

LEG. FINANCE - BILLS 1977 - 1978 834

HB 891 cont., thru HB 896 834

University in fiscal matters. I do not feel the present fiscal situation is grave. We know the problems, we have made progress, and we will continue to make progress in these areas. It would be a total waste of money and time to create the committee as outlined in HB 66. It would be a duplication of recent efforts and it would get in the way of further forward progress.

In conclusion I respectfully request that you not mandate ^{drastic} organizational changes for the University of Alaska at this time. I pledge that the University Board of Regents and the Administration will look at organization and decentralization issues and report back to you next year. I share the feelings of one constituent who wrote to the editor of our paper last week and indicated that he felt some of the re-organizational proposals for the University were akin to "curing a person's dandruff problem by chopping their head off". I don't think such drastic action is wise or warranted. We request your constructive and positive support, and we pledge to address the questions and concerns at hand. Thank you, and I will be happy to answer any questions.

An aside. Why did you guys recommend me for confirmation last year? That's a joke.

Introduced: 3/15/78
Referred: Health, Education &
Social Services and Finance

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 HOUSE BILL NO. 891

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act providing for the reorganization of the Uni-
7 versity of Alaska; and providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. FINDINGS AND PURPOSE. (a) The legislature finds

10 (1) that the accelerated growth of the University of Alaska in
11 recent years has reached the point at which the highly centralized governance
12 and administrative structure of earlier years is no longer adequate;

13 (2) that the traditional Alaskan characteristics of independence,
14 self-reliance and initiative, and the wide variety of needs and interests
15 at the various campuses, make a decentralization of control and operations
16 both desirable and feasible; and

17 (3) that decentralization of the university will also free the
18 Board of Regents to fulfill the governance functions which it alone can per-
19 form: the establishment and monitoring of policy and long-range planning.

20 (b) It is the purpose of this Act to ensure that authority and commensurate
21 responsibility are delegated to the lowest level capable of assuming
22 them, that citizens served by a branch of the University of Alaska have an
23 opportunity to influence decisions which concern them, and that, within
24 funding limitations, all citizens of the state be served.

25 * Sec. 2. AS 14.40 is amended by adding new sections to read:

26 Sec. 14.40.011. UNIVERSITY OF ALASKA. (a) The University of
27 Alaska is established as a statewide system. The purpose of the uni-
28 versity system is to provide teaching, research, and public service
29 postsecondary programs for the entire state.

1 (b) The components of the statewide university system are:

2 (1) the University of Alaska at Fairbanks, which is authorized
3 to conduct degree programs on the baccalaureate, master's, and doctoral
4 levels and to offer non-credit and off-campus courses and programs as
5 may be delegated under policies of the Board of Regents;

6 (2) the University of Alaska at Anchorage, which is author-
7 ized to conduct degree programs on the baccalaureate, master's and
8 doctoral levels and to offer non-credit and off-campus courses and pro-
9 grams as may be delegated under policies of the Board of Regents,

10 (3) the University of Alaska at Juneau, which is authorized
11 to conduct degree programs on the baccalaureate and master's levels
12 designated by the Board of Regents and to offer non-credit and off-
13 campus courses and programs as may be delegated under policies of the
14 Board of Regents; and

15 (4) the community college division, comprised of those com-
16 munity colleges in existence on the effective date of this Act, which
17 are authorized to conduct lower division programs leading to asso-
18 ciate degrees as designated for each community college by the Board of
19 Regents, and to provide non-credit and community service courses and
20 specific certificate programs authorized under policies of the Board
21 of Regents; each community college, in cooperation with a university,
22 may sponsor and conduct courses which receive credit through a univer-
23 sity.

24 * Sec. 3. AS 14.40 is amended by adding a new section to read:

25 Sec. 14.40.015. NEW CAMPUSES. In addition to the components of
26 the university specified in sec. 11(b) of this chapter, a new campus
27 of the University of Alaska may be established by the Board of Regents
28 after approval by the legislature of a plan which shall contain, as a
29 minimum,

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(1) a needs assessment;

(2) a description of the key elements of the educational programs to be offered; and

(3) a budget for the first year of operation of the campus and projected budgets for the second and third years of operation.

* Sec. 4. AS 14.40.020 is amended to read:

Sec. 14.40.020. SITE OF UNIVERSITY. The University of Alaska is the beneficiary under the provisions of the Act of Congress approved August 30, 1890, designating the Alaska Agricultural College and School of Mines as beneficiary and the four sections of land specified by the Act of Congress approved March 4, 1915, and used as a site for the Alaska Agricultural College and School of Mines are the site for the University of Alaska at Fairbanks.

* Sec. 5. AS 14.40.100 is amended to read:

Sec. 14.40.100. COLLEGE EXTENSION SERVICE. The regents may conduct, at the University of Alaska at Fairbanks, a college extension service, the leading object of which is to carry information on rural life subjects to the people of the state.

* Sec. 6. AS 14.40 is amended by adding new sections to read:

Sec. 14.40.105. RESEARCH CENTERS AND OUTREACH ACTIVITIES. The Board of Regents, upon recommendation of the president, may assign to appropriate campuses or the community college division the responsibility for operation of research centers and institutes and for off-campus teaching, research, and public service activities which may include but are not limited to the establishment of learning centers, itinerant instruction, instruction on military bases, courses taught by radio or television, and correspondence courses.

Sec. 14.40.107. INTERCAMPUS PROGRAMS. The Board of Regents, upon recommendation of the president, may establish intercampus programs

1 which it considers necessary, if funds can be made available to the
2 affected campuses.

3 Sec. 14.40.155. IMMUNITY OF REGENTS FROM PERSONAL LIABILITY.

4 Members of the Board of Regents are immune from personal liability
5 with respect to all acts done or actions taken in good faith within
6 the scope of their authority during regular and special meetings of the
7 board.

8 * Sec. 7. AS 14.40.170(a)(2) and (3) are amended to read:

9 (2) fix the compensation of the president of the university,
10 the comptroller of the university, and the chancellors, and adopt com-
11 ensation schedules or patterns for all other staff [ALL HEADS OF DE-
12 PARTMENTS, PROFESSORS, TEACHERS, INSTRUCTORS AND OTHER OFFICERS];

13 (3) approve the establishment of degree programs and deter-
14 mine their location; confer [SUCH APPROPRIATE] degrees upon completion
15 of requirements [AS IT MAY DETERMINE AND PRESCRIBE];

16 * Sec. 8. AS 14.40.170(a) is amended by adding new paragraphs to read:

17 (7) review budgets and transmit recommendations on the
18 budgets to the governor and legislature;

19 (8) approve the staffing pattern and functional responsibili-
20 ties of the president's staff;

21 (9) adopt regulations for standard administration of the
22 university system; the regulations adopted shall include, but need not
23 be limited to,

24 (A) stipulation of degrees to be offered, the degree
25 requirements and the clock hour requirements for credit courses;

26 (B) student admission standards;

27 (C) qualifications, promotion, tenure and dismissal
28 standards, and pay and fringe benefits for faculty;

29 (D) personnel policies and pay and fringe benefit

1 provisions for staff other than faculty;

2 (E) uniform accounting and business procedures;

3 (F) uniform budgeting procedures; and

4 (G) standard systemwide management information data sys-
5 tems;

6 (10) establish fee schedules for the statewide system;

7 (11) provide for both short- and long-range planning of pro-
8 grams and campus development;

9 (12) provide for both internal and external audit functions,
10 and transmit an annual audit report to the governor and legislative
11 auditor, together with its comments;

12 (13) establish policies for fiscal and management control;

13 (14) constitute the final board of appeal in all matters which
14 are within its jurisdiction, and provide for an appeal process;

15 (15) carry out other duties as prescribed by law.

16 * Sec. 9. AS 14.40.170(b) is amended by adding a new paragraph to read:

17 (3) establish policy advisory groups, both internal and
18 external, as it considers necessary.

19 * Sec. 10. AS 14.40.190 is amended to read:

20 Sec. 14.40.190. REPORT TO THE LEGISLATURE. The Board of Regents
21 shall make a written report to the legislature at the beginning of its
22 regular sessions of the condition of the university property, of all
23 receipts and expenditures, including but not limited to the administra-
24 tion and disposition of appropriated and restricted funds, and of the
25 educational and other work performed. The report shall include annually
26 updated five-year plans for program development and facilities develop-
27 ment submitted in summary form.

28 * Sec. 11. AS 14.40.210 is amended to read:

29 Sec. 14.40.210. DUTIES [POWERS] OF THE PRESIDENT OF THE UNIVERSITY.

1 The president of the University of Alaska shall [MAY]

2 (1) give general direction to the work of the institution in
3 all its departments subject to the approval of the Board of Regents;

4 (2) with the approval of the Board of Regents, appoint the
5 chancellors and the staff of the president's office; [DEANS, HEADS OF
6 DEPARTMENTS, PROFESSORS, ASSISTANTS, INSTRUCTORS, TUTORS AND OTHER
7 OFFICERS OF THE UNIVERSITY TO THE POSITIONS ESTABLISHED BY THE BOARD OF
8 REGENTS]

9 (3) provide the staff work and recommendations upon which the
10 Board of Regents may base adoption of policy and by which the board may
11 carry out its responsibility for monitoring and evaluating policy im-
12 plementation;

13 (4) provide leadership and direction for implementation of
14 policies of the Board of Regents, and provide staff assistance to the
15 chancellors to enhance and facilitate program operations;

16 (5) provide intra-system coordination, monitor and evaluate
17 the conduct of all university programs, and report periodically to the
18 Board of Regents;

19 (6) review and approve the functional organization and
20 staffing patterns submitted by the chancellors;

21 (7) provide for the compilation, publication, distribution
22 and consistent updating of the policies of the Board of Regents and regu-
23 lations of the president; and

24 (8) meet regularly with the chancellors and president's staff
25 and consult with them on the conduct of their functions.

26 * Sec. 12. AS 14.40.230 is amended to read:

27 Sec. 14.40.230. POWERS OF REGENTS TO REMOVE OFFICERS. (a) The
28 Board of Regents may remove from office any officer of the institution
29 by a majority vote of the whole board [WHEN IN ITS JUDGMENT THE GOOD OF

1 THE UNIVERSITY REQUIRES IT]. An officer removed under this section shall
2 be notified of his removal and of his opportunity to apply to the board
3 for a hearing and reconsideration of its decision.

4 (b) Upon application filed with the Board of Regents within 10
5 days of receipt of notice of removal under (a) of this section, an offi-
6 cer is entitled to a hearing before the board on the validity of the
7 cause specified in the notice of removal. The hearing shall occur within
8 30 days of the date of filing of application. Upon consideration of
9 all evidence, including evidence provided at the hearing provided in
10 accordance with this subsection, the board shall uphold or reverse the
11 decision made under (a) of this section.

12 * Sec. 13. AS 14.40 is amended by adding new sections to read:

13 ARTICLE 2A. ADMINISTRATION OF THE CAMPUSES.

14 Sec. 14.40.272. CAMPUS ADMINISTRATION AUTHORIZED. (a) Each of the
15 campuses designated in sec. 11(b)(1) - (3) and the community college
16 division established in sec. 11(b)(4) of this chapter shall be under
17 the administrative direction of a chancellor. The chancellor of each
18 campus and the chancellor of the community college division shall have
19 full authority and operational responsibility under the direction of the
20 president of the university and in compliance with the systemwide poli-
21 cies established by the Board of Regents and the regulations of the
22 president which have received the approval of the Board of Regents.

23 (b) The organizational structure of each campus, and the organiza-
24 tional structure of the community college division, shall be determined
25 by the chancellor of each campus, or the chancellor of the community
26 college division, subject to approval by the president of the university.

27 Sec. 14.40.274. DUTIES OF CHANCELLORS. The chancellor of each
28 campus, and the chancellor of the community college division, shall,
29 in relation to the unit under his administration, implement the policies

1 established by the Board of Regents and, under these policies and the
2 regulations adopted by the president, is responsible for the following
3 functions:

4 (1) leadership and supervision of all teaching, research and
5 public service programs conducted on his campus or within his division;

6 (2) presentation and submission to the Board of Regents,
7 through the president, of a complete program budget, including all
8 courses, programs and activities, regardless of their source of funding,
9 and of requests for funds to initiate or complete construction of capital
10 improvements;

11 (3) conduct of all administrative and business services
12 essential to the operation of the campus or division, and the maintenance
13 of accurate and complete books of accounts;

14 (4) employment of faculty and support services staff and
15 provision for payroll completion and personnel services;

16 (5) provision of management information data as required by
17 the Board of Regents or the president;

18 (6) provision of an annual report to the Board of Regents,
19 through the president, relating to the conduct of programs and the
20 administration of the campus or division under his supervision;

21 (7) completion of other periodic reports which may be re-
22 quested by the president or the Board of Regents.

23 Sec. 14.40.276. DELEGATION OF COMMUNITY COLLEGE DIVISION AUTHORITY
24 TO CAMPUS PRESIDENTS. The chancellor of the community college division
25 shall delegate the administration of the administrative and supervisory
26 functions described in sec. 274 of this chapter to the presidents of the
27 community college campuses within the division, to the maximum extent
28 practicable.

29 Sec. 14.40.305. DUTIES OF THE COMPTROLLER. (a) The comptroller

1 of the university shall disburse all funds provided under secs. 290 and
2 295 of this chapter to the campuses designated in sec. 11(b)(1) - (3)
3 of this chapter, to the community college division established in sec.
4 11(b) (4) of this chapter, and to other divisions of the university for
5 their use and control in accordance with budgets approved by and appro-
6 priations provided by the legislature.

7 (b) The comptroller shall provide internal audit and control and
8 budget analysis services for the Board of Regents.

9 Sec. 14.40.315. FISCAL PROCEDURES. (a) Budgets for the compo-
10 nents of the statewide system shall be prepared in accordance with
11 general requirements set out in the Executive Budget Act (AS 37.07).
12 Budget submissions shall be completed by each chancellor or campus pre-
13 sident based upon opportunity for maximum involvement in the budget
14 preparation process by persons responsible for programs, shall reflect
15 the objectives of the programs, and shall contain supporting data and
16 justifications.

17 (b) Within the process of preparation and review of budget
18 submissions, the requests of the deans, directors and department
19 heads and the actions of community college campus presidents and chan-
20 cellors shall be clearly delineated to the members of the Board of
21 Regents.

22 (c) Recommendations of the Board of Regents shall be delineated
23 and documented in the budget prepared and forwarded to the governor in
24 accordance with AS 37.07.050. Copies of the original request from the
25 campus presidents and chancellors, together with the record of all
26 requests, changes and recommendations, shall be forwarded by the presi-
27 dent of the university to the governor and the legislature.

28 (d) The budget submission for the Board of Regents and for state-
29 wide functions and purposes shall be prepared by the president and

1 provided to the Board of Regents for its review. The budget submission
2 shall be transmitted to the governor in accordance with AS 37.07.050.

3 (e) Appropriations to the statewide university system shall specify
4 the amount appropriated to each campus designated in sec. 11(b)(1) - (3)
5 of this chapter and to each community college within the community col-
6 lege division. There shall be no transfers of funds between or among
7 the campuses designated in sec. 11(b)(1) - (3) of this section, between
8 any of those campuses and the community college division, or between
9 community colleges within the community college division. Transfers
10 between allocations for a campus may be made by the chancellor, and
11 transfers between allocations for a community college may be made by
12 the president of the community college. Transfers between allocations
13 shall be reported to the president of the university, the Board of
14 Regents, the division of budget and management in the Office of the
15 Governor, and the Legislative Budget and Audit Committee.

16 * Sec. 14. AS 14.40.440 is amended to read:

17 Sec. 14.40.440. UNIVERSITY DESIGNATED BENEFICIARY OF SMITH-LEVER
18 ACT AND EMPOWERED TO CARRY ON AGRICULTURAL EXTENSION WORK. The Univer-
19 sity of Alaska is designated as the beneficiary under the provisions of
20 the Smith-Lever Act, and may administer and carry on agricultural ex-
21 tension work in the state in cooperation with the United States Depart-
22 ment of Agriculture at the university campus in Fairbanks.

23 * Sec. 15. ASSISTANCE OF ALASKA POSTSECONDARY EDUCATION COMMISSION. The
24 Alaska Postsecondary Education Commission is directed to initiate a study to
25 develop, in cooperation with the community college division chancellor and
26 the presidents of the community colleges, a plan for financial support for
27 community colleges comparable in principle to the method of providing finan-
28 cial support for elementary and secondary education. The study and plan
29 developed shall be reviewed by the Board of Regents and forwarded to the

1 division of budget and management, Office of the Governor, and the Legislative
2 Budget and Audit Committee not later than December 1, 1978.

3 * Sec. 16. TRANSITIONAL MEASURES. (a) Except as provided in AS 14.40.-
4 020, amended by sec. 4 of this Act, in AS 14.40.100, amended by sec. 5 of
5 this Act, and AS 14.40.440, amended in sec. 14 of this Act, institutes,
6 centers or activities which are under the jurisdiction of a particular campus
7 or the jurisdiction of the division of community colleges shall continue under
8 the respective jurisdiction until changed or altered by action of the Board
9 of Regents.

10 (b) Personnel and financial services, including responsibility for campus
11 administration set out in AS 14.40.272 - 14.40.276, added by sec. 13 of this
12 Act, and fiscal procedures, set out in AS 14.40.315, added by sec. 14 of this
13 Act, shall be decentralized not later than July 1, 1979. To achieve a re-
14 sponsible transition, exceptions to the requirements imposed by AS 14.40.-
15 272 - 14.40.276 and AS 14.40.315 may be made upon specific authorization by
16 the Board of Regents and approval by the Legislative Budget and Audit Com-
17 mittee.

18 * Sec. 17. AS 14.40.560 - 14.40.640 are repealed. Community colleges
19 in existence on the effective date of this section shall continue, and all
20 agreements between a unit of a community college and a school district or
21 political subdivision entered into under authority of AS 14.40.570 - 14.40.-
22 580, repealed by this section, shall continue in force until the expiration
23 date provided in the agreement or until mutually cancelled.

24 * Sec. 18. AS 14.40.010 is repealed.

25 * Sec. 19. Section 3 of this Act takes effect July 1, 1980. Sections 1,
26 2, and 4 - 18 of this Act take effect July 1, 1978.

RESOLUTION

from the

STAFF AFFAIRS AND THE ADMINISTRATIVE COMMITTEES

of the

FAIRBANKS ASSEMBLY

UNIVERSITY OF ALASKA, FAIRBANKS



John Morack, President
Fairbanks Assembly

19 April 1978

The staff, students, and faculty of the University of Alaska at Fairbanks wish at this time to express their concern about the many bills relative to the University which the Alaska Legislature is currently considering. We are disturbed that the Alaska Legislature has entered the internal affairs of the University as a result of an administrative malfunction. While well-meaning, such action threatens to destroy the constitutionally established autonomy of the University.

The University has had serious problems in the last few years in its fiscal operation, institutional planning, and decision-making. While these problems have not yet been entirely eliminated, there has been significant improvement in most areas. The fiscal operations have greatly improved in the last few months. Status reports are current and accurate, the few remaining payroll problems are minor, and the administration is seeking solutions for the cash flow problems.

The preparation of the budget has long been a most unsatisfactory process for all units of the University. Under past procedures, the central administration has taken all budget requests and synthesized them into a consolidated budget for presentation to the Regents. In many cases, local priorities are not reflected in the consolidated budget. However, the Board is currently setting up procedures for each unit to present its own budget request directly to the Board.

The Board of Regents is presently responsible for the establishment and monitoring of policy and long-range planning. We feel that the statewide perspective that the Board provides is a useful and necessary ingredient of the statewide higher educational system. We, on the Fairbanks Campus, are deeply concerned that the proposed solution to the problems which exist primarily in Anchorage and Juneau will have statewide ramifications that will be detrimental to the Fairbanks Campus. Organizational change should not be legislated, but should be determined by the Board of Regents to insure the best, most efficient, and flexible delivery of the educational programs at each campus.

