,477,000
Sexual assault	4,122,000	444,000	4,566,000
Robbery	152,000	1,216,000	1,368,000
Burglary	85,000	708,000	792,000
Larceny/theft	202,000	2,110,000	2,312,000
Auto theft	47,000	93,000	140,000
Driving while intoxicated	10,074,000	-	10,074,000
Liquor laws	-	-	-
Prostitution	-	-	-
Drug laws	-	6,097,000	6,097,000
Total	**$24,384,000**	**$13,800,000**	**$38,184,000**

Source: McDowell Group, based on attribution rates from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998); and incarceration data from Alaska Department of Corrections.

Note: Columns and rows may not total due to rounding.

This incarceration data does not include Alaska Statute Title 47 Protective Holds in Department of Corrections Facilities. Department of Corrections data does not specify the reason for each protective hold, but DOC staff indicate that the "vast majority [of protective holds] are the result of incapacitation due to alcohol use." For the years 2000-2002, there were a total of 7,920 protective holds for 3,243 individuals.[9] Estimates of the annual cost of these protective holds are not available.

Protective Services

Alcohol and other drug abuse is a primary contributor to child abuse and neglect cases in Alaska. In a study completed by the National Center on Addiction and Substance Abuse at Columbia University in 1999, it was found that parents were three times more likely to abuse their children and four times more likely to neglect their children if the parents were substance abusers. In that same study, approximately seven out of ten abused or neglected children nationwide are linked to parents who abuse alcohol and other drugs. In a study completed by the Alaska, Department of Health and Social Services, Division of Alcohol and Drug Abuse (DADA) (now part of the Department of Behavioral Health), approximately 81 percent of all Division of Family and Youth Services (DFYS) (now the Office of Children's Services) reports of child abuse involved alcohol and drug abuse.[10,11]

[9] "Analysis of Title 47 Protective Holds in Department of Corrections Facilities, CY 00-02." Undated document.
[10] *Final Report of the Alaska Criminal Justice Assessment Commission*, May 2000, published by the Alaska Judicial Council.

Methodology

Currently, there is no accurate measure of the cost to Alaska from child abuse and neglect caused by alcohol and other drug abuse. To overcome this shortfall, the research team relied on the 1999 DADA child abuse estimate and assumed that 81 percent of child protective services were attributable to alcohol and other drug abuse. These services include foster care, adoption care, residential care, and social work care through the Office of Children's Services (OCS). In addition, the Office of Public Advocacy (OPA) provides child protective services. Their services include advocacy within the legal system for children under state custody. Their total FY2003 expenditure was $13.8 million. Unfortunately, OPA was not able to provide the portion of their budget that is attributed to child protective services.

Adult protective service costs during 2003 were provided by Division of Senior and Disability Services, in the Department of Health and Social Services. The division provides assistance to adults who are unable to care for themselves, either because of physical, emotional, or mental impairment. Total expenditures on adult protective services in 2003 were $733,000. Department personnel estimate that 20 percent of all protective services cases are related to substance abuse or dependence by the care recipient. Another 20 percent of the cases the department handles are linked to substance abuse or dependence by primary caregivers or other family members.

Results

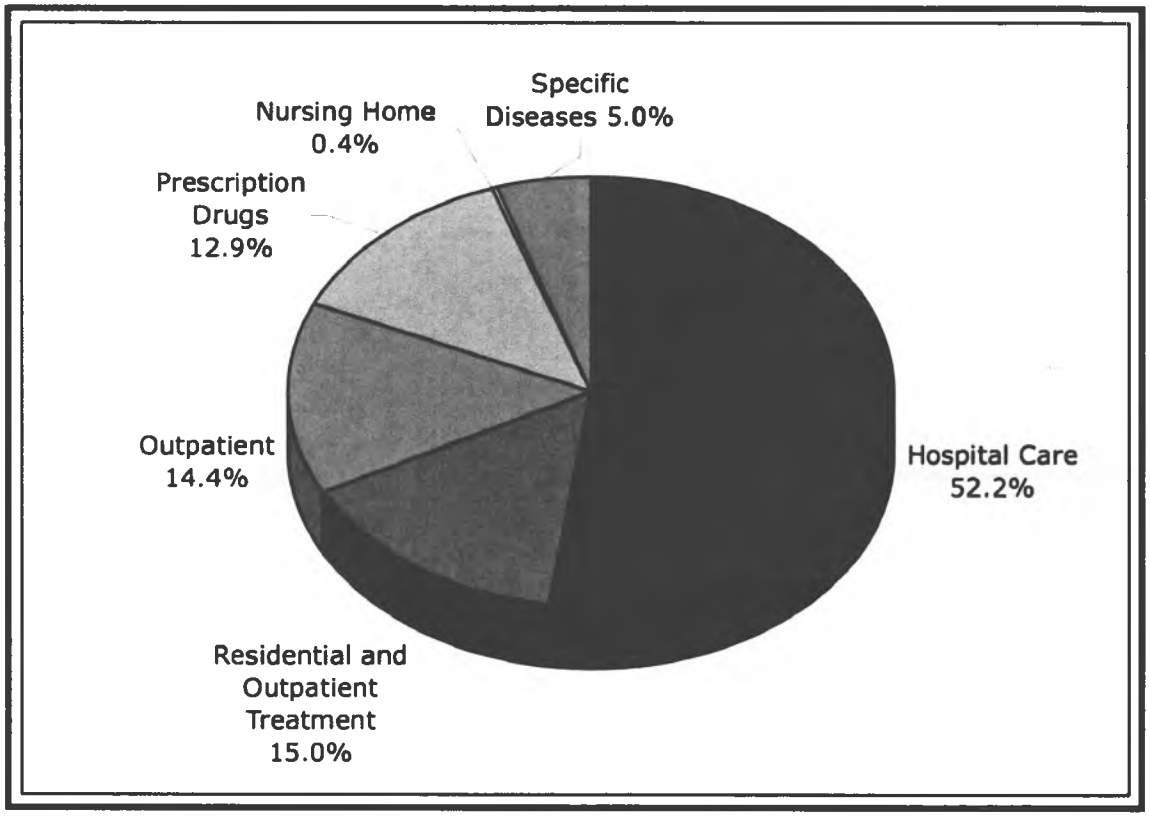
Total costs for child protective services provided by the Office of Children's Services in Alaska during fiscal year 2003 were nearly $60 million. Social work accounted for the largest expense at $18.4 million. Other expenses include $13 million for foster care services, $14 million for residential services, and $13.7 million for adoption and guardianship services. Additional program funding for child abuse prevention programs was $1.6 million.

Adult protective care services were estimated at $293,000 during 2003.

Illness and injuries stemming from alcohol and other drug abuse have significant health costs. In Alaska, health care costs related to alcohol and other drug abuse are estimated at $178 million. Alcohol and other drug-related illnesses or injuries range from acute to chronic. Acute illness includes alcohol poisoning, while chronic illness could be cirrhosis of the liver. In addition, prolonged alcohol and other drug abuse could increase the chance of other illnesses such as hypertension, diabetes, or stomach cancer.

This chapter estimates health care costs related to alcohol and other drug abuse in Alaska during 2003. Health care costs are presented for the following categories: hospital, outpatient, prescription drugs, nursing home and long term care facilities, fetal alcohol syndrome (FAS), HIV, and hepatitis B and C.

Figure 4
Distribution of Health Care Costs Related to Alcohol and Other Drug Abuse in Alaska, 2003



- Hospital costs from alcohol and other drug abuse-related injuries and illnesses in Alaska are estimated at $93 million in 2003. Alcohol abuse-related hospital care for medical illnesses and injuries costs accounted for $84.8 million, while other drug abuse-related costs were $8.2 million.

- Alcohol and other drug in-resident and outpatient drug and alcohol treatment costs from state sources were approximately $26.8 million.

- Total medical outpatient visits from alcohol and other drug abuse-related illness or injuries are estimated at 60,100 for a total cost of $25.7 million in 2003.

- Pharmaceutical and long term care costs from alcohol abuse are estimated at $23.0 million and $719,400, respectively.

- Approximately 78 HIV and HIV with AIDS cases were attributed to intravenous drug use during 2003. Total medical costs for treating these patients were $3.9 million.

- Intravenous drug abuse contributed to 344 hepatitis B and C cases in Alaska during 2003, with medical care costs of $5.1 million.

Excluded from the total values are the costs of care for individuals with Fetal Alcohol Syndrome and other Fetal Alcohol Spectrum Disorders. Data on the number of individuals living with FASD in Alaska is unavailable. However, information on the number of children born with FAS in a given year is available, as are estimates for lifetime costs of care. Estimated lifetime health care costs for the 15 FAS births in 2003 are $47.0 million.

Hospital Costs

Hospital costs from illness and injuries are a significant portion of alcohol and other drug-related health care costs. In 2003, hospital costs from illness and injuries accounted for 52 percent of total health care costs related to alcohol and other drug abuse (which totaled $178 million). Hospital costs are composed of three sources:

- Illness or injuries directly related to alcohol and other drug abuse, which might include alcohol cirrhosis or gastritis.

- Illness indirectly related to alcohol and other drug abuse, which could include cancer of the esophagus, burns, or poisoning.

- Treatment or injuries complicated by alcohol and other drug abuse resulting in lengthy hospital stays.

Methodology

To estimate injury and illness-related hospital costs from alcohol and other drug abuse, the research team relied on results of two studies: the *National Survey on Drug Use and Health,* conducted annually by the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Social Services; and *The Economic Costs of Alcohol and Drug Abuse in the United States - 1992,* NIDA/NIAAA (1998).

The NSDUH showed that 10.4 percent of Alaska's population age 12 and older was dependent upon or had abused illicit drugs or alcohol in 2003, while the U.S. national average was 4.5 percent. Alaska's portion of the U.S. substance dependent or abusing population was 0.5 percent.

No Alaska-specific data exists on the number of hospital inpatient days related to drug and alcohol abuse; to estimate this number, the research team adjusted NIDA/NIAAA (1998) estimates to reflect growth in the U.S. population, and used

the factor for Alaska's alcohol and drug-dependent population (0.5 percent) to determine the number of hospital care days in the state. The NIDA/NIAAA study reported costs for non-federal and federal/veteran inpatient care, as well as costs for alcohol and other drug-related hospital and outside physician services. Cost estimates were adjusted to reflect U.S. price inflation for health care from 1992 to 2003 and Alaska health care costs. Inflation in nationwide health care costs over the time period was approximately 56 percent according to the Bureau of Labor Statistics. During 2003, health care costs in Fairbanks (the largest Alaska city included in 2003 American Chamber of Commerce Research Associates – ACCRA cost-of-living data) were approximately 65 percent higher than a national average. After adjusting for inflation and Alaska health care costs, estimated average cost per day for hospital care in 2003 was $2,099. The daily cost for physician care averaged $504.

Total Alaska non-federal hospital costs from illness and injury-related substance abuse were estimated by applying daily hospital costs to the estimated number of hospital care days related to alcohol and other drug abuse. Hospital costs were divided into three categories for alcohol: alcohol-specific illness, alcohol-related illness, and additional costs from co-occurring alcohol disorders. Other drug categories include other drug-specific illness, other drug-related illness, and additional days from other drug disorders.

Substance abuse-related hospital stay costs for illnesses and injuries in a veterans' or federal facility were estimated using the methodology from the NIDA/NIAAA (1998) study. In that study, veterans' and federal hospital revenues accounted for 9.5 percent of total U.S. hospital revenues. By applying this proportion to non-federal hospital costs for substance abuse, the research team estimated hospital costs for the federal facilities for Alaska during 2003.

Results

The estimated total number of hospital care days related to alcohol and other drug abuse illnesses and injuries were 32,900 in Alaska during 2003. Alcohol abuse accounted for an estimated 30,000 care days, while 2,900 were from other drug abuse. Among alcohol abusers, total hospital care days were estimated as follows: specific illnesses at 2,300, related illnesses at 22,700, and co-occurring alcohol disorders at 5,000. Estimated number of hospital care days for other drug abuse-specific illnesses was fewer than 10, while hospital care days for other drug abuse-related illnesses are not included in hospital costs to avoid double counting. These costs are presented later in this chapter. Additional days from other drug disorders were estimated at 2,900 hospital care days. Table 16 presents results on the number of care days by category for Alaska in 2003.

Table 16
Hospital Costs for Illness and Injuries
Related to Substance Abuse in Alaska, 2003

	Total Care Days	Non-Federal Hospital Costs	Veteran and Federal Hospital Costs	Total Hospital Costs
Alcohol-specific illness	2,300	$6,072,400	$514,000	**$6,586,300**
Alcohol-related illness	22,700	59,164,600	5,007,800	**64,172,400**
Additional days from co-occurring alcohol disorders	5,000	12,931,600	1,094,600	**14,026,100**
Subtotal, alcohol abuse	*30,000*	*78,168,600*	*6,616,300*	***84,784,900***
Other Drug abuse-specific illness	<10	14,800	1,300	**16,100**
Other Drug abuse-related illness	*	*	*	*
Additional days from other drug disorders	2,900	7,586,700	642,200	**8,228,900**
Subtotal, other drug abuse	*2,900*	*7,601,600*	*643,400*	***8,245,000***
Total alcohol and other drug abuse	**32,900**	**$85,770,100**	**$7,259,700**	**$93,029,900**

Source: McDowell Group, based on alcohol and drug dependent population estimates from the 2003 National Survey on Drug Use and Health, from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; and U.S. hospital care days and costs per day related to alcohol and other drug abuse from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

**These costs include HIV, and Hepatitis A and B, which are presented later in the chapter.*

Alaska hospital costs from alcohol and other drug abuse-related medical injuries and illness in 2003 were estimated at $93 million (Table 16). Non-federal hospitals accounted for $85.8 million, while veterans and federal hospitals were $7.3 million. Estimated hospital costs injuries and illness related to alcohol and other drug abuse were $84.8 million and $8.2 million, respectively. Alcohol-related illnesses resulted in the highest hospital costs at $64 million.

Data maintained in the Alaska Department of Health and Social Services Alaska Trauma Registry, for the years 1997 through 2001, provides an indication of the number of accidents where alcohol and/or illegal drug use, at the time of the accident, was suspected or proven. Of approximately 22,700 trauma incidents recorded in the registry, alcohol use was suspected or proven in 24 percent of the cases and illegal drug use was suspected or proven in 10 percent of the cases.

Residential and Outpatient Alcohol and Other Drug Treatment Costs

In 2003, there were 4,006 substance abuse treatment admissions in Alaska. Just over 80 percent of these admissions were for alcohol or alcohol with secondary drug issues.

There are several categories of costs related to the treatment of alcohol and drug abuse and dependence in resident and outpatient facilities. The Alaska Department

of Health and Social Services, Division of Behavioral Health, provides grant funds to organizations and agencies throughout the state in support of drug and alcohol treatment services. Specific services include rehabilitation, counseling, case management, and other types of treatment services for individuals and families. In addition, Medicaid pays for treatment in facilities within and outside of Alaska for qualifying Alaskans. Treatment can also be paid through private insurers or private parties.

Data pertaining to the state-funded treatment, both through DBH and through Medicaid, is readily available. Data on costs borne by private insurers or private parties is not available. As a result, cost estimates presented underestimate the total cost of drug and alcohol treatment.

Funding appropriated by the DBH to support alcohol and drug abuse treatment in 2003 totaled approximately $23.3 million. Payments from Medicaid for substance abuse services in 2003 totaled $3.5 million. These payments account for treatment received in substance abuse-specific treatment facilities. Not included in these treatment costs are any services for co-occurring disorders that may have been billed by mental health or other providers. Costs for lab tests for drug and alcohol screening are also excluded from this number. Because Health and Social Services provided the data on both DBH and Medicaid directly, no estimate procedures were needed.

Data from the National Survey of Substance Abuse Treatment Services (N-SSATS) provides data on the number of treatment facilities and clients in substance abuse treatment. As of March 2004, there were 2,503 clients in substance abuse treatment in 69 facilities in Alaska. Just over half of those clients (53 percent) were in private non-profit treatment facilities, 8 percent were in private for-profit facilities, 9 percent were in local government facilities, 14 percent were in federal government facilities, and 16 percent were in tribal government facilities.[12]

Medical Outpatient Costs

Another health expense related to alcohol and other drug abuse is outpatient medical treatment for a specific disorder or illness related to alcohol and other drug abuse. Examples of specific disorders could include alcohol gastritis or cirrhosis, while a related illness could be chronic pancreatitis or cancer of the esophagus.

Methodology

Like hospital costs, specific data on alcohol and other drug abuse-related medical outpatient visits was not available for Alaska. To estimate these costs, the research team applied Alaska prevalence figures to U.S. estimates for alcohol abuse-related medical outpatient visits reported in the NIDA/NIAAA (1998) study. The NIDA/NIAAA study did not report any medical outpatient visits for other drug abuse-specific disorders because of the lack of data and causal relationships needed to estimate the medical outpatient visits. Other drug abuse medical outpatient visits related to HIV and Hepatitis B and C are presented later in the chapter.

Estimated medical outpatient visits were multiplied by the average medical outpatient cost for alcohol and other drug abuse-related illnesses and injuries. Cost estimates were adjusted to reflect changes in U.S. prices from 1992 to 2003, and

[12] N-SSATS State Profile – Alaska 2004.

Alaska health care costs. Inflation was estimated at 56 percent using U.S. consumer price index for health care expenditures from the U.S. Bureau of Labor Statistics. Alaska health care cost data came from ACCRA. During 2003, health care costs in Fairbanks (the largest Alaska city for which data were available) were approximately 64 percent higher than the average participating city. After adjusting for inflation and cost-of-health care in Alaska, the estimated average cost for an alcohol and other drug abuse-related medical outpatient visit was $504.

Results

Alcohol abuse-related medical outpatient visits in Alaska during 2003 were estimated at $25.7 million. Alcohol-related disorders accounted for 52,200 estimated visits, while alcohol-specific illnesses had an estimated 7,900 visits. Table 17 presents estimated medical outpatient visits and costs for alcohol abuse-related disorders.

Of the total $25.7 million in alcohol abuse-related outpatient medical costs in 2003, alcohol abuse-related illness and injury contributed an estimated at $22.3 million, while alcohol abuse-specific illness and injury contributed $3.4 million.

Table 17
Medical Outpatient Visits and Costs Related to Alcohol Abuse in Alaska, 2003

	Outpatient Visits	Outpatient Costs (thousands of dollars)
Alcohol-specific	7,900	$3,373,000
Alcohol-related	52,200	22,286,000
Total, Alcohol Abuse	**60,100**	**$25,659,000**

Source: McDowell Group, based on alcohol and other drug-dependent population estimates from *National Survey on Drug Abuse and Health, 2003*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; and U.S. medical outpatient and costs related to alcohol abuse from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

Prescription Drugs and Nursing Home/Long-Term Care Costs

Although not as high as hospital and medical outpatient costs, alcohol and other drug abuse also have prescription drug and nursing home costs. Prescription drugs are prescribed for alcohol abuse-specific illnesses such as cirrhosis or alcohol-related cancer. Long-term care and nursing home costs estimates are for residents who have a primary alcohol abuse-specific diagnosis.

Methodology

Alcohol-related prescription drug costs were estimated using Alaska prevalence data on substance abuse. Prevalence estimates were applied to the total U.S. prescription drug costs related to alcohol abuse, as published in the NIDA/NIAAA (1998) study. These totals were adjusted to reflect population growth, inflation, and the cost of health care in Alaska. In the study, 2.2 percent of U.S. prescription drug costs for all illnesses were attributed to alcohol abuse. Prescription drug costs related to other drug abuse were not estimated due to the lack of national data.

Nursing home costs related to alcohol abuse were estimated using data from the Alaska Department of Health and Social Services and the NIDA/NIAAA (1998) study. HSS collects data on the number of long-term care days per care facility in

Alaska, as well as the daily rate information for each facility. There were an estimated 219,400 total nursing home and long-term treatment care bed days in Alaska for all during 2003, while cost per day of care averaged $328 per day, with a range of $213 to $625 per day. The cost of Alaska nursing home care for all illnesses and injuries during 2003 was approximately $71.9 million. Based on estimates published in the NIDA/NIAAA (1998) study, approximately 1 percent of the nation's nursing home care costs can be attributed to alcohol abuse-specific illnesses. The research team applied 1 percent to total nursing home and long term care costs in Alaska during 2003.

Results

Estimated pharmaceutical costs related to alcohol abuse in Alaska during 2003 were approximately $23.0 million. Alcohol abuse-related nursing home care days totaled 2,194 in Alaska during 2003. Costs from these visits amounted to approximately $719,000.

Fetal Alcohol Spectrum Disorders

Prenatal exposure to alcohol can cause specific birth defects which may include physical, mental, behavioral, and learning disabilities. Many children with fetal alcohol disorders are not identified until they reach school age or later. Individuals with alcohol-related effects may have difficulties with attention, memory, and problem solving. Heart, liver, and kidney defects are also common, as well as vision and hearing problems.[13] Alcohol-related effects that fall within the broad category of fetal alcohol spectrum disorders (FASD) include:

- fetal alcohol syndrome (FAS),
- partial FAS (PFAS),
- fetal alcohol effects (FAE),
- alcohol-related neurodevelopmental disorder (ARND),
- and other alcohol-related birth defects (ARBD).[14]

During the past ten years, a number of FAS prevalence rates have been established. Studies by the Centers for Disease Control and Prevention indicate a national rate from 0.2 to 1.5 cases per 1,000 births across various populations.[15] Other studies, including those focusing on specific high-risk populations such as Native Americans, other minorities and families living in poverty have indicated rates from 0.5 to 5.0 per 1,000 live births. Clearly, the data is varied and limited.

In establishing a clear number of infants born each year in the United States with Fetal Alcohol Syndrome, the CDC estimates between 1,000 and 6,000 children will be born with FAS each year – a preventable birth defect and disability.

Beginning in 1997, Alaska was one of five states comprising the CDC's Fetal Alcohol Syndrome Surveillance Network (FASSNet), a program established to provide consistent and comparable FAS prevalence rates. Participating states included Arizona, Colorado, New York, Wisconsin and Alaska (however, FAS rates for Wisconsin are not available). At 1.5 per 1,000 live births, Alaska has a significantly higher rate of children born with FAS than other states in the FASSNet program. In

[13] National Organization on Fetal Alcohol Syndrome, *What is FAS/FASD?*, www.nofas.org/faqs.aspx?id=9
[14] US Department of Health and Human Services, SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence. *The Language of Fetal Alcohol Spectrum Disorders.*
[15] *FAS: Guidelines for Referral and Diagnosis*, CDC, 2004.

addition, Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives. CDC data indicates FAS prevalence rates ranging from 0.3 per 1,000 in Arizona and Colorado to 0.4 in New York.

CDC estimates that other prenatal alcohol-related conditions, such as ARND and ARBD, occur approximately three times as often as FAS.[16] Within the wider category of FASD (which would include individuals with FAS), the US is estimated to have about 10 cases per 1,000 live births. [17]

Alaska's estimated rate of all births impacted by prenatal alcohol exposure is 16.3 cases per 1,000 births, based on the 1995 to 1999 birth years. While these alcohol-related effects are closely associated with FASD, these rates are not directly comparable to national FASD rates of 10 per 1,000 live births due to differences in diagnoses and reporting at the state and national levels. Based on 16.3 cases per 1,000 and the number of live births from 1995 to 1999, approximately 160 infants are born each year in Alaska with FAS and other effects from maternal alcohol use during pregnancy. Of those, approximately 15 are born with Fetal Alcohol Syndrome (FAS).

FAS vs. FASD

It is important to remember that the information being used to determine the economic costs of care and service delivery to individuals with Fetal Alcohol Syndrome is only a small portion of the overall impact of prenatal exposure to alcohol and the resulting birth defects and disabilities. Beginning in 2000, the State of Alaska began extensive efforts to improve and expand the ability to appropriately diagnose individuals prenatally exposed to alcohol. In 2005, Alaska has a broad and regionally diverse network of diagnostic teams across the state.[18] Data collected from these teams indicate that from July 2000 through March 2005 teams have conducted 755 FASD diagnostic assessments. Of this number, 76 (10.0 percent) were diagnosed with FAS or atypical FAS; 378 (49.9 percent) were diagnosed with Static Encephalopathy; 251 (32.2 percent) were diagnosed with Neurobehavioral Disorder; and 50 (6.6 percent) were found to have no evidence of organic brain damage.

What this data indicates is that the costs associated with all alcohol-related births are much higher than those estimated just for individuals with FAS. And, as noted in the break-through research of Dr. Ann Streissguth in 1996 (Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome [FAS] and Fetal Alcohol Effects [FAE]), individuals with FAE (what is now referred to as FASD) are more likely to develop secondary disabilities and need more services than those with Fetal Alcohol Syndrome and the associated facial dysmorphology. For Alaska and the economic costs associated with all fetal alcohol spectrum disorders, the costs could be as much as 80 percent higher than indicated for FAS alone.

Economic Cost of Fetal Alcohol Syndrome

The cost of caring for and providing appropriate services to a person with FAS can be significant. These costs may include neonatal care for low birth weight to special speech therapy, behavioral management, or residential care for adults with FAS. Lifetime costs for care for children born in 2003 with FAS are estimated below. However, these costs are excluded from the total health care costs for 2003, as the component of that expenditure in 2003 alone cannot be determined.

---

[16] CDC, *Tracking Fetal Alcohol Syndrome*, www.cdc.gov/ncbddd/fas/fassurv.htm

[17] National Organization on Fetal Alcohol Syndrome, *What are the Statistics and Facts about FAS and FASD?*, www.nofas.org/faqs.aspx?id=12

[18] For information on available services go to http://health.hss.state.ak.us/fas/teams/default.htm).

Methodology

To estimate the economic costs from FAS, the research team first determined the number of live births with FAS in Alaska. The Alaska Department of Health and Social Services has closely monitored incidence of FAS in the state since 1998, as part of a U.S. Centers for Disease Control (CDC) monitoring program called the Fetal Alcohol Syndrome Surveillance Network (FASSNet), the ongoing Alaska FAS Surveillance Project and the Alaska Birth Defects Registry. The development of 13 community-based FASD diagnostic teams across Alaska has also assisted in the collection of data related to both FAS and other alcohol-related disabilities included in the FASD umbrella definition.

The Alaska FAS Surveillance Project data collection system is based on reports to the Alaska Birth Defects Registry, and uses medical chart data points to identify children with FAS or other prenatal alcohol-related conditions. DHSS staff consider the surveillance program to be highly rigorous. Alaska clinicians and case workers use a diagnostic process developed by researchers at the University of Washington Fetal Alcohol Syndrome Diagnostic and Prevention Network. Reporting of birth defects to the state registry is mandated by Alaska law. While Alaska's FAS surveillance system is believed to capture the majority of prenatal alcohol-related cases, it is possible that underreporting could make the incidence rate even higher.

For birth years 1995 to 1999, the incidence rate of FAS in Alaska is 1.5 per 1,000 live births.[19] This was the highest rate of the five states that were involved in developing the CDC FASSNet system. (The lowest rate was 0.3 FAS cases per 1,000 births.) However, the incidence of all prenatal alcohol-related conditions, including such conditions as alcohol-related birth defects (ARBD) and alcohol-related neurodevelopmental disorder (ARND), as well as FAS, is 16.3 per 1,000 live births. This incidence rate is assumed to be consistent in birth year 2003.

To estimate FAS costs in Alaska, the research team relied on data published in Health Professions Education Partnership Act of 1998 (Senate Bill 1754). The cost of treating an individual with FAS over his or her lifetime was estimated to be at least $1.4 million in 1995. These costs could include neonatal intensive care, medical and surgical services (not related to neonatal care), special speech therapy, behavioral management, and residential care. Medical and surgical service might include rectifying or monitoring hearing loss or cleft palate surgery. Residential services include special education, home care, speech therapy or institutional care. The 1995 data was adjusted for inflation using the Bureau of Labor Statistics Consumer Price Index for medical care. Additionally, costs of providing care were adjusted by the Alaska differential for cost of living (65 percent in 2003). The resulting total lifetime costs (in 2003 dollars) for providing services to an individual with FAS are estimated at $3.1 million.

The total cost for providing services to an individual with FAS born in Alaska during 2003 was estimated by multiplying the lifetime costs by the number of FAS births during that period.

Results

Table 18 presents estimated costs for FAS births in Alaska during 2003. During that period, Alaska had about 15 FAS births. Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately $47.0 million.

[19] *Susan Merrick, FAS Surveillance Project Manager, Alaska Department of Health and Social Services, personal communication, July 2005.*

Table 18
Lifetime Costs of Medical and Residential Services for Children Born with FAS in 2003

	Incidence and Costs
Alaska births in 2003	10,084
FAS incidence per 1,000 live births	1.5
FAS births	15
Lifetime FAS cost	**$47,037,000**

Source: Birth data from the Alaska Bureau of Vital Statistics. McDowell Group, based on FAS data from Alaska Department of Health and Social Services; and Health Professions Education Partnership Act of 1998, S. 1754, 108d Congress (1998).

AIDS and HIV Costs

Intravenous drug abuse among individuals who share unhygienic needles is a significant cause of AIDS and HIV. Although AIDS and HIV no longer require extensive inpatient medical care, both result in high medical expenses worth measuring separately from the hospital and outpatient costs presented above (NIDA/NIAAA, 1998).

Methodology

The State of Alaska Department of Health and Social Services Epidemiology Section compiles data on HIV and AIDS diagnoses in the state. While the section does not track individuals with HIV and/or AIDS diagnoses, it does compile cumulative counts of the number of diagnoses in the state since the first known HIV diagnosis. Of the known cases of HIV and/or AIDS, 13 percent are associated with intravenous drug use. In addition, the Epidemiology Section tracks known deaths. The section does not track the whereabouts of diagnosed individuals, and as a result no data exists regarding the number of HIV/AIDS patients who may have moved away from Alaska. For the purposes of these estimates the research team assumes that 100 percent of diagnosed individuals remain in the state, though it is recognized that this may not be the case. Additionally, we assume that 100 percent of the known deaths occurred among individuals who had been diagnosed with AIDS, although data is not available on specific cause of death.

Two steps were used to calculate other drug-related AIDS and HIV medical costs. First, AIDS and HIV costs were estimated by applying annual medical expenses from the NIDA/NIAAA (1998) study to the number of known Alaska AIDS and HIV patients in 2003. Cost data was adjusted for inflation and the cost of health care in Alaska using the same sources and methods previously reported. Annual medical expenses for each Alaska HIV patient were estimated at $30,600, while medical expenses for each AIDS patient were $68,200.

The second step was to determine the percent of AIDS and HIV medical expenses that can be attributed to other drug abuse. The Epidemiology Section reported that approximately 13 percent of AIDS and HIV cases were attributed to intravenous drug abuse. This attribution rate was then applied to medical costs for AIDS and HIV patients.

Based on the data from the Alaska Division of Public Health, a total of 597 individuals with HIV or HIV/AIDS lived in Alaska in 2003. Of those, an estimated

295 had HIV without AIDS and 302 had HIV with AIDS. An estimated 13 percent of these individuals contracted HIV through intravenous drug use.

Although the following cost estimates are limited only to those caused by intravenous drug abuse, alcohol abuse is a risk factor in contracting AIDS and HIV from unprotected sex.

Results

An estimated 78 HIV and HIV with AIDS cases in Alaska are attributable to intravenous drug use. Medical costs for treating these patients in 2003 were approximately $3.8 million. Table 19 presents the number of HIV and HIV with AIDS cases and annual medical expenses for these cases.

Table 19
Annual Medical Expenses per AIDS and HIV Case
Due to Other Drug Abuse in Alaska, 2003

	Annual Medical Expenses per Patient	Number of AIDS and HIV Patients	Total Costs due to Drug Abuse
HIV Positive	$30,600	38	$1,172,000
AIDS	$68,200	39	$2,678,000
Total	**n/a**	**78**	**$3,850,000**

Source: McDowell Group, based on AIDS and HIV case numbers from Alaska Department of Health and Social Services, Division of Public Health; and annual medical expense data from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).

Hepatitis B and C Costs

Intravenous drug abuse and sharing unhygienic needles are leading contributors to hepatitis B and C in Alaska. In fact, intravenous drug use is the largest contributor to hepatitis C. Hepatitis B and C have been linked to cirrhosis and primary hepatic cancer.

Methodology

Approximately 12 percent of hepatitis B cases and 36 percent of hepatitis C cases can be attributed to intravenous drug abuse (NIDA/NIAAA, 1998). According to the Alaska Department of Health and Social Services, there were 8 cases of hepatitis B and 952 cases of hepatitis C reported in the state in 2003. Hepatitis B infection is accompanied by acute illness, and reported cases in 2003 likely accurately represent the number of people seeking care for hepatitis B in that year. However, hepatitis C is not necessarily accompanied by acute symptoms, though long-term costs of care are generally far more significant. Due to limited data on the disease stage[20] and how many patients were cured, the report estimates the cost of treating only those hepatitis C cases reported by the Alaska Division of Public Health in 2003.

Medical expenses for hepatitis B and C were presented in the NIDA/NIAAA (1998) study by stage. Since data is limited for hepatitis B and C in Alaska, medical expenses from the NIDA/NIAAA study were averaged. Adjusting for inflation and Alaska health costs, the annual average medical expense is $3,400 for treating hepatitis B and $14,900 for hepatitis C. These costs were applied to all other drug

[20] Incubation, acute, and persistent are the three stages of hepatitis.

abuse-related hepatitis B and C cases reported in 2003 by the Division of Public Health. However, it should be pointed out that most hepatitis B and C cases required only monitoring of the disease, which is relatively inexpensive. Hepatitis B cases generally require intensive treatment but limited long-term care, while hepatitis C cases may require low levels of treatment over an extended time, leading toward intensive treatment in later stages of the disease. The study provides an approximate cost of treating hepatitis B and C cases that were newly reported during 2003.

Results

In Alaska, intravenous drug abuse attributed to one hepatitis B case and 343 hepatitis C cases during 2003. Total annual medical costs for intravenous drug abuse-related hepatitis B were $3,000. Costs associated with the treatment of hepatitis C attributed to intravenous drug abuse were an estimated $5.1 million. Table 20 presents total medical costs and number of cases for hepatitis C in Alaska during 2003.

Table 20
Annual Medical Expenses per Hepatitis C Case
Due to Drug Abuse in Alaska, 2003

	Annual Medical Expenses per Patient	Number of Patients	Total Costs due to Drug Abuse
Hepatitis C	$14,900	343	$5,114,000

Source: McDowell Group, based on hepatitis B and C case numbers from the Alaska Department of Health and Social Services; and annual medical expense data from *The Economic Costs of Alcohol and Drug Abuse in the United States – 1992* (NIDA/NIAAA, 1998).
Hepatitis B costs were not included in the table because costs were insignificant compared to Hepatitis C ($3,000).

A significant percentage of individuals with serious mental illness also are users of or dependent upon drugs and/or alcohol. Similarly, rates of serious mental illness among individuals who experience drug and/or alcohol dependence or abuse are significantly higher than among the general population. Research also indicates that adults with co-occurring serious mental illness (SMI) and substance abuse disorders are more likely to receive treatment for their mental illness than for their substance dependence.

The State of Alaska is currently undergoing a process to integrate substance abuse treatment and mental health services in the state so that individuals in need of care can receive coordinated treatment for any co-occurring disorders. In addition, the state introduced an initiative in 2004 called Bring the Kids Home. The purpose of BTKH is to support the development of in-state residential psychiatric treatment capacity for Alaskan children and youths. Though still in its nascent stage, there are already measurable impacts from the initiative.

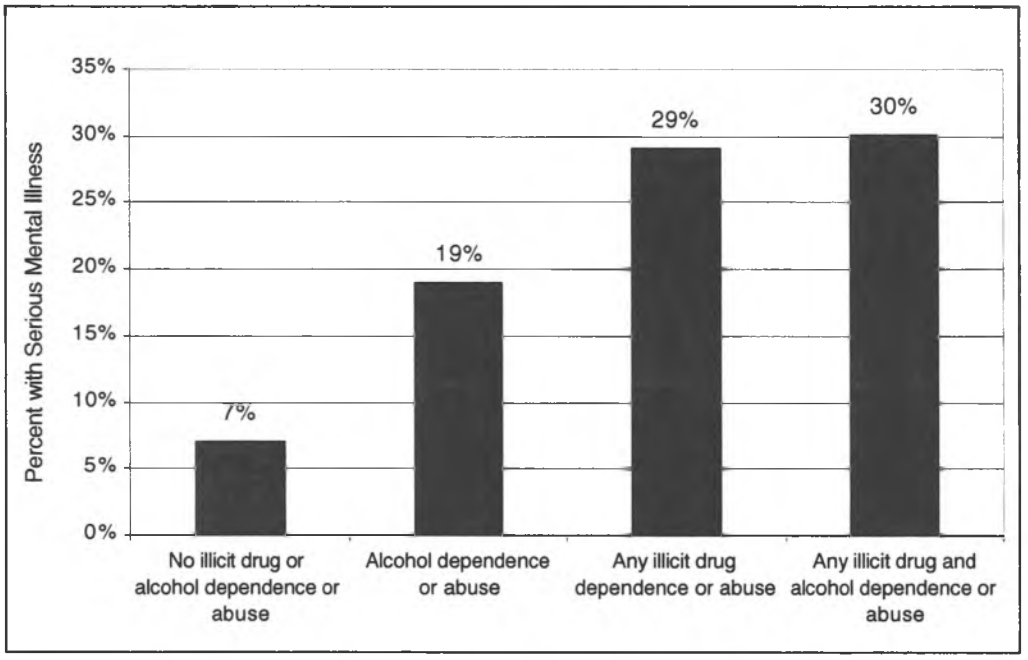
The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies published a report in 2004 on *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders* for the year 2002. The report provides data on co-occurrence of mental illness and substance dependence or abuse, as well as comparative data on the rates of treatment for individuals with these conditions, alone or in combination.

Co-Occurrence of Serious Mental Illness and Substance Dependence or Abuse

The prevalence of serious mental illness (SMI) among adults who have a substance use disorder is significantly higher than among adults who do not. Nineteen percent of adults who are dependent upon or who abuse alcohol had SMI in 2002, as did 29 percent of those with illicit drug dependence or abuse, and 30 percent of those with both drug and alcohol abuse or dependence. By contrast, only 7 percent of adults who have no substance use disorder experienced SMI (see Figure 5).

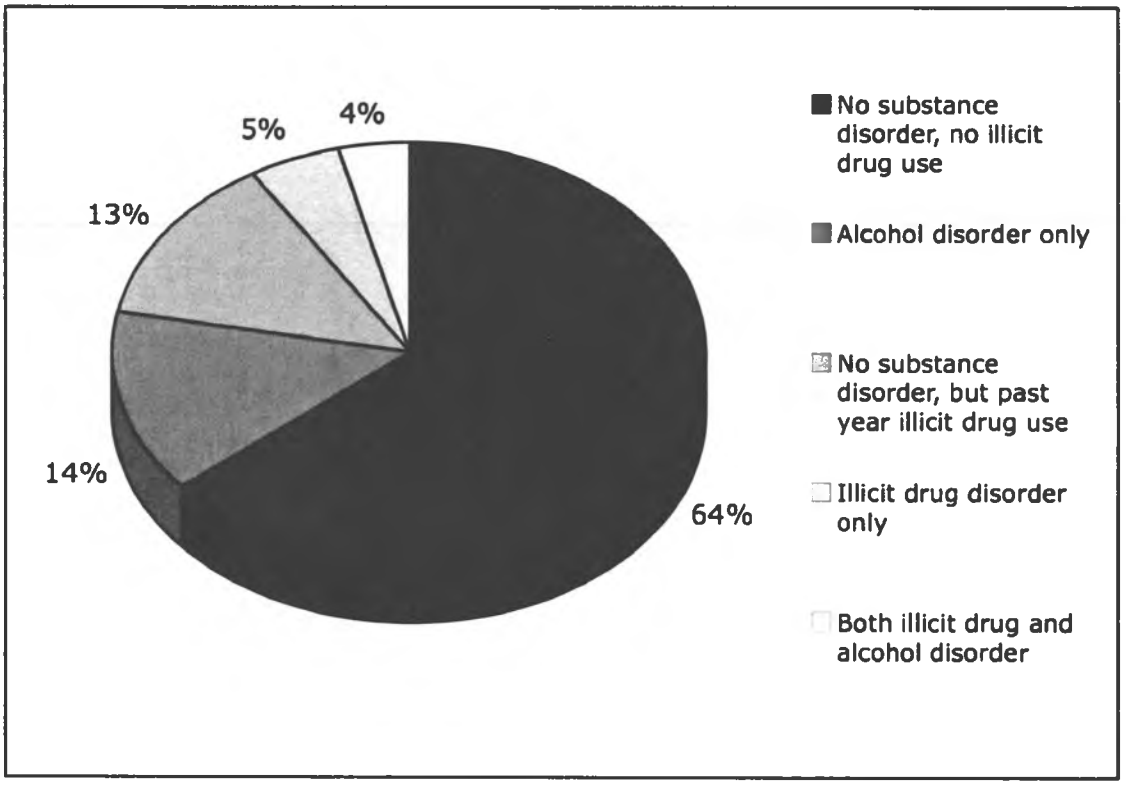
This data clearly shows that serious mental illness is much more likely to occur among the drug and/or alcohol dependent population. Likewise, among the population of adult Americans who experience serious mental illness, significant percentages of individuals are likely to have a drug and/or alcohol dependency or abuse. Of 17.5 million adults aged 18 or older who experienced SMI in 2002, 14 percent had an alcohol disorder only, 13 percent had no substance abuse disorder but had nevertheless used illicit drugs in the past year, 5 percent had an illicit drug disorder only, and another 5 percent had both illicit drug and alcohol disorders. In total, 46 percent of the population with SMI had drug or alcohol disorders or abuse, alone or in combination (see Figure 6.)

Figure 5
Serious Mental Illness among Adults Aged 18 or Older, by Substance Dependence or Abuse, 2002



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002.

Figure 6
Substance Use Disorder Among Adults With Serious Mental Illness, 2002



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002.

These data clearly show that there is a strong correlation between alcohol and or substance dependence and serious mental illness.

The analysis of the use of treatment services for either SMI or for substance dependence in the SAMHSA report revealed interesting trends in the treatment services accessed by affected individuals. Individuals with SMI only, and no substance abuse disorder, were most likely (48 percent) to receive mental health treatment. Among those individuals with SMI and substance dependence, 46 percent received only mental health treatment, while 14 percent received only specialty substance use treatment. Only 12 percent received treatment for both SMI and a substance abuse disorder. In addition, adults with SMI co-occurring with illicit drug dependence or abuse were more likely to receive mental health treatment (54 percent) than those adults who had SMI co-occurring with alcohol dependence or abuse (43 percent).

Adults who had co-occurring SMI and substance dependence or abuse were more likely to receive specialty substance use treatment than adults with substance disorders but no SMI (14 versus 5 percent).

In 1999, the Gallup Organization conducted a household telephone survey in Alaska and determined that 9.7 percent of the population aged 18 and over abused or was dependent on alcohol. Applying this percentage to the 2002 adult population in Alaska of 448,000 would result in an estimated 43,500 alcohol dependent adults in that year. Based on the co-occurrence rates presented in the SAMHSA (2002) study, this means an estimated 8,300 Alaskans had co-occurring alcohol dependence or abuse and serious mental illness in 2002. However, the Gallup survey did not assess the percentage of Alaskans whose alcohol dependence was accompanied by illicit drug dependence or abuse. It is reasonable to assume that some of the 8,300 alcohol dependent Alaskans also had illicit drug dependence or abuse. The prevalence of SMI among adults with both alcohol dependence and illicit drug use is significantly higher (30 percent versus 19 percent for alcohol only), so it is likely that the number of Alaskan adults with co-occurring SMI and alcohol and/or illicit drug dependence or abuse is even higher.

Bring the Kids Home Initiative

Like adults, children and youth experience co-occurring mental and substance abuse disorders. According to the SAMHSA Report to Congress, 2002, researches have found a link between substance abuse disorders and behavioral and mental/emotional disorders in youth. The 2001 National Household Survey on Drug Abuse found that 26 percent of 12 to 17-year-olds who had used illicit drugs in the past year had also received treatment or counseling for behavioral or mental health issues. This compared to only 16 percent of youths who had not used illicit drugs (SAMHSA, 2002).

In Alaska, there are a limited number of residential mental health treatment facilities for children and youth. When children and youth need intensive mental health treatment they often must travel to facilities outside of the state. However, according to the Alaska Division of Behavioral Health and the Mental Health Trust Authority, out-of-state treatment may not be as beneficial as services delivered close to home. Possible disadvantages of out-of-state services may include less therapeutic benefit for children and their families, longer lengths of stay and higher risk of readmission, and transitional difficulties.

To address the high rates of out-of-state institutionalization, the State of Alaska launched the "Bring the Kids Home Initiative" to support the development of in-state infrastructure and treatment opportunities for youth and children. Since the program inception in late 2004, several steps have been taken to position the state to achieve these goals. Three workgroups have been established, including one that is working to identify means to support the establishment of services and service providers in Alaska and one that is identifying ways to support the development of a treatment professional workforce. A third work group, made up of three mental health clinicians, reviews the cases of children who are under consideration for out-of-state treatment, and tries to redirect cases within the state whenever clinically possible and appropriate.

Prior to the launch of the BTKH initiative, Alaska had seen a stark increase in the number of children in out-of-state residential psychiatric treatment centers (RPTCs). There was a 200 percent increase in the number of children covered by Medicaid who received treatment in an out-of-state RPTC from 2000 to 2004. This was accompanied by a 280 percent increase in the cost of those services, from $9.9 million in 2000 to $37.8 million in 2004.

Preliminary fiscal year 2005 data, however, shows that more children were able to receive treatment in Alaska facilities. The number of children receiving services in out-of-state treatment facilities through Medicaid decreased from the previous year, and the percentage of Alaskan children receiving treatment services in-state rose to 29 percent from 22 percent the previous year. In addition, 71 children who were in out-of-state facilities have been transferred to treatment facilities within Alaska since the program inception. Additionally, there was a drop in out-of-state spending on RPTC care.

Table 21
Medicaid Residential Treatment Care Expenditures,
State Fiscal Years 2001 to 2005

	SFY01	SFY02	SFY03	SFY04	SFY05 preliminary
In-State	8,243,000	9,230,000	10,093,000	11,532,000	12,659,000
Out-of-State	17,609,000	21,752,000	30,915,000	37,794,000	34,044,000
Total	**$25,852,000**	**$30,982,000**	**$41,008,000**	**$49,326,000**	**$46,703,000**

Source: Division of Behavioral Health, "Bring the Kids Home Indicators: Baseline Data State Fiscal Years 1998-2004," May 2005; and "Bring the Kids Home Indicators: SFY05 Supplemental Data—Preliminary," August 2005.
Note: Claims for state fiscal year 2005 are still being processed; final numbers will likely be higher.

While the state continues to process insurance claims for FY05 treatment services, HSS staff indicated that the trends reflected in the preliminary data are likely representative of overall change. While expenditures for the program were modest in FY05 ($100,000), HSS staff said awareness of the BTKH initiative in the treatment community likely drove some of the shift toward Alaska-based treatment. The BTKH initiative has a budget of $2.4 million for FY06.

Needy Alaskans who qualify for public assistance receive cash and food stamps and other social services from the state. A portion of the public assistance expenditures can be attributed to alcohol and other drug abuse. As noted earlier in the report, alcohol and other drug dependence can result in reduced income, trouble finding and holding a job, or even a disability, all of which may qualify the individual for public assistance. This chapter looks briefly at the economic costs of alcohol and other drug abuse-related public assistance.

Methodology

Different methods were used to estimate the costs of alcohol and drug abuse-related public assistance at the state and federal levels. At both levels, only administrative costs of programs were considered as public assistance payments are a redistribution of income and not an actual cost to society.

At the federal level, there are two sources of public assistance costs. The first is former Supplemental Security Income (SSI) and Old Age, Survivors, and Disability Insurance (OASDI) recipients. National administrative cost figures were used to estimate the Alaska-specific portion of the federal programs, using the assumption that costs were proportional to the number of recipients. NIDA/NIAAA (1998) attribution rates were used to estimate the proportion of total costs that are attributable to drug and alcohol abuse. For SSI and OASDI recipients, 1.7 percent of the cases were related to alcohol and other drug abuse.

At the state level, public assistance programs include the Alaska Temporary Assistance Program (ATAP) and food stamp programs, and other programs such as energy assistance and child care assistance. Again, NIDA/NIAAA (1998) attribution rates were used to estimate the cost attributable to substance abuse.

For ATAP and other state programs, 4.1 percent of the cases were related. Because Alaska's dependency rates are more than twice national rates, attribution rates published in the NIDA/NIAAA (1998) study likely provide a conservative estimate of Alaska's true administration costs from public assistance. However, the lack of Alaska attribution rates for alcohol and other drug abuse-related public assistance necessitates the use of these national attribution rates published in the NIDA/NIAAA study.

Results

Administration costs from alcohol and other drug abuse-related public assistance was approximately $4.1 million in Alaska during 2003. The largest contributor was administration of payments for Alaska Temporary Assistance Program, food stamps and other state-administered assistance programs at $4.0 million, while administrative costs from former OASDI and SSI recipients totaled $170,000.

The cost of underage drinking in Alaska is a component of many of the alcohol and drug abuse-related costs already identified in this study. However, it is informative to examine specifically underage drinking costs, to place such costs in perspective relative to overall costs associated with alcohol and other drug abuse in Alaska.

This study did not include research focused on underage drinking costs. However, data from other sources is available. The Pacific Institute for Research and Evaluation (PIRE) has produced national and state-level estimates of the cost of underage drinking. PIRE data indicates that medical care costs and loss of work costs in Alaska totaled $128 million in 2001. PIRE also placed "pain and suffering" costs at $353 million. The following table provides more detail on specific sources of underage drinking costs in Alaska.

Table 22
Costs of Underage Drinking in Alaska, by Problem, 2001

	Total Costs (in millions)
Youth Violence	$329.7
Youth Traffic Crashes	77.7
High-Risk Sex, Ages 14-20	13.9
Youth Property Crime	7.6
Youth Injury	26.9
Poisonings and Psychoses	2.6
FAS Among Mothers Age 15-20	3.3
Youth Alcohol Treatment	18.9
TOTAL	$480.7

Source: Pacific Institute for Research and Evaluation (PIRE), March 2004. Posted at http://www.udetc.org/UnderageDrinkingCosts.asp

As indicated above, many of these costs have been captured in other sections of this report. The largest component of underage drinking costs, as measured by PIRE, are pain and suffering-related costs, which are not addressed at all (for adults or youth) in this report. While it is likely that some of the direct medical and work loss costs identified in the PIRE study are not reflected in this report, the potential for double-counting is high, therefore none of the costs reported in Table 22 are added to the grand total costs related to alcohol and drug abuse in Alaska, as measured in this study. Research beyond the scope of this study would be required to identify specific components of costs reported in the PIRE report that are not captured in the McDowell Group report.

EMPLOYMENT AND TAX IMPACTS OF ALCOHOL SALES

Although this report concentrates on quantifying the costs of alcohol and other drug abuse, there are some measurable economic benefits associated with the sale of alcohol. The most obvious benefit is employment. Jobs related to alcohol sales include manufacturing, wholesale trade and retail trade. Alcohol excise tax revenues go into Alaska's unrestricted general-fund budget. Other benefits, including indirect employment impacts from alcohol manufacturing and sales, are more difficult to measure and beyond the scope of this study. Earnings from these jobs help employ other residents who are not directly linked to the alcohol industry.

This chapter looks briefly at the direct employment benefits from the alcohol industry and discusses the excise tax collected from the sale of alcohol beverages.

Methodology

To measure the employment and earnings related to manufacturing and sales of alcohol, the research team relied on data published in the 2003 Employment and Earnings Report by Alaska Department of Labor and Workforce Development, Research and Analysis Division. Employment and earnings data was collected for the following industries:

- Breweries & Wineries (NAICS 31212, 31213)
- Wholesale trade for beer, wine, and distilled beverages (NAICS 4248)
- Beer, Wine, Liquor stores (NAICS 4453)
- Drinking places, Alcoholic (NAICS 7224)

Total tax revenue collected in FY2004 from the sale of alcohol beverages was published in the Tax Division Annual Report of Division Operations, by the Alaska Department of Revenue. Per gallon tax rates on alcoholic beverages were increased, on October 1, 2002, from $0.35 to $1.07 for beer, $0.85 to $2.50 for wine and $5.60 to $12.80 for liquor. As of that same date, 50 percent of the revenue is deposited in the Alcohol and Other Drug Abuse Treatment and Prevention Fund.

Results

Table 22 presents employment and earnings for alcohol-related commerce and manufacturing industries in Alaska during 2003. Total employment related to the sale of alcoholic beverages in Alaska was approximately 3,000 jobs with earnings of $62 million. Drinking establishments accounted for the most employment at approximately 1,800 jobs with $26 million in payroll.

Table 23
Employment and Earnings for Alcohol-Related Industries in Alaska, 2003

Industry	Employment	Earnings (millions)
Breweries and Wineries	90	$3.0
Wholesale trade	413	17.1
Retail trade: Liquor stores	672	15.9
Retail trade: Drinking places	1,815	25.8
Total	**2,990**	**$61.8**

Source: *2003 Employment and Earnings Report*, Alaska Department of Labor and Workforce Development, Research and Analysis Division.

Total tax revenue collected from the sale of alcohol beverages in Alaska was $32.7 million during FY 2004. This includes $14.1 million collected on sales of 1.1 million gallons of liquor, $4.3 million collected on sales of 1.7 million gallons of wine, and $14.3 million collected on sales of 14.7 million gallons of beer. Contributions of unrestricted revenue to the General Fund totaled $16.4 million, with an equal amount contributed to the fund for alcohol and drug abuse treatment programs.

LIST OF REFERENCES

Alaska Advisory Board on Alcoholism and Drug Abuse. *Annual Report, 1999, Finding the Answers to Tough Questions about Substance Abuse in Alaska.* Juneau, AK, 1999.

Alaska Department of Corrections, Division of Administration Services. *2003 Offender Profile.* Juneau, AK. 2004.

Alaska Department of Health and Social Services, Division of Behavioral Health. *Bring the Kids Home Indicators: Baseline Data State Ficsal Years 1998-2004.* Juneau, AK, May 20, 2005.

Alaska Department of Health and Social Services, Division of Behavioral Health. *Bring the Kids Home Indicators: SFY05 Supplemental Data – Preliminary.* Juneau, AK, August 4, 2005.

Alaska Department of Health and Social Services, Division of Public Health, Section of Epidemiology. *HIV Infection in Alaska, 2003.* Anchorage, AK, April 15, 2004.

Alaska Department of Health and Social Services, Division of Public Health, Bureau of Vital Statistics, Deaths by cause, data request from Mike Matthews, Juneau, AK. 2005.

Alaska Department of Health and Social Services, Division of Public Health, Section of Epidemiology. *2003 Annual (January-December) Infectious Disease Report.* Anchorage, AK, April 12, 2004.

Alaska Department of Health and Social Services, Office of Fetal Alcohol Syndrome, *Alaska's Comprehensive FAS Project Five Year Goal,* July 2002. Available from www.hss.state.ak.us/fas/AKfiveyrgoal/printable.htm.

Alaska Department of Labor and Workforce Development, Research and Analysis Section.

Alaska Department of Labor and Workforce Development, Research and Analysis Section. *Age, Race, and Sex, July 1, 2003.* Available from http://almis.labor.state.ak.us/.

Alaska Department of Public Safety. *Crime Reported in Alaska 2003.* Anchorage, AK, 2004.

Alaska Department of Revenue, Oil & Gas Audit Division. *Fall 1999 Revenue Sources Book.* Anchorage, AK, December 1999.

Alaska Department of Transportation and Public Facilities, Division of Statewide Planning. *2002 Alaska Traffic Collisions.* Juneau, AK, September 2004.

Alaska Judicial Council. *Final Report of the Alaska Criminal Justice Assessment Commission.* Anchorage, AK, May 2000.

American Chamber of Commerce Research Association. *ACCRA Cost of Living Index Fourth Quarter 2003.* Arlington, VA, 2004.

Blincoe, Lawrence. *The Economic Cost of Motor Vehicle Crashes, 1994*. U.S. Department of Transportation, National Highway Traffic Safety Administration. Washington, DC, 1994.

Centers for Disease Control and Prevention, *Tracking Fetal Alcohol Syndrome*, April 2005. www.cdc.gov/ncbddd/fas/fassurv.htm

Hadland, Jeff. *The Gender Gap in Earnings*. Alaska Economic Trends, Juneau, AK, October 2001.

Jeanne Reid *et al. No Safe Haven: Children of Substance-Abusing Parents*. National Center on Addiction and Substance Abuse at Columbia University, 1999.

Kaiser, Paul. Alaska Department of Health and Social Services, Division of Alcoholism and Drug Abuse. Personal communication on estimates for alcohol and drug abuse treatment costs during 1999. Juneau, AK. August 2001.

National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism. *The Economic Costs of Alcohol and Drug Abuse in the US, 1992*. Washington, DC, 1998. Available from http://www.drugabuse.gov/EconomicCosts/Index.html.

National Organization on Fetal Alcohol Syndrome, *What is FAS/FASD?*, 2004. Available from www.nofas.org/faqs.aspx?id=9

National Organization on Fetal Alcohol Syndrome, *What Are the Statistics and Facts about FAS and FASD?* Available from www.nofas.org/faqs.aspx?id=12

Rice, Dorothy, Sander Kelman, Leonard Miller, and Sarah Dunmeyer. *The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*. Report submitted to the Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services. Washington, DC, 1990.

Rice, Dorothy. Personal communication on estimates for present value of expected lifetime productivity for 1999.

The Robert Wood Johnson Foundation. Substance Abuse, *The Nation's Number One Health Problem*. Princeton, NJ, February 2001.

U.S. Department of Commerce, Economics and Statistics Administration, Bureau of Economic Analysis. Gross State Product, 1992-99, *Survey of Current Business*. Washington, DC, August 2001.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administratio, Fetal Alcohol Spectrum Disorders Center for Excellence. *The Language of Fetal Alcohol Spectrum Disorders*, May 2004. Available from www.ngchealth.com/gov/samhsa/fasd/pdf/WYNKLanguageFASD2.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *State Estimates of Substance Use from the 2002-2003 National Surveys on Drug Use & Health.* Available from www.oas.samhsa.gov/ nhsda.htm

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Serious Mental Illness and Its Co-Occurrence with Substance Abuse Disorders, 2002.* Rockville, MD, June 2004.

U.S. Department of Labor, Bureau of Labor Statistics. [CPI for U.S. from 1992 to 2003]. Unpublished raw data.

U.S. Department of Transportation, National Highway Transportation Safety Administration, *The Economic Cost of Motor Vehicle Crashes, 2000,* May 2002.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

April 2009

Cost Offset of Treatment Services

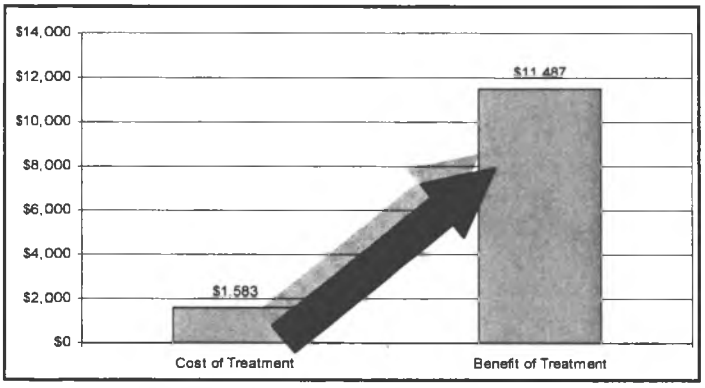
There is a great paucity on nationwide data related to the cost benefit of substance use treatment. However, the limited research in some States suggests that there is a major benefit to substance use treatment. According to recent estimates[1], the total financial cost of drug use disorders to the United States is estimated to be $180 billion annually. The economic costs of alcohol abuse were 184.6 billion in 1998[2]. Accessible and effective community-based alcohol and drug treatment is imperative to reduce society's financial burden from problems associated with drug use. As the U.S. economy faces unsustainable escalations in health care costs, we need to ensure needed substance use disorder treatment and recovery programs help reduce health and societal costs.

The benefits of treatment far outweigh the costs. Even beyond the enormous physical and psychological costs, treatment can save money by diminishing the huge financial consequences imposed on employers and taxpayers.

Cost Savings of Treatment: California, New York, and Washington

Treatment has been shown to have a benefit-cost ratio of 7:1[3]. The largest savings were due to reduced cost of crime and increased employer earnings (see Figure 1).

Figure 1. Cost Offset of Substance Abuse Treatment in California



For every **$100,000 spent on treatment,**

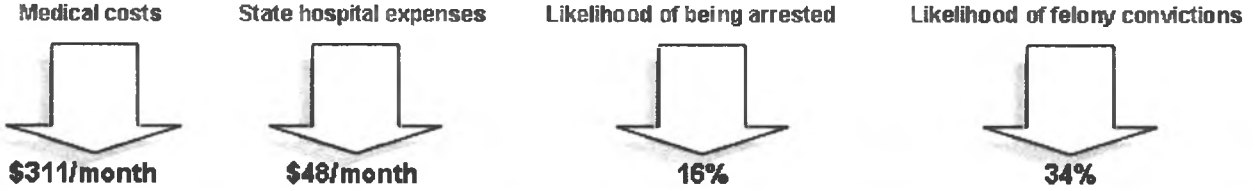
$487,000 of health care costs[4] and $700,000 of crime costs were shown to be avoided[5].

Public Assistance in Washington

A comparison of medical expenses of Medicaid clients[6] who received treatment noted these savings:

Modality	Savings per Medicaid member per month
Inpatient	$170
Outpatient	$215
Methadone	$230

Spending money on treatment has led to important health and public safety cost reductions in Washington[7]:



Health Care Utilization Savings: California

Treated patients have been shown to **reduce**[8]:

- **ER visits by 39%**
- **Hospital stays by 35%**
- **Total medical costs by 26%**

when compared to a control group.

Employers

Employees treated for substance use[9] have:

- **reduced absenteeism,**
- **reduced tardiness,**
- **lowered on-the-job injuries,**
- **fewer mistakes, and**
- **disagreements with supervisors by 75%**

Benefit-Cost Comparisons

- A study[10] comparing the direct cost of treatment to monetary benefits to society determined that on average, costs were $1,583 compared to a benefit of $11,487 (a benefit-cost ratio of 7:1).
- In an analysis[11] of methadone detoxification patients (n=102), authors observed that for every dollar spent on treatment, $4.87 of health care costs were offset.
- In comparing cost offsets in Washington State of people in treatment to non-treated, authors noted:[12] lower medical costs ($311/month); lower state hospital expenses ($48/month); lower community psychiatric hospital costs ($16/month); reduced likelihood of arrest by 16%; and reduced likelihood of felony convictions by 34%.

Health Care Utilization

- In a study[13] examining nearly 150,000 Medicaid claims for beneficiaries in six states, authors determined that people with substance abuse disorders had significantly higher expenditures for health problems compared to others.
- In comparison of medical expenses for welfare clients in Washington State[14] (n=3,235 treatment group and n=4,863 control) it was determined that substance abuse treatment was associated with a reduction in expenses of $2,500 per year.
- In reviewing selected beneficiaries in Oregon's Medicaid program,[15] researchers concluded that eliminating the substance abuse benefit led to increased medical expenditures.
- A review[16] of over 1,000 patients in a Sacramento chemical dependency program noted a substantial decline in hospital (35%), emergency room (39%), and total medical costs (26%) when compared to a control group.
- A recent article[17] on medical costs concluded that health care costs are higher for families with a person who has a dependency problem than for other similar families.

Employer Savings

An intake-to-follow-up assessment[18] study of nearly 500 people treated at Kaiser Permanente's Addiction Medicine program demonstrated significant reduction in missed work, conflict with coworkers, and tardiness. It also noted that employers break even on investing in chemical dependency treatment.

Every $1 spent on addiction treatment saves $7 in crime and criminal justice costs. When researchers added savings related to health care, the savings-to-cost ratio was 12:1.[19]

---

[1] Office of National Drug Control Policy (2004). "The economic costs of drug abuse in the United States, 1992-2002." Washington, DC: Executive Office of the President (Publication No. 207303).

[2] Harwood, Henrick. (2000). "Updating estimates of the economic costs of alcohol abuse in the United States." Report prepared by the Lewin Group for the National Institute on Alcohol Abuse and Alcoholism.

[3] Ettner, S.L., D. Huang, et al. (2006). "Benefit-cost in the California treatment outcome project: does substance abuse treatment 'pay for itself'?" *Health Services Research*, 41(1): 192-213.

[4] Hartz, D.T., P. Meel, et al. (1999). "A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification." *American Journal of Drug and Alcohol Abuse*, 25(2):207-18.

[5] NIDA, Principles of Addiction Treatment, 1999.

[6] Wickizer, T.M., A. Krupski, et al. (2006). "The effect of substance abuse treatment on Medicaid expenditures among GA clients in WA State." *Milbank Quarterly*, 84(3): 555-76.

[7] Estee, S. and D. Norlund (2003). Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report. R.a.D.A. Division and W.S.Do.S.a.H., Services, Washington State.

[8] Parthasarathy, S., C. Weisner, et al. (2001). "Association of outpatient alcohol and drug treatment utilization and cost: revisiting the offset hypothesis." *Journal of Studies on Alcohol and Drugs*, 62(1): 89-97.

[9] CATOR Connection, Comprehensive Assessment and Treatment Outcome Research, St. Paul, MN, 1990.

[10] Ettner, op cit.

[11] Hartz, D.T., P. Meek, et al. (1999). "A cost-effectiveness and cost-benefit analysis of contingency contracting-enhanced methadone detoxification." *American Journal of Drug and Alcohol Abuse*, 25(2):207-18.

[12] Estee and Norlund, op cit.

[13] Clark, R. E., M. Samnaliev, et al. (2009). "Impact of substance abuse disorders on Medicaid beneficiaries with behavioral health disorders." *Psychiatric Services*, 60(1): 35-42.

[14] Wickizer and Krupski, op cit.

[15] McConnell, K.J., N.T. Wallace, et al. (2008). "Effect of eliminating behavioral health benefits for selected Medicaid enrollees." *Health Services Research*, 43(4): 1348-65.[16].

[16] Parthasarathy and Weisner, op cit.

[17] Ray, G.T., J.R. Mertens, et al. (2007). "The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems." *Med Care*, 45(2): 116-22.

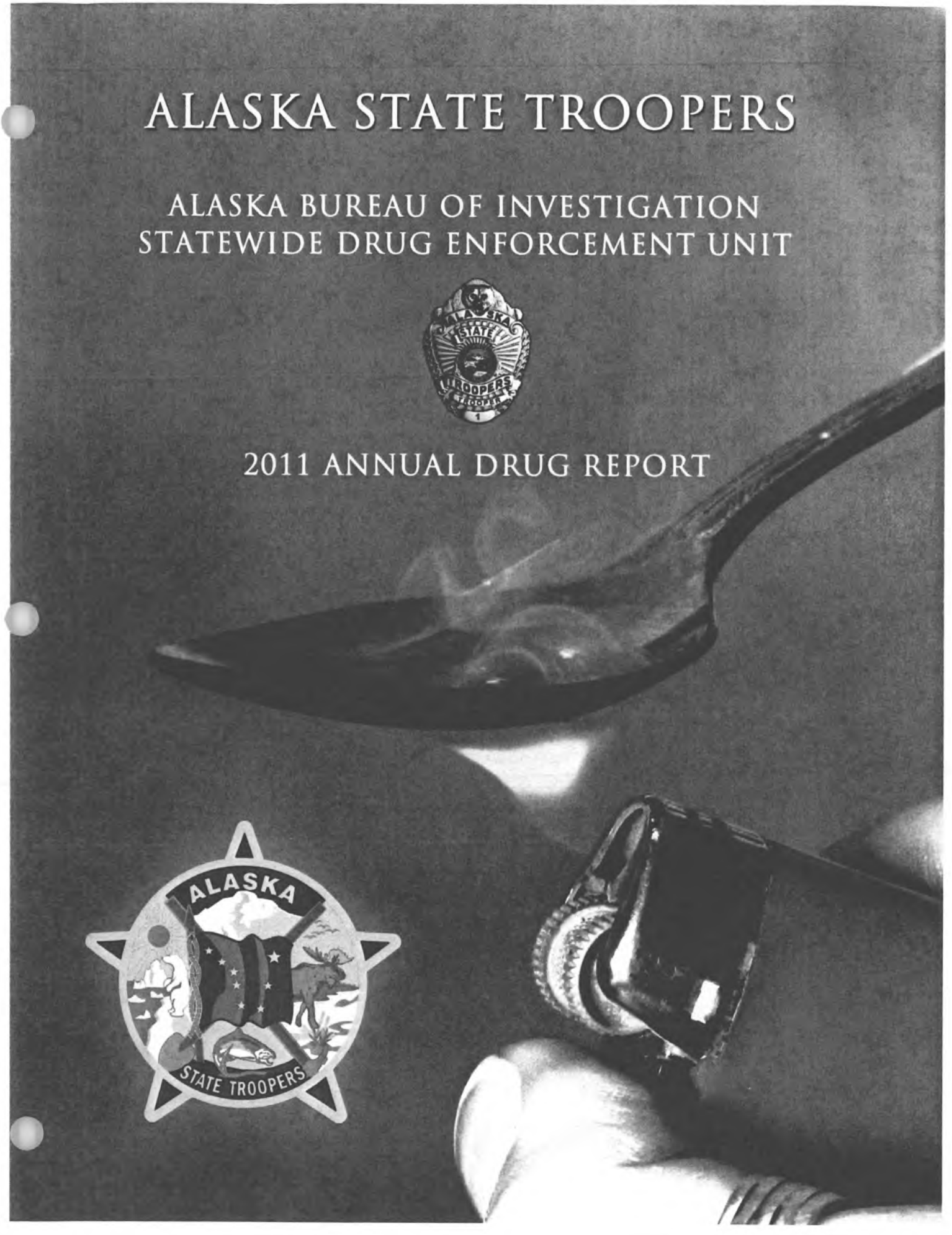
[18] Jordan, N., G. Grissom, et al. (2008). "Economic benefit of chemical dependency treatment to employers." *Journal of Substance Abuse Treatment*, 34(30): 311-19.

