HB

171

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 4/21/93 FURTHER:

DATE TURNED INTO OFFICE: 5-3-93

The Finance Committee considered CS FOR HOUSE BILL NO. 171(FIN)

"An Act providing coverage for hospice care under the Medicaid program; reordering the priorities given to optional services under the Medicaid program; and providing for an effective date."

and recommends:

[ ] replace with _____ CS _____ _____(FINANCE)

or [ ] adopt previous_____ CS _____ _____(_____)

[ ] attaches amendment(s)

[ ] same title
[ ] new title
[ ] technical title change (HB only)

[ ] adopts _____Letter of Intent

[ ] further referral to the _____

[ ] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal
DHHSS	3/9/93		10.0

[ ] Appropriation No Fiscal Note

DO PASS:

OTHER RECOMMENDATIONS:

Tom Kelly - No Rec

Steve Rieg - No Rec

Ben Shapp - No Rec

1. _____ NO REC
Co-Chair: Signature/Recommendation

2. _____ - No Rec
Co-Chair: Signature/Recommendation

FISCAL NOTE

1

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Bill Version: HB 171
(H) Publish Date: 3/22/93

Revision Date: 02/22/93
Title: An Act providing coverage for hospice care

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Claims Processing

Sponsor: Larson
Requestor:

COMPONENT SERIAL NO. 00243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	10.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	10.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	5.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	5.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	10.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)
FY 94 funds are required to modify the Medicaid Management Information System to allow the payment of claims for hospice care.

Studies suggest that hospice care tend to be cost neutral or produce cost savings. Hospice care is already available to children covered by Medicaid and to Medicare-eligible adults. There are currently no Medicare-certified hospice providers in the state. We anticipate that only a small number of recipients will use hospice care as a result of this bill. Therefore, no other fiscal impact is projected.

Prepared by: Jon Sherwood, Program Coordinator
Division: Medical Assistance
Phone: 465-5826
Date: 03/01/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health & Social Services
Date: 3/4/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information call the Governor's Legislative Office

Alaska State Legislature

Session Address:
STATE CAPITOL BUILDING
ROOM 502
JUNEAU, ALASKA 99801-1182
(907) 465-3878
FAX (907) 465-2293

Interim Address:
P.O. BOX 53
PALMER, ALASKA 99645
(907) 746-1046 - Palmer
(907) 746-3560 - FAX
(907) 376-8628 - Wasilla

Representative Ronald L. Larson

District 27

HB 171- Hospice Care
Sponsor's Statement

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare.

This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. Medicaid eligible adults are the aged, blind, disabled, and families with dependent children, as well as pregnant women. The "optional eligibles" also included, in Alaska are individuals under 21 who don't qualify for Aid to Families with Dependant Children because they aren't dependent children, and institutionalized individuals under a specified income level.

To qualify as a hospice care provider, a hospice care agency must be Medicare-certified.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital and/or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

- In addition to meeting physical needs, Hospice care offers a wealth of emotional, spiritual and practical supports to the patient and the family. Quality of life is maximized through an interdisciplinary team of physicians, nurses, physical, occupation and speech therapists, home health aides, social workers, chaplains, and volunteers. The patient and family are actually a part of the team, helping to plan and prioritize care.

- It will be the role of Hospice to provide all medications, medical equipment and supplies necessary for management of the terminal illness.

MADE in ALASKA

- Bereavement care is also available to the family for a period of 13 months after the death. Hospice offers written resources, phone calls, visits from volunteers, a support group and, as needed, bereavement counseling.

- Most important are the trained Hospice volunteers who give a wide range of services from staying with a patient while the caregiver takes a break to nursing care, homemaking services, or a listening ear.

In addition to all the positive services that Hospice care can offer a family, crucial facts make the Medicaid Hospice option a wise decision. **Hospice is a budget-neutral program.** Hospice care is one of the few programs existing in our present health care structure that models fiscal responsibility and cost-effective quality care. Hospice offers the resources to allow terminally ill persons to spend the rest of their lives, or at least more of their lives, at home.

Quite often, the alternative to Hospice care is costly nursing home placement or frequent hospitalization.

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

Position Paper
CSHB 171 (FIN)

The Department of Health and Social Services supports CS for House Bill 171 (FIN), which would include coverage of hospice care under the Medicaid program.

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare. This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. To qualify as a hospice care provider, a hospice care agency must be Medicare-certified. There are currently no Medicare-certified hospices in Alaska.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

The Department supports this effort to expand the availability of a valuable alternative for terminally ill people. It also concurs with the placement of hospice services on the Medicaid priority list. Under CSHB 171(FIN), in the case of a budget shortfall, hospice care would be eliminated before most other long term care services, but after most optional Medicaid services.

Recommended by: Kimberly B. Busch
Kimberly B. Busch
Director
Div. of Medical Assistance

Date: 4-12-93

Approved by: Theodore A. Matta
Theodore A. Matta, MD, MPH
Commissioner

Date: 13 April 1993

H:\POLICY\HSSPLAN3\LEG93\HB171\CSHB171.PP

PP-93-35

Back-up

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CSHB171(FIN)

Revision Date: 02/22/93
Title: An Act providing coverage for hospice care
Sponsor: Larson
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: Claims Processing
COMPONENT SERIAL NO. 00243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	10.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	10.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	5.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	5.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	10.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)
FY 94 funds are required to modify the Medicaid Management Information System to allow the payment of claims for hospice care.

Studies suggest that hospice care tend to be cost neutral or produce cost savings. Hospice care is already available to children covered by Medicaid and to Medicare-eligible adults. There are currently no Medicare-certified hospice providers in the state. We anticipate that only a small number of recipients will use hospice care as a result of this bill. Therefore, no other fiscal impact is projected.

Prepared by: Kimberly Busch, Director
Division: Medical Assistance
Phone: 465-5826
Date: 03/01/93

Approved by Commissioner: Theodore A. Mala, MD. MPH
Agency: Department of Health & Social Services
Date: 4/13/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information call the Governor's Legislative Office

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM April 23, 1993

SUBJECT: Sectional Summary of CSHB 171(FIN) (Hospice services in Medicaid))

TO: Representative Ron Larson

FROM: Terri Lauterbach
Legislative Counsel

You have requested a sectional summary of the above described bill. This summary is brief. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds hospice services to the optional services that may be offered under the Medicaid program.

Sec. 2. Places hospice services in the priority listing that is invoked when Medicaid is short-funded

Sec. 3. Defines "hospice services."

Sec. 4. Gives the bill a 1/1/94 effective date.

TML:lmb
93-135.lmb

WHAT DOES HOSPICE MEAN?

PHYSICIAN INFORMATION SHEET

WHAT IT MEANS TO THE PATIENT

When a patient elects the Medicare hospice benefit, they revoke their other part A benefits for treatment of their terminal illness? The hospice becomes the sole provider for their service needs, and whatever products are necessary for palliation and symptom control. This includes:

- professional services,
- pharmaceuticals
- DME
- in-patient respite
- in-patient care for symptom management

The hospice becomes a managed care program for the patient.

Benefit periods: 2 90-day periods, 1 30-day period, Indefinite 4th period

The fourth indefinite period was recently enacted. They do not go off the benefit if they fail to die in 7 months.

Revocation of benefit is possible during any benefit period, but there are limitations regarding reelection of benefit.

Admission criteria:

* Certified by physician that terminal illness with 6 months or less life expectancy.
* Choose palliative care; treatment mode past

When a person has a terminal illness, consider Hospice as an information resource on options--to patient & physician. The ultimate choice regarding treatment options (including hospice enrollment) is made by client.

WHAT IT MEANS TO THE FAMILY

The family is included as client in the plan of care:

- Support
- Respite

Bereavement program

- Assessment
- Care

WHAT IT MEANS TO THE HOMECARE PROGRAM STAFF

Philosophy of approach to care.

- Emphasis on living fully
  - Self determination
- Palliation --complete
- Totality of care

HOSPICE AND YOUR OTHER MEDICARE BENEFITS

Hospice under Medicare is designed to be more than just a collection of existing benefits with a new name. Many items and services are covered under hospice that are not covered through any other type of facility or provider.

This chart shows a comparison between hospice benefits and benefits available through hospitals and home health agencies.

