

LEG. FINANCE - BILLS 1977 - 1978 939

SB 285 cont. thru SB 300

1 office as may be prescribed by the commission.

2 (b) The state medical examiner may

3 (1) perform or direct the performance of an autopsy in any
4 death requiring investigation under this chapter;

5 (2) perform or direct the performance of necessary chemical
6 and toxicological examinations in any death requiring investigation under
7 this chapter;

8 (3) amend a previously completed death certificate in a death
9 requiring investigation under this chapter;

10 (4) order a body exhumed in a death requiring investigation
11 under this chapter;

12 (5) request the assistance of law enforcement personnel in
13 carrying out the provisions of this chapter;

14 (6) appoint or hire staff, including technical, professional
15 or clerical personnel, necessary for the administration of this chapter;

16 (7) obtain necessary technical or professional services on a
17 contractual basis;

18 (8) take possession or exercise control of the body and
19 effects of a deceased and any weapons, instruments, vehicles, buildings,
20 premises or any other thing which he has reason to believe would assist
21 in a determination of the cause and manner of death; and

22 (9) issue subpoenas, administer oaths and take statements in
23 furtherance of a determination of the cause and manner of a death re-
24 quiring investigation under this chapter.

25 (c) An associate medical examiner shall, at the direction of the
26 state medical examiner,

27 (1) perform autopsies in accordance with sec. 70 of this
28 chapter;

29 (2) determine and certify the cause and manner of a death

1 requiring investigation under this chapter; and

2 (3) perform such other related duties as may be required by
3 the state medical examiner.

4 (d) An assistant medical examiner shall

5 (1) immediately notify the state medical examiner of the
6 occurrence of a death requiring investigation under this chapter;

7 (2) conduct investigations as directed by the state medical
8 examiner and file a written report of the investigation with the state
9 medical examiner and with the district attorney nearest the place where
10 the death occurred; and

11 (3) perform other duties as directed by the state medical
12 examiner.

13 Sec. 18.52. 50. DEATHS REQUIRING DETERMINATION AND CERTIFICATION
14 OF CAUSE AND MANNER. (a) The office of the state medical examiner
15 shall determine and certify the cause and manner of any human death
16 that affects the health and safety of the public and which

17 (1) is apparently homicidal, suicidal, accidental or occurs
18 under unknown or suspicious circumstances;

19 (2) occurs when the deceased was unattended by a physician
20 during the 24 hours immediately preceding his death;

21 (3) occurs when attended by a physician, if the cause and
22 manner of death are unknown or if the attending physician is unable to
23 certify the cause and manner of death;

24 (4) is related to a disease which might constitute a threat
25 to the public health;

26 (5) results from the apparent introduction into the body of
27 any toxic substance;

28 (6) occurs while the deceased was an inmate of a public in-
29 stitution or in police custody, except when hospitalized for an organic

1 disease at the time of death;

2 (7) results from an industrial or occupational injury; or

3 (8) occurs in another jurisdiction and the body is brought
4 into this jurisdiction without proper medical certification.

5 (b) The commission may by regulation provide for the determination
6 and certification of the cause and manner of any other human death that
7 may affect the health or safety of the public.

8 Sec. 18.52.060. NOTIFICATION OF DEATH REQUIRED. (a) Any person
9 having knowledge of a death requiring investigation under this chapter
10 shall immediately notify either a medical examiner or a state or local
11 law enforcement agency of the fact and location of the death.

12 (b) A state or local law enforcement agency having knowledge of a
13 death requiring investigation under this chapter shall immediately notify
14 a medical examiner of the fact and location of the death.

15 Sec. 18.52.070. AUTOPSY. (a) If in the opinion of the state
16 medical examiner an autopsy is necessary to determine the cause and
17 manner of death, or if requested by a prosecuting attorney or an investi-
18 gating law enforcement agency, an autopsy shall be performed by the state
19 medical examiner or an associate medical examiner.

20 (b) An autopsy under this section shall be performed in accordance
21 with uniform procedures prescribed by the state medical examiner.

22 (c) A description of the findings and conclusions of the autopsy
23 shall be filed in the office of the state medical examiner and with the
24 office of the district attorney nearest the place where the death
25 occurred.

26 (d) When an autopsy is performed under this section the state
27 medical examiner or associate medical examiner may remove and retain body
28 tissues and body fluids necessary or advisable for scientific purposes.

29 Sec. 18.52.075. LABORATORIES. The state medical examiner shall

1 maintain a laboratory or laboratories suitably equipped with medical,
2 scientific and other facilities for performance of the duties imposed by
3 this chapter. The laboratory or laboratories may be maintained by con-
4 tract or in collaboration with the Department of Public Safety or other
5 agencies in the state which have facilities that can be usefully employed
6 in performing duties under this chapter.

7 Sec. 18.52.077. FORENSIC EXAMINATIONS. In any death requiring
8 investigation under this chapter forensic examinations may be performed
9 by persons other than the state medical examiner. The state medical
10 examiner shall provide for such forensic examinations as are requested
11 by a prosecuting attorney.

12 Sec. 18.52.080. PRESERVATION OF EVIDENCE AND CREMATION OF BODIES.

13 (a) In a death requiring investigation, no person may move a human body
14 or remove or in any way disturb any of the effects of the deceased or
15 instruments or weapons related to the death without the permission of the
16 investigating medical examiner, an investigating law enforcement officer,
17 or a prosecuting attorney.

18 (b) In a death requiring investigation, no person may undress,
19 embalm, cleanse the surface of the body or otherwise alter the appearance
20 of the state of the body without the permission of the investigating
21 medical examiner, an investigating law enforcement officer, or a pro-
22 secuting attorney.

23 (c) In a death requiring investigation, the body may not be cre-
24 mated unless an autopsy has been performed, or a certificate has been
25 furnished to the owner or operator of the crematory by the state medical
26 examiner stating that no autopsy is required.

27 Sec. 18.52.085. AUTHORITY TO ENTER AND SECURE PREMISES. (a) A
28 medical examiner may enter any room, dwelling, building or other place
29 in which he has reasonable cause to believe that a body or other evidence

1 of the circumstances of a death requiring investigation may be found.

2 (b) If refused entry, he may, but need not if exigent circumstances
3 exist, apply to a judge or magistrate for an order to enter the premises,
4 search for and seize a body or any evidence of the cause or manner of
5 death. Upon application supported by an affidavit setting out facts and
6 circumstances tending to show that a body or other evidence of the cause
7 and manner of death is in the place to be searched, the judge shall issue
8 an order to enter and search and seize.

9 (c) To preserve evidence, a medical examiner or an investigating
10 law enforcement officer may

11 (1) place under his custody or control, or enclose or lock
12 any room, dwelling, building or other enclosure;

13 (2) rope off or otherwise restrict entry to any open area; and

14 (3) forbid the entrance of any unauthorized person into an
15 area specified under (1) or (2) of this subsection.

16 (d) No person may enter upon any premises, enclosures or other
17 areas specified in (c) of this section without the permission of the
18 investigating medical examiner or an investigating law enforcement
19 officer.

20 Sec. 18.52.090. DISPOSITION OF BODY AND PROPERTY. (a) Upon
21 identification of a deceased, an investigating law enforcement officer
22 shall promptly attempt to locate a relative or a responsible friend
23 willing to claim the body for burial.

24 (b) When a medical examiner certifies the cause and manner of death
25 of an unknown person, or when a relative or friend is unwilling to claim
26 a body for burial within a reasonable period of time, and no provision
27 is made for the body under AS 13.50, the state medical examiner shall
28 notify the Department of Health and Social Services which shall cause
29 the body to be decently buried or cremated and the remains to be decently

1 interred.

2 (c) The investigating law enforcement agency shall take reasonable
3 action to prevent the destruction or loss of property of a deceased,
4 including premises and vehicles, which is not necessary to retain as
5 evidence and has not been retained by the medical examiner under secs.
6 40(b)(8) and 85(c) and (d) of this chapter, until a relative or a respon-
7 sible friend is notified and assumes responsibility for preserving the
8 property. If within 48 hours a relative or responsible friend cannot
9 be located who will assume responsibility for preserving the property,
10 a district judge, magistrate or public administrator shall take custody
11 and control of the property under AS 22.15.110 and 22.15.350.

12 (d) When property of a deceased has been retained by the medical
13 examiner under sec. 40(b)(8) or 85(c) and (d) of this chapter and is no
14 longer required by the medical examiner, a prosecuting attorney, or an
15 investigating law enforcement agency, that property shall be disposed of
16 in accordance with (c) of this section.

17 Sec. 18.52.100. RECORDS AND REPORTS. (a) The records and reports
18 of the office shall be available only to persons having a legitimate
19 interest in them, including member's of the deceased's immediate family
20 or their lawful representatives, a physician who treated the deceased
21 within two years preceding death, insurance companies or other entities
22 or persons with a lawful interest in the settlement of the estate of
23 the deceased, and any governmental agencies including, but not limited
24 to, prosecuting attorneys and law enforcement agencies, concerned with
25 the deaths of persons in the state.

26 (b) The state medical examiner may make reports and records of
27 the office available to persons engaged in bona fide medical or other
28 research if a research program has demonstrated that

29 (1) any threat to individual privacy which might be created

1 by the program has been minimized by methods and procedures designed to
2 prevent injury or embarrassment to any individual; and

3 (2) it will be conducted in a manner that will not reveal,
4 directly or indirectly, the identity of any deceased person.

5 Sec. 18.52.110. DEFINITIONS. In this chapter,

6 (1) "autopsy" means an examination of a body after death
7 including an external examination, opening and internal examination, and
8 the removal of any specimens necessary to a determination of the cause
9 and manner of death;

10 (2) "cause of death" means the primary or basic disease pro-
11 cess or injury ending life;

12 (3) "commission" means the Alaska Medical Examiner Commission;

13 (4) "law enforcement agency" means a public agency which
14 performs as one of its principal functions activities relating to crime
15 prevention, control or reduction, or the enforcement of the criminal
16 laws of the state or any of its political subdivisions or of the United
17 States;

18 (5) "manner of death" means the designation of the probable
19 mode of production of the cause of death, including natural, accidental,
20 suicidal, homicidal or undetermined;

21 (6) "medical examiner" means the state medical examiner,
22 associate medical examiners and assistant medical examiners;

23 (7) "office" means the office of the state medical examiner.

24 * Sec. 2. AS 12.65 is repealed and re-enacted to read:

25 CHAPTER 65. INQUESTS.

26 Sec. 12.65.011. ORDER OF INQUEST. A district judge or magistrate
27 shall, upon application by a prosecuting attorney, order an inquest into
28 the cause of a death requiring investigations under AS 18.52.

29 Sec. 12.65.021. SUMMONING JURORS FOR INQUEST. If an inquest is

1 ordered, the district judge or magistrate shall summon six persons
2 qualified by law to serve as jurors to appear at a specified place to
3 inquire into the cause and manner of the death.

4 Sec. 12.65.031. OATH OF INQUEST JURORS. When six jurors attend,
5 they shall be sworn by the district judge or magistrate to inquire who
6 the deceased was and when, where and by what means he came to his death,
7 to inquire into the circumstances attending his death, and to give a
8 true verdict according to the evidence offered or arising from an in-
9 spection of the body.

10 Sec. 12.65.041. SUBPOENA AND EXAMINATION OF WITNESSES. The dis-
11 trict judge or magistrate or a prosecuting attorney may subpoena and
12 examine as witnesses persons who, in his opinion, have knowledge of any
13 material facts attendant to a determination of the cause and manner of
14 a death requiring investigation under AS 18.52.

15 Sec. 12.65.051. VERDICT OF INQUEST JURY. After hearing any testi-
16 mony, the jury or two-thirds of their number shall give its written
17 verdict, signed by them and setting out the name of the deceased and
18 when, where and by what means he came to his death.

19 * Sec. 3. AS 18.50.230(a) is amended to read:

20 (a) A death certificate for each death which occurs in the state
21 shall be filed with the local registrar of the registration district in
22 which the death occurred within three days after death and before final
23 disposition of the body or removal of the body from the state, except as
24 provided in AS 18.52 or by regulation [IN SPECIAL PROBLEM CASES]. For
25 the purpose of this section, if the place of death is unknown, a death
26 certificate shall be filed in the registration district in which the
27 dead body is found. When a death occurs on a moving conveyance a death
28 certificate shall be filed in the registration district in which the dead
29 body is first removed from the conveyance.

1 * Sec. 4. AS 18.50.230(c) is amended to read:

2 (c) The medical certification shall be completed and signed within
3 24 hours after death by the physician in charge of the patient's care
4 for the illness or condition which resulted in death except when the
5 death requires investigation under AS 18.52 [AN OFFICIAL INQUIRY OR
6 INQUEST IS REQUIRED] and except as provided by regulation [IN SPECIAL
7 PROBLEM CASES].

8 * Sec. 5. AS 18.50.230(d) is amended to read:

9 (d) When a death occurs without medical attendance, or when
10 investigation under AS 18.52 [OFFICIAL INQUIRE] is required, the depart-
11 ment shall provide by regulation, in accordance with law, the responsi-
12 bility for completing and signing the medical certification. This sub-
13 section is intended to include, among others, cases involving a medical
14 examiner [OR A CORONER], and cases involving presumption of death.

15 * Sec. 6. AS 18.50.240(a) is amended to read:

16 (a) A fetal death certificate for each fetal death which occurs
17 in the state shall be filed with the local registrar of the registration
18 district in which the delivery occurred within three days after the
19 delivery and before final disposition of the fetus or removal of the
20 fetus from the state, except as provided by regulation [IN SPECIAL PRO-
21 BLEM CASES]. However, the filing of a certificate for a product of a
22 pregnancy of less than 20 weeks may be determined by regulation. For
23 the purposes of this section, if the place of fetal death is unknown, a
24 fetal death certificate shall be filed in the registration district in
25 which the dead fetus is found. When a fetal death occurs on a moving
26 conveyance a fetal death certificate shall be filed in the registration
27 district in which the fetus is first removed from the conveyance.

28 * Sec. 7. AS 18.50.240(c) is amended to read:

29 (c) The medical certification shall be completed and signed within

1 24 hours after delivery by the physician in attendance at or after
2 delivery except when an investigation is required under AS 18.52
3 [OFFICIAL INQUIRY OR INQUEST IS REQUIRED] and except as provided by
4 regulation [IN SPECIAL PROBLEM CASES].

5 * Sec. 8. AS 18.50.240(d) is amended to read:

6 (d) When a fetal death occurs without medical attendance upon the
7 mother at or after the delivery, or when investigation under AS 18.52
8 [OFFICIAL INQUIRY] is required, the department shall provide by regula-
9 tion, in accordance with law, the responsibility for completing and
10 signing the medical certification.

11 * Sec. 9. AS 18.50.250(a) is amended to read:

12 (a) The funeral director or person acting as the funeral director
13 who first assumes custody of a dead body or fetus shall obtain a burial-
14 transit permit before final disposition or removal from the state of the
15 body or fetus and within 72 hours after death, except as otherwise
16 authorized by regulation [FOR SPECIAL PROBLEM CASES].

17 * Sec. 10. AS 18.50.250(b) is amended to read:

18 (b) The local registrar of the registration district where the
19 death occurred shall issue a burial-transit permit when a certificate of
20 death or fetal death has been filed in accordance with this chapter,
21 except as otherwise authorized by regulation [IN SPECIAL PROBLEM CASES].

22 * Sec. 11. AS 22.15.110 is repealed and re-enacted to read:

23 Sec. 22.15.110. ADDITIONAL DUTIES OF DISTRICT JUDGE AND MAGISTRATE.
24 Each district judge and magistrate shall

25 (1) record birth, death and marriage certificates presented
26 to him for record in the manner prescribed by law;

27 (2) take custody and control of and preserve the property and
28 estate of deceased persons until a legal custodian is appointed.

29 * Sec. 12. AS 22.15.310 is amended to read:

1 Sec. 22.15.310. APPOINTMENT. When authorized by the supreme court,
2 the presiding judge in each judicial district shall appoint one or more
3 persons [A PERSON] to act as public administrator of the estates of
4 deceased persons [AND AS CORONER].