[19] NIDA, Principles of Addiction Treatment, 1999.

ALASKA STATE TROOPERS

ALASKA BUREAU OF INVESTIGATION
STATEWIDE DRUG ENFORCEMENT UNIT

2011 ANNUAL DRUG REPORT



2011 Annual Drug Report

Table of Contents

Introduction 3

Our Mission 3

Staffing and Support 4

Nature of Alaska's Drug and Alcohol Problem 5

Drugs of Choice 6
- Alcohol 7
- Cocaine 8
- Heroin 9
- Marijuana 10
- Methamphetamine 11
- Prescription Drugs 12

National Prescription Drug Take Back Program 13

Drug Enforcement Administration 14

Anchorage Police Department 15

Ted Stevens Anchorage International Airport 16

Emerging Trends in 2011 17
- Pacific Region Trends 17
- Alaska Trends 18

Summary 20

Resources 21

Introduction

The Alaska State Troopers, Alaska Bureau of Investigation Statewide Drug Enforcement Unit (SDEU) in authoring this publication, has endeavored to represent the drug situation in Alaska in a manner that provides the broadest possible picture of the true situation.

There are numerous agencies that conduct drug investigations in Alaska. While some agencies have a less formal relationship, most work closely with the Alaska State Troopers. In order to properly represent the true drug situation in Alaska, statistics from as many agencies in Alaska as possible are included in this report. Information provided by all sources should be considered when attempting to measure how drugs are impacting the citizens of this state.

We believe including as much information from all agencies involved in drug enforcement in Alaska is vital when analyzing the needs of the state in the arena of drug enforcement. However, it is important to note that the numbers alone should not be the sole source from which to make a complete assessment of the true drug situation in Alaska. To get the truest picture of the drug situation within Alaska we have attempted to take into account the anecdotal information gathered from conversations with those investigators on the frontlines of Alaska's war on drugs.

Our Mission

SDEU provides a leadership role in coordinating law enforcement's efforts to reduce the availability of illegal alcohol and controlled substances throughout Alaska. SDEU recognizes that a successful alcohol and drug program depends upon a unified effort blending traditional law enforcement techniques with demand reduction programs that address educational, social, and community concerns.

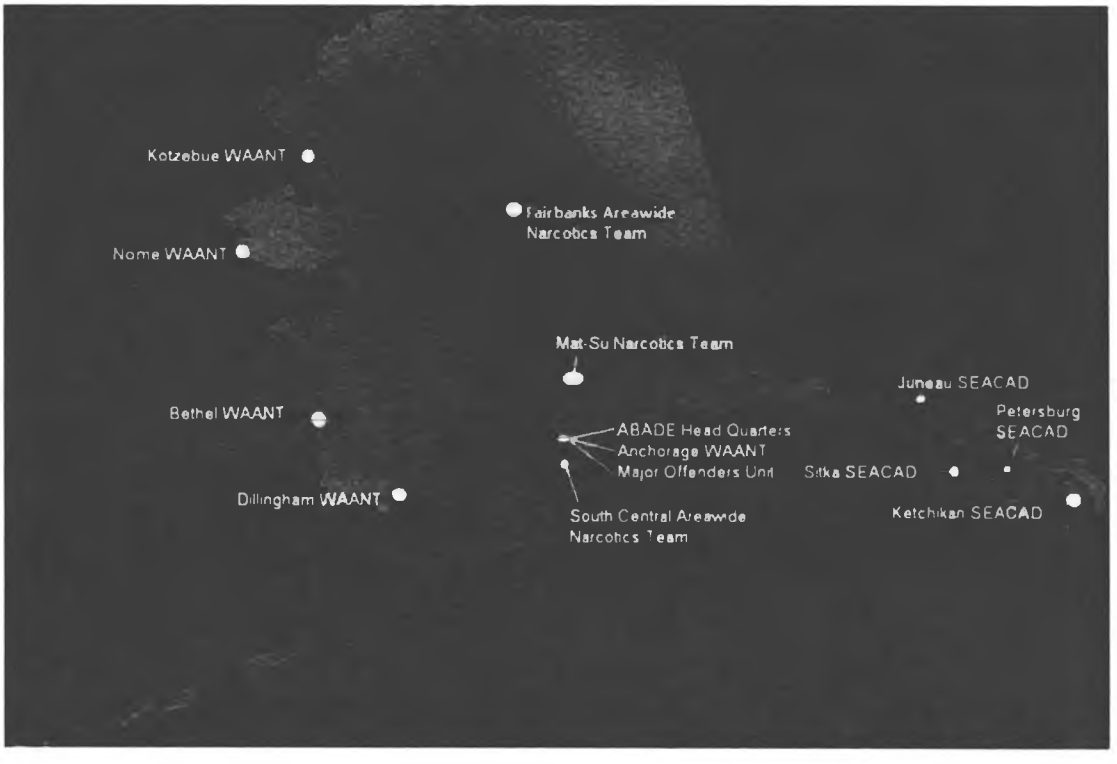
SDEU's mission is to:

- Interdict and seize alcohol and controlled substances that are illegally distributed throughout Alaska.
- Identify and arrest distributors of controlled substances and illegal alcohol.
- Provide training and investigative support to criminal justice agencies.
- Support and participate in public education programs.

Staffing and Support

SDEU recognizes that because of Alaska's geographical vastness no single law enforcement agency is capable of handling the drug and alcohol issues alone. Using a combination of federal and state funding, the Department of Public Safety helps to fund a number of multi-jurisdictional task forces around the state. SDEU encourages cooperative efforts between federal, state and local law enforcement agencies and has taken a leadership role in fostering and developing many of these cooperative arrangements through multi-jurisdictional and/or multi-agency efforts. The ABI-SDEU Headquarters office in Anchorage primarily supports seven (7) investigative task forces throughout the state. These teams are broken down by region as follows:

Alaska Interdiction Task Force / Anchorage Enforcement Group (DEA sponsored)
Fairbanks Area-wide Narcotics Team
Major Offender Unit
Mat-Su Narcotics Enforcement Team
South Central Area-wide Narcotics Team
Southeast Alaska Cities Against Drugs Task Force
Western Alaska Alcohol and Narcotics Team



Additional specific information on the individual units can be found at –

http://dps.alaska.gov/AST/ABI/SDEU.aspx

The Alaska National Guard Counter Drug Support Program (CDSP) provides additional personnel support within several SDEU units, as well as other narcotic enforcement groups. They provide operational resources, which include, but are not limited to manpower, equipment, a scent detection canine and logistical support to federal, state, and local law enforcement throughout Alaska. Financed under a special congressional appropriation, there is no cost to the state of Alaska for CDSP personnel support. This program contributes numerous resources not normally available to law enforcement agencies for assistance specific to drug investigations.

SDEU participates with and receives assistance from several investigative agencies involved in drug enforcement. These agencies include the Drug Enforcement Administration (DEA), Federal Bureau of Investigation (FBI), the US Postal Inspection Service, the Internal Revenue Service (IRS), Bureau of Alcohol, Tobacco, Firearms and Explosives (BATF) and US Immigration and Customs Enforcement (ICE). SDEU also works closely with other local law enforcement agencies.

Nature of Alaska's Drug and Alcohol Problem

Members of Alaska's law enforcement community and others who are part of Alaska's criminal justice system have long known that the greatest contributing factor to violent crimes, including domestic violence and sexual assault, is drug and alcohol abuse. It is also widely recognized that many of the accidental deaths that occur in Alaska are related to alcohol use. This is especially true in the western regions of the state and is clearly shown through statistics drawn from the Alaska State Trooper case management system. Of all cases initiated by the Alaska State Troopers in 2011, 33.6% involved drugs and/or alcohol. Of all violent crime cases, 59.5% involved drugs and/or alcohol.

While there is no question that many aspects of the drug and alcohol problem are unique to Alaska, SDEU strives to provide a continuing and coordinated effort that not only meets the needs of Alaska, but is also dovetailed with the National Drug Control Strategy. The strategy underscores the social and economic costs to society and was developed to provide general guidance and a framework for federal, state, and local agencies in developing a counter drug effort. The strategy's established objectives are:

- Strengthen efforts to prevent drug use in communities
- Seek early intervention opportunities in health care
- Integrate treatment for substance use disorders into health care and expand support for recovery
- Break the cycle of drug use, crime, delinquency, and incarceration
- Disrupt domestic drug trafficking and production
- Strengthen international partnerships
- improve information systems for analysis, assessment, and local management

Drugs of Choice

Alcohol, cocaine, heroin, marijuana, methamphetamine, and prescription drugs have been identified as the primary substances of abuse and are the focus of most law enforcement efforts.

During 2011 the number of methamphetamine labs investigated by the Alaska State Troopers has declined slightly from 11 labs in 2010 to 8 in 2011. Despite the smaller number of labs seized, methamphetamine, mainly from sources outside the state, continues to be readily available throughout the state, but is more prominent in the larger populated areas.

Perhaps just as significant are the abuse and sales of prescription drugs and the continued resurgence of the abuse of heroin in the urban areas. Alcohol and marijuana continue to be the overwhelming drugs of choice for Western Alaska.

Alcohol

Alaska's criminal justice professionals recognize that alcohol is the primary substance of abuse in Alaska and contributes to many violent, suicidal, and accidental deaths, especially in rural areas. Currently, 108 communities[1] have voted in favor of local option statutes prohibiting the sale, importation, and/or possession of all alcohol. Because alcohol remains legal in many areas of Alaska, illegal bootlegging activities continue to be a problem in the local option communities. Alcohol is frequently transported to the villages via the US Postal Service, local air carriers, private aircraft, boat, snow machines and express mailing services. Bootlegging alcohol of all types has become a very lucrative business in rural Alaska.

The United States Postal Inspector continues to support the cross deputation of investigators in SDEU's Western Alaska Alcohol and Narcotics Team. This program is the only one of its kind currently in the United States.

The economics of the illegal sales of alcohol is staggering. For example, a bootlegger can purchase a 750-milliliter bottle of alcohol legally for $10 or less in an urban liquor store. The same bottle of alcohol in Bethel, Kotzebue or Barrow may sell for $50. In the more remote communities, alcohol can easily sell for $150 to over $300 per bottle depending on the supply and demand. The initial purchase for the bootlegger involves a minimal cash investment, a maximum cash return. A dollar-for-dollar comparison of alcohol and drugs purchased in Anchorage and then resold in many Alaskan villages breaks down as follows:

Cocaine	$1.00	$1.50
Marijuana	$1.00	$4.00
Alcohol	$1.00	$15.00

* Calculated at $150 per bottle

Alcohol seized (gallons)

2009	2010	2011
582.29	774.02	682.87

Alcohol related charges/arrests

2009	2010	2011
317	363	392

[1] http://www.dps.state.ak.us/abc/docs/localopt.pdf

Cocaine

Cocaine continues to be a widely used and lucrative drug for sale in Alaska. Cocaine is readily available in most areas of the state and is seen with great frequency in powder form and crack cocaine in the major urban areas such as Anchorage and Fairbanks.

Cocaine is brought into Alaska concealed on passengers or in luggage through ports of entry such as the Ted Stevens Anchorage International Airport, and it is also shipped via the US Post Office or commercial parcel companies such as FedEx, DHL or UPS.

The cocaine brought into Alaska is typically packaged in kilogram quantities and later broken down by dealers into smaller quantities for retail sale. In powder form, it is normally sold in gram quantities for $100-150 and its primary method of ingestion is by snorting.

Crack dealers use a process involving powder cocaine, water, baking soda and heat to produce crack cocaine, which is then sold in small rocks for $20. The primary method of use for crack is by smoking.

The statistics below show powder and crack cocaine seized in 2011 by all task forces where SDEU investigators are assigned.

Cocaine seized (pounds)

2009	2010	2011
28.81	22.16	37.12

Cocaine related charges/arrests

2009	2010	2011
96	145	108

Heroin

Heroin is a highly addictive drug derived from morphine which is obtained from the opium poppy. It is a "downer" or depressant that affects the brain's pleasure systems and interferes with the brain's ability to perceive pain. It is a white to dark brown powder or tar like substance. Heroin can be used in a variety of ways, depending on the user's preference and the purity of the drug. Heroin can be injected into a vein, injected into a muscle, smoked in a water pipe or standard pipe, mixed in a marijuana joint or regular cigarette, inhaled as smoke through a straw, or snorted as a powder via the nose.

The short term effects of heroin abuse appear soon after a single dose and disappear after a few hours. After an injection of heroin, the user reports feeling a surge of euphoria accompanied by a warm flushing of the skin, a dry mouth, and heavy extremities.

Heroin use is not isolated to the metropolitan areas of Alaska. Undercover buys and interdictions of heroin have been reported in several smaller communities. Heroin is primarily imported into Alaska via parcels and body carries. Investigations have shown that heroin use crosses socio-economic boundaries.

Heroin seized (pounds)

2009	2010	2011
3.26	4.64	6.41

Heroin related charges/arrests

2009	2010	2011
64	82	118

Marijuana

Marijuana is available throughout the state and is viewed as a gateway drug to other drugs for young adults and teenagers. The 2011 Alaska Youth Risk Behavior Survey conducted by State of Alaska Department of Health and Social Services indicates that 21.2% of high school students used marijuana within the last 30 days. Demand for Alaskan-grown marijuana continues to be high as a result of its exceptional tetrahydrocannabinol (THC) content. Because Alaskan produced marijuana is extremely high quality; Alaska is considered a marijuana exporting state. However, there is also a significant market for "BC Bud" brought into Alaska from British Columbia, Canada.

SDEU teams continue to find extremely sophisticated indoor growing operations. Most commercial marijuana growing operations are found in communities along Alaska's road system. It is not unusual for sites to be located in homes with hidden or underground rooms specifically designed for the cultivation of marijuana. These rooms are often equipped with surveillance cameras and state-of-the-art timers controlling temperature, lighting, water, humidity and air purifiers. Many grows are found during and/or after fires. Also, many lease/rental and abandoned housed are damaged by the remodeling and humidity of a grow operation.

In some parts of the state, the local economy is directly affected by the influx of money from illegally produced marijuana. Proceeds from marijuana production are used for a multitude of purchases including fuel, grow equipment/supplies, utilities, vehicles, ATV's and building materials.

Processed Marijuana seized (pounds)

2009	2010	2011
258.23	316.07	260.95

Marijuana related charges/arrests

2009	2010	2011
1,011	1,040	1,211

Marijuana grows eradicated

2009	2010	2011
85	75	96

Marijuana plants seized

2009	2010	2011
5,165	3,822	7,882

Methamphetamine

Methamphetamine use continues to be an issue throughout the United States including Alaska. Methamphetamine, also known as meth, speed, crank, crystal, and ice, produces an increase in energy and alertness and a decrease in appetite. The effects, which include an intense rush, have been reported to last up to 36 hours. It can be smoked, snorted, injected, or taken orally.

The collection of hazardous materials associated with the take down of a methamphetamine lab requires a certified clean-up company to respond to the location, collect and containerize larger items as well as various chemicals found at the site. These containers are then transported to a location for safe long-term storage and/or destruction.

In previous years, the DEA has paid for this collection of materials at these lab sites. DEA suspended that funding and cleanup costs are now borne by state and local agencies.

Methamphetamine labs continue to be discovered in single and multi-family residences in many neighborhoods. In addition to meth labs producing illegal, often deadly drugs, the clandestine nature of the manufacturing process and the presence of ignitable, corrosive, reactive, and toxic chemicals at the sites, have resulted in explosions, fires, toxic fumes, and irreparable damage to human health and to the environment. Children are found residing in meth lab sites and many continue to live in dangerous environments. Loaded firearms are also frequently found at these meth labs, which increases the danger to children living in these residences.

Meth Labs seized

2009	2010	2011
9	11	8

Meth seized (pounds)

2009	2010	2011
45.70	4.53	6.20

Meth related charges/arrests

2009	2010	2011
163	185	194

For more information regarding meth education and awareness, go to:

www.montanameth.org, www.mfiles.org, www.lifeormeth.org, www.metheducation.com

Prescription Drugs

Throughout the state, the abuse of prescription drugs continues to be a significant problem. Not only does the abuse of prescription drugs create a health hazard for the users, it creates a financial impact upon the communities. The drugs vary in price and can cost anywhere from one dollar per milligram to two dollars per milligram depending on availability. With the increased demand for the drugs and a shortening of supply, many abusers may not have the money or insurance to pay for their addiction; thus increasing property and violent crimes in these communities. It has been reported that tens of thousands of dollars are being spent to feed this growing abuse and addiction.

The sale and abuse of Oxycontin/Oxycodone and Hydrocodone continued to be a significant issue in 2011. These drugs are sought for their pharmaceutical purity and ability to alter the central nervous system.

Prescription drugs have been linked to the following crimes - homicide, assault, prescription fraud, home invasion thefts and pharmacy robberies. People who are addicted to prescription drugs facilitate their addiction by doctor shopping, pharmacy shopping, forgery, and purchasing the drugs via the Internet. Law enforcement is especially concerned for the welfare of particularly vulnerable populations such as the elderly and those with severe long-term illnesses such as cancer.

It is the intent of SDEU to increase pressure on those involved in the non-medical use, abuse, and sales of these addictive drugs, by applying tried and true narcotics investigation techniques, and when ever prudent partnering with the DEA to charge these crimes in the federal system.

Hydrocodone seized (dosage units)

2009	2010	2011
281	627.50	1,051

Oxycontin/Oxycodone seized (dosage units)

2009	2010	2011
3,403.50	5,958.25	1,836.50

All other prescription drugs seized (dosage units)

2009	2010	2011
2,196.50	2,668.50	2,548

National Prescription Drug Take Back Program

This initiative addresses a vital public safety and public health issue. More than seven million Americans currently abuse prescription drugs, according to the 2009 Substance Abuse and Mental Health Administration's National Survey on Drug Use and Health. Each day approximately 2,500 teens use prescription drugs to get high for the first time according to the Partnership for a Drug Free America. Studies show that a majority of abused prescription drugs are obtained from family and friends, including the home medicine cabinet.

In an effort to address this problem, the US Department of Justice, Drug Enforcement Administration, Office of Diversion Control, in conjunction with state and local law enforcement agencies throughout the United States, conducted the first ever National Prescription Drug Take Back Day on Saturday, September 25, 2010. The purpose of this National Take Back Day was to provide a venue for persons who wanted to dispose of unwanted and unused prescription drugs. This effort was a huge success in removing potentially dangerous prescription drugs, particularly controlled substances, from our nation's medicine cabinets. There were approximately 3,000 state and local law enforcement agencies throughout the nation that participated in the event. All told, the American public turned in more than 121 tons of pills on this first National Take Back Day.

Members from the Alaska State Troopers along with the Drug Enforcement Administration, other Alaskan law enforcement agencies and other professional and community organizations worked together in April and again in October of 2011 to facilitate "Prescription Drug Take Back Days." The program resulted in the collection and proper disposal of approximately 3,500 pounds of prescription medications from around the state.

Drug Enforcement Administration

The Drug Enforcement Administration (DEA) in Alaska is deeply involved in working with all state and local drug units to enhance and facilitate investigations of major offenders throughout Alaska.

DEA in Alaska is broken down into the Anchorage District Office (ADO) along with a post of duty in Fairbanks, Alaska. The ADO is broken down into the Enforcement Group (EG) and the Alaska Interdiction Task Force (AITF). These groups operate as task forces, in that they are comprised of DEA agents as well as officers from other agencies. The EG has federally deputized task force officers from the Anchorage Police Department (APD) and the Alaska State Troopers (AST), while AITF consists of federally deputized task force officers from the AST, APD, and Airport Police, as well as several other federal agencies as needed. The Alaska National Guard Counter Drug Support Program supports DEA throughout the entire state.

DEA furnishes training to state and local agencies and in the past, has provided funding for law enforcement personnel to be trained and re-certified in a variety of drug law enforcement related topics.

DEA continues to facilitate forfeiture proceedings related to assets and funds seized as a result of criminal investigations and drug trafficking. This effort allows state and local law enforcement agencies to receive a portion of the assets seized, which in turn funds additional criminal investigations.

Drug seizures by DEA

	Cocaine (kilos)	**Heroin** (kilos)	**Marijuana** (lbs)	**Meth** (lbs)
2009	4.57	1.10	53.20	4
2010	8.54	3.71	1589.93	14.24
2011	5.77	.63	3.54	2.58

Anchorage Police Department

The Anchorage Police Department drug enforcement effort includes the Vice Unit, Special Assignment Unit, FBI Safe Streets Task Force, and a DEA Task Force. In addition to these units that specialize in drug investigations, we also have our Patrol Division that responds to immediate calls for service involving narcotics.

The Vice Unit focuses on longer term investigations targeting mid to high level dealers in the Anchorage area. Most of these investigations are three to six months in length but can last up to a year. The Vice Unit consists of one sergeant, six full-time detectives and two TDY officers from the patrol division. The Vice Unit also provides detectives for narcotics training and education in the Anchorage community.

The Special Assignment Unit focuses on short-term street level drug investigations often resulting in an immediate buy/bust. This unit has one sergeant, and 13 full-time officers including a canine officer. The Safe Streets Task Force mission consists of targeting violent offenders with an emphasis on gang members. These are often associated with the narcotics trade.

There are three full-time officers from APD assigned to the Safe Streets Task Force. Our DEA Task Force is comprised of DEA agents as well as officers from other departments; we have two Detectives currently assigned to the airport interdiction group. Their primary mission is interception of narcotics entering the state.

Drug Seizures by APD

	Crack (kilos)	**Cocaine**(kilos)	**Heroin** (kilos)	**Marijuana**(lbs)	**Meth** (lbs)
2009	1.64	7.60	2.20	150.69	3.57
2010	1.04	4.17	2.85	427.25	11.53
2011	0.72	7.40	2.78	157.71	2.69

Ted Stevens Anchorage International Airport

The Ted Stevens Anchorage International Airport Police conducts investigative efforts within the hub involving the statewide, domestic and international transportation of illegal drugs and alcohol. The mission to seize and interdict these illegal substances to prevent distribution throughout Alaska starts with a commitment to narcotics enforcement activities by assigning an officer to the DEA operated Alaska Interdiction Task Force. Additionally, uniformed officers and the department investigator conduct numerous narcotics investigations as a result of anonymous tips and complaints from airlines and cargo facilities. The department also coordinates investigative efforts with other state, federal and lower 48 law enforcement agencies. Dedication to community/customer service in this arena is paramount and officers are involved in drug education activities with our local airport businesses, schools and other private and public entities.

Drug Seizures by Anchorage Airport Police

	Cocaine (kilos)	**Heroin** (kilos)	**Marijuana** (lbs)	**Meth** (lbs)
2011	.0013	.024	4.40	.05

Emerging Trends in 2011

It is the intent of this section to familiarize the reader with some current and anticipated trends within Alaska. To do so it is important to look at the current Pacific Region picture as Alaska tends to follow suit in the following years. The National Drug Intelligence Center (NDIC) breaks the nation down into nine regions. The Pacific Region is made up of Alaska, Washington, Oregon, Idaho, Nevada, Hawaii, Guam and Northern and Central California.

PACIFIC REGION TRENDS

Methamphetamine
According to the NDIC's 2011 Drug Threat Assessment, methamphetamine continues to be the greatest threat to the Pacific Region. They report that although the domestic production of methamphetamine has declined over the region in large part due to the regulation of precursor chemicals use in its production; it is widely available throughout the region. It is further reported that the majority of methamphetamine within the region is supplied by Mexican drug trafficking organizations (DTOs) entering the country through the ports of entry and along the United States - Mexico border.

Powder Cocaine
The NDIC identifies powder cocaine as a significant issue in the Pacific Region as well. Also supplied to the United States by Mexican DTOs, the DTOs supply independent dealers and street gangs with the powder cocaine that they often times process into crack cocaine prior to distribution.

Marijuana
Marijuana is the most widely available and commonly abused drug throughout the Pacific Region. The Pacific Region leads the country in marijuana cultivation.

During 2011, utilizing funds acquired from federally forfeited illegal drug proceeds, the Alaska State Troopers (AST) commissioned the University of Alaska Anchorage (UAA) Justice Center to analyze three years of marijuana grows which were discovered by AST. The UAA study analyzed 200 marijuana grow searches conducted by AST during calendar years 2006, 2007 and 2008.

The primary purpose of the study was to provide an empirical estimate of the extent to which AST investigators' detection of marijuana odors served as a reliable indicator of the presence of illegal quantities of marijuana in structures.

Detection of marijuana odors was found to be significantly associated with the discovery of

25 or more plants.

The study titled, "The Predictive Validity of Marijuana Odor Detection" analyzed a total of 115 variables, a link to the entire 53 page report can be found in the resources section of this report.

ALASKA TRENDS

Methamphetamine

In July of 2006, pseudoephedrine regulations were adopted by the State of Alaska. This armed law enforcement professionals with a valuable tool to combat meth labs in the state. The table below shows the number of reported meth labs seized by SDEU.

Reported Meth Labs Seized in Alaska *

2007	2008	2009	2010	2011
11	12	9	11	8

* Statistic represents labs seized by SDEU only.

Although we have witnessed a decrease in the number of methamphetamine labs since 2006, SDEU has some concern due to the recent popularity of a new method in producing methamphetamine known as the "One Pot" or "Shake and Bake" method.

Methamphetamine cooks using the one pot method combine ammonium nitrate or sulfate, pseudoephedrine tablets, ether, water and the reactive metal into one container from the beginning of the process. The intent is to reduce the amount of time needed for the overall process. The dangers to the cooks and to first responders are due to the mixing of all of the ingredients in one container. The concentration of products builds pressure within the sealed container to levels beyond which the containers were built to withstand. The building pressure along with the violent reaction of the reactive metal with water can create a rupture or bursting of the container exposing the ingredients within to the outside air. Beyond the damage that is created by the bursting container, these ruptures are often accompanied by flames resulting from the flammable liquid within the container. As this method begins to gain in popularity within Alaska it will increase the danger to all citizens of Alaska from explosions, fires, and exposure to dangerous chemicals.

The number of methamphetamine lab seizures in nearly every other region of the country has shown a steady increase over the last three years due primarily to one pot labs.

As previously mentioned in this publication, methamphetamine abuse remains a significant issue within Alaska. Although the number of labs has remained relatively low, it appears that the use and abuse of the drug lingers.

Prescription Medication

More and more, prescription medications are being abused and sold. SDEU continued to see significant seizures of prescription medications in 2011. It is believed that the largest portion of these medications is being obtained through illegal means.

The latest data provided by the National Drug Intelligence Center shows that overdose deaths associated with the use of prescription medications exceeds those associated with

the use of cocaine, heroin and methamphetamine combined. This number includes both legal and illegal uses of prescription medications.

Heroin
The number of heroin seizures in our urban areas continues to grow. SDEU recognizes that there has been an increase in the availability of heroin throughout the state and it is no longer isolated to the urban areas.

Synthetic Cannabinoids
Synthetic cannabis is a term used to describe a variety of a psychoactive herbal and chemical substances which, when consumed mimic the effects of smoking marijuana. Marketed as incense and herbs, these products are sold on the internet and in smoke shops.

Although complete studies have not been conducted, some of the side effects of synthetic cannabis consumption are heart palpitations, extreme agitation, vomiting, delusions, hallucinations, and panic attacks.

In July of 2011, Alaska legislation prohibiting the sale and possession of a number of the common chemical compounds found in these synthetic cannabinoids was enacted. Following this enactment, the SDEU purchased a number of suspect products from a variety of vendors around the state. The items were submitted to the Scientific Crime Detection Laboratory (SCDL) for analysis. Additionally SDEU monitored submissions to the SCDL of these items from other law enforcement agencies.

Of the items submitted for analysis, none were found to contain any of the banned substances. This denotes compliance with the law by retailers but, changes to the chemical composition of these substances has allowed manufacturers to continue to legally market similar types of products in Alaska.

Bath Salts
Products containing MDPV (3,4 methylenedioxypyrovalerone)—marketed as "legal alternatives to cocaine or Ecstasy (MDMA)" emerged in the U.S. designer drug market during 2009. Such products have caused users throughout the country to experience severe adverse effects, and the number of calls to U.S. poison control centers related to them has trended upward. Retailers often sell these products labeled as "bath salts."

Currently legislation is under consideration by the Alaska Legislature to ban the chemicals commonly found in these products.

Summary

The Statewide Drug Enforcement Unit, with its unique ability to interdict and investigate cases across the state, recognizing that drug abuse is not confined to any one geographical location or any economic strata in our state. Drug and alcohol abuse affects all Alaskans, despite social, ethnic, racial and economic barriers.

We also recognize that the ill-gotten gains of drug traffickers and alcohol smugglers promote an increase in lawlessness of all types. This lawlessness is not isolated to the use of controlled substances. It includes, but is not limited to, burglary, theft, domestic violence assaults and murder. By the eradication of such activity and the arrest of those who would profit off the misery of others, we will make Alaska and the communities therein a much better and safer place to live and raise a family. The Alaska Bureau of Investigation, along with our partner agencies throughout the state, diligently dedicate our resources and energy toward that goal.

The Statewide Drug Enforcement Unit is committed to working with interested agencies in the fight against substance abuse throughout the state by using innovative concepts to deal with the illegal sale and distribution of alcohol and drugs. We are also committed to focusing on increased awareness and knowledge of drug abuse through educational presentations to the Public Safety Academy and in public forums, such as schools, service organizations and other community groups.

Resources

Office of National Drug Control Policy
www.whitehousedrugpolicy.gov/index.html

Office of Diversion Control
www.deadiversion.usdoj.gov/index.html

National Drug Intelligence Center
www.usdoj.gov/ndic/

Center for Substance Abuse Research
www.cesar.umd.edu/

U.S. Department of Health and Human Services
www.oas.samhsa.gov/nhsda.htm

The Partnership at Drug Free
www.drugfree.org/drug-guide

Department of Health and Social Services
http://www.hss.state.ak.us/dph/chronic/school/vrbsresults.htm

University of Alaska – "The Predictive Validity of Marijuana Odor Detection"
http://justice.uaa.alaska.edu/research/2010/1110.01.ast.marijuana/1110.01.marijuana.pdf

The 2011 Annual Drug Report is authored by the Alaska State Troopers, Alaska Bureau of Investigation Statewide Drug Enforcement Unit. It can be accessed via the Department of Public Safety internet site therefore there is no publication cost. It is intended to inform Alaskans about the type and frequency of drug related crime reported in Alaska during 2011.

The Alaska State Troopers, Alaska Bureau of Investigation supplied the majority of information presented in this report. Statistical data was provided by the Alaska State Troopers, Alaska Bureau of Investigation, the Anchorage Police Department, Ted Stevens Anchorage Airport Police and the Drug Enforcement Administration.

KTVA CBS 11 | Anchorage, Alaska News and Weather Anchorage, AK

Print this article

Addiction Treatment Advocates Call for More Alcohol Tax Money for Programs

Originally printed at http://www.ktva.com/home/outbound-xml-feeds/Addiction-Treatment-Advocates-Call-for-More-Alcohol-Tax-Money-for-Programs-140742513.html

By Corey Allen-Young
February 28, 2012

ALASKA - Calling substance abuse an epidemic in Alaska, advocates of treatment and prevention say the key to getting more people help is by increasing the amount of dollars used from the alcohol beverage tax – money they say could save lives.

The numbers are quite frankly embarrassing and heartbreaking, with substance abuse playing a role in nine of Alaska's top ten causes of death.

A list of groups from restaurants to bars to even the Anchorage Assembly say only using 50 percent of the alcohol sin tax is not enough if we want stop the tragic cycle of addiction.

"This is the best I've done being addicted to drugs," said Holly, who's getting treated for her addiction to prescription meds. "This is the cleanest I've ever been." It's a long road to recovery that Holly, who is pregnant, first started when she used drugs with a boyfriend as a teenager. "He was using them partying and I dabbled a little bit in OxyContin." It became a cycle of abuse that not even her family could get her out of.

"That was very, very scary for me. I looked for all kinds of different ways to get help," Holly said. But the problem is the help takes a lot longer than you would think because there isn't enough funding to support the demand.

"Some cases it could be six months or a year," said Anna Sappah, the executive director of Alaska Addiction Professionals Association. "[We've] got programs that aren't running at full capacity because they don't have the staff and manpower." This year, the state made $40 million on alcohol taxes. Half of it goes toward treating and preventing substance abuse. Drug counselors say the other half should be used for

treatment, as well, if we want fewer addicts.

"While people were waiting on their waiting list they actually died of the disease of addiction, either overdosed, or you'll hear of folks freezing to death," said Sappah.

"If people want help, help should be available for them," said APD spokesman Lieutenant Dave Parker. "If you have people on a waiting list, those people are motivated at least at the time that they write their name on the list."

"Really, you're not going to do it unless you're ready, nobody can force you," said Holly, who adds she and her baby are alive because she got help. The state says this year they have spent $42 million on treatment for about 7,000 people, with 450 waiting to be served.

But when you hear that 690 people were arrested for drug related offenses in Anchorage this year and that 484 sit in prisons statewide, its a push from both private and government organizations for 100 percent of the alcohol taxes to get that extra $19 million they say will lower numbers and cut down costs.

CLERK'S OFFICE
APPROVED
Date: 12-13-11

Submitted by: ASSEMBLY MEMBER FLYNN
Prepared by: Assembly Counsel
For reading: December 13, 2011

ANCHORAGE, ALASKA
AR NO. 2011–347

A RESOLUTION OF THE ANCHORAGE MUNICIPAL ASSEMBLY IN SUPPORT OF ALLOCATING 100 PERCENT OF THE EXISTING ALCOHOLIC BEVERAGE TAX RECEIPTS TO FUND ADDITIONAL TREATMENT SERVICES IN RECOGNITION OF THE OVERWHELMING UNMET DEMAND FOR SUBSTANCE ABUSE TREATMENT IN ALASKA.

WHEREAS alcohol and drug abuse are an epidemic in Alaska; and

WHEREAS Alaska consistently ranks among the top five states for alcohol and drug dependence; and

WHEREAS Alaska ranks eighth nationally for the percentage of people ages 18 years and older who need but do not receive treatment for illicit drug use; and

WHEREAS alcohol is a factor in an estimated 85 percent of reported cases of domestic violence and 80 percent of sexual assaults; and

WHEREAS the 2005 Advisory Board on Alcohol and Drug Abuse through the Alaska Department of Health and Social Services found that the economic costs of alcoholism and other drugs in Alaska annually include $367 million due to productivity loss in the workplace, $154 million on criminal justice and productive services, $178 million on health care, $35 million on traffic crashes, and $4 million for public assistance; and

WHEREAS Treatment has been shown to have a benefit-cost ratio of 7:1, and the largest savings are due to reduced cost of crime and increased employer earnings; and

WHEREAS according to the latest federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports, between 43,000 and 57,000 Alaskans age 12 or over abused or were dependent on alcohol or an illicit drug; and

WHEREAS under AS 43.60.050 (a), 50% of the taxes collected under the Alcoholic Beverage Tax (43.60.010) are deposited in the Alcohol and Other Drug Abuse Treatment and Prevention Fund; and

WHEREAS Alaska is projected to collect nearly $40 million in total existing alcohol tax receipts for Fiscal Year 2012; and

WHEREAS, there is an overwhelming unmet demand for substance abuse treatment in Alaska; and

WHEREAS tax monies collected from the sale of alcohol should be used to prevent and treat substance abuse; and

WHEREAS the Cabaret, Hotel, Restaurant & Retailers Association, Alaska Wine and Spirit Wholesalers, social service organizations, treatment providers, and faith-based organizations support increasing funds for substance abuse treatment in Alaska;

NOW THEREFORE BE IT RESOLVED that the Anchorage Assembly, in recognition of the overwhelming unmet demand for substance abuse treatment in Alaska, supports allocating 100 percent of the receipts from the existing Alcoholic Beverage Tax to fund additional substance abuse treatment services in Alaska, rather than supplanting current funding for the limited services presently available.

PASSED AND APPROVED by the Anchorage Assembly this 13th day of December, 2011.

Debbie Ossiander
Chair

ATTEST:

Barbara E. Jones
Municipal Clerk

Alaska Cabaret, Hotel,
Restaurant & Retailers Association

1503 W. 31st Ave., Suite 202 • Anchorage, Alaska 99503
(907) 274-8133 • Fax: (907) 274-8640
Toll Free In Alaska (800) 478-2427

Alaska State Legislature
Senator Johnny Ellis
716 W. 4th Ave, Ste 500
Anchorage, AK 99501

December 5, 2011

Dear Senator Johnny Ellis:

The Alaska Cabaret, Hotel, Restaurant & Retailers Association (CHARR) supports depositing 100 percent of the receipts from the existing Alcoholic Beverage Tax into the Alcohol and Other Drug Abuse Treatment and Prevention Fund, and requests that these funds be allocated into the budget to provide additional treatment services rather than supplanting current services.

Currently, only half of the revenue from the existing alcohol tax is used for substance abuse treatment and prevention. Alaska consistently ranks among the top five states for alcohol and drug dependence. Alaskans who seek treatment must be able to find and enter into treatment programs. There are far too few options available, and when someone needs help they often face long wait times. Substance abuse treatment services continue to be underfunded statewide, leaving individuals to continue the costly and tragic cycle of addiction.

According to the Federation of Tax Administrators, Alaska's alcohol tax is 3.5 to 4 times the national average which means Alaska has one of the highest excise tax rates on alcohol in the nation. These taxes produce over 38 million dollars annually, but sadly the majority of this tax revenue is not used to combat the problems related to the abuse and misuse of alcohol.

Alaska's hospitality industry pays the state government its fair share in taxes, and we support the use of this revenue to provide cost-effective, evidence based and readily available treatment. Alaska CHARR respectfully requests that you support this effort, and take action to ensure 100 percent of the existing alcohol tax revenue goes towards substance abuse treatment.

Sincerely,

Dale Fox

Dale G. Fox, CAE
President & CEO, Alaska CHARR

ANCHORAGE
CHARR
CABARET, HOTEL, RESTAURANT & RETAILERS ASSOCIATION

December 6, 2011

Dear Assembly Members;

The Anchorage Cabaret, Hotel, Restaurant & Retailers Association (CHARR) supports depositing 100 percent of the receipts from the existing Alcoholic Beverage Tax into the Alcohol and Other Drug Abuse Treatment and Prevention Fund, and requests that these funds be allocated into the budget to provide additional treatment services rather than supplanting current services.

Currently, only half of the revenue from the existing alcohol tax is used for substance abuse treatment and prevention. Alaska consistently ranks among the top five states for alcohol and drug dependence. Alaskans who seek treatment must be able to find and enter into treatment programs. There are far too few options available, and when someone needs help they often face long wait times. Substance abuse treatment services continue to be underfunded statewide, leaving individuals to continue the costly and tragic cycle of addiction.

According to the Federation of Tax Administrators, Alaska's alcohol tax is 3.5 to 4 times the national average which means Alaska has one of the highest excise tax rates on alcohol in the nation. These taxes produce over 38 million dollars annually, but sadly the majority of this tax revenue is not used to combat the problems related to the abuse and misuse of alcohol.

Alaska's hospitality industry pays the state government its fair share in taxes, and we support the use of this revenue to provide cost-effective, evidence based and readily available treatment. Anchorage CHARR respectfully requests that you support this effort, and take action to ensure 100 percent of the existing alcohol tax revenue goes towards substance abuse treatment.

Sincerely,

S. Villamides

Silvia Villamides, executive director

Fairbanks Native Association, Inc (FNA)
Behavioral Health Services

March 12, 2012

Dear Members of the Senate Finance Committee,

Thank you for introducing Senate Bill 221 to allocate 100 percent of existing alcohol tax revenue to the Alcohol and Other Drug Abuse Treatment and Prevention Fund (ADTP). In 2002, State Representative Lisa Murkowski championed HB225 to raise the alcoholic beverage tax and establish the ADTP to help provide much-needed revenue for expanded substance abuse treatment and diversion programs. Since 2003, only half of the funds collected from the existing alcohol tax have been appropriated to the ADTP. While the political reasoning for the fund was to expand treatment, decreases in general fund spending have left overall funding for substance abuse treatment and prevention reduced or stagnant.

Despite the increasing need for more substance abuse treatment and prevention, these programs are historically underfunded. Providers throughout the state report treatment beds are full to capacity, long waiting lists exist for services they offer, and there are numerous requests for services they can't provide. According to the Federation of Tax Administrators, Alaska's alcohol tax is 3.5 to 4 times the national average which means Alaska has one of the highest excise tax rates on alcohol in the nation. These taxes produce over 38 million dollars annually, but sadly the majority of this tax revenue is not used to combat the problems related to the abuse and misuse of alcohol.

Alaska consistently ranks among the top 5 states for alcohol and drug dependence. Not only does substance abuse have an extreme economic impact on the state, estimated at $738 million annually in health care costs, traffic crashes, criminal justice and public assistance, substance abuse is a reportedly a factor in 85% of sexual assault and domestic violence cases, and a contributing factor in 70% of child abuse and neglect cases. We cannot continue to ignore the substance abuse epidemic in Alaska.

The Governor should be commended for his Choose Respect initiative. Senate Bill 221 is the logical next step. We can't stop the scourge of sexual assault and domestic violence without addressing the underlying issue of alcoholism and drug abuse. With a small statutory change, all

monies collected from alcohol taxes can be put toward proven substance abuse treatment and prevention programs. The time to act is now.

Thank you for your leadership on this crucial issue.
Sincerely,

Perry R. Ahsogeak
Behavioral Health Director

Nine Star Enterprises

Education and Employment Services
"We Develop Alaska's Workforce!"

March 9, 2012

716 W. 4th Ave. Ste. 500
Anchorage AK 99501-2133
Attention to: Senator Johnny Ellis

Dear Members of the Senate Finance Committee,

Thank you for introducing Senate Bill 221 to allocate 100 percent of existing alcohol tax revenue to the Alcohol and Other Drug Abuse Treatment and Prevention Fund (ADTP). In 2002, State Representative Lisa Murkowski championed HB225 to raise the alcoholic beverage tax and establish the ADTP to help provide much-needed revenue for expanded substance abuse treatment and diversion programs. Since 2003, only half of the funds collected from the existing alcohol tax have been appropriated to the ADTP. While the political reasoning for the fund was to expand treatment, decreases in general fund spending have left overall funding for substance abuse treatment and prevention reduced or stagnant.

Despite the increasing need for more substance abuse treatment and prevention, these programs are historically underfunded. Providers throughout the state report treatment beds are full to capacity, long waiting lists exist for services they offer, and there are numerous requests for services they can't provide. According to the Federation of Tax Administrators, Alaska's alcohol tax is 3.5 to 4 times the national average which means Alaska has one of the highest excise tax rates on alcohol in the nation. These taxes produce over 38 million dollars annually, but sadly the majority of this tax revenue is not used to combat the problems related to the abuse and misuse of alcohol.

Alaska consistently ranks among the top 5 states for alcohol and drug dependence. Not only does substance abuse have an extreme economic impact on the state, estimated at $738 million annually in health care costs, traffic crashes, criminal justice and public assistance, substance abuse is a reportedly a factor in 85% of sexual assault and domestic violence cases, and a contributing factor in 70% of child abuse and neglect cases. We cannot continue to ignore the substance abuse epidemic in Alaska.

The Governor should be commended for his Choose Respect initiative. Senate Bill 221 is the logical next step. We can't stop the scourge of sexual assault and domestic violence without addressing the underlying issue of alcoholism and drug abuse. With a small statutory change, all monies collected from alcohol taxes can be put toward proven substance abuse treatment and prevention programs. The time to act is now.

Thank you for your leadership on this crucial issue. Sincerely,

David S. Alexander, President
Nine Star Education and Employment Services

Advisory Board on Alcoholism
and Drug Abuse

abada
amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 16, 2012

Senator Johnny Ellis
Alaska State Capitol, Room 103
Juneau, Alaska 99801

Re: Letter of Support for SB 221

Dear Senator Ellis,

The Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse support SB 221, a bill to ensure that the revenue from our state's alcohol taxes is used to prevent and treat substance abuse. We appreciate your work, and that of the Senate Finance Committee, to address this issue.

Our Boards have long held the position that funds available from the alcohol tax were intended to supplement and not supplant existing general fund (GF) monies for behavioral health. The legislative intent of the alcohol tax was clearly to supplement existing funding for behavioral health services. This is clear from then state Representative Lisa Murkowski's sponsor statement: the alcohol tax fund "would help provide revenue needed for the expanded treatment, therapeutic courts, diversion programs and other initiatives" then being considered by the Legislature.

Alaska consistently ranks among the states with the highest rates of binge drinking.[1] Indigenous Americans report higher rates of alcohol dependence than other ethnicities in America.[2] Alaska's alcohol taxes produce over $38 million annually. Only half of the revenue from the existing alcohol tax is expressly allocated for substance abuse treatment and prevention.

Our concern is that funds from the alcohol tax fund have been used instead of GF dollars rather than in addition to GF dollars. The result is that substance abuse treatment services continue to be underfunded statewide, leaving individuals to continue the costly and tragic cycle of addiction.

---

[1] "Prevalence of Binge Drinking Among Adults, 2010," Centers for Disease Prevention and Control *citing* Behavior Risk Factor Surveillance System data (geographic representation of state rates available online at http://www.cdc.gov/alcohol/data-stats.htm).

[2] *The NSDUH Report*, "Alcohol Dependence or Abuse: 2002, 2003, 2004" (Issue 16, 2006) (online at http://www.samhsa.gov/data/2k6/alcDepend/alcDepend.htm).

In 2005, the Advisory Board on Alcoholism and Drug Abuse published findings on the economic costs of alcoholism and other drug abuse in Alaska:

- $367 million due to productivity loss in the workplace;
- $154 million on criminal justice and protective services;
- $178 million on health care;
- $35 million on traffic crashes; and
- $4 million for public assistance.[3]

Accessible and effective community-based alcohol and drug treatment is essential to reducing society's financial burden from problems associated with alcohol and drug abuse. Even beyond helping to alleviate the enormous physical and psychological costs, access to treatment and recovery supports diminishes the huge financial consequences imposed on employers and taxpayers.

Our board members expressly support the effort to ensure that 100 percent of Alaska's alcohol tax revenue goes to substance abuse treatment and prevention programs. We appreciate your work to improve access to these important services – for the health of all our neighbors and our communities.

Sincerely,

J. Kate Burkhart
Executive Director

cc: Robert Coghill, Jr., Chairman ABADA
Dan Meddleton, Chairman AMHB

[3] *Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update*, McDowell Group Research-Based Consulting (December 2005) at 2-4 (available online at http://www.hss.state.ak.us/abada/).

Partners For Progress
1326 K Street
Anchorage, AK 99501
Ph: (907) 272-2119
Fax: (907) 272-2893
www.partnersforprogressak.org

Subject: Senate Bill 221

March 15, 2012

Dear Members of the Senate Finance Committee:

At our March 15, 2012 meeting, the Board of Directors of Partners for Progress discussed Senate Bill 221. We voted unanimously to support this bill.

Since 1999 Partners for Progress has been closely involved in the work of Alaska's Legislature, Administration, and the Court System to identify "Smart Justice" measures that better protect the public while reducing the human and monetary costs of incarceration. This year's Legislative Crime Summit highlighted a number of tested and proven measures that achieve this goal. Most involve substance abuse prevention and treatment.

Prevention and treatment of substance abuse is at the core of "Smart Justice". Providing additional funding to address the scourge of alcohol and drug abuse that underlies much of the crime in Alaska is an essential step towards curbing Alaska's ever-growing costs of incarceration while improving public protection. We urge your support for Senate Bill 221.

Respectfully,

Janet McCabe

Janet McCabe,
Chair, Partners for Progress

The TRUST

The Alaska Mental Health Trust Authority

March 16, 2012

Senator Hoffman, Finance Committee Co-chair
State capitol Room #518
Juneau, AK 99801

Senator Stedman, Finance Committee Co-chair
State capitol Room #516
Juneau, AK 99801

RE: **SB 221** – Allocation of 100 percent of existing alcohol tax revenue to the Alcohol and Other Drug Abuse Treatment and Prevention Fund (ADTP)

Dear Senators Hoffman, Stedman and members of the Finance Committee,

The Alaska Mental Health Trust Authority (The Trust) is writing in strong support of **Senate Bill 221**. This bill would allocate 100 percent of existing alcohol tax revenue to the Alcohol and Other Drug Abuse Treatment and Prevention (ADTP) fund.

Sadly, Alaska consistently ranks among the top five states for alcohol and drug dependence. In addition, many of Alaska's social ills can be linked back to substance abuse. For example, substance abuse is a reportedly a factor in 85% of sexual assault and domestic violence cases, and in 70% of child abuse and neglect cases. Furthermore, the economic impact on Alaska from substance abuse is estimated at $738 million annually in health care costs, traffic crashes, criminal justice, public assistance and lost productivity.

In an effort to ensure Alaska had revenue for substance abuse prevention strategies and treatment programs, then State Representative Lisa Murkowski, championed HB225 to raise the alcoholic beverage tax and establish the ADTP fund to generate needed revenue for these programs and services. Unfortunately, since 2003, only 50 percent of the funds collected from the existing alcohol tax have been appropriated to the ADTP fund.

The Trust and its partners have been and continue to be steadfast advocates for ensuring Alaska's continuum of health care is sufficient to help those with addictions find a path to recovery. Unfortunately, Alaskans' access to evidence based substance abuse treatment is severely limited. If these additional ADTP funds were used to supplement rather than supplant the General Funds currently used for these services, they would go a long way to helping individual Alaskans and improving the health and wellness of our state.

The Trust strongly supports SB221 and thanks the Senate Finance Committee for their leadership in helping Alaskans suffering from addiction find their path to recovery.

Sincerely,

Jeff Jessee, CEO

Cc: **Sen. Finance Committee:** Senator Olson, Senator Egan, Senator Thomas, Senator Ellis, Senator McGuire
Sen. Health & Social Services Committee: Senator Davis (chair), Senator Meyer, Senator Dyson, Senator Ellis, Senator Egan

ALASKA FEDERATION
OF NATIVES

March 16th, 2012

The Honorable Senate Finance Committee
State Capitol Building, Room 532
Juneau, Alaska 99801

Dear Senate Finance Committee Members,

On behalf of the Alaska Federation of Natives we would like to state our support for Senate Bill 221 to allocate 100 percent of the money collected by the existing alcohol tax to the Alcohol and Other Drug Abuse Treatment and Prevention Fund. It is clear that you recognize the negative effect of alcohol and drug addiction on the health and safety of Alaska Natives and you are actively seeking solutions that will reduce that impact.

We advocate for this bill on behalf of our membership wishes for a healthy future for all of Alaska. AFN represents 230 villages, through themselves or the 11 Regional Non-profits, and 12 Regional ANSCA corporations that are also members.

Senate Bill 221 is in alignment with AFN's commitment to ensuring healthier Alaska Natives. Many of the health challenges facing Alaska Natives are tied to behavioral health conditions; chief among these is substance abuse.

- 1 in 11 Alaska Native deaths is alcohol-induced
- Alcohol was the fourth leading cause of death from 1993 to 2002 (Alaska Bureau of Vital Statistics)
- Alcohol contributed to 85% of reported domestic violence cases and 80% of reported sexual assault cases between 2000-2003 (ISER, Status of Alaska Native Report, 2004)

Senate Bill 221 will help us fulfill our mission by allocating nearly 40 million dollars for substance abuse treatment and prevention services statewide. These programs continue to be underfunded leaving desperate individuals to continue the costly and tragic cycle of addiction.

Should you have any questions about our position, please feel free to contact me at (907) 274-3611.

1577 C Street, Suite 300 • Anchorage, Alaska 99501 • tel 907.274.3611 • fax 907.276.7989 • www.nativefederation.org

Sincerely,

Julie Kitka

Julie Kitka, President

Alaska Federation of Natives

1577 C Street, Suite 300 • Anchorage, Alaska 99501 • tel 907.274.3611 • fax 907.276.7989 • www.nativefederation.org

SCR

1

<TARGET><BILL>SCR 1</BILL><SUBJECT>SCR
1</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT

DATE: 3/9/11

FURTHER:
DATE TURNED IN TO OFFICE: 3/10/11

Health and Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 1

SCR 1 LUPUS AWARENESS MONTH

Designating May 2011 as Lupus Awareness Month.

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[✓] adopt **previous CS** SCR 1 (STA) *[ ] Same Title [X] New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
			✓	

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
STA			✓	1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Meyer	X			
	Ellis	X			
	ECA	X			
	Dyson	X			
CHAIR:	DAVIS	X			

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number 1
Bill Version **CSSCR 1(STA)**
(S) Publish Date 3/9/11

Identifier (file name)
Title SCR 1 LUPUS AWARENESS MONTH
Sponsor Senator Davis
Requester

Dept. Affected
Appropriation
Allocation
OMB Component Number

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Prepared by SENATE STATE AFFAIRS COMMITTEE
Division
Approved by /s/ Senator Wielechowski, Chair

Phone 465-2435
Date/Time 3/8/11 12:00 AM
Date

(Revised 1/27/2011 OMB)

COMMITTEE COPY

FISCAL NOTE #1

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. CSSCR 1(STA)

Analysis

No Fiscal Impact.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

SCR1 *"Designating May as Lupus Awareness Month"*

SPONSOR STATEMENT

SCR1 designates May as Lupus Awareness Month and encourages Alaskans to observe Lupus Awareness Month with appropriate activities that provide both lupus education and support for people diagnosed with the disease.

According to the Lupus Foundation of America, lupus is an acute, chronic and often lifelong disease affecting the immune system by causing inflammation and tissue damage. Major gaps exist in the understanding of the causes and consequences of lupus. Lupus can affect any body part, including the skin, lungs, heart, kidney, and brain. Lupus can cause seizures, strokes, heart attacks, miscarriages and organ failure. Lupus strikes mostly women of childbearing age and women of color develop lupus at a rate two-to-three times the rate that Caucasians develop lupus. Lupus is difficult to diagnose because its symptoms are similar to the symptoms of other illnesses. New drugs have not been approved by the United States Food and Drug Administration specifically for lupus during the last 50 years. Current treatment for lupus can have damaging side effects.

Each year, May is designated as Lupus Awareness Month to show support for the estimated 1.5 million Americans with lupus. More than 3,000 cases of lupus have been diagnosed in Alaska in patients 20 to 87 years of age. Ten members of the Lupus Foundation of America, Alaska Chapter recently passed away from lupus. Designating May as Lupus Awareness Month will help increase awareness of lupus and show support for those diagnosed with the disease.

Lupus Foundation of America, Inc.

What I Need to Know About Lupus

If you have been diagnosed with lupus, you will want to know as much as you can about the disease. Lupus is a chronic, autoimmune disease that can damage any part of the body (skin, joints, and/or organs inside the body). Normally the immune system produces proteins called antibodies that protect the body from foreign invaders, such as bacteria and viruses. With lupus, the immune system cannot tell the difference between these foreign invaders and the body's healthy tissues and creates autoantibodies ("auto" means "self") that attack and destroy healthy tissue. These autoantibodies cause inflammation, pain, and damage in various parts of the body.

Lupus is a disease of flares (the symptoms worsen and you feel ill) and remissions (the symptoms improve and you feel better). Lupus can range from mild to life-threatening and should always be treated by a doctor. With good medical care, most people with lupus can lead a full life.

What Causes Lupus?

No one knows what causes lupus. However, scientists believe that hormones, genetics (heredity), and environment are all involved. Hormones regulate many of the body's functions. In particular, the sex hormone estrogen is believed to play a role in lupus. Men and women both produce estrogen, but estrogen production is much greater in females.

Scientists have noted some common triggers among people who have lupus, including exposure to the sun, an infection, a medication taken to treat an illness, pregnancy, and giving birth.

However, that does not mean that estrogen, or any other hormone for that matter, causes lupus.

While no gene or group of genes has been proven to cause lupus, the disease does appear in certain families. And, although lupus can develop in people with no lupus in their family history, other autoimmune diseases may be present in some family members. Certain ethnic groups (people of African, Asian, Hispanic/Latino, Native American, or Pacific Island descent) have a greater risk of developing lupus, which may be related to genes they have in common.

Your genes may increase the chance that you will develop lupus, but scientists believe some kind of environmental trigger can set off the illness or bring on a flare, such as:

- *ultraviolet rays from the sun or from fluorescent light*
- *sulfa drugs and some tetracycline drugs, which make a person more sensitive to the sun*
- *penicillin or certain other antibiotic drugs*
- *infection*
- *a cold or a viral illness*
- *exhaustion*
- *injury*
- *emotional stress*
- *anything that causes stress to the body such as surgery, an accident, pregnancy, or giving birth*

Facts About Lupus

- Lupus is not contagious.
- Lupus is not like or related to cancer.
- Lupus is not like or related to HIV or AIDS.
- It is believed that at least 1.5 million people in the U.S. have lupus.
- More than 16,000 new cases of lupus in the U.S. are reported each year.
- Lupus strikes mostly women of childbearing age.
- Women of color are 2-3 times more likely to develop lupus.
- People of all races and ethnic groups can develop lupus.

Forms of Lupus

Systemic lupus erythematosus is the most common form of lupus, and is what most people mean when they refer to "lupus." Systemic lupus can be mild or severe. Some of the more serious complications involving major organ systems are:

- *inflammation of the kidneys (lupus nephritis)*
- *an increase in blood pressure in the lungs (pulmonary hypertension)*
- *inflammation of the heart muscle (myocarditis)*
- *hardening of the arteries (coronary artery disease)*
- *inflammation of the nervous system and brain*
- *inflammation of the brain's blood vessels*

Cutaneous lupus erythematosus is limited to the skin. Although cutaneous lupus can cause many types of rashes and lesions (sores), the most common rash is raised, scaly and red, but not itchy; it is called a *discoid rash* because the areas of rash are shaped like disks, or circles. Another common example of cutaneous lupus is a rash over the cheeks and across the bridge of the nose, known as the *butterfly rash*. Hair loss and changes in the pigment, or color, of the skin are also symptoms of cutaneous lupus.

Drug-induced lupus is a lupus-like disease caused by certain prescription drugs. The drugs most commonly connected with drug-induced lupus are hydralazine (used to treat high blood pressure or hypertension), procainamide (used to treat irregular heart rhythms), and isoniazid (used to treat tuberculosis). The lupus-like symptoms usually disappear within six months after these drugs are stopped.

Neonatal lupus is a rare condition that can affect infants of women who have lupus. At birth, the infant may have a skin rash, liver problems, or low blood cell counts, but all of these symptoms disappear completely after several months with no lasting effects. A very small percentage of infants with neonatal lupus may also have a serious heart defect; however, most infants of mothers with lupus are entirely healthy.

Another common example of cutaneous lupus is a rash over the cheeks and across the bridge of the nose, known as the butterfly rash.

What Are the Symptoms of Lupus?

Because lupus can affect so many different organs, a wide range of symptoms can occur. The most common symptoms of lupus, which are the same for females and males, are:

- *extreme fatigue (tiredness)*
- *headaches*
- *painful or swollen joints*
- *anemia (low numbers of red blood cells)*
- *fever*
- *swelling (edema) in feet, legs, hands, and/or around the eyes*
- *pain in chest on deep breathing (pleurisy)*
- *butterfly-shaped rash across cheeks and nose*
- *sun- or light-sensitivity (photosensitivity)*
- *hair loss*
- *blood-clotting problems*
- *fingers turning white and/or blue when cold (Raynaud's phenomenon)*
- *ulcers in mouth or nose*

Most people with lupus will be treated by a rheumatologist, who is a specialist in the diseases of joints and muscles.

What Kinds of Doctors Treat Lupus?

Most people with lupus will be treated by a *rheumatologist*, who is a specialist in the diseases of joints and muscles. The rashes or lesions from cutaneous lupus require treatment from a *dermatologist*, a specialist in diseases that affect the skin (including the scalp and the mouth).

Because lupus can cause damage to any part of the body, other specialists may be necessary, such as a *nephrologist*, who specializes in kidney problems; a *cardiologist*, who specializes in heart problems; a *neurologist*, who specializes in problems that affect the brain and nervous system; or a *perinatologist*, who specializes in high-risk pregnancies.

LUPUS Foundation of America, Inc

The Lupus Foundation of America (LFA) is the nation's leading nonprofit voluntary health organization dedicated to finding the causes of and cure for lupus and providing support and services to all people affected by the disease. The LFA and its network of chapters pursue this mission through programs of research, education and advocacy. Contact the LFA or a chapter that serves your area to find out how you can become involved in our mission and how we can help you. For more information call 1-800-558-0121 or visit us online at www.lupus.org.

2000 L Street, NW, Suite 710 | Washington, DC 20036 | www.lupus.org | ©2007 Lupus Foundation of America Inc.

BAND TOGETHER FOR LUPUS

Are you in the band? Join the Lupus Foundation of America (LFA) and Band Together for Lupus™ to raise awareness and educate others about the needs of people affected by lupus. We are asking that you show your support and commitment to the millions of people worldwide impacted by lupus and "band together" by wearing a purple lupus awareness wristband.

Together, we can show our support for those who are working to develop a full arsenal of new treatments, and highlight the need for safe, more tolerable, and effective medications. Most importantly, we can offer hope to the millions of people affected by the disease.

Here's how you can get involved and "band together."

- **Wear a wristband!** You can buy them at the LFA store, or from your local LFA chapter. Don't forget to share them with your friends and family.
- **Spread the word.** Ask your friends and family to join us and "band together" by sending an e-card.
- **Pledge your commitment** to "band together" and show your support for the millions of people affected by the disease.
- **Sign up to be an e-advocate and make your voice heard**. Become an e-advocate and tell Congress there is a critical need for increased funding for sound lupus research and education programs.
- **Join the band by following us Facebook, Twitter, or MySpace**. Check out our regular announcemnts on Facebook or MySpace or follow us on Twitter. Put an LFA wristband Twibbon on your Twitter account,
- **Make a donation**. Please consider making a tax-deductible contribution to help the LFA support research, education, and support services that benefit the 1.5 million Americans living with lupus and their families.
- **"Band Together" with an LFA chapter**. Find out what your local LFA chapter is doing as part of the "Band Together for Lupus" campaign.

© 2011 Lupus Foundation of America, Inc. All Rights Reserved. No part of this website may be reproduced without written permission.

2009 Annual Report

LUPUS™ Foundation of America
Alaska Chapter, Inc.

LUPUS™

Foundation of America

Alaska Chapter, Inc.

2009 Annual Report

LFA Alaska Chapter

P.O. Box 240628
Anchorage, Alaska, 99524-0628

800 307-5878
907 338-6332

www.lupusalaska.org

LUPUS FOUNDATION OF AMERICA

ALASKA CHAPTER

2009 ANNUAL REPORT

The **Lupus Foundation of America (LFA) Alaska Chapter** was founded in July of 1986 as a nonprofit, nonsectarian, primarily volunteer organization. Our chapter is affiliated with and receives organizational support from the Lupus Foundation of America (LFA), the nation's leading non-profit voluntary health organization dedicated to research, education and advocacy in finding the causes of and cure for lupus.

The **Alaska Chapter** of LFA, serving over 40 cities and communities in Alaska, strives to improve early diagnosis and treatment of lupus, support individuals, families and friends affected by the disease, and increase awareness of lupus among health professionals and the public. We do this through our strong and involved Board of Directors and our dedicated and committed volunteers.

About Lupus

It is estimated that lupus affects 1.5 million Americans nationally and over ***3,000 Alaskans.*** Lupus is a widespread life diminishing and potentially life threatening disease that causes the immune system to attack the body's own healthy tissues and organs, including the kidneys, heart, lungs, brain, blood, and skin. Common symptoms of lupus include joint pain and swelling, fevers, extreme fatigue, skin rashes, anemia, chest pains due to inflammation of the heart or lungs, and sun sensitivity, among others.

Without intervention, the number of people nationally with lupus is expected to rise to more than 2 million in the next decade. The disease is two to three more common among African Americans, Hispanics, Asians and Native Americans. While eight of the ten new cases of lupus develop among women of childbearing age, men and women of all ages, as well as children also develop the disease. At the present time, there is not a cure for lupus.

Lupus is NOT infectious, rare, or cancerous. Researchers do not know exactly what causes lupus. While scientists believe there is a genetic predisposition to the disease, it is known that environmental factors such as sun exposure, stress, toxins, and infections can play a role in triggering the disease.

Shelly's Story

In every family there is some trait passed along the generations that is recognized as a 'common thread" among members. Some families get Grandpa's eyes; some get Great Aunt Millie's dry sense of humor. For my family, our common trait is lupus.

When my mother was first diagnosed at 35, we knew very little about the disease other than the muscle pain she suffered on a regular basis. We learned more throughout the years as not one but every female member of my family was diagnosed. After my mom came my aunt, her daughter and, finally, my diagnosis at the age of 20. We have varying degrees of the disease, from my general fatigue and muscle aches to the full-blown multi-organ involvement that eventually claimed my 31 year old cousin's life. At any level it is a disease that touches and changes us all.

While no one wishes for a chronic and life threatening illness, I am grateful that the disease I have is one that, so far, has been treatable and tolerable. I take my medication each day as my only major treatment. Experience has taught me that controlling my weight and getting regular exercise and sleep can alleviate the need for the two prescription pain killers and muscle relaxers I took each day in my early twenties. Yet I am, like all lupus patients, always cautious about the road ahead and the challenges I may face. Any fever is one to question. Vacations and trips must always allow for rest and sleep, otherwise I can count on a forced "time out" from a flare. How will this affect my family life when my husband and I decide to have kids? Will my boss understand when I can't "push through" a simple cold at work like the rest of my co-workers? Issues which, for me, are mere complications become full battles for those with more severe cases.

WHAT WE DO

SUPPORT

- Organize and facilitate support groups for individuals with lupus and their families
- Provide phone support through local and toll free numbers: (907) 338-6332 and (800) 307-5878
- Provide a website with information regarding our local chapter, lupus, support options, and links to the national LFA web site
- Supply brochures, books and resource articles about lupus to individuals with lupus and their families
- Maintain a lending library of books, videos and over 600 articles
- Distribute newsletter ***LUPUS LINK*** and national LFA magazine ***LUPUS NOW*** to our Alaska Chapter members
- Provide assistance and information to requesting individuals on current lupus treatment, diagnosis and physician referrals (both within Alaska and nationally)

EDUCATION & AWARENESS

- Provide Lupus related brochures, newsletters, books and current literature to individuals as well as the Alaska medical community statewide; including doctors, clinics, nurse practitioners, dentists and chiropractors
- Present lupus information at health fairs, businesses, and conferences
- Organize continuing education opportunities on the topic of lupus for physicians, nurses, health aides, dentists, dental hygienists, and chiropractors

Cities and communities where LFA Alaska has members and provides services

Highlights and Accomplishment for 2009

Walk for Lupus Now – On September 19, 2009, the Alaska Chapter hosted the State's first Walk for Lupus Now™, a nation-wide fundraising event aimed at raising both money and awareness of this chronic and debilitating disease. The National LFA provided a grant to assist in planning and implementation of the event. Over 125 walkers and 240 donors supported the Walk for Lupus Now™ held at the Alaska Dome. The event raised $25,000 in cash and in-kind donations.

Team Alaska

Individuals and teams on the start line

2nd Wine Tasting and Silent Auction – This successful fundraising event was held in partnership with Wine Styles on April 24th at O'Malleys on the Green and raised $7,000.

Jammin Salmon" Cook Off - The Eagle River Chugiak Chamber of Commerce's IBEW Salmon Cook-Off at the Bear Paw Festival in July 2009 chose the LFA Alaska Chapter as the recipient charity for this annual fundraiser.

Health Fairs - Alaska Chapter volunteers participated in **23** Health Fairs in the communities of Anchorage, Wasilla, Palmer, Fairbanks, Seward, Girdwood and Nome.

Day of Caring –
ConocoPhillips IT Department volunteered their time and office for the 7th year in a row by preparing a mass mailing of informative letters to Alaska medical providers and post cards promoting our chapter's the *Walk for Lupus Now™*, as well as putting together the gift bags for the Walk.

Volunteers – Over **10,000** hours were provided Statewide by wonderful dedicated community volunteers supporting the Alaska Chapter of LFA.

Lupus Link – The quarterly multipage Alaska Chapter newsletter-was produced and distributed to nearly 500 LFA Alaska Chapter members as well as medical professionals and clinics Statewide.

Additional Awards, Grants & Donations

Alaska Kidney Association - award grant for $1,200 to assist the chapter in buying educational materials

Rasmuson Foundation – award grant for $14,864 to purchase office technical equipment and furnishings

Alaska Permanent Dividend –*"Pick, Click and Give"* – individual donations of $800

Payroll Deduction Program including Alaska Community Share / United Way / Combined Federal Campaign – donations of $2,198

KeyBank Leadership Grant – award grant of $500

Leadership Anchorage – selected LFA Alaska Chapter as one of four community projects for the 2009-2010 class. This project will assist in the development of a new business plan to reach and support the younger lupus population of Alaska as well as the broader lupus community in the State.

Jackie G. Page Charitable Trust – donation of $17,000 to be applied towards an Alaskan Statewide Lupus Conference

Lupus Foundation of America – award grant of $11,000 for the implementation of the first *Walk for Lupus Now* in Alaska

L to R -granddaughter Keely, Debora and daughter Michelle

Debora's Story

I have been living with lupus for 40 years. Lupus and other auto-immune diseases run in families, so my daughter and granddaughter are at increased risk of developing lupus. On average, it takes 1 - 4 years and visits to 3 doctors before patients are correctly diagnosed with lupus. For me, it took over 26 years and a multitude of doctors before I received a diagnosis of lupus.

This is my story:
At seventeen, I had a horrible rash everywhere on my body. The doctor said it was an allergic reaction. At twenty, I started having transient strokes that caused temporary loss in my visual field. The doctor said to quit taking birth control pills. In my twenties, I also had several miscarriages. In my thirties, I often felt fatigued and was hospitalized for 4 days for high fevers of unknown origin. The doctors couldn't find anything wrong with me. Finally, at age 43, I went to my doctor and complained of severe fatigue. He asked me if I was depressed (which I wasn't) and said to come back in a month if I was still feeling fatigued. A month later, I finally got a diagnosis. It was a relief to finally know what had been causing all of my medical problems.