Perhaps the most serious concern of the Fairbanks faculty, staff and students is an attempt to withdraw budgetary control from the Board of Regents. This could have a disastrous effect on University accreditation. The Northwest Association

is one of the six regional associations which accredits institutions of higher learning. In its most recent handbook on accreditation, the following statements regarding external budget control are given:

The governing board of an institution must control the institution's budget, which is the expression of the institution's plans in financial terms. Unless the governing board has control of the budget it cannot complete its planning function or ensure the implementation of its plans.

When an institution depends for its support on an external agency--state, church, or other public or private agency--the external agency will determine the amount of support it will provide and may appropriately indicate in broad terms the categories for which support is provided and the amounts. The external agency should not, through line items control or other means, determine in detail how the funds are to be spent. This is a function of the governing board and the institution's officers.

Once funds have been allocated, the normal expectation should be that the amount of funds will not be reduced. If subsequent developments necessitate reduction of the allocation, the governing board and the institution's officers should determine how and where the reductions are to be made.

If an external agency has a responsibility for pre-auditing or post-auditing it should check only on such matters as arithmetic accuracy, authenticity of signatures, consistency with the provisions of the budget, and legality; it should not question the appropriateness of a particular expenditure.¹

In summary, the University has made substantial progress in solving its problems. The House is now considering legislation that adds to rather than resolves the remaining problems. Passage of these bills will promote uncontrolled growth, threaten accreditation, and jeopardize planning and coordination. The governance and financial responsibilities of the University of Alaska must remain with the Board of Regents.

¹Accreditation Handbook; Northwest Association of Schools and Colleges, Commission on Colleges, 1977 Edition, p. 75.

FAIRBANKS FACULTY ASSOCIATION

at the University of Alaska
P.O. Box 80082, Fairbanks 99708

April 20, 1978

The Honorable Steve Cowper, Chairman, and
Members of the House Finance Committee
Alaska State House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Cowper:

The Fairbanks Faculty Association was established in 1972 to provide a forum to faculty members for the open discussion of problems affecting the performance of their educational functions and for the development of solutions to those problems; to preserve and strengthen an atmosphere of free inquiry and expression which is essential to academic excellence; to further communication and understanding among faculty, students, and administration; to study and promote improvements in faculty status; to represent faculty interests and responsibilities in policy making and budgeting for the University; to provide information to the people of Alaska and their governing officials on the goals, problems, and needs of the University and its faculty; and to cooperate with the University Assembly and other university groups to accomplish our common purpose.

The Fairbanks Faculty Association's Board of Directors strongly opposes the direct legislative influence over the management and financial operation of the University of Alaska System which is outlined in HB 410, 415, 493, and, particularly, 891. We recognize that past inadequacies in competence and leadership have diminished confidence that the statewide administration and the Board of Regents can institute the necessary controls to assure satisfactory oversight of the University's affairs. We share the frustration of the public and the Legislature with the unrealized expectations for the development and delivery of quality educational opportunities at the university level on the campuses and across the State. We have experienced the demoralizing effects of budget uncertainties and restrictions brought about by an inadequate accounting/management system and a new computer. However, we do not believe that the solution to these problems necessarily lies with the decentralization of the University of Alaska System, nor with removal of the decisions regarding budget allocations from the Board of Regents to the Legislature.

Those who believe that the Legislature will act with more responsibility than the Board of Regents for the best interests of higher education in the State of Alaska have a short memory. Even with the restricted authority of the past, legislative committees have responded to political pressures in impelling the establishment of community colleges, programs, and capital expenditures which were not considered high priorities by those responsible for the governance of the University of Alaska System, the Board of Regents. Rarely were the added costs of these endeavors adequately funded. More often, their added expenses further eroded the programs already offered by the University. It is essential that a university be insulated from political guidance if the integrity of its programs and academic freedom are to be adequately protected.

The Constitution of the State of Alaska requires that the University of Alaska shall be governed by a Board of Regents and that the regents shall, in accordance with law, formulate policy. Control of the budget can determine the policies and development of the University of Alaska perhaps more than any other single factor. Freeing "the Board of Regents to fulfill the governance functions which it alone can perform: the establishment and monitoring of policy and long range planning" is an empty promise if the Board of Regents loses the power to control the University's budget. Furthermore, the loss of budgetary control might seriously jeopardize the University's accreditation which requires that "The governing board of an institution must control the institution's budget, which is the expression of the institution's plans in financial terms." Loss of accreditation would have disastrous consequences for the University of Alaska, its faculties and students, and the public of the State of Alaska.

We believe that the administration and the Board of Regents have already made significant changes in the financial/management structure of the University and should be given every opportunity to evolve the best system of higher education attainable within the total budget allocation provided by the State of Alaska. The payroll system is working, accounts are being brought up to date, and the deficits are being identified and controlled. While commending their progress so far, and expressing a desire to give these structural changes the authority of law, it should be emphasized that the system is still not perfect. Had the previous structures been given the status of law, we would have found our present reforms even more difficult, if not impossible. The University has continuously been changing. Vice Presidential positions have come and gone. Community colleges have been affiliated with senior colleges and then not. Within the campuses, colleges have been reshuffled, contracted, and expanded. Many years of considerable and thoughtful effort have provided the system now in effect and it would seem that a pause to evaluate where we are and in what direction we should be going is now appropriate.

The Board of Regents must establish clear program and policy goals for the University of Alaska System which will set university priorities for future planning and development. A political climate favorable to attract and retain competent administrators must become a reality. The problems are recognized and attempts to solve them are underway. We believe that the proposed legislation before the House of Representatives is inappropriate for the long term best interests of the University of Alaska System of higher education and urge that it not be enacted.

Sincerely Yours,

G. Warren Smith, Presiding Officer
Fairbanks Faculty Association

GWS:db

cc: F. Diebold
H. Fate

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 15, 1978

SUBJECT: University of Alaska Budget Submission

TO: Representative Charles H. Parr
Chairman, House HESS Committee

FROM: Billy G. Berrier
Director
Division of Legal Services

You have asked whether requiring that budgets of components of the University of Alaska be submitted directly to the legislature by that component and restricting the power of the Board of Regents to commenting on or making recommendations concerning the budgets of the components would pose constitutional problems.

The question arises under Secs. 2 and 3 of Art. VII of the constitution which provide:

"Section 2. The University of Alaska is hereby established as the state university and constituted a body corporate. It shall have title to all real and personal property now or hereafter set aside for or conveyed to it. Its property shall be administered and disposed of according to law.

Section 3. The University of Alaska shall be governed by a board of regents. The regents shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session. The board shall, in accordance with law, formulate policy and appoint the president of the university. He shall be the executive officer of the board."

Since a constitution must be read as a whole under well established rules of construction, these sections must be read in conjunction with Sec. 1 of Art. II which provides:

"Section 1. The legislative power of the State is vested in a legislature consisting of a senate with a membership of twenty and a house of representatives with a membership of forty."

and with Secs. 12 and 13 of Art. IX which provide:

"Section 12. The governor shall submit to the legislature, at a time fixed by law, a budget for the next fiscal year setting forth all proposed expenditures and anticipated income of all departments, offices, and agencies of the State. The governor, at the same time, shall submit a general appropriation bill to authorize the proposed expenditures, and a bill or bills covering recommendations in the budget for new or additional revenues.

Section 13. No money shall be withdrawn from the treasury except in accordance with appropriations made by law. No obligation for the payment of money shall be incurred except as authorized by law. Unobligated appropriations outstanding at the end of the period of time specified by law shall be void."

From the proceedings of the constitutional convention only two clear areas of university autonomy emerge. The university may not be dissolved by the legislature and it may not be placed in the executive branch with a single executive at its head. The requirements of approval by the governor of the principal executive officer of an agency headed by a board of commissioners does not apply to the university. There is also some autonomy in the private gift or donation area but the extent of that autonomy is less clear.

The original proposal dealing with the university was made as part of Committee Proposal No. 12 by the Committee on the executive branch. The proposal as adopted by the delegates as part of Proposal 12 read:

"Section 6. The University of Alaska is hereby established as the state university and constituted as a body corporate. It shall have title to all the real and personal property now or hereafter set aside for or conveyed to it, to be administered and disposed of according to law. There shall be a board of regents of the University of Alaska, the members of which shall be

nominated and appointed by the Governor, by and with the advice and consent of a majority of the members of both houses of the Legislature in joint session. The Board shall have power, in accordance with law, to formulate policy, and to appoint the President of the University, who shall be its executive officer."

This adopted proposal was referred to the Style and Drafting Committee. The Convention rules gave that Committee general responsibility for language, form and consistency only. The existing constitutional language first appears in Committee Proposal 16 of the Style and Drafting Committee as sections 12 and 13 of that report. There is no indication that substantial change was intended.

Delegate Victor Fisher of the Style and Drafting Committee made a summary of Committee Proposal 16 for the delegates. He stated:

"If you would like me to, I can just run through quickly and advise the members where the various sections come from. ...Section 12 comes from 6, Section 13 comes from 6..." (Proceeding of the Constitutional Convention page 3655)

The first sentence of Sec. 3 of Art. VII may be read more than one way. It may be read to confer a degree of autonomy on the regents by carving out an area of "governing" the university distinct from "formulating policy" not subject to the limitation "in accordance with law." It may also be read only as establishing the board of regents as the executive head of the university.

The constitutional status of the board of regents would prevent establishing a single executive as head of the university.

The second reading is supported by the convention proceedings.

Section 2 of Art. VII is the first two sentences of Sec. 6 of Proposal 12. The last two sentences of Sec. 3 are the last sentence of Sec. 6. Both have changes in grammar but are identical in substance.

The third sentence of Sec. 6 reads:

"There shall be a board of regents of the University of Alaska, the members of which shall be nominated and appointed by the Governor, by and with the advice and consent of a majority of the members of both houses of the legislature in joint session."

The first two sentences of Sec. 3 of Art. VII read:

"The University of Alaska shall be governed by a board of regents. The regents shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session."

In context it appears this is also intended to be identical in substance with improvement in grammar. There is no indication that any additional grant of autonomy was intended or made.

Cases from other jurisdictions are helpful in determining the scope of autonomy but constitutional provisions vary considerably so that precedent from other states must be considered in the light of the constitution of the state compared with the Alaska constitution. There is no case law in Alaska directly on point.

In 1975, in a case not on point but involving university status, our court had occasion to examine the relationship of the university to the state. The discussion in University of Alaska v. National Aircraft Leasing Ltd. (536 P.2d 121, Alaska 1975) is germane enough that a quotation at some length is justified. The court stated:

"By constitutional provision, the University as a corporate entity holds title to all property which is conveyed or set aside to it. The disposition and administration of such property, however, is made expressly subject to a degree of legislative control. The board of regents is empowered by the constitution to "govern" the university. Nevertheless, it is obliged to formulate policy as well as appoint its chief executive "in accordance with law." The regents, moreover, hold office by virtue of the approval of both the governor and both houses of the legislature.

Through legislative enactments, the University enjoys a considerable degree of statutory independence.

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But the University is also subject to some executive and legislative control. As mentioned, the constitution provides that the regents of the University shall be appointed by the governor, subject to confirmation by the legislature. Furthermore, as has been pointed out, the formulation of university policy as well as the administration and disposition of University property are made subject to legislative enactment.

We reach this conclusion not only from article VII of the constitution, which we construe to be the expression of the will of the people of this state that there shall be an institution of higher learning within the scope of the constitutional mandate providing for public education, but also from the degree of control over the affairs of the University which is exercised by the executive and legislative branches of our government, and from the financial dependence the University has upon the state.

The Montana constitution grants broader power to the board of regents than our constitution. It provides in Sec. 9(2)(a) of Art. 10:

"The government and control of the Montana university system is vested in a board of regents of higher education which shall have full power, responsibility, and authority to supervise, coordinate, manage, and control the Montana university system..."

The Montana Supreme Court in Board of Regents of Higher Education v. Judge (543 P.2d 1323) after holding the constitution must be read as a whole without undue emphasis to the particular section dealing with the university and after examination of the cases uniformly cited as supporting the theory of university autonomy (including the California, Michigan, and Minnesota cases) stated that:

"Regent autonomy has not been asserted over the bare legislative power to appropriate in the above instances. That power, by implication in these cases and expressly in others cited by the Regents, is secure even in Michigan with its strong constitutional provision and long judicial recognition of autonomy of the regents.

We recognize here that while Montana's Constitution is not as explicit or broad as that of Michigan, the principle of regent independence was definitely intended by the drafters of the 1972 Montana Constitution. At the same time, just as in Michigan, legislative control of higher education through the appropriation process remains. The Regents are a constitutional body in Montana government subject to the power to appropriate and the public policy of this state."

but added a caveat in stating:

"However, the legislature cannot do indirectly through the means of line item appropriations and conditions what is impermissible for it to do directly. Line item appropriations become constitutionally impermissible when the authority of the Regents to supervise, coordinate, manage, and control the university system is infringed by legislative control over expenditures..."

The Michigan constitution is very much broader in its grant providing in Sec. 5 of Art. VIII:

"Sec. 5. The regents of the University of Michigan and their successors in office shall constitute a body corporate known as the Regents of the University of Michigan; the trustees of Michigan State University; the governors of Wayne State University and their successors in office shall constitute a body corporate known as the Board of Governors of Wayne State University. Each board shall have general supervision of its institution and the control and direction of all expenditures from the institution's funds..." (Emphasis added.)

There are numerous cases in Michigan on the relationship between the board of regents and the legislature. The question of the degree of control was before the Michigan Court of Appeals in Regents of University of Michigan v. State, 208 N.W. 2d 871, in a case challenging the constitutionality of certain conditions placed on 1971 appropriations to the university. The court held the conditions unconstitutional after finding the legislature was attempting to "determine who shall teach and who shall not, who shall learn and who shall not" under the guise of conditions on appropriations. The court however went on to state on page 877:

"While it must be recognized that the legislature's power to make appropriations to a constitutional university does not include and is separate from the power to control the affairs of such a university, the legislature can within reason attach conditions to its university appropriations. If a constitutional university accepts such conditioned funds, it is then bound by the conditions. There are not many decisions in this area, however, so the line between conditions the legislature can validly attach and those it cannot has not been drawn in a distinct fashion. Conditions which require the university to follow prescribed business and accounting procedures have generally been found to be valid. The courts have also sustained conditions which required, on penalty of losing part of the appropriation, annual reports to the governor, and fair and equitable distribution of an appropriation among the departments of the university of maintenance of university departments. It has also been held that the legislature can properly make non-teaching employees subject to the state's workmen's compensation law, and can require loyalty oaths by the teachers. On the other side of the line, a condition that the university move a certain department of the school has been held to be invalidly attached, an attempt to limit the amount of funds that can be spent for a given department is likewise an invalid condition. It is clear that limits should be placed on the use of the conditioned appropriation, for without such limits the legislature could use the conditioned appropriation to strip the university of its constitutional authority." (Emphasis supplied.)

Although it is difficult to determine whether the holding in this case is good law today in Michigan since the Michigan Supreme Court refused to decide the legislature-regents questions on ground of mootness and abstention in Regents of University of Michigan v. State, 235 N.W. 2d 1 (Mich. 1975) the decision appears in line with earlier Michigan cases.

The California cases which extend regent autonomy well beyond the bounds of the cases are not applicable since legislative involvement is expressly limited in Sec. 9 of Art. IV of the California Constitution which provides:

"Sec. 9. (a) The University of California shall constitute a public trust, to be administered by the existing corporation known as "The Regents of the University of California," with full powers of organization and government, subject only to such legislative control as may be necessary to insure compliance with the terms of the endowments of the university and the security of its funds...."

Our court has recognized that the constitutional limitations placed upon the independence of the university are significant. Therefore cases such as Regents v. University of Michigan v. State of Michigan (208 N.W. 2d 871) which held that regent autonomy prevailed over legislative appropriation in the instance before it are not authority for the proposition that under the Alaska Constitution the University of Alaska is not subject to control of the legislature in fiscal matters. Since that case involved an appropriation designed to attain an end not within control of the legislature, that is, control of who shall teach and who shall learn, it is extremely questionable authority even in Michigan for the general proposition of fiscal autonomy of the university.

It is my opinion, since the control over appropriations is clearly vested in the legislature by the constitution, that the constitution requires the budget to set forth all proposed expenditures and anticipated income of all departments, agencies, and offices of the state (Sec. 12, Art. IX), that the University is part of the state, (University of Alaska v. National Aircraft Leasing, supra) and the constitution provides in Sec. 13, Art. IX that "No money shall be withdrawn from the treasury except in accordance with appropriations made by law," and the university is not exempted from legislative control in the fiscal area, that the university is subject to legislative control in the areas of budgeting and accounting to the same extent as other agencies of the state government.

This control encompasses provision for the form of the budget and method of submission. The university is explicitly subject to the Executive Budget Act. (AS 37.07.-120(1)) Under that law original requests by departments and agencies are included in the material submitted to the legislature. Presumably the original request of each component would be likewise submitted as part of the university submission under current law.

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For reasons discussed earlier, it is doubtful that there is an area of regent autonomy extending beyond continuation of the board as the head of the university. Assuming autonomy, it could be argued that control of budget submission is an essential tool in governing the university and therefore placing fiscal authority over what will appear in the submitted budget in other than the board of regents is an impermissible infringement on their power to govern. In effect the components would become fiscally independent and therefore in large measure operationally independent.

This argument does not appear sound. There is clear authority for the legislature to adopt line item appropriations in the university budget. By law transfer may not be made among appropriations solely by the board of regents. The effect of the change in submittal would appear to have little operative difference in the governing of the university. Its major significance is the information given to the legislature for its use in the process of formulating the budget and appropriations.

It is, therefore, my opinion that the procedure in your question is constitutional. In the absence of a decision by our supreme court, however, a certain uncertainty exists.

BGB:jpd

Takeover in Nebraska?

Unicameral legislature could get direct coordinating control over public higher education under a proposal now before it; estimates of the impact on colleges and universities vary

By ROBERT L. JACOBSON

LINCOLN, NEB.

For nearly three years, leaders of Nebraska's unicameral legislature have been working toward enactment of a controversial proposal to give them direct coordinating control of public higher education in the state.

If adopted, the plan would amount to a unique assertion of legislative authority over academic programming—a step seemingly unparalleled even in this era of growing state-government involvement in college and university affairs. It would be put into effect through a statute incorporating distinct "role and mission" statements for each campus.

"This is action which only the legislature can take," declares a background statement on the plan.

A major goal is to prevent Nebraska's institutions from engaging in "unnecessary" duplication. Only programs specifically authorized by the act would be eligible for state tax-fund appropriations and, in the case of community colleges, for funds generated by local taxes levied under state law.

A companion measure would establish a

thing," says an administrator in higher education. "There's no way the legislature can mandate the university to do any specific thing."

In any event, by most accounts the process of developing the bill itself has been extremely elaborate, time-consuming, and expensive. Dozens of college and university officials across the state became involved over the months as they were called on to provide new statements of campus goals and priorities, along with substantial supporting data. Although no one seems to know for certain how much money was spent by the institutions, estimates of the total cost range from a half million to several million dollars.

The process also has been described as highly charged politically, with various institutions jockeying behind the scenes over specific provisions of the plans, especially the one on coordination. Yet, for all the interest and maneuvering, it is not clear which side—if any—may have gained the upper hand.

Its Own Coordinating Board

The basic proposition of the coordination plan is that Nebraska's 49-member

that certain programs were solely the province of a campus at Lincoln or Omaha was amended to assign "primary" roles.

Still, the bill as a whole seems to provide for unusually far-reaching legislative influence in higher education, telling the campuses in many instances what programs they may and may not offer with state financial support.

A case in point is a section limiting new master's programs at the state colleges to education. Another section would direct the Metropolitan Technical Community College Area in Omaha to discontinue general academic transfer programs after Sept. 1, 1980.

In addition, all of the community colleges apparently would be limited in their academic offerings to courses deemed "necessary to support vocational-technical and occupational programs."