5 * Sec. 13. AS 22.15.320 is amended to read:

6 Sec. 22.15.320. ADMINISTRATION OF DECEDENTS' ESTATES. [WHEN
7 LETTERS OF ADMINISTRATION ARE ISSUED TO A PUBLIC ADMINISTRATOR BY THE
8 SUPERIOR COURT IN HIS DISTRICT, THE PUBLIC ADMINISTRATOR IS THE LEGAL
9 CUSTODIAN OF AND SHALL ADMINISTER THE ESTATES OF DECEASED PERSONS WHO
10 LEAVE PROPERTY WITHIN THE DISTRICT.] Letters of administration shall
11 be issued to a a [THE] public administrator when (1) administration of a
12 decedent's estate is required by law, and (2) a period of 45 [30] days
13 has elapsed from the date of death with no letters testamentary or
14 letters of administration having been applied for and issued to any
15 other person entitled by law to administer the estate of the deceased
16 person. Except as otherwise provided in secs. 310 - 350 of this chapter,
17 a public administrator shall administer the estate [ESTATES] as other
18 administrators, and has all the rights and authority, and is subject to
19 all the duties and liabilities of other administrators.

20 * Sec. 14. AS 22.15.340 is amended to read:

21 Sec. 22.15.340. COMPENSATION. A public administrator is entitled
22 to [ANNUAL] compensation in an amount to be determined by the supreme
23 court, and if he is an employee of the judiciary, he is not entitled to
24 fees as other administrators.

25 * Sec. 15. AS 22.15.350 is amended to read:

26 Sec. 22.15.350. OTHER DUTIES [AS CORONER]. In addition to his
27 other duties, a public administrator who is an employee of the judiciary
28 shall perform the duties set out in sec. 110 of this chapter.

29 * Sec. 16. AS 13.15.065(a) is amended by adding a new paragraph to read:

1 (7) a public administrator appointed under AS 22.15.310.

2 * Sec. 16. AS 39.25.110 is amended by adding a new paragraph to read:

3 (16) the state medical examiner.

4 * Sec. 17. INTERIM OPERATION OF ALASKA MEDICAL EXAMINER COMMISSION. (a)
5 Between July 1, 1977 and July 1, 1978, the Alaska Medical Examiner Commission
6 provided for under AS 18.52.020, as enacted in sec. 1 of this Act shall

7 (1) meet at least once, determine the scope of its function and
8 establish rules, as necessary, for complying with this section and its
9 responsibilities under AS 18.52.025, as enacted in sec. 1 of this Act;

10 (2) develop a program and financial plan with a proposed budget for
11 fiscal year 1979 under AS 37.07.050 for submission as required through the
12 Department of Public Safety;

13 (3) establish policies, as necessary, under AS 18.52.025(b), as
14 enacted in sec. 1 of this Act, for the office of state medical examiner;

15 (4) solicit and review applications for the position of state
16 medical examiner.

17 (b) Between July 1, 1977 and July 1, 1978, the Alaska Medical Examiner
18 Commission provided for under AS 18.52.020, as enacted in sec. 1 of this Act
19 may

20 (1) appoint a state medical examiner under AS 18.52.030, as
21 enacted in sec. 1 of this Act, except that an appointment may not be effective
22 before January 1, 1978;

23 (2) adopt regulations, as necessary, under AS 18.52.025(b) to
24 implement AS 18.52, as enacted in sec. 1 of this Act;

25 (3) authorize a state medical examiner appointed under (1) of this
26 subsection to exercise those powers and duties set out in AS 18.52.035(a) and
27 18.52.040(a) and (b), as enacted in sec. 1 of this Act, which are necessary
28 to fully implement this Act on July 1, 1978, except that appointments of
29 associate and assistant medical examiners under AS 18.52.035(a) and contracts

1 for facilities and laboratories and related professional services under
2 AS 18.52.040(a)(2) and (b)(7) may not be effective before July 1, 1978.

3 * Sec. 18. This Act takes effect July 1, 1978, except that sec. 17 of
4 this Act, pertaining to certain provisions of AS 18.52 as enacted in sec. 1,
5 of this Act, takes effect July 1, 1977.

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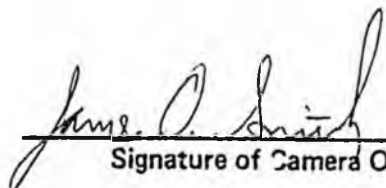
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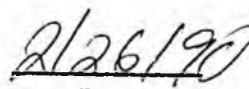
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Date

COMMITTEE REPORT
SENATE

5/20/77

April 11, 1973 Date

Mr. President:

The Committee on FINANCE has had SB 288
certification of social workers
under consideration. A majority of the members of the Committee

- recommends it do pass
- recommends it do not pass
- recommends it do pass with attached amendment(s)
- recommends it be replaced with CS for _____ and that
CS for _____ do pass
- (and) recommends it be referred to the _____
committee
- reports it back without recommendation
- AND attaches a report of its intent
- (other) _____

MEMBERS SIGNING THE MAJORITY REPORT:

<u>[Signature]</u>	<u>[Signature]</u>
<u>[Signature]</u>	<u>[Signature]</u>
<u>[Signature]</u>	<u>[Signature]</u>
<u>[Signature]</u>	<u>[Signature]</u>

MEMBERS NOT CONCURRING IN THE MAJORITY REPORT:

_____ recommends: _____

_____ recommends: _____

_____ recommends: _____

Chairman

A M E N D M E N T

OFFERED IN THE SENATE:

By: Senate HESS

To: _____ xx SENATE BILL No. CS SB 288

HOUSE BILL No. _____

PAGE: _____

LINE: _____

Page 1, lines 27 and 28: delete "and child care costs consequent to service on the board"

Page 2, line 13: delete "biennial"

L28, 29 or professional S.W.

Original sponsor: Rodey

Offered: 4/14/77
Referred: Judiciary

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 288

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the certification of social workers
7 and providing for an effective date."

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

9 * Section 1. AS 08 is amended by adding a new chapter to read:

10 CHAPTER 87. SOCIAL WORKERS.

11 ARTICLE 1. BOARD OF SOCIAL WORKER EXAMINERS.

12 Sec. 08.87.010. ESTABLISHMENT, MEMBERSHIP AND APPOINTMENT TO BOARD
13 OF SOCIAL WORKER EXAMINERS. There is established the Board of Social
14 Worker Examiners consisting of two certified professional social
15 workers, two professional social workers, and one lay person. Members
16 are appointed by the governor. The governor shall consider for
17 appointment, but need not appoint, persons nominated by the Alaska
18 Chapter, National Association of Social Workers.

19 Sec. 08.87.020. TERM OF OFFICE; COMPENSATION. (a) The initial
20 appointments to the board shall be staggered so that the lay member and
21 two other members are appointed for two years, and the other two members
22 for one year. Board members appointed initially exclusive of the lay
23 member shall meet the qualifications and examination requirements of
24 secs. 60 and 80 of this chapter. Appointments made on the expiration
25 of the initial appointments shall be made for two years.

26 (b) Members of the board receive no salary, but are entitled to
27 per diem, reimbursement for travel and child care costs consequent to
28 service on the board, and other expenses authorized by law.

29 Sec. 08.87.030. ELECTION OF OFFICERS. The board shall annually

1 elect a chairman, secretary, and other officers it requires.

2 Sec. 08.87.040. QUORUM. A majority of the members of the board
3 constitutes a quorum.

4 Sec. 08.87.050. DUTIES AND POWERS OF THE BOARD. (a) The board
5 shall adopt regulations to carry out the purposes of this chapter, in-
6 cluding regulations which

7 (1) establish a code of professional ethics which is modeled
8 on, or adopts by reference the National Professional Social Work Code of
9 Ethics promulgated by the National Association of Social Workers;

10 (2) specify requirements for biennial renewal of certificates
11 issued under this chapter;

12 (3) establish application fees, out-of-state endorsement
13 fees, examination fees, and biennial renewal fees in consultation with
14 the department.

15 (b) The board shall conduct hearings and keep records and minutes
16 necessary for carrying out the purposes of this chapter in an orderly
17 manner.

18 ARTICLE 2. CERTIFICATION AND PRACTICE.

19 Sec. 08.87.060. CERTIFICATION AS CERTIFIED PROFESSIONAL SOCIAL
20 WORKER. A person is eligible for certification as a certified pro-
21 fessional social worker if he

22 (1) is in good professional standing;

23 (2) holds a doctorate or master's degree from a school of
24 social work accredited by the Council on Social Work Education, or a
25 foreign school whose program meets the accrediting standards of the
26 Council on Social Work Education;

27 (3) has completed two years of social work practice under the
28 supervision of a certified professional social worker or professional
29 social worker, after completion of graduate education;

1 (4) provides references acceptable to the board; and
2 (5) passes the national examination of certified social
3 workers administered by the National Association of Social Workers, or
4 an equivalent examination designated by the board.

5 Sec. 08.87.070. SCOPE OF PRACTICE OF CERTIFIED PROFESSIONAL SOCIAL
6 WORKER. A person certified as a certified professional social worker
7 under this chapter may provide professional services consistent with his
8 individual social work training and experience, and consistent with the
9 professional social work code of ethics. A certified professional social
10 worker may offer professional services either independently or as an
11 employee of a public or private agency.

12 Sec. 08.87.080. CERTIFICATION AS PROFESSIONAL SOCIAL WORKER. A
13 person is entitled to be certified as a professional social worker if he

14 (1) is in good professional standing;

15 (2) holds a master's degree in social work from a school of
16 social work accredited by the Council on Social Work Education; or a
17 foreign school whose program meets the accrediting standards of the
18 Council on Social Work Education.

19 Sec. 08.87.090. SCOPE OF PRACTICE OF A PROFESSIONAL SOCIAL WORKER.
20 A person certified as a professional social worker under this chapter
21 may provide professional services consistent with his individual social
22 work training and experience, and consistent with the professional
23 social work code of ethics. A professional social worker may offer
24 professional services as an employee of a public or private agency.

25 Sec. 08.87.100. CERTIFICATION BY ENDORSEMENT. A person who is
26 licensed as a social worker by an authority other than the State of
27 Alaska may be certified as a certified professional social worker or a
28 professional social worker in Alaska if the requirements for his out-of-
29 state license or certificate at the time he was licensed are essentially

1 similar to the requirements of sec. 60 or 80 of this chapter.

2 Sec. 08.87.110. DENIAL, SUSPENSION, REVOCATION OF CERTIFICATES;
3 CENSURE. The board may deny, suspend, or revoke the certificate of a
4 person or may censure a person who has

5 (1) obtained or attempted to obtain a certificate under this
6 chapter by fraud or deceit; or

7 (2) wilfully violated a provision of this chapter or a
8 regulation adopted under this chapter.

9 Sec. 08.87.120. EXPIRATION AND RENEWAL OF CERTIFICATE. Cer-
10 tificates expire biennially on a date set by the department and may be
11 renewed by making an application for renewal to the department and by
12 meeting the requirements established by the board under sec. 50(a)(2)
13 of this chapter.

14 Sec. 08.87.130. PRIVILEGED COMMUNICATION. No certified pro-
15 fessional social worker, professional social worker, or his employee,
16 may disclose information acquired from persons consulting him in his
17 professional capacity, except with the written consent of the person.
18 This does not apply to supervisory case conferences and intra-agency
19 communications. A client or patient waives this privilege if he is the
20 plaintiff in a civil action brought against a practitioner certified
21 under this chapter if that practitioner's professional conduct is in
22 issue.

23 ARTICLE 3. PROHIBITIONS AND PENALTIES.

24 Sec. 08.87.140. VIOLATIONS. (a) It is unlawful for a person to

25 (1) fraudulently obtain or furnish a certificate, or
26 certificate renewal or record required by this chapter;

27 (2) use the title "certified professional social worker",
28 "professional social worker" or a title or designation indicating or
29 tending to indicate that he is a certified professional social worker

1 or professional social worker, unless certified by this chapter;

2 (3) wilfully violate a provision of this chapter or a regu-
3 lation adopted under this chapter.

4 (b) A person who violates this section is guilty of a misdemeanor,
5 and upon conviction is punishable by a fine of \$500, or by imprisonment
6 for one year, or by both.

7 Sec. 08.87.150. EQUITABLE RELIEF. In addition to other penalties
8 and remedies provided in this chapter, the board may seek equitable re-
9 lief to enjoin or restrain a person not certified under this chapter or
10 whose certificate is suspended, revoked, or expired, from violating any
11 of the provisions of this chapter.

12 ARTICLE 4. GENERAL PROVISION.

13 Sec. 08.87.160. APPLICABILITY OF ADMINISTRATIVE PROCEDURE ACT.
14 The board shall adopt regulations and conduct hearings in accordance
15 with the Administrative Procedure Act (AS 44.62).

16 Sec. 08.87.170. DEFINITIONS. In this chapter, unless the context
17 otherwise requires,

18 (1) "board" means the Board of Social Worker Examiners;

19 (2) "certified professional social worker" means a person
20 certified under sec. 60 of this chapter;

21 (3) "department" means the Department of Commerce and Eco-
22 nomic Development;

23 (4) "professional social worker" means a person certified
24 under sec. 80 of this chapter;

25 (5) "supervision" means at least one hour a week of personal
26 consultation with a supervisor conducted as prescribed by the board by
27 regulation; if geographical distance precludes personal weekly consul-
28 tation between a person and his supervisor, supervision may be main-
29 tained through weekly written or telephone communication as prescribed

1 by regulation of the board;

2 (6) "social work" means service or activity which assists
3 individuals or groups to effect changes in behavior, emotional responses,
4 or social conditions; and includes

5 (A) explaining and interpreting the social work aspects
6 of problem situations to individuals, families, or groups;

7 (B) the use of psychotherapy with individuals, families
8 or groups;

9 (C) assisting in social work problem solving with indi-
10 viduals, families, or groups.

11 * Sec. 3. AS 08.01.010 is amended by adding a new paragraph to read:

12 (21) Board of Social Worker Examiners.

13 * Sec. 4. This Act takes effect July 1, 1977.
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Introduced: 3/28/77
Referred: Health, Education &
Social Services and Judiciary

1 IN THE SENATE

BY RODEY

2 SENATE BILL NO. 288

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the certification of social workers;
7 and providing for an effective date."

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

9 * Section 1. AS 08 is amended by adding a new chapter to read:

10 CHAPTER 87. SOCIAL WORKERS.

11 ARTICLE 1. BOARD OF SOCIAL WORKER EXAMINERS.

12 Sec. 08.87.010. ESTABLISHMENT, MEMBERSHIP AND APPOINTMENT TO BOARD
13 OF SOCIAL WORKER EXAMINERS. There is established the Board of Social
14 Worker Examiners consisting of two certified social workers, two pro-
15 fessional social workers, and one lay person representing the rural areas
16 of the state. Members are appointed by the governor. The governor
17 shall consider for appointment, but need not appoint, persons nominated
18 by the Alaska Chapter, National Association of Social Workers.

19 Sec. 08.87.020. TERM OF OFFICE; COMPENSATION. (a) The initial
20 appointments to the board shall be staggered so that the lay member and
21 two other members are appointed for two years, and the other two members
22 for one year. Board members appointed initially exclusive of the lay
23 member shall meet the qualifications and examination requirements of
24 secs. 60 and 80 of this chapter. Appointments made on the expiration
25 of the initial appointments shall be made for two years.

26 (b) Members of the board receive no salary, but are entitled to
27 per diem, reimbursement for travel and child care costs consequent to
28 service on the board, and other expenses authorized by law.

29 Sec. 08.87.030. ELECTION OF OFFICERS. The board shall annually

1 elect a chairman, secretary, and other officers it requires.

2 Sec. 08.87.040. QUORUM. A majority of the members of the board
3 constitutes a quorum.

4 Sec. 08.87.050. DUTIES AND POWERS OF THE BOARD. (a) The board
5 shall adopt regulations to carry out the purposes of this chapter, in-
6 cluding regulations which

7 (1) establish a code of professional ethics which is modeled
8 on, or adopts by reference the National Professional Social Work Code of
9 Ethics promulgated by the National Association of Social Workers;

10 (2) specify requirements for biennial renewal of certificates
11 issued under this chapter, including a specification of the program of
12 continuing education required of social workers under sec. 150(b) of
13 this chapter.

14 (3) establish application fees, out-of-state endorsement
15 fees, examination fees, and biennial renewal fees in consultation with
16 the department.

17 (b) The board shall conduct hearings and keep records and minutes
18 necessary for carrying out the purposes of this chapter in an orderly
19 manner.