Living with any chronic and potentially life-threatening illness is a challenge. People with lupus often have to quit working because of the overwhelming fatigue combined with the unpredictable nature of the illness. After 25 years as a dental hygienist, I had to give up my work and my wonderful patients. Lupus also makes it difficult to pursue my love of gardening since being in the sun causes flare-ups of the disease. Although lupus has taken several things from me, it has also inspired me to be a better person and to live each day to the best of my ability. I volunteer my time with the Lupus Foundation of America Alaska Chapter and Big Brothers Big Sisters. My life is full of wonderful experiences and I am blessed to have amazing friends and family to support me.

Business and Community Support

- Alaska Printing
- Alaska Serigraphics
- CRW Engineering Group LLC
- Denali Alaska Federal Credit Union
- Key Bank
- Specialty Imports
- The Alaska Club
- The Alaska Dome
- Wine Styles
- ConocoPhillips
- Alaska Pure Water Products
- Fred Meyer
- Sugar Spoon Bakery
- Starbucks
- Great Harvest Bakery
- The Event Divas
- Alaska Mill and Feed
- Sacks
- Snow City Café
- Yak and Yeti Restaurant
- Allure Day Spa
- Marx Brothers Restaurant
- Heritage Coffee Company
- Alaska Brewing Company
- Title Wave
- Alaska Railroad
- Southside Bistro
- The Frame Workshop and Gallery
- Doriolas
- Corsair
- Marian Call
- Alaska Railroad

Board of Directors

Judy Powell – **Board Chair**
2143 Churchill
Anchorage, AK 99517
907-272-6390 home
907-229-4132 cell
planepowell@gci.net
Service started 2/09, Expires 2/12

Joyce Schuerger
8441 Stacy Circle
Anchorage, AK 99507
907-344-3746
sugarshack@gci.net
Service re-started 2/09, Expires 2/12

Shelly Ciarella- **Vice-Chair**
17527 Silverwood Way
Eagle River, AK 99577
907-242-7345 cell
scirarella@yahoo.com
Service started 9/07, Expires 2/11

Christine Hess
c/o Rep. Joule, State Capitol Bldg
Room 421
Juneau, AK 99801
907-465-4833 work
christine_hess@legis.state.ak.us
Service started 9/08, Expires 2/12

Billie DeVore - **Treasurer**
PO Box 220422
Anchorage, AK 99520-0422
907-272-3727 home/work
billie.d@att.net
Service started 9/06, Expires 2/10

Dawn Harrison
4255 Old Seward Highway Apt 12
Anchorage, AK 99508
907-982-2375 home
wren1313@yahoo.com
Service started 10/09

Debora Griffeth – **Past Chair**
1631 George Bell Circle
Anchorage, AK 99515-3955
907-345-3356 home
907-440-7047
griffethinalaska@yahoo.com
Service started 9/98, Expires 2/10

Barb Madden – **Secretary**
6440 Gunnison Drive
Anchorage, AK 99516
907-868=2777
barbmadden@aol.com
Service started 10/09

Roger Hyde
3104 Northwood Drive
Anchorage, AK 99517
907-277-0257 home
907-727-6933 cell
hydenout@gci.net
Service started 9/03, Expires 2/10

SCR

7

<TARGET><BILL>SCR 7</BILL><SUBJECT>SCR 7</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/22/11

Date of 5-Day Notice: 3/24/11
(in accordance with Uniform Rule 23)

FURTHER:

DATE TURNED IN TO OFFICE: 3/30/11

Health and Social Services Committee considered SENATE CONCURRENT RESOLUTION NO. 7

SCR 7-FETAL ALCOHOL SPECTRUM DISORDERS DAY

Proclaiming September 9, 2011, as Fetal Alcohol Spectrum Disorders Awareness Day.

and recommends:

[ ] be **replaced** with **CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] adopt **previous CS** _____ (_____) *[ ] Same Title [ ] New Title*

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
K. Meyer	Meyer	X			
Jim Ellis	ELLIS	X			
[illegible]	EGAN	X			
Fred Dyson	DYSON	X			
CHAIR: Bettye Davis	DAVIS	X			

Advisory Board on Alcoholism and Drug Abuse

abada amhb

Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

March 30, 2011

Senator Kevin Meyer
Alaska State Legislature
State Capitol Building
Juneau, Alaska 99801

Re: SCR 7 — FASD Awareness Day

Dear Senator Meyer,

The Advisory Board on Alcoholism and Drug Abuse and the Alaska Mental Health Board express their appreciation and support for SCR 7 declaring September 9, 2011 Fetal Alcohol Spectrum Disorders Awareness Day.

As you know, fetal alcohol spectrum disorders are 100% preventable. Raising awareness and recognition of this fact will help prevent more Alaskan children from being born affected by prenatal alcohol exposure.

Even more importantly, SCR 7 will raise awareness of the special and often very individual needs of individuals diagnosed with fetal alcohol spectrum disorders. Too often the services and supports they need to thrive – at home, at school, and in their communities – are not available. By highlighting a day that focuses on the unique issues of fetal alcohol spectrum disorders and their impact on Alaskans, we can not only support Alaskans with FASD, but also prevent future Alaskans from experiencing FASD.

Thank you for your continued work on this important issue.

Sincerely,

J. Kate Burkhart
Executive Director

Alaska State Legislature

Interim:
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0199

Session:
State Capitol Building
Juneau, Alaska 99801-1182
(907) 465-4945

Senator Kevin Meyer
Senate District O

SPONSOR STATEMENT FOR SCR 7

"Proclaiming September 9, 2011, as Fetal Alcohol Spectrum Disorders Awareness Day."

SCR 7 would proclaim September 9, 2011 as Fetal Alcohol Spectrum Disorders Awareness Day (FASD).

Alaska has the highest known incidence of FASD in the United States. This is a condition caused by prenatal exposure to alcohol, which can result in permanent brain damage, birth defects, learning disabilities, behavioral problems and most tragically, the loss of individual potential.

While FASD affects all racial and socioeconomic groups, it is a 100% preventable condition. FASD Awareness Day is observed internationally on September 9th. This serves as a reminder on the ninth day of the ninth month of the year that during the nine months of pregnancy a woman should abstain from alcohol.

SCR 7 would observe FASD Awareness Day by promoting the awareness of the effects of prenatal exposure to alcohol.

TEN THINGS YOU SHOULD KNOW ABOUT FAS

1. Drinking during pregnancy can cause permanent damage to a developing fetus.

2. FAS is one of the most common causes of mental retardation, and is the only cause that is entirely preventable.

3. According to recent State of Alaska DHSS surveillance data, more than 126 children are born at risk for FASD each year in Alaska.

4. Prenatal exposure to alcohol can cause brain damage and other permanent birth defects.

5. Obtaining an FAS diagnosis can improve an individual's ability to function in the world, and may reduce secondary disabilities like depression and school failure.

6. FASD is found in all races and all socio-economic groups – wherever women drink alcohol FASD exists.

7. There is no safe level of alcohol consumption during pregnancy.

8. Women should stop drinking prior to trying to conceive – alcohol can cause damage to a developing fetus even before a woman knows she is pregnant.

9. FASD is 100 percent preventable.

10. With the right diagnosis, support and understanding, many individuals with FASD are living happy and full lives.

From State of Alaska, Office of Fetal Alcohol Syndrome FAQ
http://www.hss.state.ak.us/fas/info/faqs.htm

Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2005 Update

Prepared for:

The Advisory Board on Alcoholism and Drug Abuse
Department of Health & Social Services

Prepared by:

Juneau • Anchorage

December 2005

Full report is available online:
http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

Fetal Alcohol Spectrum Disorders

Prenatal exposure to alcohol can cause specific birth defects which may include physical, mental, behavioral, and learning disabilities. Many children with fetal alcohol disorders are not identified until they reach school age or later. Individuals with alcohol-related effects may have difficulties with attention, memory, and problem solving. Heart, liver, and kidney defects are also common, as well as vision and hearing problems.[13] Alcohol-related effects that fall within the broad category of fetal alcohol spectrum disorders (FASD) include:

- fetal alcohol syndrome (FAS),
- partial FAS (PFAS),
- fetal alcohol effects (FAE),
- alcohol-related neurodevelopmental disorder (ARND),
- and other alcohol-related birth defects (ARBD).[14]

[13] National Organization on Fetal Alcohol Syndrome, *What is FAS/FASD?*, www.nofas.org/faqs.aspx?id=9
[14] US Department of Health and Human Services, SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence. *The Language of Fetal Alcohol Spectrum Disorders.*

Full report is available online:
http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

During the past ten years, a number of FAS prevalence rates have been established. Studies by the Centers for Disease Control and Prevention indicate a national rate from 0.2 to 1.5 cases per 1,000 births across various populations.[15] Other studies, including those focusing on specific high-risk populations such as Native Americans, other minorities and families living in poverty have indicated rates from 0.5 to 5.0 per 1,000 live births. Clearly, the data is varied and limited.

In establishing a clear number of infants born each year in the United States with Fetal Alcohol Syndrome, the CDC estimates between 1,000 and 6,000 children will be born with FAS each year - a preventable birth defect and disability.

Beginning in 1997, Alaska was one of five states comprising the CDC's Fetal Alcohol Syndrome Surveillance Network (FASSNet), a program established to provide consistent and comparable FAS prevalence rates. Participating states included Arizona, Colorado, New York, Wisconsin and Alaska (however, FAS rates for Wisconsin are not available). At 1.5 per 1,000 live births, Alaska has a significantly higher rate of children born with FAS than other states in the FASSNet program. In addition, Alaska data showed an estimated FAS prevalence rate of 4.8 per 1,000 live births among Alaska Natives. CDC data indicates FAS prevalence rates ranging from 0.3 per 1,000 in Arizona and Colorado to 0.4 in New York.

CDC estimates that other prenatal alcohol-related conditions, such as ARND and ARBD, occur approximately three times as often as FAS.[16] Within the wider category of FASD (which would include individuals with FAS), the US is estimated to have about 10 cases per 1,000 live births.[17]

Alaska's estimated rate of all births impacted by prenatal alcohol exposure is 16.3 cases per 1,000 births, based on the 1995 to 1999 birth years. While these alcohol-related effects are closely associated with FASD, these rates are not directly comparable to national FASD rates of 10 per 1,000 live births due to differences in diagnoses and reporting at the state and national levels. Based on 16.3 cases per 1,000 and the number of live births from 1995 to 1999, approximately 160 infants are born each year in Alaska with FAS and other effects from maternal alcohol use during pregnancy. Of those, approximately 15 are born with Fetal Alcohol Syndrome (FAS).

FAS vs. FASD

It is important to remember that the information being used to determine the economic costs of care and service delivery to individuals with Fetal Alcohol Syndrome is only a small portion of the overall impact of prenatal exposure to alcohol and the resulting birth defects and disabilities. Beginning in 2000, the State of Alaska began extensive efforts to improve and expand the ability to appropriately diagnose individuals prenatally exposed to alcohol. In 2005, Alaska has a broad and regionally diverse network of diagnostic teams across the state.[18] Data collected from these teams indicate that from July 2000 through March 2005 teams have conducted

[15] *FAS: Guidelines for Referral and Diagnosis*, CDC, 2004.
[16] CDC, *Tracking Fetal Alcohol Syndrome*, www.cdc.gov/ncbddd/fas/fassurv.htm
[17] National Organization on Fetal Alcohol Syndrome, *What are the Statistics and Facts about FAS and FASD?*, www.nofas.org/faqs.aspx?id=12
[18] For information on available services go to http://health.hss.state.ak.us/fas/teams/default.htm).

Full report is available online:
http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

755 FASD diagnostic assessments. Of this number, 76 (10.0 percent) were diagnosed with FAS or atypical FAS; 378 (49.9 percent) were diagnosed with Static Encephalopathy; 251 (32.2 percent) were diagnosed with Neurobehavioral Disorder; and 50 (6.6 percent) were found to have no evidence of organic brain damage.

What this data indicates is that the costs associated with all alcohol-related births are much higher than those estimated just for individuals with FAS. And, as noted in the break-through research of Dr. Ann Streissguth in 1996 (Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome [FAS] and Fetal Alcohol Effects [FAE]), individuals with FAE (what is now referred to as FASD) are more likely to develop secondary disabilities and need more services than those with Fetal Alcohol Syndrome and the associated facial dysmorphology. For Alaska and the economic costs associated with all fetal alcohol spectrum disorders, the costs could be as much as 80 percent higher than indicated for FAS alone.

Economic Cost of Fetal Alcohol Syndrome

The cost of caring for and providing appropriate services to a person with FAS can be significant. These costs may include neonatal care for low birth weight to special speech therapy, behavioral management, or residential care for adults with FAS. Lifetime costs for care for children born in 2003 with FAS are estimated below. However, these costs are excluded from the total health care costs for 2003, as the component of that expenditure in 2003 alone cannot be determined.

Methodology

To estimate the economic costs from FAS, the research team first determined the number of live births with FAS in Alaska. The Alaska Department of Health and Social Services has closely monitored incidence of FAS in the state since 1998, as part of a U.S. Centers for Disease Control (CDC) monitoring program called the Fetal Alcohol Syndrome Surveillance Network (FASSNet), the ongoing Alaska FAS Surveillance Project and the Alaska Birth Defects Registry. The development of 13 community-based FASD diagnostic teams across Alaska has also assisted in the collection of data related to both FAS and other alcohol-related disabilities included in the FASD umbrella definition.

The Alaska FAS Surveillance Project data collection system is based on reports to the Alaska Birth Defects Registry, and uses medical chart data points to identify children with FAS or other prenatal alcohol-related conditions. DHSS staff consider the surveillance program to be highly rigorous. Alaska clinicians and case workers use a diagnostic process developed by researchers at the University of Washington Fetal Alcohol Syndrome Diagnostic and Prevention Network. Reporting of birth defects to the state registry is mandated by Alaska law. While Alaska's FAS surveillance system is believed to capture the majority of prenatal alcohol-related cases, it is possible that underreporting could make the incidence rate even higher.

For birth years 1995 to 1999, the incidence rate of FAS in Alaska is 1.5 per 1,000 live births.[19] This was the highest rate of the five states that were involved in developing

[19] *Susan Merrick, FAS Surveillance Project Manager, Alaska Department of Health and Social Services, personal communication, July 2005.*

Full report is available online:
http://www.hss.state.ak.us/abada/pdf/mcdowell_rept2005_091307.pdf

the CDC FASSNet system. (The lowest rate was 0.3 FAS cases per 1,000 births.) However, the incidence of all prenatal alcohol-related conditions, including such conditions as alcohol-related birth defects (ARBD) and alcohol-related neurodevelopmental disorder (ARND), as well as FAS, is 16.3 per 1,000 live births. This incidence rate is assumed to be consistent in birth year 2003.

To estimate FAS costs in Alaska, the research team relied on data published in Health Professions Education Partnership Act of 1998 (Senate Bill 1754). The cost of treating an individual with FAS over his or her lifetime was estimated to be at least $1.4 million in 1995. These costs could include neonatal intensive care, medical and surgical services (not related to neonatal care), special speech therapy, behavioral management, and residential care. Medical and surgical service might include rectifying or monitoring hearing loss or cleft palate surgery. Residential services include special education, home care, speech therapy or institutional care. The 1995 data was adjusted for inflation using the Bureau of Labor Statistics Consumer Price Index for medical care. Additionally, costs of providing care were adjusted by the Alaska differential for cost of living (65 percent in 2003). The resulting total lifetime costs (in 2003 dollars) for providing services to an individual with FAS are estimated at $3.1 million.

The total cost for providing services to an individual with FAS born in Alaska during 2003 was estimated by multiplying the lifetime costs by the number of FAS births during that period.

Results

Table 18 presents estimated costs for FAS births in Alaska during 2003. During that period, Alaska had about 15 FAS births. Total economic costs resulting from services to all individuals with FAS in Alaska totaled approximately $47.0 million.

Table 18
Lifetime Costs of Medical and Residential Services for Children Born with FAS in 2003

	Incidence and Costs
Alaska births in 2003	10,084
FAS incidence per 1,000 live births	1.5
FAS births	15
Lifetime FAS cost	**$47,037,000**

Source: Birth data from the Alaska Bureau of Vital Statistics. McDowell Group, based on FAS data from Alaska Department of Health and Social Services; and Health Professions Education Partnership Act of 1998, S. 1754, 108d Congress (1998).

HB

15

<TARGET><BILL>HB 15</BILL><SUBJECT>HB
15</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

Mike Doogan
Representative
District 25, Anchorage

SPONSOR STATEMENT

HB 15

An Act relating to prevention and evaluation of and liability for traumatic brain injuries in student athletes

More than 60,000 high school student athletes sustain concussions each year. The number is much greater when you include middle school and younger children. The National Football League has recently begun focusing on concussions and brain trauma, raising public awareness of this serious problem, and many states are now moving to add protections for students who participate in sports or other potentially dangerous activities. While concussions and brain trauma are more prevalent in football, many other sports and activities are also dangerous, with girls' soccer resulting in the second-most concussions.

A concussion results from the brain striking the inside of the skull, and can be caused by a blow to the head, or by violent motion of the head. Though the risk can be somewhat reduced with a helmet, it cannot be prevented with external equipment. While it is nearly impossible to completely prevent an initial concussion or brain trauma, this legislation seeks to minimize complications and more permanent conditions that can be caused when athletes continue to practice or play after receiving a concussion.

HB 15 is modeled after legislation that recently passed in Washington State, known as the Zackery Lystedt Law. Zackery was a middle-school football player who was returned to a game after suffering a concussion. He sat out for about 15 minutes, and then returned to the game, forcing a game-saving fumble, but suffering a further head injury on the play. The second injury caused a brain hemorrhage that ultimately lead to the removal of both sides of Zackery's cranium, leaving him drifting in and out of a coma for three months. He has battled his way back to some sense of normalcy, but will never fully recover from this avoidable injury.

HB 15 simply requires school districts, in consultation with the Alaska School Activities Association, to develop and publish guidelines and information to educate coaches, student athletes and parents about the nature and risks of concussions and traumatic brain injuries. The bill will require that a student athlete suspected of suffering a concussion or brain trauma be removed from practice or play, and not be allowed to return until cleared by a licensed health care professional.

While there is no way to completely prevent concussions or traumatic brain injuries, we can strive to prevent the serious complications and potentially life-altering or life-threatening ramifications that can occur from continuing to practice or compete once a brain injury has occurred. This is a critical public health issue, and a responsibility to our children we should take seriously.

State Capitol
Juneau, AK 99801
907-465-4998 or 800-689-4998
Fax 907-465-4419

716 West 4th Avenue
Anchorage, AK 99501
907-269-0216
Fax 907-269-0218

Rep.Mike.Doogan@legis.state.ak.us

The bill as drafted applies these principles to school-based youth sports. While this is vital, we encourage you to consider amending the legislation to include other youth sports leagues as well. All young athletes deserve the protections offered in this bill.

The youth concussion bill provides better protection for Alaska's youth athletes by mandating a more formal, aggressive and uniform approach to the treatment of concussions. We applaud you and offer our assistance in aiding the passage of this bill.

Parents, coaches, teachers and school personnel will benefit from this measure. And, most importantly, our youth athletes will as well.

Sincerely,

Jeff Miller
Senior Vice President

SECTIONAL ANALYSIS

HB 15

An Act relating to prevention and evaluation of and liability for traumatic brain injuries in student athletes.

Section 1: Adds a new section to the uncodified law of the State of Alaska that will explain statistics, risks and challenges related to youth-related concussions, including:

(1) Concussions rank high in reported brain trauma injuries to children participating in sports and recreational activities.
(2) The CDC estimates nearly 4 million sports- and rec-related concussions in the US every year.
(3) Provides the definition of a concussion and some of the consequences of concussions – the effects may or may not include loss of consciousness; disruption of normal brain function.
(4) Explains how concussions may occur during organized or unorganized sports and rec. activities – such as through a fall or from a collision with another player.
(5) Explains that the risks of catastrophic injury or death from head injuries increase without proper evaluation and management, and if the athlete is allowed to continue participating following the concussion.
(6) Explains that, in spite of nationwide guidelines recommending individual assessment and gradual return to play following concussions, athletes continue to be returned to play prematurely – increasing risk of greater injury.

Section 2: Amends AS 14.30 by adding new sections to article 3 that would establish requirements for school district governing bodies relating to prevention and reporting. It also clarifies points of liability and damages (more details below, if needed):

Sec. 14.30.142. Concussions in student athletes: prevention and reporting.

(a) Requires school district governing body to consult with Alaska School Activities Association to develop and publish guidelines, etc. to educate coaches, student athletes and parents about the nature and risks of concussions.
(b) A student suspected of having a concussion or traumatic brain injury is immediately removed from the practice or game.
(c) Before returning to play or practice, the student must be cleared by a licensed health care provider who has received training in evaluating and managing traumatic brain injuries, including concussions.
(d) This provision explains that an evaluator may not be held liable for civil damages, except where he/she acted recklessly or with intentional misconduct or gross negligence.

Sec. 14.30.143. Concussions: school district immunity.

(a) Explains that a school district may not be held liable for injury or death resulting from the action or inaction of an employee or contractor with a non-profit youth organization if –

(1) the action/inaction occurred on school property during the delivery of services by the district or organization;

(2) the organization is under contract with the district to provide the services, and

(3) before the provision of services, the organization provided to the district written verification of –

(A) a valid insurance policy covering the injury or death in an amount not less than $50,000 per person and $100,000 per incident;

(B) compliance with the protocol for prevention and reporting of traumatic brain injury required in AS 14.30.142.

(b) This section may not be construed to impair or modify a person's ability to recover damages for harm due to negligent or reckless actions of a school or district employee or contractor or by the existence of a condition, equipment, program or structure known by the school district or organization to be unsafe.

(c) "Youth organization" means a public or private entity, qualified to do business in the state, that provides a program or service to persons under 19 years old.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 15(EDC)
(H) Publish Date: 3/31/11

Identifier (file name): HB15-EED-TLS-3-11-11
Title: "An Act relating to prevention and evaluation of and liability for traumatic brain injuries to student athletes."
Sponsor: Reps. Doogan, Kerttula, Johnson, Munoz & Gruenberg
Requester: (H)EDC

Dept. Affected: EED
Appropriation: Teaching & Learning Support
Allocation: Student & School Achievement
OMB Component Number: 2796

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost _____

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Prepared by: Cynthia Curran , Director
Phone: 465-2851
Division: Teaching & Learning Support
Date/Time: 3/11/11 2:55 PM
Approved by: Mike Hanley
Commissioner
Date: 3/11/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE #1

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. CSHB 15(EDC)

Analysis

This legislation has no fiscal impact on the Department of Education and Early Development.

Youth Concussion Education, Awareness and Advocacy

AMERICAN COLLEGE of SPORTS MEDICINE

USA Football — Football's National Governing Body

NFL

BRAIN INJURY ASSOCIATION OF WASHINGTON

Table of Contents

Introductory Letter

Frequently Asked Questions about Concussion-Prevention Laws

Zackery Lystedt Law
- Washington State Law
- Washington State Concussion Information Sheet
- Letter from Governor Gregoire to NFL Commissioner Goodell

CDC *Heads Up: Concussion in Youth Sports* Materials
- Training Course
- Fact Sheet for Parents
- Fact Sheet for Athletes
- Concussion: A Must Read for Young Athletes Poster

USA Football Materials

National Athletic Trainers' Association Press Release

Contacts

CERTIFICATION OF ENROLLMENT

ENGROSSED HOUSE BILL 1824

Chapter 475, Laws of 2009

61st Legislature
2009 Regular Session

YOUTH SPORTS--HEAD INJURY POLICIES

EFFECTIVE DATE: 07/26/09

Passed by the House April 20, 2009
Yeas 98 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 2, 2009
Yeas 45 Nays 0

BRAD OWEN

President of the Senate

Approved May 14, 2009, 11:24 a.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED HOUSE BILL 1824** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

May 18, 2009

Secretary of State
State of Washington

ENGROSSED HOUSE BILL 1824

AS AMENDED BY THE SENATE

Passed Legislature - 2009 Regular Session

State of Washington 61st Legislature 2009 Regular Session

By Representatives Rodne, Quall, Anderson, Liias, Walsh, Pettigrew, Priest, Simpson, Kessler, Rolfes, Johnson, Sullivan, and Morrell

Read first time 01/30/09. Referred to Committee on Education.

AN ACT Relating to requiring the adoption of policies for the management of concussion and head injury in youth sports; amending RCW 4.24.660; and adding a new section to chapter 28A.600 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 4.24.660 and 1999 c 316 s 3 are each amended to read as follows:

(1) A school district shall not be liable for an injury to or the death of a person due to action or inaction of persons employed by, or under contract with, a youth program if:

(a) The action or inaction takes place on school property and during the delivery of services of the youth program;

(b) The private nonprofit group provides proof of being insured, under an accident and liability policy issued by an insurance company authorized to do business in this state, that covers any injury or damage arising from delivery of its services. Coverage for a policy meeting the requirements of this section must be at least fifty thousand dollars due to bodily injury or death of one person, or at least one hundred thousand dollars due to bodily injury or death of two or more persons in any incident. The private nonprofit shall also

provide a statement of compliance with the policies for the management of concussion and head injury in youth sports as set forth in section 2 of this act; and

(c) The group provides proof of such insurance before the first use of the school facilities. The immunity granted shall last only as long as the insurance remains in effect.

(2) Immunity under this section does not apply to any school district before January 1, 2000.

(3) As used in this section, "youth programs" means any program or service, offered by a private nonprofit group, that is operated primarily to provide persons under the age of eighteen with opportunities to participate in services or programs.

(4) This section does not impair or change the ability of any person to recover damages for harm done by: (a) Any contractor or employee of a school district acting in his or her capacity as a contractor or employee; or (b) the existence of unsafe facilities or structures or programs of any school district.

NEW SECTION. **Sec. 2.** A new section is added to chapter 28A.600 RCW to read as follows:

(1)(a) Concussions are one of the most commonly reported injuries in children and adolescents who participate in sports and recreational activities. The centers for disease control and prevention estimates that as many as three million nine hundred thousand sports-related and recreation-related concussions occur in the United States each year. A concussion is caused by a blow or motion to the head or body that causes the brain to move rapidly inside the skull. The risk of catastrophic injuries or death are significant when a concussion or head injury is not properly evaluated and managed.

(b) Concussions are a type of brain injury that can range from mild to severe and can disrupt the way the brain normally works. Concussions can occur in any organized or unorganized sport or recreational activity and can result from a fall or from players colliding with each other, the ground, or with obstacles. Concussions occur with or without loss of consciousness, but the vast majority occurs without loss of consciousness.

(c) Continuing to play with a concussion or symptoms of head injury leaves the young athlete especially vulnerable to greater injury and

even death. The legislature recognizes that, despite having generally recognized return to play standards for concussion and head injury, some affected youth athletes are prematurely returned to play resulting in actual or potential physical injury or death to youth athletes in the state of Washington.

(2) Each school district's board of directors shall work in concert with the Washington interscholastic activities association to develop the guidelines and other pertinent information and forms to inform and educate coaches, youth athletes, and their parents and/or guardians of the nature and risk of concussion and head injury including continuing to play after concussion or head injury. On a yearly basis, a concussion and head injury information sheet shall be signed and returned by the youth athlete and the athlete's parent and/or guardian prior to the youth athlete's initiating practice or competition.

(3) A youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time.

(4) A youth athlete who has been removed from play may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives written clearance to return to play from that health care provider. The health care provider may be a volunteer. A volunteer who authorizes a youth athlete to return to play is not liable for civil damages resulting from any act or omission in the rendering of such care, other than acts or omissions constituting gross negligence or willful or wanton misconduct.

(5) This section may be known and cited as the Zackery Lystedt law.

Passed by the House April 20, 2009.
Passed by the Senate April 2, 2009.
Approved by the Governor May 14, 2009.
Filed in Office of Secretary of State May 18, 2009.

(INSERT SCHOOL/ORGANIZATION NAME HERE)
Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
• Headaches • "Pressure in head" • Nausea or vomiting • Neck pain • Balance problems or dizziness • Blurred, double, or fuzzy vision • Sensitivity to light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns	• Amnesia • "Don't feel right" • Fatigue or low energy • Sadness • Nervousness or anxiety • Irritability • More emotional • Confusion • Concentration or memory problems (forgetting game plays) • Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
• Appears dazed • Vacant facial expression • Confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or displays incoordination • Answers questions slowly • Slurred speech • Shows behavior or personality changes • Can't recall events prior to hit • Can't recall events after hit • Seizures or convulsions • Any change in typical behavior or personality • Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 6/15/2009

(INSERT SCHOOL/ORGANIZATION NAME HERE)

Concussion Information Sheet

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new "Zackery Lystedt Law" in Washington now requires the consistent and uniform implementation of long and well-established return-to-play concussion guidelines that have been recommended for several years:

> "a youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time"
>
> and
>
> "...may not return to play until the athlete is evaluated by a licensed heath care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

_____	_____	_____
Student-athlete Name Printed	Student-athlete Signature	Date
_____	_____	_____
Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 6/15/2009

CHRISTINE O. GREGOIRE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • www.governor.wa.gov

December 8, 2010

Roger Goodell, Commissioner
National Football League
280 Park Avenue, Floor 12W
New York, NY 10017-1206

Dear Commissioner Goodell:

From the time I was first approached to support a law to protect youth athletes from the risks of concussions, I have focused on, and learned much about, this important issue. We all share the desire to protect our children from serious, yet preventable, health risks. This is why I am pleased to share Washington State's experience with the Zackery Lystedt Law.

I feel it is my responsibility to protect the health and safety of our young athletes while carefully limiting the cost to Washington State taxpayers. Our state, like many others in our country, is facing significant budget challenges, so any new expenditures have to be carefully scrutinized.

I am thrilled to report that the Zackery Lystedt Law is working. We are seeing a decrease in concussions and other head injuries in our student athlete population. I believe the adoption of this important legislation has saved our state money in emergency medical care, rehabilitation, and other services children need when they suffer the consequences of untreated brain injuries. In addition, school districts have not been required to hire medical professionals or trainers, and no additional significant investments were needed to comply with this law.

Thank you for your leadership in working to have a version of the Zackery Lystedt Law adopted around the country. Please feel free to share this with other states as you work to keep our country's children active and safe.

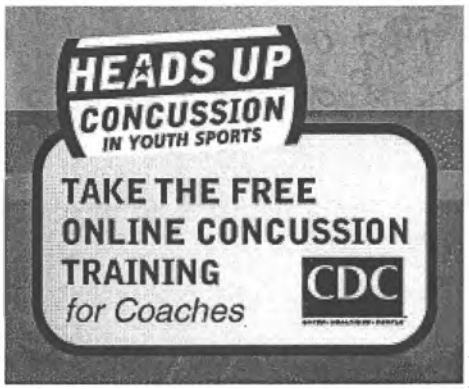
Sincerely,

Chris

Christine O. Gregoire
Governor

Happy holidays!

Centers for Disease Control and Prevention
Your Online Source for Credible Health Information



Heads Up Online Training Course

Heads Up: Concussion in Youth Sports is a free, online course available to coaches, parents, and others helping to keep athletes safe from concussion. It features interviews with leading experts, dynamic graphics and interactive exercises, and compelling storytelling to help you recognize a concussion and know how to respond if you think that your athlete might have a concussion.

What You Will Learn

This course will help you:

- Understand a concussion and the potential consequences of this injury,
- Recognize concussion signs and symptoms and how to respond,
- Learn about steps for returning to activity (play and school) after a concussion, and
- Focus on prevention and preparedness to help keep athletes safe season-to-season.

You can help make your league and school sports safer and healthier for all athletes. Learn when to make the call to pull an athlete off the field, ice, court, or track, and work with athletes, parents, and league and school officials to implement a concussion action plan and prevention strategies.

Course Highlights

Concussion Basics

- Understand concussion and what happens to the brain,
- Discover what causes a concussion, and
- Learn the potential consequences of concussion.

Recognize and Respond to a Suspected Concussion

- Focus on what to look for and when to pull athletes out of play,
- Watch for danger signs and seeking immediate medical attention, and
- Learn the four-step, "Heads Up" action plan when a concussion is suspected.

Helping Athletes Get Back to Play and to School

- Characterize the gradual steps for returning to activity (play and school), and
- Review a concussion preparedness checklist to guide you through pre-, mid-, and post-seasons.

Resource Center

- Access additional concussion information, videos, presentations by leading experts, fact sheets, communication strategies for talking with parents and athletes, and other tools.

Click here to take the training

Follow us on Facebook and learn more about concussion: www.cdc.gov/Concussion.

Page last reviewed: August 24, 2010
Page last updated: August 24, 2010
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day - cdcinfo@cdc.gov

USA.gov Government Made Easy

HEADS·UP CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports ***one or more*** symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed by Parents or Guardians	Symptoms Reported by Athlete
• Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness *(even briefly)* • Shows mood, behavior, or personality changes • Can't recall events *prior* to hit or fall • Can't recall events *after* hit or fall	• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first—usually within a short period of time (hours, days, or weeks)—can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine."
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

If you think your teen has a concussion:
Don't assess it yourself. Take him/her out of play. Seek the advice of a health care professional.

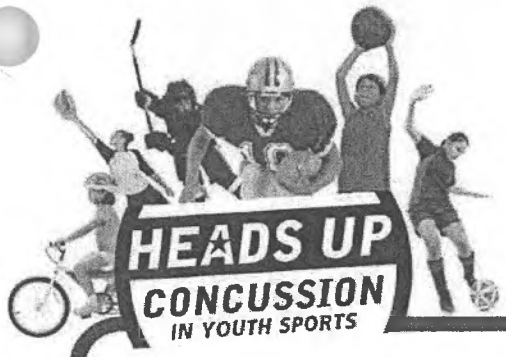
It's better to miss one game than the whole season.

For more information and to order additional materials ***free-of-charge***, visit: **www.cdc.gov/Concussion**.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

June 2010

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



A Fact Sheet for **ATHLETES**

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practices or games in any sport
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged"

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.
- **Get a medical check up.** A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

HOW CAN I PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be:
  - > The right equipment for the game, position, or activity
  - > Worn correctly and fit well
  - > Used every time you play

July 2007

It's better to miss one game than the whole season.

For more information and to order additional materials free-of-charge, visit:
www.cdc.gov/ConcussionInYouthSports

For more detailed information on concussion and traumatic brain injury, visit:
www.cdc.gov/injury

CONCUSSION

A Must Read for Young Athletes | Let's Take Brain Injuries Out of Play

CONCUSSION FACTS

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a blow to the head or body:
  - from contact with another player, hitting a hard surface such as the ground, ice, or court, or
  - being hit by a piece of equipment such as a lacrosse stick, hockey puck, or field hockey ball.
- A concussion can happen even if you haven't been knocked unconscious.
- If you think you have a concussion, you should not return to play on the day of the injury and until a health care professional says you are OK to return to play.

CONCUSSION SYMPTOMS

- Concussion symptoms differ with each person and with each injury, and may not be noticeable for hours or days. Common symptoms include:
  - Headache
  - Confusion
  - Difficulty remembering or paying attention
  - Balance problems or dizziness
  - Feeling sluggish, hazy, foggy, or groggy
  - Feeling irritable, more emotional, or "down"
  - Nausea or vomiting
  - Bothered by light or noise
  - Double or blurry vision
  - Slowed reaction time
  - Sleep problems
  - Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

WHY SHOULD I REPORT MY SYMPTOMS?

- Unlike with some other injuries, playing or practicing with concussion symptoms is dangerous and can lead to a longer recovery and a delay in your return to play.
- While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and the likelihood of long term problems.
- In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to your brain. They can even be fatal.

*For more information about concussion and other types of traumatic brain injuries, go to

www.cdc.gov/Concussion

A part of CDC's Heads Up series

What Should I Do if I Think I Have a Concussion?

DON'T HIDE IT, REPORT IT. Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.

GET CHECKED OUT. Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

TAKE CARE OF YOUR BRAIN. A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

All concussions are serious. *Don't hide it, report it. Take time to recover.*

It's better to miss one game than the whole season.

USA Football serves as the sport's national governing body on youth and amateur levels. An independent non-profit based in downtown Indianapolis, USA Football leads the game's development, inspires participation and ensures a positive experience for all youth and amateur players. USA Football was endowed by the NFL Youth Football Fund in 2002.

Working in partnership with the Centers for Disease Control and Prevention since 2007 as well as other credentialed medical organizations and doctors regarding player health and safety, USA Football stands among leaders in youth sports concussion education, particularly in youth football. The organization has built the first football-specific online youth football coaching course that includes chapters and comprehension quizzes encompassing concussion education and management, heat and hydration preparedness and equipment fitting guidelines. USA Football's members – youth football coaches, players, league commissioners and game officials – reside in all 50 states.

USA Football partners with collegiate athletic conferences, the NFL and its teams to promote concussion education through its 80-plus annual football training events and national campaigns. Dozens of articles, downloadable online resources and video promoting concussion education and management reside at usafootball.com and are available at no cost. Approximately 1 million visitors reach usafootball.com annually.

What Youth Football Coaches Should Know About Concussions

By Michael D. Goodlett, M.D., Lawrence J. Lemak, M.D.
March 11, 2009, revised December 28, 2009

Recognize the signs and symptoms of a concussion to ensure your players' safety. An easy rule of thumb to follow is when in doubt, sit them out.

WHAT COACHES SHOULD KNOW

Knowing the signs and symptoms of a concussion will help a youth football coach feel more comfortable and be more prepared in case of an emergency.

*A concussion is any change in an athlete's behavior, awareness, and/or physical feelings caused by a direct or indirect blow to the head.

*Any concussion has the potential to be a serious injury.

*Before letting an athlete go back to play, a concussion should be evaluated by a doctor.

*An athlete should never return to play while exhibiting any signs or symptoms of a concussion either at rest or with exertion. When in doubt, sit them out!

*There is an increased risk of suffering subsequent concussions after a first concussion.

*Any head injury associated with loss of consciousness must be treated as a suspected head, neck, or back injury.

*The only instances in which an athlete's helmet and shoulder pads should be removed is when a medical authority believes that it is necessary for the care of the athlete, or if the equipment interferes with the rescuers' ability to provide required CPR.

*If necessary to provide care for life-threatening conditions, it is recommended that the facemask be removed rather than the whole helmet. A tool to remove the facemask should be in the first aid kit.

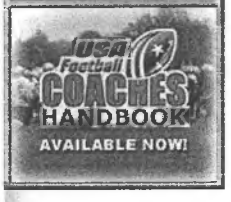
*For any head injury, activate the Emergency Action Plan and follow the emergency action steps, Check-Call-Care.

When a player is hit, he may receive a blow to the head and become unconscious or demonstrate changes in behavior. If the player regains consciousness, seems to be alert and oriented, and is eager to play, a coach may feel the player is fully recovered and allow him back into the game or practice. However, the player has suffered a concussion. Failure to recognize a concussion can potentially lead to coma and death particularly if a second impact occurs. Coaches need to be aware of the signs of concussions and treat the situation properly.

Concussions are caused by a force being transmitted to the head. The force may be caused by any direct or indirect hit to the head or body and can cause changes in behavior, awareness, or physical feeling in the injured person. Concussions often go unrecognized by coaches because they are underreported by athletes who want to continue competing. Athletes often will minimize or deny symptoms. Maintaining a high level of suspicion and having some knowledge of the individual athlete's personality helps coaches in early detection of the signals of concussion. This awareness can prevent additional concussive injury, potential long-term brain damage, or other possible catastrophic outcomes.

On-The-Field Evaluations
If there is a forceful blow to the head, with or without loss of consciousness, the coach should suspect a head injury and also be concerned that the neck or back has been injured. When caring for the player on the field, tell him not to nod or shake his head during the assessment, but to say yes or no. The player's helmet should also be left in place. The goal is to minimize movement. If the head impact has caused the player to become unconscious or show the signs of concussion listed below, activate the Emergency Action Plan and follow the emergency action steps, **Check-Call-Care**. **Check** the scene for safety and check the ill or injured athlete, **Call** 9-1-1 or the local emergency number when needed, and

MEMBERSHIP
Username email address
Password
Remember Me Log In
Join now! Forgot password?



Care for the injured player until EMS personnel arrive.

To Care For Serious Injuries To The Head, Neck, And Back
Follow basic precautions to prevent disease transmission.

Minimize movement of the player's head, neck, and back by putting your hands on both sides of the player's helmet or head. Maintain an open airway using a jaw-thrust maneuver. Have the player remain in the position that you found him until EMS personnel arrive and take over.

Monitor the player's airway, breathing, and circulation.

If life-threatening symptoms are present, it is recommended that the facemask of the athlete's helmet be removed, rather than removing the entire helmet. This will allow access to an airway should the athlete stop breathing.

A tool for removing the facemask should be in the team's first aid kit.

The coach should evaluate the symptoms listed below if he suspects a player may have a concussion requiring immediate care.

The only instance in which an athlete's helmet and shoulder pads should be removed is when a medical authority believes that it is necessary for the care of the athlete, or if the equipment interferes with the rescuers' ability to provide CPR.

Symptoms that require immediate activation of the Emergency Action Plan and immediate removal to a medical facility are:

- *Period of unconsciousness;
- *Confusion, disorientation to time and place;
- *Severe headache or vomiting;
- *Appears sleepy, pale, and is sweating;
- *Blurred vision, slurred speech, and muscle weakness;
- *Neck pain.

Checking For Concussion
If the player is removed from the field after receiving a head impact, it is important to continue evaluating the player every five minutes for at least 30 minutes.

Look at the facial expression of the athlete.

- *Does the athlete have a vacant stare or a confused facial expression?

Check the athlete's behavior.

- *Is the athlete easily distracted or slow to answer questions or follow directions?
- *Does the athlete display unusual emotional reactions, such as *crying or laughing?
- *Does the athlete have a headache or complain of nausea?
- *Is the athlete irritable and easily frustrated?
- *Does the athlete appear unusually anxious or depressed?
- *Does the athlete appear sleepy?
- *Does the athlete have significantly decreased playing ability from earlier in the contest?

Check the athlete's orientation and memory.

- *Is the athlete aware of the time of day and date?
- *Is the athlete generally confused? Questions to ask
- *Which quarter or period is it?
- *Where are we? Which field or arena?
- *Which team are we playing?
- *Which side scored the last points?
- *Which team did the athlete play in the last game?
- *Did the athlete's team win or lose in the last game?

Check for posttraumatic amnesia (the athlete's ability to remember events after the injury).

- *Ask the athlete how he got injured?
- *Ask the athlete the first thing he remembers after the injury?
- *Ask the last thing the athlete remembers before the injury?

Medical attention is required if the athlete's expression, behavior, or memory is affected. Attention should be immediate if symptoms show a deteriorating situation. When an athlete has had a concussion, he should not be allowed to return to the current game or practice, and should not be left alone. Medical evaluation following the concussion is required before a return to participation is permitted.

Postconcussion syndrome
After a player is removed from the field, he may develop symptoms of postconcussion syndrome. This can occur immediately after the injury or many hours or days later. Symptoms of postconcussion syndrome include:

- *Blurred vision
- *Fatigue
- *Ringing in the ears
- *Trouble falling asleep
- *Dizziness

- *Sleeping more or less than usual
- *Headache
- *Increased sensitivity to light and noise
- *Nausea and vomiting
- *Feeling more emotional than normal
- *Poor coordination or balance
- *Difficulty concentrating
- *Increased irritability
- *Difficulty remembering
- *Slurred speech
- *Feeling dazed or stunned
- *Seeing stars or flashing lights
- *Having double vision.

A physician may conduct neuropsychological testing or neuroimaging to assess exactly when the athlete has recovered from a concussion. No athlete should go back to play before being free of all symptoms and signs, both at rest and during exertion, and a physician has indicated the player is ready to return to competition.

Official Youth Football Development Partners

Newsletter | **Youth Football Directory** | **Press Box** | **Partners** | **Contact** | **RSS**
© 2010 USA Football, Inc. All rights reserved. **Terms** | **Privacy Policy**
Designed by **HeadRush Creative** | Powered by **Orases** technology

Email to friend Print

HEALTH & SAFETY

Concussion Awareness

CDC, NFL unite national governing bodies of sport to teach young athletes about concussions

By Joe Frollo
October 11, 2010, revised October 28, 2010

Free poster available for download and distribution to all youth leagues

The Centers for Disease Control and Prevention (CDC), the NFL and 14 national governing bodies of sport, including USA Football, are promoting a free poster designed to increase concussion awareness among young athletes, parents and coaches.

Players, coaches and parents can better recognize concussion symptoms thanks to a poster being distributed by the Centers for Disease Control and Prevention, NFL, USA Football and other national governing bodies of sport.

The poster, created by the NFL's Head, Neck and Spine Medical Committee, the CDC and the NFL Players Association, is similar to the one displayed in NFL locker rooms but geared toward a younger audience. It stresses the importance of recognizing a concussion, taking time to recover and not returning to play too soon. By walking through the steps to recognize if the athlete - or a teammate - has suffered a concussion, the goal is increased concussion awareness in all sports.

"The NFL understands its obligation to educate and inform parents, teachers, coaches and especially young athletes about the risks of concussions," NFL Commissioner Roger Goodell said. "This poster is one element of the NFL's program to assist in the development and broad dissemination of reliable medical information on concussions, which will give players, parents, coaches and others the information they need."

The poster is available online for download and order at no cost at CDC's website or by calling (800) CDC-INFO. Information on recognizing and reacting to concussions also can be found at usafootball.com and through USA Football's Put Pride Aside For Player Safety program as well as through the following national governing bodies:

USA Football's Certified Coaching Education Program, employed by youth football coaches in all 50 states, includes chapters on concussion awareness and management as well as hydration and proper equipment fitting. Health and safety videos also are available at USA Football's Health and Safety page.

"Having more than one dozen different sports be part of this initiative underscores the point that coaches, athletes and parents across all youth athletics need to be informed about this issue," USA Football Executive Director ScottHallenbeck said.

"USA Football has worked with the CDC on concussion education since 2007, and we will continue to emphasize it while teaching coaches and players proper football fundamentals for fun and safe play."

Links related to this article:

NFL and CDC create poster to educate young atheltes about concussions

More media for this article

MEMBERSHIP
Username email address
Password
Remember Me Log In
Join now! Forgot password?

NEW REVOLUTION SPEED YOUTH
Riddell
USA Football COACH
BECOME A BETTER COACH
SIGN UP TODAY
USA Football COACHES HANDBOOK
AVAILABLE NOW!

HEALTH & SAFETY

Concussion Awareness

Redskins and USA Football Welcome High School Coaches for Concussion Education

By Steve Alic
April 23, 2010, revised April 29, 2010

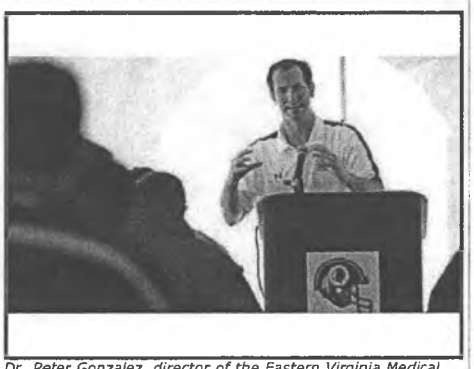
The Washington Redskins and USA Football partnered for the Redskins' inaugural Concussion Awareness and Education Forum on April 17 at Redskins Park.

Redskins Park has a history of preparing football teams for success.

Successful preparation at the football training facility earned a new and vital definition on April 17 when the Washington Redskins and USA Football partnered for the Redskins' inaugural Concussion Awareness and Education Forum for Maryland, Virginia and Washington, D.C. high school head football coaches.

Nearly 200 high school coaches traveled to Redskins Park as guests of the team to watch minicamp practice and participate in a 90-minute concussion education seminar led by USA Football's Peter Gonzalez, M.D.

Dr. Gonzalez is the director of the Eastern Virginia Medical School Sports Concussion Program in Norfolk, Va.



Dr. Peter Gonzalez, director of the Eastern Virginia Medical School Sports Concussion Program, spoke on behalf of USA Football regarding concussion awareness and management to 170 high school head football coaches at Redskins Park. The session was part of a full-day minicamp invitation that the Washington Redskins extended to high school coaches throughout Maryland, Virginia and Washington, D.C. (Photo courtesy of Ned Dishman/Washington Redskins)

Redskins General Manager Bruce Allen opened the day by welcoming the coaches and introduced Dr. Gonzalez. Each coach received a USA Football/CDC concussion awareness clipboard sticker listing concussion signs, symptoms and an action plan. This same material is given to thousands of coaches who attend USA Football's full-day coaching schools across the country. Concussion-related information is available at no cost throughout usafootball.com.

"The coaches asked good questions," Dr. Gonzalez said after the presentation. "The Redskins are to be commended - this was a great discussion and also was the largest group of high school coaches I've spoken to at any one time."

"I came to learn all I can," said Jason Meade, head football coach of Lee-Davis High School in Mechanicsville, Va., a two-hour drive from Redskins Park. Coach Meade enters his eighth season as head coach this fall. "Learning more when it comes to putting our players in a better, safer situation is important to us."

"We can't allow high school athletes who suffer concussions to return to play too soon," Dr. Gonzalez added. "If there's one thing a coach takes away from our session today, it's not allowing an athlete to return to play while still possessing the symptoms of a concussion.

"And if we even suspect someone to have suffered a concussion, there is no same-day return to play."

Concussion awareness and management is an important part of USA Football's online coaching education courses and its 80-plus training events held across the country for players, coaches and youth league commissioners.

USA Football is the official youth football development partner of the NFL, its 32 teams and the NFL Players Association. More than 60 of USA Football's events in 2010 are conducted in partnership with NFL clubs.

MEMBERSHIP
Username email address
Password
Remember Me Log in
Join now! Forgot password?

USA FOOTBALL COACH
BECOME A BETTER COACH
SIGN UP TODAY

GIVE YOUR ATHLETE THE ADVANTAGE THEY NEED TO SUCCEED . . .
GET YOUR ATHLETE TO VELOCITY SPORTS PERFORMANCE.
www.velocitysp.com

For Immediate Release
Tuesday, December 7, 2010

Contact: Jeff Miller
National Football League
(202) 662-5593

Ellen Satlof
National Athletic Trainers' Association
(214) 637-6282 x159

NATIONAL FOOTBALL LEAGUE AND THE NATIONAL ATHLETIC TRAINERS' ASSOCIATION TEAM TO PASS STATE LAWS TO PROTECT YOUTH ATHLETES FROM THE RISKS OF CONCUSSIONS

Washington, D.C., December 7, 2010 – The National Football League and the National Athletic Trainers' Association today announced a joint effort to promote legislation to raise awareness and protect youth athletes from the risks of concussions. The new partnership was announced during the Youth Sports Safety Summit in the nation's capital.

"We are pleased to team with the National Athletic Trainers' Association on a state-based legislative effort to protect youth athletes," said Jeff Miller, the NFL's vice president of government relations. "We will advance a simple, but significant shared goal -- to help prevent concussions and make sports and recreational activities safer for young athletes around the country."

The NFL and NATA have agreed to work together to pass concussion awareness and prevention laws in every state throughout the country. The league and the association will promote laws modeled on the Zackery Lystedt law in Washington State, which contains three key elements: (1) concussion education for young athletes, parents and coaches on an annual basis; (2) immediate removal of a student athlete who appears to have suffered a concussion from play or practice; and (3) mandatory clearance of that student by a health care professional who is trained in the evaluation and management of concussions before returning to play or practice.

Marjorie J. Albohm, MS, ATC, president of the National Athletic Trainers' Association added, "We know from recent cases and studies that far too many youth athletes are either playing with undiagnosed symptoms of concussions or returning to play before fully recovering from them. That's why our organization of trained health care professionals supports legislation in every state that will help coaches, youth athletes, their parents and school officials to recognize and respond appropriately to concussions. Doing so will help prevent injury, chronic impairment and even death."

-more-

The NFL and NATA also have pledged to encourage and enlist the participation of other stakeholders and advocates. Organizations already supporting the adoption of such laws include USA Football, the American College of Sports Medicine and the Brain Injury Association of Washington. To date, nine states have enacted adequate concussion awareness and prevention laws including Washington, Oregon, New Mexico, Virginia, Rhode Island, Massachusetts, Oklahoma, Connecticut and New Jersey.

National Athletic Trainers' Association (NATA) – Health Care for Life & Sport

Athletic trainers are health care professionals who specialize in the prevention, diagnosis, treatment and rehabilitation of injuries and sport-related illnesses. They prevent and treat chronic musculoskeletal injuries from sports, physical and occupational activity, and provide immediate care for acute injuries. Athletic trainers offer a continuum of care that is unparalleled in health care. The National Athletic Trainers' Association represents and supports 32,000 members of the athletic training profession. Visit www.nata.org

# # #

CONTACTS

Jeffrey A. Miller
Senior Vice President
National Football League
202-662-5593
Jeff.Miller@NFL.com

Dr. Stanley A. Herring, M.D.
Chairman
Advocacy and Education Subcommittee
NFL Head, Neck and Spine Committee
206-744-0401
sherring@u.washington.edu

Richard H. Adler
Chairman/President
Brain Injury Association of Washington
206-682-0300
radler@adlergiersch.com

Jim Whitehead
Executive Vice President and CEO
American College of Sports Medicine
317-637-9200
jwhitehead@acsm.org

Scott Hallenbeck
Executive Director
USA Football
317-614-7750
shallenbeck@usafootball.com

Click here to find out more!

Back to Article Click to Print

TIME IN PARTNERSHIP WITH CNN

Thursday, Feb. 03, 2011

Headbanger Nation

By Jeffrey Kluger

I didn't get a good look at the little boy who injured my daughter in the science museum in Mexico City. He seemed to be about 7, my daughter Elisa was not yet 3, and the two of them were part of a scrum of kids playing on an indoor patio. At precisely the wrong moment, she turned left, he turned right, and they collided. Physics being physics, the smaller mass yielded to the larger one, and my daughter fell down. She landed first on her bottom, then tipped backward and hit her head on the floor.

The sound was one that parents dread: the singular clunk of skull striking cement. I winced, Elisa wailed, and I gathered her up. Soon she stopped crying and went off to play, but even as she did, a dangerous process had begun to unfold inside her skull. (Read Dr. Mehmet Oz's column about concussions.)

When Elisa's head hit the floor, the deceleration was sudden, but — physics again — her brain stayed in motion for an instant, moving through the small intracranial space until it collided with the back of the inside of her skull. Concussive energy radiated through the tissue. As it did, channels in the neurons opened wide, allowing calcium ions to flow into the cells, depressing their ability to metabolize energy. Brain tissue began swelling, but with nowhere to go, it squeezed up against the skull wall. Shearing forces tore axons connecting the cells, damaging their myelin sheathing, which can disrupt nerve signals. All of that was the best-case scenario. The worst case was a brain bleed, which could be fatal without immediate surgery.

Within 20 minutes, Elisa grew withdrawn. An hour later, back in our hotel, she vomited and then began thrashing convulsively. We rushed her to a hospital, where doctors struggled to get a line into one of the tiny veins in her arm, shouting at her to stay awake.

"Open your eyes!" I shouted at her in English. "*Abre tus ojitos!*" my wife echoed. Elisa understood both languages; she answered in neither.

Finally, the doctors got her into a CT scanner, then administered an EEG. There was no bleeding, but there was swelling. Elisa spent three days in the hospital taking antiseizure and antiswelling medication and finally was released. On the flight home, she was a terror — but only in the way a toddler is supposed to be. (See a graphic on the physics behind concussions.)

For us, that was a first-time — and, we dearly hoped, last-time — experience, but we're hardly alone in having gone through it. In the U.S., concussions are an alarmingly commonplace injury, particularly among kids and most particularly among active, athletic ones. Up to 3.8 million Americans are getting concussed per year, according to the Centers for Disease Control and Prevention, and even that big a figure is a moving target. In 2005, the number of children who visited emergency rooms for treatment of concussions was more than twice what it had been in 1997, according to a new study in the journal *Pediatrics*. High school football players alone sustain 100,000 full-blown, diagnosed concussions per year. Flying under the radar are injuries mild enough to get passed off by coaches as a mere ding or ignored by players anxious to get back on the field.

According to a study by neuroscientist Kevin Guskiewicz of the University of North Carolina, the average college football player sustains a breathtaking 950 to 1,100 subconcussive blows per season — hits that are enough to do cumulative damage to young brain tissue but not enough to cause immediate symptoms. "There's what we call a dose response," Guskiewicz says. "After a certain number of hits, the damage starts to show."

But while football is responsible for more than half the concussions kids suffer playing team sports, there's a lot more blame to go around. The success of Title IX, which forbids gender discrimination in scholastic athletics, has led to a 900% increase in girls' sports teams since the law's passage in 1972. But guaranteeing girls equal access to sports also guarantees them equal access to injuries. Girls' soccer accounts for nearly 12% of total team-sports concussions, compared with just 6.6% for boys' soccer. Girls' basketball causes 7%. Even volleyball weighs in at 1.1%. (See a special report on women and health.)

What's more, a third of all concussions among kids are caused by nonteam activities such as ice skating, bicycling and playground recreation. Gaining fast too are newer head-cracking activities like snowboarding and extreme skateboarding. Kids may be the first group to fall in love with such sports, but they're the last group — neurologically speaking — that should engage in them.

"The immature brain is still developing," says Julian Bailes, a neurologist at West Virginia University and the medical director for the Pop Warner Youth Football program. "That makes it more susceptible to damage and more likely to suffer repetitive injury." How this shapes overall development is unknown. A child's brain is like a ship en route to somewhere: a concussion can blow it off course.

The severity of the damage — both acute and chronic — is what researchers are now trying to understand and what legislators and the sports-equipment industry are trying to control. Even as scientists look deeper into the physics, neurochemistry and genetics of brain injury, lawmakers are imposing new rules governing how kids should be assessed for concussions and when they should and should not be eligible to play. Equipment manufacturers, particularly those who make football helmets, are being pushed to redesign their product lines and reform the testing standards that essentially allow the industry to police itself. Pro teams too are feeling the heat for selling an elbow-throwing, stick-swinging, head-butting ethos that may be

fine for millionaire athletes who know what they're getting into but is hurting, and in some cases killing, the kids who emulate them.

"I keep telling kids, Your brain is not your knee. It's not your shoulder. It's your future," says neuropsychologist Gerard Gioia, chief of pediatric neuropsychology at Children's National Medical Center in Washington. "We have to protect it better than we are." (See TIME's special report "How to Live 100 Years.")

The Science of a Hit

If it's football that receives most of the attention in conversations about concussions, it's partly because the hits inflicted in the game can be so shocking. In soccer, basketball or even hockey, violence is typically a by-product of aggressive play. In football, it is the play. Guskiewicz conducts his studies by placing accelerometers in players' helmets and recording not just how often they get hit but also how hard. The unit of measure he uses is g-force. Liftoff of a Saturn V moon rocket exposed its crew to a maximum of four g's. A roller coaster may exceed six g's. College football players, by contrast, collide with each other with an impact of nearly 23 g's — and that's the average. Higher-end blows range from 85 to 100 g's. "The highest we ever recorded was 180 g's," says Guskiewicz.

Worse, it's not necessary to be hit in the head for that kind of impact to do concussive damage. A player struck in the chest can suffer whiplash just like a passenger in a car accident, and when the head snaps back and forth, the brain sloshes around with it. "One sign," says Gioia, "is when a player complains of neck pain. That's often an indicator that the head has moved around hard."

Many of those blows don't necessarily lead to a concussion, and in a way, that's unfortunate. Only about 10% of concussions lead to loss of consciousness, but the other signs are hard to miss, including headache, vomiting, dizziness, balance problems, sensitivity to light or noise, confusion, irritability and amnesia. A player with any of those symptoms is likely to be sent to the bench — at least for a while. A player whose brain has been jolted at a subconcussive level is much likelier to stay on the field and return there week after week with no recuperation time. The damage that does can be deadly. (Read Dr. Mehmet Oz's column about concussions.)

In April 2010, University of Pennsylvania football star Owen Thomas committed suicide in his off-campus apartment, having never before exhibited any sign of mental illness. When researchers at Boston University examined his brain, they found it flecked with what are called tau proteins, telltale signs of a condition known as chronic traumatic encephalopathy (CTE), which is often seen among dementia patients and NFL players with a lifetime of concussions behind them. Thomas had never sustained a concussion, but that might not have mattered.

"He'd been playing since he was 9," says neuropsychologist Robert Stern, part of the team that conducted the analysis. "That suggests he had a great deal of exposure to repeated subconcussive blows."

The link between tau and brain damage is straightforward. The protein is one of the major structural materials of nerve tissues. When the brain is shaken too hard, nerve fibers are torn and the tau is released. The brain tries to clean up the mess, and given enough time, it could. If the hits keep coming, however, the proteins just accumulate. "I describe [the tau deposits] as a form of sludge," says Bailes.

It's not unusual for players like Thomas suffering from CTE to die in violent or otherwise dramatic ways. Bailes was part of a team that found tau protein in the brain of Chris Henry, a player for the Cincinnati Bengals who was killed in 2009 when he got into an argument with his fiancée and jumped on the back of her pickup truck as she drove away — taking a fatal tumble onto the road. In 2007 wrestler Chris Benoit murdered his wife and son and then hanged himself. In 2004 former Pittsburgh Steeler Justin Strzelczyk, who suffered from hallucinations, died when he drove his car into a tractor trailer while fleeing police. Both Benoit and Strzelczyk had CTE. "This disease starts young and progresses through life," says Stern.

Until recently, doctors didn't know just how young, but they're getting an idea. Michael (not his real name) is a ninth-grade football player visiting an outpatient concussion clinic Gioia runs in Rockville, Md. Michael got clobbered in a game in mid-September, suffered many of the immediate concussion symptoms and four months later is still not well. Recovery time varies for all patients, though three months is a good benchmark; four months suggests trouble. Michael's sleep remains disturbed, his temper remains erratic, and his school performance has cratered. An honor-roll student in eighth grade, he has gotten mostly D's and F's this year. "The change," says his mother, "it's shocking."

It's not possible to diagnose anything like CTE from just those symptoms, particularly because Michael's recent academic problems began before his concussion. But he already had a history of what he calls stingers, or head blows — none of which kept him off the field. What's more, his coach allowed him to return to play only a month or so after his recent concussion, a game in which he took another blow to the head, then lost his temper and got ejected.

Michael is hardly the only student athlete playing roulette with his brain, and his coach is hardly alone in abetting such recklessness. One study has shown that up to 40% of players who experience a concussion are back on the field before their brains have fully healed. That, Gioia says, is especially worrisome since sometimes two mild injuries can do more damage than one severe one. In some cases — mercifully rare — players who return to the field before they're fully recovered may even suffer what is known as malignant brain edema, or second-impact syndrome, in which another blow to the head leads to a fatal brain bleed. About half a dozen kids per year die from second impact. (Read Dr. Mehmet Oz's column about concussions.)

It's easy enough to make the case that any person who has suffered a brain injury needs a long period of recuperation before returning to vigorous physical activity. But what about vigorous intellectual activity? The brain is a cognitive machine, and it requires an enormous amount of energy to keep its gears moving. That's a fact concussed kids often confront when they resume their classwork after an injury and find that their symptoms return the moment they crack a book. "Cognitive exertion requires a high degree of

metabolic activity," says Gioia. "If you have a brain that's already impaired, that ability is going to be reduced."

Mary, a high school junior and another patient at Gioia's clinic, has suffered three concussions over the past three years as a goalie for her soccer team. Surprisingly, it is not heading the ball that leads to most concussions in soccer — though the limited studies that have been done have looked only at young adults, and none have explored subconcussive injury. Rather, the damage is done mostly by collisions with other players or, as in Mary's case, with equipment. Her third concussion came last November, when she hit her head against the frame of the goal. She remains an honors student in the International Baccalaureate program in her high school, but the struggle to keep up that level of academic excellence has been grueling.

"I didn't have any exams until two months after the injury," she says. "But when I did, the headaches and fatigue came back immediately. I lost focus during one test and had no idea what I'd just written." She got through all the same and has gone back to school full time, but every day is a battle with pain, exhaustion and sensitivity to noise and light. She has also accepted that soccer — which was a passion — is just not an option anymore. "I can't afford another concussion," she says. (See a graphic on the physics behind concussions.)

Digging Deep

The fact that no two concussions follow the same recovery arc is one of the things that makes them so challenging to diagnose and treat. But that same particularity of injury also provides scientists insights into which people are at the greatest concussive risk.

Gender, for one thing, seems to play a role. Mary may be recovering faster from her injury than Michael is, but on the whole, females are both more susceptible to concussions than males are and suffer more-severe symptoms. So far, the reason for that gap is unclear. There is some thought that a girl's comparatively weaker neck muscles may leave her head more susceptible to violent shock. Hormones too may play a role. Among epileptic girls and women, rising and falling estrogen levels are known to make the brain more or less vulnerable to seizures. The thinking is that this may apply to concussion symptoms as well — though it's unclear whether a girl's hormonal makeup leaves her more concussion-prone throughout the month or just during menstruation. (See a special report on women and health.)

Genes may also be involved. The fact is, plenty of athletes make it through their careers battered and scarred but cerebrally intact, while others who may not get hit with any greater frequency suffer all manner of brain damage. Researchers at the Children's National Medical Center are studying the genomes of both concussed and nonconcussed kids, looking for markers that may explain the difference.

"There could be a genetic predisposition that affects metabolic activity," says geneticist Susan Knoblach. "People always assume that there's a genetic component in degenerative conditions but not acute ones, but of course there can be."

Maryland's Fairfax County has instituted a program in which student athletes spit into cups so their genetic profiles can be taken. The genomes of the ones who come down with concussions can then be compared for key similarities. Early attention is focusing on a gene that codes for a protein called ApoE, which has been implicated in Alzheimer's disease. In the long run, teasing out concussion genes could lead to better drugs or gene therapy to treat or prevent the injury. In the short run, it could help parents and coaches determine in advance which sports kids are best suited to play. Says Gioia: "We may actually find out, 'You know what? You're not set up to be a football player. You might be a better tennis player.'"

Newer brain-scanning technology is also making a difference, helping doctors diagnose concussions and track recovery. The microscopic size of tau proteins and nerve fibers makes them impossible to see without a postmortem exam, but three noninvasive techniques can help sidestep that problem. Magnetic resonance spectroscopy measures not direct damage to the brain but its metabolic activity — a good way to evaluate the very system that breaks down first when a brain is concussed. Diffusion tensor imaging can observe transmission along nerve-fiber tracks, providing a sense of the integrity of the neural wiring. And resting fMRI allows physicians to watch the brain when it's not performing a task, providing a look at basic function. (See TIME's special report "How to Live 100 Years.")

Changing the Rules

Smart medicine, of course, can do only so much to reverse the number of concussions. Smart policy must do the rest. To keep kids from hurting themselves — and to prevent coaches from enabling them — 10 states, including New Jersey, Oregon, Virginia and football-mad Oklahoma, have passed return-to-play laws requiring kids who have sustained even a suspected concussion in any sport to be pulled from play and not returned until a doctor or certified athletic trainer declares them fit. A handful of other states are considering similar legislation, and last year two separate bills along the same lines were introduced in the House of Representatives. Both will have to be resubmitted under the new GOP majority. Still, the national trend is clear: "When in doubt, sit them out" is how the advocates put it.

Most major professional sports leagues in the U.S., as well as most large universities and 4,000 high schools, now also use a computer program known as ImPACT (for Immediate Post-Concussion Assessment and Cognitive Testing) that measures such basic skills as memory, word recognition and pattern recognition. Players are required to take a baseline test at the beginning of the season and are periodically retested, especially postconcussion, to determine if there's been any erosion of skills. "I used to sit across from athletes doing paper-and-pencil memory tests," says ImPACT developer Mark Lovell, a neuropsychologist at the University of Pittsburgh Medical Center. "That would never work with large groups of kids. There aren't that many neuropsychologists alive."

Reform is also coming — slowly — to the major manufacturers of football helmets, driven mostly by the NFL, which has imposed much stricter concussion and tackling rules in the past season. The NFL is anxious both to protect its players and to shake its image as a weekly tutorial for student athletes learning all the wrong safety lessons from pros who should know better. Currently, the group that certifies helmets is the National Operating Committee on Standards for Athletic Equipment (NOCSAE), which sounds

reassuringly official except for the fact that it's essentially funded by the manufacturers themselves. NOCSAE has come under fire not only for this seeming conflict of interest but also for what critics consider unreliable testing. The larger problem, though, is that the standard football helmet was designed to prevent only lacerations and fractures — a job it does very well — and to do little or nothing to prevent concussions. "The science just isn't there today," says Dr. Robert Cantu, a neurosurgeon at Boston University and a member of NOCSAE's board. (See a graphic on the physics behind concussions.)

That's not NOCSAE's or the NFL's fault, but they're trying to do something about it. In December the league and the helmet manufacturers convened a sort of head-injury summit in New York — a gathering that also included officials from NASCAR and the military — to consider helmet modifications that could reduce the concussive carnage. For football, those modifications could include better padding, stronger chin straps and redesigned face masks that distribute shock differently. Kids' helmets must also be more than simply smaller versions of those used by adults. The padding inside all helmets is designed to compress at the forces generated by colliding adult bodies. With the smaller forces kids produce, the padding stays rigid, essentially becoming one more hard surface for the head to strike. Innovations introduced in football could ripple out to other sports' playing fields, to say nothing of battlefields.

Athletics will never be stripped of all danger, and terrible as the blown knee or wrecked elbow may be, there is always an assumption of those risks when you elect to play the game. But the brain is more than a joint or a limb. It's the seat of the self. We overlook that fact at our peril and — much worse — at our children's.

Click to Print

Find this article at:
http://www.time.com/time/specials/packages/article/0,28804,2043395_2043506_2043494,00.html

Copyright © 2011 Time Inc. All rights reserved. Reproduction in whole or in part without permission is prohibited.
Privacy Policy | Add TIME Headlines to your Site | Contact Us | Customer Service

Boston University School of Medicine

sportslegacy INSTITUTE

Department of Veterans Affairs

EMBARGOED UNTIL August 18, 2010, 8 a.m. E.T.