While many other legislatures have been increasing their fiscal oversight of academic institutions, observers note, so far none has voted to assume for itself—as Nebraska's would—the principal coordinating role over program operations.

As a rule, that responsibility is delegated to a separate statewide governing board

proposing could still be done through the appropriations process," he says.

Some campus leaders agree that that is where the power really lies. The coordination bill cannot be termed a "takeover" attempt by the legislature, says one state-college official, because "you can't really take over that which you already have."

Others, however, see an opposite tendency evolving from last year's Supreme Court ruling.

According to the state constitution, said the court, the University of Nebraska's elected board of regents is "an independent body charged with the power and responsibility to manage and operate the university as free from political influence and control as possible." The court said the legislature could not use an appropriations bill to "usurp" the regents' authority or pass a law "so detailed and specific" that it eliminated all their discretion.

Autonomy Said Illusory

Despite such language, a number of observers said at the time that true university autonomy was illusory because the legislature would continue to control state tax appropriations—about 40 per cent of

tions of higher education. In theory, at least, it would enable lawmakers to impose their own expectations on the collection of vital statistics from and about the institutions each year. The system would become the principal basis for "state-level planning, budgeting, and performance evaluation" for the campuses.

Higher Education in Limbo

Last week, however, as both plans were awaiting final action at the capitol here, a number of important questions about them remained unresolved. The result was to leave the future direction of higher-education governance in Nebraska in limbo.

Legislative sources disagreed over the coordination bill's prospects. It was said to have enough backing for passage, but time constraints in the waning days of the session plus untold political factors produced conflicting forecasts of the outcome. Although the proposed information system was given better chances, both bills were facing potential vetos by Governor J. James Exon if they did pass.

Even assuming the bill's survival, recent interviews with state and campus sources have produced varying estimates of the plan's ultimate effects.

According to some observers, the plans will accomplish pretty much what their sponsors set out to do. But others doubt they will appreciably alter the basic relationship between the legislature and the institutions.

One high state official foresees major constitutional obstacles to the coordination bill. He cites a ruling by the state Supreme Court last summer that strongly supported autonomy for the University of Nebraska and—by implication—for the state's four public colleges. Moreover, this official contends, from a practical standpoint the coordination bill may prove unenforceable because institutions would still be free to use tuition funds and other non-tax revenue to support activities excluded by the proposed legislation.

"There's no way to implement the dam-

for higher education. Through its committee on performance and audit review, as well as its staff of legislative and fiscal analysts, the legislature would monitor the institutions to be sure they were living up to the plan's specifications. For example, under the bill:

► The University of Nebraska would have "sole responsibility for all graduate programs at the specialist's and master's-degree level."

► The state colleges would be prohibited after Sept. 1, 1980, from "independently" awarding associate degrees, diplomas, or vocational certificates.

► The state's six technical community-college districts would be the only ones authorized in most fields to award associate degrees, diplomas, and certificates.

Campus officials note that a number of its more controversial aspects have been softened by amendments.

A prospective ban on a master's program in business administration at Kearney State College was amended so the program could be offered in cooperation with the university. Similarly, a requirement that "non-degree recreational and avocational programs" be self-supporting was changed to exempt the university's cooperative extension service.

The university also prevailed in a claim that some early language in the bill intruded in its "internal administrative structures and units." Thus a provision suggesting

often cited for such an approach is that it shields the campuses from undue political interference.

But in Nebraska there is a contrary view—that the environment for campus relations with the legislature is so obviously political that there is little point in pretending otherwise.

Unicameral Legislature

"The existence of an independent [coordinating] commission does not necessarily mean that political manipulation has been reduced; it would just be less visible," says State Sen. Jerome Warner, chairman of the legislature's appropriations committee and a major force behind the coordination plan.

Moreover, he says, the risk of "politicization" is lower in Nebraska than in other states because of its non-partisan, unicameral legislature, the only one in the country.

The chairman, regarded in some quarters as the state's most powerful politician, says he hopes the coordination plan also will help the legislature use its "clout" more responsibly. With a "formalized process" for its involvement, he says, the institutions will be able to see clearly how decisions are being made.

But even Mr. Warner conceded that enactment of the statute might not be essential to achieving those goals. If the bill were to die, "much of what we're

it was said, would be quickly countered by the legislature's power of the purse.

Indeed, in the weeks immediately following the court decision, many university leaders took pains to emphasize a cooperative attitude toward the legislature.

But just as the effect of the court ruling was tempered by such concerns, some people here now think there may also be a limit to what the legislature can do to control academic programs. They point, for example, to the latest campus appropriations bill, which revealed a shift away from previous attempts to specify how the university and the state colleges should allocate their funds.

It remains to be seen whether the coordination bill can effectively stop those institutions from pursuing any activities they choose to finance with non-state revenue. Even with the bill's references to academic programs, says a top university official, it contains "very little, if anything, [that] speaks to the internal management of the university. It does not seem to be directive or prescriptive."

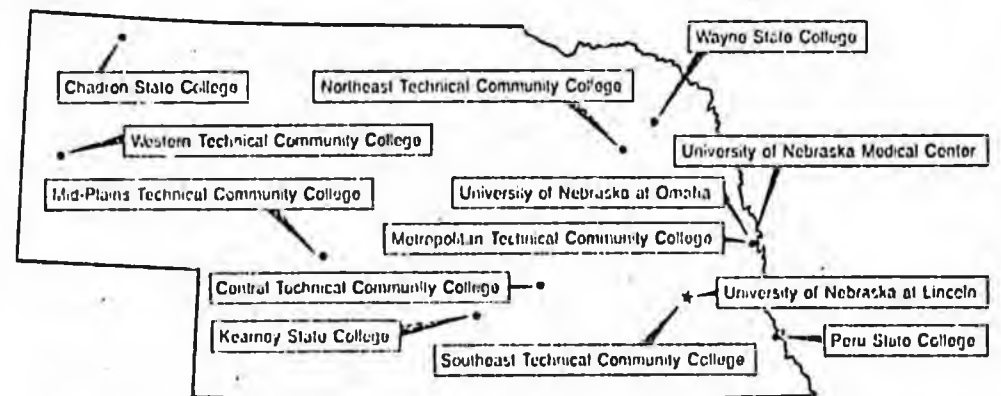
With all the uncertainty over the coordination bill, legislative and campus interest has turned increasingly in recent weeks to the plan for a uniform information system. One of its declared aims is to insure that the institutions provide "timely and accurate information concerning [their] programs, personnel, students, finances, and facilities."

Significantly, the plan is seen by the Nebraska Coordinating Commission for Postsecondary Education as a grave threat to its future. Established two years ago with authority to "develop and implement" an information system itself, the 12-member agency has since witnessed the erosion of its potential role.

The current bill fails even to acknowledge that a blueprint for such a plan already exists, having been drafted by the coordinating commission last summer at the legislature's request.

The commission has called for rejection

Continued on Page 4, Column 1



CHRONICLE MAP BY SUSAN W. BROWN

Nebraska Continued from Page 3

of the pending bill. It warns in a resolution that the plan would "in effect shift responsibility for coordination of postsecondary education from the commission to the staff of the legislature."

Nevertheless, an outside planning expert who consulted with the Nebraska legislature about the commission's own plan wonders if the legislature's version would "make that much difference" to the institutions.

The consultant, John K. Folger of the Education Commission of the States, says the telling point is not what the lawmakers have proposed in the bill, but "what they intend to do with the [campus] information after they collect it."

Realities Illuminated

Regardless of the end results of the proposals on both information-gathering and coordination, the give and take between the institutions and the legislature lately has illuminated several realities about Nebraska's higher-education scene:

► The University of Nebraska, by virtue of its greater size, more strategic locations (Lincoln and Omaha), and political connections, is better able to withstand legislative pressure than either the state colleges or the community colleges.

► The state colleges, by the same token, feel relatively vulnerable to legislative direction. They have the smallest enrollment total of all three sectors, and statewide projections give them the smallest increases over the next 20 years. Nearly 60 per cent of their budgets come from state appropriations. And, unlike the university, they are not located in major population centers.

The state colleges have been reluctant to challenge the legislature too strongly. They have declined to seek a court ruling on their own constitutional autonomy, and in their public testimony they have been careful to emphasize a positive relationship with the legislature. But they fear being squeezed out by the university

on one side and the fast-growing community colleges on the other. "We just don't think we ought to be legislated out of existence," says one state-college official.

► The community colleges probably are most subject to legislative influence because their governing boards derive their authority from state law rather than the constitution. And while about 37 per cent of their funds come from a local tax base, the largest amount—44 per cent—comes from state appropriations.

In addition, community-college sources say their own expanding enrollments (nearly 84,000 now, compared with about 96,000 at the university and 20,600 at the state colleges) have caused the senior institutions to encourage lawmakers to "limit the role" of the two-year colleges in academic areas.

The community colleges also have been troubled by legislative efforts, unsuccessful so far, to place them under a statewide governing board. They favor an independent statewide commission with authority to coordinate the activities of the various institutions.

A Personal Dimension

Another dimension of Nebraska's governance controversy is more personal. Relations between academic representatives and the legislative staff are described as strained. It is even rumored that some campus officials have grown so distrustful of a particular legislative aide that they have taken to tape-recording telephone conversations with him.

Says one troubled administrator: "Every time I've played it straight, I've been kicked in the face."

According to William S. Fuller, executive director of the coordinating commission, the proposal for legislative coordination has ended up "unifying the institutions against the legislature," whereas previously the plan produced "some real divisions" between the different sectors of higher education.

Principal Figure in Is Still Waiting for Institute and 2 colleges were fi

By LARRY VAN DYNE
WHEATON, ILL.

Harry A. Lowther, Jr., sits today in a county jail in this Chicago suburb still awaiting trial, more than two years after his indictment in a scandal that brought financial ruin to the nationally known Institute for Educational Development as well as to two small colleges.

Meanwhile, negotiations are under way between his lawyer and the state prosecutor, in an effort to bring the complicated case to a conclusion, perhaps without a trial.

The scandal received considerable attention in January, 1975, as newspaper reporters and investigators in the office of the Illinois attorney general began unraveling the skein of events that had brought Mr. Lowther, a convicted stock manipulator, into intimate financial relations with several institutions in and around American higher education.

Ties with ETS

Best known was the Institute for Educational Development, a New York-based consulting organization with close legal, financial, and governance connections to Educational Testing Service, the Princeton, N. J., corporation that develops and administers college entrance examinations.

The I.E.D. trustees, who were drawn from the E.T.S. board, agreed in 1973 to give a major role in the institute's affairs to Mr. Lowther, who presented himself and his wife, Barbara, as officials of a small suburban Chicago foun-

datation willing to help the organization with its financial problems. Unknown to the trustees at the time, the foundation, which called the Phillips Reese Foundation, had few resources and Mr. Lowther was on probation from two federal convictions for stock manipulation.

Bad Checks

The upshot of the arrangement was a financial tangle in which Mr. Lowther allegedly issued a number of bad checks drained so many assets from I.E.D. that it quickly slid into bankruptcy and was forced shut down. The episode also embarrassed the I.E.D. board, composed of several leading educators, and its chief officer, Samuel Gould, a former chancellor of State University of New York who then was a leading advocate of "non-traditional" education.

Also drawn into the scandal was Lincoln Open University, then a new, private institution with plans to offer non-traditional, off-campus education to non-adults from a headquarters in suburban Chicago. The institution, presented by the DuSable Country grand jury here in January, 1976, specifically charged Mr. Lowther with stealing more than \$160,000 from the college, much of which had originated through a grant from the Lilly Endowment of Indianapolis. Lincoln Open University is no longer in operation.

Another small, financially troubled institution, Prescott College in Arizona, was the first to

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Aetna	216.00	352.00	814.00
Connecticut General	223.00	378.50	816.50
Equitable	187.00	343.50	754.00
John Hancock	200.50	344.00	750.00
Massachusetts Mutual	196.00	337.50	737.00
Metropolitan	188.50	347.00	779.50
New York Life	189.00	337.50	751.00

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 15, 1978

SUBJECT: University of Alaska Budget Submission

TO: Representative Charles H. Parr
Chairman, House HESS Committee

FROM: Billy G. Berrier
Director
Division of Legal Services

You have asked whether requiring that budgets of components of the University of Alaska be submitted directly to the legislature by that component and restricting the power of the Board of Regents to commenting on or making recommendations concerning the budgets of the components would pose constitutional problems.

The question arises under Secs. 2 and 3 of Art. VII of the constitution which provide:

"Section 2. The University of Alaska is hereby established as the state university and constituted a body corporate. It shall have title to all real and personal property now or hereafter set aside for or conveyed to it. Its property shall be administered and disposed of according to law.

Section 3. The University of Alaska shall be governed by a board of regents. The regents shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session. The board shall, in accordance with law, formulate policy and appoint the president of the university. He shall be the executive officer of the board."

Since a constitution must be read as a whole under well established rules of construction, these sections must be read in conjunction with Sec. 1 of Art. II which provides:

Representative Charles H. Parr
Page 2
March 15, 1978

"Section 1. The legislative power of the State is vested in a legislature consisting of a senate with a membership of twenty and a house of representatives with a membership of forty."

and with Secs. 12 and 13 of Art. IX which provide:

"Section 12. The governor shall submit to the legislature, at a time fixed by law, a budget for the next fiscal year setting forth all proposed expenditures and anticipated income of all departments, offices, and agencies of the State. The governor, at the same time, shall submit a general appropriation bill to authorize the proposed expenditures and a bill or bills covering recommendations in the budget for new or additional revenues.

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"If you would like me to, I can just run through quickly and advise the members where the various sections come from. ...Section 12 comes from 6, Section 13 comes from 6..." (Proceeding of the Constitutional Convention page 3655)

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The first two sentences of Sec. 3 of Art. VII read:

"The University of Alaska shall be governed by a board of regents. The regents shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session."

In context it appears this is also intended to be identical in substance with improvement in grammar. There is no indication that any additional grant of autonomy was intended or made.

Cases from other jurisdictions are helpful in determining the scope of autonomy but constitutional provisions vary considerably so that precedent from other states must be considered in the light of the constitution of the state compared with the Alaska constitution. There is no case law in Alaska directly on point.

In 1975, in a case not on point but involving university status, our court had occasion to examine the relationship of the university to the state. The discussion in University of Alaska v. National Aircraft Leasing Ltd. (536 P.2d 121, Alaska 1975) is germane enough that a quotation at some length is justified. The court stated:

"By constitutional provision, the University as a corporate entity holds title to all property which is conveyed or set aside to it. The disposition and administration of such property, however, is made expressly subject to a degree of legislative control. The board of regents is empowered by the constitution to "govern" the university. Nevertheless, it is obliged to formulate policy as well as appoint its chief executive "in accordance with law." The regents, moreover, hold office by virtue of the approval of both the governor and both houses of the legislature.

Through legislative enactments, the University enjoys a considerable degree of statutory independence.

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at the University is also subject to some executive and legislative control. As mentioned, the constitution provides that the regents of the University shall be appointed by the governor, subject to confirmation by the legislature. Furthermore, as has been pointed out, the formulation of university policy as well as the administration and disposition of University property are made subject to legislative enactment.

We reach this conclusion not only from article VII of the constitution, which we construe to be the expression of the will of the people of this state that there shall be an institution of higher learning within the scope of the constitutional mandate providing for public education, but also from the degree of control over the affairs of the University which is exercised by the executive and legislative branches of our government, and from the financial dependence the University has upon the state.

The Montana constitution grants broader power to the board of regents than our constitution. It provides in Sec. 9(2)(a) of Art. 10:

"The government and control of the Montana university system is vested in a board of regents of higher education which shall have full power, responsibility, and authority to supervise, coordinate, manage, and control the Montana university system..."

The Montana Supreme Court in Board of Regents of Higher Education v. Judge (543 P.2d 1323) after holding the constitution must be read as a whole without undue emphasis to the particular section dealing with the university and after examination of the cases uniformly cited as supporting the theory of university autonomy (including the California, Michigan, and Minnesota cases) stated that:

"Regent autonomy has not been asserted over the bare legislative power to appropriate in the above instances. That power, by implication in these cases and expressly in others cited by the Regents, is secure even in Michigan with its strong constitutional provision and long judicial recognition of autonomy of the regents.

We recognize here that while Montana's Constitution is not as explicit or broad as that of Michigan, the principle of regent independence was definitely intended by the drafters of the 1972 Montana Constitution. At the same time, just as in Michigan, legislative control of higher education through the appropriation process remains. The Regents are a constitutional body in Montana government subject to the power to appropriate and the public policy of this state."

but added a caveat in stating:

"However, the legislature cannot do indirectly through the means of line item appropriations and conditions what is impermissible for it to do directly. Line item appropriations become constitutionally impermissible when the authority of the Regents to supervise, coordinate, manage, and control the university system is infringed by legislative control over expenditures..."

The Michigan constitution is very much broader in its grant providing in Sec. 5 of Art. VIII:

"Sec. 5. The regents of the University of Michigan and their successors in office shall constitute a body corporate known as the Regents of the University of Michigan; the trustees of Michigan State University; the governors of Wayne State University and their successors in office shall constitute a body corporate known as the Board of Governors of Wayne State University. Each board shall have general supervision of its institution and the control and direction of all expenditures from the institution's funds..." (Emphasis added.)

There are numerous cases in Michigan on the relationship between the board of regents and the legislature. The question of the degree of control was before the Michigan Court of Appeals in Regents of University of Michigan v. State, 208 N.W. 2d 871, in a case challenging the constitutionality of certain conditions placed on 1971 appropriations to the university. The court held the conditions unconstitutional after finding the legislature was attempting to "determine who shall teach and who shall not, who shall learn and who shall not" under the guise of conditions on appropriations. The court however went on to state on page 877:

"While it must be recognized that the legislature's power to make appropriations to a constitutional university does not include and is separate from the power to control the affairs of such a university, the legislature can within reason attach conditions to its university appropriations. If a constitutional university accepts such conditioned funds, it is then bound by the conditions. There are not many decisions in this area, however, so the line between conditions the legislature can validly attach and those it cannot has not been drawn in a distinct fashion. Conditions which require the university to follow prescribed business and accounting procedures have generally been found to be valid. The courts have also sustained conditions which required, on penalty of losing part of the appropriation, annual reports to the governor, and fair and equitable distribution of an appropriation among the departments of the university of maintenance of university departments. It has also been held that the legislature can properly make non-teaching employees subject to the state's workmen's compensation law, and can require loyalty oaths by the teachers. On the other side of the line, a condition that the university move a certain department of the school has been held to be invalidly attached, an attempt to limit the amount of funds that can be spent for a given department is likewise an invalid condition. It is clear that limits should be placed on the use of the conditioned appropriation, for without such limits the legislature could use the conditioned appropriation to strip the university of its constitutional authority." (Emphasis supplied.)

Although it is difficult to determine whether the holding in this case is good law today in Michigan since the Michigan Supreme Court refused to decide the legislature-regents questions on ground of mootness and abstention in Regents of University of Michigan v. State, 235 N.W. 2d 1 (Mich. 1975) the decision appears in line with earlier Michigan cases.

The California cases which extend regent autonomy well beyond the bounds of the cases are not applicable since legislative involvement is expressly limited in Sec. 9 of Art. IV of the California Constitution which provides:

"Sec. 9. (a) The University of California shall constitute a public trust, to be administered by the existing corporation known as "The Regents of the University of California," with full powers of organization and government, subject only to such legislative control as may be necessary to insure compliance with the terms of the endowments of the university and the security of its funds...."

Our court has recognized that the constitutional limitations placed upon the independence of the university are significant. Therefore cases such as Regents v. University of Michigan v. State of Michigan (208 N.W. 2d 871) which held that regent autonomy prevailed over legislative appropriation in the instance before it are not authority for the proposition that under the Alaska Constitution the University of Alaska is not subject to control of the legislature in fiscal matters. Since that case involved an appropriation designed to attain an end not within control of the legislature, that is, control of who shall teach and who shall learn, it is extremely questionable authority even in Michigan for the general proposition of fiscal autonomy of the university.