20 ARTICLE 2. CERTIFICATION AND PRACTICE.

21 Sec. 08.87.060. CERTIFICATION AS CERTIFIED SOCIAL WORKER. A
22 person is eligible for certification as a certified social worker if he

23 (1) is in good professional standing;

24 (2) holds a doctorate or master's degree from a school of
25 social work accredited by the Council on Social Work Education, or a
26 foreign school whose program meets the accrediting standards of the
27 Council on Social Work Education;

28 (3) has completed two years of social work under the super-
29 vision of a certified social worker or professional social worker, after

1 completion of graduate education;

2 (4) provides references acceptable to the board; and

3 (5) passes the national examination of certified social
4 workers administered by the National Association of Social Workers, or
5 an equivalent examination designated by the board.

6 Sec. 08.87.070. SCOPE OF PRACTICE OF CERTIFIED SOCIAL WORKER. A
7 person certified as a certified social worker under this chapter may
8 provide professional services consistent with his individual social work
9 training and experience, and consistent with the professional social
10 work code of ethics. A certified social worker may offer professional
11 services either independently or as an employee of a public or private
12 agency.

13 Sec. 08.87.080. CERTIFICATION AS PROFESSIONAL SOCIAL WORKER. A
14 person is entitled to be certified as a professional social worker if he

15 (1) is in good professional standing;

16 (2) holds a master's degree in social work from a school of
17 social work accredited by the Council on Social Work Education; or a
18 foreign school whose program meets the accrediting standards of the
19 Council on Social Work Education.

20 Sec. 08.87.090. SCOPE OF PRACTICE OF A PROFESSIONAL SOCIAL WORKER.
21 A person certified as a professional social worker under this chapter
22 may provide professional services consistent with his individual social
23 work training and experience, and consistent with the professional
24 social work code of ethics. A professional social worker may offer
25 professional services as an employee of a public or private agency.

26 Sec. 08.87.100. ENTITLEMENT TO CERTIFICATION AS A SOCIAL WORKER.
27 A person is entitled to be certified as a social worker if that person

28 (1) is in good professional standing; and

29 (2) either holds a baccalaureate degree in social work from a

1 college or university accredited by the Council on Social Work Educa-
2 tion;

3 (3) holds a baccalaureate degree from an accredited college
4 or university and has completed two years of social work experience
5 under supervision; or

6 (4) has training and experience adequate for effective per-
7 formance of certain tasks, specified by the board, in social work.

8 Sec. 08.87.110. SCOPE OF PRACTICE OF SOCIAL WORKER. A person
9 certified as a social worker under this chapter may provide professional
10 services consistent with his individual social work training and exper-
11 ience and consistent with the professional social work code of ethics,
12 but only under the supervision of a certified social worker or pro-
13 fessional social worker certified under this chapter.

14 Sec. 08.87.120. CERTIFICATION BY ENDORSEMENT. A person who is
15 licensed as a social worker by an authority other than the State of
16 Alaska may be certified as a certified social worker, professional
17 social worker, or a social worker in Alaska if the requirements for his
18 out-of-state license or certificate at the time he was licensed are
19 essentially similar to the requirements of sec. 60 or 80 of this chapter.

20 Sec. 08.87.130. CURRENT PRACTITIONERS. The board shall, upon
21 application, grant a certificate as a social worker to a person who has
22 a bachelor's degree and is employed as a social worker in the state on
23 the effective date of this Act, if the applicant has paid the appropri-
24 ate fees and applied for a certificate under this section within one
25 year of the effective date of this Act.

26 Sec. 08.87.140. DENIAL, SUSPENSION, REVOCATION OF CERTIFICATES;
27 CENSURE. The board may deny, suspend, or revoke the certificate of a
28 person or may censure a person who has

29 (1) obtained or attempted to obtain a certificate under this

1 chapter by fraud or deceit; or

2 (2) wilfully violated a provision of this chapter or a
3 regulation adopted under this chapter.

4 Sec. 08.87.150. EXPIRATION AND RENEWAL OF CERTIFICATE. (a) Cer-
5 tificates expire biennially on a date set by the department and may be
6 renewed by making an application for renewal to the department and by
7 meeting the requirements established under (b) of this section and other
8 requirements established by the board under sec. 50 of this chapter.

9 (b) A person certified as a social worker is required to undertake
10 additional courses of instruction or training in social work specified
11 by the board in order to be eligible for biennial renewal of certifi-
12 cation. If a person certified as a social worker holds a baccalaureate
13 degree in a field other than social work, that person is also required,
14 in order to be eligible for biennial renewal of certification to make
15 progress satisfactory to the board toward the completion of those under-
16 graduate courses of instruction in social work in which that person is
17 deficient.

18 Sec. 08.87.160. PRIVILEGED COMMUNICATION. No certified social
19 worker, professional social worker or social worker, or his employee,
20 may disclose information acquired from persons consulting him in his
21 professional capacity, except with the written consent of the person.
22 This does not apply to supervisory case conferences and intra-agency
23 communications. A client or patient waives this privilege if he is the
24 plaintiff in a civil action brought against a practitioner certified
25 under this chapter if that practitioner's professional conduct is in
26 issue.

27 ARTICLE 3. PROHIBITIONS AND PENALTIES.

28 Sec. 08.87.170. VIOLATIONS. (a) It is unlawful for a person to

29 (1) fraudulently obtain or furnish a certificate, or

1 certificate renewal or record required by this chapter;

2 (2) use the title "certified social worker", "professional
3 social worker" or "social worker" or a title or designation indicating
4 or tending to indicate that he is a certified social worker, profes-
5 sional social worker, or social worker unless certified by this chapter;

6 (3) wilfully violate a provision of this chapter or a regu-
7 lation adopted under this chapter.

8 (b) A person who violates this section is guilty of a misdemeanor,
9 and upon conviction is punishable by a fine of \$500, or by imprisonment
10 for one year, or by both.

11 Sec. 08.87.180. EQUITABLE RELIEF. In addition to other penalties
12 and remedies provided in this chapter, the board may seek equitable re-
13 lief to enjoin or restrain a person not certified under this chapter or
14 whose certificate is suspended, revoked, or expired, from violating any
15 of the provisions of this chapter.

16 ARTICLE 4. GENERAL PROVISION.

17 Sec. 08.87.190. APPLICABILITY OF ADMINISTRATIVE PROCEDURE ACT.
18 The board shall adopt regulations and conduct hearings in accordance
19 with the Administrative Procedure Act (AS 44.62).

20 Sec. 08.87.200. DEFINITIONS. In this chapter, unless the context
21 otherwise requires,

22 (1) "board" means the Board of Social Worker Examiners;

23 (2) "certified social worker" means a person certified under
24 sec. 60 of this chapter;

25 (3) "department" means the Department of Commerce and Eco-
26 nomic Development;

27 (4) "professional social worker" means a person certified
28 under sec. 80 of this chapter;

29 (5) "social work experience" means at least 30 hours of

1 compensated employment per week in the practice of social work;

2 (6) "social worker" means a person certified under sec. 100
3 of this chapter;

4 (7) "supervision" means at least one hour a week of personal
5 consultation with a supervisor conducted as prescribed by the board by
6 regulation; if geographical distance precludes personal weekly consul-
7 tation between a person and his supervisor, supervision may be main-
8 tained through weekly written or telephone communication as prescribed
9 by regulation of the board;

10 (8) "social work" means a service or activity which assists
11 individuals or groups to effect changes in behavior, emotional responses,
12 or social conditions; and includes

13 (A) explaining and interpreting the social work aspects
14 of problem situations to individuals, families, or groups;

15 (B) the use of psychotherapy with individuals, families
16 or groups;

17 (C) assisting in social work problem solving with indi-
18 viduals, families, or groups.

19 * Sec. 3. AS 08.01.010 is amended by adding a new paragraph to read:

20 (21) Board of Social Worker Examiners.

21 * Sec. 4. This Act takes effect July 1, 1977.

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

*Recd
5/25/77*

I. REQUEST

Bill/Resolution No. SB 288
Title relating to certification of social workers
Requested by _____ Date 3/29/77

II. FISCAL DETAIL

Agency Affected Commerce & Economic Development
Program Category Affected Protection
Budget Request Unit(s) Affected Occupational Licensing

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES		8.7	9.6	10.5		
200 TRAVEL		3.9	4.3	4.7		
300 CONTRACTUAL		3.0	3.3	3.6		
400 COMMODITIES		.4	.4	.5		
500 EQUIPMENT		1.6	0	0		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	17.6	17.6	19.3		

FUNDING (Thousands of Dollars)

GENERAL FUND		17.6	17.6	19.3		
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME						
PART TIME		1/6	1/6	1/6		
TEMPORARY						

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

Attached.

IV. DATE May 24, 1977 PREPARED BY Sharon Andrew, Director
AGENCY Div. of Occupational Licensing, Dept. of Commerce
PHONE 465-2535 & Econ. Dev.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

100	Personal Services		
	Salary - 6 man months		
	Licensing Examiner I (R-10C)	6936	
	Benefits @25.5%	<u>1769</u>	
	Total		8705
200	Travel		
	In-State trans. 3 meetings		
	avg. trans. cost \$166 X 18 trips	2988	
	less 30% absences & home town	<u>(896)</u>	
		2092	
	In-State Per Diem avg. 2 days		
	per person per mtg @55.35	1993	
	less 10% absences	<u>(199)</u>	
		1794	
	Total		3886
300	Contractual Services		
	Examinations - 30 @25.00 each	750	
	Telephone & postage	750	
	Printing & advertising including		
	public notices	1200	
	Professional fees	<u>300</u>	
	Total		3000
400	Commodities		
	Stationery and office supplies	300	
	Professional books & research material	<u>100</u>	
	Total		400
500	Equipment		
	Secretarial desk	345	
	Secretarial chair	115	
	Side chair	140	
	Utility table	150	
	IBM Selectric typewriter	<u>800</u>	
	Total		1550
TOTAL			<u>17,541</u>

Underlying Assumptions:

1. The State has a total of 88 positions in the social worker classification according to personnel records.
2. It is guessed that the State positions represent between 50% and 80% of all persons eligible for certification under HB 149.
3. Potential licensee population is estimated to range from a low of 110 to 175.
4. Grandfather clause eliminates need to provide examinations for existing population.
5. Number of new applicants per year will be approximately 20% of existing licenses or between 20 and 35 persons.
6. Inflation @10%, no program growth calculated.

100	Personal Services		
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	public notices	1200	
	Professional fees	<u>300</u>	
	Total		3000
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	Stationery and office supplies	300	
	Professional books & research material	<u>100</u>	
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5. Number of new applicants per year will be approximately 20% of existing licenses or between 20 and 35 persons.
6. Inflation @10%, no program growth calculated.

SB 288 - Licensing

①. Practice privately only if you pass a test and go through requirements ie: Cabin Fever Clinic.

②. Definition of "social worker"
Masters required - clinical work.
Prevents from person holding out as a
private worker.



ALASKA CHAPTER
NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.

P. O. Box 1615
Wrangell, Alaska 99929
March 30, 1978

Senator Clem Tillion
Finance Committee
Pouch V
Juneau, Alaska 99811

Dear Senator:

Ms. Cecelia Kleinkauf, NASW Board Member, asked me to contact you about the Southeast Alaska Health Systems Agency 1978-1979 Annual Implementation Plan. The plan will be issued in final form April 1 and includes as a first priority, supporting insurance company, federal, and state health programs directly reimbursing professional social workers.

A second priority is the licensure of "mid-level practitioners" which includes social workers. I have been assured this will be specific in the final plan. Excerpts from the draft are enclosed and I have requested Ms. Susan Stokes from HSA to send you a complete plan.

Licensure is an essential element for insurance companies to consider direct reimbursement for services. Direct reimbursement in turn is a key in broadening consumer choices. Unless a person can be assured that a mental health practitioner, for example, is covered by his insurance, he is unlikely to consider using his services. Thus, lack of licensure can act to limit the public's health service alternatives.

You are probably aware of the relationship between the HSAs and public funds through PL 93-641 and AS 18.08.011 - 18.07.111. I will be contacting you later this week to answer any questions. Thank you for your attention.

Sincerely,


Pamela A. McMillan, ACSW
Southeast Alaska Board Member

/jhm

Enclosure

HSP OBJECTIVE 2-D-2

Pass legislation to include alcoholism, drug abuse and mental health care; preventive health and home health care as standard insurance benefits for Alaska by 1983.

AIP OBJECTIVE 2-D-2

By 1979, a proposal will be developed to present to the state legislature urging them to pass legislation which would make alcoholism, drug abuse and mental health care; preventive health and home health care standard insurance benefits for the State of Alaska.

HSP OBJECTIVE 2-D-3

By 1983, Medicare and Medicaid coverage should include preventive and home health care services.

AIP OBJECTIVE 2-D-3

By 1979, a proposal will be developed to present to the federal government urging passing of legislation or amendments of regulations which would make preventive and home health care services standard Medicare and Medicaid benefits.

HSP OBJECTIVE 2-D-4

Urge federal and state health programs and insurance companies to include reimbursements for mid-level practitioners and psychiatric social workers by 1983.

AIP OBJECTIVE 2-D-4

By 1979, a proposal will be developed to present to state legislatures and congress urging passing of legislation which would require insurance companies writing policies in Alaska to include provisions for reimbursements for mid-level practitioners and psychiatric social workers.

AIP RECOMMENDED ACTIONS:

- a) Develop task force which would draft proposals for the legislature and congress.
- b) Educate insurance companies, the state and federal governments and employers concerning the benefits of the inclusion of such coverage.

AIP RESOURCE REQUIREMENTS:

WHO: A task force composed of community health council representatives, health care practitioners, legislators, insurance company officials.

FACILITIES: Existing.

FUNDING: Existing.

TIME: Unknown.

HSP OBJECTIVE 3-D-5

Develop licensure requirements for mid-level practitioners and sanitarians and require licensure by the State of Alaska by 1979.

AIP OBJECTIVE 3-D-5

Same as HSP objective 3-D-5, above.

AIP RECOMMENDED ACTIONS:

- a) Define which mid-level practitioners require licensure.
- b) Review model licensure regulations from national certifying organizations.
- c) Establish licensure requirements.
- d) The Division of Occupational Licensure will utilize existing licensure boards whenever possible for licensing mid-level practitioners and sanitarians.

AIP RESOURCE REQUIREMENTS:

WHO: Professional organizations, Division of Occupational Licensure staff.
FACILITIES: Existing.
FUNDING: Existing.
TIME: Unknown.

BENEFITS TO THE COMMUNITIES:

Licensure requirements would reduce some of the inhibiting factors for placement of mid-level practitioners needed to provide medical care in underserved communities while contributing to maintaining quality of care for people in all communities.

EVALUATION MEASURES:

Development of licensure requirements and required licensure by 1979 for mid-level practitioners and sanitarians in Alaska.



ALASKA CHAPTER
NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.
Anchorage Unit
4201 McInnes
Anchorage, Alaska 99504

March 30, 1978

Senator Clem Tillion
Pouch V
Juneau, Alaska 99811

Dear Senator Tillion:

In response to your request for additional examples of situations in which social work licensure would protect the consumer of social services, I would like to provide you with the following information.

A few years back complaints about the moral and ethical behavior of a social worker dealing with children were registered with the agency employing the social worker. It was not until intervention by law enforcement authorities, however, that action was taken to terminate the employment of the social worker. Had a social work licensing board been in existence, complainants would have had recourse to a legally established entity for revocation of that social worker's license. Furthermore, that same social worker could presently return to the state to practice, and as no licensing authority exists he could not be prevented from practicing.

A second example involves a social worker whose alcoholism problems render her unable to assist others but whose employers have had difficulty terminating her where no professional review board exists to which they can appeal. If certification or licensing were required by law, this individual would either be unable to achieve certification in the first place or be subject to review and license revocation upon complaint. In addition, this individual is educationally qualified to practice independently, and should she decide to do so, no mechanism exists now to prevent it.

Thirdly, agency representatives have stated that some of their clients have indicated a wish to be informed regarding the qualifications of the social workers assisting them, and with certification of at least Professional and Certified Professional Social Workers such clients would be able to identify social workers with the Masters Degree in Social Work.

Senator Clem Tillion

March 30, 1978

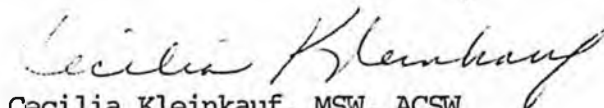
Page 2

The Southeastern Alaska Health Systems Agency has taken the position in support of certification/licensure of social workers in order to increase the opportunities for consumers of social services to secure services from as broad a range of professionals as possible. Ms. Pam McMillan, an NASW member, will be in touch with you regarding this.