	MEDICARE COVERED IN		
SERVICE ITEM	HOSPICE	HOSPITAL	HOME HEALTH AGENCY
Drugs for pain & symptom control to be used at home	YES	YES	NO
Services covered whether or not the patient is homebound	YES	---	NO
Deductibles waived	YES	NO	NO
Inpatient care to provide respite for family caring for the patient at home	YES	NO	NO
Continuous care at home during periods of crisis	YES	NO	NO
Counseling services at home for both the patient and the family	YES	NO	NO
Home Health Aides	YES	NO	YES
Bereavement Counseling	YES	NO	NO
Volunteers must be available	YES	NO	NO
Care must be continued if benefits run out	YES	NO	NO
Inpatient unit must have homelike decor	YES	NO	---

homehealth.267

NATIONAL HOSPICE ORGANIZATION

ABOUT HOSPICE

Hospice is a philosophy and concept of care for the terminally ill that is now one of the most frequently used terms in discussions of innovative approaches to health care. In 1990, the **American College of Physicians** presented to the National Hospice Organization the Richard & Hinda Rosenthal Foundation Award in recognition of the "recent original approach in the delivery of health care or in the design of facilities for its delivery [which] will increase its clinical and/or economic effectiveness." However, most people are unaware that the significant recent growth of hospice in the United States and internationally is nurtured by ancient roots.[1]

The modern hospice can trace its roots to the Irish Sisters of Charity who established St. Joseph's Hospice at London in 1905. The hospice most often recognized as the model of contemporary hospice philosophy and care is St. Christopher's in London. Started by Dame Cicely Saunders, M.D. in 1968, St. Christopher's laid the basis for a philosophy that emphasizes palliative care, i.e., pain and symptom control rather than curative care for the terminally ill.

A community based service, hospice care is provided by an interdisciplinary team of health care professionals and volunteers including physicians, nurses, counselors, therapists and aides. Using a comprehensive case management approach, hospice care is guided by a plan of care which is developed by the interdisciplinary team in conjunction with the patient and family. The goal of the plan is to care for the patient and family as the "unit of care," to provide an alert, pain-free life and to manage other symptoms so that individuals can "live until they die" with personal dignity and quality of life at home or in a home-like setting.

Responding to the directives of the Medicare Hospice Benefit Conditions of Participation[2], as well as the National Hospice Organization and JCAHO standards, most hospices offer the

---

[1] The first references to "hospice care" can be found in the ancient writings of Constantine in A.D. 335, and later with the sixth century Benedictine monks and in the ninth century under the emperor, Charlemagne.

[2] Congress first added the hospice benefit to Medicare in TEFRA 1982. In 1986, Congress made the Medicare benefit permanent and established hospice as an optional Medicaid benefit.

A STATISTICAL PROFILE OF HOSPICE CARE

- First Hospice in the United States, New Haven, CT. 1974
- Current number of U.S. hospices, 1830 including planned and non-comprehensive programs. NHO estimates **1700** comprehensive programs, as described above.
- Approximately two/thirds of the comprehensive hospices are Medicare certified.
- Over 90 percent of hospices are non-profit or government affiliated programs. Four percent are for-profit entities.
- Hospices served approximately **210,000** patients in 1990.
- The average daily census of the typical hospice program is 25 patients per day. The average length of stay is 59 days. Approximately 90 percent of all patient days were provided in the patient's home.
- Approximately two out of three patients served are over the age of 65. One percent are under the age of 18, representing 71 percent of pediatric cancer deaths.
- Eighty-four percent of hospice patients have cancer, accounting for approximately 33 percent of all cancer deaths as reported by the American Cancer Society. People living with AIDS and those with cardiovascular disease constitute the bulk of remaining hospice patient census.
- Over **20,000** people are employed nationwide in hospices and include physicians, nurses, social workers, administrators, home health aides, clergy, therapists and bereavement specialists.
- Approximately **68,000** people volunteer in hospice programs, contributing more than **5 million hours of service** annually. Two out every three hours are direct patient care hours. The Medicare Hospice Benefit Conditions of Participation require that a minimum of five percent of patient service hours be provided by volunteers.

II. Studies Showing Savings and Benefits of Hospice Care:

Through the national hospice demonstration projects conducted by the federal government, it was learned that not only was hospice care a more humane alternative of care but it resulted in cost savings as well. As a result of its cost effectiveness, the Medicare hospice benefit was created by the Tax Equity and Fiscal Responsibility Act of 1982 as a more humane alternative to the hi-technology care traditionally provided to the terminally ill. In 1986, hospice was made an option under Medicaid and the number of states offering the hospice benefit rose to 34 states by 1992.

- Savings can be realized by substituting the high cost of conventional care with the home-oriented approach of hospice care. A study by Abt Associates (Medicare Hospice Benefit Program Evaluation, Final Summary Report, July 21, 1989) stated that comparisons of hospice benefit and conventional care expenditures in the last month of life showed that conventional care was 30% higher in FY85 and 43% higher in FY86. The hospice savings were even more significant for non-cancer beneficiaries who cost $3,135 for hospice care in the last month of life compared to $4,730 for conventional care.

- Major savings in the cost of providing care to the terminally ill are directly related to the percentage of time patients are at home during the final months of life. Based on 1986 mortality data from the National Center for Health Statistics, an article in the Health Care Financing Review/Fall 1990, stated that there was an increase of 10% in the shift in place of death for cancer patients from hospitals to patients homes, and because about 94% of all hospice patients have cancer, the data suggests a possible impact of hospice use.

- A survey of hospital based hospices conducted by the American Hospital Association in 1986 identified a major reduction in the number of inpatient days for those patients cared for under the Medicare hospice benefit: the average

Meeting the Challenge For A Special Kind of Caring

Standards of a Hospice Program of Care Recommended by the National Hospice Organization

Standards For A Hospice Program

A DEFINITION

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings which provides for physical, psychological, social and spiritual care for dying persons and their families. Services are provided by a medically directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the person.

HOSPICE PHILOSOPHY

Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully and comfortably as possible. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

ACCOUNTABILITY

Principle: The hospice operates as an integral part of the health delivery system at the community level and is accountable to the community it serves and the public at large. In order to provide care in this system, a hospice must meet the fundamental requirements for operation and delivery of health services, as regulated by local, state and federal laws.

Standard 1: The hospice program establishes and maintains appropriate reports, policies and procedures to assure that the hospice is accountable to the community for the services it provides.

Standard 2: The hospice program complies with applicable local, state and federal laws and regulations governing the organization and delivery of health care to patients and families.

ACCESS TO HOSPICE CARE

Principle: Admission to the hospice program is based on an assessment of the patient and family needs, their desire for services and the program's specific admission criteria. The level of care received, including the frequency and type of services provided, is based on both initial and subsequent assessments of the patient and family's needs. Care may be provided on either a part time, intermittent basis, a regularly scheduled basis, or a continuous basis, depending upon the needs of the patient and family as reflected in ongoing assessments.

Standard 3: Access to hospice medical and nursing services is available to identified hospice patients on a 24 hour basis, 7 days a week. During hours covered by on-call staff, hospices provide for at least a minimum of medical and nursing coverage, with visit capability should further assessment or treatment be needed. Provisions are made to assure that on-call staff are informed and updated regarding care plans and level of care. Reporting mechanisms are in place to assure continuity and coordination among members of the hospice interdisciplinary team.

Standard 4: The hospice program has admission criteria that reflect the patient/family's desire and need for hospice care; the extent and role of physician participation; and diagnosis and prognosis. To the maximum extent possible, the hospice program will admit patients regardless of their diagnosis or ability to pay for services.

CONTINUITY OF HOSPICE CARE

Principle: Hospice patients and their families may experience physical, social, emotional and spiritual concerns and problems. Hospice addresses these by providing a comprehensive and coordinated program of care which includes an ongoing assessment of needs and determination of the level of care and scope of services necessary. Continuity implies that services, whether provided directly or contracted for, are coordinated in both home and inpatient settings. Services are reflective at all times of patient/family needs, and that the hospice is accountable for its care and services in both home and inpatient care settings.

Standard 5: The hospice program organizes its services to respond to patient/family needs whenever they arise. It provides both structure and staff to ensure continuation of the hospice care plan in all settings.

ACCESS TO HOSPICE INPATIENT CARE

Principle: Not all patients can be maintained at home throughout their terminal illness; some may require short term inpatient care. When such a need arises, hospice care is provided in an inpatient hospice unit. The hospice provides access to hospice inpatient services which reflect the hospice philosophy and emphasizes symptom control and enhancement of a quality of life acceptable to dying patients and their families.

Standard 6: Access to hospice inpatient care is available either directly by the hospice or through contract or arrangement with an inpatient facility. This hospice inpatient unit must comply with all applicable local, state and federal regulations, including fire and safety code regulations.

Standards For A Hospice Program

Standard 7: At a minimum, the hospice inpatient unit provides for: medical direction and coverage for all patients either directly or through agreement with the patient's personal physician; staffing coverage by an interdisciplinary team available to meet the needs of the patient/family on a 24 hour basis as needed; and, specific policies and procedures, as well as personal comfort amenities and courtesies that support and encourage a non-institutional, "home-like" environment for the patient/family. All hospice inpatient personnel must be appropriately trained in the provision of hospice interdisciplinary team care.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle: Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are reflected in assessments and plans of care developed by the interdisciplinary team. The family members are seen both as primary caregivers and as needing care and support so that their own stresses and concerns may be addressed. Attention is also given to assisting with the development of a community support network when family and friends are not available and a patient needs and wants that support.

Standard 8: The patient/family is the unit of care in hospice and support is provided to both the patient and the family. The hospice program encourages patient/family participation in the development of the inter-disciplinary team plan of care and in the provision of hospice services.