It is my opinion, since the control over appropriations is clearly vested in the legislature by the constitution, that the constitution requires the budget to set forth all proposed expenditures and anticipated income of all departments, agencies, and offices of the state (Sec. 12, Art. IX), that the University is part of the state, (University of Alaska v. National Aircraft Leasing, supra) and the constitution provides in Sec. 13, Art. IX that "No money shall be withdrawn from the treasury except in accordance with appropriations made by law," and the university is not exempted from legislative control in the fiscal area, that the university is subject to legislative control in the areas of budgeting and accounting to the same extent as other agencies of the state government.

This control encompasses provision for the form of the budget and method of submission. The university is explicitly subject to the Executive Budget Act. (AS 37.07.-120(1)) Under that law original requests by departments and agencies are included in the material submitted to the legislature. Presumably the original request of each component would be likewise submitted as part of the university submission under current law.

Representative Charles H. Parr
Page 9
March 15, 1978

For reasons discussed earlier, it is doubtful that there is an area of regent autonomy extending beyond continuation of the board as the head of the university. Assuming autonomy, it could be argued that control of budget submission is an essential tool in governing the university and therefore placing fiscal authority over what will appear in the submitted budget in other than the board of regents is an impermissible infringement on their power to govern. In effect the components would become fiscally independent and therefore in large measure operationally independent.

This argument does not appear sound. There is clear authority for the legislature to adopt line item appropriations in the university budget. By law transfer may not be made among appropriations solely by the board of regents. The effect of the change in submittal would appear to have little operative difference in the governing of the university. Its major significance is the information given to the legislature for its use in the process of formulating the budget and appropriations.

It is, therefore, my opinion that the procedure in your question is constitutional. In the absence of a decision by our supreme court, however, a certain uncertainty exists.

BGB:jpd

Comments to HESS Committee
By Jeff Cook, March 15, 1978.

My name is Jeff Cook and I am a member of the Board of Regents from Fairbanks. I want to thank you for the opportunity of testifying before your committee on the bills relative to organization and re-organization of the University of Alaska.

I will mainly be making general remarks to you, with some specifics relative to some of the bills before us. Let me start by stating that the Board of Regents is truly concerned about the University and about the problems that have surfaced in the past year. We have received and acted constructively on proposals to improve our financial and fiscal problems. We worked closely last session with you on correcting the financial ills of the system; and despite news stories or impressions to the contrary, significant and substantial progress has been made in the financial and fiscal areas of the University; and safeguards have been developed to insure that such problems don't occur in the future, and that if they do occur they can be pinpointed and corrected immediately.

I feel the Board of Regents has been more active in the affairs of the University in the past year than any previous Board. We have taken an interest and shown a dedication to our positions on the Board. We are more informed and certainly more active in the affairs of the University. Some of the past problems with the University have been due to lack of this type of involvement by the Regents, who are ultimately responsible for both the progress and problems of the University. I pledge that the Regents will continue this type of involvement and will do a better job, and that we will be open and honest in our dealing with the Legislature and the people of Alaska. We will expect this of our top administrators also.

I am against the proposals that separate the University into segments with direct reporting for budgets to the Legislature. I do not feel that the legislative floor is the place to referee budget proposals of various units of the University. The Board of Regents should solve these conflicts in a non political atmosphere.

We need a stable environment within the University system to correct the problems of the University. We need a stable environment to encourage the faculty and other employees to serve the University system well. We need a stable environment to encourage learning by our students and productivity by our research people. Such stability will not come with drastic and mandated organizational changes at this time. We have significantly met and are meeting the challenge of fiscal problems at the University. And I promise that we will address and act on the questions of organization and possible de-centralization.

The vast majority of students and faculty within the University System have indicated that they do not favor the re-organization proposals. I feel these views, especially the students as users of the educational product, are important.

As relates to any possible separation of research from the mainstream of the University campuses, I would like to quote from a recent speech to the Rotary Club by Dr. Juan Roederer, Director of the Geophysical Institute. "To impart higher education in a country that is the unquestionable leader of today's complex technological society, it just isn't enough to merely produce educated people. Our universities must mold potential leaders. It just isn't enough that students merely acquire new knowledge-- they must learn how to generate , how to create new knowledge! Creativity--be it scientific or artistic--cannot be taught; it must be instilled in the student by persistent exposure to an appropriate faculty environment. A fundamental role of research at a university is to ^{provide} this appropriate environment. It is unthinkable to operate successfully a science department without a faculty of active researchers, as it is unthinkable to operate successfully a music department without a faculty of performing musicians. The degree in which research and teaching are meshed with each other is a most conspicuous and direct measure of the strength of a given University."

I disagree with separation of the community college system from the University system. We need co-ordination with proper tracking and interface between the 4 year colleges and the community college system. I feel UAA Chancellor Wolff and ACC President Stewart have demonstrated that they can work together and coordinate for a better total system in the future. I would like to quote from Former Regent Chris Cooke of Bethel on

testimony he gave in 1976 relative to ^{separation} of the Community Colleges. "If the real problems of the community colleges can be resolved while preserving the unified structure of the University, I am sure that higher education in Alaska will be better for it in the long run. If, however, the community colleges are severed from the university and a separate administration created, it is likely that harmony and mutual understanding will never be achieved, to the detriment of all the people of Alaska ..."

We recognize problems in organization and structure from the past. Part of the reason for the problems is the growth of the University system and its progress in reaching out to more of the citizens of our State with educational programs. The University system has seen great progress despite problems in the past few years. Growth and progress always involve problems. A sign of our strength as Regents and Legislators is how we solve these problems. Let us all resolve to keep the educational system our priority, and not our personal biases as the priority.

I would like to make some specific comments on a couple of the bills at this time. Concerning House Bill 493, I feel we should not mandate moving the main office of the University to the State Capitol. This does not make sense in view of the costs involved with such a move; especially in light of past fiscal and budget problems. Also, this proposal is not consistent with the theme of most of these bills, which is to bring governance of the system closer to those using the system. I feel that this bill and the others have no guarantee of a better system or of tangible benefits to the system; yet there are some significant costs involved with some of the proposals. I have no problem with the provision of HB 493 requiring the Chancellor's original budget to be submitted to the Legislature along with the Budget proposed by the Board of Regents. President Diebold will address this matter with you in his comments.

I totally disagree with HB 666. The problems of the University are not as much caused by the structure of the University as by previous management and fiscal procedures. We have addressed the fiscal problems and have come a long way in the last year. You have a copy of the Main LeFrentz Company report which outlines both the problems and recommended solutions; which we have been implementing. You have had reports from the Commissioner of Administration indicating the great progress by the

University in fiscal matters. I do not feel the present fiscal situation is grave. We know the problems, we have made progress, and we will continue to make progress in these areas. It would be a total waste of money and time to create the committee as outlined in HB 66. It would be a duplication of recent efforts and it would get in the way of further forward progress.

In conclusion I respectfully request that you not mandate ^{drastic} organizational changes for the University of Alaska at this time. I pledge that the University Board of Regents and the Administration will look at organization and decentralization issues and report back to you next year. I share the feelings of one constituent who wrote to the editor of our paper last week and indicated that he felt some of the re-organizational proposals for the University were akin to "curing a person's dandruff problem by chopping their head off". I don't think such drastic action is wise or warranted. We request your constructive and positive support, and we pledge to address the questions and concerns at hand. Thank you, and I will be happy to answer any questions.

An aside. Why did you guys recommend me for confirmation last year? That's a joke.

COMMITTEE REPORT

HOUSE

4/19/78

FURTHER: _____

Date: 5-21-78

Mr. Speaker:

The Committee on FINANCE has had HB 896

"An Act relating to emergency medical services."

under consideration and (a majority of the committee) (the committee reports it back as follows)

() recommends it do pass () recommends it do not pass

() recommends it do pass with attached amendment(s)

(X) recommends it be replaced with CS for HB 896 (FINANCE)

and _____ () new title () same title

() AND attaches a Letter of Intent () New Fiscal Note

() reports it back without recommendation

() and recommends it be referred to the _____ Committee

MEMBERS SIGNING DO PASS:

OTHER RECOMMENDATIONS:

W. H. ...

...

...

...
Chairman

Original sponsor: Health, Education and
Social Services Committee

1 IN THE HOUSE

BY THE FINANCE COMMITTEE

2 CS FOR HOUSE BILL NO. 896 (Finance)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to emergency medical services."

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

8 * Section 1. AS 18.08.080 is repealed and re-enacted to read:

9 Sec. 18.08.080. REGULATIONS. The department shall adopt, with the
10 concurrence of the Department of Public Safety, regulations establishing
11 standards and procedures for the issuance, renewal, reissuance, revoca-
12 tion, and suspension of certificates required under sec. 82 of this
13 chapter, as well as other regulations necessary to carry out the pur-
14 poses of this chapter.

15 * Sec. 2. AS 18.08 is amended by adding new sections to read:

16 Sec. 18.08.082. ISSUANCE OF PERMITS. (a) The department shall
17 prescribe by regulation a course of training or other requirements pre-
18 requisite to the issuance of certificates which provide for the follow-
19 ing:

20 (1) certifies that a person meets the training and other
21 requirements as an emergency medical technician;

22 (2) authorizes an emergency medical technician certified
23 under this chapter to provide under the written or oral direction of a
24 physician those advanced life support services enumerated on the certi-
25 ficate;

26 (3) certifies that a person, organization, or government
27 agency which provides an emergency medical service meets the minimum
28 operating standards prescribed by the department; and

29 (4) authorizes an emergency medical service certified under

1 this chapter to provide under the written or oral direction of a phy-
2 sician those advanced life support services enumerated on the certi-
3 ficate.

4 (b) The department shall be the central certifying agency for
5 personnel certified under (a)(1) and (2) of this chapter and under
6 regulations adopted under sec. 80 of this chapter.

7 Sec. 18.08.084. CERTIFICATE REQUIRED. (a) No person may repre-
8 sent himself, nor may an agency or business represent an agent or
9 employee of that agency or business, as an emergency medical technician
10 certified by the state unless the person represented is certified as an
11 emergency medical technician under sec. 82 of this chapter.

12 (b) No person, organization, or government agency may represent
13 itself as an emergency medical service or ambulance service certified
14 by the state unless the person, organization, or government agency is
15 certified as an emergency medical service under sec. 82 of this chapter.

16 (c) No person may provide, offer, or advertise to provide ad-
17 vanced life support services outside a hospital unless authorized by
18 law.

19 (d) No person, organization, or government agency which provides,
20 offers, or advertises to provide an emergency medical service may pro-
21 vide advanced life support services unless authorized under sec. 82 of
22 this chapter.

23 Sec. 18.08.086. IMMUNITY FROM LIABILITY. (a) No person certified
24 under sec. 82 of this chapter, or person or public agency which employs,
25 sponsors or controls the activities of persons certified under sec. 82
26 of this chapter, who administers emergency medical services to an in-
27 jured or sick person may be liable for civil damages as a result of an
28 act or omission in administering those services, if done in good faith
29 and if the life of the injured or sick person is in danger. This sub-

1 section does not preclude liability for civil damages which is the
2 proximate result of gross negligence or intentional misconduct, nor
3 preclude imposition of liability on a person or public agency which
4 employs, sponsors, or controls the activities of persons certified under
5 sec. 82 of this chapter if the act or omission is a proximate result of
6 a breach of duty to act created under this chapter. For the purposes of
7 this subsection, "gross negligence" means reckless, wilful, or wanton
8 misconduct.

9 (b) No physician who in good faith arranges for, requests, recom-
10 mends, or initiates the transfer of a patient from a hospital to another
11 hospital may be liable for civil damages as a result of arranging, re-
12 questing, recommending, or initiating the transfer if

13 (1) in the exercise of that degree of knowledge or skill pos-
14 sessed, or that degree of care ordinarily exercised by physicians prac-
15 ticing the same specialty in the same, or similar communities to that in
16 which the physician is practicing, the physician determines that treat-
17 ment of the patient's medical condition is beyond the capability of the
18 transferring hospital or the medical community in which the hospital is
19 located;

20 (2) the physician has confirmed that the receiving facility
21 is more capable of treating the patient; and

22 (3) the physician has secured a prior agreement from the
23 receiving facility to accept and render the necessary treatment to the
24 patient.

25 (c) No registered nurse or licensed practical nurse who escorts a
26 patient in a means of conveyance not equipped as an ambulance may be
27 liable for civil damages as a result of an act or omission in admini-
28 stering patient care services, if done in good faith and if the life of
29 the injured or sick person is in danger. This subsection does not

1 preclude liability for civil damages which are the result of gross
2 negligence or intentional misconduct.

3 Sec. 18.08.088. PENALTY. Any person who violates a provision of
4 this chapter is guilty of a misdemeanor and upon conviction is punish-
5 able by a fine of not more than \$1,000, or by imprisonment for not more
6 than 90 days, or by both. Each violation is a separate offense.

7 * Sec. 3. AS 18.08.090 is amended by adding new paragraphs to read:

8 (7) "advanced life support" means emergency care techniques
9 provided under the written or oral orders of a physician which include,
10 but are not limited to, electric cardiac defibrillation, administration
11 of antiarrhythmic agents, intravenous therapy, intramuscular therapy, or
12 use of endotracheal intubation devices;

13 (8) "ambulance" means any publicly or privately owned means
14 of conveyance intended to be used and maintained or operated for the
15 transportation of persons who are sick, injured, wounded, or otherwise
16 helpless;

17 (9) "emergency medical care" means the services utilized in
18 responding to the perceived individual needs for immediate medical care
19 in order to prevent loss of life or aggravation of physiological or
20 psychological illness or injury;

21 (10) "emergency medical technician" means a person trained in
22 emergency medical care and certified in accordance with the regulations
23 prescribed under sec. 80 of this chapter;

24 (11) "emergency medical service" means the provision of
25 emergency medical care and transportation of the sick and injured.
26
27
28
29

Southeast Region Emergency Medical Services Council

~~GENERAL DELIVERY~~ Box 2170
SITKA, ALASKA 99835

TELEPHONE 747-8005

APR 27 1979

Representative Hugh Malone
Speaker, State House of Representatives
Pouch Y
Juneau, Alaska 99801

Dear Representative Malone:

Tom Scott has informed me that you have requested information on how our agency coordinates our use of EMS funding with that of Southeast Alaska Regional Health Corporation. Our relationship to SEARNIC has been one of assisting them in upgrading their EMS program for Southeast's native communities. During the past year, such activities have included:

1. After developing a 16 hour Emergency First Aid course which was subsequently certified by the State Department of Public Safety and the State Department of Labor, OSIA, we provided an instructor level course and trained SEARNIC's EMS Training Officer. He then brought the course to Angoon, Kake, Metlakatla, Craig/Klawock, and Hoonah. These efforts, however, halted when he resigned at the end of February.
2. SEARNIC contracted with us to provide two EMT courses. Trainees including village health aides, police, firemen and others spent two weeks in Sitka to be trained as EMT's. We involved PHS physicians and Coast Guard personnel in course instruction, as well as Public Safety Certified EMT Instructors.

We have also proposed means to further coordinate our program and SEARNIC's in the FY '79 EMS plan. All plans have been discussed with SEARNIC staff, and several are included in the enclosed report which we provided for them. These plans include:

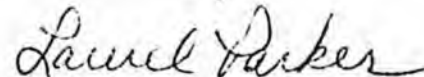
1. An additional EMT class for persons from SEARNIC communities with our agency providing instruction and SEARNIC assisting in recruitment of trainees and providing their travel and per diem expenses.
2. A first aid instructor-level course so that an instructor would be available in every community to provide ongoing CPR and first aid training for the general public. We, with PSA assistance, would provide training and SEARNIC would provide travel and per diem expenses.

3. With trained EMT's available in more communities, it is important that they have available the equipment which they are prepared to use. I discussed this with Frieda Damus, Executive Director of SEARHC, and she requested a list of that equipment indicating that this would assist them in budgeting their EMS funds. This list is included in the enclosed report.
4. We have investigated means whereby heliports might be cleared in those communities and logging camps lacking areas on which a Coast Guard HH3F helicopter may safely land. Information on heliport needs and possible solutions has been relayed to the SEARHC Director of Planning who plans to work on this project.

There is so much in the EMS field to be tackled in Southeast, that I can say with certainty that duplication of efforts has not, and will not pose a problem. This is further insured by our continual efforts to keep SEARHC abreast of our EMS efforts, and keeping informed of theirs. The presence of SEARHC's Health Aide Coordinator, and EMS Coordinator (once recruited) as well as Mt. Edgecumbe here in Sitka, facilitates coordination on a day to day basis.

Although I can provide any information that may prove helpful on our use of funds, it would be most difficult for us to do the same in a specific manner for SEARHC, as their budgetary restrictions are far fewer than ours, and we have no jurisdiction over their funds. I hope, however, that what I have provided will prove useful.

Yours truly,



Laurel Parker
Executive Director

LP:ms

Enclosures

cc: Tom Scott

Dr. Stan Hadley

Frieda Damus

Report on Emergency Medical Technician Courses

I am very pleased with the results of the two emergency medical technician classes recently given through the joint cooperation of the Southeast Alaska Regional Health Corporation and our agency. Skill improvement is reflected in the difference between pre and post-test scores shown below:

Class I Feb. 18-March 3, 1978

<u>Name</u>	<u>Residence</u>	<u>Pre-test</u>	<u>Final</u>	<u>Certification</u>
Ahrnkeil, Al	Craig	55	75	EMT
Booth, Florence	Mellakatta	41	73	EMT
Clause, George	Craig	81	91	EMT
Culp, Vern	Sitka	67	83	EMT
DeLeon, Orlino	Petersburg	28	66	ETT
Enright, Eldon	Mellakatta	39	79	EMT
Fox, Ginger	Saxman	41	64	ETT
Howard, Wm.	Sitka	47	77	EMT
Jackson, Don	Petersburg	52	84	EMT
Keene, Heleen	Klawock	38	66	ETT
LeCornu, Anne	Craig	61	85	EMT
McNeill, Sine	Klawock	69	94	EMT
Nannauck, Lottie	Kake	42	72	EMT
Nickerson, Jeff	Klawock	64	89	EMT
Smith, Harvey	Klawock	58	84	EMT
Smith, Richard	Klawock	45	65	ETT
Soboleff, G.	Tenakee	47	69	ETT
Stokes, Robb	Sitka	65	91	EMT
Williams, Roy	Petersburg	50	77	EMT
Wolfe, Trudy	Hoonah	62	77	EMT
Young, Rosemarie	Kasaan	31	82	EMT

Out of 21 participants, 17 became certified as EMT's. The 5 who did not pass the EMT final took the Emergency Trauma Training final exam which they all passed, receiving Emergency Trauma Training Certificates.

Class II March 27 - April 7, 1978

Brown, Jack	55	93	EMT
Brookman, John	53	76	EMT
Burgess, Vic Jr.	27	79	EMT
Charles, Tommy	59	54	ETT
James, Donald Sr.	29	63	ETT
Dalton, Richard Jr.	34	71	EMT
Baldane, Frieda	45	70	EMT
Jackson, Adeline	16	Incomplete	
Jim, Jesse	49	91	EMT
Johnson, Barbara	34	84	EMT
Johnson, Joe	12	70	EMT
Johnson, Skip	77	91	EMT
Kasko, Lorraine	49	78	EMT
Rubbs, Marcelene	87	97	EMT
Kushnik, Tillie	27	68	ETT

Class II Continued

Lyons, Matilda	29	77	EMT
Mathena, Douglas	58	83	EMT
McIntyre, Jerry	64	80	EMT
Milton, Robert	37	79	EMT
Natkong, Eugene	32	70	EMT
Reardon, Eric	79	96	EMT
Roberts, Alicia	32	76	EMT
Sanger, Marla	79	94	EMT
Totland, Ingwald	9	82	EMT

Housing arrangements at Sheldon Jackson proved convenient and provided trainees an opportunity to discuss class-related matters in their free time. The involvement of PHS physicians and Coast Guard personnel, besides having obvious training advantages, allowed trainees to personally interact with those persons to whom they would actually relate in an emergency medical situation.