Lastly, Alaska Chapter, NASW wishes to reiterate that legal regulation of social work practice will greatly assist in providing clients an opportunity to pay for social work services through third party insurance payments - either to agencies employing professional social workers or to private practitioners.

We hope that this information is sufficient for your purposes and that SB288 can now move as rapidly as possible to the Senate floor for action.

Sincerely,



Cecilia Kleinkauf, MSW, ACSW
Member, Board of Directors
Alaska Chapter, NASW

cc: Pat Rodey

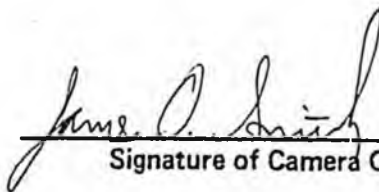
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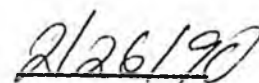
RECORDS CERTIFICATION



I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.



Signature of Camera Operator



Date

Southern Region
EMERGENCY
Medical Services Council, Inc.

Book 7 289

April 14, 1977

Senator John C. Sackett
Pouch V
Juneau, Alaska 99811

Dear Senator Sackett:

Accidents and cardiac difficulties are the two greatest killers of our fellow Alaskans. An emergency medical service system can significantly reduce the suffering or death caused by these killers and other emergent situations.

The Southern Region Emergency Medical Services Council (SREMSC) is a nonprofit corporation dedicated to the improvement of emergency medical services in South Central Alaska and the Aleutian Islands.

Senator John Sackett has recently introduced Senate Bill 289 "An Act relating to emergency medical services; and providing for an effective date". This Bill establishes a State Office of Emergency Medical Services in the Department of Health and Social Services and an Advisory Council on Emergency Medical Services. These two activities are instrumental in the development of an emergency medical service system in Alaska. Without their guidance and coordination it will be virtually impossible to establish an interrelating medical system to insure expedient and comprehensive treatment. Failure to support a state-wide approach to EMS will result in duplication of effort, waste of taxpayer's money and needless confusion in the provision of EMS.

The Southern Region Emergency Medical Services Council, Inc. would like to go on record as supporting Senate Bill 289 and we urge you to lend your assistance to the passage of this extremely important legislation.

Sincerely,

Don Endicott

Don Endicott,
President

Introduced: 3/28/77
Referred: Health, Education &
Social Services and Finance

1 IN THE SENATE

BY SACKETT BY REQUEST

2 SENATE BILL NO. 289

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to emergency medical services; and
7 providing for an effective date."

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

9 * Section 1. AS 18 is amended by adding a new chapter to read:

10 CHAPTER 8. EMERGENCY MEDICAL SERVICES.

11 Sec. 18.08.010. ADVISORY COUNCIL ON EMERGENCY MEDICAL SERVICES.

12 There is established in the Department of Health and Social Services an
13 Advisory Council on Emergency Medical Services. The council shall

14 (1) act in an advisory capacity to the commissioner in matters
15 pertaining to the planning and implementation of statewide emergency
16 medical services system; and

17 (2) act as a committee of the Statewide Health Coordinating
18 Council created under AS 18.07.011 in the area of emergency medical
19 services to assist the council in meeting its responsibilities under
20 federal and state law.

21 Sec. 18.08.020. STATEWIDE COMPREHENSIVE EMERGENCY MEDICAL SERVICES.

22 The department shall establish a statewide comprehensive emergency medi-
23 cal services system for the effective and coordinated delivery of health
24 care services under emergency conditions, whether the emergency arises
25 as a result of the patient's condition, as a result of a natural or
26 other disaster, or otherwise, administered by a statewide network with
27 the authority and resources to provide effective administration of the
28 system. The department shall

29 (1) coordinate the activities of public and private agencies

1 concerned with the planning and delivery of emergency medical services
2 in the state; and

3 (2) provide grants to public and private agencies concerned
4 with the planning and delivery of emergency medical services in the
5 state.

6 Sec. 18.08.030. COMPOSITION OF COUNCIL ON EMERGENCY MEDICAL SER-
7 VICES. The council shall consist of 11 members appointed by the gover-
8 nor. No more than seven members of the council may be persons whose
9 occupation or profession is or has been the delivery or administration
10 of emergency medical services, persons who have fiduciary obligations
11 to a health activity facility, or other health agency, or who have a
12 legal or financial interest in the delivery of any component of emergency
13 medical services.

14 Sec. 18.08.040. TERM OF OFFICE. Members of the council serve for
15 four-year terms except that of the initial appointees, the governor
16 shall appoint two members for one-year terms, three for two-year terms,
17 three for three-year terms, and three for four-year terms. A person
18 whose occupation or profession is not in any way related to the provi-
19 sion of medical services or emergency medical services shall be appointed
20 to each of the staggered terms. Vacancies shall be filled by the gover-
21 nor in the same manner as original appointments.

22 Sec. 18.08.050. SPECIAL COMMITTEES. The council may establish
23 special committees or task forces outside its membership and may recom-
24 mend persons who are not members of the council to serve as advisors or
25 consultants to any committee established to carry out the purposes of
26 the council.

27 Sec. 18.08.060. COMPENSATION AND PER DIEM. Members of the council
28 serve without compensation but are entitled to per diem and travel ex-
29 penses authorized by law for boards and commissions.

1 * Sec. 2. AS 18.05.040(a) is amended by adding a new paragraph to read:

2 (20) the development, implementation, and maintenance of a
3 statewide comprehensive emergency medical services system under the
4 provisions of ch. 8 of this title.

5 * Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-
6 070(c).

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EMS LEGISLATION OVERVIEW

The attached proposed legislation is being introduced to accomplish three purposes:

(1) To clearly establish the responsibility of providing state identified emergency medical services (EMS) and coordination as a function of the Department of Health and Social Services.

The Department would clearly be identified in the State as the lead coordinating agency for all efforts aimed at improving emergency medical services. This is important because many state and local agencies have direct or indirect involvement in EMS. The statutory authority would make it clear that the people of the State recognize the need for coordination to facilitate system improvement and avoid the duplication of effort.

(2) To establish a State Emergency Medical Services Advisory Council by Alaska Statute to provide expertise, coordination, and liaison for the building of a statewide comprehensive Emergency Medical Services System.

Statutory authority is requested for the EMS Advisory Council to give the Council the stature to attract competent people, to allow the Department to pay the travel and per diem of the Council members when they attend meetings and act in an official capacity. This is doubly important because the Comprehensive Health Advisory Council, which was the source of authority for the present EMS Advisory Council, has been disbanded.

The Emergency Medical Services Advisory Council will advise the Commissioner of the Department of Health and Social Services on all EMS policies and standards. The Council will designate committees to provide the necessary technical assistance to the EMS Office in the various areas such as training, communications, transportation, facilities, and critical care areas. The Governor will appoint eleven individuals who have an interest in improving emergency medical services in Alaska, four of whom will be consumers and not providers of emergency medical services. The Council will provide the EMS program with the necessary public input to ensure that it meets the needs of the people of the state and the particular problems unique to Alaska. It will also meet the requirements of Section 1203 of P.L. 93-154, as amended by P.L. 94-573, which mandates "assurances of the participation in the support of the system by the public, private and volunteer organizations."

Statutory authority is also proposed to make the EMS Advisory Council a Committee of the Statewide Health Coordinating Council (SHCC). The language suggested is identical to that

proposed by the Mental Health Advisory Council which is currently in the process of obtaining legislative approval. As the SHCC Council will have budgetary review authority over funds distributed under the Public Health Service Act (which incorporates the EMS program), logic would suggest mandating a continuing relationship between the two bodies.

(3) To vest the Department with authority to award grants with EMS grant funds.

Under the present system, only cost-reimbursable contracts may be used to support the EMS regions with grant funds as directed by DHEW. This is an administratively cumbersome process that demands a substantial portion of both EMS staff time and DHSS fiscal services time. It also presents cash flow problems to the contractors who must spend their own funds before they can receive payment. The grant mechanism would provide for advance payment and not require monthly billings to be processed. The State would audit each grantee annually as it does now with contracts, thereby maintaining the necessary fiscal accountability. The grant process would substantially reduce the administrative costs of this program.

Historical Perspective

The Department's Office of Comprehensive Health Planning, known now as the Office of Planning and Research, has maintained an EMS component since FY 1972. This component consists of an EMS planner position, a clerk typist, and funds for the EMS Committee of the Comprehensive Health Advisory Council (CHAC). The primary role was the planning and implementation of the EMS Standard of the Highway Safety Act of 1966. Funding for this component was originally handled through an RSA between the Department of Health and Social Services and the Department of Public Safety. In FY 1975, the Department of Public Safety agreed to transfer the two positions to the Office of Comprehensive Health Planning. The Emergency Medical Services component was funded with 100% General Fund monies. This component will remain a part of the Office of Planning and Research BRU through the FY 1977 budget period. In FY 1978, the Emergency Medical Planning component within the Office of Planning and Research will be renamed the Social Services Unit and the functions will be broadened. This alteration coincides with the establishment of the Office of Emergency Medical Services as a separate BRU.

With the advent of P.L. 93-154, the Emergency Medical Services Systems (EMSS) Act of 1973, an effort to secure funding under that Act began. In FY 1976, the Department received a grant of \$450,000 to begin implementation of a state-wide comprehensive EMSS on a regionalized basis. The grant was made for the purpose of providing funds to support the Interior Region, a state coordinating agency, and to fund regional EMS coordinators in seven other EMS regions in the state. The

Alaska State Legislature gave approval to receive and expend the funds in October of 1975, and contracts were let over the next several months to five regional health corporations, one borough health department, and one nonprofit corporation organized to coordinate EMS in its region. The Interior Region received funds to implement a comprehensive Basic Life Support System for that region which included training, upgrading communications equipment, upgrading emergency equipment in the villages, administrative support, etc. The other seven regions received funds for a coordinator's salary and travel as well as travel for the regional EMS Advisory Council. The corporations provided administrative support as in-kind match. The coordinators were to organize a regional EMS advisory council, do a resource inventory, and write an EMS plan for their region. With the receipt of the FY 1976 grant, the positions of Coordinator, Associate Coordinator, and Clerk Typist III were instituted in the Office of Planning and Research. The EMS Committee of CHAC was reactivated and brought up to strength at seven members through gubernatorial appointment.

In Fiscal Year 1977, the regional EMS plans were attached to the State's plan and grant application. The state received a federal FY 1977 grant award of \$725,000 and authority to carry over some \$77,610 of unexpended FY 1976 funds. These funds were to provide a second year of funding for the Interior Regions "1203" basic life support program, to continue support of the State EMS Office and to begin statewide training programs for all personnel involved in delivering emergency medical services Congress then passed and the President signed PL 94-573, the EMS Amendments of 1976, extending the original Act for three more years. The State expects to receive complete program funding for additional regions in FY 78.

EMS advisory council meetings have been held throughout the state and federal funding has been sufficient to allow for comprehensive local input. All of the funds for FY 76 and 77 were federal funds and the budget request for FY 78 does not request General Fund support. As stated above, complete federal program funding is anticipated to continue through FY 80. By FY 80, it is estimated that the coordinative program at the state level will consist primarily of staff and travel for a State Emergency Medical Section. The functions of the state office will involve continuing program education and the fine-tuning of the system established with the federal funds.

For an Act entitled: "An Act establishing emergency medical services as a function of the Department of Health and Social Services and creating an Advisory Council on Emergency Medical Services, and providing for an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA

*Section 1. As 18 is amended by adding a new chapter to read:

CHAPTER 8. EMERGENCY MEDICAL SERVICES

Section 18.08.010. ADMINISTRATION. The department shall be responsible for the development, implementation and maintenance of a statewide comprehensive emergency medical services system. The department shall

(1) Coordinate the activities of public and private agencies concerned with the planning and delivery of emergency medical services in the state;

(2) Provide grants to public and private non-profit agencies in the state for the delivery of emergency medical services. Application for such grants shall be submitted in the form and with information which the department by regulation prescribes.

Section 18.08.020. ADVISORY COUNCIL ON EMERGENCY MEDICAL SERVICES. There is established in the department an advisory council on emergency medical medical services. The council shall

(1) act in an advisory capacity to the commissioner in matters pertaining to the planning and implementation of a statewide emergency medical services system;

(2) act as a Committee of the Statewide Health Coordinating Council in the area of emergency medical services systems to assist that council in meeting its responsibilities under federal and state law.

Section 18.08.030. COMPOSITION. The council shall consist of 11 members appointed by the Governor. Four of the members shall be consumers and not providers of emergency medical services.

Section 18.08.040. TERM OF OFFICE. All members of the council shall serve for four-year staggered terms. Of the initial appointees, the Governor shall appoint two members for one-year terms, three for two-year terms, three for three-year terms, and three for four-year terms. One consumer shall serve in each of the above staggered terms. Vacancies shall be filled by the Governor in the same manner as original appointments.

Section 18.08.050. SPECIAL COMMITTEES. The council may create special committees or task forces outside its membership and may recommend persons who are not members of the council to serve as advisory or consultants to any committee created to carry out the purposes of the council.

Section 18.08.060. COMPENSATION AND PER DIEM. Members of the council shall serve without compensation but are entitled to per diem and travel expenses as may be authorized by law for boards and commissions.

Section 18.08.070. DEFINITIONS IN THIS CHAPTER.

- (1) "Commissioner" means the commissioner of Health and Social Services;
- (2) "consumer of emergency medical services" means a person who is not a provider of emergency medical services as defined in this section;
- (3) "department" means the Department of Health and Social Services;

(4) "emergency medical services system; means a system which provides for the arrangement of personnel, facilities and equipment for the effective and coordinated delivery of health care services under emergency conditions, occurring either as a result of the patient's condition or of natural disasters or similar situations, and which is administered by a statewide network which has the authority and resources to provide effective administration of the system;

(3) "provider of emergency medical services" means a person whose occupation or profession is, or has been, the delivery or administration of emergency medical services; a person who has a fiduciary obligation to a health activity, facility or other health agency, or a legal or financial interest in the rendering of any component of emergency medical services;

(4) "statewide health coordinating council" means that council created in accordance with AS 18.07.011.

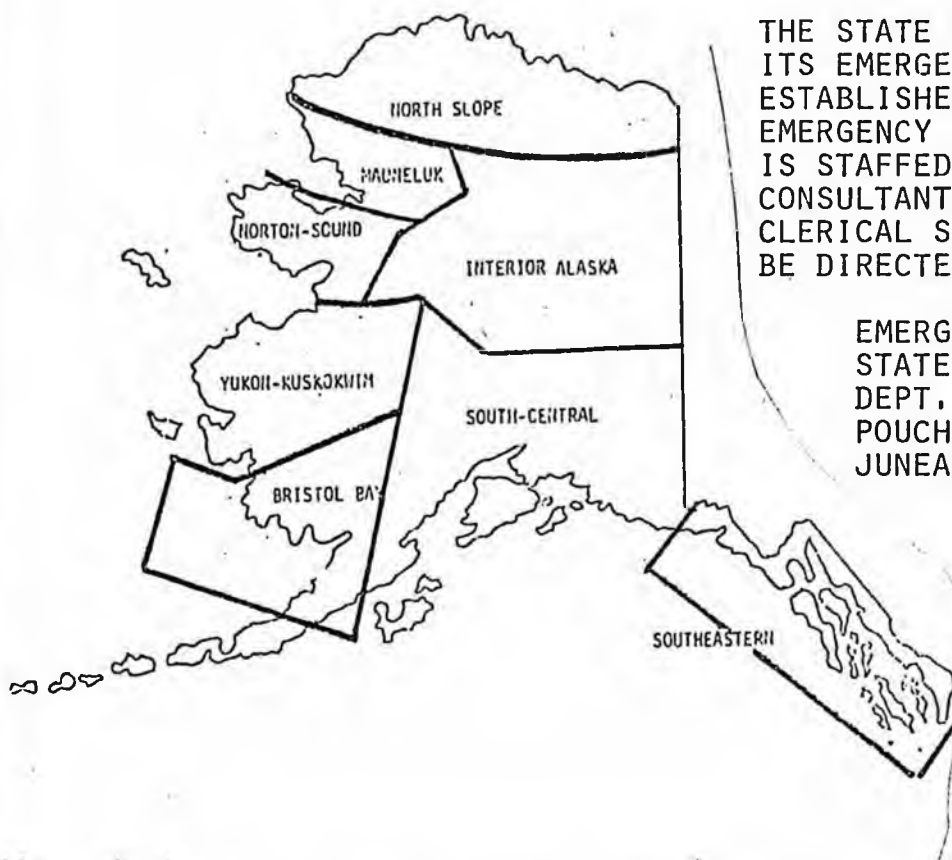
*Section 2. AS 18.05.040(a) is amended by adding a new paragraph to read:

Section 18.05.040. REGULATIONS.