Standard 9: The hospice program acknowledges that each patient/family has its own values and beliefs and is respectful of them.

Standard 10: The hospice program seeks to identify, teach, coordinate and supervise those persons acting as primary caregivers for the patient. If a primary care person is not available, the hospice program seeks to develop a substitute network. If the hospice program does not accept patients without primary caregivers, then it must provide adequate information about community resources available to them.

PAIN AND SYMPTOM CONTROL

Principle: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control and symptoms and minimize the negative side effects of interventions. Hospice programs recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing these stresses and concerns, in addition to the use of appropriate therapies.

Standard 11: The goal of hospice care is to provide optimum relief of pain and control of symptoms through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

VOLUNTEERS

Principle: An essential component of hospice care is the direct personal support for the patient/family by volunteers. Volunteers provide important perspectives in developing the interdisciplinary team plan of care and in the provision of significant hospice services.

Standard 13: A hospice program offers volunteer support to each patient/family admitted to its program of care.

Standard 14: A hospice program has an organized training program and procedures for the selection,supervision and continuing evaluation of volunteers.

HOSPICE INTERDISCIPLINARY TEAM

Principle: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. Ancillary staff are added to the team when appropriate. The team meets regularly to develop and maintain an appropriate plan of care.

Standard 15: The hospice identifies and maintains an appropriately qualified interdisciplinary team of health professionals and lay persons.

Standard 16: Emotional support for staff/volunteers is provided as an integral part of a hospice program.

Standard 17: Inservice training and continuing education are offered on a regular basis to both paid and volunteer staff.

INTERDISCIPLINARY TEAM PLAN OF CARE

Principle: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all

interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified; services provided by level of care across both the home and inpatient settings; and progress notes documenting the care given on a day-to-day basis.

Standard 18: The hospice program has a written, interdisciplinary team plan of care for each patient/family unit that includes assessments, identified problems, proposed interventions, level and frequency of services and their outcomes.

Standard 19: The hospice program maintains accurate, current, integrated clinical records for all patient/family units and provides assurances for the confidentiality of these records.

Standard 20: These clinical records must include a signed informed consent form completed by the patient or a designated representative. The consent form must inform the patient/family of the palliative nature of hospice care; the avoidance, if at all possible, of injections, diagnostic testing and curative measures; and the non-use of heroic measures to prolong the dying process.

Standard 21: These clinical records must include specific, signed instructions regarding actions to be taken when life threatening situations occur to the patient. These instructions should be prepared by the physician and the interdisciplinary team, following consultation with the patient/family, and must be consistent with the patient/family's wishes.

BEREAVEMENT

Principle: Death of a family member may result in a wide range of physical, emotional, social, familial, economic and spiritual disruptions. Grief and bereavement are normal reactions to loss and death. Grief is the highly personal response to loss; bereavement is the extended period of deprivation following the loss of a loved one. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following, the death of the patient. Hospice encourages the expression of grief, recognizes social, religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Standard 22: The hospice program provides bereavement services to the surviving family members for at least one year after the death of the patient.

Standard 23: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

QUALITY ASSURANCE AND UTILIZATION REVIEW

Principle: Hospice is committed to developing methods to measure and assure the quality of patient/family care and the appropriate utilization of hospice resources.

Standard 24: The hospice program has quality assurance and utilization review programs that include the following: statement of goals and objectives and established policies for conducting an ongoing assessment program that reflects the interdisciplinary nature of hospice services; designation of person(s) responsible for implementing policies and procedures; provisions for addressing specific problems identified in the quality assurance and utilization review processes.

Standard 25: At a minimum, the hospice program conducts on a regular basis the following activities: evaluation of services provided by both professionals and volunteers, audit of patient charts for outcomes of interventions, organizational review of hospice program, interdisciplinary team care plan review, evaluations provided by patient/families of care received, anreview of appropriate/inappropriate use of services, facilities and personnel.

A Hospice Glossary

This glossary was prepared using a variety of source materials to provide definitions. These include: *NHO Standards of Care* (1983), *Joint Commission on Accreditation of Healthcare Organizations* (manuals, 1985), *Introduction to Health Education* (Bates, Wynder, 1984) and *Webster's New Collegiate Dictionary* (1986).

Ability to pay: A phrase used to describe a patient's capability to pay for health services received. Some health providers limit their services to patients who can pay for their services.

Access: An individual's or group's ability to obtain health care. Access has geographical, financial, social, ethic and psychological elements. Many health programs have as their goal improving access to care for specific groups or equity of access for thewhole population.

Accountability: To provide for an organization substantial reasons or convincing explanations for actions; to be accountable means to furnish a justification or detailed explanation of financial activities or responsibilities. Accountability entails an obligation to periodically disclose, in adequate, detailed and consistent form the purposes, principles, procedures, relationships, results, incomes, and expenditures involved in any activity, enterprise, or assignment, so that they can be evaluated by interested parties.

Accreditation: A voluntary process, generally developed and implemented by a non-governmental body composed of professionals within the field, with input from providers, and based on optimal standards of quality care.

Administration: The fiscal and general management of a hospice program, as distinct from the general policies and procedures of the hospice program.

Admissions: Numbers of patients/ families that enter a hospice program and agree to accept the services provided by a hospice program.

Admission criteria: Guidelines or policies of a hospice program that specify the conditions under which a patient/family will be admitted. The purpose of the criteria is to control entry/admission to services, e.g., most hospices require a diagnosis of terminal illness by a physician as a prerequisite for admission.

Ancillary staff: Health professionals who provide additional services to support or supplement hospice interdisciplinary team services, including physical therapy, occupational therapy, speech therapy, nutritional counseling, respiratory therapy, and other services.

Appropriate: Descriptive of an action or policy that is suitable or compatible with a hospice program's objectives and philosophy.

Approved: Acceptable to the appropriate authority.

Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

Audit, financial: An independent review of a hospice program's financial records that accurately reflects its financial status.

Bereavement: An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following the death of a patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Bereavement services: The hospice program makes available bereavement services to the surviving family members for a period of at least one year after the death of the patient. They may include: cards to families; home visits; phone calls; group counseling; individual counseling; newsletters; and social activities.

Bylaws: The rules, regulations, or laws adopted by a hospice program for the regulation of its internal affairs and its dealings with other persons and the community at large.

Certification: A voluntary mechanism used to qualify organizations to receive public funds. If a provider chooses to participate in Medicare, for example, it must comply with a set of conditions of participation based on laws and regulations.

Chemotherapy: Provision of drugs (i.e., chemicals) taken orally, injected, inserted, topically applied, or otherwise administered, to control pain and symptoms in hospice patients.

Clergy: A person who has met the requirements of a religious

A Hospice Glossary

organization or system to serve the constituency of that religious organization or system.

Clergy services: See spiritual services.

Clinical privileges: Authorization by the governing body to provide specific patient/family care and treatment services in the organization, within well-defined limits, based on the individual's license, education, training, experience, competence, and judgment.

Community: The individuals, groups, agencies, facilities, or institutions within the locality served by the hospice program.

Confidentiality: The relationship between the hospice staff patients/families in which information is shared and exchanged with the understanding that this information is used appropriately and with respect to the patient/families' wishes and rights to privacy.

Continuing education: Education beyond initial professional preparation that is relevant to the type of patient/family care delivered in the organization, that provides current knowledge relevant to the individual's fields of practice, and that is related to findings from quality assurance activities.

Continuity of care: Services that are organized, coordinated and provided in a way that is reflective at all times of patient/family needs, and which are structured to assure that the hospice is accountable for its care and services regardless of home or in-patient setting.

Continuous basis: Hospice care is provided in the home setting on a 24 hour basis until care is no longer needed. Usually this occurs when the patient/family goes into a medical crisis, but does not need or wish to return to an inpatient setting.

Contracted services: Services provided through a formal agreement with any organization, agency or individual. The agreement, which is approved by the governing body, specifies the services, personnel, and/or space to be provided to or on behalf of the hospice program and the consideration to be expended in exchange.

Counseling: A relationship in which a person endeavors to help another understand and cope with problems.

Curative: Medical interventions used to ameliorate the cause of a disease.

Dietetic services: Services that meet the nutritional needs of patients, with emphasis on patients who have special dietary needs.

Dietitian: A person who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training and/or experience.

Discharge: The point at which the patient's active involvement with the hospice program is ended and the program no longer maintains active responsibility for the care of the patient. The actual point of discharge is determined by the hospice program in accordance with the continuum of home care and inpatient services provided.

Documentation of services: The process of writing, recording and maintaining appropriate records of services that are provided by a hospice interdisciplinary team. This process is very important to assure continuity of services, high quality of care and to justify those services that have already been provided.

Dying: The progressive failure of body systems to retain normal functioning, thereby limiting the remaining life span.

Emotional: The feeling aspect of consciousness which is subjectively experienced and expressed by physiological reactions.