Although reading difficulties posed problems for a few students, this was partly overcome by giving oral tests. Performance on practical skill demonstrations by these students, however, proved that essential information was being learned.

Below are listed numbers of EMT's now available in each community and numbers still needed, based on the following standards developed by our agency and the HSA.

- a) There should be one EMT per 50 population in every community of under 500 population.
- b) There should be one EMT per 100 population up to 25 EMT's in communities of 500-5000 population.
- c) There should be one EMT per 200 population up to .75 EMT's in communities of over 5000 population.
- d) There should be a minimum of 2 EMT's in any community.

These standards reflect minimums.

Community	Population	Total EMT's Needed	Total Now Available	Total Needed
Juneau	20,465	75	73	2
Ketchikan	10,587	58	57	0
Sitka	7,587	35	69	0
Angoon	400	5	4	1
Craig	535	5	3	2
Elfin Cove	49	2	0	2
Excursion Inlet	23	2	0	2
Gustavus	64	2	0	2
Hoonah	748	7	2	5
Hydaburg	214	4	3	1
Hyder	49	2	0	2
Kake	448	5	3	2
Kasaan	38	2	1	1

Klawock	213	4	6	0
Klukwan	103	2	1	1
Kupreanof	36	2	0	2
Metlakatla	1,050	10	4	6
Pelican	133	2	0	2
Petersburg	2,126	21	5	16
Port Alex.	60	2	0	2
Port Protection	30	2	0	2
Saxman		2	3	0
Skagway	854	9	6	3
Tenakee	86	2	2	0
Wrangell	3,152	32	35	0
Yakutat	442	5	5	0
Haines	1,980	20	6	14

Prior to the two recent courses, virtually all of Southeast's EMT's were in the 6 larger towns. Numbers above indicate that a more appropriate geographic distribution is being attained. Communities still requiring additional EMT's include Juneau, Angoon, Craig, Elfin Cove, Excursion Inlet, Gustavus, Hoonah, Hydaburg, Hyder, Kake, Kasan, Klukwan, Kupreanof, Metlakatla, Pelican, Petersburg, Port Alexander, Port Protection, Skagway, and Haines. At least one more EMT course is needed to meet the quota in SEARHC communities.

We would be interested in providing another EMT course here in Sitka, preferably this fall following fishing season. We recommend, however, that financial provisions other than CETA be made so that persons in need of training will not be prevented from taking the course due to CETA limitations.

Now that EMT's are available in these communities, we recommend that they be provided the equipment which they are prepared to use to include:

- OB Kit - clamps, gloves, scissors
- Flashlight
- B/P cuff
- Stethoscope
- Long and short backboards
- 5 Stretcher straps
- Folding stretcher with wheels
- (2) blankets
- (1) Hare traction splint
- (2) wire ladder splints
- 6-pak air splints
- (1) burn pak
- Portable suction device
- Portable oxygen
- Bag Mask
- Oropharyngeal airways (adult, child sizes)
- Cervical collar
- Bandaging supplies (Ace elastic, gauze, etc)
- Space Blankets

In the future, it will be necessary to provide refresher training for all EMT's to keep their skills updated. State regulations will most likely, once enacted, require at least 20 hours of refresher training every

two years to maintain certification. We presently offer such a course which may either be offered in a central location, or in the communities.

With EMT's now available, SEARMC may choose to make additional use of these persons in the following ways:

- a) Liason with community on EMS concerns
- b) Attendant on air charters carrying sick or injured persons to a facility.
- c) Attendant to transport victim from accident scene to clinic or airport/seaplane ramp for evacuation.

In order to accomplish the third option, communities would benefit by having a vehicle equipped as an ambulance. I understand that ambulance suppliers may provide second-hand ambulances for \$10,000 - \$15,000 and that loans to purchase these are available through the Farmer's Home Administration in Juneau at a low (5%) interest rate. I intend to further investigate funding possibilities.

Should EMT's from the larger communities such as Hoonah and Metlakatla choose to attend, and be eligible for, instructor-level courses provided by the Public Safety Academy in Sitka, they could then provide training in their own community. Benefits would include flexible scheduling around working hours, minimal cost, gaining course to the local environment and allowing trainees to remain at home. Such instructors could teach the 16 hour Emergency First Aid level, the 36 hour Emergency Trauma Training course, the 81 hour EMT course and refresher training.

The State of Alaska is presently developing modules to advance the EMT. Advance modules will go all the way up to the paramedic level. The module immediately following the EMT level, is the EMT II course which covers administration of IV solutions and use of airways.

Attached is a pre-hospital form which we have developed with input from ambulance attendants, physicians and Coast Guard personnel. Its main purpose is to provide to the physician essential information on the pre-hospital phase thereby improving his capability to evaluate the patient's condition. Carbon copies are attached so that the EMT may keep one, and the others may accompany the patient in flight. The ambulance service would then fill in pertinent information, keep a copy and pass the other on to the physician. The check list on the form also would serve as a reminder for responders. During the EMT classes, trainees used this form during practical exercises. We recommend that they be used by health aides for all emergency medical situations.

EMERGENCY MEDICAL SERVICES
PROGRAM OVERVIEW

January 1978

The State EMS program receives all of its grant funds from Region X, DEW under the authority of PL 93-154 the EMS Systems Act of 1973. This Act provides funds for the development of Emergency Medical Services Systems on a regional basis. The purpose is to upgrade and organize the delivery of these services into a preplanned system that insures that the victim of an accident or serious illness receives the care most appropriate to his problem in the quickest possible manner. The elements of the system include the following:

1. Insure that an ambulance can be easily summoned in need. The primary focus here is to develop a 911 emergency phone number in every community in the State for the dispatch of all public safety elements.
2. Insure that once a call is received an ambulance can be quickly dispatched, and that provisions have been made for backup service if the primary unit is on a call. This is usually accomplished by means of a regional dispatch center and signed mutual aid agreements among operators.
3. Under medical direction insure that the victim's condition is stabilized at the scene and maintained during transport. This is accomplished by training all ambulance personnel to the Emergency Medical Technician (EMT) level and insuring that their vehicle is adequately equipped with medical supplies, rescue equipment, and 2-way voice communications with a hospital. In the rural communities the EMT is being given advanced training in how to start intravenous (IV) fluids for the control of shock due to blood loss. In these cases direct radio contact with a physician for medical control is the ideal. In larger communities the EMT-Paramedic is the preferred training level because they can treat heart attack victims with electric shock and controlled drugs.
4. Insure that the local medical facilities are adequately equipped and staffed with personnel trained to further stabilize the patient and when necessary, transfer to the most appropriate critical care facility be it to a hospital, another institution in the state, or outside the state. This is achieved by categorizing facilities according to their ability to handle different types and severities of injuries, i.e. Homer Hospital can care for the moderately burned patient, and the burn center at Harborview Hospital in Seattle is the nearest facility to take care of major burns. The facilities are identified and a list of protocols are in place so that, hypothetically, a patient with a major burn in Homer would be treated according to burn care procedures developed by specialists and then transferred directly to Seattle (because the Anchorage hospital can only care for moderate burns). This hypothetical protocol would be accepted previously by each of the physicians involved as the best procedure to follow.

5. Insure proper rehabilitation facilities are available to return the severely injured patient to his full functioning capacity as soon as possible.

In support of the EMS system certain other functions are necessary. These include:

1. Ongoing basic training programs to insure an adequate supply of personnel, as well as refresher training programs to maintain high quality service delivery. Refresher and Continuing Education programs are especially important in Alaska. This is because our widely scattered population does not have enough serious accidents in any one locality for the providers to maintain high levels of skill. All of our providers, physicians, nurses and emergency medical technicians, need formal continuing education in the care of the critically ill and injured.
2. Public Information and Education programs are needed for two purposes. The first is to insure that people know how to call for help in the area where they live or are traveling. The second purpose is to provide information about what people can do for themselves and others when they are in need, e.g. first aid courses.
3. An important element in support is a good record-keeping and evaluation system. The systems approach requires that each element of the system is continually being evaluated as to its effectiveness in order to suggest areas for improvement. An example is evaluating EMT performance by analyzing ambulance run reports. EMT's are trained to follow certain protocols for certain types of injuries. By checking their performance areas of need for refresher training can be more easily identified. A computerized system that does this has been in operation for several years in western Pennsylvania with great success and low cost.
4. Finally, coordination efforts of the various state (Public Safety, Disaster Office, Community and Regional Affairs, Education, National Guard) and federal (Park Service, BLM, Coast Guard, Military branches, Indian Health Service) agencies that are directly involved in EMS activities in Alaska is vitally important to efficient utilization of resources.

The EMS Systems Act provides seed money to the states and regions on an incremental basis. The phases are:

- (1) Feasibility studies and planning, 1 year (1202)
- (2) Establishment and initial operation, 2 years (1203)
- (3) Expansion and Improvement, 2 years (1204)

A 1976 amendment provides another year of planning money which can be used between 1203 and 1204.

The attached informational brochure from DHEW further explains the federal program.

The history of the State's involvement with this program can best be summarized with the following outline:

- 1971 EMS planner established in Office of Comprehensive Planning
- Apr. 1974 Department of Health and Social Services applied for 1202 grant for planning;
AFN applied for 1202 grant for planning;
Mauneluk Association applied for 1204 grant for Search and Rescue.
All were not accepted based on lack of comprehensiveness. However, DHEW offered assistance for future grant application development.
- Jan. 1975 Dr. David Boyd, National Director of EMS, and several other nationally recognized speakers attended meeting in Anchorage with interested groups.
- Apr. 1975 Department of Health & Social Services submitted a 1203 grant. Tanana Chiefs Conference submitted a 1203 grant for Interior Region. Region X suggested that the applications be combined with State acting as lead agency for regional programs. Thus, funds for state office and EMT training were made available.
- Jul. 1975 Department of Health & Social Services received grant (\$450,000) to establish state office, statewide EMT training, provide implementation grant (first year 1203) to Tanana Chiefs Conference (\$220,000), and provide salaries and travel for EMS coordinators in the other 7 EMS regions.
- Nov. 1975 Legislative Budget and Audit approved revised program, and contracts were let. With three positions, Office of Planning & Research was charged with administering programs.
- Jan. 1976 Charles Ramage was hired as Associate Coordinator. State submitted grant request for second year funding of Tanana Chiefs Conference Interior program, and first year funding of 1203 programs in six other regions. Ad hoc Advisory Council met.
- Jul. 1976 State received a grant of \$725,000 which provided funds for State office, EMT training, Tanana Chiefs Conference, and regional coordinator. Funds for the additional 1203 programs were not available due to the failure of Congress to extend the 1973 law. Charles Ramage became Coordinator.

Peggy Zufelt Associate Coordinator, Thomas Scott Health Planner - a full staff for the first time.

- Aug. 1976 Congress passed \$1.35 million appropriation for FY77 to Alaska Area Native Health Service for EMS implementation in the native health corporation regions.
- Nov. 1976 Tanana Chiefs Conference turned Interior program back to State.
- Jan. 1977 Using AANHS EMS money, corporations covered half of the coordinators' salaries in six regions. Northern Region Office, Division of Public Health began administering Interior program for an interim period.
- Apr. 1977 State submitted grant application for first year 1203 grants for seven regions and 1202 grant for Advanced Life Support planning for the Interior region. Charles Ramage resigned as Coordinator. Thomas Scott appointed Acting Coordinator. Lynne Quist hired as Health Planner - temporary status.
- May 1977 Legislature passed HB407 establishing the Department as the state agency responsible for developing emergency medical services in the state and establishing an eleven member advisory council consisting of seven providers and four consumers.
- Jun. 1977 Program transferred from Office of Planning and Research to Division of Public Health
- Jul. 1977 State was awarded \$698,000 to support state office, EMT training and first year 1203 grants for Southeast (\$175,000) and Mauneluk Association (\$53,000). The Interior program was extended one year in order to complete implementation of Basic Life Support using unexpended funds from FY77.
- Aug. 1977 Dr. William Mills of Anchorage accepted position of EMS Medical Director.
- Nov. 1977 State EMS Symposium drew over 150 participants. Mrs. Hammond announced Governor's appointments to new Advisory Council. Symposium provided stronger direction to program.

Accomplishments

- Active EMS Councils in every community in the State
- Full time EMS programs in each of the eight EMS regions with only four currently receiving support from the Department.

- 90% of all ambulance personnel are trained to at least the basic Emergency Medical Technician level. Three years ago it was less than 30%.
- A need for greater emphasis on emergency care skills has been recognized for the Community Health Aides. Thus, their training and equipment have been improved substantially.
- MAT-SU Borough has adopted Borough-wide ambulance powers, established new services at Talkeetna and Willow, purchased new vehicles, and has increased cooperation with services in Anchorage.
- Kenai Borough is considering following same direction as MAT-SU.
- An advanced EMT course aimed at the rural EMT has been developed and is in use statewide. This course teaches the administration of IV fluid therapy for control of shock.
- A substantial video tape library has been established by the Alaska Hospital Research and Education Foundation of continuing education materials in emergency and critical care medicine for circulation among all hospitals in the state.
- An Artic First Aid Film strip and accompanying printed materials have been developed. This resulted from the need to develop a first aid training medium that Alaska Natives can relate to. American Red Cross materials are based on verbal learning skills whereas Alaska Natives are more visually oriented.
- EMS subsidized the Alaska Emergency Department Nurses Association for their last two annual clinical symposia.
- EMS assisted the U of A school of Nursing in its successful efforts to develop and have funded a 40 hour emergency care course that will be taught in almost every rural hospital in the State.
- EMS has started the installation of an areawide communications system for the Interior road system. When completed all ambulances, including military vehicles, on the Interior Region highway system will have two way voice communication with Fairbanks Memorial Hospital.
- We are jointly funding with the Criminal Justice Planning Agency through the Governor's Office of Telecommunications a Communication Consultant who is developing a statewide Public Safety Communications Plan that will be area specific.

Problem Areas

The EMS program must address the total system from the moment a person perceives himself or is perceived by another to be in need of EMS to the point where he no longer requires services. Many actors and actions must transpire, especially in the case of a critically injured person. Two problems stem from this total systems approach.

- (a) The sheer magnitude of the program requires very careful understanding of the problems and the solutions, and requires individuals who can relate to volunteer EMT's as well as to physicians.
- (b) The vast majority of people think EMS is pre-hospital and that the only thing needed is the upgrading of training and equipment. The total systems concept and the team approach is difficult to understand, especially because traditionally there has been little if any communication or involvement between pre-hospital providers and in-hospital providers. Another problem is communication between rural physicians and specialists in the major centers regarding appropriate care for the critically injured.

The Alaska Native Health Service received a supplemental appropriation for FY 77 of \$1.35 million and for FY78 of \$2.0 million. These funds are for EMS only and are distributed in whole to each of the health corporations. Funds are used to support the regional programs in the region that we do not fund. One corporation, Mameluk dovetails the funds into a coordinated effort. However, in three of the regions, little cooperation exists. A problem has developed wherein the native cooperations often feel that they are not receiving a fair share of the "State's" money.

The EMS program is a medical care program. In other states it has been successful only where there was extensive physician leadership and involvement. During the first two years of this program physician involvement was next to nothing. So far this year we are beginning to gain support. Thanks to Dr. Fraser, three major regions have medical directors. However, much more active physician involvement is necessary to give the program a sound medical base.

When the program was initiated the State was divided into eight regions (see map). The eight region structure has proven to be less than effective in developing "total" EMS Systems. The Bush Areas send all critically injured patients to Anchorage for definitive treatment. We are now considering reducing the eight regions to three to conform to the HSA boundaries.

Finally, there is a lack of data for planning and evaluation. The EMS program is one federal program that realizes the importance of systematically evaluating how the system is functioning as well as planning the expenditure of funds based on demonstrated need. The development of a coordinated patient record keeping system is one of the mandated components that has received little more than lip service. Planning is hampered by this lack of data.

Prospects

Up to this point the program has been one of haphazardly throwing grant applications together each year so that the feds can give us money, regardless of the quality of the application. The applications have really been the best that could be produced at the time by the people involved, with definite improvements in quality in each subsequent application. However, there has been little real planning and no long range planning.

This year we are developing a large range policy plan that lays out a funding strategy through FY 84 and establishes status and systems goals for each region in the state. A draft has been developed and will be presented to the State EMS Advisory Council at their meeting of January 20-21, 1978 for their comments. It will then be circulated widely throughout the State for further comment, be reworked accordingly and then presented to the Council for final recommendations. We hope to be able to maintain the plan as a dynamic tool that will be reviewed and updated on an annual basis to provide the basis for EMS Systems development in the future.

Another major effort will be renewed cooperation between those state and federal agencies that have EMS responsibilities, especially the AANHS and the State Department of Public Safety. Both of these agencies spend funds on EMS systems development in the State.

We hope to have in place a Critical Care Committee of physicians specialists in the area of Burns, Trauma, Cardiac, Poison, High Risk Infants, Psychiatric, and Spinal Cord Injuries. The Committee will develop treatment and triage protocols for the critically injured. These will be used by providers at the various levels of care as guides for the stabilization and treatment of the patients.

Emergency Medical Services Systems Development: A National Initiative

DAVID R. BOYD

P III - LEGISLATION

Abstract—The passage of the Emergency Medical Services Systems (EMSS) Act of 1973 by Congress has provided the mechanism and funds for communities to develop regional EMS delivery systems across the Nation. With the passage of the EMSS Act, the Congress mandated that emergency medical care programs funded with Federal dollars must address, plan, and implement a "systems approach" for the provision of emergency response and medical care. In the EMSS Act, some fifteen component requirements have been identified to assist system planners, coordinators, and operators in their attempts to establish comprehensive, area-wide and regional EMS programs. These components are: manpower, training, communications, transportation, facilities, critical care units, public safety agencies, consumer participation, accessibility to care, transfer agreements, standard medical record keeping, consumer information and education, evaluation, disaster linkage, and mutual aid agreements. Development of a national program, its projects, and progress, is the basis of this report.

INTRODUCTION

CONSIDERABLE improvements are now being made in the delivery of emergency medical care, with major advances the result of the development of a "systems approach" and the integration of standardized vehicles, communications and medical equipment, training programs, emergency facilities, and critical care unit capabilities. Advances in on-site care by physician agents (Emergency Medical Technicians-Ambulance and Paramedics) in radio telecommunications with medical professionals have been shown to be effective in improving patient care for a wide variety of emergency, critically ill, and injured patient categories, especially those suffering from acute myocardial infarction and major trauma. Pioneering programs [1] in Miami, FL (Magel); Nassau County, NY (Lambrew); Charlottesville, VA (Crampton); Seattle, WA (Cobb); and Illinois (Boyd) have illustrated the necessary systems design, treatment protocols, technical adaptations, facilities orientation, and organizational structure that are required for successful program development.

It is now quite apparent that significant improvements in emergency and critical care of all types of emergency patients can be realized if a sound integration of all of the essential components of an EMS system are logically structured and directed towards delivering ideal care to "real" patients in need. Heretofore, some debate has existed as to which component, or subsystem, is the most important. However, current consensus is that only a comprehensive EMS program, logically

planned and staged, will develop and mature so that all patients in need will receive the most appropriate care in the prehospital, hospital, interhospital, critical care, and rehabilitative phases. An EMS system must then develop a sound sequence of comprehensive program activities on a regional basis if the needs of all potentially emergent patients are to be properly anticipated and receive adequate response.

THE EMERGENCY MEDICAL SERVICES SYSTEMS ACT OF 1973

The passage of the Emergency Medical Services Systems (EMSS) Act of 1973 (P.L. 93-154) by Congress [2] has provided the mechanism and funds for communities to develop regional emergency medical services delivery systems across the nation. With the passage of the EMSS Act, the Congress mandated that the emergency medical care programs funded with Federal dollars must address, plan, and implement a "systems approach" for the provision of emergency response and medical care. In the EMSS Act, some fifteen component requirements have been identified to assist system planners, coordinators, and operators in their attempts to establish comprehensive, area-wide and regional EMS programs. These components are listed below.