(20) the development, implementation and maintenance of a statewide comprehensive emergency medical services system.

*Section 3. This act takes effect immediately in accordance with AS 01.10.070(c).

ALASKA EMERGENCY MEDICAL SERVICES



THE STATE OF ALASKA, IN ORDER TO IMPROVE ITS EMERGENCY MEDICAL SERVICES SYSTEM, ESTABLISHED IN FY 76 A STATE OFFICE OF EMERGENCY MEDICAL SERVICES. THE OFFICE IS STAFFED WITH A COORDINATOR, PROGRAM CONSULTANT, ASSOCIATE COORDINATOR, AND CLERICAL SUPPORT. CORRESPONDENCE SHOULD BE DIRECTED TO:

EMERGENCY MEDICAL SERVICES
STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES
POUCH H - 01A
JUNEAU, ALASKA 99811

STAFF:

CHARLES RAMAGE
COORDINATOR

THOMAS D. SCOTT II
PROGRAM CONSULTANT

PEGGY A. ZUFELT
ASSOCIATE COORDINATOR

ALASKA IS DIVIDED INTO EIGHT EMERGENCY MEDICAL SERVICES REGIONS, WHICH ACCORD WITH TRADITIONAL SOCIO-GEOGRAPHIC, TRANSPORTATION, AND SETTLEMENT PATTERNS. IN EACH REGION, A NATIVE HEALTH CORPORATION, LOCAL GOVERNMENT UNIT OR OTHER NON-PROFIT ENTITY SERVES AS THE AGENCY TO COORDINATE RESOURCES INTO A VIABLE EMERGENCY MEDICAL SERVICES REGIONAL SYSTEM.

REGIONAL COORDINATORS & CONTRACTORS

LAUREL PARKER
SOUTHEASTERN ALASKA EMS COUNCIL
P.O. BOX 1654
JUNEAU, ALASKA 99802

LYNNE QUIST
BRISTOL BAY AREA HEALTH CORP.
P.O. BOX 233
DILLINGHAM, ALASKA 99723

ELISE PATKOTAK
NORTH SLOPE BOROUGH
P.O. BOX 456
BARROW, ALASKA 99723

RICHARD PAULEY
SOUTHERN REGION EMS COUNCIL
1135 WEST 8TH SUITE #1
ANCHORAGE, ALASKA 99501

PAUL IRVIN
YUKON KUSHOKWIM HEALTH CORP.
P.O. BOX 523
BETHEL, ALASKA 99559

FRAN MCAFEE
NORTON SOUND HEALTH CORP.
P.O. BOX 966
NOME, ALASKA 99762

DAN SNYDER, JR.
MAUNELUK ASSOCIATION
P.O. BOX 255
KOTZEBUE, ALASKA 99752

JEANNE OSTNES
INTERIOR REGION EMS
DIVISION OF PUBLIC HEALTH
ARTIC HEALTH BLD
WEST RIDGE OF UNIVERSITY OF ALASKA
FAIRBANKS, ALASKA 99701

COMMISSIONER PAGE

Francis S. L. Williamson

Commissioner

Department of Health and Social Services

In Alaska, the medical emergency has long been a source for tales of heroism, valor, and endurance. Behind these tales, however, has been the reality of acceptance by Alaskans, as a way of life, of accident and trauma and their possible fatal consequences. Whether isolated in a small community or a bush cabin, whether on a hunting or fishing trip, or traveling by automobile or snowmachine, Alaskans often realize that should an accident or sudden illness strike, the distance from communication may make calling for aid difficult if not impossible. Geography, distance and weather conditions make evacuation difficult. When few trained personnel are available to render essential medical attention, the result can be fatal.

Statistics confirm our subjective impression that ordinary accidents in Alaska can be fatal. Our accidental death rate per 100,000 population is more than double that of the remainder of the U. S. A full 33% of our deaths are attributed to the trauma caused by accidents, suicide, and homicide, compared to only 8% of the deaths in the rest of the U. S., being attributable to those causes. These awesome statistics highlight a need for a more systematic, dependable means of treating the victims of accidents or other medical emergencies.

EMERGENCY MEDICAL SERVICES SYSTEM (EMSS)

The passage, in 1973, of the national Emergency Medical Services Systems Act (P.L. 93-154) gave Alaska the resources to cope with our serious medical emergency problem. For the first time in the U. S. a comprehensive emergency medical services system was conceptualized in legislation and funds were appropriated



Francis S. L. Williamson

to health agencies to identify and develop such a system. By enacting this law, Congress recognized that emergency medical services means something more than an ambulance carrying a patient to the nearest hospital emergency room. Two crucial factors in the care of the critically ill and injured were recognized: the speed with which definitive care is offered and the appropriateness of the care rendered.

In enumerating the factors relevant to appropriate care, the Emergency Medical Services Systems Act emphasized: (1) patient stabilization at the scene and during transfer by Emergency Medical Technicians (EMT) operating an appropriately equipped ambulance; (2) communication between the ambulance and the

hospital so that verbal assistance may be given to the EMT at the scene; (3) rapid identification of situations in which patients require medical resources not available locally and a preplanned system of transferring patients to the appropriate facility; (4) transfer to rehabilitation facilities.

The Emergency Medical Services Systems Act emphasizes coordination between medical resources with overall administrative responsibility vested in a state agency and with operational authority vested in specific regions and localities throughout the state.

ALASKA'S EMERGENCY MEDICAL SYSTEM

Passage of P.L. 93-154 provides an opportunity for Alaska to use funds to permit us to replace the traditional informal response to crisis with a sophisticated, systematized approach.

In 1975, the Department of HEW, Division of Emergency Medical Services, approved a grant application from the Alaska Department of Health and Social Services. Alaska's first-year funds were aimed at three primary objectives: to establish a state office of Emergency Medical Services, to support the development of the Interior Region Plan of the Tanana Chiefs Health Authority in Fairbanks, and to establish a statewide infrastructure for regional coordination.

The state was divided into eight Emergency Medical Service regions, generally following the lines of the Indian Health Service boundaries, which in turn, conformed to primary patient flow patterns. Through contracts with nonprofit health corporations and local government entities, a regional coordinator was funded for each region. The regional coordinators formed local emergency medical services advisory councils, conducted resource and needs surveys of their regions, and wrote regional plans which were submitted for funding under the second-year grant. At the state level, staff were hired to administer the grant and to work closely with the regional coordinators to develop a coordinated statewide emergency medical service delivery system.

In 1976, the Department of Health and Social Services received second-year grant. This grant provided for continued support of the Interior Region program and the regional coordinators. Training monies for emergency medical technicians and other health care providers were also granted. During this second-year grant period, efforts will be made to involve the medical community in developing the emer-

gency medical services system. The most important areas of physician involvement will be in the development of subsystems in the critical areas of cardiac problems, trauma, burns, poisoning, behavioral and neonatal care. Within each of these critical care areas, physicians will be asked to help determine the optimum levels of care and the best means of attaining those levels.

Already, progress has been made in the area of neonatal care. The Alaska Newborn Project, developed by Dr. David Spence of the Division of Public Health, Department of Health and Social Services, with the assistance of Dr. Thomas McCabe, has implemented a statewide support system for the care of high-risk infants. Three transport incubators with trained personnel, located in Fairbanks, Anchorage, and Juneau, stand ready to care for regional neonatal emergencies. High-risk infants will be transported by these units to Providence Hospital's Newborn Special Care Nursery where they will receive needed intensive care. A manual describing the use of the system, including procedures for the treatment, transportation and support of the newborn, has been written by Dr. Dion Roberts of Anchorage, and Dr. Thomas Porter of Anchorage. The High Risk Infant Transport Manual is being distributed to physicians and hospitals throughout the state.

Similar protocols for each critical care area will be implemented during the next several years. As the state's emergency medical services system is developed and implemented, each emergency patient's needs will be assessed as he/she enters the system to assure that the most appropriate care and treatment will be rendered.

Those of us who have lived in Alaska for any period of time, especially those who have lived in the rural and bush areas of the state, know the frustrations of obtaining adequate treatment for the victim of a life-threatening emergency. Such frustration is heightened when we know that the technology exists to provide the necessary care and to avoid unnecessary death and disability. The State of Alaska has begun an effort to develop a strong, comprehensive, statewide emergency medical services system. An administrative structure emphasizing the need for coordination has been established on both the state and regional levels. The program is ready to move forward. With the leadership of the medical community, no matter where in Alaska a medical emergency occurs, we can increase the victim's chances for survival.

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Senate Bill 289
Title An Act relating to emergency medical services
Requested by _____ Date 4/6/77

II. FISCAL DETAIL

Agency Affected Department of Health & Social Services
Program Category Affected Planning and Research
Budget Request Unit(s) Affected Emergency Medical Services

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES						
200 TRAVEL		11.3	12.4	13.6	14.9	16.3
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		11.3	12.4	13.6	14.9	16.3

FUNDING (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
GENERAL FUND						
FEDERAL FUNDS		11.3	12.4	13.6	14.9	16.3
OTHER (Specify)						

POSITIONS

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
FULL TIME						
PART TIME						
TEMPORARY						

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

This legislation will not affect the current and proposed Emergency Medical Services BRU. Budget figures on this fiscal note reflect costs for State EMS Advisory Council meetings. Projected figures for FY79 - FY82 are based on a 10% inflation factor.

Projected Travel: Attend quarterly board meetings, 24 trips (4 meetings X average 6 council members travelling) X \$375 per trip (average air fare \$275 plus 2 days per diem @ \$50/day) \$9,000

1 council member to attend 1 regional and 2 national symposia. 3 trips X \$750 per trip. 2,250

IV. DATE 4/6/77 PREPARED BY *Janice Carter*
AGENCY Emergency Medical Services
PHONE 465-3027

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

A Total Emergency Medical System for the State of Maryland

R. ADAMS COWLEY, MD
Director, Division of Emergency Medical Services
State Department of Health and Mental Hygiene
22 S. Greene St.,
Baltimore, MD 21201.

Introduction

The failure to provide for emergency illness, accidental death and disability can no longer be tolerated as an insoluble health problem. In Maryland, the medical expertise and technology are now available to reduce accidental death and disability rates in our state. Through better utilization of these existing emergency resources using a total systems approach to emergency health care delivery, immediate improvement in emergency medical care can be realized. Furthermore, geographic factors and the current medical environment in Maryland lend themselves to the initiation of a statewide system of emergency medical services (EMS).

When every American has access to first-rate emergency care, we will have satisfied the most urgent demand of our current crisis in health care and guarantee to the consumer the most fundamental health right of all—the right to life.¹

Magnitude of the Problem

The Committee on Emergency Medical Services, Division of Medical Sciences of the National Research Council, has stated that accidental injury and acute illness generate a staggering demand on ambulance and rescue services, allied health personnel, physicians, nurses and hospitals for the delivery of emergency medical services. According to their report, accidental injury is the leading cause of death among all persons aged 1-38.

Each year more than 32 million US citizens are injured. Of these, more than 110,000 die, 11 million require bed care for a day or more and 400,000 suffer lasting disability at a cost of nearly \$3 billion in medical fees and hospital expenses and over \$4 billion in lost wages. Those requiring hospitalization occupy an average of 65,000 beds for 22 million bed days under the care of 88,000 hospital personnel. This hospital load is equivalent to 30 500-bed hospitals. One out of every eight beds in a general hospital is occupied by an accident victim.

To compound these tragic statistics, accidents take the lives of young and healthy individuals who otherwise could expect to enjoy long and productive lives. In addition to the human loss, the cost to society in terms of productive manhours is devastating.² The total cost is over \$29 billion a year.³

According to the *JAMA* supplement on *Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care*, it is estimated that 1,000,000 persons in the United States experience acute myocardial infarction each year and more than 650,000 die annually of ischemic heart disease. About 350,000 of these deaths occur outside the hospital, usually within two hours of

the onset of symptoms. Thus, sudden death from heart attack remains the gravest medical emergency today.⁴

This emergency is closely followed by accidental death as a result of drowning, electrocution, suffocation, drug and alcohol intoxication, falls, poisonings, attempted suicide and automobile accidents. Together, sudden death from heart attack and accidental death are responsible for one-fourth of all mortalities in the US annually. However, aggressive emergency medical care without delay, made possible by a preplanned, well-organized system of response, could save many of these victims.

Although transportation is an important aspect, emergency transportation alone, without capability for care in transit, does not constitute emergency care. The major elements of emergency health care delivery are life support through resuscitation and stabilization of the victim at the scene of the life-threatening emergency, stabilization during transportation, continuing care at a definitive center appropriately equipped to manage that life-threatening problem and rehabilitative care. These and other variables of emergency service combine, often randomly at present, to determine the survival of the patient. This is unacceptable in the Maryland system.

The success of a system of emergency medical care depends on the cooperation and participation of numerous elements in the community. Initial planning and determination of resources and needs must be the responsibility of local residents, representatives of health care providers and consumers. Multi-jurisdictional councils must be formed to insure compatibility of equipment, standards and procedures among elements in the system and between adjacent systems.

State and national guidelines and standards must be adhered to and ongoing critical evaluation of the system must provide the basis for continual modification and growth. These activities should remain the responsibility of the local regional council working in close cooperation with other councils and state authorities.

When all of these resources are brought together and focused on the emergency victim, we will be able to offer all citizens the best emergency medical care that science can provide and consequently decrease death and disability in our state due to life-threatening medical emergencies.⁵

Program Goal and Objectives

Governor Marvin Mandel and the Legislature have mandated the development of a statewide emergency medical services system through the creation, by Executive Order in February, 1973, of the Division of Emergency Medical Services (DEMS) and the Maryland Institute for Emergency Medicine (MIEM), formerly known as the Center for the Study of Trauma. The DEMS, a service organization, is working with providers of emergency care throughout the

Region II (Mid-Maryland) encompasses Frederick and Washington Counties; it operates in collaboration with contiguous areas of southern Pennsylvania, West Virginia and Virginia.

Region III (Metropolitan Baltimore) includes Baltimore City and the Counties of Baltimore, Anne Arundel, Harford, Howard and Carroll; it operates in collaboration with contiguous areas of Pennsylvania.

Region IV (Eastern Shore) encompasses Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Somerset, Wicomico and Worcester counties; it operates in collaboration with parts of Delaware and Virginia.

Region V (Metropolitan Washington) consists of Montgomery, Prince George's, Charles, Calvert, and St. Mary's Counties and, by mutual agreement, the District of Columbia and four counties and two cities in northern Virginia.

Most agencies and institutions dealing with emergency services agree that the system must not only be regionalized but coordinated to avoid delays in patient care. As a first step, the regions must assess their current capabilities and needs in three areas: rescue equipment (ambulance and communication equipment), rescue manpower and emergency facilities. Once identified, the necessary equipment can be obtained, training programs begun and emergency care moved on its way toward a uniformly high level statewide.

Regional EMS Advisory Councils

In keeping with the State plan, a volunteer EMS Advisory Council has been organized in each region to provide for lay and professional participation in developing and instituting an emergency service system.

Council members include hospital authorities, physicians, nurses, County and State health department officials, consumers, representatives of ambulance and rescue organizations, fire and police departments, municipal government and civil defense.

In each region, the EMS Advisory Council determines local EMS needs, coordinates local emergency medical resources and provides regional input into the statewide program. A major program undertaken by all the Regional EMS Advisory Councils was to develop a regional plan in conjunction with the State plan. Based on guidelines established by Congress in the Emergency Medical Service System Act of 1973, this plan provides for Federal financial support for the development of better emergency medical services.

In developing this plan, each regional council was required to address the following components of an EMS system: 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 and 15) mutual aid agreements.

Resource requirements identified in these regional

plans were combined into a statewide grant request which was recently submitted to HEW.

The Regional EMS Advisory Councils have already made much progress in defining and providing for local EMS needs. Some highlights of their activities are presented below.

Appalachia Region

Garrett and Allegany Counties are each represented by 15 members on the Council which is officially recognized and operated under the authority of the two County Commissions. As noted above, the Council recently completed its regional EMS plan utilizing planning funds obtained in a Federal grant.

The Council has performed a detailed survey of ambulance service needs in the region which included a study of the ambulance vehicles and equipment, ambulance staffing and the geographic coverage of the present ambulance services. The Council has been instrumental in obtaining Federal funds from various sources to bring the ambulance services up to a high standard, and it has developed standards within the region for the training levels of ambulance dispatches and attendants.