Contact: Gina DiGravio, 617-638-8480, **gina.digravio@bmc.org**
Jenny Eriksen, 617-638-6841, **jenny.eriksen@bmc.org**
Kristin Pressly, 781-687-4988, **kristin.pressly@va.gov**

BOSTON UNIVERSITY AND DEPARTMENT OF VETERANS AFFAIRS RESEARCHERS DISCOVER BRAIN TRAUMA IN SPORTS MAY CAUSE A NEW DISEASE THAT MIMICS ALS

Two former NFL players died after being diagnosed with Lou Gehrig's Disease; New findings suggest they had a new disease associated with repetitive brain trauma

(BOSTON) – The Center for the Study of Traumatic Encephalopathy (CSTE) at Boston University School of Medicine (BUSM) and Department of Veterans Affairs (VA) announced today that they have provided the first pathological evidence that repetitive head trauma experienced in collision sports is associated with motor neuron disease, a neurological condition that affects voluntary muscle movements. The most common form of motor neuron disease is amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease. The findings will be published in the September issue of the *Journal of Neuropathology and Experimental Neurology* (**http://journals.lww.com/jneuropath**).

The finding was discovered by Ann McKee, MD, and colleagues at the CSTE. McKee, a CSTE Co-Director, is an associate professor of neurology and pathology at BUSM, as well as Director of Neuropathology for the Department of Veterans Affairs at the Bedford VA Medical Center, where this research was conducted.

McKee and the CSTE researchers made this groundbreaking pathological discovery while examining the brains and spinal cords of 12 athletes donated by family members to the CSTE Brain Bank at the Bedford VA Medical Center. Three of these 12 athletes, including former professional football players Wally Hilgenberg and Eric Scoggins, as well as an unidentified former military veteran and professional boxer, developed motor neuron disease late in their lives. The former football players were diagnosed clinically with ALS, which is a progressive neurodegenerative disease that attacks motor nerve cells in the brain and spinal cord, resulting in muscle weakness and atrophy. ALS affects fewer than two in 100,000 patients annually, and 30,000 Americans currently live with the disease. The majority of ALS cases (90-95 percent) are considered "sporadic," meaning of unknown cause, although it has long been suspected to involve a complex interaction between multiple genetic and environmental risk factors.

In this study, funded in part by an unrestricted gift from the National Football League (NFL) to the CSTE, McKee found that when they died, all 12 athletes showed neuropathological evidence of chronic traumatic encephalopathy (CTE), a progressive degenerative brain disease characterized by deposits of an abnormal form of *tau* protein and believed to be caused by repetitive head trauma. In the three athletes with motor neuron disease, abnormal *tau* protein deposits were not only found throughout the brain, but also in the spinal cord.

CSTE researchers also discovered that 10 of 12 CTE victims had a second abnormal protein, TDP-43, in their brains. Of those 10, only three had TDP-43 in the brain *and* the spinal cord, and those were the three athletes diagnosed with motor neuron disease. TDP-43 is also found in individuals with sporadic ALS although in the athletes with repetitive brain trauma, the TDP-43 pathology was more severe than found in sporadic ALS and was accompanied by extensive *tau* pathology. The brains and spinal cords of normal individuals show no TDP-43 or *tau* deposition.

These new findings suggest that the motor neuron disease that affected the three athletes is similar to, but distinct from sporadic ALS and represents a disease never described previously in the medical literature. This new disease, referred to as chronic traumatic encephalomyopathy (CTEM) by McKee and colleagues is likely caused by the repetitive head trauma experienced by athletes in contact sports.

The association between head trauma and ALS is supported by the medical literature, in which the risk of ALS has been reported to be higher among contact sport athletes and veterans. A study of professional soccer players in Italy found that the incidence rate of ALS was 6.5 times higher than in the general population. An increased incidence of ALS has also been reported in American football players, including three players from the 1964 San Francisco 49ers who died from ALS. Based on the number of retired NFL players with ALS, it is estimated that the risk is at least 8 times higher than in the adult male population. Among Veterans with a history of head injuries, their risk of ALS was 2.3 times higher than normal, and Gulf War Veterans have a twofold increased risk. In fact, since 2008, the US Department of Veterans Affairs has considered ALS as a presumptively compensable illness for all veterans. The discovery of this new ALS-like disease by the BU CSTE investigators suggests that one possible reason for the increased risk of clinically diagnosed ALS in veterans and in contact sport athletes may be the exposure to repetitive head trauma, including concussions, subconcussive blows and blast injuries.

These findings raise the question of whether head injuries may have contributed to Lou Gehrig's motor neuron disease, and whether he also suffered from CTEM. Gehrig, nicknamed the "Iron Horse," played football at Columbia University before becoming a legendary member of the New York Yankees and playing in 2,036 consecutive games, a record that stood for more than 60 years. Gehrig suffered at least five documented concussions and was reported to have been knocked unconscious for five minutes after taking a pitch to the head while not wearing a helmet. He played the next day.

"When we read reports about cases of the disease being linked to specific activities or experiences, such as the increased risk associated with military service, or this one regarding professional athletes, we are reminded of just how complex of a disorder ALS is. We're hopeful that this new work may shed light on potentially exciting new possibilities for biomarker and therapy development," said Steve Perrin, PhD, CEO and Chief Scientific Officer of the ALS Therapy Development Institute.

Responding to these new findings, Hunt Batjer, MD and Richard Ellenbogen, MD, the co-chairmen of the NFL's new Head, Neck and Spine Committee, stated, "We are pleased that the NFL has provided the support necessary for this research and look forward to continued discussion of the findings within our medical committee and with other researchers to better understand their clinical implications."

McKee now has analyzed the brains of more than 35 athletes and found evidence of CTE in 12 of 13 former NFL players. These brains were acquired primarily through the efforts of CSTE co-director Chris Nowinski who is also president of the non-profit Sports Legacy Institute. The CSTE maintains a registry of more than 350 living athletes who have agreed to donate their brain and spinal cord following death and to undergo telephone-based interviews and assessments during life. Robert Stern, PhD, CSTE co-director and an associate professor of neurology at BUSM, oversees the CSTE registry as well as a study about to begin of retired NFL players who undergo extensive neurological, cognitive, psychiatric, cerebrospinal fluid and neuroimaging studies. Robert Cantu, MD, a clinical professor of neurosurgery at BUSM and co-director of the CSTE, was recently appointed senior advisor to the NFL Head, Neck and Spine Committee.

COORDINATES WOULD BE PLACED HERE

****

Wally Hilgenberg died in 2008 at the age of 66 after a three-year battle with ALS. After graduating from the University of Iowa, Mr. Hilgenberg played 12 seasons with the Minnesota Vikings and three with the Detroit Lions as a linebacker.

Eric Scoggins died in 2009 at the age of 49 after a two-year battle with ALS. After graduating from the University of Southern California, he played one season for the San Francisco 49ers before playing two seasons in the United States Football League, for the Los Angeles Express and the Houston Gamblers.

Early symptoms of ALS often include increasing muscle weakness, especially involving the arms and legs, and progressive problems with speech, swallowing and breathing. Because voluntary muscle action is progressively affected, patients in the later stages of the disease may become totally paralyzed. In nearly all cases, ALS is fatal.

The CSTE (**www.bu.edu/cste/**) was founded in 2008 and is the leading center in the world studying the long-term effects of repetitive brain trauma in sports and the military. The CSTE was created as a collaboration between Boston University (BU), Sports Legacy Institute (SLI) and the Department of Veterans Affairs. Co-directors of the BU CSTE include Robert Cantu, MD, a clinical professor of neurosurgery at BUSM, Ann McKee, MD, an associate professor of neurology and pathology at BUSM, Chris Nowinski, and Robert Stern, PhD, an associate professor of neurology at BUSM. The mission of the CSTE is to conduct state-of-the-art research of CTE, including its neuropathology and pathogenesis, the clinical presentation, biomarkers, and course, the genetics and other risk factors for CTE, and ways of preventing and treating this cause of dementia. Brain trauma is increasingly seen as a public health crisis due to the discovery of CTE in a number of recently deceased athletes, most of whom have been studied at the CSTE. McKee also identified CTE in the only former NHL player examined, Reggie Fleming. The CSTE's groundbreaking research created a dramatic change in the understanding of and response to brain trauma and concussions in all sports, especially football. The BU CSTE has received grants from the National Institute on Aging and the National Operating Committee on Standards in Athletic Equipment (NOCSAE), and has received an unrestricted gift from the NFL.

CTE, originally referred to as "dementia pugilistica" because it was believed to only affect boxers, is a progressive brain disease believed to be caused by repetitive trauma to the brain, including concussions and subconcussive blows. It is characterized by deposits of an abnormal protein called *tau* in the form of neurofibrillary tangles, glial tangles, and neuropil threads throughout the brain, and, in some cases, the presence of another abnormal protein – associated with motor neuron disease – known as TDP-43. These abnormal proteins are associated with the impaired functioning and eventual death of brain cells. Early on, CTE sufferers may display symptoms such as memory impairment, emotional instability, erratic behavior, depression and problems with impulse control. CTE may eventually progress to full-blown dementia. Although similar to Alzheimer's disease, CTE is pathologically distinct, and it is the only known preventable cause of dementia.

CSTE co-directors Cantu, McKee and Nowinski serve on the NFL Players Association Mackey/White Traumatic Brain Injury Committee, which includes, and is chaired by, CSTE registry member Sean Morey. In addition, Cantu serves as a senior advisor to the newly created NFL Head, Neck and Spine Committee.

Sports Legacy Institute is a 501(c)(3) nonprofit corporation founded in 2007 to solve the sports concussion crisis. SLI is dedicated to education, prevention, treatment and research on the effects of concussions and other brain injuries in athletes and the military. SLI partnered with Boston University School of Medicine to form the Center for the Study of Traumatic Encephalopathy in 2008.

BRAIN INJURY ASSOCIATION OF WASHINGTON

Journey Toward Understanding: Concussion & Mild Brain Injury

Introduction

Three little monkeys jumping on the bed.
One fell off and bumped his head.
Took him to the doctor and the doctor said,
"That's what you get for jumping on the bed!"

This nursery rhyme tells a story about concussion--the bumps, bangs and shakings to the brain that many adults and children experience. Unfortunately, just like the monkeys jumping on the bed, professionals may not understand concussion well enough to offer support and to help individuals who sustain concussions. People with concussions may just try and "shake it off" and, thus, not be evaluated and treated properly by professionals. It is not uncommon for individuals to be sent home from emergency rooms (ERs) with no follow-up care or to end up with long-term problems that no one understands. This paper will define concussion, present the common symptoms of concussions and discuss ways to help people who sustain concussions.

Each year, it is estimated that approximately 1.5 million people experience concussions. Vehicular crashes (cars, motorcycles, bicycles), sports/recreational activities (football, hockey, playgrounds), abuse/assault (shaken baby syndrome, beatings), falls (young children and the elderly) and other events all have been implicated. It is easy to see that almost any activity can put a person at risk for a concussion. It is a little surprising that people do so well avoiding concussions and equally not surprising that many of us have had concussions.

It is important to note that concussions clearly are associated with lifestyle and parallel other similar lifestyle injuries. If you are involved actively in sports that put your body at risk for muscle pulls, strains, sprains and broken bones, then your chances of a concussion also are great. The Centers for Disease Control and Prevention (CDC) estimates 300,000 sports-related concussions in the United States each year. The more risk to your body, the more risk of serious harm and permanent damage, and the greater the chances that a concussion or more permanent brain injury can occur.

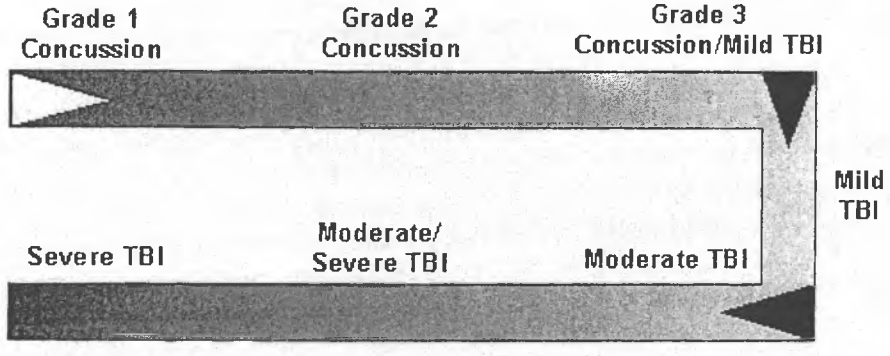
If your job involves heavy labor in farm or construction settings, your chances of physical injury increase and the chances of a concussion increases as well. The use of substances, such as alcohol, that alter your judgment and coordination about everyday activities, like driving or even walking, put you at risk for physical injury and, therefore, at similar risk for a concussion or more serious brain injury. Children--especially younger children--are susceptible to sustaining concussions from falls, play activities and abuse. Lastly, older individuals with balance problems may be prone to falls that can result in not only broken hips, but concussions as well.

What is Concussion?

It is important to understand that a concussion is a physical injury to the brain that causes a disruption of normal functioning just like any other physical injury disrupts your normal functioning. For example, some ankle injuries (i.e., sprains and fractures) are more disruptive

than others, just as some brain injuries are more disruptive than others. The better we understand any injury, the better our chances are for a speedier and healthier recovery.

There is some confusion as to the definition of a concussion and the definition of a mild traumatic brain injury (MTBI). Brain injury can be viewed along a continuum that incorporates concussion, mild brain injury, moderate brain injury and severe brain injury. Each type of brain injury varies depending upon: 1) whether the person was unconscious, 2) how long he/she was unconscious, 3) the length of their amnesia, 4) the resulting cognitive, behavioral and physical problems and 5) the recovery. Viewed as a continuum, the severity of brain injuries can be represented as follows:



As one can see, the definition for a Grade 3 concussion and a MTBI tend to overlap on this continuum.

To further clarify, a concussion is defined as a trauma (i.e., a blow to the head or a serious whiplash) that induces an alteration in mental status (physical or cognitive abilities) that may or may not involve a loss of consciousness.
Concussion as detailed by guidelines developed by the American Academy of Neurology (AAN) and the Brain Injury Association (BIA), commonly is divided into three different types.

Grade 1 Concussion

- Person is confused but remains conscious.
- SIGNS: Temporarily confused, dazed, unable to think clearly, has trouble following directions
- TIME: Symptoms clear within 15 minutes

Grade 2 Concussion

- Person remains conscious, but develops amnesia .
- SIGNS: Similar to Grade 1
- TIME: Symptoms last more than 15 minutes

Grade 3 Concussion

- Person loses consciousness
- SIGNS: Noticeable disruption of brain function exhibited in physical, cognitive and behavioral ways.
- TIME: Unconsciousness for seconds or minutes

It is important to note that a person can sustain a concussion (Grades 1 & 2) without losing consciousness. A Grade 3 concussion involves the loss of consciousness, even if only briefly. As defined by the American Congress of Rehabilitation Medicine, MTBI is a traumatically induced physiological disruption of brain function as manifested by some or all of the following:

- Any period of loss of consciousness
- Any loss of memory for events immediately before or after the incident
- Any alteration in mental state at the time of incident
- Focal neurological deficits that may or may not be transient but does not exceed:
  1. Loss of consciousness of approximately 30 minutes or less
  2. An initial Glasgow Coma Scale score of 13-15 after 30 minutes
  3. Post-traumatic amnesia (PTA) of no more than 24 hours

If concussion and MTBI are seen as part of the brain injury continuum, with Grade 3 concussion and MTBI overlapping, one can get a better understanding of how these definitions compliment each other and enhance our understanding. BIA estimates that approximately 75% of all brain injuries fall in the "concussion-MTBI continuum."

The Functional Mechanics of Concussion

Two mechanisms currently are believed to underlie the changes following concussion. In the first, a sudden movement or direct force applied to the head can set the neural matter of the brain in motion even though the brain is well protected in the skull and very resilient. This motion squeezes, stretches and sometimes tears the neural cells, changing the precise balance and distance the cell's axons and dendrites maintain to transmit or process information.

The second mechanism involves changes that occur in the neuron's ability to produce energy for the cell's vital functions in structures called mitochondria. An initial increase in energy production occurs followed by a dramatic decrease that affects the ability of the cell to produce structural proteins to preserve the diameter of the axon. This change occurs gradually after the time of impact and may be responsible for the delay in symptoms sometimes observed.

The changes that occur affect the electrical or chemical aspects of neural cell functioning and result in unusual processing of normal information. (For this reason, radiologic studies that look at the structure of the brain, such as CT scans and MRI, are most frequently read as normal after concussion/MTBI.) This actually is quite adaptive because the brain cells automatically keep working to reconnect or establish normal impulse transmission. Even the loss of consciousness is adaptive, because the brain shuts down all unnecessary functions until the most important life sustaining neural adjustments are made. Unfortunately, sometimes these neural adjustments cannot be made quickly enough and death can occur.

As a person recovers, the cells re-establish the precise balance needed to ensure effective information processing, but this may mean some compensation or adjustments to the neural cell's original alignments. The more often neural cells must compensate or adjust to injury, the more likely the task takes longer and may not be as complete. For example, when a person sprains or fractures an ankle, professionals recommend cold/heat treatments, rest and supports (i.e., cast, brace) and specific exercises to help the ankle adjust to the injury and recover maximal function. Depending on the severity of the ankle injury (i.e., sprain, fracture) and what is required after recovery (i.e., long distance running, ballet), the severity of the injury to the ankle can disrupt a person's life. Obviously, a human brain is much more complicated than an ankle. Yet similarly, rest, supports (i.e., compensations, modifications) and "exercises" (i.e., therapies, education) for the brain may be recommended to rehabilitate and restore useful

function. Depending on the severity of the concussion and what the person needs to do (i.e., care for a family, return to work or school, manage a large company), a concussion can disrupt a person's life for a short period of time or even longer.

To review, a concussion causes a disruption of normal brain function that may be a temporary inconvenience or result in permanent changes in brain function. Where there are complicating factors, the disturbance in brain function can be fatal. Because of the potential life-threatening danger associated with brain injury, the severity of any brain injury--including concussion--is determined at the time of the injury, based on measures of physical, cognitive and behavioral responsiveness. Again, the three categories commonly used to describe brain injury--mild, moderate and severe--indicate only how seriously impaired the person was at the time of the injury. Thus, on the brain injury scale of severity, a concussion usually is classified as a MTBI because the alterations in brain function are not severe enough or do not last long enough to be classified as moderate or severe brain injury. In the moderate and severe classifications, there appears to be direct damage to the brains neural network with long-term difficulties related to the sites of the damage. The long-term effects of MTBI on brain cell recovery and functioning and behavior vary across individuals. However, for most individuals, no long-term neuronal changes are noted after three to four months and the cognitive and behavioral adjustments return to normal.

Exceptions to this rule exist. Studies indicate that age (i.e., 40 years or older), the presence of a systemic disease (i.e., diabetes mellitus), and possibly female gender affect the recovery process. Other risk factors for delayed recovery include a history of previous brain injury or when situational and personality factors play a role in recovery. For example, individuals who sustain a second concussion while still symptomatic from the first one may sustain what is termed "second impact syndrome." This condition is very serious and can result in lifelong impairments, coma and even death. Individuals who sustain a series of multiple concussions over time (i.e., boxers, abused children) may be left with permanent impairments and disabilities. People who have mental health issues or other disabilities (i.e., attention deficits, learning disabilities) may find that a concussion further complicates their behavioral and learning challenges. Also, even litigation issues may complicate a person's recovery.

The symptoms of concussions cover a wide range of perceptual, sensory, cognitive, emotional and behavioral features. The TABLE below lists the common early and late symptoms of concussion:

Early Symptoms:

- Headache
- Dizziness or vertigo
- Lack of awareness of surroundings
- Nausea with or without memory dysfunction
- Vomiting

Later Symptoms:

- Persistent low grade headache
- Lightheadedness
- Poor attention and concentration
- Excessiveness or easy fatigue
- Intolerance of bright light or difficulty focusing vision
- Intolerance of loud noises
- Ringing in the ears

- Anxiety and depressed mood
- Irritability and low frustration tolerance

As you can see, many of the symptoms listed above are common to a variety of other natural human experiences. Feeling scared or anxious can make our vision change and cause dizzy feelings and numerous "fight or flight" reactions. Muscle cramps in the neck can give headaches, just as not having our usual dose of caffeine causes headaches. A virus can make us feel "spaced-out" and affect our balance. Depression can affect our cognitive abilities and memory. Being angry over changes due to an injury such as a broken arm can make us irritable and affect our motivation. And, as with concussion, if everyone else feels you "should be over it by now," being treated unfairly may cause hopelessness that makes it difficult to concentrate and sleep.

Recovery Variations after Concussion

Concussions vary, depending upon the type and the individual, hence, recovery varies as well. Some commonly asked questions by individuals who sustained concussions include:

Why is there so much variation in symptom presentations? This variation can best be explained because people differ and their perceptual experience of sensations such as pain and distress remains subjective. Without a technology (i.e., more sophisticated CT/MRI scanning technology) to measure these individual experiences, it remains difficult to determine when the brain's coping or healing has taken place and when the individual's reaction to the process has left perceptual and learned phenomena. Thus, we need to monitor the symptoms of concussion in order to monitor recovery. The following checklist can help individuals and their families monitor their recovery one to three months after a concussion so they can report this information to their physician or therapist. Symptoms that persist beyond the usual recovery time for concussion need to be evaluated and treated more carefully.

Physical Symptoms

- Headache, dizziness, lightheadedness
- Vomiting or nausea
- Numbness or tingling
- Balance problems, clumsiness, drops things, trips often
- Fatigue, tires easily, needs extra sleep, drowsiness, trouble falling asleep or staying asleep
- Sensitivity to light and noise
- Blurry vision
- Ringing in ears

Cognitive Symptoms

- Confusion, in a "fog," has befuddled expression, gets mixed up about time and place
- Attention or concentration problems, inability to do more than one thing at a time, unable to return to a task if interrupted
- Memory problems, forgets things
- Takes longer to get things done or complete assignments
- Has problems organizing thoughts or words, misunderstands things

Behavioral Symptoms

- Restless, irritable, fussy
- Acts without thinking

- Becomes upset easily, loses temper
- Sadness, depressed mood
- Anxiety, nervousness

Why some people adjust better after a concussion than others? Research in cognitive-behavioral therapy supports the notion that: 1) looking at the positive aspects of recovery, 2) taking steps to gain control of your rehabilitation and 3) knowing that fundamental healthy behavior requires a focused rehearsed plan all can contribute to dealing better with the many sensations and feelings that often follow concussion. Concussion needs to be taken seriously and modifications to a person's life (i.e., home, work, school) need to be made during the recovery period. Just because a person "looks great" does not mean that they are recovered fully. Having a good plan for recovery and knowledge about concussion helps individuals feel more in control and lessens their anxiety.

Why do concussive symptoms change over time? It now appears that during the first months after concussion the brain begins to heal and evidence suggests that there is little trace of brain damage after three to four months. During this period of time, sleep patterns return to normal, sensations mirror the brains recovery and efforts to return to normal and develop a sense of self are influenced by the rehabilitation process. For example, many strange sensations accompany recovery from a sprained or fractured ankle, including pain from the efforts a person makes to accommodate the recovery time (such as muscle atrophy), as well as sleeping and exercise changes due to limitations. Brain function is much more complex to understand and monitor. Yet, just as an ankle can "return to normal" over time, so can the brain after concussion.

Why can't professionals tell if there is permanent brain injury over time? Without doing an autopsy, brain function can only be estimated. For example, neurological testing can provide information about what a person might be able to do at this point in time, but without the same information from before the concussion, it is only possible to estimate how a concussion affected performance. Many professionals use various tools to help them understand the degree of brain damage (i.e., CAT scans, MRI, neuropsychological batteries, neurolinguistic assessment, functional behavioral analysis), but these tools are only approximations and it is difficult to predict the total impact a brain injury may have on a person's life. The best "predictor" is the person with the injury working with a dedicated team of professionals to identify and compensate for permanent damage.

Is permanent brain damage always bad? This is a trick question because the easy answer is that damage always means a loss of brain cells. Yet, many people can attest that the loss of brain cells does not mean that they themselves are "lost". Rather, many individuals have found the strategies and techniques they have used to cope with brain injury have been helpful in assisting them to become the person they felt they wanted to be all along--happy, loved, productive and important. The experience of coping with a rehabilitation or treatment program has helped them: 1) appreciate their talents, 2) give up bad habits and 3) become more mindful of what they truly wanted out of life. This is not to minimize the tremendous changes brain injury causes for people and their families, but rather to emphasize the importance of good treatment programs and community support to help people re-define their lives.

Treatment Recommendations

The only cure for brain injury is prevention. Obviously, the treatment of concussion starts with prevention. Thoughtful preparation before activities--knowing your limits; minimizing risk to one's head by wearing protective gear such as seat belts, helmets, hard hats; and being

substance free when activities require concentration such as driving, bicycling, swimming, boating and skiing--all will reduce the likelihood of injury. Unfortunately, concussions often are difficult to prevent even with careful preparation and protective gear.

Immediately after a concussion, emergency care may be required. Since life-threatening complications--usually due to brain swelling and bleeding--can occur from any brain injury regardless of the type, all brain injuries must be taken seriously. The proper assessment of concussion by emergency medical professionals and physicians is critical.

AAN and the BIA have developed a clear, scientifically based set of guidelines for the medical management of concussion in sports that is used by team physicians, coaches and athletic trainers and can easily be adapted for all concussions. Thus, after the type of concussion has been determined, management guidelines are implemented. If an adult sustains a Grade 1 or 2 concussion, it may be wise for that person to rest for two or three days before returning to regular activities and not operate a motor vehicle for at least a week. If a child crashes a bicycle and the physician has examined and given them a clean bill of health, it is wise to keep the child off the bicycle for a week. As always with children, the rule should be that if it has wheels, you need a helmet.

The potential danger with concussion is sustaining a second one before allowing the brain time to rest and recovery from the first one (as we would for a broken ankle). The chart below summarizes AAN's management recommendations for athletes returning to play after concussion, but reworded for the general audience. Please remember that all concussions are potentially serious and an individual should be examined by a physician if there is any doubt about their safety.

Grade 1 Concussion Management Guidelines

If the person has no symptoms or mental status abnormalities 15 minutes after the injury, he/she can resume normal activities. All symptoms from the concussion must have disappeared, first at rest and then with exertional testing, before the individual can return to regular activities.

Grade 2 Concussion Management Guidelines

The individual should refrain from activities for at least one week, again only after the person is asymptomatic at rest and during exertion. Additionally, a physician should perform a neurological exam before the individual is allowed to go back to regular activities. If the individual experiences a worsening in headaches and other concussion symptoms and/or these symptoms last longer than a week, a CT scan or MRI is recommended.

Grade 3 Concussion Management Guidelines

One month should be the minimum period for an individual to return to rigorous activity. For an individual with a brief loss of consciousness (i.e., seconds), he/she can return to regular activities only after being asymptomatic for at least one week. For a person who had a prolonged loss of consciousness (i.e., minutes), he/she can resume normal activities no sooner than after two weeks of rest. A thorough neurological examination and a neuro-imaging study (i.e., CT scan, MRI) should be performed on all individuals who have been rendered unconscious for brief periods of time. The individual should be admitted to the hospital if any signs of pathology are detected and/or the mental status of the person remains abnormal.

Recovery after concussion--just like a sprained or fractured ankle--takes time. An individual with a broken ankle would not go out the next day and run a marathon. That individual likely would take time out from work, rest and put the leg up, use crutches, attend therapy, if necessary, and allow the ankle time to recover. Too often after concussion, many individuals immediately return to work or school, push themselves to think as well and as quickly as they did before and expect that in a day or two they are recovered fully. One of the problems with concussion is that people try and "get back on the horse" too quickly. The danger in doing this is that the person could sustain a second concussion (i.e., the athlete returns to the game; the child gets back on his/her bicycle; the person resumes driving a car) that could cause more serious injury to the brain. Or, if individuals push themselves to perform and/or are expected to perform by their colleagues and family too soon after the concussion, the symptoms may become exacerbated.
After a concussion, it is wise for people to modify their lives by: 1) reducing workloads, 2) building in rest periods, 3) giving more time to finishing projects, 4) developing a written plan to refer to when confused or uncertain, 5) using a notebook/calendar to write things down and check-off when completed, 6) writing down schedules with time, place and person and 7) avoiding the use of alcohol or other substances that may slow recovery.

It is also important to monitor symptoms over the next one to three months and report this data to one's physician and other treating professionals. Family members can become more knowledgeable about concussion and help the person make accommodations, monitor symptoms and ensure that--just like with a broken ankle--the person is given ample healing time. The use of other professionals, such as a Neuropsychologist, can help through testing to determine a person's strengths, needs and preferences. Psychologists and counselors may be extremely beneficial in helping people with more serious injuries to understand and adjust to any changes caused by the concussion. BIA, its chartered state affiliates and support groups may provide the person with education about concussion and where to go for additional help.

Conclusion

Concussion is the most common of all brain injuries. It needs to be better understood, evaluated and treated. Individuals who sustain concussions may experience an array of symptoms, both short, and long term. The important thing is to take any concussion seriously and recognize that recovery is dependent on many things.

About the Authors...

William Frey, PhD, maintains a private clinical psychology practice in Rutland, VT, specializing in behavioral medicine with a focus on traumatic brain in jury rehabilitation. He received his BA from Villanova University (1967) and his MS (1969) and PhD (1976) from the University of Vermont. In addition to his clinical practice, he has held faculty positions at the University of Vermont, St. Michael's College and Middlebury College and, most recently, had been interim Dean of Student Development at Green Mountain College in Poultney, VT. He has been a President of the Vermont Psychological Association (1985-1987) and a founding board member or the Vermont Head Injury/Stroke Independence Project (1983-1986). He has published articles on mild traumatic brain injury and the impact of brain injury on sense of self and has developed an ecologically-based rehabilitation model for traumatic brain injury.

Ronald C. Savage, EdD, has worked with children, adolescents and young adults with neurological injuries and disabilities for over 25 years. Presently, Dr. Savage is Executive Vice President for Professional Development at Bancroft NeuroHealth in New Jersey. He is the former Senior Vice President of Behavioral Health and Rehabilitative Services at The May

Institute in Massachusetts and the former Director of Clinical Services for Rehabilitative Services of New York and the company's for rehabilitation facilities. In addition, Dr. Savage has taught at the elementary and secondary school level as a classroom teacher and as a special educator, as well as teaching at several colleges and universities. Dr. Savage presently holds academic appointments at Tufts University, Department of Rehabilitation Medicine; Northeastern University, Department of Psychology; The George Washington University School of Education; and the Laboratorio de Neuropsicologia, Universidad de Sevilla, Spain. Dr. Savage has presented at over 200 conferences, training seminars and grand rounds presentations in the past four years. He has published numerous articles, chapters, manuals and books on children, adolescents and adults with traumatic brain injuries and other neurological disabilities.

References

Centers for Disease Control and Prevention: Facts about Concussion and Brain Injury. U.S. Dept of Health and Human Resources, Washington, DC, 2000.

Frey WF: Psychotherapeutic interventions for mild traumatic brain injury. In: Educational Dimensions of Acquired Brain Injury. RC Savage & GF Wolcott (Eds). Austin, TX: PRO-ED, 1995.

Kelly J & Savage RC: Concussions in Sports. Brain Injury Source. 3(2): 34-37, 1999.

Kelly J & Rosenberg J: The development of guidelines for the management of concussion in sports. Journal of Head Trauma Rehabilitation. 13(2): 53-65, 1998.

McCrea M, Kelly J & Randolph C: The Standardized Assessment of Concussion (SAC) Manual. Alexandria, VA: Brain Injury Association, 1997.

Savage RC: Bing, Bang, Bong: When your Child has a Concussion. Wake Forest, NC: L&A Publishing, 2000.

Content Edited By

Lisa Ward, Director of Communications, Brain Injury Association
Monique J. Marino, Publications Manager, Brain Injury Association

NATIONAL FOOTBALL LEAGUE

March 15, 2011

The Honorable Mike Doogan
House of Representatives
Alaska State Capitol
Room 112
Juneau, Alaska 99801

RE: HB 15 – Student Athlete Traumatic Brain Injuries

Dear Representative Doogan:

The National Football League is pleased to support HB 15 – the Student Athlete Traumatic Brain Injuries bill. The bill will help raise awareness and protect youth athletes from the dangers of preventable brain injuries.

The NFL is playing a leading role on this important issue for the safety of our own players as well as athletes at all levels of sports. Our primary rule is this: the medical decisions of health care professionals take precedence over the playing decisions of coaches and players. Given our experience at the professional level, we believe a similar approach is appropriate and necessary when dealing with concussions in youth sports.

Concussions can occur in male and female athletes of any age and in any sport or recreational activity. In fact, the Centers for Disease Control and Prevention estimates that there may be as many as 3.8 million sports and recreational-related concussions each year in the United States.

In addition, medical researchers have determined that children and teenagers whose brains still are developing are more susceptible to concussions than adults, and they recover more slowly. Recognizing and responding to concussions when they first occur aids recovery and helps to prevent prolonged concussion symptoms, chronic impairment and even death.

That is the reason the NFL supports the passage of this bill and similar legislation in states throughout the country. HB 15 contains three core principles: (1) concussion education for youth athletes, parents and coaches on an annual basis; (2) immediate removal of a youth athlete who is suspected of sustaining a concussion from play or practice; and (3) mandatory clearance of that youth athlete by an appropriate licensed health care professional before returning to play or practice.

1201 Pennsylvania Avenue NW, Suite 645, Washington, DC 20004 Tel 202.662.6650 Fax 202.662.6860

The future of our state depends on the brains of the individuals that reside here. HB 15 is one tool to giving Alaska's youth the best opportunity to become community and business leaders as adults.

The Alaska Brain Injury Network appreciates your leadership in sponsoring this important legislation. You have our support.

Sincerely,

Jill Hodges
Executive Director

alaska brain injury network

3745 Community Park Loop, Ste. 140
Anchorage, Alaska 99508
office: (907) 274-2824 fax: (907) 274-2826
www.alaskabraininjury.net

The Honorable Mike Doogan
Alaska House of Representatives
Alaska State Capitol, Rm 400
Juneau, Alaska 99801

Dear Representative Doogan,

Thank you for introducing HB 15, an act relating to prevention and evaluation of and liability for concussions in student athletes.

The Alaska Brain Injury Network, Inc (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury. ABIN's eighteen member board represents all regions of Alaska and at least 50 percent are TBI survivors or family members. We fully support HB 15.

ABIN has become the leader in understanding the needs of Alaskans with brain injury. ABIN has heard from 800 Alaskans requesting brain injury services since 2007. In addition, ABIN has heard public testimony from hundreds of Alaskans from Anchorage, Juneau, Fairbanks, Kenai, Barrow, Nome, Kodiak, Dillingham, Bethel, Copper River Basin, Tok, Ketchikan, Sitka, Homer, and more.

There are an estimated 10,000 Alaskans who have experienced long-term difficulties from a moderate to severe brain injury. The number of Alaskans experiencing a concussion or Mild TBI (mTBI) who visit the emergency department is estimated at 3,000 per year. Concussion and brain injury need to be taken seriously. With proper diagnoses, management, and treatment, research shows 80-90 percent of people experiencing a concussion or mTBI will recover fully. HB 15 is vital to ensuring our youth athletes have the best chance of recovery after an injury. When a concussion is not properly managed, prolonged recovery or even death from a second impact may result.

The National Football League, National Hockey League, the United States Olympic teams, majority of collegiate teams, and most recently in many states, even high school and youth sports teams have protocols and guidelines for concussion identification and return to play. Many of the leagues also require a cognitive baseline which is the first step to providing the best data to assess for a concussion when symptoms appear. If an athlete is suspected of a concussion, the assessment guidelines and return to play protocol are in place for the safety of the athlete, as well as ensuring the team has the strongest players in the game. A player who is normally elite, but then suffers a concussion, may temporarily have difficulty making quick decisions, their speed and reaction time may be compromised, and they may clumsily handle the ball. This compromised state caused by the concussion may hinder the team, and more importantly may put the athlete at risk for serious, life-long disability. No one wants to see an athletic child or young adult become disabled due to a decision to keep a kid in the game for a win or because of lack of education of what concussion symptoms may look like.

HB 15 will ensure that coaches have a basic understanding of concussion, student athletes will begin to understand the seriousness of concussion on and off the field, and parents may begin to understand brain injury better as well. This legislation is an opportunity to improve the public's awareness of the seriousness of concussion and brain injury, and keep our student athletes safe.

ALASKA ATHLETIC TRAINERS ASSOCIATION

Alaska Athletic Trainers Association
PO Box 872710
Wasilla, AK 99687

March 15, 2011

Representative Doogan,

The Alaska Athletic Trainers Association fully supports the language of House Bill 15 and Senate Bill 22, *Student Athlete Traumatic Brain Injuries*. This legislation serves to raise awareness and protect youth athletes from the risks of concussions. The Alaska Athletic Trainers Association pledges to support the following key elements: (1) concussion education for young athletes, parents and coaches; (2) immediate removal of a student athlete who appears to have suffered a concussion from play or practice; and (3) mandatory clearance of that student by a health care professional who is trained in the evaluation and management of concussions before returning to play or practice.

Athletic trainers are health care professionals who specialize in the prevention, diagnosis, treatment and rehabilitation of injuries and sport-related illnesses. We prevent and treat chronic musculoskeletal injuries from sports, physical and occupational activity, and provide immediate care for acute injuries. Athletic trainers offer a continuum of care that is unparalleled in health care.

The Alaska Athletic Trainers Association is also working toward licensing athletic trainers in the state of Alaska. A licensed athletic trainer is one who has established qualifications and works within a scope of practice. Alaska is one of only three states that do not regulate athletic trainers and we feel it is time to change that. We hope you will support our professional endeavor for licensing athletic trainers in Alaska.

Sincerely,

B. Shelden

Brenda Shelden
Certified Athletic Trainer
President of the Alaska Athletic Trainers Association
(907)841-8942

The National Football League, USA Football, the Brain Injury Association of Washington, and the American College of Sports Medicine, among many other organizations, strongly support the adoption of laws to prevent traumatic brain injury in youth athletes in all fifty states. The Zackery Lystedt law, passed in Washington state, through the efforts and hard work of advocates in the medical, educational and athletic fields represents model legislation. The bill includes three elements essential to protecting youth athletes in all sports:

(1) Inform and educate youth athletes, their parents and guardians and require them to sign a concussion information form;
(2) Removal of a youth athlete who appears to have suffered a concussion from play or practice at the time of the suspected concussion; and
(3) Requiring a youth athlete to be cleared by a licensed health care professional trained in the evaluation and management of concussions before returning to play or practice.

This packet of materials includes information about the Zackery Lystedt law and frequently asked questions regarding it. In addition, educational materials on the topic of youth concussions are included. These documents published by the Centers for Disease Control and Prevention and USA Football and endorsed by the American College of Sports Medicine, the National Football League, USA Football, and the Brain Injury Association of Washington will provide significant information about youth concussions.

As of November 2010, nine states have adopted laws containing the three key provisions of the Zackery Lystedt law. We encourage you to adopt a similar law in your state and encourage you to reach out to our organizations if we can be of assistance.

Sincerely,

Jeffrey A. Miller
Vice President
Government Relations and Public Policy
National Football League

Stanley A. Herring, M.D.
Chairman
Advocacy and Education Subcommittee
NFL Head, Neck and Spine Committee

Richard Adler
Chairman/President
Executive Board
Brain Injury Association-Washington

James R. Whitehead
Executive Vice President and CEO
American College of Sports Medicine

Scott Hallenbeck
Executive Director
USA Football

FREQUENTLY ASKED QUESTIONS ABOUT CONCUSSION-PREVENTION LAWS

How widespread are concussions among youth athletes?

An estimated 400,000 high school athletes sustained concussions while participating in five major male sports and four major female sports during the 2005-2008 school years[i]. In addition, experts believe that the prevalence of sports-related concussions among young people in all sports is significantly higher than reported.

Moreover, the number of youth athletes taken to emergency rooms with sports-related concussions doubled during the 10-year-period from 1997 to 2007[ii]. Meanwhile, among youth aged 14 to 19, emergency room visits for concussions sustained during team sports more than tripled over the same period[iii].

What dangers do these head injuries pose to young athletes?

A concussion is a type of traumatic brain injury, or TBI, which changes the way the brain normally works. Recognizing and responding to concussions when they first occur help to aid recovery and to prevent prolonging concussion symptoms, chronic brain damage or even death. Yet, a recent study estimated that more than 40 percent of high school athletes return to participate in school athletics before they have fully recovered from these serious head injuries[iv].

Do concussions involve youth athletes in all sports and at any age or is it just an injury sustained by boys who play football?

Concussions can occur in athletes of any age and in any sport or recreational activity. In fact, each year, U.S. emergency departments treat an estimated 135,000 sports-related and recreation-related TBIs, including concussions, among children ages 5 to 18[v]. In addition, children and teens are more likely to get a concussion and take longer to recover than adults. While youth sports concussions often are associated with football, the rate of concussions in girl's high school soccer is almost as high. Research also indicates that there may be gender differences in how boys and girls recover from concussions.[vi]

How many states have enacted laws related to concussion-awareness, prevention and management?

As of October 2010, eight states have adopted similar concussion-awareness and prevention laws initially adopted in Washington, known as the Zackery Lystedt law, including Oregon, New Mexico, Connecticut, Oklahoma, Virginia, Massachusetts and Rhode Island. In many other states, active coalitions are pushing to enact similar legislation.

What are the key elements of a concussion-prevention and management bill?

An effective concussion-prevention bill follows the example of the State of Washington's Zackery Lystedt law. It includes three essential elements: (1) inform and educate student athletes, their parents and guardians and require them to sign a concussion information form; (2) removal of a student-athlete who appears to have suffered a concussion from play or practice at the time of the suspected

concussion; and (3) requiring an athlete to be cleared by a licensed medical professional trained in the evaluation and management of concussions before returning to play or practice.

There is an international consensus on return to play guidelines for youth, adopted at the 3rd International Conference on Concussion in Sport in Zurich, in November 2008, which states that "It is not appropriate for a child or adolescent athlete with concussion to RTP on the same day as the injury regardless of the level of athletic performance."[vii]

What is the cost of implementing a concussion prevention and awareness bill?

Zero. The bill is revenue neutral. There are no mandates in the bill and no requirements that resources be spent to hire or train medical professionals or to purchase equipment. Free information on concussions for high school and youth coaches, parents, athletes, as well as school professionals is publicly available on the Centers for Disease Control and Prevention's (CDC) website at www.cdc.gov/Concussion, including a youth concussions poster found at www.cdc.gov/concussion/pdf/poster_Eng.pdf designed to hang in every locker room across the country.

What are the penalties for violating the concussion prevention and awareness law? Who is liable if the law is not followed?

There is no liability attached to Washington's Zackery Lystedt law. It does not mandate any civil or criminal penalties, nor does it create greater liability for individuals and/or organizations. Indeed, the education and awareness efforts and requirement of medical clearance before return to play has decreased the variability of care and decreased liability. Wherever the law is passed, the community can determine if and how to monitor and enforce the law.

What about implementing the law in rural areas where it may be more challenging to find medical professionals?

The law does not require a specific medical specialist to participate in every evaluation. Rather, the language of the Washington statute requiring an athlete "to be cleared by a licensed medical professional trained in the evaluation and management of concussions before returning to play or practice" permits a wide range of qualified individuals to determine a youth athlete's suitability for returning to play. For example, in Washington State, the Washington Interscholastic Activities Association decided that qualifying medical professionals included: medical doctors, osteopaths, nurse practitioners, athletic trainers, and physician assistants.

What is the impact of concussion-prevention laws on private sports organizations?

These laws may be written in such a way as to apply not only to public sports organizations but also to private sports organizations, many of which maintain public-sector connections/affiliations (such as the use of public facilities). For example, in Washington private sports groups are required by law to carry insurance to play on publicly-owned playing fields. The Zackery Lystedt law amended that insurance-based law to require private nonprofits to comply with the policies on the management of concussions and head injuries in youth sports.

What impact have concussion-prevention laws had in states that have passed them?

The Zackery Lystedt law was the first concussion-prevention state law to pass in 2009. While no comprehensive and detailed assessment can yet be made, early and anecdotal data suggests that the law is having an immediate and positive impact. It is helping meet a critical goal -- preventing preventable brain injuries and making sports and recreational activities safer for youth.

What organizations have supported such measures?

A broad coalition of groups representing teachers and parents, sports medicine, medical professionals, school administrators, the disability community and athletic organizations have supported concussion-prevention legislation at the state and federal level. These organizations include the National Football League, American College of Sports Medicine, USA Football, National School Boards Association, Parent Teacher Association, National Association of School Nurses, National Council of Youth Sports, The Sarah Jane Brain Foundation, National Disability Rights Network, National Athletic Trainers' Association, National Association of Health and Fitness, the Brain Injury Association of America, the Brain Injury Association of Washington, and many others.

What law, if any, has Congress proposed or passed regarding concussion prevention and awareness?

The "Protecting Student Athletes from Concussions Act of 2010" incorporates the same core principles of the Lystedt law and was introduced in Congress in September of 2010. If passed, the bill would require school districts to develop and implement a minimum standard, community-based plan for concussion safety and management. Of course, states would be able to implement standards far exceeding these basic, minimum standards.

Where may I find/read a copy of the Zackery Lystedt law?

The Zackery Lystedt law may be found in this packet. It may also be found online by visiting: http://www.leg.wa.gov/CodeReviser/documents/sessionlaw/2009pam3.pdf

Where may I find more information about the dangers of concussions and passing a law in my state?

More information about concussions may be found on the website of the CDC. You also may watch an NFL-produced video about enacting a concussions-prevention law in your state, which is available at NFL.com/youthconcussions and on the CDC's website as well.

---

[i] Nationwide Children's Hospital, Concussions Clinic, Ohio State University
[ii] Bakhos L., Linakis J., et al. "Emergency Department Visits for Concussions in Young Child Athletes," Pediatrics, 2010.
[iii] Ibid.
[iv] Center for Injury Research and Policy at Nationwide Children's Hospital, Columbus, Ohio
[v] Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, 2007.
[vi] Journal of Athletic Training, 2007
[vii] McCrory P, Meeuwisse W, et al. "Consensus Statement on Concussion in Sport, 3rd International Conference on Concussion in Sport," Clinical Journal of Sports Medicine, 2009.

HB

16

<TARGET><BILL>HB 16</BILL><SUBJECT>HB
16</SUBJECT><COMM>SHSS27</COMM></TARGET>

Representative Mike Hawker
Alaska State Legislature

Session:
State Capitol
Juneau, AK 99801
907 465-4949 direct
800 478-4950 toll free
907 465-4979 fax

Interim:
716 W 4th Avenue
Anchorage, AK 99501
907 269-0244 office
907 269-0248 fax

Chair:
Legislative Budget & Audit Committee

House District 32:
Eagle River
Anchorage
Rainbow
Indian
Bird
Girdwood
Portage
Whittier
Sunrise
Hope

House Bill 16
Sponsor Statement

Short Title: Extend Senior Benefits Payment Program

House Bill 16 would extend the Alaska Senior Benefits Program to June 30, 2015.

The Senior Benefits Program provides monthly cash assistance to state residents age 65 years or older whose household income does not exceed 175% of the federal poverty guidelines for Alaska. Specifically, the program pays:

- $250 per month to individuals with income of 75% or less of FPG
- $175 per month to individuals with income between 75% and 100% of FPG
- $125 per month to individuals with income between 100% and 175% of FPG

The program assists approximately 10,000 Alaskan seniors, with a total cost of $21 million projected for this fiscal year. If it is not extended, the program will sunset on June 30, 2011.

House Bill 16 Background Information
Alaska Senior Benefits Program Statutes

Title 09. CODE OF CIVIL PROCEDURE

Chapter 09.38. ALASKA EXEMPTIONS ACT

(a) An individual is entitled to exemption of the following property:

(11) [See delayed amendment note]. benefits paid or payable under AS 47.45.301 - 47.45.309.

Sec. 47.45.301. Alaska senior benefits payment program. [See delayed repeal note]..

(a) The Alaska senior benefits payment program is established in the Department of Health and Social Services to provide cash benefits as far as practicable under appropriations provided by law.

(b) The department shall administer the program and adopt regulations under AS 44.62 to carry out the purposes of the program.

(c) If the department estimates that appropriations for the program are insufficient to meet the demands of the program in a fiscal year, the department may reduce or eliminate the cash benefit available to recipients.

Sec. 47.45.302. Cash assistance benefit. [See delayed repeal note]..

(a) An individual is eligible for a cash assistance benefit under the program if the individual

(1) is 65 years of age or older;

(2) is a resident of the state;

(3) has a household income that does not exceed 175 percent of the annual federal poverty line for Alaska, as determined by the United States Department of Health and Human Services and revised under 42 U.S.C. 9902(2);

(4) has not received a longevity bonus payment under AS 47.45.010 - 47.45.160 for the same period; and

(5) applies on a form provided by the department; the department may use an abbreviated form for an individual who received a payment under an assistance program for seniors that paid $120 a month and was administered by the department on or before the effective date of this section.

(b) An eligible individual shall receive a monthly cash assistance payment beginning on August 1, 2007, as follows:

(1) $250 if the individual's household income does not exceed 75 percent of the federal poverty line for Alaska;

(2) $175 if the individual's household income does not exceed 100 percent but is above 75 percent of the federal poverty line for Alaska;

(3) $125 if the individual's household income does not exceed 175 percent but is above 100 percent of the federal poverty line for Alaska.

(c) Cash assistance provided under this section is subject to appropriation.

Sec. 47.45.304. Continuation of benefits. [See delayed repeal note]..

An eligible individual who leaves the state may not receive a cash benefit under AS 47.45.302 during the absence unless the individual's absence is temporary and is for one of the following reasons:

(1) to receive medical treatment for the individual;

(2) to accompany the individual's family member who is receiving medical treatment outside the state; or

(3) for a vacation, business trip, or other absence of less than 30 consecutive days, unless the individual has applied for and received a time extension from the department for special circumstances.

Sec. 47.45.306. Appeal rights. [See delayed repeal note]..
An individual who receives a determination from the department that denies, limits, or modifies a cash benefit under AS 47.45.301 - 47.45.309, other than a determination under AS 47.45.301 (c) to reduce or eliminate benefits, may request a hearing before the department under regulations adopted by the department.

Sec. 47.45.308. Ability to recover or recoup improper assistance or benefits. [See delayed repeal note]..
An individual is liable to the department for the value of assistance or benefits improperly paid to the individual under AS 47.45.302 or former AS 47.45.310 or 47.45.320 if the improper payment was based on inaccurate or incomplete information provided by the individual. In a civil action brought by the state to recover from the individual the value of assistance or benefits improperly paid under AS 47.45.302 or former AS 47.45.310 or 47.45.320, the state may recover from the individual the costs of investigation and prosecution of the civil action, including attorney fees as determined under court rules.

Sec. 47.45.309. Definitions. [See delayed repeal note]..
In AS 47.45.301 - 47.45.309,

(1) "department" means the Department of Health and Social Services;

(2) "eligible individual" means an individual who meets the requirements of AS 47.45.301 - 47.45.309 and regulations adopted under those statutes for eligibility for the program;

(3) "family member" means a person who is

(A) legally related to an eligible individual through marriage or guardianship; or

(B) an eligible individual's sibling, parent, grandparent, son, daughter, grandson, granddaughter, uncle, aunt, niece, nephew, or first cousin;

(4) "program" means the senior benefits payment program established in AS 47.45.301 - 47.45.309;

(5) "resident" has the meaning given in AS 47.25.430 (a).

Senior BENEFITS PROGRAM

Fact Sheet
January 24, 2011

The Alaska Senior Benefits Payment Program was established on August 1, 2007 and, unless reauthorized, is set to end on June 30, 2011. It pays cash benefits to Alaskans who are age 65 or older and have low to moderate income. Cash payments are $125, $175, or $250 each month depending on income.

Recipients

- There were 10,093 Senior Benefits recipients as of December 2010. Of these, 5,534 were also Adult Public Assistance recipients.

- Number and percent of seniors at each payment level in December 2010.
  - ✓ $250 - 1,071 (10.6%)
  - ✓ $175 - 3,872 (38.4%)
  - ✓ $125 - 5,150 (51.0%)

- Average age of recipients is 75. The maximum age is 105.

Program Expenditures

- Currently, projected program benefit expenditures for FY 2011 are $21.0 million. Projected benefit expenditures for FY 2012 are $21.7 million.

Eligibility and Payment

- Eligibility and payment amount is based on gross annual income (before any deductions are taken for taxes, Medicare premiums, etc.).

Senior Household Size	Senior Benefits Program Gross Annual Income Limit Effective 3/1/2011		
	$250 monthly payment	**$175 monthly payment**	**$125 monthly payment**
Individual	$10,200 ($850 per month)	$13,600 ($1,134 per month)	$23,800 ($1,984 per month)
Married Couple	$13,785 ($1,149 per month)	$18,380 ($1,532 per month)	$32,165 ($2,680 per month)

- Income limits may change yearly along with Alaska's federal poverty level. The $250, $175, and $125 monthly payments correspond to 75 percent, 100 percent, and 175 percent of the federal poverty level for Alaska, respectively.

- Assets, such as savings, are not counted for eligibility.

- Payments are not available to seniors living in the following institutions:
  - ✓ Prison or jail,
  - ✓ nursing home,
  - ✓ Alaska Pioneers' Home or Alaska Veterans' Home, or
  - ✓ Public or private institution for mental disease

Geographic Distribution by Census Area, December 2010

Census Area	Number of Recipients
Aleutians East	23
Aleutians West	14
Anchorage	3,636
Bethel	558
Bristol Bay	7
Denali	13
Dillingham	150
Fairbanks North Star	747
Haines	83
Juneau	338
Kenai Peninsula	934
Ketchikan Gateway	251
Kodiak	220
Lake and Peninsula	39
Matanuska-Susitna	1,250
Nome	238
North Slope	38
Northwest Arctic	159
Prince of Wales	185
Southeast Fairbanks	187
Sitka	98
Skagway/Hoonah/Angoon	68
Valdez/Cordova	171
Wade Hampton	255
Wrangell/Petersburg	149
Yakutat	15
Yukon/Koyukuk	259
Unidentified	8
Grand Total	10,093

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: HB 16
(H) Publish Date: 1/31/11

Identifier (file name): HB016-DHSS-SBPP-01-28-2011
Title: Extend Senior Benefits Payment Program
Sponsor: Hawker
Requestor: House Finance

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Senior Benefits Payment Program
OMB Component Number: 2897

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services		486.0	486.0	486.0	486.0		
Travel		9.7	9.7	9.7	9.7		
Contractual		169.7	169.7	169.7	169.7		
Supplies		43.5	43.5	43.5	43.5		
Equipment							
Land & Structures							
Grants & Claims	1,968.1	19,776.4	22,349.3	22,970.9	23,606.5		
Miscellaneous							
TOTAL OPERATING	**1,968.1**	**20,485.3**	**23,058.2**	**23,679.8**	**24,315.4**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	1,968.1	20,485.3	23,058.2	23,679.8	24,315.4		
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,968.1**	**20,485.3**	**23,058.2**	**23,679.8**	**24,315.4**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time		6	6	6	6		
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared by: Ron Kreher, Acting Director — Phone 465-2680
Division: Public Assistance — Date/Time 1/28/11 5:30 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 1/28/2011
DHSS Finance & Management Services

(Revised 12/29/2010 OMB)

Analysis:

Analysis:

The Senior Benefits Payment Program helps low income seniors who are age 65 or older remain independent in the community by providing a monthly income supplement to help meet their basic needs, such as food and housing. Currently the program is set to expire on June 30, 2011. This legislation continues the program through June 30, 2015. As of December 2010, the current program enrollment was 10,093. The number and percent of seniors at each payment level was:

* $250 - 1,071 (10.6%)
* $175 - 3,872 (38.4%)
* $125 - 5,150 (51.0%)

Assumptions:

* Current staffing levels for the program will be maintained and will consist of one Eligibility Technician III, four Eligibility Technician I's, and one Office Assistant I.
* Annual expenditures for Personal Services, Travel, Contractual, and Supplies will remain constant for FY 2012 through FY 2015.
* Projected grant expenditures in FY 2011 are expected to be about $21.0 million. A supplemental for $1.3 million has been requested in FY 2011.
* Annual grant expenditures are expected to increase in response to a projected caseload growth of 3% annually in the out years.
* Grant expenditures for FY 2012 through FY 2015 are expected to increase as follows:
-- 3.55 percent in FY 2012
-- 2.78 percent in FY 2013
-- 2.78 percent in FY 2014
-- 2.77 percent in FY 2015

With the exception of the amount shown in the FY12 appropriation needed column, all of the represented costs are contained in the governor's proposed FY12 budget.

See attached projected caseload and grant expenditures.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: HB 16
(H) Publish Date: 1/26/11

Identifier (file name): HB016-DHSS-SBPP-01-21-2011
Title: Extend Senior Benefits Payment Program
Sponsor: Hawker
Requestor: House HSS

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Senior Benefits Payment Program
OMB Component Number: 2897

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services		486.0	486.0	486.0	486.0		
Travel		9.7	9.7	9.7	9.7		
Contractual		169.7	169.7	169.7	169.7		
Supplies		43.5	43.5	43.5	43.5		
Equipment							
Land & Structures							
Grants & Claims	1,968.1	19,776.4	22,349.3	22,970.9	23,606.5		
Miscellaneous							
TOTAL OPERATING	**1,968.1**	**20,485.3**	**23,058.2**	**23,679.8**	**24,315.4**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	1,968.1	20,485.3	22,848.1	23,164.4	23,488.3		
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,968.1**	**20,485.3**	**22,848.1**	**23,164.4**	**23,488.3**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time		6	6	6	6		
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared by: Ron Kreher, Acting Director — Phone 465-2680
Division: Public Assistance — Date/Time 1/21/11 5:00 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 1/21/2011
DHSS Finance & Management Services

(Revised 12/29/2010 OMB)

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. HB 16

Analysis:

Analysis:

The Senior Benefits Payment Program helps low income seniors who are age 65 or older remain independent in the community by providing a monthly income supplement to help meet their basic needs, such as food and housing. Currently the program is set to expire on June 30, 2011. This legislation continues the program through June 30, 2015. As of December 2010, the current program enrollment was 10,093. The number and perc ent of seniors at each payment level was:

* $250 - 1,071 (10.6%)
* $175 - 3,872 (38.4%)
* $125 - 5,150 (51.0%)

Assumptions:

* Current staffing levels for the program will be maintained and will consist of one Eligibility Technician III, four Eligibility Technician I's, and one Office Assistant I.
* Annual expenditures for Personal Services, Travel, Contractual, and Supplies will remain constant for FY 2012 through FY 2015.
* Projected grant expenditures in FY 2011 are expected to be about $21.0 million.
* Annual grant expenditures are expected to increase in response to a projected caseload growth of 3% annually in the out years.
* Grant expenditures for FY 2012 through FY 2015 are expected to increase as follows:
-- 3.55 percent in FY 2012
-- 2.78 percent in FY 2013
-- 2.78 percent in FY 2014
-- 2.80 percent in FY 2015

With the exception of the amount shown in the FY12 appropriation needed column, all of the represented costs are contained in the governor's proposed FY12 budget.

Senior Benefit CASELOAD Summary (progra

	CY/PY Caseload Change	FY10 Cases Projection	CY/PY Caseload Change	FY11 Cases Projection	CY/PY Caseload Change	FY12 Cases Projection	CY/PY Caseload Change	FY13 Cases Projection	CY/PY Caseload Change	FY14 Cases Projection	CY/PY Caseload Change	FY15 Cases Projection	CY/PY Caseload Change	FY16 Cases Projection	
July	840	9,973	166	10,139	302	10,441	253	10,694	380	11,074	280	11,354	345	11,700	July
Aug	665	9,974	184	10,158	303	10,461	265	10,726	370	11,096	292	11,388	335	11,723	Aug
Sep	613	9,973	193	10,166	316	10,482	276	10,758	360	11,119	304	11,423	324	11,746	Sep
Oct	685	10,006	167	10,173	330	10,503	287	10,790	350	11,141	316	11,457	325	11,782	Oct
Nov	678	9,987	122	10,109	415	10,524	298	10,823	340	11,163	328	11,491	326	11,817	Nov
Dec	672	9,959	134	10,093	452	10,545	310	10,855	330	11,185	340	11,526	327	11,853	Dec
Jan	673	9,982	283	10,265	302	10,566	321	10,888	320	11,208	352	11,560	328	11,888	Jan
Feb	605	9,946	350	10,296	292	10,588	333	10,921	310	11,230	353	11,583	340	11,924	Feb
Mar	545	10,038	289	10,327	282	10,609	344	10,953	299	11,253	354	11,607	353	11,960	Mar
Apr	402	10,075	282	10,357	273	10,630	356	10,986	289	11,275	355	11,630	366	11,995	Apr
May	286	10,108	281	10,389	263	10,651	368	11,019	279	11,298	355	11,653	378	12,031	May
Jun	200	10,086	334	10,420	253	10,673	380	11,052	268	11,320	356	11,676	391	12,067	Jun
Monthly Average	572	10,009	232	10,241	315	10,556	316	10,872	325	11,197	332	11,529	345	11,874	
Percent C	6.1%		2.3%		3.1%		3.0%		3.0%		3.0%		3.0%		

Senior

	Difference	FY10 Expend Actual	Difference	FY11 Expend Projection	Difference	FY12 Expend Projection	Difference	FY13 Expend Projection	Difference	FY14 Expend Projection	Difference	FY15 Expend Projection	Difference	FY16 Expend Projection	
July	990.0	3,145.9	39.2	3,185.1	20.2	3,205.3	40.4	3,245.7	60.7	3,306.3	44.7	3,351.0	55.1	3,406.1	July
Aug	-40.9	1,595.6	25.1	1,620.7	47.9	1,668.6	42.2	1,710.8	59.1	1,769.9	46.6	1,816.4	53.4	1,869.8	Aug
Sep	89.4	1,598.9	17.0	1,615.9	56.0	1,671.9	44.0	1,715.9	57.5	1,773.4	48.5	1,821.9	51.7	1,873.6	Sep
Oct	98.6	1,598.4	14.5	1,612.9	62.4	1,675.3	45.8	1,721.1	55.9	1,777.0	50.4	1,827.4	51.8	1,879.2	Oct
Nov	96.4	1,586.0	4.1	1,590.1	88.5	1,678.6	47.6	1,726.2	54.3	1,780.5	52.3	1,832.8	52.0	1,884.8	Nov
Dec	96.8	1,583.2	17.2	1,600.4	81.6	1,682.0	49.4	1,731.4	52.7	1,784.1	54.3	1,838.3	52.1	1,890.5	Dec
Jan	80.5	1,573.8	42.9	1,616.7	68.6	1,685.4	51.3	1,736.6	51.0	1,787.6	56.2	1,843.9	52.3	1,896.1	Jan
Feb	96.9	1,587.2	34.4	1,621.6	67.2	1,688.7	53.1	1,741.8	49.4	1,791.2	56.3	1,847.5	54.3	1,901.8	Feb
Mar	78.4	1,612.4	14.0	1,626.4	65.7	1,692.1	54.9	1,747.0	47.8	1,794.8	56.4	1,851.2	56.3	1,907.5	Mar
Apr	-531.1	1,041.6	589.7	1,631.3	64.2	1,695.5	56.8	1,752.3	46.1	1,798.4	56.5	1,854.9	58.3	1,913.3	Apr
May	-439.5	1,165.8	470.4	1,636.2	62.7	1,698.9	58.7	1,757.5	44.4	1,802.0	56.7	1,858.7	60.4	1,919.0	May
Jun	291.8	1,051.3	589.8	1,641.1	61.2	1,702.3	60.5	1,762.8	42.8	1,805.6	56.8	1,862.4	62.4	1,924.8	Jun
Total		**19,147.9**		**20,998.4**	**746.1**	**21,744.5**	**604.7**	**22,349.3**	**621.6**	**22,970.9**	**635.6**	**23,606.5**	**660.0**	**24,266.5**	
		* see note													
Monthly Average	75.6	1,595.0	154.9	1,749.9	62.2	1,812.0	50.4	1,862.4	51.8	1,914.2	53.0	1,967.2	55.0	2,022.2	
t Change	5.0%		9.7%		3.6%		2.8%		2.8%		2.8%		2.8%		

	FY10 With Supplemental	FY11	FY12	FY13	FY14	FY15	FY16
	18,926.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4
	256.0	0.0	0.0	0.0	0.0	0.0	0.0
	19,182.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4
	19,147.9	20,998.4	21,744.5	22,349.3	22,970.9	23,606.5	24,266.5
	34.5	(1,222.0)	(1,968.1)	(2,572.9)	(3,194.5)	(3,830.1)	(4,490.1)

Revised projections to accurally reflect the percentage breakdown between the three pmt amounts. Instead of 11% for $250 it is 10%, instead of 43% $175 it is 40% and instead of 46% for $125 it is 50%. mds 110310

2.78% 2.78% 2.77% 2.80%

RP needs to be requested for FY11 to cover projected shortage based on 10% increase in FY11 compared to FY10 mds 120610

Requested FY11 Supplemental for $1,300.0 of additional GF.122310mds

3.55%

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 15, 2011

Representative Mike Hawker
Alaska State Capitol, Room 502
Juneau, AK 99801-1182

Subject: Support for HB 16

Dear Representative Hawker:

The Alaska Commission on Aging (ACoA) is pleased to offer our enthusiastic support of HB 16, a bill sponsored by you to reauthorize the Senior Benefits program which is scheduled to sunset on June 30, 2011. Because this program provides a critical financial safety net for Alaska seniors, the Alaska Commission on Aging supports the extension of the sunset date to 2015 or beyond.

The Senior Benefits program, originally initiated by you and enacted by the Legislature in 2007, has been an invaluable program for modest-income seniors who are on small fixed incomes to assist them to live with dignity and independence in their home communities. Alaskans age 65 and over with incomes up to 175% of poverty are eligible for a calibrated monthly cash benefit based on income through the Senior Benefits program. Although the monthly payments are not large amounts, they can make a significant difference in whether or not an older Alaskan is able to afford food, rent, fuel, medication, and other necessities. Many low-income seniors do not have cash reserves that allow for emergencies or the increasing cost of living.

In fiscal year 2010, the average monthly enrollment in the Senior Benefits Program was 10,009. Among the Department of Health and Social Services' nine regions, there is wide variation in the percentage of seniors age 65 and over who receive Senior Benefits. Statewide, less than one in five seniors (19.1%) participates in the Senior Benefits program. Region 1 (the Bethel/Wade Hampton area), long recognized as a very low income region of the state, has over 50 percent of seniors participate in the program. The Aleutian Islands, Region VIII, also has a high rate of participation – more than twice as high as the state's average rate.

The Alaska Commission on Aging strongly recommends that the 2011 Legislature vote to extend the sunset date for the Senior Benefits Program, enabling the program to continue to support those seniors most vulnerable to economic stresses. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879 or denise.daniello@alaska.gov) should you require additional information. Thank you so much for your support of this important program for older Alaskans.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

January 24, 2011

The Honorable Mike Hawker
Member of the House of Representatives
Alaska Capitol, Room 502
Juneau, AK 99801-1182

RE: HB 16 (Hawker) – Support

Dear Representative Hawker:

The Alaska Food Coalition is pleased to express our support for HB 16 which will extend the Senior Benefits Program for another four years. At least 1/3 of the Alaska Food Coalition membership serves the senior population. Our members identify hunger, or food insecurity, as a growing problem among the senior population in Alaska.

The Hunger in America 2010 study found 42% of adult pantry and soup kitchen clients in Alaska were 50 and older. Of those pantry visitors 65 and older, 57.8% told us they experienced low or very low food security; they worry about or don't know if they will have enough food. The study also found, of all pantry clients in Alaska:

- 43% had to choose between buying food and paying for utilities
- 45% had to choose between buying food and paying for rent or mortgage
- 35% had to choose between buying food and medicine

Among households with 1 senior member age 65 or older, 21.8% participate in a home delivered meal program. Agencies who deliver home meals have reported a 20% increase in requests for services. The Salvation Army Older Alaskans Program in Anchorage estimates there are twice as many seniors in Anchorage in need of their services. The Yakutat Senior Center serves an average of 42 meals a day; double what they served the previous year. According to data from the Alaska Department of Public Assistance, food stamp recipients age 60 and over increased by 22% in 2009. The need is clear; our low-income seniors need help paying for basic needs.

We want all Alaskans to be hunger free, food secure. There is no question the Senior Benefits Program has helped Alaskan seniors put food on their tables, and will continue to do so with continued funding. We appreciate your leadership on this issue and wish to express our sincere thanks to you for helping Alaska Seniors live full and productive lives.

We ware also thankful to Representatives Millet, Lynn, Gara and Tuck for signing up to co-sponsor HB16.

Please do not hesitate to contact Vanessa Salinas, Alaska Food Coalition Manager if you have any questions, 907-222-3103 afc@foodbankofalaska.org

Thank you for all that you do for Alaska.

Sincerely,

Heather Harris
Alaska Food Coalition President

CC: Representative Charisse Millet
Representative Les Gara
Representative Bob Lynn
Representative Chris Tuck

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

January 19, 2011

The Honorable Mike Hawker
Member of the House of Representatives
Alaska Capitol, Room 502
Juneau, AK 99801-1182

RE: HB 16 (Hawker)—Support

Dear Representative Hawker:

On behalf of the members of AARP in Alaska, we are pleased to indicate our very strong support for HB 16 which will extend the Senior Benefits program for another four years.

There is no doubt that the Senior Benefits program has proven to be an invaluable help to many older Alaskans who might not be able to afford to stay here without it.

We all recognize that Alaska's seniors face high health care costs as well as high energy costs.

The Senior Benefits program has allowed over 10,000 older Alaskans to deal with these costs and to remain citizens of our state.