- 1) The provision of manpower.
- 2) Training of personnel.
- 3) Communications.
- 4) Transportation.
- 5) Facilities.
- 6) Critical care units.
- 7) Use of public safety agencies.
- 8) Consumer participation.
- 9) Accessibility to care.
- 10) Transfer of patients.
- 11) Standard medical record keeping.
- 12) Consumer information and education.
- 13) Independent review and evaluation.
- 14) Disaster linkage.
- 15) Mutual aid agreements.

The Division of Emergency Medical Services (DEMS), Department of Health, Education, and Welfare (HEW), the established Federal lead agency, has developed Program Guidelines in which under chapter III, [3] "Special Program Guidance," the clinical significance of the systems approach in developing an EMS system is described. While an EMS system must respond to all declared emergency calls within its appropriate geographic region (including the nonemergency

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80 percent, the truly emergent 15 percent, and the critical cases—5 percent), there has been a special identification of those well identified critical patient groups which demand a competent system for survival. It is to the survival of these critical patients (trauma, burns, acute cardiac, high risk and premature infants, poisonings, psychiatric, drug, and alcohol overdose) that a "system" conceptualization and initial system efforts must be directed in order to insure the development of a sound, medically competent, and comprehensive EMS system.

EMERGENCY MEDICAL CARE ISSUES

The central theme and intent of the EMSS Act is to develop systems of emergency medical care that would significantly decrease current death and disability rates. The goal of the national EMS program is to initiate regional planning and integration of the fifteen mandatory components so as to provide the essential and appropriate EMS emergency and critical care services for all emergency patients.

The current EMS patient problem is compounded by the 65 million citizens who enter the system each year. At least 80 percent of these patients cannot be considered "true medical emergencies." Another 15 percent are real emergencies which require urgent care (i.e., minor trauma, infectious diseases, and other acute general medical and surgical problems). The remaining 5 percent are the critically ill and injured patients. This last group was not salvageable only a few years ago, but today, these lives can be saved if initial, definitive, and rehabilitative care is given in time and the patient is moved through the regional system and provided essential medical care.

Specific planning of regional EMS response to these particular critical care categories assumes that in time all critical medical emergencies will receive better care, and will benefit from sound regional EMS systems planning and operations.

Likewise, certain local occupational and/or recreational hazards must also be addressed with a goal toward prevention. These special target patient groups provide each regional system with an opportunity to develop evaluation criteria for systems performance and patient outcomes (distribution and survival).

EMS SYSTEMS DEVELOPMENT

Each regional emergency medical service plan must include a description of the general and specific protocols for the emergent and nonemergent patients in its delivery system. It must also include a detailed explanation of care and triage patterns for critical groups by identifying the patient treatment needs as well as the involvement of the systems operational components (vehicles, telecommunications, manpower, facilities). These care patterns will depend upon the clinical patient demands, the sophistication of the transportation capability, the level of care during transportation, the communications coordination, the delivery to a categorized general hospital or designated critical care facility, and the migration into the rehabilitation phase. These patient care programs must be established with appropriate backup relationships by written arrangements among the various pro-

vider elements in order to insure a sound and competent regional EMS system.

When an individual becomes seriously ill or injured it is manifested in a specific way. Patients have accidents. They have heart attacks. They are burned. They have problems at birth. They are poisoned with alcohol, drugs, or other toxicants. They have emotional disturbances resulting in varying degrees of psychiatric instability. The planners of EMS systems must consider the general patient population and these easily identifiable and significant critical patient groups that exist within the geographic regional area. An in-depth knowledge of the demography, epidemiology, and clinical requirements associated with these critical patient groups is mandatory to effective EMS planning and operations.

In many circumstances the initial patient access, response, and transportation considerations are general in nature until the severity of the patient's (diagnostic-specific) problem becomes clarified. As soon as this clarification develops, a rather specific patient treatment and triage plan must be activated to include the prehospital, hospital, interhospital phases, as well as the specialty care unit and later the specific rehabilitation services necessary for each illness and injury.

It is now a fairly well accepted position across the country that initial and definitive medical care for each of the target patient groups can be improved, and most of these patients can be salvaged by an effective EMS system. The design of an EMS system will need to include certain organizational and operational changes. There must also be additional adaptations of treatment in the prehospital, hospital, and interhospital phases with proper modification of existing and new technology that will enable paraprofessional, and professionals to successfully manage and treat all emergent problems at the scene and during movement through the system whether they occur in urban, metropolitan, rural, or wilderness areas [4].

The development of an EMS system usually starts with an initial upgrading of existing resources and then progresses through periods of increasing sophistication. That is, following the establishment of a basic life support (BLS) system within the region, there usually is a logical progression to the advanced life support (ALS) system due to the increasing capabilities of the EMS region.

BASIC LIFE SUPPORT SYSTEM

A BLS system includes all of the fifteen components. However, certain ones are more critical, at least early on. BLS services can be effectively provided by the integration of nationally accepted minimal standards for ambulance personnel (e.g., Emergency Medical Technician-Ambulance, EMT-A [5], ambulances of the Department of Transportation (DOT) specification [6], two-way voice medical communications (VHF or UHF band) [7], and standard equipment as recommended by the American College of Surgeons [8]). Effective placement of these vehicles, staffed by two EMT-A's, can provide emergency medical care with patient stabilization, airway clearance, hemorrhage control, shock management with MAST trousers [9], initial wound care, and fracture stabilization. Under medical control (physician directed), specific noninter-

ventive treatment in which the EMT-A's have been previously trained can be applied. The transportation subsystem must be developed in the context of a sound hospital/critical care unit categorization program. The categorization of the facilities [10], [11] (hospital emergency department, critical care unit, and rehabilitation center) [12] is a major aspect of any program and is critical in the initial development of a BLS system. It gives identification and direction to all mobile, communications, transportation, and manpower elements at even the basic level, and makes possible the sound conceptualization of a delivery system for all emergency patients, while also providing a standard for clinical impact and EMS process evaluation. Most communities have begun their EMS systems in this manner, causing a considerable increase in public awareness of the need for improved EMS.

ADVANCED LIFE SUPPORT SYSTEM

Most urban communities, and now even [13] some rural regions, have progressed to an ALS system. This involved a much more sophisticated level of EMS systems planning and operations with highly skilled field personnel, EMT-Paramedics, trained to successfully identify and aggressively treat life-threatening emergencies (shock, cardiorespiratory failure, and cardiac dysrhythmias) at the scene and enroute to the hospital. At the ALS level, mobile units are equipped with appropriate intravenous fluids, drugs, and usually with some form of bioelectrical communications (telemetry). This enables paramedics with proper physician backup to perform expert diagnosis, treatment, and triage of critical patients. The need for a sound categorization of facilities during the BLS period is quite obvious due to the requirements for a medical communications control facility, and standardized treatment and regionwide triage protocols that ensure a progressive and continued enhancement of critical care for patients from the field to initial care facilities and on to the definitive advanced care facility, as is appropriate for each individual case and locale.

The components of an ALS system are as outlined here. ALS is the more sophisticated and logical progression of BLS, in which extensively trained EMT-Paramedics can provide true resuscitation (CPR) and specific interventive measures (e.g., endotracheal or esophagogastric intubation), intravenous therapy, specific cardiac dysrhythmia detection, and control with drugs and electrocounershock. These life savings techniques administered by EMT-Paramedics are always undertaken, except in rare circumstances, under the direct control of a physician or physician-surrogate in contact by voice and EKG telemetry. Most urban and many metropolitan communities (over 50 000 population) have initiated these ALS prehospital mobile intensive care unit (MICU) programs and have realized a major impact on the trauma, cardiac, and other critical patients. In many parts of the country, this increased capability of critical care will need to be developed not only in the central metropolitan areas, but also, with a further extension of satellite critical care units, in outlying community hospitals. This restructuring and resource development approach will affect primary and secondary transportation, communications, and EMS manpower, all of which must be upgraded to meet

this advanced level of care, particularly in the prehospital and interhospital phases of development. While most of the activity in the ALS system is currently in the metropolitan areas, an appreciation of the need for ALS and critical care services for the rural and outlying areas is now developing. A national goal will be to realize these essential emergency and critical care services for the rural emergency patient at the scene and during the long transportation periods to distant appropriate treatment facilities.

It is these health care aspects that must be stressed in EMS planning and operations with detailed narratives of what the emergency care situation is, how the proposed EMS system will respond to an emergency patient in a certain locale, and how the patient will be evaluated, treated, and transported to an appropriate hospital or critical care unit.

REGIONALIZATION OF EMERGENCY MEDICAL SERVICES

A regional EMS system is one that is geographically described by existing natural patient care flow patterns. It must be large enough in size and population to provide definitive care services to the majority of general emergency and critical patients. Where highly sophisticated medical resources are not available within the region, arrangements must be made for obtaining these patient care services in an adjoining region. Various counties and cities will need to be grouped together. Therefore, the region will tend to be much larger than previously considered by independent local governmental operations. Identifying the regional EMS delivery area, with its critical patient origin and distribution patterns, is the essential issue in defining regional boundaries.

The regional EMS operational and organizing unit must attempt to pull together the EMS services within the entire medical-geographic area. The planning and evaluation process must be based upon sound clinical considerations with state, local, and interjurisdictional relationships being maintained. In these EMS regions the provider elements within the appropriate geographical area will need to work together to solve mutual problems. An EMS Council should be developed with advisory input into these regional EMS programs and encouraged to maintain contact with other local, regional, and state health and public safety authorities. The EMS region must be contiguous with the adjoining regions. Regional planners must recognize that population in the fringe areas of a region may need to develop dual plans and allow for intercommunications with adjoining regional EMS plans and operations. A coordination mechanism also must be developed between intrastate and interstate regions.

The EMS system must be integrated through an appropriate regional organization so that the total EMS resources can be effectively utilized to meet the needs of the geographical area. The financial resources of the region must be sufficient and mobilized to develop and sustain the EMS system operation. The EMS system must be interfaced with the total health care delivery system for the region. The EMS system resources must be linked to local disaster organizations in order to respond to sporadic high intensity needs of a natural disaster within the regional service area and adjoining service areas.

EMERGENCY MEDICAL SERVICES SYSTEM COMPONENTS

The EMSS Act of 1973 requires that plans developed and systems established, expanded, and improved with funds under this Act, address the following components.

1) Manpower—An adequate number of health professionals, allied health professionals, and other health personnel, including ambulance personnel, with appropriate training and experience.

This means sufficient numbers of all types of personnel to provide EMS on a 24-h a day basis, 7 days a week, within the service area of the system.

The EMS system must emphasize recruitment of veterans of the Armed Forces with military training and experience in health care fields and of appropriate public safety personnel in such areas. The major manpower elements to be considered are as follows:

- First Responders—fire, police, and other public safety elements;
- Communicators—EMS/Resources Dispatcher;
- Emergency Medical Technician—Ambulance (EMT-A);
- Emergency Medical Technician—Paramedic (EMT-Paramedic);
- Registered Nurses—Emergency Department;
- Registered Nurses—Critical Care Units;
- Physician—Emergency;
- Physician—Specialty (medical, surgical, pediatric, psychiatry);
- EMS Systems Medical Director;
- EMS Systems Administrator;
- EMS Systems Coordinators.

2) Training—The provision of appropriate training (including clinical training) and continuing education programs which a) are coordinated with other programs in the system's service area which provide similar training and education and b) emphasize recruitment and necessary training of veterans of the Armed Forces with military training and experience in health care fields, and of appropriate public safety personnel including: police, firemen, lifeguards, park rangers, and other public employees charged with maintaining the public safety.

3) Communications—Provisions for linking the personnel, facilities, and equipment of the system by a central communications system so that requests for emergency health care services will be handled by a communications facility which a) utilizes emergency telephonic screening, b) utilizes or will utilize the universal emergency telephone number 911, and c) will have direct communication connections and interconnections with the personnel, facilities, and equipment of the system and with other appropriate emergency medical services systems.

The EMS communications system should include a command and control center which is responsible for establishing those communications channels and allocating those public resources essential to the most effective and efficient EMS management of the immediate problem. The center should have the necessary equipment and facilities to permit imme-

mediate interchange of information essential for the system's resource management and control. The essentials of such a command and control center are that a) all requests for system response are directed to the center; b) all system response is directed from the center; and c) all system liaison with other public safety and emergency response systems is coordinated from the center.

The EMS communications system must address access, allocation of resources, management (central dispatch), and medical control for BLS and ALS.

In most states a physician must assume legal responsibility for all care rendered in an emergency at the scene of an incident and enroute to the hospital. Such supervision may take one of several forms depending upon resources available and the configuration of the system in a particular area. In most states, BLS measures are considered to represent emergency first aid and do not require strict medical supervision although a physician remains responsible for the training and actions of nurses and emergency medical technicians rendering such care. When ALS is required, physician supervision becomes mandatory. In most systems, medical supervision is provided through the availability of voice communications between a physician and emergency medical technician in the field. The communications may rely solely on a telephonic link from the scene of the incident to the physician, but usually involves radio communications or a combination of radio and telephone linkages between the EMT in the field and the physician. Although it is generally agreed that medical supervision may best be given by a physician located in a hospital, it is often not practical to do so, especially in rural areas where frequency of utilization of the emergency rescue service is low, and inhospital physicians on a 24-h a day basis are not available. In such areas, the EMT must be patched to the physician, via dedicated phone lines, in the major hospital within the region.

In most urban areas, medical supervision is provided through a central base hospital resource. It is emphasized here that it is quite impractical in terms of available frequencies and from the standpoint of expense to have every hospital in an urban area providing medical supervision to ambulances bringing patients to each of these hospitals. Most importantly, personnel at each of the receiving hospitals cannot be expected to be familiar with the radio equipment and communications procedure with resultant communications failures. Furthermore, where multiple users are sharing a frequency, information may become interchanged which may lead to errors in diagnosis and treatment. Therefore, for urban areas it is imperative that medical supervision be regionalized and confined to one base hospital communications center as appropriate to the needs of the area.

Telemetry of biological signals, primarily of the electrocardiogram (EKG) has been found to be a useful adjunct to voice communications especially in the treatment of the acute cardiac emergency. The absolute need for telemetry of the EKG will vary from system to system, again, depending upon the level of training of available rescue personnel and the frequency of exposure of such personnel to the need to monitor the EKG. In programs which use volunteer rescue personnel, telemetry becomes a more important adjunct than in programs

utilizing highly trained full time EMT's with a high frequency of exposure.

Treatment protocols for each major emergency are an important aspect of medical supervision. They provide a basis for the training of all EMT's and afford the opportunity for standardization of training programs on a regional basis, establish a medical legal standard of care for the patient with an emergent problem and, through a standardized approach to the patient, facilitate cooperation between rescue personnel in approaching a given problem and allow for meaningful evaluation of training efforts and patient outcome. Such protocols can be simple or complex as required by the patient type and will be influenced by such factors as the level of training of available rescue personnel and the length of transport time to the nearest appropriate medical facility. These treatment protocols must be approved by a consensus of area physicians, based on available national standards and implemented on a regional basis.

The supervising medical resource facility must be responsible for notification of the other receiving associate hospital so that it will be aware of the problem and what has already been done in order to expeditiously assume responsibility for the care of the patient immediately upon arrival. Furthermore, this communications resource facility should be responsible for decisions that relate to transportation triage of a patient to a special care unit in accordance with previously developed patient transfer guidelines and agreements. It should have the capability of hospital-to-hospital communications for the purpose of determining Emergency Department capability and bed availability information which is necessary in effective coordination of patient disposition. There must of course be a linkage between this regional resource facility and the responsible unit for dispatching all emergency vehicles.

The communications element should include the following.

Access providing public interface system to emergency resource system:

- o 911.
- o Alternative single access number.

Resource management function:

- o Central Dispatch.
- o Coordination of EMS and other public services.

Medical Control:

- o Medical communications to hospital for triage, diagnosis, and treatment.

Hospital to Mobile Unit:

- o Basic voice.
- o Basic voice/advanced biomedical telemetry.

Hospital to Hospital Unit:

- o Basic voice.
- o Relayed biomedical telemetry.

4) *Transportation*—This component shall include an adequate number of necessary ground, air, and water vehicles and other transportation facilities properly equipped to meet the transportation and EMS characteristics of the system area. Such vehicles and facilities must meet appropriate standards relating to locations, design, performance, and equipment; and the operators and other personnel for such vehicles and

facilities must meet appropriate training and experience requirements.

The elements of transportation should include the following.

Ground—Basic Life Support Elements:

- o Ambulance vehicles meeting DOT/GSA specifications and including equipment recommended by the American College of Surgeons, HEW/DOT.
- o Radio communications providing two-way voice for vehicle control and for medical control and consultation.
- o At least two EMT-A's on each ambulance.
- o Locations permitting (for 95 percent of all calls) a maximum of a 10 min response time in metropolitan areas.
- o Locations permitting (for 95 percent of all calls) a maximum of a 30 min response time in rural areas.

Ground—Advanced Life Support Elements:

- o All elements of a ground Basic Life Support component, plus personnel trained to the EMS-Paramedic level must address specific clinical items in medical service plan.
- o Extra communications to provide advanced biomedical telemetry.
- o Extra equipment for critical care procedures.

Air:

- o Helicopters
 - Primary response—unique use depending on geographic constraints.
 - Secondary response, 30-150 mi transport radius.
- o Fixed Wing
 - Greater response for 150 mi transport radius.
- o Water
 - Special geographical considerations.
- o Snow Mobile
 - Special geographical considerations.

5) *Facilities*—This component shall include an adequate number of easily accessible emergency medical service facilities which are collectively capable of providing service on a continuous (24 h a day, 7 days a week) basis, which have appropriate standards relating to capacity, location, personnel, and equipment, and which are coordinated with other health care facilities of the system.

Categorization of the emergency capabilities of hospitals is an [14] established EMS systems concept [15]. Since the mid-1960's there has been considerable discussion about the need for the categorization of the general and specialty hospital emergency care capabilities on a regionalized basis. Medical professionals and organizations and interested health agencies have recognized and supported the need for adoption and implementation of EMS facility categorization. Unfortunately, little positive action has taken place in many states at the regional and local levels to implement programs that integrate the principles of established national categorization guidelines and that assess the individual hospitals' general and special care resources and potentials to effect sound regional EMS system development.

The concept of categorization of all emergency care facilities originates from the realization that emergency patients have varying magnitudes of injury and illness and that all hospitals have varying capabilities with which to provide adequate initial and/or definitive care. It is also realized that a categorization program must address the needs of all emergency medical patients and, therefore, deal with the growing numbers of nonemergent (primary care), truly emergent, and critically ill and injured patients. Effective categorization must involve all of the emergency receiving facilities and ascertain both the general (HORIZONTAL) and specialty (VERTICAL) care capability for all emergency patients. Categorization efforts should utilize the principles of established National Guidelines and in addition develop statewide criteria for implementation on a regional basis (CIRCULAR).

Categorization has relevance in urban, suburban, rural, and wilderness areas. The categorization concept will have additional significant effects on the utilization of EMS manpower and other EMS resources by eliminating duplication, providing additional data and information for improving EMS systems development, and should help check the spiraling costs of improved medical care. The basic purpose of categorization is to identify the readiness and capability of each hospital within a region to receive, diagnose, and treat all emergency patients, especially those with serious or critical injuries or illnesses, in an adequate and expeditious manner. Ambulance personnel, law enforcement and public safety officers, and the public must be knowledgeable of the designations of the hospitals within the region in order for the system to operate effectively and selectively utilize the appropriate hospital to which critically ill or injured patients are to be transported for treatment.

Elements for facilities consideration include the following.