Emotional support: The provision of psycho-social services that assist and support the patient/family during that period of time when they cope with their feelings and responses to the loss, grief and change in their family structure which occurs when the patient dies.

Employees: Individuals who agree to work and provide their services under the administrative direction of the hospice program. Employees may receive wages and other compensation in exchange for their work, or they may provide their services without payment, as an in-kind contribution to the hospice program.

Facility: The building(s), equipment and supplies necessary for the

A Hospice Glossary

implementation of inpatient services for hospice patients/families.

Family: The relatives and/or other significantly important persons who provide psychological, emotional and spiritual support of the patient. The "family" need not be blood relatives to be an integral part of the hospice care plan.

Fiscal management: The policies and procedures used to plan and control a hospice program's overall financial operations.

Goal: An expected result or condition that takes time to achieve and is specified in a statement of relatively broad scope that provides guidance in establishing intermediate objectives directed toward attainment of that goal.

Governing body: The individual(s), group or agency that has ultimate authority and responsibility for the overall operation of the organization.

Grief: The highly personal response to loss. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

Home: The patient's place of residence. Home is the place where most terminally ill patients choose to spend their remaining days.

Home care services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to patients/families in the home.

Home health agency: An organization that provides services to individuals in their place of residence. Many home health agencies receive compensation for their services provided to Medicare beneficiaries. Some home health agencies operate a hospice program as a separate division of their total program.

Home health aide services: Personal care services provided in the home. Services may include assistance in the activities of daily living (e.g., helping the patient bathe, care for his or her hair or teeth, exercise and retain necessary self-help skills). Services may also include specific household tasks to maintain a safe environment in areas of the home used by the patient (e.g., changing the bed and doing laundry essential to the cleanliness of the patient).

Homemaker services: Services that are provided to assist patients to remain in their homes. Services may include assistance in personal care (e.g., assisting the patient to the bathroom or in and out of bed); maintenance of a safe and healthy environment (e.g., cleaning the patient's bedroom, bath and kitchen, doing personal laundry and preparing meals); and other services, as appropriate to the homemaker's responsibilities.

Hospice care: Care provided by a hospice program that is designed to meet the physical, social, emotional and spiritual needs of dying patients and their families.

Hospice program: A hospice program is a coordinated program of palliative and supportive services provided in both home and in-patient settings which provides for physical, psychological, social and spiritual care for dying patients and their families. Services are provided by a medically-directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the patient. Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully as comfortably as possible.

Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

Hospice program director: The chief administrative officer of the hospice program who provides overall policy direction, is responsible for the fiscal operations, and implements work plans and procedures.

Incident report: Documentation of an event of action that is likely to lead to adverse effects and/or that varies from established policies and procedures pertaining to patient/family care.

Infection control program: Organized, on-going activities within a hospice program to control and monitor the spread of infectious diseases within the hospice, including both home and in-patient settings. Part of this program involves establishing and maintaining specific policies and procedures proper

procedures for proper disposal of human discharges and surveillance of staff and patients for infections acquired during their contact with a hospice program.

Informed consent: A full understanding by a competent body of the risks and benefits of particular medical procedure or set of procedures. Prior to admission to hospice, the patient/family must sign an agreement that states they understand the nature and scope of hospice care, including the fact that hospice care is palliative and not curative, and that they agree to cooperate in the provision of care.

Inpatient services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to patients/families in an inpatient setting.

Inpatient settings: Services provided in a setting where the needs of acutely ill patients/families can be met. This care is provided on a 24 hour basis and involves the full hospice interdisciplinary team. During the last months of life, a dying patient may have episodes of acute illness that require the intensive services capability of an in-patient setting.

In-service education: Organized education designed to enhance the skills of interdisciplinary team members or teach them new skills relevant to their responsibilities and disciplines.

Interdisciplinary team: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. The team is coordinated by a qualified health care professional and is medically supervised. The team meets regularly to develop and maintain an appropriate plan of care. (See Interdisciplinary team services.)

Interdisciplinary team conference: A meeting during which interdisciplinary team members review one or more interdisciplinary team care plans to update patient/family physical and/or psychological status and initiate any changes in the care plan.

Interdisciplinary team plan of care: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified, services provided by level of care across both the home and inpatient settings, and progress notes documenting the care given on a day-to-day basis.

Interdisciplinary team services: A group composed of individuals from various professions and disciplines who interact on a regular basis and have a working knowledge of the assessment and care of the patient/family by each member of the team. The team services are characterized by the ability by all members and disciplines to allow their roles to overlap while simultaneously providing emotional support to each other and maintaining a respect for each other's skills, training and interventions.

Intermittent basis: Provision of hospice services at intervals as they are needed by the patient/family. During the final six months of life, the patient/family may go through a number of crises that require a higher level of intensity of hospice services than at other times.

Interventions: Specific actions designed to interfere, stop or ameliorate the natural course of an illness or human disease. In hospice, interventions are limited to those that are palliative and not curative. These interventions may, however, address a range of patient/family needs, including physical, spiritual, social and emotional concerns.

License: Authorization to practice in the professional discipline by an individual may be mandated by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law and violation imposes a penalty.

Licensure: Licensure standards are the minimum standards which must be met to provide service as a hospice. In contrast to accreditation and certification, licensure is mandatory if specified by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law, and violation imposes a penalty.

Medical director: A fully licensed physician who is charged with the responsibility of acting as consultant to the interdisciplinary team and, as requested, to attending physicians with regard to pain and symptom management, as well as acting as liaison with physicians in the community.

Medical records: Specific records maintained by a hospice that document all services provided by the

A Hospice Glossary

interdisciplinary team to a patient/family.

Medical staff: A single organized body that is accountable to the governing body and has the overall responsibility for the quality of professional services provided by individuals with clinical privileges.

Medication: Any substance, whether prescription or over-the-counter drug, that is taken orally, injected, inserted, topically applied, or otherwise administered to the patient.

Nursing services: Patient/family care services pertaining to the palliative, curative, rehabilitative and preventive aspects of nursing, performed and/or supervised by a registered nurse pursuant to interdisciplinary team care plans.

Objective: An expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement and is related to the attainment of that goal.

Outcomes: The final results or consequences from specific interventions taken. In hospice, the death of the patient is anticipated and is not defined as an outcome. Appropriate hospice outcomes focus on control of pain and symptoms and quality of the remaining days that the patient/family spends together.

Pain and symptom control: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control pain and symptoms and minimize the negative side effects of interventions. Hospice programs recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing those stresses and concerns, in addition to the use of appropriate therapies. Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

Palliative care: Intervention that focuses primarily on reduction or abatement of the physical and psychosocial symptoms of terminal illness.

Patient/family as unit of care: The specific unit for whose needs hospice is organized. In hospice, this unit is the patient/family. Services are structured (e.g., record/keeping) and then delivered (e.g., visits at home with family members). In contrast, most health providers have, as their unit of care, the individual patient.

Personal care: Assistance rendered to the patient in bathing, dressing, mobility, or any other activities of daily living and personal hygiene.

Pharmacist: A person who has a degree in pharmacology and is licensed and registered to prepare, preserve, compound and dispense drugs and chemicals in the state in which he or she practices.

Physical: Relating to the body, its structure, characteristics and functions.

Physician: A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in conformity with applicable law.

Physician, attending: The primary physician selected by the patient to be responsible for his or her medical care.

Physician, hospice: Any licensed medical practitioner on the hospice staff (compensated or not) who is knowledgeable about hospice principles and active in the development and implementation of interdisciplinary team plans of care for patients and families.

Primary caregivers: The person designated by the patient to give emotional support and/or physical care to the patient. This person may be an individual who has personal significance to the patient but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. If the patient has no designated primary careperson, the hospice may, according to individual program policy, make an effort to designate a primary careperson.

Prognosis: The prospect of recovery, or a forecast of the natural history of a disease or illness. In hospice, usually prior to admission, a patient must have been given a prognosis by a physician of less than six months to live.

Program director: The person who has the authority and responsibility, as delegated by the governing body, to accomplish program-specific goals and objectives, implement program policy and manage personnel and resources.

Psychological/social work services: Counseling and/or therapy, as appropriate, that assists the patient/family in minimizing stresses and problems that arise from social, economic or psychological situations and assists the patient/family in maximizing positive aspects and opportunities for growth. Services are provided, as appropriate to the skills

required, by the persons who have education, training and/or experience in the care of hospice patients/families and demonstrated ability in counselling and casework.

Psychosocial assessment: The evaluation of a patient's/family's environment, religious background, financial status, and other pertinent psychosocial information that may contribute to the development of an interdisciplinary team care plan.

Qualified: Having the experience, education and demonstrated competence deemed appropriate by the hospice program to meet the requirements and fulfill the responsibilities of a specific function or duty.

Quality assurance: Ongoing assessment program that measures the quality of the interdisciplinary hospice services provided; It includes provisions for addressing specific problems identified and followup to determine the effectiveness of corrective actions.

Registered nurse: A nurse who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse.