We want Alaskans to be able to stay here after retirement. The Senior Benefits program is essential to achieve that goal.

On behalf of all those older Alaskans who may not be aware of your continued leadership on this issue, please accept our thanks for all that you have done, continue to do, and will do in the future.

We are pleased to thank Representatives Millet, Lynn, Gara and Tuck for signing up to co-sponsor HB 16.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Representative Charisse Millet
Representative Les Gara
Representative Bob Lynn
Representative Chris Tuck

Matsu Legislative Information
— Office —
600 E. Railroad Ave.
Wasilla, AK. 99654-8135

January 12, 2011

Barbara A. Schumacher
P.O. Box 873505
Wasilla, AK. 99687

To Whom it may concern,
Please think very carefully about the Senior Benefits Program, here in Alaska. It has been a great source of comfort & financial stability to me for the last 3 years. I shudder to think what it would mean to your Senior Constituents, who benefit so greatly from this program if it were to be discontinued
Thank you for your consideration.

Sincerely,
Barbara A. Schumacher - age 75
BARBARA A. SCHUMACHER
Wasilla, AK.

Date: January 12, 2011

To: MatSu Legislative Office

To whom it may concern;

I am the daughter of a Wasilla area resident senior citizen. It has come to my attention that the State needs to seek renewal for the Alaska Senior Citizen Benefits Program. I strongly support this program and urge the State to petition for renewal of this very important service to our Seniors. The Senior Care benefits that my mother receives allow her that tiny bit of extra wiggle room on her fixed retirement income, without which, her standard of living will become negatively affected.

Many Alaskan Seniors are in similar, or worse, situations. Without these benefits the State would surely see a rise in emergency medical care resulting from senior's not getting the medications, doctor visits, appropriate food, etc. they need because of less income.

Please support the continued funding for the Alaska Senior Citizen Benefits Program.

Sincerely,

Mrs. Katherine McLaughlin
PO Box 8043
Chenega Bay, Alaska 99574

SENATE BILL NO. 21

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY SENATOR WIELECHOWSKI

Introduced: 1/7/11
Referred: Prefiled

A BILL

FOR AN ACT ENTITLED

"An Act extending senior benefits."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** Section 4, ch. 1, FSSLA 2007, is amended to read:

Sec. 4. AS 09.38.015(a)(11); AS 47.45.301, 47.45.302, 47.45.304, 47.45.306, 47.45.308, and 47.45.309 are repealed June 30, **2015** [2011].

ALASKA STATE LEGISLATURE

Session
State Capitol, Rm. 101
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

Interim
716 W. 4th Ave, Ste. 540
Anchorage, AK 99501
(907) 269-0120
Fax: (907) 269-0122

Senator_Bill_Wielechowski@legis.state.ak.us

Chair
State Affairs Committee

Co-chair
Joint Armed Services Committee

Vice Chair
Resources Committee
Judiciary Committee

Member
Admin Reg Review

SENATOR BILL WIELECHOWSKI

Sponsor Statement

Senate Bill 21 – Extending The Senior Benefit Program

"An Act extending senior benefits."

Senate Bill 21 would extend the Alaska Senior Benefits Program for another four years to June 30, 2015.

The Senior Benefits Program provides a monthly cash assistance to Alaskan seniors who are age 65 or older and have an income less than 175% of the federal poverty guidelines for the state of Alaska.

The program pays a monthly assistance of:

- $250 to seniors with a monthly income limit of $846 (75% FPG)
- $175 to seniors with a monthly income limit of $13,530 (100% FPG)
- $125 to seniors with a monthly income limit of $1,972 (175% FPG)

The program assists approximately 10,000 Alaskan seniors and costs an estimated $20 million a year. Without action, this benefit will sunset on June 30, 2011.

This bill is supported by many senior groups, including the Alaska Commission on Aging, the Older Persons Action Group and the AARP.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **SB021**
() Publish Date:

Identifier (file name): SB021-DHSS-SBPP-01-27-11
Title: Extend Senior Benefits Payment Program
Sponsor: Wielechowski, Kookesh, Meyer, Paskvan, McGuire
Requestor: Senate HSS

Dept. Affected: Health and Social Services
Appropriation: Public Assistance
Allocation: Senior Benefits Payment Program
OMB Component Number: 2897

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services		486.0	486.0	486.0	486.0		
Travel		9.7	9.7	9.7	9.7		
Contractual		169.7	169.7	169.7	169.7		
Supplies		43.5	43.5	43.5	43.5		
Equipment							
Land & Structures							
Grants & Claims	1,968.1	19,776.4	22,349.3	22,970.9	23,606.5		
Miscellaneous							
TOTAL OPERATING	**1,968.1**	**20,485.3**	**23,058.2**	**23,679.8**	**24,315.4**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	1,968.1	20,485.3	23,058.2	23,679.8	24,315.4		
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**1,968.1**	**20,485.3**	**23,058.2**	**23,679.8**	**24,315.4**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time		6.00	6.00	6.00	6.00		
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared by: Ron Kreher, Acting Director — Phone 465-2680
Division: Public Assistance — Date/Time 1/28/11 5:45 PM
Approved by: Alison Elgee, Assistant Commissioner — Date 1/28/2011
DHSS Finance & Management Services

Analysis:

Analysis:

The Senior Benefits Payment Program helps low income seniors who are age 65 or older remain independent in the community by providing a monthly income supplement to help meet their basic needs, such as food and housing. Currently the program is set to expire on June 30, 2011. This legislation continues the program through June 30, 2015. As of December 2010, the current program enrollment was 10,093. The number and percent of seniors at each payment level was:

* $250 - 1,071 (10.6%)
* $175 - 3,872 (38.4%)
* $125 - 5,150 (51.0%)

Assumptions:

* Current staffing levels for the program will be maintained and will consist of one Eligibility Technician III, four Eligibility Technician I's, and one Office Assistant I.
* Annual expenditures for Personal Services, Travel, Contractual, and Supplies will remain constant for FY 2012 through FY 2015.
* Projected grant expenditures in FY 2011 are expected to be about $21.0 million. A supplemental for $1.3 million has been requested in FY 2011.
* Annual grant expenditures are expected to increase in response to a projected caseload growth of 3% annually in the out years.
* Grant expenditures for FY 2012 through FY 2015 are expected to increase as follows:
-- 3.55 percent in FY 2012
-- 2.78 percent in FY 2013
-- 2.78 percent in FY 2014
-- 2.77 percent in FY 2015

With the exception of the amount shown in the FY 2012 appropriation needed column, all of the represented costs are contained in the governor's proposed FY 2012 budget.

See attached projected caseload and grant expenditures.

Senior Benefit CASELOAD Summary (progra

	CY/PY Caseload Change	FY10 Cases Projection	CY/PY Caseload Change	FY11 Cases Projection	CY/PY Caseload Change	FY12 Cases Projection	CY/PY Caseload Change	FY13 Cases Projection	CY/PY Caseload Change	FY14 Cases Projection	CY/PY Caseload Change	FY15 Cases Projection	CY/PY Caseload Change	FY16 Cases Projection	
July	840	9,973	166	10,139	302	10,441	253	10,694	380	11,074	280	11,354	345	11,700	July
Aug	665	9,974	184	10,158	303	10,461	265	10,726	370	11,096	292	11,388	335	11,723	Aug
Sep	613	9,973	193	10,166	316	10,482	276	10,758	360	11,119	304	11,423	324	11,746	Sep
Oct	685	10,006	167	10,173	330	10,503	287	10,790	350	11,141	316	11,457	325	11,782	Oct
Nov	678	9,987	122	10,109	415	10,524	298	10,823	340	11,163	328	11,491	326	11,817	Nov
Dec	672	9,959	134	10,093	452	10,545	310	10,855	330	11,185	340	11,526	327	11,853	Dec
Jan	673	9,982	283	10,265	302	10,566	321	10,888	320	11,208	352	11,560	328	11,888	Jan
Feb	605	9,946	350	10,296	292	10,588	333	10,921	310	11,230	353	11,583	340	11,924	Feb
Mar	545	10,038	289	10,327	282	10,609	344	10,953	299	11,253	354	11,607	353	11,960	Mar
Apr	402	10,075	282	10,357	273	10,630	356	10,986	289	11,275	355	11,630	366	11,995	Apr
May	286	10,108	281	10,389	263	10,651	368	11,019	279	11,298	355	11,653	378	12,031	May
Jun	200	10,086	334	10,420	253	10,673	380	11,052	268	11,320	356	11,676	391	12,067	Jun
Monthly Average	572	10,009	232	10,241	315	10,556	316	10,872	325	11,197	332	11,529	345	11,874	
Percent C	6.1%		2.3%		3.1%		3.0%		3.0%		3.0%		3.0%		

Senior

	Difference	FY10 Expend Actual	Difference	FY11 Expend Projection	Difference	FY12 Expend Projection	Difference	FY13 Expend Projection	Difference	FY14 Expend Projection	Difference	FY15 Expend Projection	Difference	FY16 Expend Projection	
July	990.0	3,145.9	39.2	3,185.1	20.2	3,205.3	40.4	3,245.7	60.7	3,306.3	44.7	3,351.0	55.1	3,406.1	July
Aug	-40.9	1,595.6	25.1	1,620.7	47.9	1,668.6	42.2	1,710.8	59.1	1,769.9	46.6	1,816.4	53.4	1,869.8	Aug
Sep	89.4	1,598.9	17.0	1,615.9	56.0	1,671.9	44.0	1,715.9	57.5	1,773.4	48.5	1,821.9	51.7	1,873.6	Sep
Oct	98.6	1,598.4	14.5	1,612.9	62.4	1,675.3	45.8	1,721.1	55.9	1,777.0	50.4	1,827.4	51.8	1,879.2	Oct
Nov	96.4	1,586.0	4.1	1,590.1	88.5	1,678.6	47.6	1,726.2	54.3	1,780.5	52.3	1,832.8	52.0	1,884.8	Nov
Dec	96.8	1,583.2	17.2	1,600.4	81.6	1,682.0	49.4	1,731.4	52.7	1,784.1	54.3	1,838.3	52.1	1,890.5	Dec
Jan	80.5	1,573.8	42.9	1,616.7	68.6	1,685.4	51.3	1,736.6	51.0	1,787.6	56.2	1,843.9	52.3	1,896.1	Jan
Feb	96.9	1,587.2	34.4	1,621.6	67.2	1,688.7	53.1	1,741.8	49.4	1,791.2	56.3	1,847.5	54.3	1,901.8	Feb
Mar	78.4	1,612.4	14.0	1,626.4	65.7	1,692.1	54.9	1,747.0	47.8	1,794.8	56.4	1,851.2	56.3	1,907.5	Mar
Apr	-531.1	1,041.6	589.7	1,631.3	64.2	1,695.5	56.8	1,752.3	46.1	1,798.4	56.5	1,854.9	58.3	1,913.3	Apr
May	-439.5	1,165.8	470.4	1,636.2	62.7	1,698.9	58.7	1,757.5	44.4	1,802.0	56.7	1,858.7	60.4	1,919.0	May
Jun	291.8	1,051.3	589.8	1,641.1	61.2	1,702.3	60.5	1,762.8	42.8	1,805.6	56.8	1,862.4	62.4	1,924.8	Jun
Total		**19,147.9**		**20,998.4**	**746.1**	**21,744.5**	**604.7**	**22,349.3**	**621.6**	**22,970.9**	**635.6**	**23,606.5**	**660.0**	**24,266.5**	
		* see note													
Monthly Average	75.6	1,595.0	154.9	1,749.9	62.2	1,812.0	50.4	1,862.4	51.8	1,914.2	53.0	1,967.2	55.0	2,022.2	
t Change	5.0%		9.7%		3.6%		2.8%		2.8%		2.8%		2.8%		

	FY10 With Supplemental	FY11	FY12	FY13	FY14	FY15	FY16
	18,926.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4
	256.0	0.0	0.0	0.0	0.0	0.0	0.0
	19,182.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4	19,776.4
	19,147.9	20,998.4	21,744.5	22,349.3	22,970.9	23,606.5	24,266.5
	34.5	(1,222.0)	(1,968.1)	(2,572.9)	(3,194.5)	(3,830.1)	(4,490.1)
	Revised projections to accuratly reflect the percentage breakdown between the three pmt amounts. Instead of 11% for $250 it is 10%, instead of 43% $175 it is 40% and instead of 46% for $125 it is 50%. mds 110310			2.78%	2.78%	2.77%	2.80%
	RP needs to be requested for FY11 to cover projected shortage based on 10% increase in FY11 compared to FY10 mds 120610						
	Requested FY11 Supplemental for $1,300.0 of additional GF.122310mds						
			3.55%				

Preliminary Testimony List for SB21
An Act To Extend The Senior Benefit

Denise Daniello, Alaska Commission on Aging

Marie Darlin, Alaska Commission on Aging and AARP volunteer.

Mary Sullivan, Manager of the Seniors Behavioral Health Coalition

Sandy Camery, Executive Director of Mabel T. Caverly Senior Center

ALASKA STATE LEGISLATURE

Session

State Capitol, Rm. 101
Juneau, AK 99801
(907) 465-2435
Fax: (907) 465-6615

Interim

716 W. 4th Ave, Ste. 540
Anchorage, AK 99501
(907) 269-0120
Fax: (907) 269-0122

Senator_Bill_Wielechowski@legis.state.ak.us

Chair
State Affairs Committee

Co-chair
Joint Armed Services Committee

Vice Chair
Resources Committee
Judiciary Committee

Member
Administrative Regulation Review

SENATOR BILL WIELECHOWSKI

SENIOR BENEFIT FACT SHEET 1

How It Works

Low-income seniors are eligible for monthly benefit amounts of $125, $175 or $250 a month **based on gross annual income**.

	$250 monthly payment (75% Federal Poverty Guideline)	$175 monthly payment (100% FPG)	$125 monthly payment (175% FPG)
Individual [1]	$10,148 ($846 a month)	$13,530 ($1,128 a month)	$23,678 ($1,972 a month)
Married Couple [2]	$13,658 ($1,139 a month)	$18,210 ($1,518 a month)	$31,868 ($2,646 a month)

Eligibility is based on **gross annual income**, before deductions are taken for taxes, Medicare premiums, etc. Assets such as savings accounts are not considered.

Income limits are tied to the **Federal Poverty Guideline for Alaska** and are updated annually.

Percentage of Seniors **at each payment level**:
$250 - 10.6%
$175 - 38.5%
$125 - 50.9%

The program cost **$19.6 million last year**, with $460,600 (2.3%) going to administrative costs. It's projected cost for the **upcoming year is $2.1 million**. [LINK]

SENIOR BENEFIT FACT SHEET 2: Who Benefits

The average age of a recipient is **75 years**.

There were **10,109 senior Alaskans** who received a monthly Senior Benefit in 2010. [HHS]

Alaskans are not eligible for the senior benefits if they are in **prison/jail, live in an institution for mental disease, live in a nursing home or currently reside in an Alaska Veterans' Home or Alaska Pioneers Home.**

Senior Benefit recipients by region
Alaska Committee On Aging

# of Senior Benefits Recipients	Nov. 2010:	% of Seniors Age 65+:
Statewide	*10,109*	*19.3%*
I. Bethel Area	812	57.4%
II. Interior	1,214	17.0%
III. North Slope	38	10.7%
IV. Anchorage	3,642	17.7%
V. Southcentral	2,353	18.0%
VI. Aleutians	35	16.3%
VII. Southwest	421	28.8%
VIII. Northwest	401	39.4%
IX. Southeast	1,188	17.0%

SENIOR BENEFIT FACT SHEET 3: The Need

In 2010, the financial advisory organization "MoneyRates" ranked Alaska as **the third-worst state in the nation in which to retire**, citing in part the high cost of living. [MoneyRates]

In Alaska, **14% of seniors** live below the poverty level. An estimated **4,000 Alaska seniors** rely on food stamps. [Kaiser Family]

Health care costs have skyrocketed in Alaska over the past decade, **growing by 53.9% versus the 29.1% rise in the overall price index. [Alaska Economic Trends 2010]**

The average cost of food in Alaska is at least 20% higher than the national average. Based on the "Thrifty Plan," the cheapest USDA food plan with all meals cooked at home, the average Alaska senior spends **$2,171.99 - $2,085.36** on food a year. [USDA]

How much more expensive things are in Alaska than in the Lower 48 [AK Econ Trends]

	Groceries	Housing	Utilities	Transportation	Health Care
Anchorage	29.3%	37.0%	1.9%	18.2%	27.6%
Fairbanks	23.9	50.2	59.4	26.5	44.3
Juneau	30.4	34.8	30.8	25.7	42.2
Kodiak	45.0	21.9	27.5	40.5	28.7

Energy Costs In Alaskan Cities, Rural Towns [AK Econ Trends]

	One Gallon Heating Oil	One Gallon Gasoline	One Gallon Propane
Anchorage	$3.26	$3.33	$4.60
Bethel	$4.62	$5.37	$7.84
Fairbanks	$3.07	$3.29	$3.75
Juneau	$3.08	$3.11	$3.68
Kenai-Soldotna	$2.75	$3.65	$4.35
King Salmon	$3.87	$4.45	$6.23
Nome	$4.38	$4.49	$5.70
Sitka	$2.69	$3.15	$3.50

10 worst states for retirement

by Richard Barrington | Money-Rates Columnist

What makes a place the ideal spot for retirement -- and what makes other places a potential disaster for retirees?

There are several personal choices that make some places more attractive than others -- where your children and grandchildren live is probably at the top. But there are some more objective and measurable factors that determine whether a state is a good or a bad place for retirees. The following are the factors MoneyRates.com used to determine the 10 best and worst states for retirement:

- **Economic factors.** Using a combination of cost of living in major metropolitan areas, unemployment and tax burden, MoneyRates.com rated the 50 states from best to worst according to economic conditions.
- **Climate.** Americans tend to set the thermostat at around 68 degrees. So, MoneyRates.com used this as the standard, and rated states according to how far their monthly temperatures varied from 68 degrees.
- **Crime rate.** Security is a particular concern for senior citizens, so violent and property crime rates were used to rank the safety of the state.
- **Life expectancy.** States conducive to long lives are naturally well-suited for retirees.

For frequently updated data, such as unemployment, the most recently available monthly figures were used, whereas for other criteria that reflect longer-term trends, such as climate, more historical information was used.

Data sources: ACCRA Cost of Living Index, the Bureau of Labor Statistics, the Tax Foundation, the National Oceanic and Atmospheric Administration, MSNBC, the U.S. Census Bureau, Bloomberg Business Week.

No. 5: Maryland

- *Economic factors*: Cost of living is 126 percent of the national average, unemployment is at 7.1 percent, and the average state and local tax burden is 10.8 percent.
- *Climate*: Average monthly temperatures range from 32.24 degrees in January to 75.44 degrees in July.
- *Crime rate*: 9th in the nation in violent crime, and 21st in property crime.
- *Life expectancy:* 76.3 years.
- *Reason for low rank:* Between the cost of living and the tax burden, Maryland is

expensive, and the high rate of violent crime is also troubling.

No. 4: South Carolina

- *Economic factors*: Cost of living is 97 percent of the national average, unemployment is at 10.8 percent, and the average state and local tax burden is 8.8 percent.
- *Climate*: Average monthly temperatures range from 44.12 degrees in January to 80.08 degrees in July.
- *Crime rate*: 1st in the nation in violent crime, and 2nd in property crime.
- *Life expectancy:* 74.8 years.
- *Reason for low rank:* You can find things to like in South Carolina -- the pleasant climate, for example -- but the high crime rates would be enough to scare off many retirees, and the life expectancy (one of the lowest in the nation) is a downside.

No. 3: Alaska

- *Economic factors*: Cost of living is 128 percent of the national average, unemployment is at 7.7 percent, and the average state and local tax burden is 6.4 percent.
- *Climate*: Average monthly temperatures range from 16.5 degrees in January to 59.0 degrees in July.
- *Crime rate*: 8th in the nation in violent crime, and 23rd in property crime.
- *Life expectancy:* 77.1 years.
- *Reason for low rank:* The nation's lowest tax burden is more than offset by the high cost of living, and the harsh climate and high rate of violent crime are not friendly to retirees.

No. 2: Michigan

- *Economic factors*: Cost of living is 97 percent of the national average, unemployment is at 13.1 percent, and the average state and local tax burden is 9.4 percent.
- *Climate*: Average monthly temperatures range from 18.87 degrees in January to 68.32 degrees in July.
- *Crime rate*: 10th in the nation in violent crime, and 27th in property crime.
- *Life expectancy:* 76.3 years.
- *Reason for low rank:* The high unemployment rate is indicative of a severely damaged economy, the climate is a little rough, and the violent crime rate is a concern.

No. 1: Nevada

- *Economic factors*: Cost of living is 105 percent of the national average, unemployment is at 14.3 percent, and the average state and local tax burden is 6.6 percent.
- *Climate*: Average monthly temperatures range from 30.43 degrees in January to 71.94 degrees in July.
- *Crime rate*: 3rd in the nation in violent crime, and 13th in property crime.
- *Life expectancy:* 75.8 years.

- *Reason for low rank:* Nevada has the second lowest tax rate in the country, but scored poorly on just about every other criterion. Gambling enthusiasts may disagree, but high crime rates and a dismal economy make Nevada a bad bet for retirees.

For the full list of states, check our blog post Best and worst states for retirement: The complete list.

About the Author

Richard Barrington has earned the CFA designation and is a 20-year veteran of the financial industry, including having served for over a dozen years as a member of the Executive Committee of Manning & Napier Advisors, Inc. Richard has written extensively on investment and personal finance topics.

AARP

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

February 1, 2011

The Honorable Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska Capitol, Room 30
Juneau, AK 99801-1182

RE: HB 16 (Hawker) and SB 21 (Wielechowski)—Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we are pleased to indicate our very strong support for HB 16, authored by Representative Mike Hawker which will extend the Senior Benefits program for another four years as well as SB 21, authored by Senator Bill Wielechowski. SB 21 has a Primary co-sponsorship by your Committee colleague Senator Kevin Meyer as well as co-sponsorship by your Committee colleague Senator Johnny Ellis. Senators Kookesh, McGuire and Paskvan are also primary co-sponsors and Senators French and Menard are co-sponsors. Representative Hawker's HB 16 has twenty-one co-sponsors and passed the House 37-0.

There is no doubt that the Senior Benefits program has proven to be an invaluable help to many older Alaskans who might not be able to afford to stay here without it.

We all recognize that Alaska's seniors face high health care costs as well as high energy costs.

The Senior Benefits program has allowed over 10,000 older Alaskans to deal with these costs and to remain citizens of our state.

We want Alaskans to be able to stay here after retirement. The Senior Benefits program is essential to achieve that goal.

AARP recommends an "AYE" vote for HB 16 as well as for SB 21.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Egan
Senator Ellis
Senator Meyer
Senator Dyson
Senator Wielechowski
Representative Hawker

Alaska State Legislature

Please enter into the record my testimony to the Senate Health & Social Services
committee name

Committee on SB 21, dated 2-2-11
bill # / subject public hearing date

TO: Honorable Senators of the State of Alaska

Regarding SB 21.

FROM: Mary Wallis

I am very concerned about the potential loss of Senior Benefits.
I am a 70 year old woman whose annual social security benefit is $11,976.
I also have a part-time job for my past employer which grosses $1940 annually
(which I have to pay SE taxes on).

Since I retired at age 64, my benefits can never increase, and without the help of my family,
I could not survive financially.
But my mother, Dorothy Westphal, is 89 years old and will need our help.

Please consider situations such as mine, and others who have worse situations.
Frankly I will have a very tough time getting by without the help from Senior Benefits.
Thank you for your attention.

Signed: Mary Wallis
Testifier

Representing (optional)

5125 Silver Salmon Drive #15 Kenai, AK 99661
Address

(907 283-0668)
Phone number

PHONE CALL

FOR Senator Davis DATE 2-1-11 TIME 11:29 A.M. P.M.

M Dixie Hood - Age 77

OF 789-2068

PHONE ~~24~~ Mr. Voelkmar → 3862200 CELL

MESSAGE Sr. Benefits Legistion Gross Income & Net Income

SIGNED p.m.

- [x] TELEPHONED
- [ ] RETURNED YOUR CALL
- [ ] PLEASE CALL
- [ ] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

Matsu Legislative Information
— Office —
600 E. Railroad Ave.
Wasilla, AK. 99654-8135

January 12, 2011

Barbara A. Schumacher
P.O. Box 873505
Wasilla, AK. 99687

To Whom it may concern,
Please think very carefully about the Senior Benefits Program, here in Alaska. It has been a great source of comfort & financial stability to me for the last 3 years. I shudder to think what it would mean to your Senior Constituents, who benefit so greatly from this program if it were to be discontinued
Thank you for your consideration.

Sincerely,
Barbara A. Schumacher - age 75
BARBARA A. SCHUMACHER
Wasilla, AK.

Date: January 12, 2011

To: MatSu Legislative Office

To whom it may concern;

I am the daughter of a Wasilla area resident senior citizen. It has come to my attention that the State needs to seek renewal for the Alaska Senior Citizen Benefits Program. I strongly support this program and urge the State to petition for renewal of this very important service to our Seniors. The Senior Care benefits that my mother receives allow her that tiny bit of extra wiggle room on her fixed retirement income, without which, her standard of living will become negatively affected.

Many Alaskan Seniors are in similar, or worse, situations. Without these benefits the State would surely see a rise in emergency medical care resulting from senior's not getting the medications, doctor visits, appropriate food, etc. they need because of less income.

Please support the continued funding for the Alaska Senior Citizen Benefits Program.

Sincerely,

Mrs. Katherine McLaughlin
PO Box 8043
Chenega Bay, Alaska 99574

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

January 19, 2011

The Honorable Bill Wielechowski
Member of the Senate
Alaska Capitol, Room 101
Juneau, AK 99801-1182

RE: SB 21 (Wielechowski, Kookesh, Meyer, Paskvan, McGuire)—Support

Dear Senator Wielechowski:

On behalf of the members of AARP in Alaska, we are pleased to indicate our very strong support for SB 21 which will extend the Senior Benefits program for another four years.

There is no doubt that the Senior Benefits program has proven to be an invaluable help to many older Alaskans who might not be able to afford to stay here without it.

We all recognize that Alaska's seniors face high health care costs as well as high energy costs.

The Senior Benefits program has allowed over 10,000 older Alaskans to deal with these costs and to remain citizens of our state.

We want Alaskans to be able to stay here after retirement. The Senior Benefits program is essential to achieve that goal.

On behalf of all those older Alaskans who may not be aware of your leadership on this issue, please accept our thanks for all that you have done, continue to do, and will do in the future.

We are pleased to thank Senators Kookesh, Meyer, Paskvan, and McGuire as prime co-sponsors and Senators French and Menard as co-sponsors for SB 21.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Albert Kookesh
Senator Kevin Meyer
Senator Joe Paskvan
Senator Lesil McGuire
Senator Hollis French
Senator Linda Menard

Jennie Chin Hansen, President
Addison Barry Rand, Chief Executive Officer

Senior Snapshot: Older Alaskans in 2009

Older Alaskans are a highly diverse group of individuals, living a great variety of lifestyles in communities large and small. Statistics about our senior population do not capture the unique personalities and circumstances of all the seniors we know. Nevertheless, information about some aspects of the collective lives of Alaska's seniors illustrates many of the issues of concern to older Alaskans and their advocates.

The Alaska Commission on Aging has gathered a selection of data on older Alaskans in order to provide a sketch of the older residents of our state and their well-being. In our ***Senior Snapshot: Older Alaskans in 2009***, we offer a number of data points, which corroborate the following observations:

- For the second year in a row, Alaska has the fastest-growing senior population of the 50 states, with an increase of almost 50% among individuals age 65 and older during the past ten years.

- While senior populations in several regions have grown especially rapidly in the past seven years (for example, the Southcentral region's seniors have increased by over 60%), all nine regions have witnessed an increase in their senior populations of at least 18% during this time period.

- Older baby boomers are swelling the ranks of the youngest group of seniors, now the fastest-growing age group, second to the 85-and-older group, whose members are the most frail, the most likely to struggle with Alzheimer's disease and related dementias (ADRD), and the most likely to depend on home- and community-based care as well as institutional long-term support services.

- While Alaska seniors appear less likely to be living in poverty than the national average among seniors, many of them are struggling to get by financially. Over 20 percent of Alaskans age 65 and older are receiving a modest monthly cash supplement from the Senior Benefits Program, a percentage which varies greatly by location, from 13 percent in the North Slope region to 59 percent in the Bethel/Wade Hampton region. To qualify for this program, seniors must have incomes below 175% of the federal poverty level for Alaska. In 2009, that meant no more than $23,678 for a single senior, and no more than $31,868 for a couple.

- Retired seniors as a whole contribute approximately $1.7 billion annually to Alaska's economy, including their retirement income and health care spending. While Alaska's "retirement industry" may not yet be competing with those of Florida or Arizona, this source of cash flow is in fact one of the state's top industries. And its value is enhanced by the fact that it produces local spending and is environmentally benign, stable, year-round, compatible with other industries, spread throughout the state, and helps create economies of scale (particularly in health care) which benefit the entire population.

- Alaskan seniors are more likely than U.S. seniors as a whole to die of causes linked to behavioral health issues. Older Alaskans have high suicide rates as well as high rates of accidental deaths and alcohol-induced deaths. These figures suggest that behavioral health programs targeted to seniors with depression, other mental illness, and substance abuse problems could have a dramatic impact on our seniors' quality of life.

- In spite of these areas of unfavorable comparison, Alaska's seniors are actually healthier than the national average – less likely to die from any of the leading causes of death and less likely to die in a given year from *any* cause of death. Alaskan seniors' age-adjusted death rates are substantially lower than those of U.S. seniors as a whole. For every 100,000 Alaskans age 65 and older, only 3,818 die in a given one-year period, while for every 100,000 U.S. seniors, 4,722 die during that period. In other words, an Alaskan senior is 19 percent less likely to die (from any cause) during a given year than his or her U.S. counterpart.

- Alaskan seniors report higher levels of self-described disability than do U.S. seniors as a whole. The BRFSS (Behavioral Risk Factor Surveillance System, a Public Health phone survey) asks whether they are "limited in their activities because of physical, mental, or emotional problems." Alaskan seniors are about 20 percent more likely to answer, "Yes."

- Today's Pioneer Home residents are more likely than not to require care at Level III, the most advanced level of care, which includes 24-hour nursing care. This presents the Pioneer Homes with a challenge because it is a very different mix of residents from that which the homes were originally designed to serve. However, one reason for this more intensive level of need is that older Alaskans are able to remain in their own homes longer today thanks to more comprehensive home- and community-based services. The average Pioneer Home resident today is more than six years older than the average resident of a decade ago.

- A substantial number of complaints about abuse and neglect involving seniors are being received by agencies such as Adult Protective Services and the Long-Term Care Ombudsman's Office. Cases of abuse, neglect and exploitation of seniors may involve friends and family members, paid caregivers, telemarketers, and others. Reports to Adult Protective Services have increased by 169% in the last four years alone.

Senior Snapshot: Older Alaskans in 2009

Population Age 60+	2008	% of Area's Total 2008 Pop.	Seniors Change Since 2001	Comments
Statewide Total	*79,850*	*11.7%*	*+43.2%*	*All census areas. 4.6% increase over 2007.* **NOTE 1**
I. Bethel Area	2,089	8.5%	+18.3%	Bethel, Wade Hampton
II. Interior	11,254	10.8%	+46.5%	Fairbanks NSB, Yukon-Koyukuk, Denali, SE Fbks
III. North Slope	579	8.6%	+19.6%	North Slope Borough
IV. Anchorage	31,220	11.0%	+39.6%	Municipality of Anchorage
V. Southcentral	19,533	13.5%	+61.1%	Kenai Peninsula, Mat-Su, Valdez-Cordova
VI. Aleutians	471	6.6%	+26.3%	Aleutians East, Aleutians West
VII. Southwest	2,307	11.1%	+36.7%	Bristol Bay, Dillingham, Kodiak, Lake & Peninsula
VIII. Northwest	1,588	9.4%	+21.2%	Nome, Northwest Arctic
IX. Southeast	10,809	15.6%	+35.4%	Haines, Juneau, Ketchikan, Prince of Wales, Sitka, Skagway-Hoonah-Angoon, Wrangell-Petersburg, Yakutat
		% of AK Seniors:		
Age 60-64	30,395	38.1%	+62.9%	Older baby boomers entering this group. **NOTE 2**
Age 65-74	31,019	38.8%	+34.1%	
Age 75-84	13,795	17.3%	+24.1%	
Age 85+	4,641	5.8%	+61.4%	
Rank Among States in Growth of Senior Population	Ranking: #1	AK Growth, 1998-2008: 49.8%	U.S. Avg. Growth: 13.0%	Age 65+. **NOTE 3**

Economic Status			Comments
Seniors' Economic Contribution to Alaska	2004: $1.461 billion*	2008: $1.662 billion**	*ISER figure from "Report on the Economic Well-Being of Alaska Seniors" (2007) **2009 ACOA estimate. **NOTE 4**
Percent in Poverty (Age 65+)	Alaska, 2008:	U.S., 2008:	2009 Current Population Survey/American Social and Economic Supplement
Below 100% FPL	3.4% (Rank: #51)	9.7%	Not adjusted for higher living costs in Alaska (FPL = Federal Poverty Level)
Average Monthly Social Security Pmt, Age 65+	AK, Dec. 2008: $1,087	U.S., Dec. 2008: $1,123	A total of 45,710 Alaskans age 65+ received Social Security benefits (92%). Social Security Administration. **NOTE 5**
Average Monthly PERS Pmt	$1,503.57	# of seniors: 10,705	AK Dept. of Administration, Div. of Retirement & Benefits. Public Employees Retirement System. **NOTE 6**
Average Monthly TRS Pmt	$2,715.70	# of seniors: 4,087	AK Dept. of Administration, Div. of Retirement & Benefits. Teachers Retirement System. **NOTE 7**
# of Senior Benefits Recipients	Nov. 2009:	% of Seniors Age 65+:	Alaska Division of Public Assistance. **NOTE 8**
Statewide	*9,987*	*20.2%*	*7.3% increase over Nov. 2008 statewide total*
I. Bethel Area	812	58.9%	0.6% increase over Nov. 2008 region total
II. Interior	1,200	17.6%	8.2% increase over Nov. 2008 region total
III. North Slope	45	13.2%	9.8% increase over Nov. 2008 region total
IV. Anchorage	3,572	18.6%	6.5% increase over Nov. 2008 region total
V. Southcentral	2,363	19.3%	9.8% increase over Nov. 2008 region total
VI. Aleutians	39	20.3%	21.9% increase over Nov. 2008 region total
VII. Southwest	422	29.7%	9.0% increase over Nov. 2008 region total
VIII. Northwest	413	40.2%	5.6% increase over Nov. 2008 region total
IX. Southeast	1,120	16.5%	8.7% increase over Nov. 2008 region total
Seniors (Age 60+) on Food Stamps	Nov. 2009: 3,861 (60+)	Nov. 2009: 2,239 (66+)	Alaska Division of Public Assistance; senior (age 60+) Food Stamp recipients up 22% since November 2008

Senior Snapshot: Older Alaskans in 2009

Avg. Mo. Benefit (Food Stamps)	$160.72 (Age 60-65)	$99.23 (Age 66+)	Alaska Division of Public Assistance. **NOTE 9**
Seniors Receiving Old Age Assistance (Adult Public Assistance)	November 2009: number of AK seniors: 5,045 (29.1% of all APA)	November 2009: average amount of APA monthly benefit, all recipients: $277.91	Alaska Division of Public Assistance. **NOTE 10**
Senior Medicaid Eligibles	Dec. 2009: 9,064	% of Senior Pop.: 11.4%	Alaska Division of Public Assistance

Senior Health	Alaska	U.S.	Comments
# with ADRD (estimate)	2008: 5,702	5,300,000	AK estimate based on national prevalence rates by age group. **NOTE 11**
Age-adjusted death rate (per 100,000 seniors 65+)	2008: 3,817.6	2006: 4,721.9	Alaska Bureau of Vital Statistics. **NOTE 12**
Suicide rate (per 100,000 seniors age 65+)	2004-2008: 19.9	2006: 14.2	Alaska Bureau of Vital Statistics. **NOTE 13**
Other accidental deaths (per 100,000 age 65+)	2004-2008: 78.2	2006: 53.8	Alaska Bureau of Vital Statistics. "Other accidental deaths" exclude fatal falls. **NOTE 14**
Alcohol-induced deaths	2004-2008: 34.0	2006: 11.6	Alaska Bureau of Vital Statistics. **NOTE 15**
Leading causes of death:	2008 (AK):	2006 (U.S.):	Alaska Bureau of Vital Statistics. **NOTE 16**
Cancer	1,015.1	1,040.0	Per 100,000 age 65+
Heart diseases	833.1	1,370.2	Per 100,000 age 65+
Stroke	250.7	314.0	Per 100,000 age 65+
Chronic lower respiratory diseases	285.1	286.8	Per 100,000 age 65+
Alzheimer's disease	157.7	192.3	Per 100,000 age 65+
Diabetes mellitus	133.5	140.5	Per 100,000 age 65+
Binge drinkers	2.7%	3.2%	Age 65+ - 2008 BRFSS. **NOTE 17**
Heavy drinkers	3.4%	3.0%	Age 65+ - 2008 BRFSS. **NOTE 18**
Smokers	9.7%	8.2%	Age 65+ - 2008 BRFSS. **NOTE 19**
Disabled seniors	39.4%	32.7%	Age 65+ who are "limited in activities because of physical, mental or emotional problems" – 2008 BRFSS. **NOTE 20**
Obese seniors	31.6%	22.9%	Age 65+ - 2008 BRFSS. **NOTE 21**
People with "frequent mental distress"	2008: Age 65+: 8.7% Age <65: 13.5%	2006: Age 65+: 17.9% Age <65: 14.2%	2006, 2008 BRFSS. **NOTE 22**
Pioneer Home residents at Level III	12/31/2009: 58.1%		Data provided by Div. of Pioneer Homes. Level III is the most advanced level of care.
Avg. age of PH resident	Sept. 1, 2009: 82.3 years	1998: 76 years	Data provided by Div. of Pioneer Homes.
Nursing home costs – private room, daily rate	AK, 2009: $618*	U.S. avg, 2009: $219	*AK: highest cost in the U.S.; MetLife Mature Market Institute, 2009 Market Survey of Long-Term Care Costs
Older Alaskans Medicaid waiver recipients	FY 2009: 1,651	FY 2008: 1,536	Info from Senior & Disability Services. **NOTE 23**
Senior grants clients	FY 2009: 15,352	FY 2008: 16,502	Info from Senior & Disability Services. **NOTE 24**

Senior Snapshot: Older Alaskans in 2009			
Senior Safety			**Comments**
Long-Term Care Ombudsman complaints	FY 2009: 337	FY 2008: 208	Complaints involving seniors (age 60+) in long-term care. Data from the Office of the Long-Term Care Ombudsman
Adult Protective Services reports	FY 2009: 2,748	FY 2005: 1,021	Adult Protective Services (APS), Senior & Disabilities Services
Corrections intakes of seniors	CY 2009 636:	CY 2008: 787	Intakes of seniors (age 60+) to correctional facilities any time during 2009; info from AK Dept. of Corrections
Senior offenders in AK prisons	12/31/2009: 150	12/31/2008: 148	Per AK Dept. of Corrections; 144 are male, 6 female; 141 felony, 9 misdemeanor,

NOTES:

1. Data from Alaska Department of Labor and Workforce Development's 2008 population estimates. Regions are those used by the Alaska Department of Health & Social Services. "The Alaska State Plan for Senior Services, FY 2008 – FY 2011" prescribes funding by region for those grant programs which include federal Older Americans Act money.

2. Data from Alaska Department of Labor and Workforce Development's 2008 population estimates. Percent of area population column shows percent of statewide population in each age group.

3. Data from "A Profile of Older Americans: 2009," Administration on Aging, U.S. Department of Health and Human Services. The five states with the fastest-growing senior populations during the decade from 1998 through 2008 were Alaska (49.8%), Nevada (48.1%), Arizona (39.7%), Utah (33.7%), and New Mexico (31.3%). Rhode Island and Washington, DC saw a decline in senior population during this decade. Alaska's gains reflect the choices of more and more seniors to remain in the state after retirement.

4. The University of Alaska Anchorage's Institute for Social and Economic Research (ISER) estimated the 2004 cash contribution of Alaska retirees age 60 and older at $1.461 billion. The estimate is contained in the 2007 ACOA-commissioned "Report on the Economic Well-Being of Alaska Seniors," available on the Commission's website at: http://www.hss.state.ak.us/acoa/documents/seniorWellbeingReport.pdf . The Commission estimated seniors' 2009 contributions by applying the increases in the Anchorage Consumer Price Index for 2005 (3.1%), 2006 (3.2%), 2007 (2.2%), and 2008 (4.6%) to the 2004 base figure.

5. Data obtained from Social Security Administration's website. Alaska average includes all Alaska residents age 65 and older who receive Social Security retirement benefits, a total of 45,710 people. U.S. average includes all U.S. residents age 65 and older who receive Social Security retirement benefits. The Alaska average monthly payment may be lower because of the high percentage of Alaska retirees who are subject to the "Windfall Elimination Provision," which limits Social Security retirement benefits to many individuals receiving public employee pensions.

6. Figures on PERS (Public Employee Retirement System) benefits include PERS retirees age 60 and older who currently reside in Alaska.

7. Figures on TRS (Teachers Retirement System) benefits include TRS retirees age 60 and older who currently reside in Alaska.

8. Alaskans age 65 and older with incomes up to 175% of the Federal Poverty Level (FPL) for Alaska are eligible for the Senior Benefits Program. For 2009, 175% of the Alaska FPL was $23,678 for a single senior and $31,868 for a couple.

9. Seniors age 65 and older often have higher incomes than those in the 60 – 64 age group because they are receiving Social Security retirement benefits or other benefits that begin at age 65. Hence the lower average monthly Food Stamps value for the 65+ population.

10. Adult Public Assistance is a supplement to SSI, so recipients must be either certified as disabled by the Social Security Administration (with severe long-term disabilities that impose mental or physical limitations on their day-to-day functioning) or be age 65 and older. There are income limits for the program, which is intended to assist aged or disabled individuals in attaining self-support or self-care.

11. ADRD: Alzheimer's disease and related dementias. Alaska ADRD population was estimated by the Alaska Commission on Aging based on national (per Dr. Denis Evans, 1990) prevalence rates of three percent for those age 65 to 74, 18.7 percent for those age 75 to 84, and 47.2 percent for those age 85 and older. National estimate is for 2009, from the Alzheimer's Association's "2009 Alzheimer's Facts and Figures." "The dramatic rise in Alzheimer's underscores that the disease has the ability to undermine the entire U.S. health care system," according to Stephen McConnell, Ph.D., the vice president of advocacy and public policy for the Alzheimer's Association.

12. The age-adjusted death rate shows how many people out of every 100,000 in a particular age group died during a given time period. For states like Alaska with fewer than 100,000 people in the 65-and-older age group, adjustments are made to produce a comparable figure. This statistic tells us that Alaskans age 65 and older were substantially less likely to die from any cause than U.S. seniors as a whole.

13. Alaska's senior suicide rate is 40% higher than that of U.S. seniors as a whole.

14. Alaska's "Other Accidental Deaths" (excluding fatal falls) are 45% higher for seniors here compared with the U.S. as a whole.

15. Alaska seniors are nearly three times more likely than U.S. seniors as a whole to experience an alcohol-induced death.

16. Note that Alaska seniors are less likely to die from any of the six leading causes of death. Death rates from cancer, diabetes mellitus, or chronic lower respiratory disease are slightly lower. Death rates from stroke and Alzheimer's disease are moderately lower. And death rates from heart disease are substantially lower in Alaska.

17. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing multi-state phone survey conducted in Alaska by the Division of Public Health. Binge drinking is defined as males having five or more drinks on one occasion or females having four or more drinks on one occasion.

18. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing multi-state phone survey conducted in Alaska by the Division of Public Health. Heavy drinking is defined as adult men having more than two drinks per day or adult women having more than one drink per day.

19. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing multi-state phone survey conducted in Alaska by the Division of Public Health. Smokers are defined as current smokers.

20. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing multi-state phone survey conducted in Alaska by the Division of Public Health. Seniors with disabilities include those age 65 and over who say that they are limited in their activities because of physical, mental, or emotional problems.

21. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing multi-state phone survey conducted in Alaska by the Division of Public Health. "Obese" individuals are defined as those with a body mass index (BMI) of 30.0 or greater.

22. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing multi-state phone survey conducted in Alaska by the Division of Public Health. "Frequent Mental Distress" was defined as having 14 or more days of "not good" mental health during the last 30 days. "Frequent Mental Distress" was last assessed in the national BRFSS survey in 2006. However, the Alaska BRFSS survey includes this measure each year.

23. To qualify for services under the Older Alaskans Medicaid Waiver program, individuals must be age 65 or older, income-eligible for Medicaid, and must meet nursing home level-of-care requirements. Waiver services are home- and community-based services (such as meal programs, chore assistance, and care coordination) that allow the individual to continue living in his or her own home.

24. The figure shown represents an unduplicated count of seniors served in "registered services," those services for which data on individual participants is collected. Senior grant programs include Nutrition, Transportation and Support Services (NTS), Senior In-Home Services, Adult Day Services, Family Caregiver, and ADRD Education and Support. The senior grant programs are available to individuals age 60 and older.

HB

21

<TARGET><BILL>HB 21</BILL><SUBJECT>HB
21</SUBJECT><COMM>SHSS27</COMM></TARGET>

SENATE COMMITTEE REPORT

DATE: 2/16/11

FURTHER: Finance

DATE TURNED IN TO OFFICE: 3/10/11

Health and Social Services Committee considered CS FOR HOUSE BILL NO. 21(FIN)

HB 21-SUICIDE PREVENTION COUNCIL MEMBERS

"An Act relating to the membership of the Statewide Suicide Prevention Council."

and recommends:

[ ] be **replaced** with **SCS** _____ (_____)

[ ] Same Title [ ] Technical Title Change or [ ] New Title & SCR No._____

[ ] adopt **previous SCS** _____ (_____)

[ ] Same Title [ ] Technical Title Change or [ ] New Title & SCR No._____

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

Dept Abbr.	
ADM	LEG
CED	LAW
COR	LWF
CRT	MVA
EED	DNR
DEC	DPS
DFG	REV
GOV	DOT
DHS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
~~DHS~~	~~✓~~			

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
DHS	✓			1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
Ki Meyer	Meyer	X			
[signature]	Ellis	X			
[signature]	Egan	X			
[signature]	Dyson	X			
CHAIR: Bettye Davis	DAVIS	X			

Alaska State Legislature

Representative Anna Fairclough – House District 17

House Bill 21

"An Act relating to the membership of the Statewide Suicide Prevention Council."

House Bill 21 would simply increase the number of members appointed to the Statewide Suicide Prevention Council from 16 members to 17 members and create an age requirement for the youth member.

The additional member would be appointed by the Governor and would give representation on the council for members of our military. Suicide among our military is on the rise and having an individual familiar with the lives and challenges our military members face on a daily basis is crucial to their overall well-being.

The new member must be one of the following; discharged from, retired from, or engaged in active duty military service or someone who is a mental health provider, social worker, or other person actively providing a health care service to discharged, retired, or active military personnel.

House Bill 21 also changes the requirement for the youth member who is appointed to the council. Currently this appointee has to be enrolled in the 9^{th}, 10^{th}, 11^{th}, or 12^{th} grade of a secondary school. This member would be changed allowing the youth to be 16 years of age when appointed, but not older than 20 years of age. This will allow our youth members to continue to serve beyond completion of their secondary school education and allow for continuity on the council.

Thank you for your consideration of this legislation. I appreciate your support of House Bill 21.

Below is the link to the FY2010 Annual Report from the Statewide Suicide Prevention Council:

http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/2010SSPCAnnualReport.pdf

Session: Alaska State Capitol • Juneau, AK 99801 • 907-465-3777 • Fax 907-465-2819
Interim: 10928 Eagle River Road, Suite 238 • Eagle River, AK 99577 • 907-694-8944 • Fax 907-694-8945
Representative_Anna_Fairclough@legis.state.ak.us

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 21(STA)
(H) Publish Date: 1/26/11

Identifier (file name): HB021-DHSS-SPC-01-21-11
Title: Suicide Prevention Council Members
Sponsor: Fairclough, Gardner, Herron
Requestor: House State Affairs

Dept. Affected: Health and Social Services
Appropriation: Behavioral Health
Allocation: Suicide Prevention Council
OMB Component Number: 2651

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel	4.0		4.0	4.0	4.0	4.0	4.0
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**4.0**	**0.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health	4.0		4.0	4.0	4.0	4.0	4.0
Other Interagency Receipts							
TOTAL	**4.0**	**0.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**

Estimate of any current year (FY2011) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared by: Melissa W Stone
Division: Behavioral Health
Phone: 269-3410
Date/Time: 1/21/11 4 30 PM

Approved by: Alison Elgee
Assistant Commissioner, Finance & Management Services
Date: 1/21/2011

(Revised 12/29/2010 OMB)

COMMITTEE COPY

FISCAL NOTE #1

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. CSHB 21(STA)

Analysis:

This bill will increase the size of the Statewide Suicide Prevention Council by one member, from a total membership of 16 to 17. The additional member being requested is someone specifically representing the military. In addition, the definition of the youth member has been revised to include an age demarcation, and eliminates the need to be currently enrolled in a secondary school in Alaska.

The proposed changes will result in increased travel costs for the Council. Four meetings are held each year at varying locations. Based on historical costs, it is estimated that the additional travel costs for an additional council member will be $3,950.00 per year.

HB 218

<TARGET><BILL>HB 218</BILL><SUBJECT>HB 218</SUBJECT><COMM>SHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE

State Capitol Building
Juneau, Alaska 99801-1182

Sponsor Statement House Bill 218

"An Act prohibiting an insurer from using a drug formulary system of specialty tiers under certain circumstances."

Specialty medications used to treat complex chronic diseases continue to be the fastest growing segments of overall drug spend. While traditional drug spend slowed to an increase of only 1.5% in 2008, specialty drug spend continued its steady climb, increasing 15.4%*

House Bill 218 protects patients with critical illnesses from sudden changes in their drug treatment and therapy protocols which may un-expectantly deprive the patient from critical therapies due to the inability to pay for the drug or sufficient time to plan alternative financial or therapeutic strategies.

Currently, insurance companies can change their reimbursement policies with only a 30 day notice, often forcing the patient to absorb thousands of dollars of unexpected costs for expensive specialty drug therapy. By extending the notification period the savings for the patient will be absorbed by rest of the policy holders on the plan.* This may give the patient additional time to explore other options which may allow for a transition to a more affordable plan with similar therapeutic results.

Without these specialty drugs quality of life deteriorates and long term health care costs may increase. Additionally, cost savings may be achieved by exploring options like management through specialty pharmacies that use drug-utilization monitoring specifically designed for hard to manage conditions.

*2008 Specialty Drug Trend Report, Cura Script Specialty Pharmacy

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 21, 2012

SUBJECT: Drug formulary tiers (HB 218, Work Order No. 27-LS0728\B)

TO: Representative Wes Keller
Attn: Janet Ogan

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. States legislative findings relating to the need for prescription drugs, the categories and specialty tiers for certain drugs, the cost of drugs, excessively high payments for drugs, the need to inform patients about the cost of drugs that exceed insurance coverage; and the disparity in insurance payments for unique categories or tiers for patients whose life and health depend on certain drugs.

Section 2. States the legislative intent is to provide information to patients about the cost of drugs for certain diseases and conditions.

Section 3. Allows a health care insurer that provides coverage for drugs in unique categories or specialty tiers to impose cost sharing, deductibles, or copayment terms that exceed the cost sharing, deductibles, or copayments of nonpreferred brand drugs or the drug's equivalent if the insurer notifies the insured of the cost sharing, deductibles, or copayment terms at least 90 days before the terms apply.

Section 4. Provides that the notice requirements in sec. 3 apply to health insurance plans offered, issued for delivery, delivered or renewed on or after the effective date.

If I may be of further assistance, please advise.

DCB:plm
12-120.plm

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **HB 218**
Fiscal Note Number:
() Publish Date:

Identifier (file name): HB218-DCCED-INS-02-23-12
Title: Prescription Drug Specialty Tiers
Sponsor: House Health & Social Services
Requester: House Health & Social Services

Dept. Affected: DCCED
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by: Linda Hall, Director — Phone: 907-465-2560
Division: Insurance — Date/Time: 2/23/12 5:00 PM
Approved by: JoEllen Hanrahan, Director Administrative Services — Date: 2/24/2012
Commerce, Community and Economic Development

(Revised 1/17/2012 OMB)

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. HB 218

Analysis

Section 1 lists legislative findings including the cost sharing obligations for certain drugs are becoming prohibitively expensive, that some health plans have established specialty tiers for drugs and are requiring patients to pay a higher percentage of the costs of these drugs, seeking to ensure patients are well informed about cost sharing requirements and recognizing the disparities caused by these cost burdens.

Section 2 lists legislative intent of providing patients with timely information relating to the cost of prescription drugs essential for treatment of certain diseases.

Section 3 amends AS 21.42 to only allow cost sharing for specialty tiers of drugs that exceed the cost sharing for a non-preferred brand drug, only if the insurer notifies the insured of the cost sharing at least 90 days before the terms apply.

These provisions have no anticipated fiscal impact on the Division of Insurance.

LEGISLATIVE RESEARCH SERVICES

Alaska State Legislature
Division of Legal and Research Services
State Capitol, Juneau, AK 99801

(907) 465-3991 phone
(907) 465-3908 fax
research@legis.state.ak.us

Memorandum

TO: Representative Beth Kerttula
FROM: Chuck Burnham, Legislative Analyst
DATE: March 9, 2012
RE: Prescription Drug Formulary "Tiers" in Health Insurance Plans and the Impacts of HB 218
LRS Report 12.228

You asked a number of questions about prescription drug formulary tiers in health insurance plans and the impacts of HB 218. Specifically, you wanted to know the following:

- ***The definition of "drug formulary" and "value-based drug formulary;"***
- ***Whether insurers in Alaska use tiered formularies and a list of drugs included in tiers 4 or higher;***
- ***The states that have prohibited coinsurance on "specialty tiers" in prescription drug formularies for high cost pharmaceuticals and the costs and benefits to those states of doing so;***
- ***The impacts on health insurance premiums for Alaskans should HB 218 be enacted, thereby requiring insurers to provide policyholders with notice at least 90 days prior to increasing premiums, co-pays, or coinsurance for prescription drugs.***

Brief Summary

Alaska's major private health insurers employ 4-tier prescription drug formularies in a number of their various plans. New York is the only state thus far to prohibit such plans; however, Vermont has placed a one-year moratorium on the practice, and numerous other states are variously studying the issue and considering measures to curb or eliminate specialty drug tiers.

Because HB 218 primarily seeks to increase notification timeframes for a relatively small percentage of the state's population, it is unlikely that its passage will have a significant impact on health premiums in Alaska.

Formulary Basics

Health insurance plans that offer prescription drug coverage for pharmaceuticals and other patient-administered treatments often categorize those medications under a formulary, which lists drugs approved for coverage by the insurer for specific medical conditions. For many years, insurers often divided these drugs into three tiers according to their costs, and required differing levels of co-pay—typically a flat rate paid by the policyholder—for each tier. So, for example, an insurer may charge a $10 co-pay for less expensive, "tier 1" substances, and respective co-pays of $20 and $50 for higher cost drugs in tiers 2 and 3. This flat-rate co-pay model serves both to reduce costs to the insurer, thereby allowing for lower premium rates system wide, and to provide predictable and relatively low-cost medications to the insured.

Enter Tier 4

Two events in recent years combined to challenge the traditional 3-tiered system. First, in recent decades pharmaceutical companies have increasingly developed highly effective "specialty drugs" to treat complex chronic diseases like rheumatoid arthritis, multiple sclerosis, and certain cancers. These drugs are very expensive to develop and produce and extremely costly to purchase. Further, because these substances are used to treat chronic diseases, the costs are not only very high per dose but potentially recurring monthly throughout a lifetime of disease. Second, the 2006 enactment of the Medicare "Part D" prescription drug plan allowed insurers participating in the program to place specialty drugs in a separate tier and charge more for them. Private insurers rapidly adopted the model, creating tiers 4 and higher, and switched their policyholders' portion of costs from *co-pay* to *coinsurance*, which charges a *percentage* of the price of the prescription rather than a flat rate.

As a result, policyholders who had been paying $10, $20, or $50 per month for their medications were met with pharmacy bills many times those amount—upwards of $2,000 per month in some cases.[1]

To be fair, the advent of specialty drugs has placed insurers in a difficult situation. Annual inflation rates on such medications have increased much faster than for other healthcare services, which, in turn, have been climbing at a rate multiple times that of overall inflation in the U.S. economy. The Kaiser Family Foundation reports 17 percent inflation for specialty drugs in 2010, and that spending on these medications often accounted for 15 percent to 25 percent of an employer's total pharmacy benefit costs.[2] Insurers, employers and benefit plan designers have stemmed, somewhat, the rate of growth of specialty tier plans over the past two years through various methods, including steering clients to "value-based formularies," which offer access to generic drugs and pharmacies through which discount prices have been negotiated. Nonetheless, the proportion of plans that use specialty tiers doubled from 2008 to 2011, comprising 14 percent of all prescription drug benefit plans by the end of that period.[3]

Specialty Tiers in Alaska

In fiscal year 2011, the private health insurance market in Alaska—that which would be impacted by HB 218 (we provide information on plans not covered under the bill below)—was dominated by two insurers: Premera Blue Cross Blue Shield and Aetna. The companies respectively hold 56.69 percent and 10.19 percent of the total market, and their collective market share of over two-thirds dwarfs the next largest private health insurer, United Healthcare Insurance, and its 3.97 percent of the customer base.[4]

According to plan documents, Premera's standard tier 4 coinsurance rate is 30 percent, although this rate may differ under the variables of specific plans.[5] Aetna publishes multiple rates for its various small group prescription drug plans, ranging from 30 percent to 50 percent.[6] These rates compare to typical co-pays for tiers 1-3 of $10-$100.[7]

States Respond

We found just one state—New York—that has prohibited insurance companies from creating specialty tiers with coinsurance models. (Vermont put in place a one-year moratorium on specialty tiers effective May 6, 2011.) California Assembly Bill (AB) 310, which is currently under consideration, proposes to ban specialty tiers and limit co-pays to $150 per monthly prescription. Other states, such as Louisiana and Texas, have set mandatory 60-day notification schedules that must be met before changes to prescription drug costs can be made. At least seven other states have undertaken studies of the impacts of specialty tiers on costs, access to drugs, and outcomes, among other measures, as a first step toward regulating the issue. Various measures prohibiting, limiting, or otherwise regulating the use of specialty tiers are currently under consideration across the country.[8]

---

[1] Julie Appleby, "Workers Squeezed as Employers Pass Along High Costs of Specialty Drugs: Some Employers Make Patients Pay a Percentage of Cost Instead of a Co-Pay," Kaiser Health News, August 22, 2011, *http://www.kaiserhealthnews.org/Stories/2011/August/22/Workers-Squeezed-As-Employers-Pass-Along-High-Costs-Of-Specialty-Drugs.aspx*.

[2] Richard Farris, Vice President and National Practice Leader, Rare and Specialty Therapeutics, Medco Health Solutions, Inc., as quoted by Julie Appleby.

[3] "Employer Health Benefits 2011 Annual Survey," Exhibit 9.1, Kaiser Family Foundation, *http://ehbs.kff.org/Default.aspx?page=abstract&id=2*.

[4] "Division of Insurance 73rd Annual Report," Alaska Department of Commerce, Community, and Economic Development, *http://commerce.alaska.gov/insurance/Insurance/programs/Consumers/pubs/annual%20reports/annual_report_73.pdf#page=86*.

[5] "How Drug Benefits Work," Premera Blue Cross Blue Shield, *https://www.premera.com/stellent/groups/public/documents/xcpproject/pharm_tier_drug_benefits.asp*.

[6] "Alaska Plan Guide," Aetna, *http://www.aetna.com/employer-plans/document-library/states/ak_plan_guide.pdf*.

[7] Aetna appears to offer low-cost plans that charge a co-pay for certain tier 2 and tier 3 drugs.

[8] "Specialty Tiers/Coinsurance," The Alliance for Biotherapeutics, June 2011, *http://www.bioalliance.org/Downloads/Policy-CoinsuranceAndSpecialtyTiers.pdf*.

Impacts on Premium Costs

You were particularly interested to know if prohibiting specialty tiers increased health insurance premium rates in New York, which enacted its prohibition October 31, 2010. Our research located no study of the law's impact on premiums, and we expect that insufficient time has elapsed to allow a complete understanding of the law's impact on costs.

California's Health Benefits Review Program—comprised of a research team from several of the state's prestigious universities—conducted a study of the medical, financial, and public health impacts of AB 310, the bill currently under consideration. The group projected that the prohibition on specialty drug tiers would increase per month, per member premiums by an average of between zero and $3.69, depending on the market in question (group, individual, Health Management Organizations [HMO], etc.). Total net premium expenditures were projected to increase by roughly $31.7 million (0.0332 percent) as aggregate premium increases caused by the bill would be largely offset by reduced overall co-pays across the pool of 20.9 million policyholders impacted by the bill.[9]

Projected Impact of HB 218 on Premiums

As you know, HB 218 does not contemplate an outright prohibition on specialty tiers per se. Rather, the bill prohibits the use of the 4-tier model for the purpose of establishing deductibles, co-pays, or coinsurance unless the insurer provides policyholders notice of at least 90 days prior to changing the cost terms of their prescription drug coverage. Nonetheless, in a letter to House Health, Education, and Social Service Committee Chair Representative Wes Keller, Premera Blue Cross Blue Shield of Alaska Senior Vice President Jack C. McRae states that the notification timeframe in HB 218 will "inflate costs for specialty drugs and will increase overall healthcare premiums for Alaskans."[10]

Although not required by Alaska law, Premera's current policy, as stated by Mr. McRae, is to provide its policyholders notice 30 days prior to changes on costs associated with prescription drugs. Therefore, assuming that the insurer would comply with the increased notification timeline in HB 218 rather than discontinue its tier for specialty drugs, the impact of the legislation would be to increase by 60 days the amount of notice required prior to changing costs associated with medications. Further limiting the impact of the bill is the proportion of Alaskans to which it would apply if enacted. According to Insurance Division Director Linda Hall, the bill does not apply to public plans (state and federal employees, Medicare, Medicaid, Indian Health Service) or self-insured plans that are merely administered by insurers, which are most commonly funded by large organization like the State of Alaska and companies with a large pool of employees.[11, 12] Individuals covered by public and self-insured health plans, combined with the approximately 16 percent of uninsured Alaskans, total 85 percent of the state's population. The provisions of HB 218 would, therefore, apply to the remaining 15 percent of residents covered by state-regulated, "fully-insured" health plans in the private market.

The change to which Mr. McRae refers in his letter of opposition to HB 218 is, then, an additional 60 days of notice provided to 15 percent of the Alaska population. Presumably, the cost associated with the bill would be two months of the difference in cost between the proposed increase in price to drugs for which Premera is, by definition, already funding at a lower rate (that is, if the drug in question were not already being funded, notification of price change would not be in question). Although we are aware of no study on the impact of the changes described above, assuming the cost projections in the study of California AB 310—which, again, would *completely prohibit* specialty tiers—are remotely accurate, the cost of a 60-day delay in implementing increased costs for specialty drugs would, presumably, be a small fraction of the maximum per month premium increases projected by that study. We asked Director Hall for her views on the likely impact of HB 218 on premiums. She stated that the bill was unlikely to bring significant increases.

We hope this is helpful. If you have questions or need additional information, please let us know.

---

[9] "Analysis of Assembly Bill 310," California Health Benefits Review Program Report to the 2011-2012 California Legislature, April 14, 2011, p. 11, *http://www.chbrp.org/docs/index.php?action=read&bill_id=120&doc_type=3.*

[10] Documents associated with HB 218 are available online at *http://www.legis.state.ak.us/basis/get_documents.asp?session=27&bill=HB218.*

[11] Ms. Hall can be reached at (907) 269-7900.

[12] Self-insured and public plans are exempted from state regulation under the federal Employee Retirement and Security Income Act of 1974 (ERISA), as amended (P.L. 93-406, 29 USCS § 1002). More information on ERISA and its treatment of different types of plans is available at *http://www.allhealth.org/briefingmaterials/erisaregulationofhealthplans-114.pdf.*

Fact Sheet
AB 310 – Assemblywoman Fiona Ma
Fair Specialty Drug Payments

Summary: AB 310 would prohibit health plans and insurers from using "co-insurance" and cap out-of-pocket co-pay costs for patients.

Background & Problem:
When patients pay for drug medications, many health care plans include a pricing structure. The tiers are often labeled 'generic,' 'preferred,' and 'non-preferred' and each have a set cost-sharing amount. For example, $10 for generic, $30 for preferred and $60 for non-preferred.

In 2006, Medicare Part D plans (PDPs) started introducing a fourth level known as a "specialty tier," which provides the plan with the ability to use a co-insurance to share the costs of the most expensive medications with the patient

Many private healthcare and drug plans have copied this model for the most expensive medications, but instead of a fixed amount like in Medicare, plans may now require enrollees to pay co-insurance, which is a percentage of the cost of medications. These plans have been charging patients, on average, 25 to 33 percent, which can end up costing the patient thousands of dollars a month out of pocket. These extortionate co-insurance charges can be as high as over $8,000 per month.

The Kaiser Family Foundation Employer Health Benefits 2010 survey reports a dramatic increase in specialty tiers, using the co-insurance method of payment. Nationwide, in 2004, only 3% of workers were in a plan with four or more tiers of coverage. However, in 2010 that number increased to 13%, covering more than 20 million Americans. Data also indicates that in 2006, 50% of Medicare drug plans used specialty tiers. In 2008, specialty tiers were represented in 81% of Medicare plans.

In addition, Prime Therapeutics released a study in 2009 that measured multiple sclerosis medication OOP expense association with decline to fill rate. It showed that when MS medication OOP expenses were greater than $200 the decline to fill rate compared was six times greater than if the co-payment was less than $100.

Many of the drugs on specialty tiers are used to treat conditions such as: cancer, autoimmune conditions like Crohn's disease, lupus, multiple sclerosis, myasthenia gravis, myositis, psoriasis, scleroderma, rheumatoid arthritis, hemophilia and other bleeding disorders, hepatitis, primary and secondary immune deficiencies, neuropathy, and transplant patients.

Drugs found on specialty tiers have been in the marketplace for over twenty years and have been covered by insurance plans without charging co-insurance. Many of these therapies have remained at the same price, with the exception of new generations of these drugs. These drugs have no generic alternatives, are used to treat rare diseases, genetic disorders, and chronic conditions that without treatment will lead to disability and death.

Solution:
Beginning January 1, 2012 AB 310 prevents health plans and insurers from using the co-insurance method of payment. The bill also places $150 dollar out-of-pocket cap for a one month supply of medication, or its equivalent for prescriptions for longer periods, as adjusted for inflation.

In addition, AB 310 makes sure that if a health care service plan provides for a limit on patients' annual out-of-pocket expenses, the patients' out-of-pocket costs of covered prescription drugs shall be included in that limit.

Support:
The National Multiple Sclerosis Society (Sponsor)
The Alliance for Plasma Therapies (Sponsor)

Contact:
Nick Hardeman, 916.319.2012
Kasey O'Connor, 916.319.2012

Brenda Robertson
22500 Columbia Glacier Loop
Anchorage, AK 99577-9572

July 13, 2011

The Honorable Wes Keller
Alaska House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Keller:

The new specialty drug tiers have caused us to have to consider stopping my husband's MS medication. Our Co-Pay went from $30/mo to nearly $1200/mo. No financial assistance applies to us although it is a major financial burden. Other states have laws banning tier 4 drug pricing (New York, etc). Does it make sense to have people stopping their meds & making more hospital trips? Please direct me how to get this on someone's radar so this can be dealt with. I am sure there are many others suffering as well. ALL MS medications are now tier 4. I would appreciate anything you can do. It looks like the HB 218 only requires 90 days notice. The problem is the same, in 90 days people will just have to stop their medication. We have always paid our own way, not on welfare, don't take govt assistance...but $1200 a month? Plus our massive insurance premiums we pay each month?? We need help - please let me know if there is anything you can do.

Sincerely,

Brenda Robertson
907-350-0502

Alaska State Legislature

Please enter into the record my testimony to the (H) HSS
committee name

committee on HB No. 218 dated 2/28/12
bill/subject

- I strongly support HB 218 and encourage this committee to pass this Bill for my daughter + other Alaskans who take "specialty" drugs.
- My daughter was diagnosed with "juvenile idiopathic arthritis" when she was about 11. For about 5 years, she was only able to attend school part-time; she was hospitalized about 2, and up to 4 times per year for "joint injections"; she could not participate in sports because of the inflamation + instabilities in her joints.
- Then, she started taking a "biologic" - a specialty drug! She began improving in 3 months and went back to school full-time.
- She is now in her 1st year at UAA - attending full-time. She was accepted into the UAA Honors College, has declared a chemistry major, + wants to study medicine!
- This specialty drug has been amazing for my daughter + our family. The cost is pretty amazing too - $400/week or $1600/month
- Because of the cost, I strongly support HB 218 because it gives us notice to make the right decisions.
- Please support this Bill to make sure my daughter, and other Alaskans like her, are able to continue on the path to be productive citizens of our communities + our State.

Signed: Barbara A. Jones Barbara A. Jones
Testifier

myself
Representing (Optional)

PO Box 90041, Anchorage AK 99509
Address

907-248-0427
Phone No.

2/28 Legislative Information Office

Advocates for Responsible Care

We will be their voice until their voices are heard.