- Regional categorization with accepted state or national criteria with at least one Category II hospital providing 24 h physician coverage in the emergency department in each EMS region.
- Regional EMS advisory groups to plan and carry out the categorization plan. These groups should include hospital administrators, physicians, nurses, other providers, and health system planners.
- Regional plans for mutual agreement of categories, use of critical care units, systems linkages (transfer agreements), and resource sharing.

6) Critical Care Units—This component requires providing access (including appropriate transportation) to specialized critical medical care units. These units should be in the number and variety necessary to meet the demands of the service area. If there were no such capabilities in the EMS region, then the system must provide access to such capabilities in neighboring regions.

Specialized critical medical care units should include trauma intensive care centers/units, burn centers/units, spinal cord centers, poison control and alcohol detoxification centers, coronary care units, high risk infant units, drug overdose and psychiatric centers, and others as appropriate.

A twofold issue here is the availability of critical care service units within the EMS region or in neighboring regions. Specialty care services should provide an adequate number of beds in the region or access to critical care units in neighboring areas. An operational plan for utilization of critical care units should be developed, including trained personnel, equipment and transportation, triage and interhospital treatment protocols. The EMS system should include the development of professional advisory groups (trauma, burn, cardiac, etc.) to work with EMS programs to insure that these critical services are being appropriately utilized and interrelate across political boundaries.

7) Public Safety Agencies—Provisions must be made for effective utilization of appropriate personnel, facilities, and equipment of each public safety agency in the area.

"Effective utilization" means the integration of public safety agencies into standard EMS and disaster operating procedures of the regional system. It also includes the shared use of personnel and equipment, such as helicopters and rescue boats, appropriate for medical emergencies.

Public Safety agency personnel are most frequently the first responders to an emergency patient. The EMS system must therefore work with these agencies to ensure the use of special equipment, proper training of staff, linked communications, and the development of cooperative operating procedures.

8) Consumer Participation—The EMS system must make provisions in its system management that persons residing in the area and having no professional training or experience may participate in the policy making for the system.

While there is no federally required percentage of consumer participation in EMS planning or advisory organizations, reasonable consumer representation should be provided. One approach would be to involve the committee of the advisory council of the local planning Agency which has consumer representation.

9) Accessibility to Care—The EMS system must provide necessary emergency services to all patients without prior inquiry as to the ability of the patient to pay.

The EMS system must not require evidence of the ability to pay prior to care for the services of ambulance, hospital, or critical care units. The system should provide the means to monitor for restrictive measures that may eliminate any person or group of people from equal quality of services within the region.

10) Transfer of Patients—The EMS system shall provide for transfer of patients to facilities which offer definitive follow-up care and rehabilitation as is necessary to effect the maximum recovery of the patient.

The transfer agreement is necessary to facilitate communication and cooperation of key professional providers (physicians) within the system. Actual letters that describe the transfer requirements for the critical target patients are essential contracts of regional EMS development. They not only open the radial lines of communications between the physician in the outlying area with a patient problem beyond his capability to the center physician with the necessary resources, but they also will establish the manner and mechanism by which

critical patients will be initially treated and retransported through the system. Only through this transfer agreement method will physicians at varying care capability levels come together and decide mutually on treatment, triage, educational, and evaluation protocols.

In urban areas, areawide prehospital treatment and triage protocols will have to be established by councils of key professional providers for the various specialty patient groups. These programs will necessarily "bypass" the nearest hospital as special critical cases are identified.

11) Standardized Patient Recordkeeping—Each EMS regional system shall provide for a standardized patient record-keeping system which covers the treatment of the patient from initial entry into the system through his discharge from it, and shall be consistent with patient records used in follow-up care and rehabilitation of the patient [17].

The minimal patient records necessary for the EMS system are the dispatcher records, the ambulance records, the emergency department, and critical care records. In order to fulfill requirements of evaluation and reports to Congress, certain information must be available to be derived from these records.

- Patient identification information: the records must be designed so that the dispatcher record, ambulance record, and emergency department record on each patient can be compared for evaluation and management purposes.
- Patient access information: How did the patient access the system (arrive at emergency department)?
- Timing of ambulance services: response time, time at scene, and travel time to hospital.
- Patient condition: at scene, upon arrival in emergency department, and critical care unit.
- Patient treatment: at scene, during transport, in hospital.
- Patient diagnostic and treatment services: at emergency department, in hospital, and critical care unit.
- Disposition of patient: discharged, referred for outpatient care, referred to another hospital, admitted, died.
- Condition of patient: at discharge from emergency department, in hospital, and critical care unit.

12) Public Information and Education—The EMS system shall provide programs of public education and information for all people in the area so they know about the system, how to access it, how to use it properly, and how to pay for it. Successful systems operation depends not only upon the organizers, but also the participants. Continued support, particularly in the arena of competition for dollars, requires community commitment. To secure that commitment, the EMS system must keep its public informed. Programs should stress the general dissemination of information regarding appropriate methods of medical self-help and first-aid and the availability of CPR training programs, and other preventive oriented resources.

13) Independent Review and Evaluation—Each EMS system must provide for a) periodic, comprehensive, and independent review and evaluation of the extent and quality of the emer-

gency health care services provided in the system's service area and b) submission to the Secretary of the reports of each such review and evaluation.

It is intended that such review and evaluation be periodic and comprehensive so that changes in emergency health care can be determined. The evaluation should be conducted by a qualified organization other than the grantee project personnel.

There is no intention to require sophisticated and expensive research oriented evaluation from funds granted under Sections 1203 and 1204. What is required is that persons not associated with the project conduct a review and evaluation of the extent and quality of the services provided. As a minimum the reviewer should have available:

- a description of the EMS resources, capability and performance measures at the start of the period being evaluated;
- a description of the interventions brought about during the period to include both clinical and EMS components;
- a description of the EMS resources, capability, and performance measures of the period being evaluated;
- clinical output or impact evaluations of death and disability should include the clinical patient target groups.

14) Disaster Linkage—The EMS system must have a plan to assure that the system will be capable of providing emergency medical services in the system's service area during mass casualties, natural disasters, or national emergencies.

The EMS system is not the regional health disaster organization. It is the emergency medical program that will work with other agencies during a disaster to provide emergency medical care. The EMS system must have links to the local, regional, and state disaster plans, and participate in exercises to test disaster plans at least biannually.

15) Mutual Aid Agreements—Each EMS system must provide for the establishment of appropriate arrangements with EMS systems or similar entities serving neighboring areas for the provision of emergency medical services on a reciprocal basis where access to such services would be more appropriate and effective in terms of the services available, time, and distance.

Arrangement among EMS regional systems and similar entities serving neighboring areas must be written agreements, signed by individuals authorized to act for the respective parties with respect to such agreements, and reviewed and reevaluated at least once a year. Such agreements should cover the exchange of service coverage, communication linkages, licensure and certification, and reimbursement.

EMS SYSTEMS MANAGEMENT

National experience with public and private funds has demonstrated that a few strategic factors are paramount to successful operations and management of an EMS system effort. The following elements must be addressed in order to develop and maintain an integrated total EMS system.

- Action Plan for EMSS Area—A comprehensive and detailed and progressive plan must be created for establishment, operation, and expansion of the EMS system.

- Lead Agency—A lead agency must be identified as the responsible operations unit for the EMS system including grants management control and operations coordination of the involved community and regional organizations and resources.
- Financial Support—Appropriate means of financial support for initial and continued EMS operations must be considered. Such financial support may be derived from various Federal programs, state and local funds, general revenue sharing funds, third party payments, and direct payments from patients.

The intent of the EMSS Act is to fund EMS projects on a multigovernmental and multicomunity basis. At the present time there are a few regions in the country where an "ideal" appropriate regional health authority exists. Such an organization or special health consortium must be developed usually with reliance on the established state health office (or major Metropolitan Health Agency) with its established management and regulatory capability for successful program initiation and support.

EMS LEGISLATION

The Emergency Medical Services Systems Act of 1973 called for "a study to determine the legal barriers to effective delivery of medical care under emergency conditions," [18]. The report of the Committee on Interstate and Foreign Commerce of the House of Representatives (H.R. Rep. No. 601, 93rd Cong., 1st Sess. 19 (1973)) stated that "legal barriers include situations where existing state laws prevent appropriate emergency services as well as situations where the absence of needed legislation fails to encourage and require such services." The report described some of the legal barriers which were included in testimony before the Committee, including: restrictive licensing laws, absence of laws requiring ambulance personnel to have adequate training, absence of laws requiring adequate design and equipment for ambulances, and inadequacies of state "Good Samaritan" laws.

The study revealed that the absence of enabling legislation at the state level rather than the presence of specific legislation provisions which preclude delivery of service, represent the major "legal barriers" to the development of regional systems of emergency medical care. Because of this, state legislatures should enact comprehensive laws to create and control the many components of the areawide emergency medical services system. State legislation should address the following areas:

- Definition of an areawide EMS system.
- Creation of a state governmental unit to plan, develop, and coordinate EMS activities in the state, emphasizing areawide systems with intersystem cooperation and including interstate cooperation.
- Ambulance services, including licensing of ambulances and ambulance services; standards for vehicle design, equipment for medical care and for communication; and personnel.
- Personnel, including definition of categories of personnel involved in EMS, training, and certification requirements, and explicit definitions of which services the

various categories are authorized to perform under specific circumstances.

- Emergency medical facilities, including a requirement for participation in areawide systems and a requirement for systemwide categorization of hospitals by the level of care they can provide.
- "Good Samaritan" legislation.
- Responsibility for providing care, including responsibility of the general public, health professionals, ambulance services, and hospital emergency facilities.
- Financial responsibility for care, defining who is responsible for paying for care provided.

National program efforts will focus on how to assist state legislatures in implementing such legislation that will encourage the development of regional EMS systems. The EMS system will be enhanced and placed on more solid foundations by the enactment of adequate EMS legislation by state legislatures.

EMS SYSTEM EVALUATION

At this time it is impossible to determine how many lives are being saved and the amount that disability is being reduced because of EMS systems. To date, evaluation of the emergency medical care programs have been geared toward the survey approach, resources documentation, and data on subsystems (e.g., transportation, training, etc.). Essential data must be obtained to evaluate the clinical effectiveness of regional EMS systems. There must be developed new methodologies for "tracking" and evaluating emergency medical care for specific patient groups, e.g., trauma, burns, etc., within the system. These analyses will allow programmatic decisions as to the appropriateness of utilization of facilities, personnel, equipment, clinical treatment, and cost effectiveness.

The following should be the basic ingredients for the development of an evaluation strategy. It is appreciated that at present the "state of the art" of systems evaluation is rather primitive across the country. This is consistent with the relative development stage of most EMS systems at this time. As EMS projects grapple with the multiple components and organizational changes, they must also comprehend the basic precepts of evaluation methodology [19].

The following are basic to an evaluation strategy.

a) Development of a descriptive narrative of the organization's operational components, and "clinical systems" design and implementation. A key evaluation task for each program will be that of the narrative description of the relative systems changes implemented and perceived as the EMS system develops. This essential evaluation component cannot be overlooked and is essential for subsequent steps b), c), and d), described below.

b) Structural analysis and resource development. In this area one must describe some of the key implementation aspects (radio-installed, ambulances placed, etc.) that are well identified phenomena of an EMS program. These will be necessary in the area of organization and management, at least the six clinical tracer and impact groups, and at least one parameter for each of the fifteen components.

This inventory assessment will describe these key structural phenomena and provide some guidance as to the quality of

each parameter, (implementation of 911, dispatch, categorization). Much of this data will include resources data for program information sources. Of these parameters within each of these areas some will be of state or national significance.

c) EMS activities or processes. Those structural components now implemented (e.g., communications, 911 dispatchers, ambulances, trauma units, etc.) all have activity levels which can be counted using operations data; for instance, counting trauma victims admitted to a specialized designated trauma unit, or the numbers of calls via the 911 access number. With this approach even during the initial years, a program will be capable of monitoring the very basic process elements of the system and will be able in future years to develop ratios, indices, and correlations among or between systems components.

Rates of utilization and appropriate clinical and cost benefit data can subsequently be developed. Section c) will also have some parameters of national significance but more importantly this data will be most useful to the actual operation, management, and development for each system.

Again, this type of basic information is necessary and relates to section d).

d) Patient outcome and program impact. In this section, critical clinical questions must be enunciated in the evaluation strategy, and the evolution from simple to complex evaluation approaches will parallel each system's growth and maturity. There are at least four types of impact evaluation essential to documentation of a comprehensive and successful system.

1. Compliance studies. As the program narratives are developed (section a), resources developed (section b), and activity levels counted (section c), the effect of these on critical patient groups will be seen. The care of a patient at the scene, transport to a facility following a described program narrative (e.g., critical major trauma, sent to a trauma center) can be counted at the center and with surveys for similar patients in nondesignated facilities will give patient "fit" or compliance to a prior "care system" set. The first such patient and all subsequent patients "test" the system in this tracer method.

In the initial years of most programs, this simple analysis is possible and will relate to patient "systems" compliance and later outcome effectiveness.

2. Death and disability impact can be measured by national norms, peer judgments, or using newly developed indices or morbidity.

Interest here will obviously be along the lines of hard data (e.g., lives, deaths), and these can only be attributed to the system's effectiveness if in fact the patient was responded to and "processed" appropriately through the system according to established protocols.

3. As EMS systems mature, studies of death and disability on regional bases will be possible and necessary to show that these changes in death risk for a certain emergency are operative throughout the entire geographic region. So far only two such papers have appeared in the literature.

4. And finally, the evaluation of treatment effects, therapy alternatives, program options, phases of implementation, and other experimental studies, will be possible in regional

programs as the level of maturity and sophistication progresses, sound BLS and ALS systems.

This very basic but progressive evaluation strategy will provide a graduated experience in evaluations methodology for newly developing EMS programs.

Peer review has achieved great national importance among physicians in the United States in the past several years, consequent upon Federal legislation mandating PSRO and hospital quality assurance programs. Emergency medical care also requires peer review, not only from the standpoint of physician performance but also with nursing and EMT-A and EMT-Paramedic personnel. Professional and paraprofessional alike should critique the delivery of their specialized services within the system on a regular basis. Likewise, emergency room personnel have a responsibility to review overall performance of their colleagues, in order to upgrade care, identify deficiencies in training or equipment, and to rectify any errors which inevitably will creep into the EMS system.

DEVELOPMENT OF REGIONAL EMS SYSTEMS

During the first two years of the Program, 235 of the 300 state designated EMS Regions have received funding under the Emergency Medical Services Systems Act of 1973. One hundred and ten of these regions, serving a population of 77 000 000 are in some phase of operational development: 83 are developing a BLS capability under Section 1203, and 27 are developing an ALS capability under Section 1204. In addition, 125 regions covering a population of 87 500 000 have prepared plans for the development of regional systems under Section 1202.

A year-by-year summary of activity follows.

Fiscal Year 1974

Eighty-five grants covering 126 regions and serving a population of 83 200 000 were awarded in the amount of \$17 000 000.

Section of Act	Number of Grants	Number of Regions	Dollar Amount	Population Served
1202	53	90	\$ 2 250 000	63 000 000
1203	21	27	10 400 000	18 900 000
1204	11	9	4 350 000	6 300 000
Total	85	126	\$ 17 000 000	88 200 000

Fiscal Year 1975

One hundred and sixteen grants, covering 174 regions and serving a population of 121 800 000 were awarded in the amount of \$32 242 800.

Section of Act	Number of Grants	Number of Regions	Dollar Amount	Population Served
1202	56	82	\$ 4 617 800	57 400 000
1203	49	66	19 500 000	45 200 000
1204	11	26	8 125 000	18 200 000
Total	116	174	\$32 242 800	121 800 000

Extensions were also approved during fiscal year 1975 for 18 regions that were awarded grants in fiscal year 1974: 17 under Section 1203 and 1 under Section 1204.

Fiscal Year 1976

Fifty two grants covering 63 regions and serving a population of 44 100 000 were awarded in the amount of \$29 115 300.

Section of Act	Number of Grants	Number of Regions	Dollar Amount	Population Served
1203 ¹	41	51	\$21 836 475	35 700 000
1204	11	12	7 278 825	8 400 000
Total	52	63	\$29 115 300	44 100 000

Because of constraints in the current Act, no new regions will be planned or new systems will begin operations during fiscal year 1976.

Training

Section 776 of the Act provided funds for training during fiscal year 1974 only. Under this section, 76 grants and 2 contracts were awarded in the amount of \$6 666 869. These awards provided training for 36 350 individuals:

Discipline	Number of Trainees
EMT (Basic and Advanced)	25 000
Emergency Department Nurses	4000
Emergency Department Physicians	1200
EMS Administrators/Coordinators	150
Other	6000
Total	36 350

Under other authorities, the Health Resources Administration continued to fund applications for EMS training during fiscal year 1975. They awarded 9 grants in the amount of \$813 191 under Section 772, health professions special grants and contracts, and 39 grants in the amount of \$4 432 492 under Section 792, grants to improve the quality of training for allied health professions.

Research

In fiscal year 1974, five grants and 14 contracts were awarded in the amount of \$3 311 070 under Section 1205. In fiscal year 1975, 14 grants and four contracts were awarded in the amount of \$4 444 474 under Section 1205. These awards supported research in the four major categories described in Section 1205 (a).

Category	Dollar Amount
I. Medical Techniques	\$1 022 766
II. Methods	3 657 995
III. Devices	2 181 325
IV. Delivery	692 476
Total	\$7 754 474

¹ Funding limited to second year awards under Section 1203, and first and second year awards under Section 1204.

DISCUSSION

The time has come in this country when a strong positive force must coordinate all of the excellent, well developed medical resources and available technology to impact upon and improve patient care services for all emergency patients. The EMS problem was identified in 1966 by the National Research Council in "Accidental Death and Disability: the Neglected Disease of Modern Society," [20] and is now an accepted soluble nationwide medical problem.

The heretofore frequently isolated islands of excellence have often been separated by areas of confusion and fragmentation into single component emergency care efforts. In addition, there are many communities where emergency care is poor because of disarray, even disrepair, in terms of providing a system of emergency care, especially in the rural, the wilderness, and inner city areas. Previous local, state, and Federal initiatives have addressed single components or those parts of a system that seemed to represent the most acute and obvious need at the time. It is now apparent that a system must include all of the 15 components and is no more effective than its weakest links. Further development of one or two of the chosen strong links will not make the chain stronger and will not create a better system of care for the critically ill or injured victim. The "nonsystems" approach has been due to a combination of local ignorance, provincial prerogative, and lack of guidance by the Federal Government. The passage of the EMSS Act of 1973 now provides an opportunity to establish health priorities for emergency medical care at the local, regional, state, and national levels of our society, and to foster the development of a comprehensive and sound EMS systems approach that will affect all communities, especially the rural, the economically depressed, and the medically underserved areas.

ORGANIZATIONAL RESPONSIBILITIES

It is now quite obvious that an EMS system must incorporate a certain well identified and credible organizational unit to coordinate all of the various provider, community, and governmental interests. This unit must be the focal point for ensuring the system's integration from a systems access, a first responder's identification [1], communications coordination, patient transportation (primary and secondary), initial hospital, critical care facilities as well as linkages into rehabilitation. While no individual organization has the responsibility for all of these components, the operations unit must coordinate these many activities of the EMS system and must represent the professionally and publicly supported EMS Services Council for policy development, advice, grievances, and resources utilization.

CRITIQUE OF EMERGENCY AND CRITICAL CARE DELIVERY

It is now well recognized that patients are still being lost unnecessarily because of systems failure, not simply because of neglect of injuries or severity of medical problems. Prior to

current trends in management, many emergency cases were, more or less justifiably, treated conservatively because of the attitude that they were too "sick" to get well. Now that well established techniques of resuscitation and emergency medicine and surgery have been disseminated, an extremely aggressive approach in prehospital and hospital care phases is being shown to salvage lives. This sophisticated, aggressive, and coordinated approach to emergency care is not without significant cost and demands in terms of emergency medical services resources, especially manpower. Only by a consolidation of experience, personnel, vast medical resources, operating rooms, intensive care, X-ray, blood banks, etc., on a regional basis can such a program be developed and supported by the civilian community.