The Council has provided leadership within the region which will soon result in the establishment of central alarms in both Allegany and Garrett Counties. (A central alarm is a communication center for dispatching all fire and ambulance equipment in a county. All but five Maryland counties presently operate alarms, and of these five, four are working to establish the system in their counties.)

The Council also has been a driving force behind the establishment of the Appalachia Interstate EMS Consortium (discussed more fully below) and has been participating with the Consortium in evaluation of the current hospital capabilities within their region.

Among its other activities, the Council continues to collaborate with the Western Maryland Heart Association in the establishment of Cardiac Rescue Technician programs. It has sponsored the development and conduct of a specialized ambulance drivers' training course which may well become a model for use throughout Maryland where volunteer ambulance attendants are used.

Dr. William Buser, Garrett County, was the first chairman of the Council; Lieutenant William Turnbull, Maryland State Police, is the current chairman.

Mid-Maryland

This two-county council consists of 34 members with equal representation from Frederick and Washington Counties. Also recognized and operating under the aegis of the two County Commissions, the Council recently completed its regional plan for emergency medical services.

The Council has been assisting Washington County officials in the establishment of the Washington County Central Alarm which will soon be operational. Like the Appalachia Council, the Mid-Maryland EMS Advisory Council has been involved in establishing a

of the following organizations: the Maryland Hospital Association, the Maryland Department of Planning, the Maryland State Police, the Maryland Department of Transportation, the Comprehensive Health Planning Agency, the Maryland Department of Education, the Maryland State Firemen's Association, the Maryland State Ambulance and Rescue Association and the Medical and Chirurgical Faculty of Maryland.

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Members represent all participants in the statewide system including Med-Chi, the MD Hospital Association, the MD State Police, Municipal and County Governments, MD State Ambulance and Rescue Association, MD State Firemen's Association and the Division of Emergency Medical Services.

A *Medical Management Consultant Group* has been established to assist in determining medical needs in the delivery of emergency medical care that require further study and implementation. Members were selected on the basis of specialty area, geographic location and representation of organizations involved in EMS.

Members of this group are: Drs. Robert Wilder, Wallace Sadowsky, Donald Wenger, Donald Gann, John Clark, Leonard Schleris, A. Gibson Packard, Ernest Austin, Gina Glick, Peter Fahrney, Richard Myers, Elliott Fishel, Benjamin White, Paul Joliet, Robert Adkins; Larry Lawrence; Drs. Sam Seeley, John Stafford, Nathan Schnaper; Agnes Kemerer, RN; Drs. Russell Fisher, John Harvey, Ronald Gutberlet, George Simons and John Marsh.

The following organizations are represented by physician membership in the Medical Management Consultant Group: American Heart Association, American Academy of Orthopedic Surgery, American College of Emergency Physicians; MD Hospital Association, Trauma Committee, American College of Surgeons, County Health Officers of MD; Department of Health and Mental Hygiene, Johns Hopkins Hospital, Baltimore City and County Fire Department Training, American Trauma Society and Critical Care Medicine.

To date, such items as the Cardiac Rescue Technician program, proposed legislation including the Good Samaritan and Cardiac Rescue Technician Laws and Guidelines for Statewide Uniformity of Care have been discussed and acted upon by this group at their bi-monthly meetings.

The following task forces have also been formed: EMS Training Committee—Dr. Robert Wilder, Chairman; Medical-Legal Committee—Dr. Donald Wenger,

Chairman; Categorization Committee—Dr. John Harvey, Chairman and Cardiac Rescue Training Committee—Dr. Leonard Schleris, Chairman.

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The Consortium operates on an interstate basis much as Regional EMS Advisory Council within Maryland operates on an intrastate basis. The Interstate Consortium is concerned only with those emergency medical service activities that demand interstate coordination.

An example is in the field of Emergency Medical Technician-Ambulance (EMT-A) training. Each of the three states operates its own EMT-A training program under the Federal Department of Transportation and HEW guidelines. The Consortium has arranged for the recognition of reciprocal certification of EMT-A's among the states.

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Recognizing the need to foster interstate cooperation and communication, DEMS organized Maryland, Delaware, Pennsylvania, Virginia and West Virginia, and the District of Columbia into a *Mid-Atlantic EMS Council*. Through officially-designated state representatives, the Council negotiates cooperative agreements and fosters the development and adoption of compatible State legislation and standards in order to insure reciprocity.

The Council also facilitates the sharing of resources across State boundaries, and works toward a larger regional concept for EMS. Ideally, other states would participate in the creation of similar regional groups.

These councils assure all citizens the opportunity to participate in the development and implementation of a statewide and interstate EMS system. The system is founded on the concept of volunteerism, already well-established in Maryland, and its success ultimately depends on voluntary cooperation and participation.

Maryland EMS System Components

What are the detailed elements of this system? It has

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

A Total Emergency Medical System for the State of Maryland

R. ADAMS COWLEY, MD
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Introduction

The failure to provide for emergency illness, accidental death and disability can no longer be tolerated as an insoluble health problem. In Maryland, the medical expertise and technology are now available to reduce accidental death and disability rates in our state. Through better utilization of these existing emergency resources using a total systems approach to emergency health care delivery, immediate improvement in emergency medical care can be realized. Furthermore, geographic factors and the current medical environment in Maryland lend themselves to the initiation of a statewide system of emergency medical services (EMS).

When every American has access to first-rate emergency care, we will have satisfied the most urgent demand of our current crisis in health care and guarantee to the consumer the most fundamental health right of all—the right to life.¹

Magnitude of the Problem

The Committee on Emergency Medical Services, Division of Medical Sciences of the National Research Council, has stated that accidental injury and acute illness generate a staggering demand on ambulance and rescue services, allied health personnel, physicians, nurses and hospitals for the delivery of emergency medical services. According to their report, accidental injury is the leading cause of death among all persons aged 1-38.

Each year more than 52 million US citizens are injured. Of these, more than 110,000 die, 11 million require bed care for a day or more and 400,000 suffer lasting disability at a cost of nearly \$3 billion in medical fees and hospital expenses and over \$4 billion in lost wages. Those requiring hospitalization occupy an average of 65,000 beds for 22 million bed days under the care of 88,000 hospital personnel. This hospital load is equivalent to 30 500-bed hospitals. One out of every eight beds in a general hospital is occupied by an accident victim.

To compound these tragic statistics, accidents take the lives of young and healthy individuals who otherwise could expect to enjoy long and productive lives. In addition to the human loss, the cost to society in terms of productive manhours is devastating.² The total cost is over \$29 billion a year.³

According to the *JAMA* supplement on *Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care*, it is estimated that 1,000,000 persons in the United States experience acute myocardial infarction each year and more than 650,000 die annually of ischemic heart disease. About 350,000 of these deaths occur outside the hospital, usually within two hours of

the onset of symptoms. Thus, sudden death from heart attack remains the gravest medical emergency today.⁴

This emergency is closely followed by accidental death as a result of drowning, electrocution, suffocation, drug and alcohol intoxication, falls, poisonings, attempted suicide and automobile accidents. Together, sudden death from heart attack and accidental death are responsible for one-fourth of all mortalities in the US annually. However, aggressive emergency medical care without delay, made possible by a preplanned, well-organized system of response, could save many of these victims.

Although transportation is an important aspect, emergency transportation alone, without capability for care in transit, does not constitute emergency care. The major elements of emergency health care delivery are life support through resuscitation and stabilization of the victim at the scene of the life-threatening emergency, stabilization during transportation, continuing care at a definitive center appropriately equipped to manage that life-threatening problem and rehabilitative care. These and other variables of emergency service combine, often randomly at present, to determine the survival of the patient. This is unacceptable in the Maryland system.

The success of a system of emergency medical care depends on the cooperation and participation of numerous elements in the community. Initial planning and determination of resources and needs must be the responsibility of local residents, representatives of health care providers and consumers. Multi-jurisdictional councils must be formed to insure compatibility of equipment, standards and procedures among elements in the system and between adjacent systems.

State and national guidelines and standards must be adhered to and ongoing critical evaluation of the system must provide the basis for continual modification and growth. These activities should remain the responsibility of the local regional council working in close cooperation with other councils and state authorities.

When all of these resources are brought together and focused on the emergency victim, we will be able to offer all citizens the best emergency medical care that science can provide and consequently decrease death and disability in our state due to life-threatening medical emergencies.⁵

Program Goal and Objectives

Governor Marvin Mandel and the Legislature have mandated the development of a statewide emergency medical services system through the creation, by Executive Order in February, 1973, of the Division of Emergency Medical Services (DEMS) and the Maryland Institute for Emergency Medicine (MIEM), formerly known as the Center for the Study of Trauma. The DEMS, a service organization, is working with providers of emergency care throughout the

state. The MIEM serves as a resource center devoted to developing and disseminating new concepts in therapy, teaching, research, management and systems engineering applied to EMS problems.

The overall goal is to insure that every citizen will receive the best emergency medical care regardless of type of illness or injury, its severity, the citizen's personal circumstances, or his geographical location.

The Division has defined the following objectives for the statewide emergency medical services system:

1. To establish a statewide EMS system consisting of regions, subregions, local subsystems and specialty referral facilities coordinated by a communication and transportation network as an integral part of the health delivery system.
2. To provide total emergency care from the time of the emergency through resuscitation, definitive care and rehabilitation by the maximum use of technological support throughout the cycle.
3. To develop all phases of the program utilizing community and areawide planning and cooperation with existing Federal, State and local agencies.
4. To develop and implement subsystems in capabilities of hospitals, communications, transportation, training and education, public information and evaluation.
5. To promote the latest concepts of patient management within the hospital environment so that the patient is not in a system of medical care which leads only to the hospital door.
6. To use the MIEM as a true State Institute and employ it as the nucleus to develop broad programs in patient care management, professional training and research. This Institute will provide an environment wherein all agencies and educational institutions interested in the improvement of emergency health care delivery may participate.
7. To promote a close liaison with the State Medical Examiner so that pertinent information regarding accidental deaths and injury can be evaluated and correlated to improve EMS.
8. To develop methodology utilizing systems analysis techniques for evaluating patient care, education and research so that changes in management of the program may be implemented as required.
9. To develop a system of cost-analysis and cost-effectiveness of the delivery of EMS so that with appropriate modifications and restructuring of the mechanisms of delivery these costs may be ordered or rechannelled for improved care.
10. To develop a total system that will be financially and administratively self-supporting within the community so that continued subsidization from other resources will be required only for new and unusual projects.

Thus, the purpose of the statewide EMS program is to improve the delivery of emergency medical care and thereby decrease mortality, morbidity, hospitalization and disability. Current knowledge and technology are applied to the maximum extent, limited only by the availability of resources. Detailed evaluation and effectiveness studies will be an underlying theme throughout the program's evolution.

Inventory and Planning

The outcome of any medical emergency depends on two basic factors: the quality of initial, definitive and rehabilitative care and the time intervals involved in the delivery of that care. This requires a preconceived and coordinated plan, a communication system and professional and allied health personnel cooperating with hospitals, transportation services and the public.

A plan was developed in March, 1971, entitled *A Plan for the Organization of a Statewide System of Trauma Facilities Utilizing the Already Available Resources within the State of Maryland for the Care of the Critically-Injured Patient* and submitted to Governor Mandel at his request.

This plan described all the components needed for a systematized EMS program.⁶ After a careful inventory of resources available throughout the state, encompassing all of the ingredients for an emergency health care delivery system, a second, more detailed plan was submitted to the Secretary of Health and Mental Hygiene in May, 1973.

This plan, again based on the regional concept, further identified the EMS problem, goals and objectives. It encompassed communications, transportation, education, training, implementation and evaluation. Approved at the state level, it became the foundation for Maryland's statewide Emergency Medical Services System.⁷

Regionalization

Five EMS regions, defined according to the Executive Order to encompass the entire state, were formed on the basis of jurisdictional patient flow patterns, medical capability and geographical factors (Figure 1).

Region 1 (Appalachia) consists of Garrett and Allegany Counties; it operates in collaboration with contiguous areas of Pennsylvania and West Virginia with traditionally reciprocal patient flow.

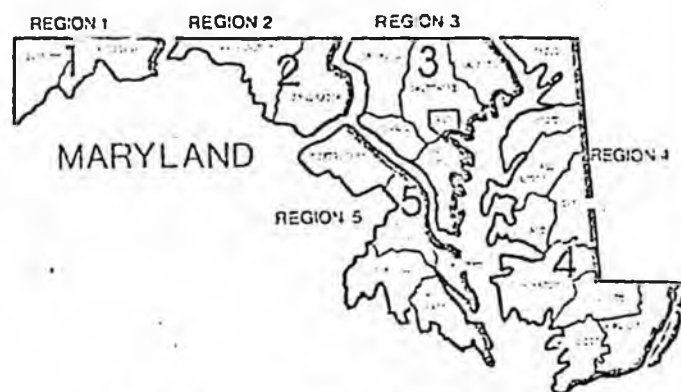


FIG. 1: Maryland EMS Regions by County.

Region II (Mid-Maryland) encompasses Frederick and Washington Counties; it operates in collaboration with contiguous areas of southern Pennsylvania, West Virginia and Virginia.

Region III (Metropolitan Baltimore) includes Baltimore City and the Counties of Baltimore, Anne Arundel, Harford, Howard and Carroll; it operates in collaboration with contiguous areas of Pennsylvania.

Region IV (Eastern Shore) encompasses Cecil, Kent, Queen Anne's, Caroline, Talbot, Dorchester, Somerset, Wicomico and Worcester counties; it operates in collaboration with parts of Delaware and Virginia.

Region V (Metropolitan Washington) consists of Montgomery, Prince George's, Charles, Calvert, and St. Mary's Counties and, by mutual agreement, the District of Columbia and four counties and two cities in northern Virginia.

Most agencies and institutions dealing with emergency services agree that the system must not only be regionalized but coordinated to avoid delays in patient care. As a first step, the regions must access their current capabilities and needs in three areas: rescue equipment (ambulance and communication equipment), rescue manpower and emergency facilities. Once identified, the necessary equipment can be obtained, training programs begun and emergency care moved on its way toward a uniformly high level statewide.

Regional EMS Advisory Councils

In keeping with the State plan, a volunteer EMS Advisory Council has been organized in each region to provide for lay and professional participation in developing and instituting an emergency service system.

Council members include hospital authorities, physicians, nurses, County and State health department officials, consumers, representatives of ambulance and rescue organizations, fire and police departments, municipal government and civil defense.

In each region, the EMS Advisory Council determines local EMS needs, coordinates local emergency medical resources and provides regional input into the statewide program. A major program undertaken by all the Regional EMS Advisory Councils was to develop a regional plan in conjunction with the State plan. Based on guidelines established by Congress in the Emergency Medical Service System Act of 1973, this plan provides for Federal financial support for the development of better emergency medical services.

In developing this plan, each regional council was required to address the following components of an EMS system: 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 and 15) mutual aid agreements.

Resource requirements identified in these regional

plans were combined into a statewide grant request which was recently submitted to HEW.

The Regional EMS Advisory Councils have already made much progress in defining and providing for local EMS needs. Some highlights of their activities are presented below.

Appalachia Region

Garrett and Allegany Counties are each represented by 15 members on the Council which is officially recognized and operated under the authority of the two County Commissions. As noted above, the Council recently completed its regional EMS plan utilizing planning funds obtained in a Federal grant.

The Council has performed a detailed survey of ambulance service needs in the region which included a study of the ambulance vehicles and equipment, ambulance staffing and the geographic coverage of the present ambulance services. The Council has been instrumental in obtaining Federal funds from various sources to bring the ambulance services up to a high standard, and it has developed standards within the region for the training levels of ambulance dispatches and attendants.

The Council has provided leadership within the region which will soon result in the establishment of central alarms in both Allegany and Garrett Counties. (A central alarm is a communication center for dispatching all fire and ambulance equipment in a county. All but five Maryland counties presently operate alarms, and of these five, four are working to establish the system in their counties.)

The Council also has been a driving force behind the establishment of the Appalachia Interstate EMS Consortium (discussed more fully below) and has been participating with the Consortium in evaluation of the current hospital capabilities within their region.

Among its other activities, the Council continues to collaborate with the Western Maryland Heart Association in the establishment of Cardiac Rescue Technician programs. It has sponsored the development and conduct of a specialized ambulance drivers' training course which may well become a model for use throughout Maryland where volunteer ambulance attendants are used.