Specialty Tier Story Submission

Today health insurance companies are creating a fourth and fifth tier of drugs, called *Specialty Tier* drugs. *Specialty Tier* medications include drugs that are injected, infused, taken orally, inhaled, or that require special dosing and handling, close supervision, or monitoring. Specifically these include medications for Rheumatoid Arthritis, Systemic Lupus, Cancer, MS, plasma therapies and other life-threatening and chronic diseases. Unlike the co-payments for the other tiers, health insurance companies are charging an extraordinarily high co-insurance (higher cost for the drug) for *Specialty Tier* medicines. This co-payment/co-insurance is 20-35% of the cost of the drug. Many individuals cannot afford this out-of-pocket expense for their *Specialty Tier* medications. This practice is restricting access to much-needed medications for patients with serious chronic diseases.

Advocates for Responsible Care (ARxC) are leading an initiative to stop the high co-insurance/co-payments for *Specialty Tier* medications in Georgia. We are asking persons who are dependent upon these medications to share with us their stories. We want to know how an increase in the cost of these specialty drugs will affect their illness and their access to these vital medications. We will use these stories to help mobilize a Georgia-wide effort to end the rise in out-of-pocket costs for *Specialty Tier* medications.

If you are dependent upon a *specialty tier* medication please share your story at http://advocatesforresponsiblecare.org/Story_Submission.html.

If you would like to learn more the issue, how you may be affected, and how you can get involved in the movement to stop health insurance providers from increasing the costs for *Specialty Tier* medications please visit our website at http://advocatesforresponsiblecare.org/Specialty_Tiers.html. You can also follow ARxC on Facebook at Advocates for Responsible Care or on twitter @ARxCAdvocates.

The Advocates for Responsible Care empower individuals to achieve their maximum wellness with a strong voice as health care advocates, effectively reducing cultural incompetency and health care delivery disparity.

National Multiple Sclerosis Society

Eliminate Tier IV or Specialty Tiering in Prescription Drug Coverage

Position

Multiple sclerosis (MS) is an often disabling, autoimmune disease affecting the central nervous system. Although there is no cure for MS, appropriate medication can slow the disease progression, reduce the frequency and intensity of flare-ups, and allow people with MS to live active and productive lives.

People with MS depend on access to affordable disease modifying therapies for improving and maintain quality of life. The annual cost of these drugs ranges from $16,500 to more than $30,000. Many are forced to stop their prescribed therapy because they cannot afford the cost-sharing associated with these high prices.

As drug prices climb, health insurance companies, including those administering Medicare Part D plans, address these increasing costs by creating a new cost sharing mechanism within their drug plans. This mechanism, called "specialty tiers," introduces a fourth tier to the traditional three tiered drug formulary structure. The fourth tier is reserved for the most expensive medications such as MS therapies. Instead of companies charging a fixed co-pay for tier IV drugs, patients are responsible for a co-insurance or a percentage (20 to 35 percent or more) of the cost of the tier IV drug. Co-insurance can amount to thousands of dollars in out-of-pocket costs to patients for drugs critical to the treatment of their disease.

Request

The National Multiple Sclerosis Society supports efforts to prohibit the practice of specialty tiering or implementing a tier IV by health insurance companies, including Medicare Part D plans. Such a practice creates a barrier to access of medically necessary medication to improve the quality of life of people with MS and will raise overall health care costs.

Supporting Rationale

National Multiple Sclerosis Society

- Health insurance companies, including those administering Medicare Part D plans, are adopting a new pricing system for expensive drugs. This new system adds a tier IV or a "specialty tier" to the company's traditional three tiered drug plan.

- Rather than charging a fixed co-pay ($10 for generic, $25 for preferred, $50 for non-preferred), companies charge patients a co-insurance or a percentage (20 to 35 percent or more) of the cost of the high-priced drug. Co-insurance can amount to thousands of dollars in out-of-pocket costs to patients for drugs critical to the treatment of their disease.

- The extraordinary disparity in cost-sharing and co-insurance resulting from specialty tiering imposes a significant burden on patients whose health depends on expensive drugs and constitutes an undue and unjust discrimination based on their disease, disability, or condition.

- People with MS depend on disease modifying therapies that range in cost from $16,500 to more than $30,000 annually. With no generic alternative available, a patient's choice is limited to paying significant out-of-pocket costs or not taking their prescribed medication.

- The below chart estimates the monthly cost of four common MS therapies and shows the estimated monthly cost for those who are subject to a tier IV co-insurance.

MS Therapy	Monthly Cost	25% Co-Pay	33% Co-Pay
Avonex	$2,270	$567	$749
Betaseron	2,198	549	725
Copaxone	2,110	527	696
Rebif	2,347	586	775

- If subject to a 25 to 33 percent co-insurance, the medication to treat MS would cost between $525 and $775 out-of-pocket each month. People with MS rely on access to these vital drugs in order to live active and productive lives. These co-insurance rates place a significant barrier to access of these medically necessary drugs.

March 16, 2012

Representative Kurt Olson
State Capitol Room 24
Juneau, Alaska 99801

Vice-Chair Craig Johnson
State Capitol Room 216
Juneau, Alaska 99801

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

Re: HB 218, Specialty Pharmacy Tiers

Dear Chair Olson, Vice-Chair Johnson, and Members of the Committee,

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our opposition to HB 218, pertaining to specialty pharmacy tiers, in its current form.

HB 218 requires member notification related to cost sharing, deductibles or copayments of pharmaceuticals in certain tiers at least 90 days before the terms apply. This bill imposes a new notification requirement that is duplicative of existing notifications already provided to our members about their coverage and changes to benefits. In addition, this notification requirement is duplicative of a new federal healthcare reform requirement. This additional notification requirement will increase costs and premiums for consumers. It can also create confusion for our members who will receive several notices already provided by Premera, as well as notices required by the healthcare reform requirement.

Regarding notice to members, Premera provides timely information to members and groups about our benefit plans, including pharmacy benefits and cost sharing. Currently, we notify members with this information upon initial plan enrollment and renewal. We also notify members if and when a pharmaceutical tier is added to their current pharmacy benefit plan. If there is a change to the prescription drug formulary that would impact member cost sharing, Premera notifies impacted members by mail 30 days before such changes occur. We also provide a notice 45 days in advance of a premium change.

As part of federal healthcare reform, beginning September 23, 2012, insurers will be required to provide a ***Summary of Benefits and Coverage*** document, inclusive of a specific section on prescription drugs and related cost sharing. This document must be provided during application for individuals and groups, upon renewal, and upon request by the member. A change at mid-year, or more specifically, a change that impacts the information provided in the summary document, triggers a notification requirement to members at least 60-days prior to the effective date of the change. This requirement and mid-year notice will impact all plans: grandfathered and non-grandfathered individual and group coverage as well as self-funded plans.

Because of existing notification requirements and processes and the imminent federal healthcare reform requirement to provide ***Summary of Benefits and Coverage*** information to members and group health plans, we oppose HB 218.

Thank you for your consideration. I would be happy to answer any questions that you may have.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

P.O. Box 327
Seattle, WA 98111

tel 425.918.5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

February 14, 2012

Representative Wes Keller
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 218, Specialty Pharmacy Tiers

Dear Representative Keller,

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our concerns with HB 218, pertaining to specialty pharmacy tiers.

Premera currently provides notification regarding our policy on cost sharing, deductibles or copayment terms applicable to specialty pharmacy to our members 30 days before the terms apply. To date, we've received no complaints about this approach from members: the 30-day advance notice allows members time to meet with their providers to discuss specialty drug prescription options. Members may face cost sharing changes during the year for different reasons, including a formulary change when a generic drug becomes available. Premera notifies impacted members by mail 30 days before such changes that would impact cost sharing. HB 218 includes a shift to a 90-day notification timeframe. This change will inflate costs for specialty drugs and will increase overall healthcare premiums for Alaskans. If implemented, this change could also impact and raise state employee insurance rates.

Premera Blue Cross Blue Shield of Alaska covers over 70,000 members and provides comprehensive coverage to our members, with the majority of our plans including prescription drug coverage. We currently offer a four-tier pharmacy benefit for our members. Drugs are classified into tiers by an independent committee of experts, including doctors, pharmacists, health economists, a bioethicist and a member representative. This committee continuously reviews new and existing drugs, evaluates how well drugs work, and how their cost and effectiveness compare to similar drugs used for the same condition, then compares how much additional benefit a drug provides to the extra cost in comparison to a standard treatment for the same medical condition.

It is important to note the following for specialty pharmacy:

- The Centers for Medicare and Medicaid Services (CMS) classifies specialty pharmacy as pharmaceuticals often used to treat complex, chronic medical conditions. The drugs have fewer generic alternatives and may require increased physician involvement and special storage and handling.

- The average price of specialty drugs can cost $2,000 - $2,500 for 30-day supply.

- Expenses for drugs are the fastest growing segment of healthcare, with **expenses for specialty drugs growing at the fastest rate in the drug category (15%-20% per year).**

P.O. Box 327
Seattle, WA 98111

tel 425.918.5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association

- Specialty drugs comprise **more than 16% of total pharmaceutical spending** in the U.S. today. If current trends continue, by 2030, specialty pharmacy costs will exceed $1 trillion/ year and account for as much as 44% of a health plan's total drug expenditures.[1]

- Less than 3% of private health plan members use specialty pharmaceuticals; however, these members account for **25-30% of total private payer medical costs.**

- Medicare first created a specialty drug tier or 4th tier to help manage rising drug costs.

- An insurer's use of drug formulary tiering is an effective cost management tool, for the insurer and for its members and allows insurers to continue to provide access to these critical drugs.

We would oppose any prohibition on specialty drug tiering, including a prohibition on imposing higher cost sharing for specialty drugs.

Thank you for your consideration. I would be happy to answer any questions that you may have.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

[1] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2706163/

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

March 13, 2012

Representative Wes Keller
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 218, Specialty Pharmacy Tiers

Dear Representative Keller,

We at Premera Blue Cross Blue Shield of Alaska continue to have concerns with HB 218, pertaining to pharmacy tiers and wanted to make you aware of a requirement in the Affordable Care Act (ACA) that will require specific information about coverage and benefits, including pharmacy benefits, to be provided to members at certain times.

The language of this bill imposes mandatory notification processes on insurers that are duplicative to current processes and new federal reform requirements and further, would add costs and confusion for our members. Specifically, HB 218 requires member notification related to cost sharing, deductibles or copayments of pharmaceuticals in certain tiers at least 90 days in advance of term applicability.

Premera provides timely information to members and groups about our benefit plans, including pharmacy benefits and cost sharing for tiers. Currently, we notify members about this information on an annual basis, upon initial plan enrollment or upon plan renewal. We also notify members if and when a pharmaceutical tier has been added to their current pharmacy benefit plan. Premera notifies impacted members by mail 30 days before such changes that would impact cost sharing.

In addition, as part of healthcare reform under the Affordable Care Act beginning September 23, 2012, insurers will be required to provide a summary of benefits and coverage document, inclusive of a specific section on drugs and cost sharing. This document must be provided during open enrollment periods for individuals and groups. A change at mid-year, or more specifically, a change that impacts the information provided in the summary document, triggers a 60-day notification requirement to members. This requirement will impact all plans: grandfathered and non-grandfathered individual and group coverage as well as self-funded plans.

We wanted you to be aware of this imminent ACA requirement as part of the discussion on HB 218.

Thank you for your consideration. I would be happy to answer any questions that you may have.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

P.O. Box 327
Seattle, WA 98111

tel 425.918.5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association

Cynthia Laubacher
Senior Director,
Western Region

Medco Health Solutions, Inc.
1100 Kimberly Court
Roseville, CA 95661

tel 916-771-3328
fax 916-771-0438
cynthia_laubacher@medco.com
www.medco.com

medco

March 15, 2012

Representative Wes Keller, Chair
House Health & Social Services Committee
Alaska State Capitol
Juneau, AK, 99801

Re: House Bill 218: Oppose

Dear Representative Keller:

Medco Health Solutions regrets that it must respectfully oppose House Bill 218 requiring plans to provide 90-day notice of changes in copays/coinsurance for specialty prescription drugs. Medco is the parent company of Accredo Health Group, one of the nation's leading specialty pharmacies. Our clients including public and private payers, union trusts and health plans, rely on us to help manage their specialty drug costs.

According to the Utilization Review Accreditation Committee (URAC), "Specialty drugs or pharmaceuticals usually require special handling, administration, unique inventory management, a high level of patient monitoring and more intense support than conventional therapies. They could include all routes of administration."

Specialty drugs are very expensive, sometimes as much as $10,000/month or more. If a plan changes from a fixed copay for a specialty drug to a percent copay, it is possible that patients will see an increase in their monthly cost. It would be highly unusual for a plan to make this change in the middle of a benefit year. However, as our clients attempt to manage their costs, they may make a change at the start of the benefit year. Plan members are notified in advance of changes in the benefit cost structure. In our experience, usually a plan that goes from a fixed copay to a percentage copay will place a cap on the copay - say $250 per prescription. So, circumstances wherein the cost, for example increases from $100 to $1,000 is extraordinarily rare.

The average cost for a generic Rx at retail is $25.00 and the average copay is about $8.00 or a 34% member cost share. The average cost for a brand at retail is about $150 and the average brand copay is $30.00 or about a 20% member cost share. The average cost for a specialty Rx at retail is between $1,500 & $2,000. Plans generally seek to maintain a 20-25% member cost share in order to help them control costs. If we look into the future we find that by 2013, 80% of prescriptions will be generics and this will represent about 25% of plan costs, 19% of

prescriptions will be for non-specialty brands which will represent about 55% of plan costs, and specialty brands will be about 1% of prescriptions and 20% of plan costs.

Plan sponsors typically provide members with a 30 day notice prior to implementing a benefit change. HB 218 requires plans to provide 90-day notice of changes in the cost sharing requirements for drugs in a specialty tier. In late September, the federal Affordable Care Act will require plans to provide 60 day notice. HB 218 creates a conflicting standard that will create unnecessary duplication and confusion in the marketplace as plans are required to send 90-day and then 60 day notices to patients regarding the same benefit change.

For these reasons, we respectfully must oppose HB 259. Please feel free to contact me with questions.

Sincerely,

CYNTHIA M. LAUBACHER
Senior Director, State Government Affairs

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 9, 2012

SUBJECT: Single subject (Amendment to CSHB 218(L&C), Work Order No. 27-LS0728\D.2)

TO: Representative Wes Keller
Attn: Janet Ogan

FROM: Dennis C. Bailey
Legislative Counsel

You have asked whether amendment 27-LS0728\D.2, which relates to establishing a reinsurance program for residents who are high risk, could be added to CSHB 218(L&C), which relates to insurance for certain specialty drugs, without violating the single subject requirements of art. II, sec. 13 of the Alaska Constitution.

The single subject requirement

Under art. II, sec. 13, Constitution of the State of Alaska, "[e]very bill shall be confined to one subject unless it is an appropriation bill or one codifying, revising, or rearranging existing laws." This provision of the Alaska Constitution is frequently referred to as the "single subject requirement." Each bill may only contain provisions related to the bill's single subject.

The standard adopted by the Alaska Supreme Court in regard to the single subject requirement states that an "act should embrace some one general subject; and by this is meant, merely, that all matters treated of should fall under some one general idea, be so connected with or related to each other, either logically or in popular understanding, as to be part of, or germane to, one general subject." *Gellert v. State*, 522 P.2d 1120, 1123 (Alaska 1974). The Alaska Supreme Court has held that the purpose of this constitutional provision is to guard against legislative log-rolling, "the practice of 'deliberately inserting in one bill several dissimilar or incongruous subjects in order to secure the necessary support for passage of the measure.'" *Evans v. State*, 56 P.3d 1046, 1069 (Alaska 2002), quoting from *Gellert*, *supra* at 1122.

Alaska's single subject rule has been interpreted by the Alaska Supreme Court to permit very broad subject matter in a bill without violating the single subject requirement. In construing the single subject rule, the Court will "resolve doubts in favor of validity" and "in order to warrant the setting aside of enactments for failure to comply, the violation must be substantial and plain." *Suber v. Alaska State Bond Committee*, 414 P.2d 546, 557 (Alaska 1966); see also *Evans* and *Gellert*, *supra*, and *Short v. State*, 600 P.2d 20

(Alaska 1970). Specifically, the Court has held that bills relating to such broad themes as "civil actions," "taxation," "transportation," and "land" are acceptable. *Evans*, 56 P.3d at 1070; *North Slope Borough v. Sohio Petroleum*, 585 P.2d 534, 545 (Alaska 1978); *Yute Air Alaska, Inc. v. McAlpine*, 698 P.2d 1173, 1181 (Alaska 1985); *State v. First National Bank of Anchorage*, 660 P.2d 406 (Alaska 1982).

The single subject rule has been so broadly construed by the Court that the Court itself has expressed misgivings about the construction possibly rendering the rule meaningless. *See Yute Air Alaska, Inc.*, *supra* at 1180 - 1183, and *First National Bank of Anchorage*, *supra* at 414 - 415. However, without this broad construction, "statutes might be restricted unduly in scope and permissible subject matter, thereby multiplying and complicating the number of necessary enactments and their interrelationships." *Gellert*, *supra* at 1122, and quoted by *Galbraith v. State*, 693 P.2d 880, 886 (Alaska App. 1985). The Court appears reluctant to impose a stricter standard. *See Yute Air Alaska, Inc.*, *supra* at 1180 - 1181. But, the single subject rule is still of concern at least in obvious cases. *See Croft v. Parnell*, 236 P.3d 369 (Alaska 2010) (initiative proposing new oil production tax and new "clean elections" program violated the single-subject rule).

Conclusion

Under the Alaska Supreme Court's liberal interpretation of the rule, in my opinion, a court would find that the subject of the amendment, which relates to reinsurance for high risk residents, and CSHB 218(L&C), which relates to insurance for specialty tiers of prescription drugs, both address the single subject of "insurance."

Please be aware that because the house bill is now in the senate and the amendment requires a title change, a concurrent resolution suspending the rules must be approved in order to amend the bill.

If I may be of further assistance, please advise.

DCB:ljw
12-266.ljw

AMENDMENT

OFFERED IN THE SENATE

TO: CSHB 218(L&C)

Page 1, line 2, following "**circumstances;**":

Insert "**relating to a reinsurance program reinsuring residents who are high risks;**"

Page 1, line 6, following "FINDINGS":

Insert "FOR SECTION 3"

Page 2, line 14:

Delete "This"

Insert "Section 3 of this"

Page 2, following line 29:

Insert new bill sections to read:

"* **Sec. 4.** AS 21.55.220(c) is amended to read:

(c) Each member of the association shall share the losses due to claims expenses of the state plans issued or approved for issuance by the association**; each member of the association shall share the losses of a reinsurance program established by regulations adopted under AS 21.55.400 reinsuring residents who are high risks;** [,] and **each member of the association** shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments allocated to the payment of benefits shall be the liability of the members. Each member shall share in the claims expense of the state plans**, the**

[AND] operating and administrative expenses of the association**, and the losses of a reinsurance program established by regulations adopted under AS 21.55.400 reinsuring residents who are high risks,** in an amount equal to the ratio of the member's total major medical premiums, received from or on behalf of state residents, as divided by the total major medical premiums received by all members from or on behalf of state residents, as determined by the director.

*** Sec. 5.** AS 21.55.400 is amended to read:

Sec. 21.55.400. Duties of director. The director may

(1) approve the selection of the plan administrator by the association and approve the association's contract with the plan administrator, including the coverages and premiums to be charged;

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(3) undertake, directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) formulate general policy and adopt regulations**, including regulations establishing a reinsurance program reinsuring residents who are high risks,** that are reasonably necessary to administer this chapter."

Renumber the following bill sections accordingly.

ACHIA
ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

P.O. Box 1090
Great Bend, KS 67530
1-888-290-0616

www.achia.com

Administered by: Benefit Management, Inc.

April 8, 2012

Senator Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801

RE: Support for Children's Reinsurance Program

Dear Senator Davis,

On behalf of the Alaska Comprehensive Health Insurance Association (ACHIA), we are asking for your support for the establishment of children's reinsurance program which would provide access to health insurance coverage for children under the age of 19.

The ACHIA Board and the Division of Insurance have been wrestling with the fact that there are no child-only health insurance policies available in Alaska's insurance market today. Other states are facing the same issue. This problem has arisen, in part, as a result of the federal healthcare reform law. We have developed a solution to this problem and would like the opportunity to present it to the Senate Health and Social Services Committee. The solution would take the form of an amendment that we hope the Committee would consider with favorable action. We have identified a "vehicle" which is currently in the Committee that could serve as a "carrier" of this amendment. We have obtained the permission of the sponsor of the "vehicle" to attach our amendment to the bill, and all we need is an opportunity to present this amendment to the Committee. Finally, the Division of Insurance supports the amendment.

Given that there are no child-only health insurance policies available for purchase in the state, the ACHIA Board believes this situation needs to be changed. Allowing ACHIA to take on the reinsurance function is a simple, proven solution.

A children's reinsurance program would allow insurers to offer individual policies to children throughout the year by spreading the risk of enrolling high cost children across the entire commercial market. The proposed approach also provides premium stability for individuals and families in Alaska. If this amendment is passed, insurance companies in Alaska will be able to immediately start selling child-only policies.

The ACHIA Board sees an unmet need with respect to children being able to obtain coverage in the individual marketplace, but current Alaska statutes which govern ACHIA do not allow ACHIA to help remedy the problem. The proposal before you would allow ACHIA to fulfill this role, under the direction of the Division of Insurance. On behalf of the ACHIA Board, we are committed to working with the Legislature, state agencies, and insurers in Alaska to establish this program to benefit the youngest residents.

Thank you for your consideration of this proposal which will provide immediate and year-round access to health coverage for children in Alaska.

Sincerely,

Cecil D. Bykerk, FSA, MAAA
Executive Director
Alaska Comprehensive Health Insurance Association (ACHIA)

Marilyn W. Kasmar, RNC, MBA
Alaska Primary Care Association
Board member of ACHIA

cc: Director Linda Hall
Board of Directors

HB 310

<TARGET><BILL>HB 310</BILL><SUBJECT>HB 310</SUBJECT><COMM>SHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE
Representative Bob Herron

Official Business

State Capitol
Juneau, Alaska
99801-1182

CS HB 310 (FIN) – State Immunization Program

"An Act temporarily reinstating the child and adult immunization program in the Department of Health and Social Services; and providing for an effective date."

Version 27-LS1273\I
Staff Contact: Liz Clement 465-6576

SPONSOR STATEMENT

HB 310 is a temporary measure to reinstate the Alaska Immunization Program (AIP), which supplies vaccinations to uninsured and underinsured Alaskans to effectively limit the occurrence of vaccine-preventable diseases in Alaska, to its former level of coverage. Without the protection these vaccines provide, Alaska communities are vulnerable.

For decades, Federal funding ensured the AIP could make preventative vaccines accessible to all Alaskans desiring them. But that funding has seen a sharp downturn – from $4.3 Million in FY2010, to a mere $700 thousand in FY2013. These reductions have cut the number of vaccines available to children, and completely discontinued offerings for adults.

Preventative vaccines control diseases such as whooping cough, lockjaw, pneumonia, meningitis, polio, and others – silently saving lives every day. Prevention, generally, is key – and by far the most cost-effective way to address health issues. If we do not prevent, we will have to treat, at far greater human and financial cost.

HB 310 makes no changes to the historically Federally funded program, and existing exemption policies for medical and religious reasons will continue.

HB 310 temporarily substitutes state funding for the decrease in federal funding to AIP, through FY2015, while we seek a more permanent solution. It preserves Alaskans' ability to choose for themselves, while providing a humane and business-smart solution to the growing problem of unnecessary disease wracking our communities.

Please join me in support of HB 310.

ALASKA STATE LEGISLATURE
Representative Bob Herron

Official Business

State Capitol
Juneau, Alaska
99801-1182

CS HB 310 (FIN) – State Immunization Program

Version 27-LS0147\I
Staff Contact: Liz Clement 465-6576

SECTIONAL SUMMARY

Section 1. Gives legislative intent that the Alaska Immunization Program be reinstated as it existed in the state in 2009, before the loss of significant federal funds. States that the program exists to make preventive vaccines available to underinsured children, as well as uninsured and underinsured adults.

Sections 2. Establishes a child and adult immunization program in the Department of Health and Social services, and requires the department to determine eligibility, adopt regulations, and apply for available funds. Also establishes standards for provider and recipient participation in the program and types of vaccinations covered.

Section 3. Authorizes the Department of Health and Social Services to adopt regulations governing administration of the program.

Section 4. Sets a repeal date for the program: June 30, 2015.

Section 5. Sets an immediate effective date.

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **CSHB 310(FIN)**
Fiscal Note Number: **2**
(H) Publish Date: **4/4/12**

Identifier (file name): HB310CS(FIN)-DHSS-EPI-04-02-12
Title: State Immunization Program
Sponsor: Representative Herron
Requester: House Finance Committee

Dept. Affected: Health and Social Services
Appropriation: Public Health
Allocation: Epidemiology
OMB Component Number: 296

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities	4,496.0	700.0	4,496.0	4,496.0			
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**4,496.0**	**700.0**	**4,496.0**	**4,496.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts		70.0					
1003	GF Match							
1004	GF	4,496.0	630.0	4,496.0	4,496.0			
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**4,496.0**	**700.0**	**4,496.0**	**4,496.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

The CS (FIN) version I amends Section 2, subsections (f), (g) & (h). Sec. (f)(1) adds meningococcal and rotavirus vaccines for children. Sec. (f)(2) adds zoster vaccine for adults. Sec. (g)(2) allows vaccines to be subtracted if the disease is eradicated or high-grade scientific evidence indicates it will result in optimal efficacy and efficiency. Sec. (h) adds a new section stating procurement is subject to available funding. The changes in this CS will reduce the risk of additional disease outbreaks for more preventable diseases. The changes increase the fiscal note by $1,596.0 but otherwise have no significant operational impact.

Prepared by: Ward B. Hurlburt, M.D., MPH / Chief Medical Officer-Director — Phone 269-6680
Division: Public Health — Date/Time 4//2012 10:00:00 AM
Approved by: Nancy Rolfzen, Assistant Commissioner — Date 4/2/2012
DHSS Finance & Management Servcies

(Revised 1/17/2012 OMB)

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. CSHB 310(FIN)

Analysis

This CS (FIN) requires the Department of Health and Social Services to establish an immunization program that would purchase and distribute recommended vaccines to children and adults who do not have coverage elsewhere. The intent is to restore funding to the 2009 level before federal cuts were implemented. Limited vaccine funding for this population is available through Section 317 of the U.S. Public Health Service Act ("317") and administered by the Centers for Disease Control and Prevention. Funding has been cut 84% from $4.3 million in 2010 to $700 thousand in 2013. As a result, by January 2012, the Immunization Program has stopped supplying all adult vaccines and select childhood vaccines: influenza, pneumoccocal, rotavirus, human papillomavirus, and meningococcal.

This CS (FIN) has an immediate effective date. It is assumed that the program is implemented on July 1, 2012. Currently the department has regulations in place to implement this program immediately. These are all vaccines the department has provided in the past and the infrastructure is still in place. The fiscal note does not involve any administrative costs because they are already in the base budget. This bill has a sunset date of June 30, 2015.

This CS (FIN) would provide vaccine to enrolled providers for an estimated 47,000 underinsured children under the age of 19 years and about 110,000 doses of vaccines to underinsured and uninsured adults that reside in Alaska. Underinsured children under the age of 19 years would receive vaccines required for school attendance, plus meningococcal, influenza, pneumococcal, and rotavirus vaccines. Underinsured or uninsured adults age 19 years and older would receive influenza, pneumococcal, tetanus/diptheria/pertussis (Tdap), and zoster (shingles) vaccines. The Commissioner may add vaccines based on federal Advisory Committee on Immunization Practices' recommendations and available funding. Vaccines may be dropped if the disease has been declared eradicated by the Centers for Disease Control and Prevention or the commissioner finds that available high-grade scientific evidence indicates that subtracting the vaccine results in optimal efficacy and efficiency. The procurement of vaccines is subject to available funding.

Projected costs of selected vaccines for the total eligible population are based on the CDC's forecasting model and state and national immunization data. An 80% immunization rate is assumed for most vaccines (the recommended level to maintain immunity at the community level). The estimated annual cost of the vaccines (2013 prices) are below.

Vaccines required for school attendance: $1,400.0;
Pneumococcal vaccine for infants: $1,250.0;
Influenza vaccine annually for ages 6 months to 18 years: $300.0;
Rotavirus vaccine for infants: $ 409.0;
Meningococcal vaccine for adolescents: $207.0;
Pnuemococcal vaccine for adults ages 50 years and older: $250.0;
Influenza vaccine annually for adults ages 19 years and older: $400.0;
Tdap vaccine for adults ages 19 years and older: $700.0;
Zoster vaccine for adults ages 50 years and older (4% immunization rate): $980.0

The fiscal note takes into account funds the department assumes it will have to apply toward this vaccine program. The total cost to operate the program is estimated at $5,896.0. The Division of Public Health's base budget for immunizations includes $700.0 of the Federal "317" funds. The FY2013 Governor's Budget request also includes an increment for $700.0 ($630.0 GF, $70.0 Fed). The remaining $4,496.0 GF is requested in this fiscal note.

Department of Health and Social Services
William H. Hogan, MSW, Commissioner

3601 C Street, Suite 540
Anchorage, AK 99503 http://www.epi.alaska.gov

Division of Public Health
Ward Hurlburt, MD, MPH, CMO/Director

Local (907) 269-8000
24 Hour Emergency 1-800-478-0084

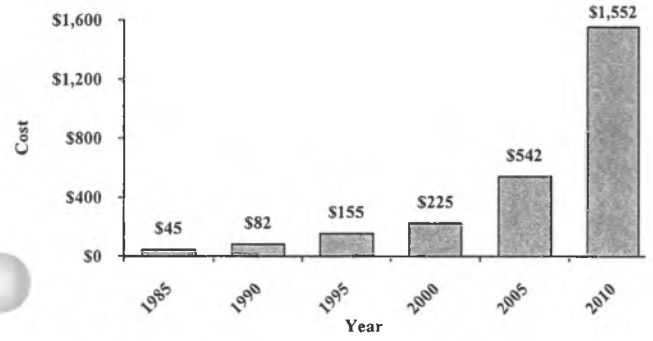
Editor:
Joe McLaughlin, MD, MPH

Bulletin No. 31 October 6, 2010

Only Pediatric/Adolescent Vaccines to be Supplied by State Beginning in 2011

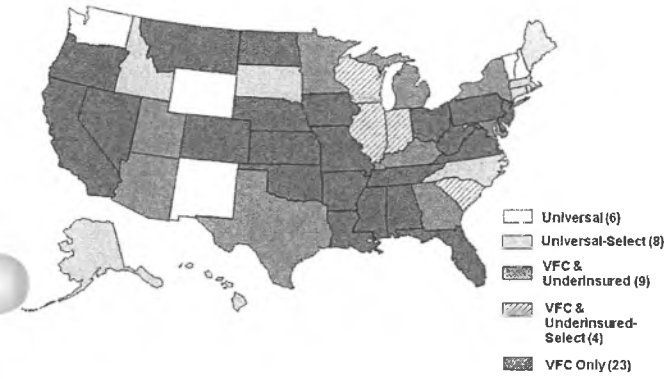
For over 30 years the Alaska Immunization Program maintained a "universal" vaccine program, distributing at no cost all Advisory Committee on Immunization Practices (ACIP)-recommended pediatric and selected adult vaccines to public and private providers in Alaska. This vaccine distribution has been supported almost entirely with two sources of federal funding. The *Vaccines for Children (VFC) Program* pays for vaccines for children who meet certain federal criteria. *Section 317 of the U.S. Public Health Service Act (317)* covers the cost of vaccines for the approximately one-third of Alaska children who are not VFC-eligible, as well as adult vaccines. As a federal entitlement program, VFC funding increases to support newly recommended vaccines for children; however, 317 funding has not kept pace with rapidly rising vaccine costs, which have risen almost seven-fold in the last 10 years (Figure 1).

Figure 1: Alaska Immunization Program Estimated Cost to Purchase Recommended Vaccines for One Child from their Year of Birth through Age 18 Years, for Selected Years from 1985 through 2010



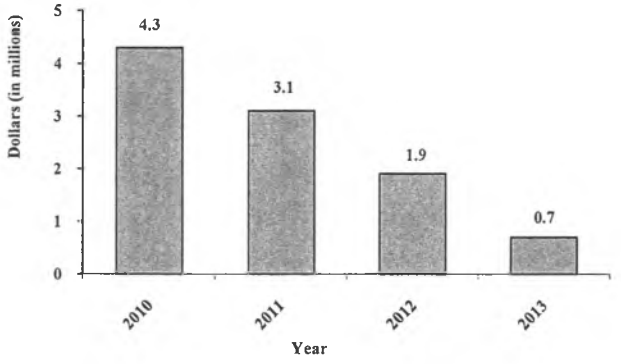
The rising cost and growing number of recommended vaccines has made it increasingly challenging for Alaska to maintain its vaccine distribution policy; however, these challenges are not unique to Alaska. Almost one-half (23/50) of U.S. states supply vaccines only for VFC-eligible children, i.e., vaccines are not supplied for children who do not meet program eligibility criteria or for adults. Other state vaccine supply policies include *universal purchase* (all vaccines for all children), *universal purchase select* (vaccines for all children except selected expensive vaccines available for VFC-eligibles only), and *VFC and underinsured* and *VFC and underinsured select* (varying levels of coverage for underinsured children) (Figure 2).

Figure 2: Public Purchase Pediatric Vaccine Supply Policy — United States, July 2010[1]



Alaska's vaccine purchases are supported almost entirely with funding from the U.S. Centers for Disease Control and Prevention (CDC). In 2008, CDC informed Alaska that the state had been of pediatric vaccines. In 2007, the Immunization Program discontinued shipments of adult influenza vaccine to private providers. In January 2009, the state limited the provision of human papillomavirus (HPV) and meningococcal conjugate vaccines to children who met the federal eligibility requirements of the Vaccines for Children (VFC) Program.[2] These program modifications helped trim vaccine costs by more than $2 million per year. However, CDC has notified Alaska that, beginning in 2011, the state's 317 vaccine dollars will be reduced by ~$1.2 million for each of the next 3 years, at which time Alaska's funding will be proportionate to that received by other immunization programs in the United States (Figure 3). Therefore, a change in Alaska's vaccine supply policy is necessary (Box).

Figure 3: Projected 317 Vaccine Funding for Alaska, 2010–2013



Box. The Alaska Immunization Program's 2011 Vaccine Supply Policy

Due to the increased cost of vaccines and federal 317 funding cuts, the following Alaska Immunization Program vaccine supply policy will become effective on **January 1, 2011**:

- All ACIP-recommended pediatric vaccines except HPV and MCV4 will continue to be supplied for all children through age 18 years. HPV and MCV4 will continue to be available for VFC-eligible children only.
- **Adult vaccines that historically have been provided by the Alaska Immunization Program (i.e., influenza, pneumococcal, tetanus/diphtheria) will no longer be supplied to public or private sector providers.**

Alternate Resources Available for Adult Vaccines

Private insurance policies and Medicare frequently support the cost of adult vaccines. Resource information related to Medicare billing and other potential funding sources is posted on the Section of Epidemiology website.[3] Manufacturer contact information for vaccine ordering also is included.

Conclusion

Although the Alaska Immunization Program regrets this policy change for adult vaccines, we are pleased that we can continue to provide pediatric vaccines at the current level throughout 2011. As the state's 317 funding levels continue to decrease over the next 3 years, this pediatric policy may need to be reconsidered. We will also continue to monitor the implementation of the Patient Protection and Affordable Care Act to determine its potential impact on vaccine funding in the future. To the greatest extent possible, we will continue our commitment to eliminate vaccine-preventable diseases in Alaska's children.

References

1. Vaccine Financing/Supply Policy, University of Michigan Division of General Pediatrics, Child Health Evaluation and Research Unit and the Association of Immunization Managers, July 2010. Available at:

Department of Health and Social Services
William J. Streur, Commissioner

3601 C Street, Suite 540
Anchorage, AK 99503 http://www.epi.Alaska.gov

Division of Public Health
Ward B. Hurlburt, MD, MPH, CMO/Director

Local (907) 269-8000
24 Hour Emergency 1-800-478-0084

Editors:
Joe McLaughlin, MD, MPH
Louisa Castrodale, DVM, MPH

Bulletin No. 28 October 19, 2011

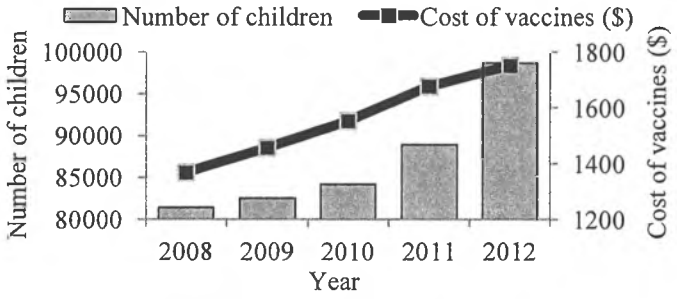
Further Cuts in State-Provided Vaccines for VFC-Ineligible Children in 2012

Background

In Alaska, state-supplied childhood vaccines are funded almost entirely through two federal funding sources. The primary source is the *Vaccines for Children (VFC) Program*, which pays for all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for children who are Medicaid eligible, American Indian/Alaska Native, and uninsured. Underinsured children (i.e., children with private health insurance that covers no or only selected vaccines, or caps vaccine coverage at a certain amount) are also eligible to receive VFC vaccine, but only if they are seen at a specified Rural Health Clinic (RHC) or at a Federally Qualified Health Center (FQHC). FQHCs are health centers designated by the federal Health Resources and Services Administration to provide health care to medically underserved populations.

The second funding source is *Section 317 of the U.S. Public Health Service Act (317),* which provides limited vaccine funding for VFC-ineligible persons (i.e., adults, fully insured children, and underinsured children who are not seen at a FQHC or a RHC). The number of VFC-ineligible children in Alaska is increasing steadily, as is the cost to fully vaccinate a child through age 18 years (Figure).[1,2] Of the estimated 98,689 Alaska children who will be VFC-ineligible in 2012, 46,884 (48%) will be underinsured.[1]

Figure. Number of VFC-Ineligible Children and Estimated Cost of Recommended Vaccines for One Child from Birth through Age 18 Years — Alaska, 2008–2012



On October 6, 2010, the Section of Epidemiology (SOE) published a *Bulletin* describing a $1.2 million annual decrease in Alaska's 317 federal funding for 3 years starting in 2011 (from $4.3 million in 2010 to $700,000 in 2013).[3] The rationale for the cuts was that Alaska had been "significantly overfunded" relative to other state immunization programs for many years and, due to budgetary constraints, the U.S. Centers for Disease Control and Prevention (CDC) was no longer able to support Alaska's universal immunization program.[3]

In order to absorb this enormous reduction in 317 funding, the Alaska Immunization Program has implemented mitigation measures over the past 2 years, including the following:

- Discontinuation of 317-funded adult vaccines;[3]
- Discontinuation of 317-funded meningococcal (MCV4) and human papillomavirus (HPV) vaccine for VFC-ineligible children;[3]
- Requiring dose-level accountability for state-supplied vaccine;[4] and
- Educating providers on ways to reduce vaccine wastage.[5]

In addition to HPV and MCV4, the following three vaccines will no longer be supplied by the state for VFC-ineligible children: as of January 2012, *pneumococcal conjugate (PCV 13) and rotavirus*; as of July 2012, *influenza* (Table).

Table. State-Supplied Vaccines that will be Available to VFC-Ineligible Children in Alaska in 2012

ACIP Recommended Childhood Vaccines	Estimated Cost of Vaccines for VFC-Ineligible Children in 2012	State-Supplied Vaccines Available in 2012 to VFC-Ineligible Children
DTaP	$234,038	Available
Hepatitis A	$177,755	Available
Hepatitis B	$106,463	Available
Hib	$137,498	Available
HPV	$350,307	Not available *(as of 1/09)*
Influenza	$371,881	Not available *(as of 7/12)*
MCV4	$256,695	Not available *(as of 1/09)*
MMR	$143,497	Available
PCV 13	$1,655,175	Not available *(as of 1/12)*
Polio	$152,783	Available
Rotavirus	$530,870	Not available *(as of 1/12)*
Td/Tdap	$132,449	Available
Varicella	$779,434	Available
Total Cost	**$5,028,845**	**$1,863,917** (for available vaccines)

Some Good News

In the near future, public health centers statewide will be able to provide VFC-funded vaccines to underinsured children.

Here's how: FQHCs are allowed to vaccinate underinsured children using VFC vaccine. Additionally, FQHCs are allowed to delegate their authority to (i.e., deputize) public health VFC providers (e.g., public health centers and local health departments) to vaccinate underinsured children on their behalf. On September 23, 2011, the Anchorage Neighborhood Health Center (an FQHC) signed a memorandum of agreement with SOE that authorizes the Alaska Immunization Program to administer delegation of authority to SOA public health centers statewide to vaccinate underinsured children using VFC vaccine. PHCs will implement this authority as soon as possible.

Recommendations

1. Health care providers *must screen all children for VFC-eligibility at each visit* prior to administering state-supplied vaccine;[6] VFC-ineligible children may only receive select state-supplied vaccines (Table).
2. Underinsured children may be referred to an FQHC, RHC, or public health center where they are eligible to receive all ACIP-recommended vaccines for free under the VFC Program.
3. Manufacturer contact information for vaccine ordering is posted on the SOE website to assist providers in purchasing vaccines for VFC-ineligible children.[7]

References

1. Unpublished data obtained from CDC's 2011 Vaccine Cost Affordability Tool.
2. CDC's Vaccine Price List. Updated September 29, 2011. Available at: http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm
3. Section of Epidemiology *Bulletin*. "Only Pediatric/Adolescent Vaccines to be Supplied by State Beginning in 2011." No. 31, October 6, 2010. Available at:

Transforming Health Care in Alaska
2011 Report/2010-2014 Strategic Plan Update

Alaska Health Care Commission

Ward Hurlburt, MD, MPH, Chair
Patrick Branco
C. Keith Campbell
Valerie Davidson
Jeffrey Davis
Emily Ennis
Paul Friedrichs, MD
Allen Hippler
T. Noah Laufer, MD
David Morgan
Lawrence Stinson, MD
Ex Officio Members:
Linda Hall
Senator Donny Olson, MD
Representative Wes Keller

Deborah Erickson, Executive Director

Sean Parnell
Governor
State of Alaska

William J. Streur
Commissioner
Department of Health & Social Services

6. Immunization against Vaccine-Preventable Disease

Findings

- Until the mid-20th century infectious diseases were a leading cause of illness, disability and death in Alaska. Few effective treatment and preventive measures existed. Since that time there has been a dramatic decline in the burden of infectious disease in the population due to significant achievements in control measures, especially for those diseases for which vaccines have been developed.

- During the 20th century the success of biomedical science in development of vaccines combined with the success of the public health system in immunizing the population led to the eradication of smallpox from the worldwide population and the elimination of polio from the U.S. population. Furthermore, immunizations have resulted in substantial declines in other diseases that had previously been a common cause of serious illness and death among children, such as measles, mumps, rubella, diphtheria, tetanus, pertussis, and bacterial meningitis.

- Despite remarkable progress in vaccine development and use, there are a number of challenges in maintaining sufficient immunization levels to protect the population.
    - Vaccination schedules have become increasingly complex. U.S. children require 19 doses of vaccine by age 35 months to be protected against 11 childhood diseases.
    - The success of immunization policies in controlling once-dreaded diseases has led to complacency among some subsets of the population toward vaccines.
    - Insufficient and erroneous information about vaccine safety and effectiveness creates confusion among parents, who must recognize immunizations as an important tool in protecting their children's health and actively seek them.
    - Health care providers must be kept informed of the latest developments and recommendations.
    - Vaccine supplies and financing must be made more secure.
    - Researchers must address increasingly more complex questions about safety, efficacy, indications, contraindications, and delivery.
    - Information technology must be used to support timely vaccination.
    - Adolescents and adults must be targeted for vaccine-preventable diseases that affect their age groups, such as influenza and pneumonia.

- Alaska's childhood immunization rate has declined in recent years to nearly the lowest in the nation. Alaska's rate of immunization completion for children ages 19 months to 35 months was just 56.6% in 2009, compared to the national average of 70.5%, ranking Alaska 49th among the 50 states and leaving Alaska's children vulnerable to preventable diseases that can result in serious complications, preventable hospitalizations, and in some cases death.

- The Alaska Division of Public Health, Department of Health & Social Services, maintained a "universal vaccine program" (providing all recommended childhood and adult vaccines to public and private health care providers in the state) for over three decades. The vaccine program was supported almost entirely with federal funding from two different sources, one of which is reducing its annual allocation to Alaska by $3.6 million in a phased 3-year reduction starting in FFY 11.

- As a result of the loss of funding the state discontinued provision of all adult vaccine and of human papillomavirus and meningococcal vaccines for children in FFY 11, and will no longer provide the following childhood vaccines for children who are not eligible for the Vaccines for Children Program ("VFC"; a program for children who are American Indian/Alaska Native, on Medicaid, or uninsured) beginning in FFY 12: influenza, pneumococcal conjugate, and rotavirus.
- Elimination of the universal vaccine program is expected to have the following consequences:
    - Reduction in the number of small private medical practices that provide vaccine to their patients due to the complexities of maintaining separate vaccine supplies (per VFC administrative requirements), and the cost of up-front purchase of expensive vaccine;
    - Reduced immunization coverage leading to increased risk of vaccine-preventable diseases such as measles, mumps, pertussis, chicken pox and hepatitis A; and,
    - Inability to maintain a stockpile of vaccine to support timely response to outbreaks of vaccine-preventable disease.

Recommendations

- The Alaska Health Care Commission recommends the State of Alaska ensure the state's immunization program is adequately funded and supported, and that health care providers give priority to improving immunization rates in order to protect Alaskans from serious preventable diseases and their complications.

Rosalyn Singleton MD
ANTHC Immunization Program
Address: AIP-CDC, 4055 Tudor Centre Dr
Anchorage, AK 99508
907-729-3418

February 10, 2012

RE: Letter of Support, House Bill 310

As a long-time Alaska pediatrician I am writing in support of House Bill 310 to temporarily reinstate the child and adult immunization program.

For over 30 years, the Alaska Department of Health and Social Services Immunization Program had a "universal" vaccine program – distributing all recommended childhood and adult vaccines to public and private providers in Alaska. These vaccines were supported almost entirely with 2 sources of federal funding. Vaccines for Children (VFC) Program (an entitlement program) pays for children who meet federal criteria; and Section 317 of the U.S. Public Health Service Act covered the cost for children not VFC-eligible and adult vaccines. In 2008, the federal government notified the State that the State had been "overfunded" with 317 funding compared with other states and that Centers for Disease Control would be decreasing the Section 317 funding to the State during 2010 to 2013 from $4.3 million to $0.7 million. Therefore, Alaska is losing $3.5 million dollars in federal funding for critical vaccines between 2010 and 2013.

This staged funding decrease started in 2011 –

- In 2011 the State stopped providing any adult vaccine.
- In 2012, the State Immunization Program will no longer provide the following childhood vaccines to non-VFC eligible children: *influenza, pneumococcal conjugate, rotavirus, and varicella.*
- In 2013, the State Immunization Program will no longer provide any vaccines except for VFC eligible children.

Why should we be concerned?

1. When faced with the complexities of maintaining two separate vaccine supplies for VFC and non-VFC eligible children, as well as fronting the cost for expensive vaccines, many small medical practices will stop providing vaccines to their patients.
2. This decrease in provision of vaccines will result in a critical decrease in immunization coverage (proportion of vaccinated children) in children, leading to increased risk of outbreaks from diseases like measles, mumps, pertussis, chicken pox and hepatitis A. Vaccines are cost saving. Alaska cannot afford further downward trend in coverage – in 2009 our 2 year old vaccination rate was 49th in the nation.
3. The State could be left without an adequate vaccine supply and infrastructure to allow for timely response to outbreaks of measles, mumps, hepatitis A, pertussis, if such outbreaks were to occur in Alaska.

House Bill 310 is a stop-gap measure to fill the gap left by the reduction in federal funding and reinstate the Alaska Immunization Program's ability to provide vaccine for under-insured and uninsured Alaskans currently not covered by other programs. I urge Alaskans to support this bill.

Sincerely,

Rosalyn Singleton

Rosalyn Singleton, MD, MPH

MARY ANN JACOB, M.D.

2841 DeBarr Rd.
Suite 45
Anchorage, AK 99508

T (907) 274-0274
F (907) 274-7809
jacobmd@mac.com

December 1, 2011

Dear Ms. Erickson,

As a pediatrician in a small, solo practice, I am writing to voice my support for the Alaska Health Care Commission's recommendation that the Alaska legislature fully fund the immunization and vaccine program.

Changes in funding will lead to small practices like my own being unable to provide vaccine for our patients. I have estimated the costs for the first year to be equivalent to hiring another full-time employee. But, even more importantly, ethically, I feel medical practices should try to provide vaccines to their pediatric patients. This is part of the "medical home" model which we are being encouraged to follow, which is associated with better outcomes for children. If patients have to go to another clinic for their vaccines, some of them will forget or "be too busy". The end result will be a less immune set of children, more susceptible to infectious diseases that should be things of the past. The recent pertussis outbreak in California (10,000 case, 10 deaths) stands as a warning for what Alaska could be facing. The treatment of these diseases is much more expensive than their prevention by vaccination. At a time when Alaska is ranked 49th in vaccination rates among the United States, we really cannot afford this short-sighted approach.

Sincerely yours,

Mary Ann Jacob, M.D., F.A.A.P.

STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

February 27, 2012

The Honorable Wes Keller, Chair
The Honorable Alan Dick, Chair
House Health & Social Services Committee
Alaska State Capitol, Rooms 432 & 104
Juneau, AK 99801-1182

Subject: Support for HB 310, Temporary Reinstatement of the Child and Adult Immunization Program

Dear Chair Keller and Chair Dick:
The Alaska Commission on Aging (ACoA) supports passage of HB 310, a bill to re-establish and fund the child and adult immunization program as it existed in 2009 targeting children and adults who are uninsured and underinsured. This legislation is authored by Representative Herron and co-sponsored by Representatives Wilson, Costello, Gruenberg, Edgmon, and Holmes.

Preventive services, such as immunizations, are important tools for maintaining the health of all Alaskans at every stage of life. Immune systems weaken with age, which place older people at greater risk for severe illness from influenza and pneumonia. The U.S. Preventive Services Task Force (2011) recommends influenza and pneumococcal vaccinations for persons age 65 and older. The Alaska Behavior Risk Factor Surveillance System (BRFSS 2011) reports underutilization of these vaccines by seniors with more than 36 percent reporting not receiving a flu shot within the past year and 33.5 percent having never received a pneumonia vaccination. Older adults who receive immunizations from providers who do not accept Medicare reimbursement and seniors who have not contributed to Medicare would not be eligible for free immunizations, which may explain some of the underutilization by the senior population of these vaccines. In addition, seniors ages 60 to 64 who are not eligible for Medicare and are low-income, uninsured or unemployed may find the cost of obtaining flu and pneumonia vaccines prohibitive. For these reasons, HB 310 will help increase senior access to immunizations.

A growing number of Alaska seniors are grandparents raising their grandchildren on a fixed income with limited insurance coverage. They desire healthy grandchildren who have access to the recommended immunizations recognized by public health standards. Medicare does not cover the cost of childhood immunizations. Rather than seeing their grandchildren go without immunizations, which are required for admission to public schools, many grandparents will make personal and financial sacrifices to insure their grandchildren receive the recommended immunizations.

Although not on the list of select immunizations, the ACoA recommends consideration of the shingles vaccine as a qualified immunization targeting low-income uninsured/underinsured older adults. Shingles most often strikes older people, particularly those with weakened immune systems. Shingles, caused by the varicella zoster (or the "chicken pox" virus on first infection), is a debilitating and painful rash that can be accompanied by irritation and nerve inflammation. The Centers for Disease Control and Prevention recommends the vaccine for all people over the age of 60. The shingles vaccine has been shown effective in reducing the number of outbreaks by 55 percent in a recent study of 300,000 elderly patients however it is used by only 11 percent of the older adult population. While Medicare and most insurance plans cover the cost of the vaccination, some seniors may need to pay deductibles, co-pay expenses, or the full cost of the vaccine if their provider does not accept Medicare

reimbursement. These additional costs are believed to be contributing to the underutilization of the shingles vaccine by seniors.

The ACoA supports HB 310 as a temporary measure to ensure that select vaccines are made available to underinsured and uninsured Alaskans of all ages. We appreciate your consideration and support of this legislation. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Representative Herron
Representative Seaton
Representative Kerttula
Representative Miller
Representative Millett
Representative Peggy Wilson
Representative Costello
Representative Gruenberg
Representative Edgmon
Representative Holmes

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T. 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

February 14, 2012

The Honorable Wes Keller, Co-Chair
House Health and Social Services Committee
Alaska Capitol, Room 432
Juneau, AK 99801-1182

RE: HB 310 (Herron)—Support
State Immunization Program

Dear Chair Keller:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the House Health and Social Services Committee to support HB 310, authored by your Committee colleague Representative Bob Herron and co-sponsored by Representatives Peggy Wilson, Mia Costello, Max Gruenberg, Bryce Edgmon, and Lindsey Holmes.

In the past, Alaska and Alaskans of all ages have benefited from a comprehensive vaccination program primarily funded by the federal government. HB 310 would provide state funding to make up the shortfall on a temporary basis.

From the standpoint of older citizens, AARP recognizes that providing free vaccines for influenza, pneumonia, and TDaP to adults is a good effective public health measure.

From the standpoint of grandparents, AARP members recognize that restoring the thirteen previously covered vaccines for children is an excellent decision for our state leadership to make.

According to the Vaccine Research Group at the Mayo Clinic, 50,000 to 70,000 Americans die each year from diseases that could be prevented by vaccines.

Vaccine-preventable diseases have many costs, both economical and social. Parents who need to stay home to take care of sick children lose time from work. Preventable diseases also result in more physician visits, hospitalizations and even death. Vaccinations work. Think of the savings for Medicaid and PERS and TRS if we can restore the vaccination program and prevent costly illnesses.

Vaccines are like seat belts. We wear them to prevent injury or death if someone decides to run a red light. We still need to have vaccines available to prevent injury or death from bacteria and viruses that exist and can still be passed on to us.

AARP requests an "AYE" vote on HB 310.

Jennie Chin Hansen, President
Addison Barry Rand, Chief Executive Officer

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Alan Dick
Representative Bob Herron
Representative Paul Seaton
Representative Sharon Cissna
Representative Bob Miller
Representative Charisse Millett

Providence Alaska Medical Center
3200 Providence Drive
PO Box 196604
Anchorage, Alaska 99519-6604
t: (907) 562 2211
www.providence.org/alaska

PROVIDENCE
Alaska
Medical Center

February 28, 2012

The Honorable Bob Herron
Alaska State House of Representatives
State Capitol, Room 411
Juneau, AK 99801

Dear Representative Herron:

As physician leaders of Providence Health and Services, Alaska's largest health system, we write today to thank you for introducing HB 310, and offer our strong support for this legislation.

We recognize the individual and public health consequences of unchecked infectious disease and believe that HB 310, with the goal of temporarily reinstating funding through the Department of Health and Social Services for adult and child immunizations is a positive step. Providence believes it is our heritage and responsibility to advocate specifically for our state's most vulnerable population; our children.

Thank you again for introducing this legislation and thank you too for your work on behalf our public's health.

Sincerely,

Richard Mandsager, MD
CEO, Providence Alaska Medical Center

Tom Hunt, MD
Physician Chief Executive,
Providence Medical Group Alaska

Michael Acarregui, MD, MBA
Medical Director, Pediatric Subspecialty Services, Providence Alaska Medical Services

cc: Representative Wes Keller
Commissioner Bill Streur

Alaska State Chapter
3209 Denali Street, Suite 200
Anchorage, AK 99503
(907) 276-4111
1-800-478-5245
Fax: (907) 276-3375

marchofdimes.com

February 22, 2012

The Honorable Bob Herron
State Capitol, Room 411
Juneau, AK 99801

RE: Support for House Bill 310 pending in the Senate Finance Committee

Dear Representative Herron:

We are writing to you to express the support of March of Dimes for **House Bill 310.** Historically, the March of Dimes has been centrally involved in immunization issues as the organization was founded in 1938 with the mission to prevent polio.

The March of Dimes supports ongoing efforts to increase immunization rates so that children are protected from vaccine-preventable diseases to assure that such diseases of the past do not return. In our view, the nation should pursue the goals that all eligible children complete the recommended series of immunizations, and that no family face financial barriers to obtaining full immunization for their children.

House Bill 310 intends to reinstate the immunization program as it existed and was administered by the Department of Health and Social Services in 2009 by providing additional state funding and authorization to fill the gap left by a reduction in federal funding for immunization.

Childhood immunizations are among the most cost-effective preventive health measures known:

- Every dollar invested in immunizing a child fully saves $16.50 in medical and societal costs.
- Every dollar invested in varicella (chicken pox) vaccine saves $4.37 in direct medical costs and other societal costs.

March of Dimes is a leading nonprofit organization for maternal, infant and child health. With chapters nationwide and its premier event, March for Babies, March of Dimes works to improve the health of women, infants and children. **We urge you bring House Bill 310 before the Senate Finance Committee for a vote and to ensure passage of this important piece of legislation.**

Sincerely,

Janie Odgers
State Director

Cherie Curry
Public Affairs Chair

march of dimes

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

February 10, 2012

Jack C. McRae
Senior Vice President

Representative Bob Herron
State Capitol Room 411
Juneau, Alaska 99801

Re: HB 310, Temporary Child and Adult Immunization Program

Dear Representative Herron,

I am writing in support of House Bill 310, which seeks to *temporarily reinstate* the child and adult immunization program in the Department of Health and Social Services.

As one of the largest healthcare insurers in Alaska, Premera Blue Cross Blue Shield of Alaska provides comprehensive, tailored services to our members, including innovative programs focused on wellness and prevention. We agree with you that prevention is important in ensuring a healthier future for Alaskans. Our plans echo that sentiment: Premera currently covers all CDC recommended vaccinations for members under age 19 and certain vaccines for adults. This is provided without cost sharing.

We believe HB 310 and its temporary establishment of a state-funded immunization program is a good approach to the process of determining a permanent solution to the gap in federal funding for vaccinations that Alaska is experiencing. Other states have also realized a decrease in federal Vaccines for Children (VFC) and Section 317 funding and have created innovative, durable solutions to this funding gap to sustain full vaccination program financing. We look forward to working with you, the Department of Health and Social Services, in conjunction with the Alaska Health Care Commission, on developing a sustainable solution for the State that takes into account Alaska's needs and financial constraints.

In the meantime, we believe that the approach outlined in HB 310, to put in place a temporary, state-funded solution to vaccination access for children and adults in Alaska, is financially sensible and offers the state ample time to develop a carefully planned, fairly funded and permanent program.

Thank you for your time and consideration and please give either myself or Jerry Reinwand (907/586-8966), our lobbyist in Juneau, a call if you have any questions pertaining to this letter.

Sincerely,

Jack C. McRae

Jack C. McRae

P.O. Box 327
Seattle, WA 98111

tel 425.918.5757
fax 425.918.5635
jack.mcrae@premera.com

www.premera.com

An Independent Licensee of the
Blue Cross Blue Shield Association

ALASKA
PRIMARY CARE ASSOCIATION
supporting Alaskans' health care homes

4/2/12

Marilyn Kasmar, CEO
Alaska Primary Care Association
903 W. Northern Lights Blvd., Suite 200
Anchorage, Alaska 99503
907-929-2722
Marilyn@alaskapca.org

Dear Members of the House and Senate Committees:

I am writing in support of HB 310. The Alaska Primary Care Association represents the 143 (and growing) clinics operated by our 25 Community Health Center organizations. As such, we understand the vital importance of vaccination to Alaska's public health. There are immunizations available for many potentially deadly diseases, and it is disheartening to see that some Alaskans will not have access to the vaccines they need to stay healthy because the Alaska Immunization Program is no longer adequately funded.

While only temporary, this bill helps ensure that Alaskans of all ages will have access to the vaccinations they need to remain healthy. It also provides ample time for all parties to come together and work towards a more permanent solution.

The health of Alaskans and their families is an important issue, and HB 310 helps address a growing problem. I urge your support.

Sincerely,

Marilyn Kasmar, CEO
Alaska Primary Care Association

HCR

1

<TARGET><BILL>HCR 1</BILL><SUBJECT>HCR
1</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

State Capitol, Suite 422
Juneau, AK 99801-1182
Phone: 465-4939
Fax: 465-2418
Toll Free: (800) 465-4939
Representative_Pete_Petersen@legis.state.ak.us

716 W. 4th Ave, Suite 380
Anchorage, AK 99501-2133
Phone: 269-0265
Fax: 269-0264

Representative Pete Petersen

Serving Northeast Anchorage and Muldoon

Sponsor Statement

HCR: Pancreatic Cancer Awareness Month

Over 43,000 people were diagnosed with pancreatic cancer in the United States (US) in 2010. Almost 37,000 will die from the disease. Pancreatic cancer is the fourth leading cause of cancer death in the US and ranks as one of the deadliest cancers with no real improvement in survival rates in the last 40 years. Three-fourths of pancreatic cancer patients die within one year of diagnosis; this is because by the time symptoms of pancreatic cancer first appear, it is usually too late for an optimistic prognosis. All of this while only receiving 2% of the National Cancer Institute's federal research funding.

The Pancreatic Cancer Action Network (PANCAN) is the first and only national patient advocacy organization to serve the pancreatic cancer community in Alaska. PANCAN focuses their efforts on public policy, research funding, patient services, and public awareness and education related to developing effective treatments and finding a cure for pancreatic cancer. The Alaska Bureau of Vital Statistics reported 158 Alaskan deaths from pancreatic cancer during 2006-2008.

Increasing awareness will lead to expanded research into locating the disease's causes, enhancing early detection, and developing effective treatments. Raised awareness will also lead to more knowledge about pancreatic cancer among Alaskans and directly enhance the good health and well-being of our state's residents.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHCR 1(HSS)
(H) Publish Date: 3/11/11

Identifier (file name): HCR1-LEG-COU-03-02-2011
Title: Declare Nov 2011 - "Pancreatic Cancer Awareness Month"
Sponsor: Representative Petersen
Requester: House Health and Social Services Committee

Dept. Affected: Legislature
Appropriation: Legislative Council
Allocation: Session Expenses
OMB Component Number: 782

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version

initial Version

Prepared by: Shane Miller, Finance Manager — Phone: 465-6626
Division: Administrative Services Division — Date/Time: 3/2/11 2:13 PM
Approved by: Pamela Varni, Executive Director — Date: 3/2/2011
Legislative Affairs Agency

(Revised 12/29/2010 OMB)

FISCAL NOTE #1

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. CSHCR 1(HSS)

Analysis

This fiscal note has zero impact on the Legislative Affairs Agency.

- An estimated 43,140 Americans will be diagnosed with pancreatic cancer in the U.S., and over 36,800 will die from the disease.
- Pancreatic cancer is one of the few cancers for which survival has not improved substantially over nearly 40 years.
- Pancreatic cancer is the 4th leading cause of cancer-related death in the United States.
- Pancreatic cancer has the highest mortality rate of all major cancers. 94% of pancreatic cancer patients will die within five years of diagnosis – only 6% will survive more than five years. 75% of patients die within the first year of diagnosis.
- The average life expectancy after diagnosis with metastatic disease is just three to six months.
- Few risk factors for developing pancreatic cancer are defined. Family history of the disease, smoking, age, and diabetes are risk factors.
- Pancreatic cancer may cause only vague symptoms that could indicate many different conditions within the abdomen or gastrointestinal tract.
- Symptoms include pain (usually abdominal or back pain), weight loss, jaundice (yellowing of the skin and eyes), loss of appetite, nausea, changes in stool, and diabetes.
- Treatment options for pancreatic cancer are limited. Surgical removal of the tumor is possible in only approximately 15% of patients diagnosed with pancreatic cancer. Chemotherapy or chemotherapy together with radiation is typically offered to patients whose tumors cannot be removed surgically. Only three drugs are FDA-approved for the treatment of pancreatic cancer: fluorouracil (5-FU), gemcitabine (Gemzar®), and erlotinib (Tarceva®).
- Pancreatic cancer is a leading cause of cancer death largely because there are no detection tools to diagnose the disease in its early stages when surgical removal of the tumor is still possible.
- The National Cancer Institute (NCI) spent an estimated $89.4 million on pancreatic cancer research in 2009. This represented a mere 2% of the NCI's approximate $5 billion cancer research budget for that year.

Source for statistics: American Cancer Society: Cancer Facts & Figures 2010 and NCI Funded Research Portfolio.

Representative Petersen:

In February 2010 my 65 year old father, David Shew, Sr., began experiencing severe abdominal pains. This was a symptom my family assumed would turn out to be a gallbladder problem or something simple like acid reflux. Unfortunately, a simple diagnosis was not in the cards. On March 14th, 2010 my father was diagnosed with metastatic pancreatic cancer. We knew that this diagnosis was a death sentence. Once a person has been diagnosed with the condition, the general life expectancy is only 5 to 8 months. We were lucky...my father lived 11 months after his diagnosis. He passed away on February 12, 2011, a week shy of his 66th birthday. My father, who was an Alaskan, a veteran, and a friend to everybody he met, experienced a long, painful journey to his final days.

Upon receiving the devastating news of my father's illness and finding out that this is also the type of cancer that killed my paternal grandmother, the feelings of hopelessness and helplessness set in. Once the shock wore off, I knew I had to do something. I had to make sure that my father's legacy would live on and that I would—from here on out—be his voice. I educated myself about the disease and I found support online through an organization called the Pancreatic Cancer Action Network. To my disappointment there were no organizations or support groups in Anchorage (or Alaska for that matter), and nowhere to turn locally. I vowed that in the future, Alaskans suffering from pancreatic cancer and their family members would have local access to information, education, and support resources. They will have a way to get involved and a way to have their stories heard locally, at home. This is a disease that few understand and those who have not been touched by it cannot fathom the impact, pain, and devastation. It is vital to have a support network and a place to turn.

Thank you, thank you, thank you for doing what you're doing and for helping me to fulfill one of the last promises I made to my father. That promise is that I will do whatever possible to create awareness about this disease so that there is hope in the future and those diagnosed will have a fighting chance to survive.

Sincerely,

--

Kim McFadden, Volunteer
Community Representative
Anchorage, Alaska
Pancreatic Cancer Action Network
www.pancan.org

Phone: (907) 444-4874

David Shew Sr.

Anchorage resident David Odell "Dave" Shew Sr., 65, died Feb. 12, 2011, in Anchorage after a yearlong battle with pancreatic cancer.

A memorial service will be at 1 p.m. Friday at the Fort Richardson Chapel. After the service, Dav be interred with military honors at 2:30 p.m. at Fort Richardson National Cemetery.

A celebration of life after both services will be at the Down Under on Fort Richardson.

Born Feb. 18, 1945, in Johnson City, Tenn., Dave was one of nine children born to Ernest and Kathleen Shew. He honorably served in the U.S. Air Force for 21 years. He continued working C Service for the Army after his retirement, and at the time of his cancer diagnosis was working on Richardson for the Shaw Group.

Dave had a passion for fishing, 4-wheeling, the outdoors, photography and collecting things. He loved treasure-hunting at g sales. He also loved his dogs, Taffy and Miah. He had an amazing sense of humor and never met a stranger.

Dave is survived by his wife, Cindy Shew of Anchorage; three children: daughter and son-in-law, Tracy and Mike Johnson o Wasilla, daughter, Kim McFadden of Anchorage, and son, David O. Shew Jr. of Emerald Isle, N.C.; seven grandchildren, As Bilak of Jacksonville, N.C., Aimee Waldrep, Joshua Brown and Samantha McFadden of Anchorage, Alexis Shew, David O. III and Jackson Shew of Emerald Isle, N.C.; four brothers, Bobby, Lloyd, Donald and Richard Shew; two sisters, Peggy Kepl and Doris Gabert, all in Tennessee; and many nieces and nephews.

Dave was a beloved husband, father and friend. He loved his family, friends, and his country above all.

In lieu of flowers, the family suggests donations in the name of David O. Shew Sr. to the Pancreatic Cancer Action Network, www.pancan.org; or to donate by phone, please call: Pancreatic Cancer Action Network at 877-272-6226.

Arrangements are with Cremation Society of Alaska; www.alaskacremation.com.

Published in adn.com from February 20 to February 21, 2011

PANCREATIC CANCER ACTION NETWORK®
ADVANCE RESEARCH. SUPPORT PATIENTS. CREATE HOPE.

March 9, 2011

The Honorable Pete Petersen
State Capitol, Room 422
Juneau, AK 99801-1182

Dear Representative Petersen:

I am writing to you today on behalf of the Pancreatic Cancer Action Network to thank you for your leadership in raising awareness about pancreatic cancer by introducing HCR 1, which recognizes November 2011 as "Pancreatic Cancer Awareness Month". As the national patient advocacy organization that works with volunteers across the country to find answers for this devastating disease, we greatly appreciate your support for this bill.

Approximately 43,140 Americans will hear that they have pancreatic cancer this year and 75% of those will die within the first year of their diagnosis. Only 6% will make it to the 5-year survival mark. In fact, pancreatic cancer is the only major cancer with a five-year survival rate still in the single digits and remains the 4th leading cause of cancer death in the United States, but currently receives only 2% of the federal government's cancer research budget at the National Cancer Institute. Through awareness efforts like your resolution and the *Pancreatic Cancer Research & Education Act* (S. 362/H.R. 733), legislation which has been introduced in the U.S. Congress to require the National Cancer Institute to develop a long-term and comprehensive strategic plan for this disease, we hope to find early detection tools and treatments that will begin to lower these statistics.

Your work on the HCR 1 signifies an important step towards helping us raise awareness about this deadly disease. We thank you again for your continuing support of increasing awareness about pancreatic cancer.