The concept of adequate emergency medical care requires an organizational responsibility which provides sound planning for the prehospital and hospital critical care services; and must engender community and region wide patient triage with well established, practical, and refined medical care plans that involve the care at the scene during transportation, in hospitals, and critical care phases of patient services. The whole aggressive systems approach must be without weaknesses or gaps, and continually needs to be reassessed and evaluated to assure optimal operation.

FEDERAL INVOLVEMENT IN EMS DEVELOPMENT

A large body of representatives from the many interested professional medical and health groups appeared in Washington in 1971, and testified at the Congressional Hearings on the Emergency Medical Services Systems Development Act of 1972, unanimously supporting the critical need for improvement of care of emergency patients. They also indicated that such care should and would be improved by the systems approach. Much of this testimony was given by witnesses from organizations who stated that they were convinced that the following pertains. "An environment now exists in the nation for the development of comprehensive total emergency medical services systems on a regional and statewide basis. The lack of provision for emergency illness, accidental death, and disability can no longer be classified as an insoluble health problem, as medical expertise and technology are available in this country which can easily be applied to this previously neglected situation." The essence of the opinions and precepts stated by those interested in the national EMS problem was that the "neglected disease of modern society" could now be effectively handled by efficient utilization of expert care principles and by organizing and improving, in each community across the nation, the existing and developing EMS resources and care capabilities. It was obvious that Federal direction would be an essential catalyst for a national EMS systems development program.

This organized systems approach to the care of emergency victims has been proven already in some areas. It has also been proven that by such a systems approach, a more effective return on the current and future investments of Federal dollars can be anticipated.

EMS AS A COMPONENT OF THE TOTAL HEALTH CARE DELIVERY SYSTEM

The coordination of established medical services and public safety efforts brings the emergency medical care program to an interface with community service activities heretofore outside the scope of established medical practice. Community involvement by a wide spectrum of the public, private, and governmental entities gives an emergency medical service system a new dimension to health care that has not previously been a major consideration in American medical practice. An additional result of the regional EMS system effort will be the demonstration of how other essential nonemergent health services and programs might be stylized similar to EMS on a geographic and service demand basis. Some experience already suggests that programs such as blood, organ transplantation, and rehabilitation services as well as quality assurance programs might be enhanced by regional systems models.

The national EMS system effort will improve the quality of care for the critically injured and ill citizens across the country. Due to its unique characteristics, emergency medical care provides a rare opportunity for experience in many other phases of health care delivery. It is anticipated that the "ripple effect" in the EMS effort may extend beyond the limits of acute care phases to many functional component areas.

The success of any EMS system is dependent upon the wisdom of its leadership and appropriate integration of resources, operations management, and financial planning into an effective program. The major task of the Division of Emergency Medical Services is to provide current and timely technical assistance and guidance by communicating results of lessons learned from established and ongoing operational EMS projects.

REFERENCES

- [1] D. R. Boyd et al., "Regionalization of trauma patient care: The Illinois Experience," in *Surgery Annual*, L. M. Nyhus, Ed. New York: 1975, pp. 25-52.
- [2] Public Law 93-154: *Emergency Medical Services Systems Act of 1973*. 93rd Congress, S.2410. 1973.
- [3] *Emergency Medical Services Systems: Program Guidelines*. U.S. Department of Health, Education, and Welfare, Health Services Administration, Division of Emergency Medical Services. Revised 1975. (HSA-75-2013)
- [4] *Selected Bibliography: Rural Emergency Medical Services*. U.S. Department of Health, Education, and Welfare, Health Services Administration, Division of Emergency Medical Services. 1976. (HSA-76-2028)
- [5] *Training of Ambulance Personnel and Others Responsible for Emergency Care of the Sick and Injured at the Scene and During Transport*. National Research Council, National Academy of Sciences, 1968. (HSA-74-2027)
- [6] *Federal Specifications—Ambulance—Emergency Medical Care Vehicle*. U.S. General Services Administration, January 2, 1974 (with revision), 1974. (Specification KKK-A-1822)
- [7] *Medical Communications Services*. U.S. Federal Communications Commission. Federal Register 39:26116-26126, July 16, 1974, also, *Emergency Medical Services Communication Systems*. U.S. Department of Health, Education, and Welfare, Emergency Medical Services Program, 1972 (HRA-74-3209)
- [8] *Essential Equipment for Ambulance*. Bulletin. American College of Surgeons, pp. 7-13, May 1970.

Original sponsor: Health, Education and
Social Services Committee

Offered: 4/19/78
Referred: Finance

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR HOUSE BILL NO. 896

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to emergency medical services."

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

8 * Section 1. AS 18.08.080 is repealed and re-enacted to read:

9 Sec. 18.08.080. REGULATIONS. The department shall adopt, with the
10 concurrence of the Department of Public Safety, regulations establishing
11 standards and procedures for the issuance, renewal, reissuance, revoca-
12 tion, and suspension of certificates required under sec. 82 of this
13 chapter, as well as other regulations necessary to carry out the pur-
14 poses of this chapter.

15 * Sec. 2. AS 18.08 is amended by adding new sections to read:

16 Sec. 18.08.082. ISSUANCE OF PERMITS. (a) The department shall
17 prescribe by regulation a course of training or other requirements pre-
18 requisite to the issuance of certificates which provide for the follow-
19 ing:

20 (1) certifies that a person meets the training and other
21 requirements as an emergency medical technician;

22 (2) authorizes an emergency medical technician certified
23 under this chapter to provide under the written or oral direction of a
24 physician those advanced life support services enumerated on the certi-
25 ficate;

26 (3) certifies that a person, organization, or government
27 agency which provides an emergency medical service meets the minimum
28 operating standards prescribed by the department; and

29 (4) authorizes an emergency medical service certified under

1 this chapter to provide under the written or oral direction of a phy-
2 sician those advanced life support services enumerated on the certi-
3 ficate.

4 (b) The department shall be the central certifying agency for
5 personnel certified under (a)(1) and (2) of this chapter and under
6 regulations adopted under sec. 80 of this chapter.

7 Sec. 18.08.084. CERTIFICATE REQUIRED. (a) No person may repre-
8 sent himself, nor may an agency or business represent an agent or
9 employee of that agency or business, as an emergency medical technician
10 certified by the state unless the person represented is certified as an
11 emergency medical technician under sec. 82 of this chapter.

12 (b) No person, organization, or government agency may represent
13 itself as an emergency medical service or ambulance service certified
14 by the state unless the person, organization, or government agency is
15 certified as an emergency medical service under sec. 82 of this chapter.

16 (c) No person may provide, offer, or advertise to provide ad-
17 vanced life support services outside a hospital unless authorized by
18 law.

19 (d) No person, organization, or government agency which provides,
20 offers, or advertises to provide an emergency medical service may pro-
21 vide advanced life support services unless authorized under sec. 82 of
22 this chapter.

23 Sec. 18.08.086. IMMUNITY FROM LIABILITY. (a) No person certified
24 under sec. 82 of this chapter, or person or public agency which employs,
25 sponsors or controls the activities of persons certified under sec. 82
26 of this chapter, who administers emergency medical services to an in-
27 jured or sick person may be liable for civil damages as a result of an
28 act or omission in administering those services, if done in good faith
29 and if the life of the injured or sick person is in danger. This sub-

1 section does not preclude liability for civil damages which is the
2 proximate result of gross negligence or intentional misconduct, nor
3 preclude imposition of liability on a person or public agency which
4 employs, sponsors, or controls the activities of persons certified under
5 sec. 82 of this chapter if the act or omission is a proximate result of
6 a breach of duty to act created under this chapter. For the purposes of
7 this subsection, "gross negligence" means reckless, wilful, or wanton
8 misconduct.

9 (b) No physician who in good faith arranges for, requests, recom-
10 mends, or initiates the transfer of a patient from a hospital to another
11 hospital may be liable for civil damages as a result of arranging, re-
12 questing, recommending, or initiating the transfer if

13 (1) in the exercise of that degree of knowledge or skill pos-
14 sessed, or that degree of care ordinarily exercised by physicians prac-
15 ticing the same specialty in the same, or similar communities to that in
16 which the physician is practicing, the physician determines that treat-
17 ment of the patient's medical condition is beyond the capability of the
18 transferring hospital or the medical community in which the hospital is
19 located;

20 (2) the physician has confirmed that the receiving facility
21 is more capable of treating the patient; and

22 (3) the physician has secured a prior agreement from the
23 receiving facility to accept and render the necessary treatment to the
24 patient.

25 (c) No registered nurse or licensed practical nurse who escorts a
26 patient in an aircraft not equipped as an ambulance may be liable for
27 civil damages as a result of an act or omission in administering patient
28 care services, if done in good faith and if the life of the injured or
29 sick person is in danger. This subsection does not preclude liability

1 for civil damages which are the result of gross negligence or inten-
2 tional misconduct.

3 Sec. 18.08.088. PENALTY. Any person who violates a provision of
4 this chapter is guilty of a misdemeanor and upon conviction is punish-
5 able by a fine of not more than \$1,000, or by imprisonment for not more
6 than 90 days, or by both. Each violation is a separate offense.

7 * Sec. 3. AS 18.08.090 is amended by adding new paragraphs to read:

8 (7) "advanced life support" means emergency care techniques
9 provided under the written or oral orders of a physician which include,
10 but are not limited to, electric cardiac defibrillation, administration
11 of antiarrhythmic agents, intravenous therapy, intramuscular therapy, or
12 use of endotracheal intubation devices;

13 (8) "ambulance" means any publicly or privately owned means
14 of conveyance intended to be used and maintained or operated for the
15 transportation of persons who are sick, injured, wounded, or otherwise
16 helpless;

17 (9) "emergency medical care" means the services utilized in
18 responding to the perceived individual needs for immediate medical care
19 in order to prevent loss of life or aggravation of physiological or
20 psychological illness or injury;

21 (10) "emergency medical technician" means a person trained in
22 emergency medical care and certified in accordance with the regulations
23 prescribed under sec. 80 of this chapter;

24 (11) "emergency medical service" means the provision of
25 emergency medical care and transportation of the sick and injured.
26
27
28
29

Introduced: 3/20/78
Referred: Health, Education &
Social Services and Finance

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

1 IN THE HOUSE

2 HOUSE BILL NO. 896

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - SECOND SESSION

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13 chapter, as well as other regulations necessary to carry out the pur-
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15 * Sec. 2. AS 18.08 is amended by adding new sections to read:

16 Sec. 18.08.082. ISSUANCE OF PERMITS. The department shall pre-
17 scribe by regulation a course of training or other requirements pre-
18 requisite to issuance of a certificate authorizing a person to provide
19 emergency medical services, including those services involved in ad-
20 vanced life support, or to operate an ambulance, or both. A certificate
21 authorizing a person to provide those emergency medical services which
22 are enumerated on the certificate, or to operate an ambulance, or both,
23 shall be issued upon successful completion of such requirements.

24 Sec. 18.08.084. CERTIFICATE REQUIRED. No person may provide,
25 offer or advertise to provide emergency medical services, including
26 advanced life support, nor operate, or offer or advertise to operate an
27 ambulance on a regular basis, unless authorized by a certificate issued
28 under sec. 82 of this chapter.

29 Sec. 18.08.086. IMMUNITY FROM LIABILITY. (a) No person certified

1 under sec. 82 of this chapter, or person or public agency which employs,
2 sponsors or controls the activities of persons certified under sec. 82
3 of this chapter, who administers emergency medical services to an in-
4 jured or sick person may be liable for civil damages as a result of an
5 act or omission in administering those services, if done in good faith
6 and if the life of the injured or sick person is in danger. This sub-
7 section does not preclude liability for civil damages the proximate
8 result of gross negligence or intentional misconduct, nor preclude im-
9 position of liability on a person or public agency which employs, spon-
10 sors, or controls the activities of persons certified under sec. 82 of
11 this chapter if the act or omission is a proximate result of a breach of
12 duty to act created under this chapter. For the purposes of this sub-
13 section, "gross negligence" means reckless, wilful, or wanton misconduct.

14 (b) No physician who in good faith arranges for, requests, recom-
15 mends, or initiates the transfer of a patient from a hospital to another
16 hospital may be liable for civil damages as a result of arranging, re-
17 questing, recommending, or initiating the transfer if

18 (1) in the exercise of that degree of knowledge or skill pos-
19 sessed, or that degree of care ordinarily exercised by physicians prac-
20 ticing the same specialty in the same, or similar communities to that in
21 which the physician is practicing, the physician determines that treat-
22 ment of the patient's medical condition is beyond the capability of the
23 transferring hospital or the medical community in which the hospital is
24 located;

25 (2) the physician has confirmed that the receiving facility
26 is more capable of treating the patient; and

27 (3) the physician has secured a prior agreement from the
28 receiving facility to accept and render the necessary treatment to the
29 patient.

1 Sec. 18.08.088. PENALTY. Any person who violates a provision of
2 this chapter is guilty of a misdemeanor and upon conviction is punish-
3 able by a fine of not less than \$50 nor more than \$100, or by imprison-
4 ment for not less than 10 days nor more than 90 days, or by both. Each
5 violation is a separate offense.

6 * Sec. 3. AS 18.08.090 is amended by adding new paragraphs to read:

7 (7) "advanced life support" means a level of pre-hospital and
8 inter-hospital emergency care under the written or oral direction of a
9 physician, which includes, but is not limited to, basic life support
10 functions, cardiopulmonary resuscitation (CPR), cardiac monitoring,
11 cardiac defibrillation, administration of antiarrhythmic agents, intra-
12 venous therapy, administration of specific medications and drugs and
13 solutions, or use of adjunctive ventilation devices;

14 (8) "ambulance" means any publicly or privately owned means
15 of conveyance intended to be used and maintained or operated for the
16 transportation of persons who are sick, injured, wounded, or otherwise
17 helpless;

18 (9) "emergency medical services" means the services utilized
19 in responding to the perceived individual needs for immediate medical
20 care in order to prevent loss of life or aggravation of physiological or
21 psychological illness or injury.

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
EMERGENCY MEDICAL SERVICES SECTION

POUCH H-06C
JUNEAU, ALASKA 99811

HB 896

May 4, 1978

Honorable Hugh Malone
Speaker of the House
Pouch V.
Juneau, Alaska 99811

Dear Mr. Malone:

Enclosed is the fiscal note requested for CSHB 896. This fiscal note replaces all previous notes for both HB 896 and the Committee Substitute.

If we can be of any further assistances please don't hesitate to call 465-3027.

Sincerely,

Thomas D. Scott

Thomas D. Scott
Coordinator

cc: Legislative Finance
Budget & Management

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HB 896
 Title An Act relating to emergency medical services
 Requested by Representative Hugh Malone Date 5/2/78

II. FISCAL DETAIL

Agency Affected Health & Social Services
 Program Category Affected Health
 Budget Request Unit(s) Affected Emergency Medical Services, Certification & Licensing

EXPENDITURES (Thousands of Dollars)

	FY 78	FY 79	FY 80	FY 81	FY 82	FY 83
100 PERSONAL SERVICES			87.8	93.0	98.7	104.5
200 TRAVEL			10.9	11.5	12.2	12.9
300 CONTRACTUAL			4.8	5.1	5.4	5.7
400 COMMODITIES			.6	.6	.7	.7
500 EQUIPMENT			2.6	-0-	-0-	
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL			106.7	110.2	117.0	123.8

FUNDING (Thousands of Dollars)

GENERAL FUND			106.7	110.2	117.0	123.8
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME			3/36	3/36	3/36	3/36
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This analysis assumes the responsibility for certification of emergency medical technicians (EMT) will be delegated to the Emergency Medical Services Section, Division of Public Health. No fiscal impact is expected in FY79 as the current staff of the section will assume responsibility for the drafting and promulgation of regulations and procedures in conjunction with the State EMS Advisory Council.

It is anticipated that there will be 850 certifiable personnel. Based on high turnover of volunteer EMT's and projected expansion of ambulance services, it is further anticipated that approximately 20 EMT courses will be required annually. Certification should occur upon completion of the course. The fiscal note therefore provides for a training coordinator position and travel beginning in FY80 to administer the certification exam (both written and practical) throughout the state

IV. DATE 5/2/78 PREPARED BY Hugh Malone
 AGENCY Emergency Medical Services - Public Health
 PHONE 465-3027
 Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)

in coordination with courses being conducted. The coordinator will also evaluate course content and instructors in terms of the minimum training standards to be established in the regulations. A clerk typist position will be necessary for clerical support and maintaining certification records. The position will be located in Anchorage, which is the location of the statewide EMT training program being conducted on an itinerant basis through a grant to the Southern Region EMS Council. It's central location also reduces travel costs.

It is further assumed that the responsibility for certification of ambulance services will be delegated to the Certification and Licensing Section, Division of Public Health. This function will also begin July 1, 1979 following development of regulations. Travel to inspect 40-45 ambulance services will be combined with inspections of other health facilities in the area for more efficient use of manpower and funds. Therefore projected travel amounts are only half as costs will be pro-rated among other funding sources within the Certification and Licensing BRU.

A detailed analysis of expenditures is attached. Inflation is computed at 6% per year beginning July 1, 1979.

Emergency Medical Services BRU

Personal Services

Training Coordinator, SR 18
\$2156/mo x 12 = \$25,872
FICA 1562 Benefits 4463
Health Insurance 986

\$ 32,883

Clerk Typist III
\$1092/mo x 12 = \$13,104
FICA 793 Benefits 2260
Health Insurance 986

17,143

6% inflation factor

3,001

Total Personal Services

\$ 53,027

Travel

Travel to 20 locations to administer
exam at an average cost of \$260 per
trip. Average includes air fare to
bush communities and mileage to areas
around Anchorage as well as three
days per diem.

20 trips x \$260 x 6% inflation

\$ 5,512

Contractual

Communication: phone, postage etc.

100/mo x 12 mo

\$ 1,200

Printing and Advertising: forms & notices

1,500

Rent 140/mo x 12

1,820

6% inflation factor

271

Total Contractual

\$ 4,791

Commodities

General Office consumables \$50/mo

600

Equipment

Desk, secretarial

\$ 362

Chair, secretarial

85

File cabinet w/lock

213

Typewriter

792

Chair, executive

85

Desk, executive

350

Bookcase

75

Total Equipment

\$ 2,232

TPS 4/01

Certification & Licensing BRU

Health Facilities Surveyor

R-18 2156 x 12 mos x 6%

inflation = 27,424

Benefits = 4730 FICA = 1659

Health Ins. = 986

\$34,799

Travel to inspect 40-45
ambulance services will
necessitate 15 trips to
areas throughout the state
at an average cost of \$700
per trip, including air fare,
auto rental and per diem.
15 x \$700 x 50%

5,250

Executive desk

300

Chair

85

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSHB 896
 Title An act relating to emergency medical services
 Requested by Representative Hugh Malone Date 4/18/78

II. FISCAL DETAIL

Agency Affected Health & Social Services
 Program Category Affected Health
 Budget Request Unit(s) Affected Emergency Medical Services

EXPENDITURES (Thousands of Dollars)

	FY 78	FY 79	FY 80	FY 81	FY 82	FY 83
100 PERSONAL SERVICES			53.0	56.2	59.6	63.1
200 TRAVEL			5.6	5.9	6.3	6.7
300 CONTRACTUAL			4.8	5.1	5.4	5.7
400 COMMODITIES			.6	.6	.7	.7
500 EQUIPMENT			2.2	-0-	-0-	-0-
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL			66.2	67.8	72.0	76.2

FUNDING (Thousands of Dollars)

	FY 78	FY 79	FY 80	FY 81	FY 82	FY 83
GENERAL FUND			66.2	67.8	72.0	76.2
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

	FY 78	FY 79	FY 80	FY 81	FY 82	FY 83
FULL TIME			2/24	2/24	2/24	2/24
PART TIME						
TEMPORARY						

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 AGENCY Emergency Medical Services
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TDS 4/25/78