Dr. William Buser, Garrett County, was the first chairman of the Council; Lieutenant William Turnbull, Maryland State Police, is the current chairman.

Mid-Maryland

This two-county council consists of 34 members with equal representation from Frederick and Washington Counties. Also recognized and operating under the aegis of the two County Commissions, the Council recently completed its regional plan for emergency medical services.

The Council has been assisting Washington County officials in the establishment of the Washington County Central Alarm which will soon be operational. Like the Appalachia Council, the Mid-Maryland EMS Advisory Council has been involved in establishing a

Cardiac Rescue Technician training program within its region, has identified deficiencies in the ambulance service within the region, and has worked with the ambulance companies in obtaining Federal grants to correct these deficiencies.

It has also actively collaborated with the Appalachia Interstate EMS Consortium in the hospital capabilities evaluation. This Council has been particularly concerned with developing an increased Med-Evac helicopter capability within the region and, as has the Appalachia Regional EMS Advisory Council, initiated actions with the telephone company and the two County Commissions leading toward the establishment of 9-1-1 within the region.

Dr. R. R. Roberts of Frederick County was the first chairman of the Council and he has recently been succeeded by Dr. John Marsh of Washington County.

Metropolitan Baltimore

The Board of Directors of a private, non-profit corporation, Emergency Medical Services Development, Inc. (EMSDI), serves as the regional council. EMSDI has developed and implemented a national demonstration project involving a regional EMS communications system. The system has been funded by a \$1.2 million Federal grant and provides a coordinated ambulance-to-hospital communication system through a centralized emergency medical resource center.

In conjunction with the system, 28 ambulance telemetry units have already been installed. In addition, the Council has been working with the Regional Planning Council of Metropolitan Baltimore to establish 9-1-1 throughout the metropolitan area.

EMSDI has coordinated the training of approximately 200 Cardiac Rescue Technicians within its region. It continues its effort to improve the ambulance service capability for the five counties and the city of Baltimore that comprise its region.

The present Chairman of the Board of EMSDI, Mr. Paul Becker, is the Administrator of the Greater Baltimore Medical Center. He has succeeded Dr. Joseph Berman of Sinai Hospital.

Eastern Shore

Having obtained a \$40,000 Federal planning grant, the Eastern Shore Region has completed its regional EMS plan. Working with the Comprehensive Health Planning Council of the Eastern Shore which administered the grant, the Eastern Shore EMS Advisory Council has addressed considerable attention to the problems of ambulance attendant training in remote rural areas. The Council recently completed a region-wide evaluation of hospital emergency service capabilities which involved development of written questionnaires as well as site visits to each hospital. The Council is currently working with Peninsula General Hospital and ambulance services to develop the first Cardiac Rescue Technician training program on the Eastern Shore. Dr. Frank Drew of Eastern Memorial Hospital recently completed his term as the first chairman of the council; he has been succeeded by Dr. George Himes of Peninsula General Hospital.

Metropolitan Washington

This Council consists of representatives from the District of Columbia and the surrounding counties of Virginia and Maryland. In addition to regional representation, each of the State EMS offices within Maryland, Virginia and in the District of Columbia are represented on the Council.

Six local EMS councils have been formed within the region, three of them in Maryland. Representatives from these local councils make up the majority of the Regional EMS Advisory Council. The Council, collaborating with the Metropolitan Washington Regional Medical Program which obtained a \$45,000 Federal grant for the purpose, recently completed its regional EMS plan. It has been conducting a hospital capabilities evaluation throughout the three-state area and it also has been instrumental in obtaining a design for a regional EMS communication system.

The latter has been conducted with the assistance of the technical consultants retained to design the remainder of the Maryland EMS communication system; this insures compatibility throughout the state and within this large metropolitan region.

The current chairman of the Council, is Dr. Alan Kaplan from Maryland. In accordance with the Council bylaws, the next chairman would be from the District of Columbia.

Regional Coordinators

Each of the Regional EMS Advisory Councils is supported by a regional coordinator and his secretary who serve a liaison function between the central division office, regional councils and providers of emergency care. They assist the regional councils in writing grants, developing budgets and assessing EMS needs. The regional coordinators are also one of the immediate channels of communication through which regional councils contribute their ideas to the state-wide system.

They attend council meetings and work closely with hospital administrators, physicians, nurses, ambulance personnel and other providers in their region. They assist the regions and central office in coordinating the various EMS workshops and seminars conducted throughout the state. Each regional coordinator reports to the chief coordinator who is responsible for their activities and rapport with both the professional and public elements in the system.

All parties involved in emergency medical services are encouraged to utilize the resources provided by the regional coordinators to solve their EMS problems.

Other Councils

The Division seeks the aid and guidance of many citizens, professional and lay, providers and consumers in developing a statewide EMS system. Various councils have been formed to insure adequate representation of all interested persons.

The *Regional EMS Advisory Council* (REMSAC) is composed of four members from each of the five Regional EMS Advisory Councils and representative

of the following organizations: the Maryland Hospital Association, the Maryland Department of Planning, the Maryland State Police, the Maryland Department of Transportation, the Comprehensive Health Planning Agency, the Maryland Department of Education, the Maryland State Firemen's Association, the Maryland State Ambulance and Rescue Association and the Medical and Chirurgical Faculty of Maryland.

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been recognized that what happens in the first hour after injury will largely determine a critically-injured person's chances for survival. Specifically, victims of life-threatening medical emergencies must be treated quickly by properly-trained rescue personnel, immediately brought to a medical facility capable of aggressive management of their particular medical emergencies without delay and kept alive during transport.

Translated, survival depends on training of rescue personnel, communications, rapid evacuation and transportation, availability of and access to specialized medical facilities and public education and participation.

Training and Continuing Education

During the first critical minutes following injury or sudden severe illness, the ambulance attendant may well be the first medically-trained person to care for the emergency victim. The attendant's competence and level of skill could be the single most important factor in the victim's chances for survival with minimum disability.

To achieve maximum training for ambulance attendants in Maryland, the State has recognized and accepted the course curriculum as approved by the DOT, National Highway Traffic Safety Administration, for the 81-hour EMT-A course. This course is specifically designed to prepare individuals to be ambulance attendants, i.e., to operate all standard ambulance equipment and provide basic life support to critically ill and injured persons at the scene and in transit.

To date over 4,000 of the state's 8,000 ambulance attendants are certified EMT-As. The DEMS objective is to train every ambulance attendant in the state to EMT-A level. Following initial certification, refresher courses are planned at three-year intervals.

Standardized training programs for Cardiac Rescue Technicians (CRTs) with unified program standards, skills maintenance and certification methods have recently been introduced. CRTs are trained on telemetry equipment, taught administration of IVs and certain drugs ordered by a physician and many other advanced emergency life-saving skills. These programs are currently offered on a limited scale and will be expanded as funds and staffing permit.

A variety of educational programs for physicians, nurses and others involved in the delivery of emergency health care are also underway throughout the state. In an innovative pilot program, physicians from emergency departments throughout the state will participate this fall in an intensive seven-day residential training program conducted under the auspices of MIEM.

The visiting physicians will be exposed to a variety of emergency treatment and clinical skills and receive a thorough introduction to the statewide system through briefings at the various specialty referral centers. Transportation, accommodations and a stipend are awarded the attending physicians. The DEMS objective is to offer the program each year to one physician from the emergency department of each hospital in the state.

An intensive continuing education program is also underway for emergency department nurses. Building

upon skills gained from a series of regional workshops which include such subject areas as *Crisis Intervention*, *The Changing Role of the Emergency Room Nurse*, *Burns and Pediatric Emergencies*, nurses will be invited to attend a month-long residential program conducted under the auspices of MIEM.

Focusing on specific skills required by the trauma nurse such as physical diagnosis, pathophysiology and patient management, the program will also include sessions conducted at the specialty referral centers. The DEMS objective is to offer the program annually to two nurses from the emergency department of each hospital in the state.

A large number of nursing workshops and specialized physician's seminars have been presented in cooperation with various hospitals throughout the state, and final planning is currently underway for a multi-track three-day workshop to be held in the fall. This statewide workshop, with specialized sessions for physicians, nurses and ambulance attendants, will focus on specific skills, as well as on national trends in emergency health care delivery.

Rapid Evacuation and Transportation

The state's volunteer and paid ambulance and rescue squad system and the State Police Med-Evac Helicopter Program combine to form the finest emergency medical transportation and evacuation system in the country. The Med-Evac Helicopter Program, a key component in the system, was developed by MIEM and the MD State Police and it now operates in collaboration with MIEM and DEMS.⁸

To provide better coverage for the Air Med-Evac Program, the Aviation Section of the MD State Police, the MIEM and the DEMS are working out formal agreements to incorporate the services of the National Park Services Aviation Section and the 217th Medical Detachment stationed at Fort Meade.

This additional support will provide citizens with total helicopter coverage for emergency transports.

Traditionally in Maryland, emergency patients were routinely transported to the nearest hospital regardless of the severity of illness or injury, or the medical capabilities of the destination facility. Though response time was quite good, too many severely ill or injured patients were not receiving the immediate aggressive care they required. (It will be the responsibility of the regions to evaluate EMS hospital care capability so that the patients in their regions are directed to the facility that can provide care for the injuries incurred.) While it is estimated that 85% or more of emergency victims can be effectively treated at the nearest local or area-wide hospital, an additional 10% may require more comprehensive treatment as typified by a larger multi-disciplinary-staffed general hospital. The remaining 5% require rapid evacuation to a specialty care center where thorough and aggressive treatment of a particular life-threatening illness or injury is provided.

The presence of such specialty referral centers in Maryland and the rapid evacuation and transportation capabilities of the Med-Evac program enable care pro-

viders to move their emergency patients to the appropriate facility, usually within one hour, from almost anywhere in the state.

Experience with the Med-Evac program since its implementation in 1969 has clearly demonstrated that rapid evacuation and transportation via helicopter to a specialty care facility does indeed have a dramatic impact on the survival of critically ill multiple trauma victims, and the system continues to grow.

In 1973, 840 medical transports were made, while in 1974, over 1,000 emergency critically ill or injured persons were transported by State Police helicopters to specialty referral centers for specialized medical care.

Specialty Referral Centers

The State of Maryland is fortunate in having several sophisticated, specialized treatment facilities centrally-located in Baltimore and accessible to the entire state.

The State Police Med-Evac helicopters are utilized to transport emergency critically ill or injured patients to these designated referral centers only. At a physician's request, patients can be transported to the following referral facilities: the MD Institute for Emergency Medicine, the Pediatric Emergency Trauma Center at Johns Hopkins Hospital, the Baltimore City Hospitals Kiwanis Burn Unit and the MD State Intensive Care Neonatal Programs at Baltimore City and University of MD Hospitals.

The MD Institute for Emergency Medicine provides care for those persons with emergency life-threatening illness or injury in addition to its research and teaching functions. A majority of patients are victims of multiple trauma and shock resulting from highway crashes, violence, drownings, poisonings, industrial mishaps, falls and accidents of all kinds.

Ever-ready teams of surgeons, anesthesiologists, physicians, nurses and physician assistants provide aggressive, life-saving treatment around the clock. The facilities and the staff are geared specifically to treat the direct multiple trauma victim and the interhospital transfers whatever the life-threatening problem. The MIEM also treats gas gangrene patients from all over the East Coast in its pressurized hyperbaric oxygen chamber.

Additionally, MIEM traumatologists remain available for consultation at all times through the Systems Communication Center.

The Johns Hopkins Hospital Pediatric Emergency Trauma Center provides services for children similar to those which MIEM provides for adults. The program at Hopkins is tailored to meet the special needs—emotional, physical and psychological—of critically ill or injured children. Pediatricians and pediatric surgeons render specialized medical and surgical care to the child with a life-threatening problem in carefully designed and equipped facilities.

The casual, cheerful atmosphere is intended to be as non-threatening and afford as much privacy as possible to the injured or ill child. Patients are brought to the children's unit via State Police helicopter or local

ambulance from Baltimore as well as from outlying regions of the state.

The Baltimore City Hospitals Kiwanis Burn Unit provides intensive management of approximately 100 burn patients annually. Critical burn victims of all ages are admitted from anywhere in the state. The nine-bed unit offers long-term comprehensive therapy to the burn victim. The medical team consists of special nursing personnel, plastic surgeons, general surgeons, psychiatrists, pediatricians, anesthesiologists and internists. A social worker, physical and occupational therapists and volunteer workers from the Burn Victims Aid Society of MD are involved daily with the patient's psychological, rehabilitative and social readjustment problems.

The MD State Intensive Care Neonatal Program at Baltimore City and University of MD hospitals have been combined into a cooperative program. Critically sick and premature, newborn infants are referred by physicians from anywhere in the state and are transported by the State Police Med-Evac helicopters in portable incubators with their own oxygen supply.

In 1972 and 1973, 510 infants were referred: 314 to Baltimore City Hospitals, 196 to the University of MD Hospital.⁹ Some hospitals may refer all of their premature infants, while others may refer only those with severe abnormalities. Referring physicians and families are continually informed of the baby's status and frequent visits to the baby's bedside are encouraged.

All of these specialty referral centers are serviced by MD State Police Med-Evac helicopters and offer specialized medical care to any person in the state with particular life-threatening emergencies.

Physicians throughout Maryland are encouraged to utilize the services of these facilities for those patients whose exceptional medical needs cannot be met by local resources. As required, other specialty referral centers will be established.

Communications

The MIEM has demonstrated through forewarning of patient arrival, including patient status and extent of injuries, that emergencies can arrive by appointment.¹⁰

Many hospital emergency rooms in Maryland are not forewarned of the arrival by ambulance of seriously ill or injured patients. It is only after the arrival of the ambulance at the emergency room door that the emergency room physician has an opportunity to assess the problem and gather the necessary resources to manage the emergency.

Valuable time is lost seeking qualified staff specialists, equipment and other needs. Similarly, ambulance crews have no way of knowing if a particular hospital can manage a certain case because of temporary work loads, staffing and bed space. They cannot receive medical consultation at the scene or in transit from a physician in the destination facility.

Ambulances out of their local area (e.g., on a long distance transport to Baltimore) are usually out of radio contact with anyone and have no easy means to

viders to move their emergency patients to the appropriate facility, usually within one hour, from almost anywhere in the state.

Experience with the Med-Evac program since its implementation in 1969 has clearly demonstrated that rapid evacuation and transportation via helicopter to a specialty care facility does indeed have a dramatic impact on the survival of critically ill multiple trauma victims, and the system continues to grow.

In 1973, 840 medical transports were made, while in 1974, over 1,000 emergency critically ill or injured persons were transported by State Police helicopters to specialty referral centers for specialized medical care.

Specialty Referral Centers

The State of Maryland is fortunate in having several sophisticated, specialized treatment facilities centrally-located in Baltimore and accessible to the entire state.

The State Police Med-Evac helicopters are utilized to transport emergency critically ill or injured patients to these designated referral centers only. At a physician's request, patients can be transported to the following referral facilities: the MD Institute for Emergency Medicine, the Pediatric Emergency Trauma Center at Johns Hopkins Hospital, the Baltimore City Hospitals Kiwanis Burn Unit and the MD State Intensive Care Neonatal Programs at Baltimore City and University of MD Hospitals.

The MD Institute for Emergency Medicine provides care for those persons with emergency life-threatening illness or injury in addition to its research and teaching functions. A majority of patients are victims of multiple trauma and shock resulting from highway crashes, violence, drownings, poisonings, industrial mishaps, falls and accidents of all kinds.

Ever-ready teams of surgeons, anesthesiologists, physicians, nurses and physician assistants provide aggressive, life-saving treatment around the clock. The facilities and the staff are geared specifically to treat the direct multiple trauma victim and the interhospital transfers whatever the life-threatening problem. The MIEM also treats gas gangrene patients from all over the East Coast in its pressurized hyperbaric oxygen chamber.

Additionally, MIEM traumatologists remain available for consultation at all times through the Systems Communication Center.

The Johns Hopkins Hospital Pediatric Emergency Trauma Center provides services for children similar to those which MIEM provides for adults. The program at Hopkins is tailored to meet the special needs—emotional, physical and psychological—of critically ill or injured children. Pediatricians and pediatric surgeons render specialized medical and surgical care to the child with a life-threatening problem in carefully designed and equipped facilities.

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ambulance from Baltimore as well as from outlying regions of the state.