Sincerely,

Megan Gordon Don

Megan Gordon Don
Director, Government Affairs
Pancreatic Cancer Action Network
202-742-6776
mgdon@pancan.org

PANCREATIC CANCER ACTION NETWORK
ADVANCE RESEARCH. SUPPORT PATIENTS. CREATE HOPE.

www.pancan.org | 877.272.6226

It's Time for a Death Defying Strategy:
Support the Pancreatic Cancer Research & Education Act (S. 3320/H.R. 745)

We're Not Making Progress on pancreatic cancer and the consequences are deadly

- Pancreatic cancer is one of the deadliest cancers and is one of the few cancers for which survival has not improved substantially in nearly 40 years. In fact, pancreatic cancer is the only one of the top 10 cancer killers that still has a five-year survival rate in the single digits.[1]
- The number of new pancreatic cancer cases and the number of deaths caused by pancreatic cancer are increasing – not decreasing. Most alarmingly, the expected number of new pancreatic cancer cases is projected to increase by 55% between the years 2010 and 2030.[2]
- 94% of those diagnosed with pancreatic cancer die within the first five years because there are no early detection tools or effective treatments for this disease. Given the research discovery timeline, it is unlikely we will have the tools required to manage the significant, projected increase in expected cases unless we take dramatic action now.
- The National Cancer Institute (NCI) does not currently have a strategic plan to make progress on this deadly killer.

We Need to Step Up the investment in pancreatic cancer research

- Currently, the NCI allocates just 2% of its $5 billion annual budget for pancreatic cancer research.
- There is no question that when researchers are properly funded, research advances follow:
    - While in 2009 NCI funded approximately 8,700 research grants, contracts and intramural research projects across all forms of cancer, only 471 (approximately 5%) were relevant to pancreatic cancer.[3]
    - Further, NCI currently funds significantly fewer pancreatic cancer researchers at any funding level compared to the other top five cancer killers. In 2009, only 334 pancreatic cancer researchers were funded, compared to 1,558 breast cancer researchers, 838 prostate cancer researchers, 835 lung cancer researchers and 820 colorectal cancer researchers.[3]
- Less than 2% of the NCI's 2009 awards for early-career and established investigators (K, F and T awards) had relevance to pancreatic cancer. Even more troubling, NCI reduced the total funding allocated for these important awards from their 2008 level.[3]
- Given the lack of funding for pancreatic cancer research, senior scientists from other areas of biomedical and cancer research do not have the incentive to apply their knowledge to this disease.
    - Out of the researchers who received NCI funding specifically for pancreatic cancer research, only 32 received funding totaling $500,000 or more, a level appropriate for senior scientists. By comparison, this level of funding was awarded to 240 researchers in breast cancer, 108 in prostate cancer, and 110 in colorectal cancer. The positive survival trends in these other cancers strongly suggest that these larger grants are necessary to further progress and attract investigators.[3]

We Need a Unique and Targeted approach to studying this disease

- Pancreatic cancer tumors are different than many other tumors. The cellular make-up of the tumors is different and therefore, specialized research techniques must be applied.
- Numbers are also an issue. An estimated 43,140 Americans will be diagnosed with pancreatic cancer in 2010 compared to 209,060 with breast cancer.[1]
- Due to the wide geographic dispersion of relatively few pancreatic cancer patients, few individual medical centers treat a sufficient numbers of patients to conduct statistically significant research.
- Furthermore, because few patients qualify for surgery and most patients die quickly after diagnosis, scant pancreatic cancer tissue is available for research.
- Additionally, many patients who might consider participating in clinical trials are too sick to do so or die before they can enroll.
- These are challenges that can be overcome, but they require a concerted effort by NCI to develop a specific strategic plan to address these and other challenges in pancreatic cancer research in addition to an infusion of targeted research funding.

The Pancreatic Cancer Action Network is a nationwide network of people dedicated to working together to advance research, support patients and create hope for those affected by pancreatic cancer.

HCR

3

<TARGET><BILL>HCR 3</BILL><SUBJECT>HCR
3</SUBJECT><COMM>SHSS27</COMM></TARGET>

REPRESENTATIVE CATHY MUÑOZ

HCR 3 – Promoting the Safety and Protection of Older Alaskans

A devastating problem of elder abuse has been on the rise in Alaska. Over the past four years Adult Protection Services in the Department of Health and Social Services has received an alarming 169% increase in the reports of harm. The Ombudsman Office for Long-term Care has seen a corresponding increase in the reports of harm at 200% in the past three years. The most common allegations are self-neglect, abuse, neglect, and financial exploitation.

Older Alaskans enrich the lives of our communities and provide knowledge of culture and history. As the population of older Alaskans continues to increase it is essential we recognize the complex health needs and services which need to be offered to provide independence and dignity to every individual.

I encourage all Alaskans to take a step forward in recognizing this growing problem. Your support of HCR 3 will help to raise awareness of elder abuse and will promote the safety and protection of older Alaskans.

REPRESENTATIVE CATHY MUÑOZ

MEMORANDUM

TO: Senator Bettye Davis
Health & Social Services Committee Chair

FROM: Representative Cathy Muñoz

DATE: March 29, 2011

RE: Changes to CS HCR 3 (HSS)

The House Health and Social Services Committee adopted two amendments that recognize family and community involvement. "Be it Resolved" language was added to reflect the Department of Health & Social Services support to provide family services and enable independent living, in addition to recognizing family and community who provide an essential source of security and well-being for vulnerable Alaskans.

An amendment passed on the House floor to include language identifying "centers for independent living" under the support for efficient and early intervention services (page 3, line 13). Centers for Independent Living have served seniors for many years and provide a variety of abuse prevention and response services.

STATE CAPITOL • JUNEAU, ALASKA 99801-1182 • (907) 465-3744 • FAX (907) 465-2213
REPRESENTATIVE_CATHY_MUNOZ@LEGIS.STATE.AK.US

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: HCR 3
() Publish Date

Identifier (file name): HCR3-LEG-COU-03-09-2011
Title: "Relating to Promoting the Safety and Protection of Older..."
Sponsor: Representative Muñoz
Requester: House Health and Social Svcs Committee

Dept. Affected: Legislature
Appropriation: Legislative Council
Allocation: Session Expenses
OMB Component Number: 782

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version

Initial Version

Prepared by: Shane Miller, Finance Manager — Phone: 465-6626
Division: Administrative Services Division — Date/Time: 3/9/11 1:29 PM
Approved by: Pamela Varni, Executive Director — Date: 3/9/2011
Legislative Affairs Agency

(Revised 12/29/2010 OMB)

Analysis

This fiscal note has zero impact on the Legislative Affairs Agency.

STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

March 1, 2011

Representative Cathy Muñoz
Alaska State Capitol, Room 403
Juneau, AK 99801-1182

Subject: Support for HCR 3

Dear Representative Muñoz:

The Alaska Commission on Aging (ACoA) is pleased to offer our support of HCR 3, a resolution sponsored by you to help raise awareness about the growing problem of elder abuse and to promote safety and protection of older Alaskans.

Elder abuse is a devastating and unrecognized problem that oftentimes goes unreported and can have life-threatening consequences. According to a report from the National Institute of Justice (March 2009), approximately 11% of people age 60 years and older suffer some form of abuse every year. Other studies have shown that elderly victims of abuse, exploitation and neglect have twice the risk of dying within a year. The National Center on Elder Abuse estimates that only one out of six elder abuse incidents (excluding the cases of self-neglect) are reported to authorities. The majority of cases go unreported as elders/seniors are often reluctant to report the abuse, particularly if the abusers are family members, for fear of shaming the family or losing that person's care. Sometimes well-meaning family and other unpaid caregivers suffer from "caregiver burnout" that can lead to mistreatment. According to Dr. Lisa Gibbs, University of California, "Elder abuse is where child abuse was 30 years ago," referring to society's lack of awareness of the mistreatment of vulnerable adults.

Alaska continues to lead all states in the rate of growth of people age 60 and older; they number 85,100, according to 2009 estimates from the Alaska Department of Labor and are projected to triple in size over the next 25 years due to the aging of the baby boomer population. Moreover, Alaska has the fastest growing population of the "oldest old" (those 85 years and older) many of whom are frail, have high health care needs, and are most at risk for Alzheimer's disease and related dementias in addition to other complex behavioral needs. Older adults with dementia are particularly vulnerable to abuse as well as persons who live in isolation. As the number of assisted living homes has increased significantly over the last three years for seniors and people with developmental disabilities, so have complaints from elderly residents and their family caregivers to the Office of the Long-Term Care Ombudsman concerning quality of care in assisted living settings. Adult Protective Services, an agency under the Division of Senior and Disabilities Services, reports a 169% increase in their reports of harm. While the increase in reporting may be partly attributed to growing social awareness, the increase in the senior population, particularly among the "oldest old" (persons age 85 years and older), and the current times of economic insecurity may also contribute to mounting threats of neglect, fraud, and abuse directed toward the most vulnerable.

Please accept our sincere appreciation for your efforts to improve protection and safety for Alaska's most vulnerable citizens. We look forward to working with you to raise public awareness about the prevalence of elder abuse in Alaska and to develop strategies to protect Alaska's vulnerable elderly citizens from harm. Please feel free to contact Denise Daniello, ACoA's Executive Director, by phone (465-4879) or email (denise.daniello@alaska.gov) for questions or help in promoting this effort. Thank you.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

STATE OF ALASKA

DEPARTMENT OF REVENUE
Alaska Mental Health
Trust Authority

SEAN PARNELL, GOVERNOR

Office of the Long Term Care Ombudsman

3745 Community Park Loop. Suite 200
Anchorage AK 99508
Phone (907) 334-4480
Fax (907) 334-4486

March 1, 2011

Representative Cathy Munoz
Alaska State 27th Legislature
Capitol Building
Juneau, AK

Re: HCR 3 "Relating to promoting the safety and protection of older Alaskans"

Dear Rep. Munoz:

The Office of the Long Term Care Ombudsman investigates and resolves complaints made by, or on behalf of, older Alaskans in long term care facilities. Our five staff visit skilled nursing facilities and assisted living homes across the state to advise seniors of their rights and to resolve problems the seniors identify. Like other state and local agencies, our staff work hard to protect older Alaskans who may not be able to advocate for themselves.

I am grateful for your sponsorship of HCR 3, promoting public awareness of elder maltreatment. I also pledge my program's commitment to improving coordination with DHSS and other state agencies in whatever way will serve the cause of elder justice.

With our state's growing senior population, and with the rising number of public complaints coming into our office, I believe that this is the right time to bring public attention to the needs of vulnerable older Alaskans.

Sincerely,

Diana Weber

Diana Weber
State of Alaska Long Term Care Ombudsman
3745 Community Park Loop, Suite 200
Anchorage, AK 99508

Adult Protective Services – Quick Fact Sheet

Issue: Reports of Harm for Alaskan Elders

The following analysis focuses on reports of harm received by Adult Protective Services (APS) that involved Alaskan elders, identified as **individuals who were 60 years or older** at the time of report. The following analysis represents data for fiscal years 2009 and 2010.

The **average age of elders** who have been the subject of a substantiated APS report of harm for both FY09 and FY10 was **75 years old.**

There were a total of 701 reports of harm for Alaskan elders in FY09. Of these, 308 were substantiated and the remaining 393 were unsubstantiated. In FY10 there were 813 total reports of harm for Alaskan elders. Of those, 343 were substantiated, and the remaining 470 were unsubstantiated.

Regional Analysis of APS Substantiated Reports of Harm:

Region	FY09	% of total	FY10	% of total
Anchorage Region	156	50.7%	176	51.3%
Interior Region	29	9.4%	32	9.3%
Northwest Region	5	1.6%	8	2.3%
Southcentral Region	72	23.4%	98	28.6%
Southeast Region	26	8.4%	17	5.0%
Southwest Region	20	6.5%	12	3.5%
Total number of substantiated cases	**308**	**100.0%**	**343**	**100.0%**

Abuse, Exploitation, and/or Neglect by a Family Member:

Family member involvement	FY09	% of total	FY10	% of total
Cases involving family members	78	25.3%	90	26.2%
Total number of substantiated cases	**308**	**100.0%**	**343**	**100.0%**

Substantiated Allegation Analysis:

Type of allegation	FY09	% of total	FY10	% of total
Abandonment	3	1.0%	4	1.2%
Abuse-Mental	19	6.2%	30	8.7%
Abuse-Physical	19	6.2%	30	8.7%
Abuse-Sexual	1	0.3%	0	0.0%
Exploitation-Financial	66	21.4%	64	18.7%
Exploitation-Person	3	1.0%	12	3.5%
Neglect	47	15.3%	32	9.3%
Self-Neglect	150	48.6%	171	49.9%
Total number of substantiated allegations	**308**	**100.0%**	**343**	**100.0%**

Gender Analysis:

Gender	FY09	% of total	FY10	% of total
Male	115	37.3%	144	42.0%
Female	193	62.7%	199	58.0%
Total number of substantiated cases	**308**	**100.0%**	**343**	**100.0%**

PRESS RELEASE
Alaska Commission on Aging
February 17, 2009

We're #1: Alaska Tops in Senior Population Growth

The number of people age 65 and older grew faster in Alaska than in any other state during the decade between 1997 and 2007. Seniors still make up just eleven percent of Alaska's population, a far lower proportion than in states like Florida or Arizona. But with a growth rate of 49.6 percent in the last ten years, the number of older Alaskans is increasing at a rate more than four times the national average.

For years, Nevada laid claim to the fastest-growing senior population in the U.S. As of this year, it has fallen to second place.

The surprising statistics conjure up images of seniors packing up their households and migrating to the frozen 49th state en masse. Are wagon trains of older Americans in Winnebagos motoring up the Alaska Highway, bearing signs that read, "Last Frontier or Bust"?

Not exactly. In fact, the number of seniors leaving Alaska is roughly equal to the number who move here. Out-migration patterns have not changed substantially in decades. Many Alaskans still retire to warmer, sunnier locations. So what explains the senior population surge?

What we're witnessing is not a change in *current* retiree preferences but rather the maturing of *past* trends in Alaskan population movements.

Thousands of working-age people migrated to Alaska during the 1970s oil pipeline construction and the era of post-pipeline spending growth in the early 1980s. With the continental U.S. experiencing a steep recession during that period, young people, many of them born in the 1940s and 1950s, moved north to fill jobs in the state's rapidly-expanding economy.

The new arrivals put down roots in Alaska; they bought homes, raised families, and enjoyed the state's natural beauty and rugged outdoor lifestyle. Now heading into their retirement years, a large number of them are choosing to stay.

The selective migration of thousands of people in a limited age range during the 1970s and early 1980s created a population spike which has

steadily moved into higher and higher age groups. Like the "pig inside the python," this concentrated population may even decrease slightly over time, but it remains a large, visible anomaly in the state's demographic portrait. (To view the population distribution by age group, go to http://laborstats.alaska.gov/?PAGEID=67&SUBID=115 and click on the graph of "Alaska's Changing Population" to see the changes unfold over time.)

It's true that other states' populations have prominent baby boomer segments as well. But because so many of Alaska's boomer and slightly-older residents arrived during a narrow band of time, leaving their parents' generation behind in their states of origin, our state has long had proportionately more residents in the boomer and slightly-older age groups than other states.

In addition to those who moved to Alaska from elsewhere, Alaska Natives – whose numbers had also expanded rapidly during the "baby boom" era – are highly likely to remain in the state during their senior years.

Increases in life expectancy also play a role in the increasing number of seniors. In fact, the fastest-growing age group in Alaska is the 85-and-older group. Individuals in this group are the most likely to be in frail health, disabled, and in need of supportive services.

Finally, the aging parents of some of our 1970s and 1980s migrants do come to Alaska to be cared for by their offspring in their later years. However, there is no indication that this group represents a large proportion of our state's seniors.

Our fast-growing senior population primarily consists not of newcomers from other states but of our long-time friends and neighbors, those who built up many of modern Alaska's institutions and our communities' infrastructures.

While the growing number of seniors means Alaska must increase its capacity to supply the services and supports they will need, the state can expect a net gain in its quality of life thanks to the presence of more older Alaskans. As volunteers in civic enterprises, caregivers within their families, and mentors of cultural and professional achievement, not to mention the estimated $1.6 billion they contribute annually to the state's economy, seniors represent an incomparable asset for Alaska.

Other states, and even some cities, invest in advertising campaigns to attract senior residents to their communities. They recognize the tremendous economic and community leadership benefits seniors bring with them. The "retirement industry" is well-known as one of the most positive contributors to any economy. According to the Report on the Economic Well-Being of Alaska Seniors (2007), the retirement pension and health care funds this industry draws in are spent locally (triggering an economic multiplier effect), and senior spending is stable, year-round, environmentally benign, compatible with other industries, and helps produce economies of scale (particularly in health care) which benefit all segments of the population.

Alaska has the immense good fortune to be rapidly gaining seniors with no public investment in advertising at all. Our seniors are part of the latest greatest American retirement boom – without having to pack their bags or abandon their favorite people and places. And Alaska will benefit from their wisdom, perspective, and community contributions.

References:

A Profile of Older Americans: 2008, Administration on Aging, U.S. Department of Health and Human Services:
http://www.mowaa.org/Document.Doc?id=69

Alaska Department of Labor & Workforce Development population website:
http://laborstats.alaska.gov/?PAGEID=67&SUBID=115

Report on the Economic Well-Being of Alaska Seniors (2007):
http://www.hss.state.ak.us/acoa/documents/seniorWellbeingReport.pdf

WHO MUST REPORT?

Physicians or other licensed health care providers

Mental health professionals including licensed marital and family therapists

Pharmacists

Nursing home, residential care, and health care facility administrators

Guardians and Conservators

Police Officers

Village Public Safety Officers

Village Health Aids

Social Workers

Members of the Clergy

Personal Care Attendant

Home Health Aide

Emergency Medical Technician or Paramedic

Caregiver of Vulnerable Adults

Certified Nurses Aide

Employees of service grant agencies funded by the Department of Administration for the provision of services to older Alaskans, the Department of Health and Social Services, and the Council on Domestic Violence and Sexual Assault

ANY PERSON MAY REPORT.

DESIGNATIONS OF OTHERS TO PROVIDE PROTECTIVE SERVICES

Alaska law authorizes the Division of Senior Services to designate and train other state agencies, community service providers, or individuals to provide protective services.

Guiding Principles of Adult Protection

- When interests compete, the adult client is the person we are charged to serve; not the community concerned about safety, the landlords concerned about property, citizens concerned about crime or morality, families concerned about their own health or finances.
- When interests compete, the adult client is in charge of decision-making until she or he voluntarily delegates responsibility to another or the court grants responsibility to another.
- Freedom is more important than safety. The person can choose to live in harm or even self-destructively provided she or he has the capacity to choose, does not harm others, and commits no crime.
- In the ideal case, protection of adults seeks to achieve simultaneously, and in order of importance: freedom, safety, least disruption of life-style and least restrictive care alternative.

To obtain copies of Alaska Statute 47.24.010-.900. Contact the Division of Senior and Disabilities Services

at 1-800-478-9996

or 269-3666 in Anchorage

State of Alaska

Adult Protective Services

Program Information

Legal Rights

Services

Div. of Senior and Disabilities Services
Department of Health & Social Services
550 W. 8th Ave
Anchorage, AK 99501

1-800-478-9996

Anchorage: 269-3666
Fax: 269-3648

Fairbanks 451-3187
Fax: 451-3186

Juneau 465-4791
Fax: 465-4665

www.hss.state.ak.us/dsds/aps.htm

RIGHTS OF VULNERABLE ADULTS

- Right to expect that information about one will be shared only on a need to know basis and only as necessary to insure that one can receive coordinated services and protection.
- Right to give informed consent in accepting services.
- Right to have services delivered in the least restrictive manner that meets one's needs.
- Right to voluntarily accept or reject services except where the vulnerable adult lacks decision making capacity, is unable to consent, or is incapacitated.
- Right to receive assistance through utilizing family and other informal support systems.
- Right to all possible alternatives to formal legal action in the form of guardianship or conservatorship except where decision making capacity is lacking or protection of the adult requires it.

WHAT IS ADULT PROTECTION?

SERVICES THAT PREVENT OR STOP HARM FROM OCCURRING TO VULNERABLE ADULTS

Alaska law requires that protective services not interfere with the elderly or disabled adults who are capable of caring for themselves.

Vulnerable adults have a physical or mental impairment or condition that prevents them from protecting themselves or from seeking help from someone else.

Alaska law defines vulnerable adults to include adults 18 years of age or older, not just the elderly.

The harm they suffer may result from abandonment, abuse, exploitation, neglect or self-neglect.

ABANDONMENT is the desertion of a vulnerable adult by a caregiver.

ABUSE is the intentional or reckless non-accidental non-therapeutic infliction of pain, injury, or mental distress, or sexual assault.

EXPLOITATION is the unjust or improper use of another person or their resources for one's own benefit.

NEGLECT is the intentional failure of caregiver to provide essential services.

SELF-NEGLECT is the act or omission by a vulnerable adult that results, or could result in the deprivation of essential services necessary to maintain minimal mental, emotional, or physical health and safety.

See Alaska Statute 47.24.010.900 (Amended 1994)

EXAMPLES OF SERVICES

Information and Referral
Investigation of Reports
Protective Placement
Guardianship/Conservatorship Counseling
Care Coordination
Training and designation of local community resources to provide services.

WHAT MUST BE REPORTED?

Any incident in which a vulnerable adult suffers harm from abandonment, exploitation, abuse, neglect, or self neglect. If in doubt, make the report.

MAKE REPORTS TO WHOM?

Reports can be made to the central reporting number for the Division of Senior Services within 24 hours at 1-800-478-9996. Reports can be made to local law enforcement agencies in the event that a report cannot be made to the Division. Local law enforcement agencies are mandated to investigate and take appropriate action to protect vulnerable adults.

IMMUNITY FROM LIABILITY

Persons who make reports in good faith are immune from liability and protected by law from retaliation.

CONFIDENTIALITY OF REPORT

Investigation reports and reports of the abandonment, abuse, exploitation, neglect, or self-neglect of a vulnerable adult are confidential and are not subject to public inspection and copying.

Investigation reports may be used by appropriate agencies or individuals inside and outside the state in connection with investigations or judicial proceedings involving the abandonment, abuse, exploitation, neglect, or self-neglect of a vulnerable adult.

Individuals who report abandonment, abuse, exploitation, neglect, or self-neglect of a vulnerable adult may remain anonymous.

HCR

5

<TARGET><BILL>HCR 5</BILL><SUBJECT>HCR
5</SUBJECT><COMM>SHSS27</COMM></TARGET>

Alaska State Legislature

State Capitol, Room 102
Juneau, AK 99801
Phone: 465-2689
Fax: 465-3472
Toll Free (800) 665-2689
Representative_Paul_Seaton@legis.state.ak.us

345 W. Sterling Highway
Suite 102B
Homer, AK 99603
Phone: 235-2921
Fax: 235-4008

REPRESENTATIVE Paul Seaton
District 35

HCR 5
Sponsor Statement

Short Title: A resolution relating to prevention of disease and to vitamin D.

HCR 5 urges the State of Alaska to adopt a disease prevention model of health and to increase the awareness of the preventative benefits of vitamin D supplementation, and increase vitamin D availability to reduce health impacts and costs.

Mounting scientific evidence suggests a correlation between vitamin D sufficiency and significant decrease in incidence of cancer, diabetes, heart disease, rheumatoid arthritis, chronic pain, Seasonal Affective Disorder, oral disease, influenza, upper respiratory illness, tuberculosis, multiple sclerosis, osteoporosis, fractures in the elderly, autism, rickets, pregnancy complications, and hepatitis C.

For seven months out of the year, the sun angle is too low for Alaskans to be able to produce vitamin D from sunlight. Partly due to this long "vitamin D winter," Alaska has some of the lowest blood serum levels of vitamin D in the country. Correspondingly, Alaska also has relatively high rates of chronic disease. For example, according to the Alaska Division of Public Health, chronic diseases (cancer, heart disease, respiratory disease, and stroke, respectively) make up four of the top five causes of death in the state. These diseases come at a great cost both socially and financially to our state.

Deficiency in vitamin D may contribute heavily to this steep social and financial cost. Two studies mentioned in HCR 5 demonstrate this. The first one, examining the economic burden of vitamin D deficiency, estimated that Canada could lower the death rate by 37,000 deaths and save $14.4 billion dollars per year by increasing the national average of vitamin D blood serum levels. The second, similar study showed that the United States could have 50,000—63,000 fewer deaths and save $40-56 billion per year with sufficient population levels of vitamin D.

Alaska State Legislature

State Capitol, Room 102
Juneau, AK 99801
Phone: 465-2689
Fax: 465-3472
Toll Free (800) 665-2689
Representative_Paul_Seaton@legis.state.ak.us

345 W. Sterling Highway
Suite 102B
Homer, AK 99603
Phone: 235-2921
Fax: 235-4008

REPRESENTATIVE Paul Seaton
District 35

With higher rates of chronic disease in northern latitudes, and fewer and fewer federal dollars coming in to cover the escalating healthcare and Medicaid costs in Alaska, it is imperative to prevent—rather than just treat—chronic disease. Prevention of chronic disease is a matter of lifestyle: healthy diet, frequent exercise, and adequate levels of vitamins and nutrients. Most people understand this, but are unaware that vitamin D deficiency needs to be addressed in every community of this state.

HCR 5 asks Governor Sean Parnell to establish "prevention of disease" as a primary model of health care in Alaska, and for the Department of Health and Social Services and health care providers to increase attention to vitamin D deficiency and promote supplementation. It also asks the Department to provide vitamin D supplements to the elderly, children, and pregnant women. Vitamin D supplementation is a low-cost measure that could help save lives, and significantly improve the health of many Alaskans, while saving millions of dollars in health treatment costs.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: HCR 5
() Publish Date

Identifier (file name): HCR5-LEG-COU-03-02-2011
Title: Relating to Prevention of Disease and to Vitamin D
Sponsor: Representative Seaton
Requester: House Health and Social Services Committee

Dept. Affected: Legislature
Appropriation: Legislative Council
Allocation: Session Expenses
OMB Component Number: 782

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time							
Part-time							
Temporary							

Why this fiscal note differs from previous version

Initial Version

Prepared by: Shane Miller, Finance Manager — Phone 465-6626
Division: Administrative Services Division — Date/Time 3/2/11 1:51 PM
Approved by: Pamela Varni, Executive Director — Date 3/2/2011
Legislative Affairs Agency

(Revised 12/29/2010 OMB)

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. HCR5

Analysis

This fiscal note has zero impact on the Legislative Affairs Agency.

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version **HCR005\M**
() Publish Date

Identifier (file name): HCR005-DHSS-PHN-03-09-11
Title Vitamin D Supplements
Sponsor Rep. Seaton
Requester House HSS

Dept. Affected Health and Social Services
Appropriation Public Health
Allocation Nursing
OMB Component Number 288

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2012**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other (please identify)							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2011) cost

POSITIONS

Full-time	**0**	0	0	0	0	0	0
Part-time							
Temporary							

Why this fiscal note differs from previous version (if initial version, please note as such)

Not Applicable. Initial version.

Prepared by Ward B. Hurlburt, M.D., MPH - Chief Medical Officer / Director
Division Public Health
Approved by Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services

Phone 269-6680
Date/Time 3/4/11 12:00 AM
Date 3/9/2011

(Revised 1/27/2011 OMB)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. HCR005

Analysis

This House Concurrent Resolution relates to the prevention of disease and the benefits of Vitamin (Vit.)D.

The division is submitting a zero fiscal note because no new authorization is necessarily invoked by passage of this resolution. Should the Legislature decide to require the department to undertake activities through additional legislation, an additional appropriation will be necessary.

This analysis estimates the cost of implementing the four activities in the resolution if the division were to implement them, although the division has no plans to do so at this time. The assumptions used to calculate the fiscal note are detailed on page 3.

The resolution includes language that encourages or urges the Department of Health and Social Services to implement four activities in regards to Vitamin D supplements. The activities are

(1) to increase attention to Vit. D deficiency, Vit. D testing, and to promote awareness of the long-term health benefits of and increased chances of cancer survival with sufficient levels of Vit. D;
(2) investigate substituting Vit. D supplementation for influenza vaccination as a less costly method for preventing influenza;
(3) provide Vit. D supplements to the elderly to prevent bone loss, falls, fractures, and other age-related health problems; and
(4) provide Vit. D supplements to pregnant women and infants to prevent pregnancy complications, preterm births, type 1 diabetes, and rickets.

For the first activity, the department would contract for professional services to create an awareness campaign on the benefits of Vit. D. at an estimated cost of $50.0. This would be an ongoing cost.

For the second activity, the department would require $100.0 for a PhD-level epidemiologist (1 FTE, existing PCN, Range 20/A) plus $35.0 for overhead (rent, utilities, etc.). The epidemiologist would conduct a study investigating subsitution of Vit. D supplemention for influenza vaccination as a less costly method of preventing influenza. This study would take at least three years. This is a conservative estimate and could be double or triple the amount depending on the final study design.

For the third and fourth activities, the department would provide Vit. D supplements through Public Health Nursing Clinics at a cost of $211.2 annually. Elderly, pregnant women, and infants who go to the clinics would receive a limited office visit to determine if Vitamin D supplements were indicated. Of the approximately 17,200 public health clinic clients seen in 2011, it is assumed 3,225 (18.75%) could have received one or more 90-day supplies of Vit. D supplements. The client would receive a limited office visit each time the client came to the clinic for more supplements to determine if Vit. D was still medically necessary and evaluate their health condition. Public Health Nursing would report their results to the epidemiologist conducting the Vit. D study.

The total cost for Years 1 to 3 would be $396.2. Years 4 and 5 would be $261.2 since the second activity for a study would be completed by then.

(Continued on page 3.)

FISCAL NOTE

STATE OF ALASKA
2011 LEGISLATIVE SESSION

BILL NO. HCR005

Analysis Continued

Assumptions:

Clients
17,200 total clients served by Public Health Nursing, 2011
75% percent PHN clients who are elderly/pregnant women/infants
12,900 clients eligible for Vit. D supplements
25% percent clients eligible who receive Vit. D
3,225 clients eligible who receive Vit. D
806 clients (25%) visit 1/year
806 clients (25%) visit 2/year
806 clients (25%) visit 3/year
807 clients (25%) visit 4/year

Medical Supply Unit Cost
$ 1.20 Cost is $0.10 per Vit. D pill (over-the-counter, wholesale)
At 1 dose per week, with 12 doses dispensed per clinic visit (90-day supply)
$ 25.00 Cost of 15 min. limited office visit for each clinic visit (max. 4 /year)
$ 26.20 total cost per clinic visit for Vit. D

Total Annual Cost
$ 211,238 medical supplies for dispensing Vit. D
$ 100,000 personal services for 1 FTE epidemiologist (Range 20/A) to investigate Vit. D as substitute for influenza vaccine (Years 1-3)
$ 85.000 contractual costs for awareness campaign of benefits of Vit. D ($50.0); overhead for 1 FTE ($35.0)
$ 396,238 total annual cost Year 1

This analysis includes only the direct medical supply and administrative costs of implementing the resolution. The cost savings if patients opted for Vit. D supplements in lieu of influenza vaccine are not included in this analysis. Nor does it include the additional cost of treating patients who did not get vaccinated for influenza and later became ill.

The annual cost per person for Vit. D supplements (assuming 52 doses, 4 visits) is $104.80. In comparison, the medical supply unit cost of influenza vaccine is approximately $33-$66 annual cost per person (assuming $8/dose plus $25 limited office visit for 1-2 doses/year).

The resolution notes that part of the budget of the Department of Health and Social Services is used to treat illnesses that could be prevented with adequate blood serum levels of Vit. D. Those potential costs savings are not included in this analysis as the amount of avoided costs are indeterminate and would likely not be realized in the time frame covered by the fiscal note.

Breast cancer risk by 25(OH)D

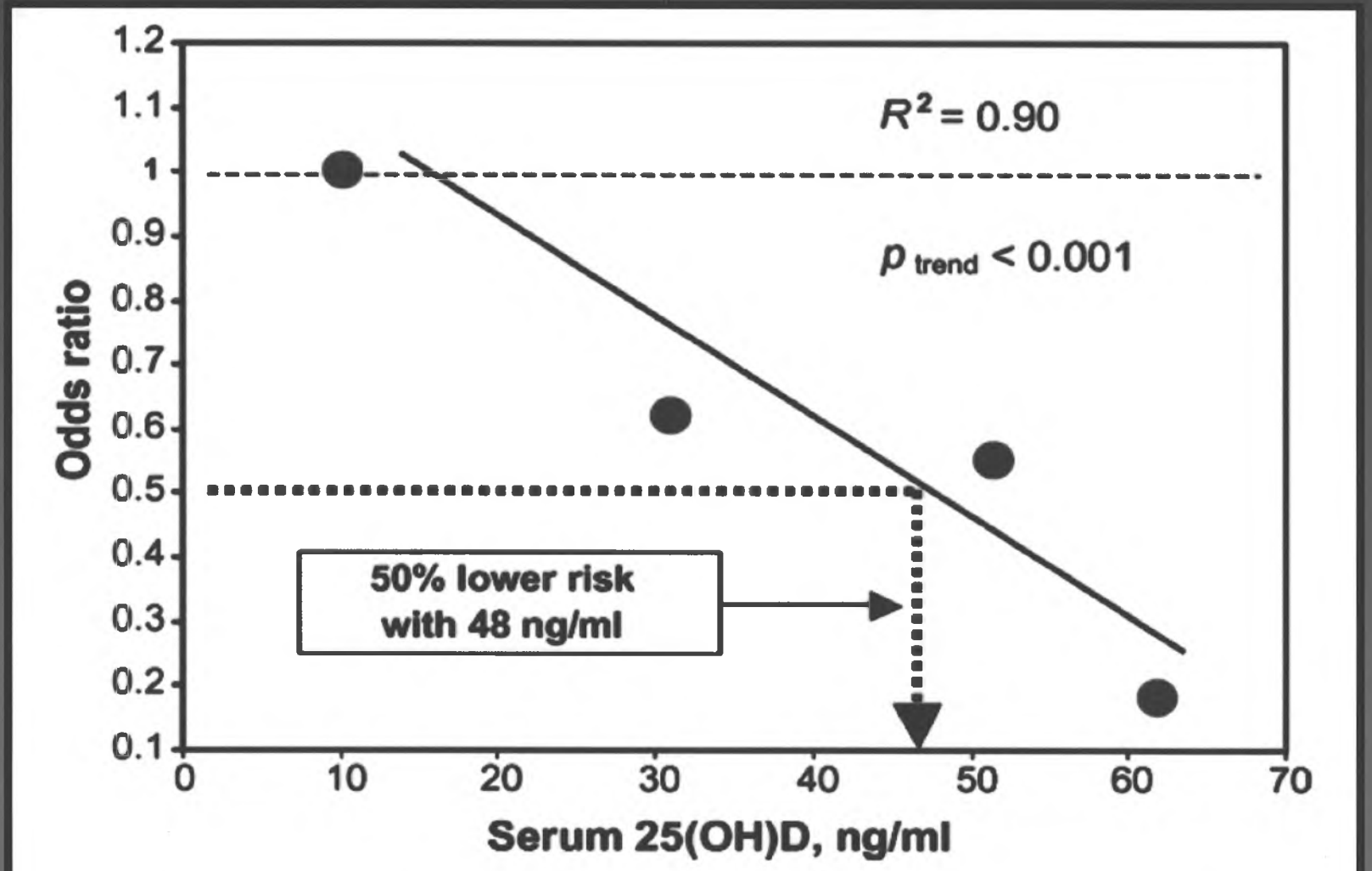
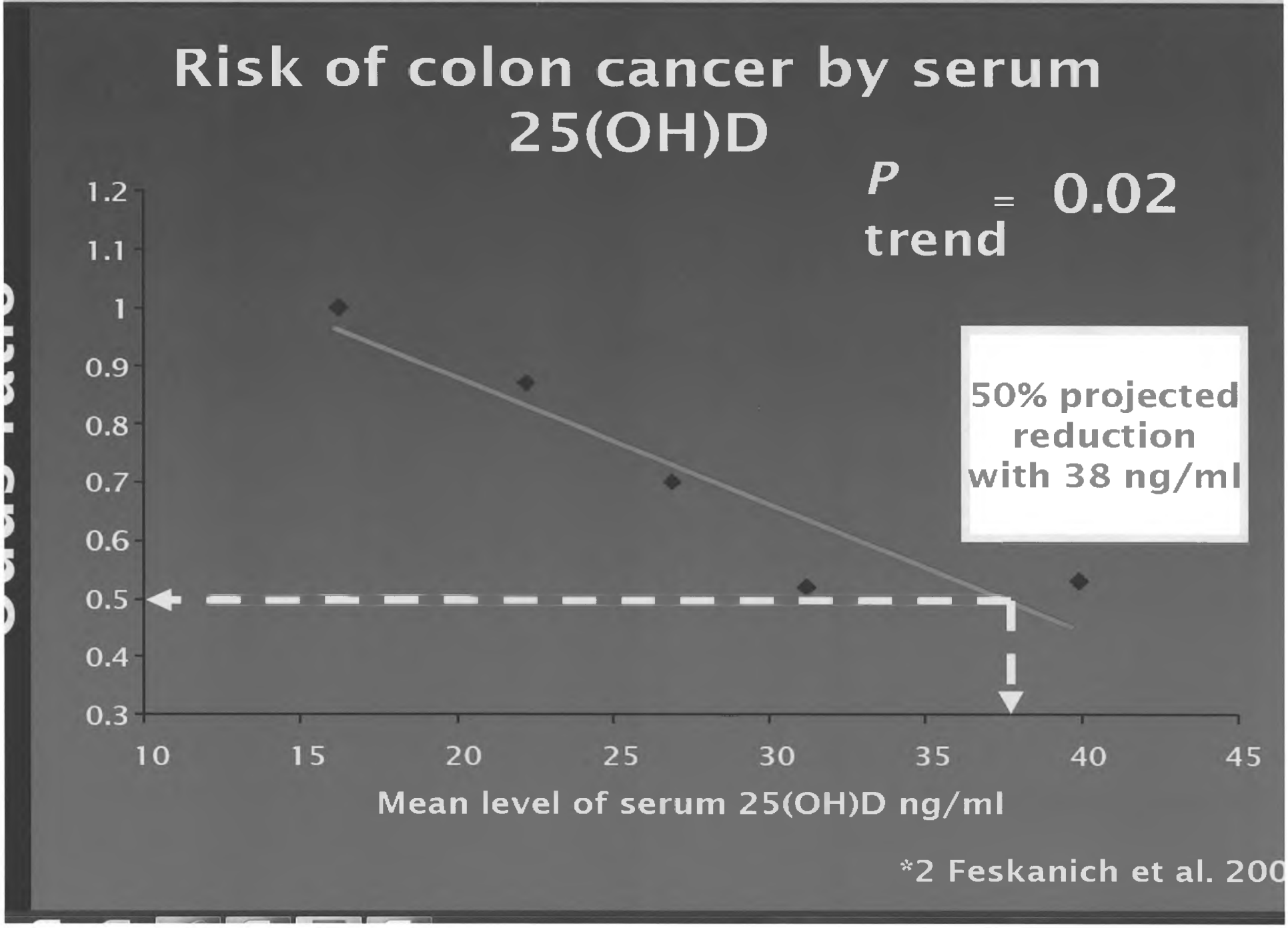


Fig. 2. Dose–response gradient of risk of breast cancer according to serum 25-hydroxyvitamin D concentration, St. George's Hospital, London

Risk of colon cancer by serum 25(OH)D



*2 Feskanich et al. 200

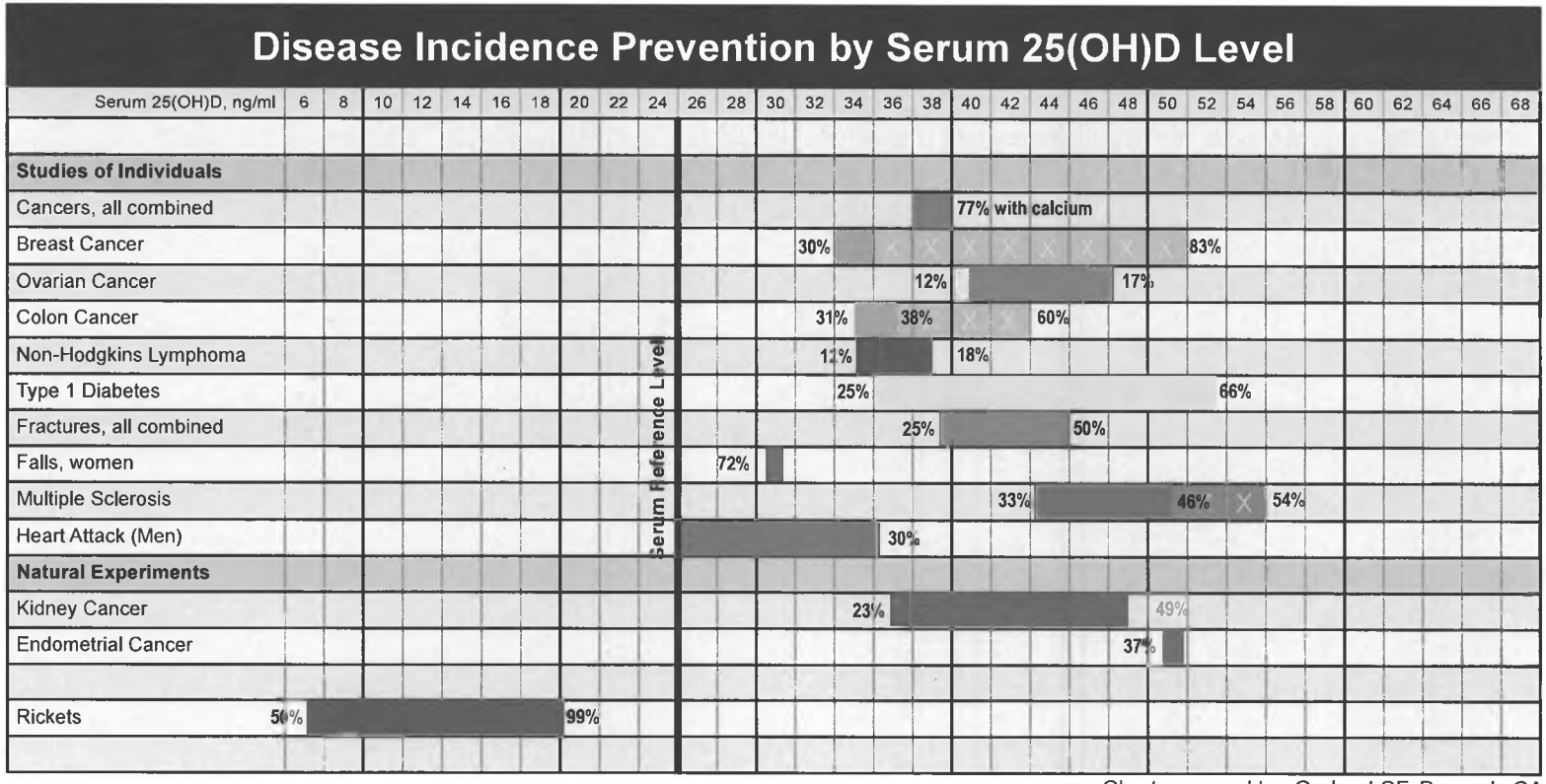


Chart prepared by: Garland CF, Baggerly CA

Legend:
All percentages reference a common baseline of 25 ng/ml as shown on the chart.
%'s reflect the disease prevention % at the beginning and ending of available data. Example: Breast cancer incidence is reduced by 30% when the serum level is 34 ng/ml vs the baseline of 25 ng/ml. There is an 83% reduction in incidence when the serum level is 50 ng/ml vs the baseline of 25 ng/ml.
The x's in the bars indicate 'reasonable extrapolations' from the data but are beyond existing data.

References:
All Cancers: Lappe JM, et al. Am J Clin Nutr. 2007;85:1586-91. Breast: Garland CF, Gorham ED, Mohr SB, Grant WB, Garland FC. Breast cancer risk according to serum 25-Hydroxyvitamin D: Meta-analysis of Dose-Response (abstract).American Association for Cancer Research Annual Meeting, 2008. Reference serum 25(OH)D was 5 ng/ml. Garland, CF, et al. Amer Assoc Cancer Research Annual Mtg, April 2008,. Colon: Gorham ED, et al. Am J Prev Med. 2007;32:210-6. Diabetes: Hyppönen E, et al. Lancet 2001;358:1500-3. Endometrium: Mohr SB, et al. Prev Med. 2007;45:323-4. Falls: Broe KE, et al. J Am Geriatr Soc. 2007;55:234-9. Fractures: Bischoff-Ferrari HA, et al. JAMA. 2005;293:2257-64. Heart Attack: Giovannucci et al. Arch Intern Med/Vol 168 (No 11) June 9, 2008. Multiple Sclerosis: Munger KL, et al. JAMA. 2006;296:2832-8. Non-Hodgkin's Lymphoma: Purdue MP, et al. Cancer Causes Control. 2007;18:989-99. Ovary: Tworoger SS, et al. Cancer Epidemiol Biomarkers Prev. 2007;16:783-8. Renal: Mohr SB, et al. Int J Cancer. 2006;119:2705-9. Rickets: Arnaud SB,
Copyright GrassrootsHealth, 03/23/10 www.grassrootshealth.net

SEASONAL VARIATION IN SERUM 25-HYDROXYVITAMIN D IN HEALTHY FAIRBANKS, ALASKA RESIDENTS: RELATION TO DIET AND SUNLIGHT EXPOSURE

A

THESIS

Presented to the Faculty of the University of Alaska

In Partial Fulfillment of the Requirements

for the Degree of

MASTER OF SCIENCE

By

Meredith Grant Tallas, B.S.

Fairbanks, Alaska

December 1986

ABSTRACT

This study tested the hypothesis that lower UV radiation during the Fairbanks winter may cause seasonal vitamin D deficiencies. Forty-seven adult Caucasians (mean age, 34 years) donated monthly blood samples and gave 4-day food and sunlight exposure records during one year. There was a highly significant seasonal variation in serum 25-(OH)vitamin D (25-OHD), with the lowest mean mid-winter value above deficiency levels, and a yearly mean of 27 ng/ml for the full group. Analyses of variance indicated significant effects of vitamin D intake, sunlight exposure and sex on serum 25-OHD. Vitamin D intake appeared to be a more important factor determining year-round 25-OHD levels than sunlight exposure. Males had yearly mean 25-OHD levels 16% higher than females and 25% of the females, but none of the males, had yearly means less than 20 ng/ml indicating that females were at greater risk for the development of vitamin D deficiency.

4/2005 thru 3/2007
Ketchikan

RESEARCH

Research and Professional Briefs

Vitamin D Deficiency in a Nonrandom Sample of Southeast Alaska Natives

JOSEPH T. FROST, MPH, RD; LANI HILL, FNP

ABSTRACT

Serum vitamin D has recently been inversely associated with risk for type 2 diabetes. Recent literature suggests that many more individuals than generally thought suffer from vitamin D deficiency. Southeast Alaskan Natives are at an increased risk due to limited sunlight exposure and possible inadequate vitamin D intake. Therefore, the relationship between vitamin D and glucose should be investigated specifically in the southeast Alaska Native population. A review of lab records yielded 83 charts of patients found to have a serum 25-hydroxyvitamin D during a 2-year period. Upon review of these charts, only nine of 83 vitamin D levels were found to exceed the 32 ng/mL (80 nmol/L) threshold. Age and vitamin D levels were associated in a positive linear relationship ($r=0.354$, $P=0.028$). The patients in the lowest vitamin D quartile were younger in age compared to the highest quartile (14.6 years, 95% confidence interval: 4.9, 24.29; $P=0.004$). The high rate of deficiency noted in this sample suggests this population should be further assessed for vitamin D deficiency. Future studies are needed to confirm the association between a vitamin D deficiency and diabetes incidence in this population.
J Am Diet Assoc. 2008;108:1508-1511.

Although traditionally associated with calcium absorption and bone health, expanded roles for vitamin D, including a relationship to diabetes, have recently been reported in the literature. Low serum 25-hydroxyvitamin D levels have been found in individuals with diabetes compared to controls (1,2). The Third Nutrition and Health Examination Survey revealed an inverse association between risk of diabetes and 25-hydroxyvitamin D levels (3). A similar association was seen in the Nurses' Health Study (4). Serum 25-hydroxyvitamin D levels were found to be inversely associated with pancreatic beta cell function, thus suggesting a cause and effect relationship with diabetes (5). Recent research suggests that many more individuals than generally thought, especially those in northern latitudes or with other sunlight restrictions, are deficient in vitamin D (6-9). Both the recommended levels of serum vitamin D and the Adequate Intake from food sources have recently been suggested to be inadequate. At these levels it is thought the beneficial effect of vitamin D cannot be achieved. (6,8,10-12). Despite being at an increased risk for vitamin D deficiency due to limited sunlight exposure (13,14) and lactose intolerance (up to 80%) (15), southeast Alaskan Natives have not been included in vitamin D deficiency studies. The objectives of this study were to investigate vitamin D deficiency in the southeast Alaskan Native population and its possible role in the incidence of diabetes.

METHODS

A manual review of lab records for the 2-year time period of April 1, 2005, to March 30, 2007, was used to identify patients who had 25-hydroxyvitamin D tests completed as part of their care received at the Ketchikan Indian Community Tribal Health Clinic, a native health clinic on an Alaskan island that receives an annual rainfall of 12.5 feet per year. (Natives with varying degrees of native ancestry and who belong to one of 557 federally recognized tribes qualify for health care through Indian Health Service policies. In general, the term *American Indian* or *Alaskan Native* refers to those with native, although not necessarily exclusive, ancestry. Therefore, degree of Native blood varies in this population.)

This review yielded a nonrandom sample of 83 charts of Alaskan Natives. We conducted a retrospective electronic and manual review of these charts to investigate the possible relationship between serum vitamin D levels and abnormal glucose levels.

Electronic and paper charts of individuals known to have the test performed were reviewed, and test results for serum vitamin D and glucose, sex, age, and body mass index (BMI) were recorded. In the event of multiple vitamin D tests, only the initial test was used in data analysis. In all cases, the fasting glucose measured closest to the date of the initial vitamin D test was recorded. Glucose values obtained more than 1 year apart from the vitamin D test were excluded from the analysis. Of the 83 patients, fasting blood glucoses were recorded for 51.

J. T. Frost is a Lieutenant Commander in the US Public Health Service; at the time of the study, he was the diabetes coordinator at the Ketchikan Indian Community Tribal Health Clinic, Ketchikan, AK, and a graduate student in the School of Public Health and Health Sciences, University of Massachusetts, Amherst. L. L. Hill is a family nurse practitioner, Ketchikan Indian Community Tribal Health Clinic, Ketchikan, AK.

Address correspondence to: Joseph Thomas Frost, MPH, RD, 692 Maquam Shore Rd, Swanton, VT 05488. E-mail: joefrostrd@yahoo.com

Manuscript accepted: February 29, 2008.

Copyright © 2008 by the American Dietetic Association.

0002-8223/08/10809-0011$34.00/0
doi: 10.1016/j.jada.2008.06.427

© 2008 by the American Dietetic Association

Table. Demographic data, 25-hydroxyvitamin D levels, and fasting glucose levels of patients with and without diabetes (n=83 except where otherwise noted)

	Patients with diabetes (n)	Patients without diabetes (n)	*P* value
Sex			
Male	12	16	
Female	16	39	
	mean±SD[a]		
Age[b] (y)	56±14	45±16	0.004
BMI[bc]	38.9±9.2	31.9±7.2	0.001
25-hydroxyvitamin D (ng/mL)	15.7±8.6	17.8±12.1	0.348
Fasting glucose[ab] (mg/dL)	139.8±49.9 (n=16)	96.2±11.1 (n=35)	<0.001

[a]SD=standard deviation.
[b]Denotes category of statistical significance at the $\alpha=.05$ level.
[c]BMI=body mass index; calculated as kg/m^2.

Data from 2-hour oral glucose tolerance tests are not reported because only five were recorded. Random glucose levels were not analyzed due to multiple variables affecting their results. Vitamin D samples were drawn in-house and sent to a commercial laboratory for analysis using immunochemiluminometric assay. The threshold for the laboratory's vitamin D assay is 7.0 ng/mL (17.5 nmol/L); for data analysis all "undetectable" values were assigned 7.0 ng/mL (17.5 nmol/L).

Minitab version 15 (2007, Minitab Inc, State College, PA) was used for statistical analysis. Univariate regression calculations were done. Subjects were divided into quartiles based on vitamin D levels and comparisons were made using two-sample *t* tests with regard to glucose values, sex, age, and BMI. Results were considered significant at the $\alpha=.05$ level.

The protocol for this study was granted expedited status under 45 CFR 46.110 by the Alaska Area Institutional Review Board in Anchorage. It was also approved by Ketchikan Indian Community Tribal Health Clinic Administration staff, the Ketchikan Indian Community Health Board, and the Ketchikan Indian Community Tribal Council.

RESULTS AND DISCUSSION

Of the 83 Native patients found to have received a 25-hydroxyvitamin D test during the 2-year period, 55 were female and 28 were male, with a mean age of 49 years (range=19 to 94 years) (Table). Twenty-eight of these patients were diagnosed with diabetes, of which all but two were vitamin D–deficient. Of the 55 without diabetes, only seven were vitamin D–sufficient (Figure). Subjects without diabetes were younger (−10.39, 95% confidence interval [CI]: −17.31, −3.47; $P=0.004$), had a lower BMI (−7.05, 95% CI: −11.06, −3.05; $P=0.001$), and had lower fasting blood glucose values (−43.63, 95% CI: −61.29, −25.97; $P=<0.001$). The mean (±standard deviation) 25-hydroxyvitamin D level was 17.1±11.0 ng/mL (42.8±27.5 nmol/L). Using two-sample *t* tests, no significant differences were found between sexes. Results indicated a significant positive linear relationship of age with respect to vitamin D levels ($r=0.354$, $P=0.028$).

Subjects were divided into quartiles based on 25-hydroxyvitamin D levels. These quartiles were compared in terms of sex, age, BMI, and fasting blood glucose values. With the exception of age, no statistically significant differences were observed between quartiles. The lowest quartile was on average 14.6 years younger compared with the highest quartile (95% CI: −24.29, −4.91; $P=0.004$). Patients known to have diabetes were then removed from the analysis (to control for confounding from the diabetes disease process or treatment, which may affect vitamin D), yielding similar results.

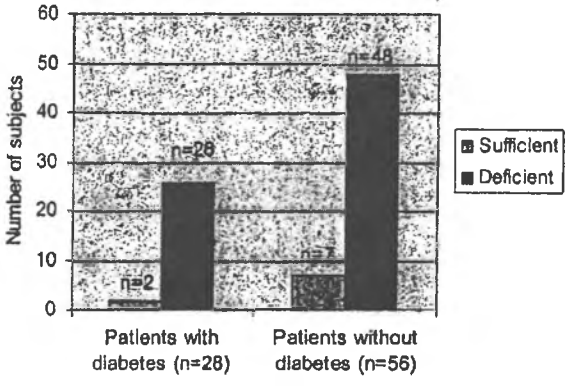


Figure. Vitamin D sufficiency of patients with and without diabetes using 32 ng/mL (80 nmol/L) as the minimum value for sufficiency.

No statistically significant relationships between vitamin D levels and blood glucose levels were observed. However, only nine of 83 vitamin D values were more than the recommended threshold of 32 ng/mL (80 nmol/L), and 18 of the vitamin D levels were so low that their actual value was undetectable. Although we cannot extrapolate these results to say that 89% of the population is vitamin D–deficient, the data suggest a basis for further investigation. It would seem unlikely to observe such a high rate of deficiency in this study, if there were not a high prevalence of vitamin D deficiency, even with perceptive clinicians ordering vitamin D tests for patients they thought to be at high risk for deficiency. The intent

of the study to compare serum glucose values between individuals of high and low serum vitamin D levels was somewhat undermined by the fact that so few normal values were observed. In fact, even the highest quartile of vitamin D values included values much less than the threshold of vitamin D deficiency.

The high prevalence of vitamin D deficiency found in this study is supported by studies reporting vitamin D deficiency in populations at higher latitudes or with otherwise limited sunlight exposure (although not at the magnitude found in this convenience sample) (7,8,12,13). The positive linear correlation between age and vitamin D levels found in this study differs from the common belief that vitamin D levels decrease with age. However, this positive correlation has been reported previously (7).

The finding related to subjects with known diabetes is also intriguing; only two of the 28 patients had 25-hydroxyvitamin D levels more than the 32 ng/mL (80 nmol/L) threshold. This is consistent with previous reports of vitamin D deficiency in patients with diabetes (1,2). Again, this is not a random sample but it does represent 20% of the known patients with diabetes per the Ketchikan Indian Community Diabetes Management System database. From a chart review we cannot determine that low vitamin D levels were a risk factor for diabetes in these individuals; however, this possibility deserves further investigation.

There are clear limitations to the design of this study. First, the study is retrospective in nature and therefore cannot determine causality. Second, this study did not assess known contributors to serum 25-hydroxyvitamin D levels, such as diet, supplementation, sunlight exposure, and medications that may interfere with vitamin D absorption and/or utilization. The results include 59 vitamin D levels measured during autumn and winter months, when vitamin D levels are thought to be lowest. Furthermore, the study consisted of a convenience sample of patients who were likely tested by providers on their suspicion that the patients had low vitamin D status. The study was not powered to detect differences; however, these data support the need for a larger study to investigate this association.

Despite these limitations, this study design offered a cost-effective opportunity to explore the possibility of vitamin D deficiency in this population and its relationship with diabetes. Given southeast Alaskan Natives' high risk for vitamin D deficiency, the increasing incidence of diabetes (100% to 125% in 14 years) (16), and recent research associating diabetes and vitamin D status, these results should not be dismissed. Although it is tempting to disregard vitamin D deficiency in this population as a genetic difference in normal values, it must be noted that African Americans also have lower vitamin D levels and have a 33% higher risk for cancer (17). Nor should Chiu and colleagues' conclusion that increasing a person's blood concentration of 25-hydroxyvitamin D from 10 ng/mL (25 nmol/L) to approximately 30 ng/mL (75 nmol/L) would improve insulin sensitivity by 60% be easily dismissed as not applicable to the native population (5).

Future efforts to explain the increase in incidence of diabetes should consider decreasing vitamin D–rich fish and fish oil consumption in the native population and the potential resultant decrease in serum vitamin D levels. It has been reported that in at least one group of Alaskan Natives that the consumption of traditional foods is much less common in younger natives compared with elders: 50% less in some categories of native food (18). Decreased traditional food consumption combined with additional lifestyle changes (eg, increased automobile use, more indoor activities, sedentary lifestyle) may be promote vitamin D deficiency.

CONCLUSIONS

This study suggests southeast Alaskan Natives may be at risk for vitamin D deficiency. To the extent that vitamin D plays a role in the etiology of diabetes and other chronic disorders, Alaskan Natives with vitamin D deficiency may be at increased risk for these diseases. This study's finding of decreased vitamin D levels in younger individuals is of concern from a public health standpoint and should be further evaluated. Specifically, the possibility that elder natives consume more fish and fish oils and therefore have higher vitamin D levels should be considered. Registered dietitians should be aware of the emerging expanded role of vitamin D in chronic diseases such as diabetes, and should consider vitamin D status in their nutrition assessments, especially for patients with limited sun exposure.

The corresponding author is a commissioned officer in the United States Public Health Service but is submitting this manuscript as an individual and not on behalf of the Federal Government.

The authors thank Carolyn E. Ford, PhD, for her contribution to the conceptual design of the protocol, and the Ketchikan Indian Community/Official Village of Saxman Health Board and the Ketchikan Indian Community Tribal Council for their permission to conduct this research.

References

1. Scragg R, Holdaway I, Singh V, Metcalf P, Baker J, Dryson E. Serum 25-hydroxyvitamin D3 levels decreased in impaired glucose tolerance and diabetes mellitus. *Diabetes Res Clin Pract*. 1995;27:181-188.
2. Isaia G, Giorgino R, Adami S. High prevalence of hypovitaminosis D in female type 2 diabetic population. *Diabetes Care*. 2001;24:1496.
3. Scragg R, Sowers M, Bell C. Serum 25-hydroxyvitamin D, diabetes, and ethnicity in the Third National Health and Nutrition Examination Survey. *Diabetes Care*. 2004;27:2813-2818.
4. Pittas AG, Willett WC, Dawson-Hughes B, Manson JE, Li T, Hu FB. Vitamin D and calcium intake in relation to type 2 diabetes in women. *Diabetes Care*. 2006;29:650-656.
5. Chiu KC, Chu A, Go VW, Saad MF. Hypovitaminosis D is associated with insulin resistance and β cell dysfunction. *Am J Clin Nutr*. 2004; 79:820-825.
6. Thomas MK, Lloyd-Jones DM, Thadhani RI, Shaw AC, Deraska DJ, Kitch BT, Vamvakas EC, Dick IM, Prince RL, Finkelstein JS. Hypovitaminosis D in medical inpatients. *N Engl J Med*. 1998;338:777-783.
7. Tangpricha V, Pearce EN, Chen TC, Holick MF. Vitamin D Insufficiency among free living healthy young adults. *Am J Med*. 2002;112: 659-662.
8. Sullivan SS, Rosen CJ, Halteman WA, Chen TC, Holick MF. Adolescent girls in Maine are at risk for vitamin D insufficiency. *J Am Diet Assoc*. 2005;105:971-974.
9. Ziambaras K, Dagogo-Jack S. Reversible muscle weakness in patients with vitamin D deficiency. *West J Med*. 1997;167:435-439.
10. Raloff J. Vitamin D: What's enough? ScienceNews Web site. www.sciencenews.org/articles/20041016/bob9.asp. Accessed January 15, 2007.
11. Hollis BW. Circulating 25-Hydroxyvitamin D levels indicative of vitamin D sufficiency: Implications for establishing a new effective dietary intake recommendation for vitamin D. *J Nutr*. 2005;317-322.

12. Glerup H, Mikkelsen K, Poulsen L, Hass E, Overbeck S, Thomsen J, Charles P, Eriksen EF. Commonly recommended daily intake of vitamin D is not sufficient if sunlight exposure is limited. *J Intern Med*. 2000;247:260-268.
13. Holick MF, Jenkins M. *The UV Advantage: The Medical Breakthrough that Shows How to Harness the Power of the Sun for Your Health*, 1st ed. New York, NY: ibooks; 2003.
14. City profile for Ketchikan, Alaska. City-Data.com Web site. http://www.city-data.com/city/Ketchikan-Alaska.html. Accessed January 15, 2007.
15. Duncan IW, Scott EM. Lactose intolerance in Alaskan Indians and Eskimos. *Am J Clin Nutr*. 1979;25:867-868.
16. Schraer C, Ramesh M. Special Diabetes Programs for Indians Grant: Outcomes in Alaska. Anchorage, AK: Alaska Annual Diabetes Conference; December 2006.
17. Garland CF, Garland DC, Gorham ED, Lipkin M, Newmark H, Mohr SB, Holick MF. The role of vitamin D in cancer prevention. *Am J Public Health*. 2006;96:252-261.
18. Nobmann ED, Ponce R, Mattil C, Devereux R, Dyke B, Ebbesson SE, Laston S, MacCluer J, Robbins D, Romenesko T, Ruotolo G, Wenger CR, Howard BV. Dietary intakes vary with age among Eskimo adults of northwest Alaska in the GOCADAN Study, 2000-2003. *J Nutr*. 2005;135:856-862.

The Journal of Nutrition, Health & Aging
Volume 3, Number 1, 1999

THE JOURNAL OF NUTRITION, HEALTH & AGING

VITAMIN D VS BROAD SPECTRUM PHOTOTHERAPY IN THE TREATMENT OF SEASONAL AFFECTIVE DISORDER

F. MICHAEL GLOTH, III*, WASIF ALAM**, BRUCE HOLLIS***

* The Division of Geriatrics, The Department of Medicine, The Union Memorial Hospital and The Division of Geriatric Medicine and Gerontology, Depart-ment of Medicine, The Johns Hopkins University School of Medicine, Baltimore, Maryland. ** The Department of Medicine, The Union Memorial Hospital, Baltimore, Maryland. *** Department of Pediatrics, Children's Hospital, Medical University of South Carolina, Charleston, South Carolina. Correspondence to Dr. F. Michael Gloth III, Division of Geriatrics, The Union Memorial Hospital, 201 East University Parkway, Baltimore, Maryland 21218-2895. Phone: 410-554-2923; FAX: 410-554-6794.

Abstract: Seasonal Affective Disorder (SAD) is prevalent when vitamin D stores are typically low. Broad-spectrum light therapy includes wavelengths between 280-320 nm which allow the skin to produce vitamin D. This study was designed to test the hypothesis that vitamin D deficiency might play a role in SAD. A prospective, randomized controlled trial was conducted in a group of 15 subjects with SAD. Eight subjects received 100,000 I.U. of vitamin D and seven subjects received phototherapy. At the onset of treatment and after 1 month of therapy subjects were administered the Hamilton Depression scale, the SIGH-SAD, and the SAD-8 depression scale. All subjects also had serum levels of 25-hydroxyvitamin D (25-OH D) measured before and 1 week after intervention therapy. All subjects receiving vitamin D improved in all outcome measures. The phototherapy group showed no significant change in depression scale measures. Vitamin D status improved in both groups (74% vitamin D group, $p < 0.005$ and 36% phototherapy group, $p < 0.01$). Improvement in 25-OH D was significantly associated with improvement in depression scale scores (r^2=0.26; p=0.05). Vitamin D may be an important treatment for SAD. Further studies will be necessary to confirm these findings.

Introduction

Because some evidence exists demonstrating a therapeutic effect of full spectrum light on people with a diagnosis of seasonal affective disorder (1,2), we hypothesize that depletion of vitamin D ("the sunshine vitamin") may have a role in the development of this syndrome. Similarly, it has been demonstrated that vitamin D status declines during winter (3,4), a time when Seasonal Affective Disorder is prevalent.

Poor nutritional habits, particularly in relation to dairy products and other foods supplemented with vitamin D, that many older adults may have, could obviate some of the obvious benefits of food supplementation (5,6). Liver disease, renal disease, and malabsorption, as well as some medications, also may affect vitamin D metabolism. These factors play a role in some form or another in many people.

Vitamin D deficiency has been associated with muscle weakness, abnormalities of bone metabolism, bone pain, fatigue, and various other metabolic abnormalities (7,8,9). There are many reasons to consider vitamin D deficiency as a source of Seasonal Affective Disorder (SAD) as well. First there is an intriguing temporal relationship between a nadir for vitamin D status and what, as the name of the disorder implies, is felt to be a peak occurrence of Seasonal Affective Disorder in the general population. Second, vitamin D receptors exist on many organs including the skin and brain (10, 11, 12, 13, 14, 15, 16). The vitamin D receptors in the brain and in many other sites thusfar have no clearly identified function. Third, phototherapy has been described as being useful in Seasonal Affective Disorder when full spectrum light is used. Coincidentally, the skin requires ultraviolet wavelengths in the range of 280 to 320 nm to convert 7-dehydrocholesterol to cholecalciferol (vitamin D_3). Full spectrum light includes ultraviolet wavelengths in the range of 280 to 320 nm.

This study was designed to identify a population diagnosed with SAD and to determine their vitamin D status and their clinical and serologic response to either dietary vitamin D supplementation or exposure to full-spectrum light.

Methods

Fifteen subjects diagnosed with Seasonal Affective Disorder (Seasonal Pattern Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition)(17) and belonging to a support group for patients with SAD were enrolled into the study after providing informed consent. The protocol, which was approved by the Institutional Review Boards at the Sheppard and Enoch Pratt Hospital and the Union Memorial Hospital, involved obtaining psychological testing for SAD and Depression and serum samples for the measurement of levels of 25 hydroxyvitamin D (25 OHD) in a fasting state at entry into the study. Serum 25-hydroxyvitamin D was measured using a modification of a previously reported technique involving a direct radioimmuno-assay employing an antibody to the 23,24,25,26,27-petanor-C(22)-carboxylic acid of vitamin D (18). Subjects were screened for liver disease, renal disease, and malabsorption, as well as certain medications, that may

100,000 IU single dose ≈ 3,300 IU/d
Full spectrum light at 2 hr./d

fect vitamin D metabolism. Subjects could have had no treatment changes for the prior 3 months and did not have any other treatment changes during the month of study. Subjects were then randomized using computer generated randomization to receive one of two interventions. Either 100,000 I.U. of vitamin D (ergocalciferol) once as a single dose or scheduled exposure to full spectrum light on a daily basis. After 1 week, a repeat serum measure of vitamin D metabolites was obtained. Vitamin D is fat soluble and a single large dose of vitamin D typically raises the vitamin D status into the normal range for months (19).

≈3300 IU/d

Phototherapy was provided by a Sol-Lux-I phototherapy Unit (Triple "H" Associates, Owings Mills, Maryland). This is a 58.125 cm x 33.125 cm x 10.625 cm portable unit that produces 2,500 Lux of full spectrum light at 120 cm. Subjects had 2 hours of exposure per day verified by entries into a logbook.

At the end of one month (all subjects were evaluated between February and March) repeat psychological testing (Hamilton Depression Scale, the Combined Hamilton/SAD-8 or SIGH-SAD, and the SAD-8)(20,21,22), was obtained by an investigator blinded to the intervention. One month was selected for follow up because it was a period of time in which vitamin D status would improve regardless of the intervention chosen, and it was felt that this would allow sufficient time for an end-organ response. Mean baseline scores were compared between the vitamin D and phototherapy groups using a t-test. A comparison of mean change in test scores between the two groups was also made using analysis of variance (ANOVA testing). Vitamin D status was also compared in a similar fashion. Vitamin D status was measured after 1 week of treatment to determine whether overall vitamin D status improved into the normal range with intervention.

Regression analyses were also done between the change in vitamin D status and the change in each of the pschological tests for the combined population to ascertain a potential relationship between improvement in vitamin D status and resolution of depression in SAD.