Risk assessment: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

Service: A functional division of a program or an interdisciplinary team. Also, the delivery of care.

Social: The interactions of persons with their families and communities.

Social services: See (Psychological/ social work services.)

Spiritual service: Spiritual support provided by a member of the interdisciplinary team, community clergy, or a person identified by the patient/family as supportive with regard to spiritual or religious matters.

Staff: Paid or volunteer interdisciplinary team members who provide hospice services.

Staff support: Organized activities designed to provide psychological/ social support to hospice employees as they respond personally to the loss, grief and change experienced by patients and their families.

Supervision: The direction of the provision of services and the individuals who provide the services, and the review of the services provided, in accordance with written program policies, procedures and job descriptions.

Terminal disease: An illness for which treatment directed toward cure or control of the disease process is no longer possible or effective.

Terminally ill: Individuals suffering from a disease with a prognosis of six months or less to live.

Transfer: Movement of the patient/ family from one service or location to another (e.g., the patient and family or designated primary careperson).

Unit: A functional division of a facility or institution. Also, a person or group regarded as a whole (e.g., the patient and family or designated primary careperson.)

Utilization review: The process of using predefined criteria to evaluate whether the hospice's services and resources are necessary, cost efficient and effectively utilized.

Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation. More specifically, a patient care volunteer is an individual who agrees to serve on an interdisciplinary team as a companion of the patient/family and provide psycho-social support to the patient/ family during the remaining days of the patient's life. A bereavement care volunteer agrees to provide psycho-social support to the surviving family following the patient's death.

Volunteer support: Activities designed to assist and support volunteers as they work in their roles as patient care and bereavement volunteers.

Written agreement: A formal agreement with any organization, agency, or individual specifying the services, personnel and/or space to be provided to or on behalf of the hospice program, as well as the monies to be expended, if any, in the exchange. The agreement is approved by the governing body, in accordance with hospice program policy.

National Hospice Organization

Addendum to

Standards of a Hospice Program of Care
Recommended by the National Hospice Organization

Original Standard:

Standard 14

A hospice program has an organized training program and procedures for the selection, supervision and continuing education of volunteers.

Revised Standard:

Standard 14 (A)

The hospice program has an organized training program which covers at a minimum the following topics: introduction to hospice, concepts of death and dying, communication skills, care and comfort measures, understanding diseases and conditions, psychosocial and spiritual dynamics of death and dying, the hospice family, managing personal stress, the bereavement process, and the role of the volunteer in hospice.

Standard 14 (B)

The hospice program has established policies and procedures for the selection, retention and continuing education of hospice volunteers and volunteers are regularly evaluated using performance criteria defined by the hospice.

11/90

Suite 901 • 1901 North Moore Street • Arlington, Virginia 22209 • (703) 243-5900 • FAX (703) 525-5762

HB 172

HOUSE COMMITTEE REPORT

(11)

Date Referred: March 5, 1993 FURTHER REFERRALS:

Date of Committee Action: 3/16/93

The FINANCE Committee considered: HB 172

HOUSE BILL NO. 172 WILDLIFE CONSERVATION TAG AND FEE

"An Act relating to the wildlife conservation tag and to entry onto state game and wildlife sanctuaries, state game refuges, state range areas, and fish and game critical habitat areas; and providing for an effective date."

RECOMMENDATIONS: be replaced with CS HB172 (Fin) [ ] the same title [ ] ~~a~~ new title

[ ] have attached amendments(s)

[ ] do pass

[ ] do not pass

[✓] no recommendations

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[X] fiscal impact F&G

[ ] zero fiscal note _____

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Ronald D. Larson LARSON	X	Therriault	+		
Gussenhoven	X				

Ronald D. Larson

CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CSHB 172(FIN)

Revision Date: 4/5/93 | Department Affected: Fish and Game

Title: An Act relating to the wildlife conservation tag and to entry onto state game and wildlife sanctuaries | BRU: Wildlife Conservation

Component: Wildlife Conservation

Sponsor: Representative Williams

Requestor: House Finance | COMPONENT SERIAL NO. 0473

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	9.0	4.6	4.7	4.8	4.9	5.0
TRAVEL						
CONTRACTUAL	33.3	18.9	15.0	15.0	15.0	15.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	42.3	23.5	19.7	19.8	19.9	20.0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE: 1005	17.0	23.7	27.4	31.1	34.7	38.4

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	25.3	0.0	0.0	0.0	0.0	0.0
1005 GF Program Receipts	17.0	23.5	19.7	19.8	19.9	20.0
1006 GF/MHTIA						
Other						
TOTAL	42.3	23.5	19.7	19.8	19.9	20.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: $ 0.0

ANALYSIS: (Attach a separate page if necessary.)
See attached page.

Prepared By: John Schoen | Phone: 267-2280

Division: Wildlife Conservation | Date: 4/5/93

Approved by Commissioner: Carl L Rosier

Agency: Department of Fish and Game | Date: 4/7/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

The Finance Committee Substitute exempts Alaskan residents from the tag requirements of the Wildlife Conservation Tag and further increases the voluntary nature of this revenue source. Consequently, both revenue and operating costs are predicted to be considerably lower (see below). Costs of administration will exceed revenue generation over the short-term, and under the committee substitute the department will not be able to depend on mandatory sales to support the cost of establishing the program or ensure a favorable cost/revenue ratio. The annual increase in voluntary sales of the tag will depend largely on the amount of support and cooperation the department receives from the tourism industry in marketing this product to their clients. The tourism industry has indicated a willingness to cooperate with the department on a voluntary tag program. However, we have not yet developed a clear strategy for effectively marketing and promoting this product. The long-term outlook for generating a substantial revenue base from this program is unclear at this time.

Operating assumptions:

1. In the first year (FY94) approximately two man-months of a Wildlife Biologist II or Project Assistant position will be needed to help establish the program. Thereafter, one man-month/annum will be needed to continue the program.

2. Contractual costs include design, purchase, distribution of the "proof of purchase" element of the legislation. These costs also cover development, production, distribution, promotion, and inventory costs of the tag itself (i.e., patch, emblem, decal, stamp, or other item). Once the program is established and the marketability of tags is determined, costs are expected to decline.

Revenue assumptions:

1. The wildlife conservation tag fee will be $10.00; lower than had formerly been forecast but more in line with the need to generate revenue almost exclusively from voluntary sales.

2. Voluntary sales will start at 500/annum; double in the second year; and increase by 20 percent annually through FY99.

3. Sales of tags to nonresident visitors at Round Island (Walrus Islands State Game Sanctuary) will remain constant at 82/annum and nonresident applicants for McNeil Sanctuary viewing permits will increase from 1120 to 1960/annum through FY99.

4. Additional revenue may be earned from the sale of required tags at Pack Creek State Game Sanctuary or other state game refuges, as appropriate. However, no such projections are included in this fiscal analysis.

8-LS0650\K
Utermohle
4/2/93

CS FOR HOUSE BILL NO. 172( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES WILLIAMS, Phillips, Larson, Davies, Bunde, Finkelstein, Porter, Ulmer, James, Mulder

A BILL

FOR AN ACT ENTITLED

"An Act relating to the wildlife conservation tag and to entry onto state game and wildlife sanctuaries; relating to the issuance of citations for violations under the Fish and Game Code; and providing for an effective date."

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

* Section 1. FINDINGS. The legislature finds that

(1) the diversity of wildlife species in Alaska and the size of Alaska make wildlife management extremely expensive;

(2) the growth in Alaska's human population has placed pressure upon wildlife habitat and wildlife populations and has increased demand for use and appreciation of wildlife;

(3) the Board of Game and other resource management agencies need current, accurate wildlife population and human use data for regulatory and planning purposes;

(4) the quality and extent of wildlife information provided by the Department of Fish and Game have a direct effect on the types and levels of human use of wildlife that are allowed;

(5) the establishment of a wildlife conservation tag program will allow more Alaskans to directly and actively support wildlife conservation programs in the state through the voluntary purchase of a wildlife conservation tag;

(6) a wildlife conservation tag program will benefit wildlife conservation programs in the state through revenue generated by the voluntary purchase of a wildlife conservation tag by nonresidents who want to support the conservation of wildlife in the state or who use certain state game and wildlife sanctuaries to view, study, and enjoy wildlife;

(7) revenue generated through the sale of wildlife conservation tags should be used to supplement, but not supplant, funds available from other sources for wildlife conservation, wildlife education, and wildlife viewing.

* Sec. 2. AS 16.05.165 is amended to read:

Sec. 16.05.165. FORM AND ISSUANCE OF CITATION. (a) When a peace officer stops or contacts a person concerning a violation of this title except AS 16.51 and AS 16.52 or of a regulation adopted under this title except AS 16.51 and AS 16.52 that is a misdemeanor or a violation, the peace officer may, in the officer's discretion, issue a citation to the person as provided in AS 12.25.180.