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5. Cowley, R.A.: A Study of Shock and Trauma in Man Utilizing the Resources of a Clinical Shock Trauma Unit, *Maryland State Medical Journal*, March, 1967, Vol. 16, No. 3, p. 63.
6. Center for the Study of Trauma. University of Maryland. A Plan for the Organization of a Statewide System of Trauma Facilities Utilizing the Already Available Resources Within the State of Maryland for the Care of the Critically-Injured Patient. March, 1971.
7. Division of Emergency Medical Services, Maryland State Department of Health and Mental Hygiene. A Plan for an Emergency Medical Service Program for the State of Maryland.
8. Cowley, R.A., et al: A Economical and Proved Helicopter Program for Transporting the Emergency Critically Ill and Injured Patient in Maryland, *J. of Trauma*, Dec., 1973, Vol. 13, No. 12, p. 1029.
9. Maryland State Police Statistics.
10. Cowley, R.A., A.B. Cooper III, D.E. Towson, L. Scherlis: A Statewide Communication System to Support a Regional Program for Emergency Health Care Delivery in Maryland, *Maryland State Medical Journal*, January, 1973, Vol. 22, No. 1, p. 61.

Medical Miscellany

AMA Sues HEW

The date for implementation of utilization review regulations in hospitals and other health facilities participating in Medicare and Medicaid programs was extended from Feb. 1, 1975 to July 1 by HEW Secretary Caspar Weinberger.

He said the reason for the extension was to "Allow all providers to come into full compliance and to avoid the loss of eligibility to participate in Medicare and Medicaid programs before July 1."

The AMA, joined by 10 patients and five Illinois physicians, filed its first suit ever against HEW on Feb. 20 to seek both a preliminary and permanent injunction against implementation of the regulations.

In addition, Weinberger heard opposition to the regulations from the American Hospital Assn. and the Oklahoma Congressional delegation, which pointed out the difficulty of implementing the rules in small rural hospitals.

PHYSICIAN PLACEMENT SERVICE

The Medical and Chirurgical Faculty of the State of Maryland maintains a placement service for the convenience of Maryland physicians, hospitals and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to the Physician Placement Service, 1211 Cathedral St., Baltimore, MD 21201, phone (301) 539-0872.

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities which might be available in Maryland.

Journal announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

Referral Patients Accepted

The NCI-VA Medical Oncology Branch, located at the Veterans Administration Hospital in Washington, DC, accepts referrals of patients with the following malignancies:

1. Microscopically-proven, inoperable bronchogenic carcinoma, especially small cell (oat cell) carcinoma. Patients must not have received prior radiotherapy or chemotherapy. Such patients will be treated with chemotherapy, radiotherapy or a combination of these modalities, depending on histologic subtype and stage of disease. Selected patients may also receive intensive therapy in the protected environment of a laminar air flow room.
2. Microscopically-proven, metastatic prostatic adenocarcinoma (Stage D) patients who have not received prior chemotherapy or hormonal therapy. Such patients will be treated with hormonal therapy alone or in combination with chemotherapy.
3. Microscopically-proven hepatocellular carcinoma (hepatoma) patients without prior chemotherapy. Such patients will be placed on chemotherapy trials.

Both veteran and non-veteran patients are eligible for these studies. Preference will be given to ambulatory patients who live within commuting distance.

Patients are hospitalized on the 30-bed ward for intensive work-up. Ambulatory patients are then discharged and followed in the ambulatory care clinic. Hospitalization, ambulatory care and antineoplastic agents are provided free of charge.

The referring physician might choose to participate in treatment and followup or to entrust total care of his patients to our service. In either case, we will provide initial and follow-up reports at appropriate intervals.

Physicians interested in having their veteran or non-veteran patients referred may write or telephone Dr. Lawrence Broder, Dr. Francisco Tejada, or the undersigned.

MARTIN H. COHEN, MD
Acting Chief, NCI-VA Medical Oncology Branch
Veterans Administration Hospital
50 Irving St., NW, Wash. DC 20422
1-(202) 389-7275 or 389-7276.

THE INSTRUCTIVE VISITING NURSE ASSOCIATION OF BALTIMORE IUNA Health Care in the Home

Voluntary, non-profit community service staffed by registered nurses, physical therapists, licensed practical nurses and home health aides.
Ability to pay not a requirement for service.

5 East Read Street
Baltimore, Maryland 21202

539-3961

MEMBER OF THE COMMUNITY CARE
CERTIFIED HOME HEALTH AGENCY - ACCREDITED COMMUNITY NURSING SERVICE



COMMITTEE REPORT
SENATE

_____ Date

Mr. President:

The Committee on FINANCE has had SB 289
relating to emergency medical services
under consideration. A majority of the members of the Committee

- recommends it do pass
- recommends it do not pass
- recommends it do pass with attached amendment(s)
- recommends it be replaced with CS for _____ and that
CS for _____ do pass
- (and) recommends it be referred to the _____
committee
- reports it back without recommendation
- AND attaches a report of its intent
- (other) _____

MEMBERS SIGNING THE MAJORITY REPORT:

MEMBERS NOT CONCURRING IN THE MAJORITY REPORT:

_____ recommends: _____
_____ recommends: _____
_____ recommends: _____

_____ Chairman

COMMITTEE REPORT

3/28/77

SENATE

**Finance

4-11-77 Date

Mr. President:

The Committee on Health Education & Social Services has had SB 289

~~relating to emergency medical services~~
under consideration. A majority of the members of the Committee

- recommends it do pass
- recommends it do not pass
- recommends it do pass with attached amendment(s)
- recommends it be replaced with CS for _____ and that CS for _____ do pass
- (and) recommends it be referred to the _____ committee
- reports it back without recommendation
- AND attaches a report of its intent
- (other) _____

MEMBERS SIGNING THE MAJORITY REPORT:

2	<u>Bradley</u>	<u>NO PASS</u>	_____
2	<u>Wicks</u>	<u>DO PASS</u>	_____
2	<u>PATRICK RODEY</u>	<u>DO PASS</u>	_____
	<u>Strom/Hadley</u>	<u>NO REC</u>	_____

MEMBERS NOT CONCURRING IN THE MAJORITY REPORT:

_____ recommends: _____

_____ recommends: _____

_____ recommends: _____

Strom/Hadley
Chairman
rovec

Introduced: 3/28/77
Referred: Health, Education &
Social Services and Finance

1 IN THE SENATE

BY SACKETT BY REQUEST

2 SENATE BILL NO. 289

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to emergency medical services; and
7 providing for an effective date."

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

9 * Section 1. AS 18 is amended by adding a new chapter to read:

10 CHAPTER 8. EMERGENCY MEDICAL SERVICES.

11 Sec. 18.08.010. ADVISORY COUNCIL ON EMERGENCY MEDICAL SERVICES.

12 There is established in the Department of Health and Social Services an
13 Advisory Council on Emergency Medical Services. The council shall

14 (1) act in an advisory capacity to the commissioner in matters
15 pertaining to the planning and implementation of a statewide emergency
16 medical services system; and

17 (2) act as a committee of the Statewide Health Coordinating
18 Council created under AS 18.07.011 in the area of emergency medical
19 services to assist the council in meeting its responsibilities under
20 federal and state law.

21 Sec. 18.08.020. STATEWIDE COMPREHENSIVE EMERGENCY MEDICAL SERVICES.

22 The department shall establish a statewide comprehensive emergency medi-
23 cal services system for the effective and coordinated delivery of health
24 care services under emergency conditions, whether the emergency arises
25 as a result of the patient's condition, as a result of a natural or
26 other disaster, or otherwise, administered by a statewide network with
27 the authority and resources to provide effective administration of the
28 system. The department shall

29 (1) coordinate the activities of public and private agencies

1 concerned with the planning and delivery of emergency medical services
2 in the state; and

3 (2) provide grants to public and private agencies concerned
4 with the planning and delivery of emergency medical services in the
5 state.

6 Sec. 18.08.030. COMPOSITION OF COUNCIL ON EMERGENCY MEDICAL SER-
7 VICES. The council shall consist of 11 members appointed by the gover-
8 nor. No more than seven members of the council may be persons whose
9 occupation or profession is or has been the delivery or administration
10 of emergency medical services, persons who have fiduciary obligations
11 to a health activity facility, or other health agency, or who have a
12 legal or financial interest in the delivery of any component of emergency
13 medical services.

14 Sec. 18.08.040. TERM OF OFFICE. Members of the council serve for
15 four-year terms except that of the initial appointees, the governor
16 shall appoint two members for one-year terms, three for two-year terms,
17 three for three-year terms, and three for four-year terms. A person
18 whose occupation or profession is not in any way related to the provi-
19 sion of medical services or emergency medical services shall be appointed
20 to each of the staggered terms. Vacancies shall be filled by the gover-
21 nor in the same manner as original appointments.

22 Sec. 18.08.050. SPECIAL COMMITTEES. The council may establish
23 special committees or task forces outside its membership and may recom-
24 mend persons who are not members of the council to serve as advisors or
25 consultants to any committee established to carry out the purposes of
26 the council.

27 Sec. 18.08.060. COMPENSATION AND PER DIEM. Members of the council
28 serve without compensation but are entitled to per diem and travel ex-
29 penses authorized by law for boards and commissions.

1 * Sec. 2. AS 18.05.040(a) is amended by adding a new paragraph to read:
2 (20) the development, implementation, and maintenance of a
3 statewide comprehensive emergency medical services system under the
4 provisions of ch. 8 of this title.

5 * Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-
6 070(c).

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ALASKA STATE LEGISLATURE

TENTH Legislature FIRST Session

SENATE BILL NO. 289

By SACKETT BY REQUEST

"An Act relating to emergency medical services; and providing for an effective date."

emergency medical services

Introduced in the Senate 3/28, 1977

HISTORY IN THE SENATE

19	77	Read first time and referred to Committee on Health Education and Social Services and Finance										
3	28	Reported back with <i>Hess</i> recommendation that <i>3 days in order, to finance</i>										
		Read second time and										
		Read third time and										
		<table border="0"> <tr> <td>PASS</td> <td>Effective Date</td> </tr> <tr> <td>Yeas</td> <td>Yeas</td> </tr> <tr> <td>Nays</td> <td>Nays</td> </tr> <tr> <td>Absent</td> <td>Absent</td> </tr> <tr> <td>Excused</td> <td>Excused</td> </tr> </table>	PASS	Effective Date	Yeas	Yeas	Nays	Nays	Absent	Absent	Excused	Excused
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		Reconsideration										
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PASS	Effective Date											
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Nays	Nays											
Absent	Absent											
Excused	Excused											
		Reported correctly engrossed Signed by President Sent to House										

SECRETARY OF THE SENATE

HISTORY IN THE HOUSE

19		Read first time and referred to Committee on										
		Reported back with recommendation that										
		Read second time and										
		Read third time and										
		<table border="0"> <tr> <td>PASS</td> <td>Effective Date</td> </tr> <tr> <td>Yeas</td> <td>Yeas</td> </tr> <tr> <td>Nays</td> <td>Nays</td> </tr> <tr> <td>Absent</td> <td>Absent</td> </tr> <tr> <td>Excused</td> <td>Excused</td> </tr> </table>	PASS	Effective Date	Yeas	Yeas	Nays	Nays	Absent	Absent	Excused	Excused
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		Reconsideration										
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PASS	Effective Date											
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Nays	Nays											
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		Reported correctly engrossed Signed by Speaker Returned to Senate										

CHIEF CLERK OF THE HOUSE

HISTORY IN THE SENATE

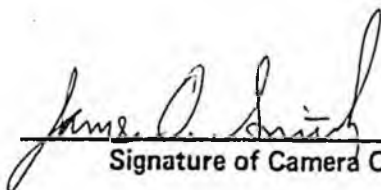
19		Received from House
		Reported correctly enrolled
		Sent to Governor
	 By Governor
		Filed with Lt. Governor
		Chapter No



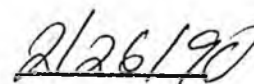
RECORDS CERTIFICATION



I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.



Signature of Camera Operator



Date

COMMITTEE REPORT

4-28-77

HOUSE

May 16, 1977 Date

Mr. Speaker:

The Committee on FINANCE has had SB 295

under consideration. A majority of the members of the Committee

- recommends it do pass
- recommends it do not pass
- recommends it do pass with attached amendment(s)
- recommends it be replaced with CS for _____ and that CS for _____ do pass
- (and) recommends it be referred to the _____ committee
- reports it back without recommendation
- AND attaches a report of its intent
- (other) _____

MEMBERS SIGNING THE MAJORITY REPORT:

<u>[Signature]</u>	<u>[Signature]</u>	_____
<u>[Signature]</u>	<u>[Signature]</u>	_____
<u>[Signature]</u>	<u>[Signature]</u>	_____
<u>[Signature]</u>	<u>[Signature]</u>	_____

MEMBERS NOT CONCURRING IN THE MAJORITY REPORT:

_____ recommends: _____

_____ recommends: _____

_____ recommends: _____

[Signature]

Chairman

BY SACKETT, FERGUSON, HOHMAN
AND KERTTULA

1 IN THE SENATE

2 SENATE BILL NO. 295

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to construction of public works by the
7 Department of Transportation and Public Facilities."

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

9 * Section 1. AS 35.15.010 is amended to read:

10 Sec. 35.15.010. CONSTRUCTION BY DEPARTMENT. Except as provided in
11 AS 44.33.300, it shall be the general policy of the department to re-
12 quire the construction of all public works under bid contract. However,
13 when the estimated cost of a construction project is less than \$100,000
14 [\$20,000], or when it appears to be in the best interests of the state,
15 the department may perform the work, notwithstanding any other provisions
16 of law.

17 * Sec. 2. AS 35.15.030 is amended to read:

18 Sec. 35.15.030. ADVERTISEMENT, BIDS, CONTRACTS, AND INFORMAL BIDS.
19 When the estimated cost of any construction under this chapter exceeds
20 \$100,000 [\$20,000], the department shall, except as provided in sec. 10
21 of this chapter and in AS 44.33.300, proceed to advertise, request bids,
22 and award the contract in the manner provided in secs. 40 and 50 of this
23 chapter. When any proposed construction contract is for a sum less than
24 \$100,000 [\$20,000], it is discretionary with the department whether the
25 contract is advertised and awarded in accordance with secs. 40 and 50 of
26 this chapter. In all events the department shall request informal bids
27 from as many contractors as can be requested conveniently.

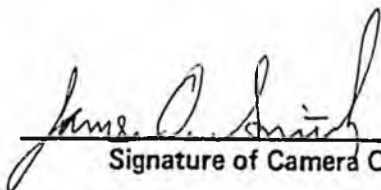
21 COMMITTEE COPY



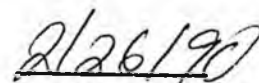
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Signature of Camera Operator



Date

Original sponsor: Croft

Offered: 5/3/77
Referred: Finance

1 IN THE SENATE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR SENATE BILL NO. 300

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the granting of employment prefer-
7 ence to handicapped persons under the State Personnel
8 Act."

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

10 * Section 1. AS 39.25.150 is amended by adding a new paragraph to read:

11 (25) the granting of employment preference to severely handi-
12 capped persons; this includes the right to provisional appointment
13 without competitive examination for periods up to four months; and the
14 granting of eligibility to a severely handicapped person provisionally
15 appointed under the rules who demonstrates his ability to perform the
16 job for permanent appointment without competitive examination; pro-
17 visional employment under this paragraph may not exceed four months
18 during a 12-month period; "severely handicapped" as used in this para-
19 graph means persons certified by the director of the division of voca-
20 tional rehabilitation to be severely handicapped.

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Introduced: 4/4/77
Referred: Health, Education
and Social Services and
Finance

1 IN THE SENATE

BY CROFT

2 SENATE BILL NO. 300

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

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12 handicapped persons, including the right to provisional appointment
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14 and the granting of eligibility to a severely handicapped person pro-
15 visionally appointed under the rules who demonstrates his ability to
16 perform the job for permanent appointment without competitive examina-
17 tion; provisional employment under this paragraph may not exceed four
18 months during a 12-month period; as used in this paragraph "severely
19 handicapped" means persons certified by the director of the division of
20 vocational rehabilitation to be severely handicapped.

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THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SB. 300

Title An Act relating to the granting of employment preference to handicapped

~~persons under the State Personnel Act~~

Requested by Senator Croft

Date 5/5/77

II. FISCAL DETAIL

Agency Affected All

Program Category Affected All

Budget Request Unit(s) Affected All

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

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

IV. DATE 5/5/77

PREPARED BY Kellus Sewell

AGENCY Administration

PHONE 465-2277

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) House HESS

Senator Croft