Results

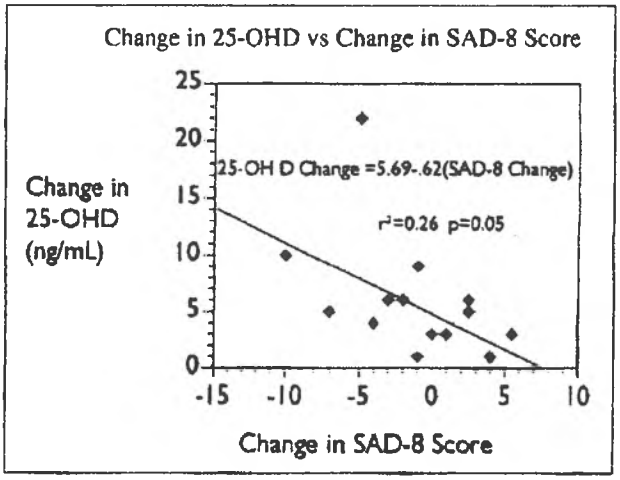
Baseline characteristics of the two groups were similar with regards to age (range 15-61 years), sex (14 females, 1 male), race (Caucasian), psychological test scores (Table 1 following page), and vitamin D status. The mean test scores for all psychological tests significantly improved in the group treated with vitamin D (Table I). None of the tests improved significantly in the group receiving phototherapy. The scores in the vitamin D supplementation group were also significantly better post-treatment when compared to the phototherapy post-treatment group (See Figure 1).

Vitamin D status in the groups was similar (11.0 ± 3.6 ng/mL vitamin D supplementation group vs 13.7 ± 3.1 ng/mL phototherapy group) at baseline. Following 1 week of treatment vitamin D status in the vitamin D supplementation group increased by 74% (19.1 ± 8.2 ng/ml; paired t-test p=0.003) compared to a 36% change (18.6 ± 2.5 ng/mL paired t-test p=0.007) in the phototherapy group.

A significant linear relationship was seen between improvement in vitamin D status and changes in SAD-8 scores before and 1 month after treatment in both groups combined (see Figure 1).

Figure 1

Improvement in vitamin D status was significantly associated with improvement in SAD-8 scores when both cohorts were examined together



Discussion

Subjects identified with SAD all responded favorably to vitamin D supplementation while phototherapy did not consistently result in improvement. A combined analysis of the phototherapy group and the vitamin D supplementation group demonstrated a significant association between improvement in vitamin D status and SAD-8 scores. While the association was significant, one subject demonstrated an inordinately large increase in vitamin D (>20ng/mL). Removal of this potential outlier (analysis and regression not shown) only strengthened the relationship statistically.

Outside of abstracts, one other report has been published which pursues the role of vitamin D with SAD (23). This study selected women with only mild SAD-type symptoms and used 400 I.U. supplementation. Thus, the study cohort and the treatment regimen were substantially different. Serum levels of 25-hydroxyvitamin D were measured but not specifically reported in that study. That study did not show a benefit to the relatively small doses of vitamin D. Possible explanations for different outcomes in our study include: 1) The 400 I.U. supplement in the Harris study may have been inadequate to

substantially improve vitamin D status (24); 2) the outcome measures were different and, with milder symptoms, may not have had adequate sensitivity to detect changes; 3) baseline vitamin D status may not have been low, in which case supplementation would not be likely to have an effect.

It is of interest to note that, on average, our subjects had a vitamin D status below 15 ng/mL (38 nmol/L). Such levels have been associated with other physiologic aberrations, e.g. secondary hyperparathyroidism (5). Vitamin D supplementation also led to significant improvements in vitamin D status.

Vitamin D status seems to play a role in SAD and may play a role in the overall effect of phototherapy. By chance, the phototherapy group had higher baseline vitamin D status. Perhaps phototherapy responses in this study would have also been statistically evident if baseline and post-treatment differences in vitamin D status were of a greater magnitude. In this relatively modest study, the change in vitamin D status in the phototherapy group was less than the difference in the oral supplementation group which may explain the lack of response seen with phototherapy. This would support the hypothesis that inconsistent results of phototherapy may be associated with inadequate exposure to effectively alter vitamin D status or an incorrect diagnosis at the onset.

The present study design did not incorporate a placebo which may be a legitimate criticism in this limited study. Under the circumstances, however, the phototherapy control group may actually parallel the function of a placebo arm.

While these results are by no means conclusive, the findings are provocative enough to stimulate interest in additional studies with larger sample sizes. Such studies with similar results are necessary before the suggestion of a causal relationship can be confidently presented. Nevertheless, it is intriguing to consider that some of the depression seen in seniors who are confined indoors and likely to be vitamin D deficient may be attributable to SAD which may be amenable to simply replenishment with vitamin D.

Acknowledgments: The authors would like to acknowledge Dr. Henry Hyman, for assistance with the phototherapy boxes and all of the participants for their interest and dedication.

Table I

Depression scale differences before and after interventions and between cohorts (vertical)

	Baseline	Post Treatment	Difference	p
Vitamin D (n=8)				
Hamilton	10.9	6.2	-4.7	0.040
SAD-8	6.0	2.8	-3.2	0.003
Comb'd (SIGH-SAD)	16.9	9.1	-7.8	0.008
Phototherapy (n=7)				
Hamilton	12.6	11.3	-1.3	0.49
SAD-8	6.9	7.4	0.5	0.77
Comb'd (SIGH-SAD)	19.4	18.7	-0.7	0.85
Mean Difference				
Hamilton	1.7	5.0		
SAD-8	0.9	4.7		
Comb'd (SIGH-SAD)	2.5	9.6		
p				
Hamilton	0.73	0.28		
SAD-8	0.73	0.07		
Comb'd (SIGH-SAD)	0.69	0.14		

References

1. Rosenthal NE, Sack DA, Gillin JC, Lewy AJ, Goodwin FK, Davenport Y, Mueller PS, Newsome DA, Wehr TA. Seasonal Affective Disorder. Arch Gen Psychiatry. 1984; 41: 72-80.
2. Rosenthal NE. Diagnosis and treatment of seasonal affective disorder. JAMA. 1993; 270:2717-20.
3. Sherman SS, Hollis BW, Tobin JD. Vitamin D status and related parameters in a healthy population: The effects of age, sex, and season. J Clin Endocrin Metab. 1990; 71: 405-13.
4. Dawson-Hughes B, Dallal GE, Krall EA, Harris S, Sokoll LJ, Falconer G. Effect of vitamin D supplementation on wintertime and overall bone loss in healthy postmenopausal women. Ann Intern Med. 1991; 115: 505-12.
5. Gloth III FM, Gundberg CM, Hollis BW, Haddad JG, Tobin JD. The prevalence of vitamin D deficiency in a cohort of home-bound elderly subjects compared to a normative matched population in the United States. JAMA. 1995; 274: 1683-6.
6. Sherman SS, Hollis BW, Tobin JD. Vitamin D status and related parameters in a healthy population: The effects of age, sex, and season. 1990. 71: 405-13.
7. Aksnes L, Rodland O, AAnskog D. Serum levels of vitamin D3 in elderly and young adults. Bone & Min. 1988; 3, 351-57.
8. Skaria J, Katiyar BC, Srivastava TP, Dube B. Myopathy and neuropathy associated with osteoma-lucia. Acta Neurol Scan. 1975, 51; 37.
9. Young A, Edwards RHT, Jones DA et al. Quadriceps muscle strength and fibre size during the treatment of osteo-malnocia. In: Stokes IAF, Stokes J, eds. Mechanical factors and skeleton. 1981: 137-45.
10. Pike JW, Goorzle, LL, Haussler MR. Biochemical evidence for 1,25-dihydroxyvitamin D receptor macromolecules in parathyroid, pancreatic, pituitary, and placental tissues. Life Sci. 1980; 26: 407-14.
11. Gelbard HA, Stern PH, U'Prichard DC. 1 Alpha 25-hydroxyvitamin D3 nuclear receptors in pituitary. Science. 1980; 209; 1247-9.
12. Merke J, Milde P, Lewicka S, et al. Identification and regulation and regulation of 1,25-dihydroxyvitamin D3 receptor activity and biosynthesis of 1,25-dihydroxyvitamin D3; studies in cultured bovine aortic endothelial cells and human dermal capillaries. J Clin Invest. 1989; 83: 1903-15.
13. Barsony J, McKoy W, De Grange DA, Liberman UA, Marx SJ. Selective expression of a normal action of the 1,25-dihydroxyvitamin D3 receptor in human skin fibroblasts with hereditary severe defects in multiple actions of that receptor. J Clin Invest. 1989; 83: 2093-2101.
14. Merke J, Hofmann W, Goldschmidt D, Ritz E. Demonstration of 1,25-(OH)2 D3 receptors and action in vascular smooth muscle cells in vitro. Calcif Tiss Int. 1987: 41: 112-4.
15. Provvedini DM, Tsoukas CD, Deftos LJ, Manolagas SC. 1,25-dihydroxyvitamin D3 receptor in human leukocytes. Science. 1983; 221: 1181-3.
16. Pillai S, Bikle DD, Elias PM. 1,25-dihydroxyvitamin D production and receptor binding in human keratinocytes varies with differentiation. J Biol Chem. 1988; 263: 5390-5.
17. American Psychiatric Association, Committee on Nomenclature and Statistics. Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. Washington, DC: American Psychiatric Association; 1994.
18. Hollis BW, Kamerud JQ, SR Selvaag, JD Lorenz, Napoli JL. Determination of vitamin D status by radioimmu-noassay using I125-labelled tracer. Clin Chem. 1993; 39: 529-33.
19. Weisman Y, Schen RJ, Eisenberg Z, et al. Single oral high dose vitamin D3 prophylaxis in the elderly. J Am Ger Soc 34: 515-8, 1986.
20. Hamilton M. J Neurol Neurosurg Psychiatry. 1960, 26:56.
21. Williams JBW, Link MJ, Rosenthal NE, Amira L, Terman M. Structured interview guide for the Hamilton depression rating scale seasonal affective disorder version (SIGH-SAD). From SAD Assessment Tools Packet, Society for Light Treatment and Biological Rhythms, Wilsonville, OR. 1992.
22. Rosenthal NE, Hefferman MM. Bulemia, Carbohydrate Craving, and Depression: A Central Connection. In Nutrition and the Brain, Eds., Wurtman RJ, Wurtman JJ. Raven Press, New York, 1986, p 161-162.
23. Harris S, Dawson-Hughes B. Seasonal Mood Changes in 250 Normal Women. Psychiatry Res. 1993; 49: 77-87.
24. Gloth III FM, Tobin JD, Sherman SS, Hollis BW: Is the recommended daily allowance for vitamin D too low in the homebound elderly? J Am Geriatr Soc. 1991: 39(2): 137-41.

Record: 1

Title: Comparisons of estimated economic burdens due to insufficient solar ultraviolet irradiance and vitamin D and excess solar UV irradiance for the United States.

Authors: Grant WB; Garland CF; Holick MF

Author Address: Sunlight, Nutrition and Health Research Center (SUNARC), 2107 Van Ness Avenue, Suite 403B, San Francisco, CA 94109-2529, USA. wgrant@sunarc.org

Source: Photochemistry And Photobiology [Photochem Photobiol] 2005 Nov-Dec; Vol. 81 (6), pp. 1276-86.

Publication Type: Comparative Study; Journal Article; Research Support, N.I.H., Extramural; Research Support, Non-U.S. Gov't

Language: English

Journal Information: *Country of Publication:* United States *NLM ID:* 0376425 *Publication Model:* Print *Cited Medium:* Print *ISSN:* 0031-8655 (Print) *Linking ISSN:* 00318655 *NLM ISO Abbreviation:* Photochem. Photobiol. *Subsets:* MEDLINE

MeSH Terms: Cost of Illness*
Health Expenditures*
Ultraviolet Rays*/adverse effects
Vitamin D/*physiology
Cataract/economics; Dietary Supplements; Great Britain; Humans; Keratosis/economics; Melanoma/economics; Melanoma/etiology; Multiple Sclerosis/economics; Neoplasms/economics; Neoplasms/etiology; Osteoporosis/economics; Risk Reduction Behavior; Skin Neoplasms/economics; Skin Neoplasms/etiology; Sunlight; United States; Vitamin D/pharmacology

Abstract: Vitamin D sufficiency is required for optimal health, and solar ultraviolet B (UVB) irradiance is an important source of vitamin D. UVB and/or vitamin D have been found in observational studies to be associated with reduced risk for over a dozen forms of cancer, multiple sclerosis, osteoporotic fractures, and several other diseases. On the other hand, excess UV irradiance is associated with adverse health outcomes such as cataracts, melanoma, and nonmelanoma skin cancer. Ecologic analyses are used to estimate the fraction of cancer mortality, multiple sclerosis prevalence, and cataract formation that can be prevented or delayed. Estimates from the literature are used for other diseases attributed to excess UV irradiation, additional cancer estimates, and osteoporotic fractures. These results are used to estimate the economic burdens of insufficient UVB irradiation and vitamin D insufficiency as well as excess UV irradiation in the United States for these diseases and conditions. We estimate that 50,000-63,000 individuals in the United States and 19,000-25,000 in the UK die prematurely from cancer annually due to insufficient vitamin D. The U.S. economic burden due to vitamin D insufficiency from inadequate exposure to solar UVB irradiance, diet, and supplements was estimated at $40-56 billion in 2004, whereas the economic burden for excess UV irradiance was estimated at $6-7 billion. These results suggest that increased vitamin D through UVB irradiance, fortification of food, and supplementation could reduce the health care burden in the United States, UK, and elsewhere. Further research is required to confirm these estimates.

Grant Information: AR3696312 United States AR NIAMS NIH HHS; M01RR00533 United States RR NCRR NIH HHS

Substance Nomenclature: 1406-16-2 (Vitamin D)

Entry Dates: *Date Created:* 20051215 *Date Completed:* 20060609 *Latest Revision:* 20071114

Record: 1

Title: An estimate of the economic burden and premature deaths due to vitamin D deficiency in Canada.

Authors: Grant WB; Schwalfenberg GK; Genuis SJ; Whiting SJ

Author Address: Sunlight, Nutrition, and Health Research Center (SUNARC), San Francisco, CA 94164-1603, USA. wbgrant@infionline.net

Source: Molecular Nutrition & Food Research [Mol Nutr Food Res] 2010 Aug; Vol. 54 (8), pp. 1172-81.

Publication Type: Journal Article; Research Support, Non-U.S. Gov't; Review

Language: English

Journal Information: *Country of Publication:* Germany *NLM ID:* 101231818 *Publication Model:* Print *Cited Medium:* Internet *ISSN:* 1613-4133 (Electronic) *Linking ISSN:* 16134125 *NLM ISO Abbreviation:* Mol Nutr Food Res *Subsets:* MEDLINE

MeSH Terms:
Health Care Costs*
Mortality*
Vitamin D/*administration & dosage
Vitamin D/*physiology
Vitamin D Deficiency/*economics
Vitamin D Deficiency/*physiopathology
25-Hydroxyvitamin D
2/blood; Adult; Calcifediol/blood; Canada/epidemiology; Child; Female; Humans; Infant; Male; Nutrition Policy; Pregnancy; Vitamin D Deficiency/epidemiology; Vitamin D Deficiency/prevention & control

Abstract: The objective of this work is to estimate the economic burden and premature death rate in Canada attributable to low serum 25-hydroxyvitamin D (25(OH)D) levels. Vitamin D deficiency has been linked to many diseases and conditions in addition to bone diseases, including many types of cancer, several bacterial and viral infections, autoimmune diseases, cardiovascular diseases, and adverse pregnancy outcomes. Canadians have mean serum 25(OH)D levels averaging 67 nmol/L. The journal literature was searched for papers reporting dose-response relationships for vitamin D indices and disease outcomes. The types of studies useful in this regard include randomized controlled trials, observational, cross-sectional, and ecological studies, and meta-analyses. The mortality rates for 2005 were obtained from Statistics Canada. The economic burden data were obtained from Health Canada. The estimated benefits in disease reduction were based on increasing the mean serum 25(OH)D level to 105 nmol/L. It is estimated that the death rate could fall by 37,000 deaths (22,300-52,300 deaths), representing 16.1% (9.7-22.7%) of annuals deaths and the economic burden by 6.9% (3.8-10.0%) or $14.4 billion ($8.0 billion-$20.1 billion) less the cost of the program. It is recommended that Canadian health policy leaders consider measures to increase serum 25(OH)D levels for all Canadians.

Substance Nomenclature:
1406-16-2 (Vitamin D)
19356-17-3 (Calcifediol)
21343-40-8 (25-Hydroxyvitamin D 2)

Entry Dates: *Date Created:* 20100810 *Date Completed:* 20101130

Update Code: 20101209

PMID: 20352622

Database: MEDLINE

Dr Emily A. Kane ND, LAc
Natural Healthcare
Juneau AK 99801

3-8-11

I strongly support any legislation or resolutions that would promote awareness of, and apply remedies to, Vitamin D deficiency which is rampant in Alaska.

We have become an indoor society. I have been checking Vit D levels routinely in my primary care practice for five years. Not one Alaskan who does not supplement with 3-6,000 IU's daily is replete. The fix is cheap: a year's worth of Vit D3 drops costs about $20.

Sincerely,
Dr Emily A. Kane

The FNB Has Failed Millions

After 13 year of silence, on Nov. 30, 2010, the quasi-governmental agency the Institute of Medicine's (IOM) Food and Nutrition Board (FNB) recommended that a 3-pound premature infant take virtually the same amount of vitamin D as a 300-pound pregnant woman. While that 400 IU/day dose is close to adequate for infants, 600 IU/day in pregnant women will do nothing to help the three childhood epidemics most closely associated with gestational and early childhood vitamin D deficiencies: asthma, autoimmune disorders, and – as recently reported in the largest pediatric journal in the world – autism. Professor Bruce Hollis of the Medical University of South Carolina has shown that pregnant and lactating women need at least 5000 IU/day, not 600.

The FNB also reported that vitamin D toxicity might occur at an intake of 10,000 IU/day (250 micrograms/day), although it could produce no reproducible evidence that 10,000 IU/day has ever caused toxicity in humans and only one poorly conducted study indicating that 20,000 IU/day may cause mild elevations in serum calcium, but not clinical toxicity.

Viewed with a different measure, this FNB report recommends that an infant should take 10 micrograms/day (400 IU) and a pregnant woman 15 micrograms/day (600 IU). As a single, 30-minute dose of summer sunshine gives adults more than 10,000 IU (250 micrograms), the FNB is apparently also warning that natural vitamin D input – as occurred from the sun before the widespread use of sunscreen – is dangerous. That is, the FNB is implying that God does not know what she is doing.

Disturbingly, this FNB committee focused on bone health, just as it did 14 years ago. It ignored the thousands of studies from the last 10 years that showed higher doses of vitamin D help: heart health, brain health, breast health, prostate health, pancreatic health, muscle health, nerve health, eye health, immune health, colon health, liver health, mood health, skin health, and especially fetal health. Tens of millions of pregnant women and their breast-feeding infants are severely vitamin–D deficient, resulting in a great increase in the medieval disease rickets. The FNB report seems to reason that if so many pregnant women have low vitamin D blood levels then it must be OK because such low levels are so common. However, such circular logic simply represents the caveman existence (never exposed to the light of the sun) of most modern-day pregnant women.

Hence, if you want to optimize your vitamin D levels – not just optimize the bone effect – supplementing is crucial. But it is almost impossible to significantly raise your vitamin D levels when supplementing at only 600 IU/day (15 micrograms). Pregnant women taking 400 IU/day have the same blood levels as pregnant women not taking vitamin D; that is, 400 IU is a meaninglessly small dose for pregnant women. Even taking 2000 IU/day of vitamin D will only increase the vitamin D levels of most pregnant women by about 10 points, depending mainly on their weight. Professor Bruce Hollis has shown that 2000 IU/day does not raise vitamin D to healthy or natural levels in either pregnant or lactating women. Therefore supplementing with higher amounts – like 5000 IU/day – is crucial for the woman who wants her fetus to enjoy optimal vitamin D levels, and the future health benefits that go along with it.

For example, taking only two of the hundreds of recently published studies: Professor Urashima and colleagues in Japan gave 1200 IU/day of vitamin D3 for six months to Japanese 10-year-olds in a randomized controlled trial. They found that vitamin D dramatically reduced the incidence of influenza A as well as the episodes of asthma attacks in the treated kids, while the placebo group was not so fortunate. If Dr. Urashima had followed the newest FNB recommendations, it is unlikely that 400 IU/day treatment arm would have done much of anything and some of the treated young teenagers may have come to serious harm without the vitamin D. Likewise, a randomized controlled prevention trial of adults by Professor Joan Lappe and colleagues at Creighton University, which showed dramatic improvements in the health of internal organs, used more than twice the FNB's new adult recommendations.

Finally, the FNB committee consulted with 14 vitamin D experts and – after reading these 14 different reports – decided to suppress them. Many of these 14 consultants are either famous vitamin D researchers, like Professor Robert Heaney at Creighton or, as in the case of Professor Walter Willett at Harvard, the single best-known nutritionist in the world. So, the FNB will not tell us what Professors Heaney and Willett thought of its new report? Why not?

Today, the Vitamin D Council directed our attorney to file a federal Freedom of Information (FOI) request to the IOM's FNB for the release of these 14 reports.

Most of my friends, hundreds of patients, and thousands of readers of the Vitamin D Council newsletter (not to mention myself) have been taking 5000 IU/day for up to eight years. Not only have they reported no significant side effects, indeed, they have reported greatly improved health in multiple organ systems. My advice, especially for pregnant women: continue taking 5000 IU/day until your 25(OH)D is between 50 and 80 ng/mL (the vitamin D blood levels obtained by humans who live and work in the sun and the midpoint of the current reference ranges at all American laboratories). Gestational vitamin D deficiency is associated not only with rickets, but a significantly increased risk of neonatal pneumonia, a doubled risk for preeclampsia, a tripled risk for gestational diabetes, and a quadrupled risk for primary cesarean section.

The FNB has failed millions of pregnant women whose as-yet unborn babies will pay the price. Let us hope that the FNB will comply with the spirit of "transparency" by quickly responding to our Freedom of Information requests.

John Cannell, MD
Vitamin D Council
1241 Johnson Avenue, #134
San Luis Obispo, California 93401

◆

February 7, 2011

Sharon L. Norton, RN
Suicide Prevention Council Member
PMHNP Graduate Student
61025 Ohlson Mountain Road
Homer, AK 99603

Representative Paul Seaton
345 W. Sterling Hwy. Suite 102B
Homer, Alaska 99603

RE: Preventative Health - Vitamin D Resolution

I appreciate your efforts and agree that research links Vitamin D deficiency and insufficiency to depression, bone disorders, cancer, immune disease, diabetes, and coronary disease, at the very least. Therefore, I support your resolution.

Perhaps, an addendum to your resolution might address a list of micronutrients including Vitamins and Minerals be drawn annually by all primary healthcare providers and with all initial mental health assessments. I would suggest expanding, at the very least, to include Niacin, B12, folate (folic acid), thiamine, Vitamin D and trace minerals including iron, magnesium, and selenium. Scientific evidence links a variety of psychiatric symptoms with deficiency and insufficiency as components to psychiatric syndromes.

I receive healthcare through Indian Health Services and have had few of these labs drawn to my knowledge as late as age 60. My Father is 83, a diabetic, with hypertension, hyperlipidemia, skin cancer, and situational depression who receives services through the VA. The labs listed below were not drawn, any time recently that I am aware of, *until* I made a request of a local practitioner October of 2010. Which found the labs to be: Vitamin D 25 OH Total level of 21, optimum levels range from 30-100 with <20 deficient and 20-30 insufficient, B12 was 127, low was indicated at 180 and high 914, and his Iron was 23, low indicated at 45 and high 182. I plan to request a recheck at his next VA visit this month. His diet has improved and he has been taking supplements I would like to evaluate any improvement or lack thereof. Additionally, I am awaiting my own lab results as we speak.

A large majority of Alaska's citizens would not know to request these labs. It is, therefore, up to the State of Alaska to protect the physical & mental

health and wellbeing of Alaska's people, of all ages. We seek as healthcare professionals and legislative representative's to address the prevention of medical and mental illness; not only personal and family short and long term impact, but as our obligation to address and curb the economic impact on Alaska as a whole.

Additionally, I would support, as an indication of need, an Alaskan research study to evaluate levels of vitamins and minerals, using a very large sample group of both rural and urban Alaskans (not less than 20,000), with a variety of ages, listing medical and psychiatric diagnoses, and comparing regions, those consuming the traditional Native diet compared to Western diet, and those taking supplements with those not. *Including,* those individuals of all ages having threatened and attempted suicide. In order to discover whether levels may or may not suggest a relationship to depression and other psychiatric symptoms potentially contributing to suicide. With a follow-up study evaluating diet changes and vitamin and mineral supplements provided over time.

I appreciate your addressing the preventative health of Alaskans.

With Kindest Regards,

Sharon Norton

Sharon Norton, RN

[Reference links attached.]

References links that support my response [sorry I did not have time to format them correctly].

Page 844 http://books.google.com/books?id=u-ohbTtxCeYC&pg=PA844&lpg=PA844&dq=vitamin+deficiency+and+depression+scientific+evidence&source=bl&ots=9fBDwji4xU&sig=Q8Su0TNEtpPOa3s6WUahWQmyj0Q&hl=en&ei=vFFOTYbeA42isQPL6onCg&sa=X&oi=book_result&ct=result&resnum=10&ved=0CGAQ6AEwCQ#v=onepage&q=vitamin%20deficiency%20and%20depression%20scientific%20evidence&f=true

Mayoclinic http://www.mayoclinic.com/health/vitamin-d/NS_patient-vitamind/DSECTION=evidence suggests among many other diagnoses that:
Seasonal affective disorder (SAD) is a form of depression that occurs during the winter months, possibly due to reduced exposure to sunlight. In one study, vitamin D was found to be better than light therapy in the treatment of SAD. Further studies are necessary to confirm these findings.

NYU Medical Center http://www.med.nyu.edu/content?ChunkIID=21566 Other micronutrients are also commonly deficient in elderly populations. A small study among nursing home residents found that low levels of the mineral selenium was associated with depression. Moreover, 8 weeks of mineral supplementation tended to improve the mood of the most seriously depressed patients with low selenium levels.

Science Direct: http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6WN2-4C0D0FP-YT&_user=10&_coverDate=02/28/1991&_rdoc=1&_fmt=high&_orig=search&_origin=search&_sort=d&_docanchor=&view=c&_searchStrId=1633643654&

Lance Armstrong Foundation: http://www.livestrong.com/article/309794-what-vitamin-mineral-deficiencies-cause-anxiety/

National Institute of Health: Vitamin D in fibromyalgia depression and anxiety
http://www.ncbi.nlm.nih.gov/pubmed/16850115

National Institute of Health: Vitamin D in over weight and obese:
http://www.ncbi.nlm.nih.gov/pubmed/18793245

National Institute of Health: Vitamin D and Women with Depression in the Winter
http://www.ncbi.nlm.nih.gov/pubmed/19616172

National Institute of Health: Vitamin D and Depression in Japanese
http://www.ncbi.nlm.nih.gov/pubmed/19690578

National Institute of Health: Vitamin D and Depression in Young Adults
http://www.ncbi.nlm.nih.gov/pubmed/21067618

Crystal Rogers

From: Rep. Paul Seaton
Sent: Tuesday, February 15, 2011 9:19 AM
To: Crystal Rogers
Subject: FW: thanks for HCR 5

From: Joy Lyon [mailto:jlyon@aeyc-sea.org]
Sent: Monday, February 14, 2011 6:21 PM
To: Rep. Paul Seaton
Subject: thanks for HCR 5

Dear Representative Seaton,

I just read the resolution on promotion of Vitamin D in Alaska, and I would like to personally thank you for your leadership in this area.
I told a group of pediatricians at a meeting today, and we are all so pleased that this important health issue is getting attention thanks to your resolution.
This is an example of a low or no-cost health care solution.

Thanks again, and if testimony on this is needed please let me know and I will be happy to help get the word out.

Joy Lyon, M.A.
Executive Director
AEYC Southeast Alaska
Main 907.789-1235 or 888-785-1235
Fax 907.789-1238
jlyon@aeyc-sea.org
www.aeyc-sea.org

www.threadalaska.org
connecting early care and education to Alaska

Crystal Rogers

From: Rep. Paul Seaton
Sent: Tuesday, April 05, 2011 8:46 AM
To: Crystal Rogers
Subject: FW: HCR 5 - Vitamin D

From: Kirstie Shirey [mailto:kirstie_shirey@yahoo.com]
Sent: Friday, April 01, 2011 9:47 PM
To: Rep. Paul Seaton
Subject: HCR 5 - Vitamin D

To Paul Seaton,

Hello,
My name is Kirstie Shirey. I'm twenty years old and am in college to become a early childhood teacher. I'm writing this e-mail for both myself, and class. I was given a list of things to choose from, this was one that was easy and something I believe in. I am low in Vitamin D, and my father is also is low.

Vitamin D, something that everyone needs. I think that a lot of people don't know how little they are getting. Even those who go outside everyday and are active don't get a lot of sun. It's to cold, with clouds, snow, and bundled up with little skin showing for the little sun Alaska gets in the winter.

support bill HCR 5.

Thank you for taking the time to read my little e-mail.

Sinisterly
Kirstie Shirey

March 9, 2011

The Honorable Wes Keller
Chair, House Health & Social Services Committee
Alaska Capitol, Room 427
Juneau, Alaska 99801

Dear Representative Keller,

On behalf of the more than 12,000 U.S. members of the American Academy of Dermatology Association (AADA), I am writing to point out several inaccuracies contained in HCR 5 regarding vitamin D. HCR 5 misrepresents several findings of the cited scientific literature, and as such endangers the health of Alaska's citizens by overemphasizing the role of vitamin D in disease prevention.

The AADA would not want HCR 5 to be used as grounds to legitimize use of indoor tanning beds as a means for increasing vitamin D levels. In 2010, the Institute of Medicine (IOM) released an exhaustive review of scientific literature and revised its previous recommendations on vitamin D intake. Of particular note, the IOM stated that individuals should not increase their exposure to UV radiation in order to increase their vitamin D levels, because of the risk of developing skin cancer and melanoma.

The AADA would like to point out specific omissions (**noted in bold**) in the cited data in HCR 5, which erroneously make the case for substantial vitamin D supplementation:

- A 2007 article published in the American Journal of Clinical Nutrition reported that a study that compared cancer rates of a group ***of post menopausal women*** taking 1100 IU of vitamin D supplements in combination with calcium to cancer rates of a group taking a placebo found the risk of developing any cancer after four years was 60 percent lower in the group taking vitamin D supplements *(page 1, line 16 – page 2, lines 1-4);*
- A 2007 article published in the American Journal of Preventative Medicine reported that a study found blood serum levels of vitamin D of at least 33 ng/ml ***to be associated with a 50 percent lower risk of colorectal cancer incidence*** compared with blood serum levels of vitamin D of less than 12 ng/ml *(page 2, lines 9-12)*;
- A 2001 study published in the Lancet found that children in Finland who received 2,000 IU a day of vitamin D for the first year of life 78 percent reduced risk of type 1 diabetes ***over the ensuing 31 years*** compared to children receiving 400 IU a day of vitamin D *(page 2, lines 23-26)*;
- The Centers for Disease Control and Prevention report that influenza vaccine effectiveness varies greatly ***based on the age and immunocompetence of the vaccine recipient and the degree of similarity between the viruses in the vaccine and those in circulation*** *(page 3, line 22-23)*;

American Academy of Dermatology Association
Excellence in Dermatology™

1445 New York, Ave., NW,
Suite 800
Washington, DC 20005-2134

Main: 202.842.3555
Fax: 202.842.4355
Web site: www.aad.org

Ronald L. Moy, M.D., F.A.A.D.
President

Daniel M. Siegel, M.D., M.S., F.A.A.D.
President-Elect

Suzanne M. Connolly, M.D., F.A.A.D.
Vice President

Zoe D. Draelos, M.D., F.A.A.D.
Vice President-Elect

Robert D. Greenberg, M.D., F.A.A.D.
Secretary-Treasurer

Suzanne Olbricht, M.D., F.A.A.D.
Assistant Secretary-Treasurer

Ronald A. Henrichs, C.A.E.
Executive Director & CEO

- A 2010 article published in the American Journal of Clinical Nutrition reported that a study of a group of Japanese school children who received ***1200 IU*** of vitamin D ***had a decreased incidence of influenza compared to children receiving placebo. The reduction was more prominent in specific subgroups of children who had not been taking other vitamin D supplements and who started nursery school after age 3*** *(page 3, lines 27-30)**; and***
- A 2010 article in The Lancet reported that the risk of multiple sclerosis increases with latitude ***~~and with low blood serum levels of vitamin D~~*** *(page 4, lines 3-4).*

The key information missing from the above whereas clauses misrepresent the scientific data regarding vitamin D health benefits by neglecting to include critical information on the populations involved in the studies and the intent of the research.

While there are epidemiologic studies that show a statistical relationship between lower vitamin D levels and a higher incidence of some of these diseases, there are also multiple studies that have suggested an inverse association between vitamin D intake and cancer. There is some evidence that too much vitamin D may be harmful. Further, well-designed prospective studies of vitamin D intake and its association to diseases are needed to better assess this ambiguous association.

The AADA recommends vitamin D should be obtained through a healthy diet which includes drinking milk, eating foods which are good sources of vitamin D, and taking vitamin supplements. Intentional exposure to ultraviolet light from indoor tanning beds or the outdoor sun to produce optimum levels of vitamin D is not recommended, as ultraviolet (UV) radiation exposure is associated with increased risk of skin cancer and melanoma.

> **FURTHER RESOLVED** that the Alaska State Legislature urges the Department of Health and Social Services to provide vitamin D supplements to the elderly to prevent bone loss, falls, fractures, and other age-related health problems;

Studies have demonstrated that calcium and vitamin D are two essential nutrients, long known for their joint role in bone health. The AADA supports use of vitamin D supplements taken orally (according to the Institute of Medicine recommended dosage) along with calcium for the elderly to prevent bone loss, falls, and fractures. It is critical for overall health, that individuals follow the recommendations of their physician and abide by the guidelines of the Institute of Medicine as there is emerging evidence that too much of these nutrients may be harmful.

> **FURTHER RESOLVED** that the Alaska State Legislature urges the Department of Health and Social Services to investigate substituting vitamin D supplementation for influenza vaccination as a less costly method for preventing influenza;

Studies have not conclusively demonstrated than vitamin D supplements will prevent infectious diseases; yet, numerous studies have conclusively demonstrated that vaccines are very effective in preventing infectious diseases. Vigorous vaccination practices and healthy living conditions will lower the rates of preventable infectious diseases and also reduce morbidity and mortality from these preventable diseases.

HCR 5 would endanger patients by replacing a proven method of disease prevention with a vitamin supplementation program which has not been tested to protect the general population from infectious disease, such as influenza.

> **FURTHER RESOLVED** that the Alaska State Legislature urges the Department of Health and Social Services to provide vitamin D supplements to pregnant women and infants to prevent pregnancy complications, preterm births, type 1 diabetes, and rickets.

The AADA strongly cautions the Alaska Legislature to further review the scientific literature regarding vitamin D, and disease prevention before moving forward with a supplementation program aimed at specific, vulnerable segments of the population. Moreover, it is critical that the public be appropriately educated about vitamin D and be encouraged to consult their physician before taking any vitamin supplements. Lastly, Alaskans should be educated about the dangers of ultraviolet radiation (UV). As stated previously, UV radiation from the sun and indoor tanning beds is associated with a significant increased risk in the development of skin cancer and melanoma. The public should be educated about proper sun protection and urged to avoid UV exposure from indoor tanning devices.

Thank you for the opportunity to provide written comments on HCR 5. For further information, please contact Kathryn Chandra, Assistant Director of State Policy for the AADA, at kchandra@aad.org or (202) 712-2615.

Sincerely,

Ronald L. Moy, MD, FAAD
President, American Academy of Dermatology Association
RLM/kgc

CC: Alaska House Health & Social Services Committee Members
Jim Jordan, Executive Director, Alaska State Medical Association

PERSPECTIVE

JBMR

Why the IOM Recommendations for Vitamin D Are Deficient

Robert P Heaney[1] and Michael F Holick[2]

[1]Creighton University , Omaha, NE, USA
[2]Department of Medicine, Division of Endocrinology, Boston University Medical Center, Boston, MA, USA

ABSTRACT

The IOM recommendations for vitamin D fail in a major way on logic, on science, and on effective public health guidance. Moreover, by failing to use a physiological referent, the IOM approach constitutes precisely the wrong model for development of nutritional policy.
© 2011 American Society for Bone and Mineral Research.

KEY WORDS: VITAMIN D; NUTRITIONAL POLICY; EVOLUTIONARY PHYSIOLOGY

Introduction

In the past two years, vitamin D supplement sales to consumers have increased by more than 100% per year.[1] Now, following publication of the report[2] on Dietary Reference Intakes (DRIs) for calcium and vitamin D by the Institute of Medicine (IOM), many physicians report that they are decreasing their vitamin D recommendations to patients. This change was explicitly proposed by members of the IOM panel in their various media statements. While a small fraction of consumers may well have all the vitamin D they need, on balance, we consider a general downward trend to be harmful to the health of the public.

Both the authors of this Perspective served as members of the panel that drafted the 1997 report of the IOM on the DRIs for calcium and vitamin D. That report was the first issued by the IOM under the then-new evidence-based guidelines for evaluating studies and making recommendations. We are thus familiar with the process and, most important, with vitamin D itself. On the basis of this experience, we respectfully dissent from many of the findings and recommendations in the current report, and we set forth here a small fraction of the reasons for that dissent.

The IOM report (and its presentation to the media) stressed that its recommendations for vitamin D were based primarily on the intake (and serum 25-hydroxyvitamin D concentration) needed to ensure skeletal health and that, in the panel's judgment, there was insufficient evidence to make any recommendations with respect to nonskeletal benefits, if any. Second, the report concluded that a serum level for 25-hydroxyvitamin D [25(OH)D] of 20 ng/mL was sufficient to ensure bone health. And third, the panel concluded that since the bulk of the American public had 25(OH)D values that were above 20 ng/mL, most individuals were getting all the vitamin D they needed and had no reason for further supplementation. These conclusions fail on three grounds: logic, science, and guidance.

First, logic. Since the panel, in its judgment, concluded that it did not know whether there might be nonskeletal benefits (or at what blood level they could be ensured), then it is patently incorrect to say that they know that people are getting enough. The most the panel could have said logically was, "Here's what you need for bone; most people get that much; we do not know whether more would confer possible nonskeletal benefits." That, at least, would have been an honest communication of the state of the issue as the panel apparently understands it. However, to state publicly that the general public does not need more goes well beyond what the panel admits it knows.

Second, science. The statement that skeletal health can be ensured at serum 25(OH)D levels of 20 ng/mL is simply incorrect. Without going into an exhaustive recital of all the evidence pointing to a skeletal need for higher levels, we cite here three illustrative observations that, in our collective judgment, indicate that instead of 20 ng/mL, a serum level of 30 ng/mL is closer to the bottom end of the acceptable range for skeletal health. First, there is the large randomized, controlled trial in the United Kingdom that raised serum 25(OH)D level from 21 to 29 ng/mL and produced a 33% reduction in all major osteoporotic fractures combined.[3] The fact that other trials, with less good compliance, failed to reproduce that effect does not negate the evidence of a well-conducted trial. Second, there are the many meta-analyses of Bischoff-Ferrari and colleagues[4,5] demonstrating that, taken overall, fracture reduction with vitamin D does not occur reproducibly below serum 25(OH)D

Received in original form December 6, 2010; revised form December 21, 2010; accepted December 23, 2010. Published online January 4, 2011.
Address correspondence to: Robert P Heaney, MD, Creighton University, 601 North 30th Street, Suite 4841, Omaha, NE 68131, USA. E-mail: rheaney@creighton.edu
For further discussion on this topic, please see Reid and Avenell (J Bone Miner Res. 2011;452–454. DOI: 10.1002/jbmr.327).

Journal of Bone and Mineral Research, Vol. 26, No. 3, March 2011, pp 455–457
DOI: 10.1002/jbmr.328
© 2011 American Society for Bone and Mineral Research

levels of 30 ng/mL and for some fractures even 40 ng/mL. Finally, there is the demonstration, in a large German autopsy series (strangely misinterpreted by the panel), that osteoid seam width—the histologic hallmark of vitamin D deficiency—does not reach fully normal values until serum 25(OH)D levels are above 30 ng/mL.[6] [N.B.: Of 33 patients with 25(OH)D values between 20 and 30 ng/mL, more than half (18) had elevated osteoid volume. A Recommended Daily Allowance (RDA), by definition, meets the need of 97.5% of the population.] In a closely related finding, investigators from South Australia[7] showed seasonal variation in osteoid seam width and mineral appositional rate, reflecting variations in serum 25(OH)D precisely within the 20 to 30 ng/mL range, that is, above the IOM panel's "adequate" level.

Additionally, there is an apparent inconsistency between the recommended intake (600 IU/day for all individuals up through age 70) and the bottom end of the acceptable 25(OH)D serum concentration range (let alone higher values). As virtually universal experience with vitamin D supplementation demonstrates, 600 IU/day, if the body's sole input of vitamin D, would not be enough to produce a value of even 10 ng/mL, let alone 20 ng/mL or above. There is a generally recognized "rule of thumb" to the effect that each additional 100 IU of vitamin D per day raises serum 25(OH)D concentration by approximately 1 ng/mL. That is, in fact, a "rounding up" for convenience of calculation. Several studies indicate that the response increment is closer to 0.7 ng/mL/100 IU.[8,9] Either way, 600 IU/day will not suffice without appreciable solar and dietary input. Furthermore, as is also widely recognized, 600 IU/day produces barely perceptible changes in individuals who are overweight or obese (now better than 50% of the US adult population). Hence the increase from the 1997 DRIs, while welcome, and certainly in the right direction, is simply inconsistent with current professional experience. It not only is inadequate, by itself, to meet even the panel's recommended serum levels, but this internal inconsistency detracts from the credibility of the whole report inasmuch as it flies in the face of the everyday experience of clinicians who recommend supplements to their patients and measure the resulting responses.

Finally, guidance. At already noted, the panel indicated that it was uncertain about extraskeletal benefits—benefits that might accrue at intakes above the new intake recommendations. At the same time, the panel raised the upper-level intake "TUIL" to 4000 IU/day. (The report acknowledges that intakes up to 10,000 IU/day are probably safe for everyone and applied an uncertainty factor[10] to that 10,000-IU figure to generate the 4000-IU TUIL. It is important to stress that the TUIL is not a limit but instead constitutes an assurance of safety for such an intake.) One should have thought that even a very simplistic game-theory approach would have led to a guidance statement such as the following: "We do not know whether taking more vitamin D than we are currently recommending will help you, but it could, and we can assure you that supplemental intakes up to at least 4000 IU/day are safe." Such a statement, couched, perhaps, in less straightforward language, nevertheless would provide guidance that both the public and governmental agencies could find useful. Instead, we now have only a confused public.

Beyond these errors and inconsistencies, though, serious as they are, lies a much deeper flaw in the approach taken by the panel, exemplified by a quote from one of the panel members to the *New York Times* at the time of release of the report.[11] The statement was simply that the "onus" (ie, burden of proof) fell on anyone who claimed benefits for intakes higher than the panel's current recommendations. This is an approach that is correct for drugs, which are foreign chemicals and which do carry an appropriately heavy requirement for proof. For drugs, the position of privilege is given to the placebo. And in the current IOM report, the privilege is given to a serum 25(OH)D level that is effectively the status quo. We judge that this is exactly backward for nutrients. The privilege instead must be given to the intake that prevailed during the evolution of human physiology, the intake to which, presumably, that physiology is fine-tuned. So far as can be judged from numerous studies documenting the magnitude of the effect of sun exposure,[12,13] the primitive intake would have been at least 4000 IU/day and probably two to three times that level, with corresponding serum 25(OH)D levels ranging from 40 to 80 ng/mL. The fact that primitive levels would have been higher than current IOM recommendations does not, of course, prove their necessity today. But such intakes should be given the presumption of correctness, and the burden of proof must be placed on those who propose that lower intakes (and lower serum levels) are without risk of preventable dysfunction or disease. The IOM, in its report, has utterly failed to recognize or meet that standard.

Finally, we commend the IOM panel for their concern about safety, certainly an appropriate posture for a body crafting public policy. However, the standards adopted by the panel for taking into evidence papers indicating possible risk were, we note, far lower than those the panel required to indicate benefit. Additionally, many of the purported risks were, on their face, implausible and inconsistent with the experience of population subgroups that routinely have serum levels in the range mentioned by the panel as possibly risky (eg, approximately 50 ng/mL). We note that one of the widely accepted Hill[14] criteria for acceptance of observational data is precisely biologic plausibility. Furthermore, we consider it highly implausible that serum levels such as prevailed during hominid evolution could carry more risk than benefit for the populations concerned. Had that been the case, one should have expected that natural selection would have eliminated those prone to such risks.

In this Perspective, we have deliberately avoided a mind-numbing laundry list of the vast number of factual inaccuracies and misinterpretations in the report. We are informed that there is a request, through the Freedom of Information Act, to obtain the external review comments submitted to the IOM in response to a prepublication draft. When those materials become available, those interested can review the many problems with the IOM report in detail. For now, our recommendation to the American public is that the IOM report should be taken with a grain of salt (another nutrient the IOM finds risky).

Disclosures

Both authors state that they have no conflicts of interest.

References

1. [2010] Supplement Business Report, *Nutrition Business Journal*, September 28, 2010.
2. Institute of Medicine (IOM). *Dietary Reference Intakes for Calcium and Vitamin D*. Washington, DC: National Academies Press, 2011.
3. Trivedi DP, Doll R, Khaw KT. Effect of four monthly oral vitamin D_3 (cholecalciferol) supplementation on fractures and mortality in men and women living in the community: randomized, double-blind, controlled trial. BMJ. 2003;326:469–474.
4. Bischoff-Ferrari HA, Willett WC, et al. Fracture prevention with vitamin D supplementation. JAMA. 2005;293:2257–2264.
5. Bischoff-Ferrari HA, Willett WC, Wong JB, et al. Prevention of non-vertebral fractures with oral vitamin D and dose dependency. Arch Intern Med. 2009;169:551–561.
6. Priemel M, von Domarus C, Klatte TO, et al. Bone mineralization defects and vitamin D deficiency: histomorphometric analysis of iliac crest biopsies and circulating 25-hydroxyvitamin D in 675 patients. J Bone Miner Res. 2010;25:305–312.
7. Need AG, Horowitz M, Morris HA, Moore R, Nordin C. Seasonal change in osteoid thickness and mineralization lag time in ambulant patients. J Bone Miner Res. 2007;22:757–761.
8. Heaney RP, Davies KM, Chen TC, Holick MF, Barger-Lux MJ. Human serum 25-hydroxy-cholecalciferol response to extended oral dosing with cholecalciferol. Am J Clin Nutr. 2003;77:204–210.
9. Heaney RP, Armas LAG, Recker RR, Grote J, Horst RL. Vitamin D_3 is more potent than vitamin D_2 in humans. J Clin Endocrinol Metab. 2011; DOI: 10.1210/jc.2010-2230 [Epub ahead of print].
10. Hathcock JN, Shao A, Vieth R, Heaney RP. Risk assessment for vitamin D. Am J Clin Nutr. 2007;85:6–18.
11. Kolata G. Report questions need for 2 diet supplements. *New York Times*, November 29, 2010. Available at www.nytimes.com/2010/11/30/health/30vitamin.html?
12. Holick MF. Environmental factors that influence the cutaneous production of vitamin D. Am J Clin Nutr. 1995;62(Suppl):638–645S.
13. Armas LAG, Dowell S, Akhter M, et al. Ultraviolet-B radiation increases serum 25-hydroxyvitamin D levels: the effect of UVB dose and skin color. J Am Acad Dermatol. 2007;57:588–893.
14. Hill AB. The environment and disease: association or causation? Proc R Soc Med. 1965;58:295–300.

HCR

20

<TARGET><BILL>HCR 20</BILL><SUBJECT>HCR 20</SUBJECT><COMM>SHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE

Interim:
P.O. Box 109
Wrangell, AK 99929
Phone: (907) 874-3088
Fax: (907) 874-3055

Session:
State Capitol, Room 406
Juneau, AK 99801-1182
Phone: (907) 465-3824
1-800-686-3824
Fax: (907) 465-3175

REPRESENTATIVE PEGGY WILSON
HOUSE DISTRICT 2

SPONSOR STATEMENT
House Concurrent Resolution 20
"A Resolution designating February 2012 as American Heart Month."

HCR 20 raises awareness of the nation's leading cause of death: cardiovascular disease.

This unfortunate disease causes an average of one American death every 39 seconds or nearly 2,200 deaths each **day**. It is the costliest disease in the nation, with direct and indirect costs estimated to be $297,700,000 a year.

The American Heart Association's 2020 impact goal seeks to improve cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular disease and stroke by 20 percent through research, population-level and community-level interventions, and public health and policy measures

The passage of this resolution would join Alaska and the American Heart Association in raising awareness of this disease by celebrating February 2012 as "American Heart Month" and promoting education and awareness by encouraging citizens to learn the warning signs of heart attack and stroke.

Circulation

JOURNAL OF THE AMERICAN HEART ASSOCIATION

American Heart Association.
Learn and Live.

Defining and Setting National Goals for Cardiovascular Health Promotion and Disease Reduction. The American Heart Association's Strategic Impact Goal Through 2020 and Beyond

Donald M. Lloyd-Jones, Yuling Hong, Darwin Labarthe, Dariush Mozaffarian, Lawrence J. Appel, Linda Van Horn, Kurt Greenlund, Stephen Daniels, Graham Nichol, Gordon F. Tomaselli, Donna K. Arnett, Gregg C. Fonarow, P. Michael Ho, Michael S. Lauer, Frederick A. Masoudi, Rose Marie Robertson, Véronique Roger, Lee H. Schwamm, Paul Sorlie, Clyde W. Yancy and Wayne D. Rosamond

Circulation published online January 20, 2010
Circulation is published by the American Heart Association. 7272 Greenville Avenue, Dallas, TX 72514
Copyright © 2010 American Heart Association. All rights reserved. Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/early/2010/01/20/CIRCULATIONAHA.109.192703.citation

Subscriptions: Information about subscribing to Circulation is online at http://circ.ahajournals.org//subscriptions/

Permissions: Permissions & Rights Desk, Lippincott Williams & Wilkins, a division of Wolters Kluwer Health, 351 West Camden Street, Baltimore, MD 21202-2436. Phone: 410-528-4050. Fax: 410-528-8550. E-mail: journalpermissions@lww.com

Reprints: Information about reprints can be found online at http://www.lww.com/reprints

Downloaded from http://circ.ahajournals.org/ by guest on January 25, 2012

AHA Special Report

Defining and Setting National Goals for Cardiovascular Health Promotion and Disease Reduction

The American Heart Association's Strategic Impact Goal Through 2020 and Beyond

Donald M. Lloyd-Jones, MD, ScM, FAHA, Chair;
Yuling Hong, MD, MSc, PhD, FAHA*; Darwin Labarthe, MD, MPH, PhD, FAHA*;
Dariush Mozaffarian, MD, DrPH, FAHA; Lawrence J. Appel, MD, MPH, FAHA;
Linda Van Horn, PhD, RD, FAHA; Kurt Greenlund, PhD*; Stephen Daniels, MD, PhD, FAHA;
Graham Nichol, MD, MPH, FAHA; Gordon F. Tomaselli, MD, PhD, FAHA; Donna K. Arnett, PhD, FAHA;
Gregg C. Fonarow, MD, FAHA; P. Michael Ho, MD, PhD; Michael S. Lauer, MD, FAHA;
Frederick A. Masoudi, MD, MPH; Rose Marie Robertson, MD, FAHA; Véronique Roger, MD, FAHA;
Lee H. Schwamm, MD, FAHA; Paul Sorlie, PhD; Clyde W. Yancy, MD, FAHA;
Wayne D. Rosamond, PhD, FAHA; on behalf of the American Heart Association Strategic Planning Task Force and Statistics Committee

Abstract—This document details the procedures and recommendations of the Goals and Metrics Committee of the Strategic Planning Task Force of the American Heart Association, which developed the 2020 Impact Goals for the organization. The committee was charged with defining a new concept, *cardiovascular health*, and determining the metrics needed to monitor it over time. Ideal cardiovascular health, a concept well supported in the literature, is defined by the presence of both ideal health behaviors (nonsmoking, body mass index <25 kg/m^2, physical activity at goal levels, and pursuit of a diet consistent with current guideline recommendations) and ideal health factors (untreated total cholesterol <200 mg/dL, untreated blood pressure $<120/<80$ mm Hg, and fasting blood glucose <100 mg/dL). Appropriate levels for children are also provided. With the use of levels that span the entire range of the same metrics, cardiovascular health status for the whole population is defined as poor, intermediate, or ideal. These metrics will be monitored to determine the changing prevalence of cardiovascular health status and define achievement of the Impact Goal. In addition, the committee recommends goals for further reductions in cardiovascular disease and stroke mortality. Thus, the committee recommends the following Impact Goals: "By 2020, to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%." These goals will require new strategic directions for the American Heart Association in its research, clinical, public health, and advocacy programs for cardiovascular health promotion and disease prevention in the next decade and beyond. (***Circulation.*** **2010;121:586-613.)**

Key Words: AHA Special Reports ■ obesity ■ quality of life ■ epidemiology ■ risk factors ■ quality of care

Circulation

When introducing broad new concepts and objectives that will drive the agenda for the American Heart Association (AHA) for the next decade, it is necessary to provide a detailed accounting of the processes that resulted in the consensus recommendations of the Goals and Metrics Committee of the Strategic Planning Task Force of the AHA.

*The findings and conclusions in this report are those of the authors and do not necessarily reflect the official position of the Centers for Disease Control and Prevention.

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This document was approved by the American Heart Association Science Advisory and Coordinating Committee on November 6, 2009. A copy of the document is available at http://www.americanheart.org/presenter.jhtml?identifier=3003999 by selecting either the "topic list" link or the "chronological list" link (No. KB-0016). To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: Lloyd-Jones DM, Hong Y, Labarthe D, Mozaffarian D, Appel LJ, Van Horn L, Greenlund K, Daniels S, Nichol G, Tomaselli GF, Arnett DK, Fonarow GC, Ho PM, Lauer MS, Masoudi FA, Robertson RM, Roger V, Schwamm LH, Sorlie P, Yancy CW, Rosamond WD; on behalf of the American Heart Association Strategic Planning Task Force and Statistics Committee. Defining and setting national goals for cardiovascular health promotion and disease reduction: the American Heart Association's Strategic Impact Goal through 2020 and beyond. *Circulation.* 2010;121:586–613.

Expert peer review of AHA Scientific Statements is conducted at the AHA National Center. For more on AHA statements and guidelines development, visit http://www.americanheart.org/presenter.jhtml?identifier=3023366.

Permissions: Multiple copies, modification, alteration, enhancement, and/or distribution of this document are not permitted without the express permission of the American Heart Association. Instructions for obtaining permission are located at http://www.americanheart.org/presenter.jhtml?identifier=4431. A link to the "Permission Request Form" appears on the right side of the page.

© 2010 American Heart Association, Inc.

Circulation **is available at http://circ.ahajournals.org** **DOI: 10.1161/CIRCULATIONAHA.109.192703**

Downloaded from http://circ.ahajournals.org/ by guest on January 25, 2012

This committee, which was composed of members of the Statistics Committee, the Strategic Planning Task Force, and other ad hoc members, was formed in February 2008 and met regularly through June 2009. Its recommendations were formally approved by the AHA National Board of Directors in February 2009. The final recommendation of the committee, as approved by the Board of Directors, was that the AHA 2020 Impact Goals should be as follows:

"By 2020, to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%."

Although important refinements in monitoring and improving rates of cardiovascular diseases (CVDs) and stroke were also to be considered and are reviewed here, the major challenge confronted by the committee was to address cardiovascular health as an Impact Goal: How to define it and how to measure it. This document details the commission, underlying rationale, processes, and recommendations of the committee, which outline bold new strategic directions for the AHA in cardiovascular health promotion and disease prevention for the next decade and beyond.

Public Health Burden of CVD and Stroke

Despite 4 decades of declines in age-standardized CVD and stroke death rates, the numbers of heart disease, stroke, and related vascular deaths continue to make these by far the leading causes of morbidity and mortality in the United States.[1,2] The burden of CVD and stroke in terms of life-years lost, diminished quality of life, and direct and indirect medical costs also remains enormous.[2] Downward shifts in population levels of cholesterol, blood pressure, and smoking account for nearly half (after adjustment for the impact of increasing prevalence of obesity and diabetes) of the decline in coronary heart disease (CHD) deaths that would have been expected in 2000 on the basis of rates in 1980; wider use of effective treatments among persons with existing CVD accounts for an equal share in this decline. Offsetting trends in prevalence of obesity and diabetes, as well as growth in the older population at highest risk for CVDs, have contributed to the persistent national CVD and stroke burden.[3] Very recent data also suggest a slowing of reductions in coronary death rates[4] and growing numbers of hospitalizations for acute and chronic manifestations of CVD, such as heart failure and atrial fibrillation.[1,2] It has also become clear that many CVDs with ultimate outcomes in adulthood actually have their origins during childhood. Unfortunately, there are disturbing trends of increasing obesity, increasing severe obesity, and increasing prevalence of hypertension and type 2 diabetes mellitus in the pediatric population.[2] These trends will very likely result in future increases in the burden of CVD and stroke among adults, including a trend for events to occur at younger ages.

As the leading voluntary health organization in the field of heart diseases and stroke, the AHA has taken a major leadership role in promoting the implementation of interventions that have contributed to the improvements in CVD and stroke morbidity and mortality rates seen to date. The AHA policies and programs designed to achieve the AHA 2010 Impact Goal appear to have contributed substantially to improvements in morbidity and mortality, as reviewed below.

However, it appears clear that the AHA and the nation must add a substantial new effort in the coming decade, building on the gains to date, if we are to arrest or reverse a rising tide of CVD events due to aging of the population and ongoing adverse levels of unhealthy behaviors (dietary imbalance, physical inactivity, smoking) and unhealthy risk factors (adverse blood lipids, high blood pressure, diabetes, obesity). To design and implement this next phase of CVD and stroke prevention, the AHA has decided not only to continue efforts at reducing CVD but also to adopt a major new focus: To improve cardiovascular health in the population as a whole. This fundamental expansion of prevention efforts will require an array of new tools and competencies for implementing public health policy and population- and community-level interventions to complement the traditional, predominantly medically oriented interventions that the AHA has promoted successfully in the past. To understand the new role being charted for the AHA, a review of past and current AHA efforts is warranted, because they laid the foundation for the new 2020 Impact Goals.

Development of the AHA 2010 Impact Goal

Process

The AHA 2010 Impact Goal was developed by a task force appointed by the Board of Directors in 1999. The task force began with a process to rank order risk factors, risk behaviors, and disease states in the order that they should be addressed to have a significant effect on CVD and stroke. Approximately 170 scientists were selected from the various executive committees of scientific councils within the AHA and were surveyed for their responses. The rank-ordering results showed CHD and stroke in the positions of highest importance. Risk factors followed in order of importance, with smoking, high blood pressure, high cholesterol, and physical inactivity deemed the most important, in that order. Obesity and diabetes were later added to the list as major risk factor metrics; nutrition ultimately was not included because of challenges present at that time for measurement of population nutritional habits in the United States.

Groups of scientists within the 2010 Task Force were assigned to each of the priority disease states and risk factors to estimate potential reductions for each by 2010. The group referenced trends for the previous decades and projected forward to 2010, considering various scenarios for treatment and control of risk factors and implementation of acute and chronic therapies. One portion of this group recommended that the 2010 Impact Goal aim for 30% relative reductions in CHD and stroke mortality, as well as in the prevalence of each of the risk factors. Another portion of this group recommended 20% reductions be targeted. Consensus was reached around a compromise goal of 25% reductions as the target for the 2010 Impact Goal.

Product

The final version of the goal approved in February 2004 by the AHA Board of Directors was, "By 2010, to reduce coronary

Downloaded from http://circ.ahajournals.org/ by guest on January 25, 2012

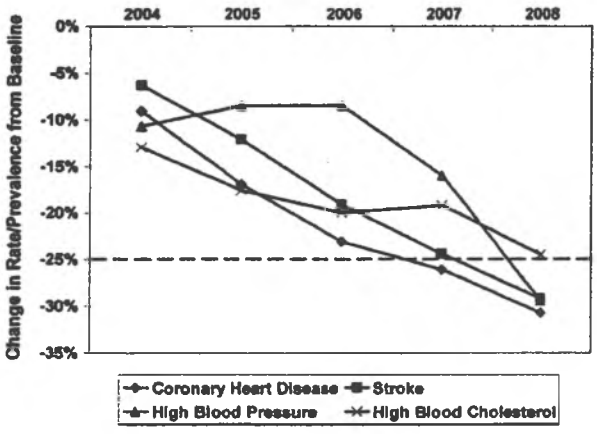


Figure 1. Trajectory of mortality rates from CHD and stroke, rate of uncontrolled high blood pressure, and prevalence of high blood cholesterol from 2004 to 2008.

heart disease, stroke, and risk by 25%," with the following indicators:

- Reduce death rate due to CHD and stroke by 25%;
- Reduce prevalence of smoking, high blood cholesterol, uncontrolled high blood pressure, and physical inactivity by 25%; and
- Eliminate the growth of obesity and diabetes (0% increase).

Levels of mortality rates and risk factor prevalences in 1999 were used as the baseline. The goal also aligned well with the objective and goals of the US Healthy People 2010 focus area 12 on heart disease and stroke, although indicators and target goals were not identical.

From 2000 on, AHA staff and volunteers worked from this Impact Goal to develop multiple supporting goals in the areas of prevention, treatment, acute care, and resources. At the time, the 2010 Impact Goal and its supporting strategic programs represented a bold step for a voluntary health organization in the arena of national and public health policy focused on treatment and acute care. The concept of quantifying the impact on death rates and risk factors was a critical step in the evolution of the AHA's prevention strategies. The 2010 goal focused the AHA's agenda, efforts, and resources on a national scale and in a concerted way that had not been present previously.

Progress

Despite the ambitious nature of the 2010 Impact Goal, the targets for most components of the first 3 indicators were achieved well in advance of 2010 (Figure 1). The goals for indicators of smoking, physical inactivity, obesity, and diabetes have proven to be more difficult to achieve and will represent major challenges to the even more ambitious 2020 Impact Goal. The achievement of lower mortality goals was accomplished in part as the result of the work of practitioners and scientists engaged in the medical prevention and treatment of acute and chronic atherosclerotic CVD by accelerating existing trends toward lower heart disease and stroke death rates. Similarly, public health and policy measures instituted before the development of the 2010 goals had emphasized the importance of elimination of smoking, the importance of physical activity, and the control of risk factors for CHD and stroke such as high blood pressure and dyslipidemia. The work of the AHA also contributed to these declines through the development of guidelines and their implementation in the "Get With the Guidelines" programs and numerous other initiatives.

Monitoring of the 2010 Impact Goal revealed by 2008 a 30.7% reduction in the death rate due to CHD, a 29.2% reduction in the death rate due to stroke (data from the National Vital Statistics Sample), a 29.4% reduction in uncontrolled high blood pressure (data from the National Health and Nutrition Examination Survey [NHANES] 2005–2006), a 24.5% reduction in prevalence of high cholesterol (NHANES 2005–2006), and a 15.8% reduction in prevalence of smoking (data from the National Health Interview Survey 2006) compared with baseline levels (http://www.cdc.gov/nchs/deaths.htm, http://www.cdc.gov/nchs/nhanes.htm, http://www.cdc.gov/nchs/nhis.htm, and the AHA Heart Disease and Stroke Statistics—2009 Update[2]). There was only limited impact on other risk factors, including increases in prevalence of obesity and diabetes, and a small 2.5% reduction in those not engaged in moderate or vigorous physical activity (National Health Interview Survey 2006).

Proposal for 2020

The strategic approach and progress toward the 2010 Impact Goal pointed to innovations that are required to define and implement new strategies for improving cardiovascular health and preventing disease events and deaths. Accordingly, in June 2007, the AHA Board of Directors commissioned a Strategic Planning Task Force of the AHA to oversee drafting and implementation of the 2020 Impact Goal, with a directive to incorporate the novel aim of improving the cardiovascular health of all Americans while reducing death due to CVD and stroke.

In addition to refining the longstanding focus on reducing the burden of CHD and stroke mortality, the charge for the Goals and Metrics Committee suggested that the design of the new metric for cardiovascular health would require that attention be paid to a number of critical issues. Success in this task would enable the AHA to undertake a new and more proactive organizational mission, not only continuing the tremendous success in improved treatment but also addressing the need for a new and expanded emphasis on prevention, control of risk, improving quality of life, and promoting health rather than solely treating disease. It was acknowledged that at that time, no comprehensive metric for cardiovascular health existed, and the committee was charged with developing such a metric.

In addition, it was recommended that the committee broaden its scope to encompass all of CVD and stroke mortality, not just CHD and stroke, in support of existing and future programs and initiatives of the AHA in all areas of CVD. This is important because it recognizes areas such as congenital heart disease, which is the leading cause of mortality of any congenital defect and is an area in which progress is being made in prevention and treatment. As with the 2010 goal, an implicit aspect of the 2020 Impact Goal is

Downloaded from http://circ.ahajournals.org/ by guest on January 25, 2012

the ability to measure the current status and progress of each component with nationally representative samples. Thus, although further focus on reducing the incidence of nonfatal CVD events was also suggested, it was acknowledged that this would entail establishing means for national surveillance of nonfatal events. Other areas for consideration were to include quality of life, quality of care, and health disparities, although each of these areas also presents significant challenges with regard to measurement over time in nationally representative samples. With this charge, the committee began its work to develop recommendations to complete the following draft 2020 Impact Goals statement: **"By 2020, to improve the cardiovascular health of all Americans by __% while reducing deaths from cardiovascular diseases and stroke by __%."**

Defining and Measuring Cardiovascular Health

Concepts of Prevention

In considering the concept of cardiovascular health, the committee took into account 3 key concepts in health promotion and disease prevention: (1) The power of primordial prevention; (2) the evidence that CVD and risk factors for it often develop early in life; and (3) the appropriate balance between population-level approaches for health promotion and disease prevention and individualized high-risk approaches. These concepts informed the definition of cardiovascular health, as well as the metrics that would be needed to monitor it and the strategies that would be needed to improve it across the lifespan.

Primordial Prevention

Most clinicians are familiar with the concepts of secondary and primary prevention. In secondary prevention, efforts are aimed at preventing the recurrence of clinical events in patients who have manifest clinical disease. For example, therapeutic lifestyle change and aspirin and statin medications are used to prevent recurrent myocardial infarction (MI) in patients who have already experienced an MI. In primary prevention, efforts focus on preventing the first occurrence of a clinical event among individuals who are at risk. Examples are the use of blood pressure–lowering medications and dietary intervention in patients with hypertension to prevent the first occurrence of stroke. As such, primary prevention efforts are aimed at individuals who already have adverse levels of known risk factors. However, as reviewed below, once adverse levels of risk factors are present, even in young adulthood and middle age, substantial elevations in long-term and lifetime risks for CVD and stroke are largely unavoidable. Furthermore, whereas clinical guidelines impose thresholds on risk factor levels to guide decision making, the association of risk factor levels with CVD risk is continuous and graded across all levels. Therefore, it is of paramount importance to focus on prevention at all levels of risk. Risk factors may result in the development of subclinical atherosclerosis and other myocardial and vascular changes over the course of years to decades. In turn, subclinical CVD typically precedes the occurrence of clinical events by years to decades. Thus, it makes sense that avoidance of adverse levels of risk factors in the first place may be the most effective means for avoiding clinical events during the remaining lifespan.

This is the meaning of *primordial prevention*, a concept introduced by Strasser in 1978.[5] On a population-wide basis, primordial prevention was conceived as a strategy to prevent whole societies from experiencing epidemics of the risk factors. The corresponding strategy at the individual level is to prevent the development of risk factors in the first place. Although this terminology may be unfamiliar to some, the strategy of promoting healthy behaviors for this purpose is well recognized and common to many guidelines and recommendations in CVD prevention, especially those that focus on childhood and adolescence.[6] Thus, primordial prevention has relevance and urgency in the high-income nations of today, given the substantial burden of obesity and the adverse health behaviors and environment that often begin in childhood and are present in most high-income nations, especially the United States. Primordial prevention was also a guiding feature of the Healthy People 2010 goals for heart disease and stroke prevention, which include prevention of risk factors.[7] The concept of primordial prevention therefore formed a cornerstone for the committee's deliberations in defining ideal cardiovascular health.

High-Risk and Population-Wide Approaches to Prevention

Rose[8,9] articulated the important complementary relation between interventions that focus on individuals at highest risk (the high-risk strategy) and those that address the risk distribution in the entire population (the population-wide strategy). Primary prevention requires a focus on individuals known to be at risk for disease. Hence, screenings for elevated cholesterol or blood pressure in at-risk groups are key facets of CVD prevention guidelines, even in children and adolescents.[6] By identifying and treating those at the highest risk for events because of markedly elevated risk factor levels, a number of clinical events may be avoided. Indeed, a large proportion of the reductions in CHD mortality experienced in the United States and other high-income nations since the 1960s has been ascribed to the development and institution of efficacious primary and secondary prevention interventions in people at elevated risk[3]; however, individuals with markedly elevated levels of risk factors are relatively uncommon in the population.[2,10] It is widely recognized that the majority of CVD and stroke events occur in individuals with average or only mildly adverse levels of risk factors, simply because this is where the majority of the population lies.[9,10] Therefore, for effective disease prevention, population-level strategies are essential to shift the entire distribution of risk. As explained by Rose, health thus becomes an issue for populations and not just for individuals, and health promotion and disease prevention strategies must embrace both high-risk and population strategies. Of the 2, however, greater power resides with the population strategy when risk is widely diffused throughout the whole population, as is the case for CVD.[9]

For example, Stamler[11] has demonstrated that modest and achievable reductions in salt intake in populations can likely

Downloaded from http://circ.ahajournals.org/ by guest on January 25, 2012