(b) The supreme court shall specify by rule or order those misdemeanors and violations that are appropriate for disposition without court appearance, and shall establish a schedule of bail amounts. Before establishing or amending the schedule of bail amounts required by this subsection, the supreme court shall appoint and consult with an advisory committee consisting of two officers of the division of fish and wildlife protection of the Department of Public Safety, two representatives of the Department of Fish and Game, two district court judges, and the chairpersons of the House and Senate Judiciary Committees of the legislature. The maximum bail amount for an offense may not exceed the maximum fine specified by law for that offense. If the misdemeanor or violation for which the citation is issued may be disposed of without court appearance, the issuing peace officer shall write on the citation the amount of bail applicable to the offense [VIOLATION].

(c) A person cited for a misdemeanor or violation for which a bail amount has been established under (b) of this section may, within 15 days after the date of the citation, mail or personally deliver to the clerk of the court in which the citation is

filed by the peace officer

(1) the amount of bail indicated on the citation for that offense; and

(2) a copy of the citation indicating that the right to an appearance is waived, a plea of no contest is entered, and the bail is forfeited.

(d) When bail has been forfeited under (c) of this section, a judgment of conviction shall be entered. Forfeiture of bail and all seized items is a complete satisfaction for the misdemeanor or violation. The clerk of the court accepting the bail shall provide the offender with a receipt stating that fact.

(e) If the person cited fails to pay the bail amount established under (b) of this section or to appear in court as required, the citation is considered a summons for a misdemeanor or violation, as appropriate.

(f) Notwithstanding other provisions of law, if a person cited for a misdemeanor or violation for which a bail amount has been established under (b) of this section appears in court and is found guilty, the penalty that is imposed for the offense may not exceed the bail amount for that offense established under (b) of this section.

* Sec. 3. AS 16.05.350 is amended to read:

Sec. 16.05.350. EXPIRATION OF LICENSES AND TAGS. Licenses and tags required under AS 16.05.330 - 16.05.430, except biennial licenses, the nonresident special sport fishing license, the resident trapping license, and the waterfowl conservation tag, expire at the close of December 31 following issuance. Biennial licenses expire after December 31 of the year following the year of issuance. The resident trapping license expires at the close of September 30 of the year following the year in which the license is issued. The waterfowl conservation tag expires at the close of January 31 of the year following the year of issue of the tag. The wildlife conservation tag provided under AS 16.05.828 expires at the close of December 31 following issuance.

* Sec. 4. AS 16.05 is amended by adding a new section to read:

Sec. 16.05.828. WILDLIFE CONSERVATION TAG PROGRAM. (a) In order to provide support for the wildlife conservation activities of the department, there is established the wildlife conservation tag program.

(b) The department shall provide a patch, emblem, decal, stamp, or other suitable item to serve as a wildlife conservation tag. The wildlife conservation tag and proof of purchase of a wildlife conservation tag shall be available through vendors of fish and game licenses and other outlets at the discretion of the commissioner.

(c) Notwithstanding AS 16.05.080, the commissioner shall establish the fee for a wildlife conservation tag by regulation. The commissioner may establish a different fee for residents and nonresidents. The commissioner may establish a different fee, or waive the requirement for a wildlife conservation tag under this section, for a person who is

(1) under the age of 16 years or over the age of 59 years;

(2) a public employee engaged in official business; or

(3) a contractor or agent for a public agency while the contractor or agent is engaged in the business of the agency.

(d) A nonresident shall

(1) have in the nonresident's physical possession a valid proof of purchase of a wildlife conservation tag, and comply with other applicable statutes and regulations including requirements for permits, in order to enter the McNeil River State Game Sanctuary or the Walrus Islands State Game Sanctuary; and

(2) provide a valid proof of purchase of a wildlife conservation tag at the time of application for a permit to enter the McNeil River State Game Sanctuary or the Walrus Islands State Game Sanctuary if a permit from the department is required for entry to the sanctuary.

(e) A wildlife conservation tag may not be required

(1) for access to or from private property within or adjoining a state game or wildlife sanctuary;

(2) to use a public easement or right-of-way across a state game or wildlife sanctuary;

(3) of a person for whom the commissioner has waived the wildlife conservation tag requirement under (c) of this section.

(f) The commissioner may request the legislature to designate by law additional state game and wildlife sanctuaries, state game refuges, state range areas,

or state fish and game critical habitat areas where possession of a wildlife conservation tag is required to enter, or to apply for a permit to enter, the sanctuary, refuge, or area.

(g) The department may contract with a person to perform the responsibilities of the department under this section to provide a wildlife conservation tag. Contracting under this subsection is governed by AS 36.30 (State Procurement Code), except that a contract may include provisions for advance payment or reimbursement for services performed under the contract.

(h) The revenue received from the sale of wildlife conservation tags may be appropriated by the legislature to the department for programs that benefit wildlife conservation, wildlife education, and wildlife viewing. In this subsection, "wildlife" has the meaning given "game" in AS 16.05.940.

(i) A person commits a violation if the person intentionally or knowingly enters upon a state game or wildlife sanctuary where the person is required to physically possess proof of purchase of a wildlife conservation tag under this section and does not have proof of purchase of a wildlife conservation tag in the person's physical possession. Upon conviction of the violation, the person may be sentenced to pay a fine not to exceed twice the fee that the person would have had to pay to obtain a wildlife conservation tag at the time the person committed the violation. In this subsection, "intentionally," "knowingly," and "violation" have the meanings given in AS 11.81.900.

* Sec. 5. AS 16.05.925 is amended to read:

Sec. 16.05.925. PENALTY FOR VIOLATIONS. Except as provided in AS 16.05.430, 16.05.722, 16.05.723, 16.05.828. 16.05.831, and 16.05.860, a person who violates AS 16.05.920 or 16.05.921, or a regulation adopted under this chapter or AS 16.20, is guilty of a class A misdemeanor.

* Sec. 6. AS 16.20.094 is amended to read:

Sec. 16.20.094. AUTHORITY TO ADMINISTER. Subject to AS 16.05.828(d) - (e), the [THE] boards may adopt regulations governing entry, development, construction, hunting, fishing, and all other uses or activities not in conflict with AS 16.20.096 and 16.20.098 for the purpose of preserving the natural habitat and the fish and game of the Walrus Islands State Game Sanctuary.

* Sec. 7. AS 16.20.096 is amended by adding a new subsection to read:

(b) Except as provided under AS 16.05.828(e), a nonresident may not enter the Walrus Islands State Game Sanctuary without having in the person's possession a proof of purchase of a wildlife conservation tag.

* Sec. 8. AS 16.20.162(e) is amended to read:

(e) Subject to AS 16.05.828(d) - (e), the [THE] boards may adopt regulations governing access, entry, development, construction, fishing, and other uses and activities affecting the natural habitat, fish and wildlife, and public use of the McNeil River State Game Sanctuary.

* Sec. 9. AS 16.20.162 is amended by adding a new subsection to read:

(g) Except as provided under AS 16.05.828(e), a nonresident may not enter the McNeil River State Game Sanctuary without having in the person's possession a proof of purchase of a wildlife conservation tag.

* Sec. 10. This Act takes effect January 1, 1994.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CSHB 172(RES)

Revision Date: 3/4/93

Department Affected: Fish and Game

Title: An Act relating to the wildlife conservation tag and to entry onto state game and wildlife sanctuaries

BRU: Wildlife Conservation. Administration

Component: Wildlife Conservation

Sponsor: Representative Williams

Requestor: House Resources

COMPONENT SERIAL NO. 0473. 0479

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	15.2	9.2	9.5	9.8	10.1	10.4
TRAVEL						
CONTRACTUAL	37.3	22.9	18.0	18.0	18.0	18.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	52.5	32.1	27.5	27.8	28.1	28.4
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE: 1005	40.5	52.0	60.0	68.1	76.9	86.6

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	12.0	0	0	0	0	0
1005 GF/Program Receipts	40.5	32.1	27.5	27.8	28.1	28.4
1006 GF/MHTIA						
Other						
TOTAL	52.5	32.1	27.5	27.8	28.1	28.4

POSITIONS:

FULL-TIME						
PART-TIME	1	1	1	1	1	1
TEMPORARY						

Estimate of current year (FY93) Impact: $ 0

ANALYSIS: (Attach a separate page if necessary.)
See attached page.

Major Prepared By: John Schoen and Kristin Wright

Phone: 267-2280

Division: Wildlife Conservation, Administration

Date: 3/4/93

Approved by Commissioner: Don Rosenberg

Agency: Department of Fish and Game

Date: 3/4/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

(Rev. 12/92)

For further distribution information call the Governor's Legislative Office

8-LS0650\E.3
Utermohle
3/16/93

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE WILLIAMS

TO: CSHB 172(RES)

Page 2, lines 2 - 6:

Delete all material and insert:

"(5) the establishment of a wildlife conservation tag program will allow more Alaskans to directly and actively support wildlife conservation programs in the state through the voluntary purchase of a wildlife conservation tag;

(6) a wildlife conservation tag program will benefit wildlife conservation programs in the state through revenue generated by the voluntary purchase of a wildlife conservation tag by residents and nonresidents who want to support the conservation of wildlife in the state or who use state game and wildlife sanctuaries, refuges, ranges, and critical habitat areas to view, study, and enjoy wildlife;

(7) revenue generated through the sale of wildlife conservation tags should be used to supplement, but not supplant, funds available from other sources for wildlife conservation, wildlife education, and wildlife viewing."

8-LS0650\E.2
Utermohle
3/16/93

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE WILLIAMS

TO: CSHB 172(RES)

Page 4, line 10:

Delete "or"

Page 4, line 11 after "AS 16.05.341":

Insert ";

(5) a public employee engaged in official business; or

(6) a contractor or agent for a public agency while the contractor or agent is engaged in the business of the agency"

8-LS0650\E.4
Utermohle
3/17/93

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE WILLIAMS

TO: CSHB 172(RES)

Page 4, lines 12 - 25:

Delete all material and insert:

"(d) A person shall

(1) have in the person's physical possession a valid proof of purchase of a wildlife conservation tag, and comply with other applicable statutes and regulations including requirements for permits, in order to enter

(A) the McNeil River State Game Sanctuary and the Walrus Islands State Game Sanctuary; and

(B) if designated by the commissioner by regulation,

(i) the Stan Price State Wildlife Sanctuary; or

(ii) a state game refuge, state range area, or fish and game critical habitat area;

(2) provide a valid proof of purchase of a wildlife conservation tag at the time of application for a permit to enter a state game or wildlife sanctuary, state game refuge, state range area, or a state fish and game critical habitat area if

(A) a permit from the department is required for entry to the sanctuary, refuge, or area; and

(B) the commissioner has established by regulation that applicants for permits to enter the sanctuary, refuge, or area shall possess a wildlife conservation tag at the time of application for the permit."

Page 5, line 23:

Delete "possess"

Insert "physically possess proof of purchase of"

Page 5, line 25:

After "have"

Insert "proof of purchase of"

After "person's"

Insert "physical"

Alaska State Legislature

Committees:

House Resources, Chairman

Community & Regional Affairs

Labor & Commerce

Representative William K. Williams

During Session:
State Capitol
Juneau, AK 99801-1182
(907) 465-3424
Fax (907) 465-3[illegible]

In Ketchikan:
352 Front Street
Ketchikan, AK 99901
(907) 247-4672
Fax (907) 225-8546

POSITION PAPER ON HB 172(RES)
AN ACT ESTABLISHING A WILDLIFE CONSERVATION TAG PROGRAM

CSHB 172(Res) creates a wildlife conservation tag program that would encourage, and in some areas require, that non-consumptive users of Alaska's wildlife help to pay for wildlife management and the programs and facilities they use.

Wildlife viewing is a fast-growing form of recreation in the world, and is one of the biggest drawing cards for tourism in Alaska. Careful management and development of viewing areas is important to protect the wildlife while enhancing visitor opportunities. This bill is a "user pays" approach to generating funds to support this growing area of wildlife use.

The primary thrust of HB 172 is a voluntary program. Participants would pay a fairly small price for the tag, and receive a pin or patch or other memento to show that they have supported the wildlife conservation program.

In addition, CSHB 172 designates two sanctuaries in the state (McNeil River and Walrus Island) where possession of the tag would be required for entry. The bill authorizes the commissioner of Fish and Game to designate additional areas of the state to the list of mandatory tag areas in the future. Purchase of an annual tag would allow an individual to apply to enter any of the areas of the state where tags are required. The bill provides exemptions from the requirement for this tag for individuals who already possess other sport hunting or fishing licenses or are engaged in subsistence activities.

The price of the tag is left to the department but will necessarily be kept low since the goal is to sell large numbers of the tags to those who voluntarily purchase them. While the bill provides for some flexibility for differential prices, the department is currently planning for an initial charge of $15 for the tag. It will be the responsibility of the Department of Fish and Game to come up with a catchy logo and appealing pin or other memento, and to publicize and promote the tag program in order to successfully raise substantial amounts of new revenue for watchable wildlife management, facilities, education and programs.

DEPARTMENT OF FISH AND GAME
POSITION PAPER

Bill No: House Bill 172

Sponsor: Representative Bill Williams

Division: Division of Wildlife Conservation

Bill Title: "An Act relating to the wildlife conservation tag and to entry onto state game and wildlife sanctuaries, state game refuges, state range areas, and fish and game critical habitat areas; and providing for an effective date."

Department Position: Support

The department supports House Bill 172. This legislation is a response to the growing public interest in wildlife viewing, wildlife conservation, and wildlife education. A national survey performed a few years ago showed that wildlife watching was the fastest growing segment of wildlife oriented recreation. The department estimates that in Alaska over 288,000 people participated in wildlife viewing in 1985.

Alaska's wildlife is, along with our scenery, the major attraction bringing tourists to Alaska. Tourism is one of the major industries in Alaska. Alaska is facing stiff competition from other states, Canada, and other countries for these tourism customers. This legislation would provide a funding source to develop improvements and programs for an important component of the visitor industry.

Wildlife viewing is also popular with Alaska's residents. The department has developed areas such as Creamer's Field near Fairbanks and Potter's Marsh near Anchorage, which are visited extensively by residents.

The Department of Fish and Game constructed a board walk and parking lot to improve public access to this marsh. The board walk was also designed to protect the fragile marsh ecosystem, which would otherwise be damaged by the many visitors to the marsh. Improvements have also been made at Creamer's Field. Between these two projects, approximately one-half million dollars has been spent in capital improvements.

McNeil River State Wildlife Sanctuary is one of the most famous wildlife viewing sites in the world. It is so popular that the number of people applying to visit the area exceeds what the department can allow into the area, while preserving the quality of the area for the bears and their human visitors. As a consequence, permits to enter the area are issued on a lottery basis. The

on of Wildlife Conservation spent $64,522 in FY92 to run the am at McNeil River. Revenues from the visitors to the area in year were $24,225.

Currently the Division of Wildlife Conservation is spending $371,700 in FY93 on what we call our watchable wildlife program. Most of the budget for the Division of Wildlife Conservation is provided by hunters and trappers. Virtually none of the cost of the watchable wildlife program is paid by the "users" of watchable wildlife, because there is no mechanism to recover from the users any of those costs. That is what this legislation offers as a modest beginning.

The primary revenue raising potential of this legislation is dependent on voluntary sales of wildlife conservation tags. In exchange for their voluntary contribution, people will receive a commemorative pin or other product, and the satisfaction of knowing that they have made a small contribution toward supporting an activity which they believe to be important.

The success of the voluntary program will depend on an attractive cost for the tag, a desirable commemorative product, and a successful marketing effort for the program.

In order to gear up and provide a minimum promotion of this new program, House Bill 172 provides that visitors be required to purchase a wildlife conservation tag before entering three of Alaska's most outstanding wildlife viewing opportunities. These are McNeil River State Wildlife Sanctuary, Walrus Island State Wildlife Sanctuary, and Stan Price State Wildlife Sanctuary. The department believes that this would provide a modest level of assured funding to develop a successful voluntary program.

Commissioner's Signature for Don Somerville Date: 3/2/93

Division of Wildlife Conservation spent $64,522 in FY92 to run the program at McNeil River. Revenues from the visitors to the area in that year were $24,225.

Currently the Division of Wildlife Conservation is spending $371,700 in FY93 on what we call our watchable wildlife program. Most of the budget for the Division of Wildlife Conservation is provided by hunters and trappers. Virtually none of the cost of the watchable wildlife program is paid by the "users" of watchable wildlife, because there is no mechanism to recover from the users any of those costs. That is what this legislation offers as a modest beginning.

The primary revenue raising potential of this legislation is dependent on voluntary sales of wildlife conservation tags. In exchange for their voluntary contribution, people will receive a commemorative pin or other product, and the satisfaction of knowing that they have made a small contribution toward supporting an activity which they believe to be important.

The success of the voluntary program will depend on an attractive cost for the tag, a desirable commemorative product, and a successful marketing effort for the program.

In order to gear up and provide a minimum promotion of this new program, House Bill 172 provides that visitors be required to purchase a wildlife conservation tag before entering three of Alaska's most outstanding wildlife viewing opportunities. These are McNeil River State Wildlife Sanctuary, Walrus Island State Wildlife Sanctuary, and Stan Price State Wildlife Sanctuary. The department believes that this would provide a modest level of assured funding to develop a successful voluntary program.

Commissioner's Signature for Don Somerville Date: 3/2/93

Back-up

Alaska Environmental Lobby, Inc.

P.O. Box 22151 Juneau, Alaska 99802 907-463-3366

Position Paper

THE ALASKA ENVIRONMENTAL LOBBY SUPPORTS SB 107 AND HB 172 "CONSERVATION TAG"

SB107 and HB 172 are very similar to last year's HB 446. They require a conservation tag, similar in concept to a hunting or fishing license, for entry into three state game and wildlife sanctuaries (McNiel River State Game Sanctuary, Stan Price State Wildlife Area and Walrus Islands State Game Sanctuary). This legislation also allows the commissioner by regulation to add other state game refuges, range areas or fish and game critical habitat areas to the program.

The Alaska Environmental Lobby believes that nonconsumptive users of state refuges, game sanctuaries and critical habitat areas should pay a share of the management costs. Currently, the total allocation for wildlife viewing-related programs in the Division of Wildlife Conservation, Dept. of Fish and Game is only 3% of the Division's total budget. More money is necessary to meet the growing demands in this area. Estimated revenue from the Department of Fish and Game's Fiscal Notes is $55,500 in fiscal year 1994, rising to $101,600 in fiscal year 1999. The potential for ADF&G to enhance wildlife viewing opportunities, which are very important to both the environmental community and the tourism industry, would be a wise investment in Alaska's economic future .

SB 107 and HB 172 are similar bills, but they have one important difference. In the current form of SB 107, the revenue may be used to "enhance" these programs. We feel the word "enhance" is not strong enough to ensure that the money will be used for its intended purpose. We recommend that this section of SB 107 be amended using the language of HB 172. HB 172 states:

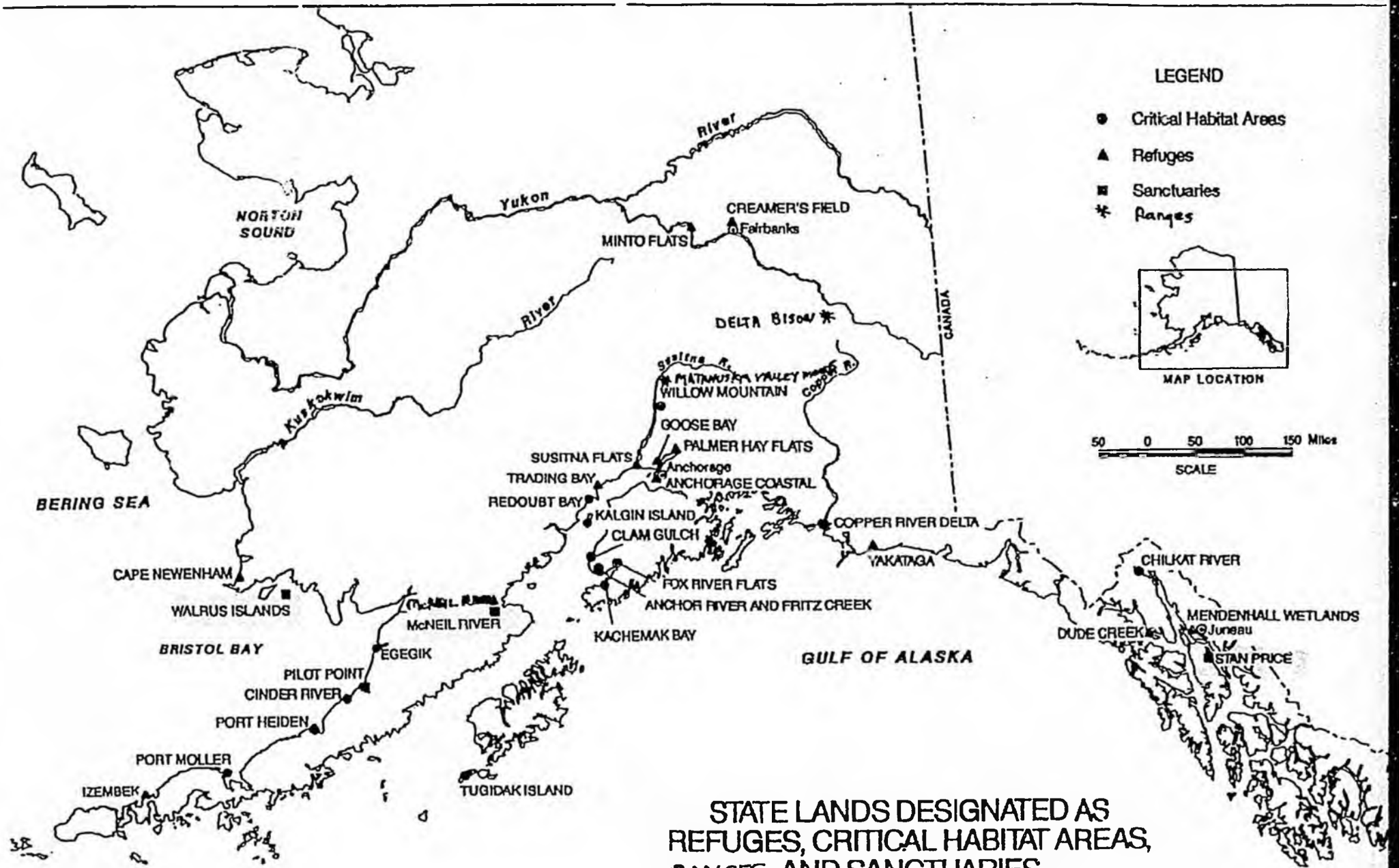
> "the revenue received from the sale of wildlife conservation tags may be appropriated by the legislature to the department for programs that benefit non-game species of wildlife, threatened and endangered species of wildlife, wildlife education and wildlife viewing."

We do not want to see this money disappear into the General Fund and used for non-wildlife related programs.

AEL would also like to see mandatory tags for more state game refuges, range areas and critical habitat areas added to this program , especially those areas most used by nonconsumptive users.

Prepared by Mary Forbes, February 25, 1993 AEL Volunteer

32 areas in state



STATE LANDS DESIGNATED AS REFUGES, CRITICAL HABITAT AREAS, RANGES AND SANCTUARIES

United States Department of Agriculture | Forest Service | Region 10 Tongass National Forest

Admiralty Monument Kootznoowoo Wilderness
8461 Old Dairy Road
Juneau, Alaska 99801
(907) 586-8790

Reply To: 1510

Date: March 18, 1993

Ms. Mary McDowell
Staff Assistant for
Representative Bill Williams
Alaska House of Representatives
Juneau, AK 99801-1182

Dear Ms. McDowell:

Thank you for the opportunity to review the draft of House Bill No. 172 related to the proposed Wildlife Conservation Tag Program. This proposed legislation has bearing on management of the Pack Creek Cooperative Management Area, which is a brown bear viewing area on Admiralty Island comprised of National Forest System lands, and the Stan Price State Wildlife Sanctuary (State land). This highly successful cooperative effort has produced a coveted visitor destination which requires considerable interagency coordination.

State Statute (AS 16.20.150) mandates that the Sanctuary be managed "compatibly with the United States Forest Service's management of the adjacent upland." We have reviewed the Committee Substitute proposed by the House Resources Committee and have worked with you and staff from the Department of Fish and Game and Legislative Legal Services to assure compliance with that objective.

We believe the three proposed amendments to the Committee Substitute for HB 172 (two dated 3/16/93, one dated 3/17/93 by Rep. Williams) satisfactorily resolve our concerns about the effects this legislation could have on management of the Pack Creek Cooperative Management Area.

The Forest Service values the cooperative relationship we have with the Department of Fish and Game in the management of this area.

Sincerely,

VIVIAN K. HOFFMAN
Monument Ranger

cc: ADF&G-C.Bruce

Alaska Wilderness Recreation and Tourism Association

To: The Honorable Bill Williams
From: Nancy R. Lethcoe, President
Date: March 19, 1993

RE: HB 172 Watchable Wildlife Tag

The Alaska Wilderness Recreation and Tourism Association thanks you for your continued efforts on behalf of HB 172.

I have reviewed proposed amendments 650\E.3, 650\E.4 and 650\E.5 with our executive board. We support these amendments.

I raised AVA's concerns about limiting the commissioner's ability to make tags mandatory in aditional areas again with the executive board. There is strong support of the bill's current language.

Again, we appreciate your support of this bill and hope that it will be passed out of the House Finance Committee quickly.

P.O. Box 1353, Valdez, AK 99686. Phone: 907-835-4300. Fax: 907-835-4836

HB 175

HOUSE COMMITTEE REPORT

(11)
Date Referred: March 30, 1993 FURTHER REFERRALS:

Date of Committee Action: 4/8/93

The FINANCE Committee considered: HB 175

HOUSE BILL NO. 175 APPROP:WOMEN IN MILITARY SERVICE MEMORIAL

"An Act making an appropriation for a grant for construction of the Women In Military Service Memorial; and providing for an effective date."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title
[ ] have attached amendments(s)
[✓] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal impact _____ [ ] fiscal note(s) _____

[ ] zero fiscal note _____ [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Oswald D. Lan LARSON	X	Terry Martin MARTIN		X	
E.P. MacLean MACLEAN	X				
Mark Hanley HANLEY	X				
Jean Fagnell PARNELL	X				
Tom Thernstrom THERNSTROM	X				
Richard Foster FOSTER	X				

E.P. MacLean Oswald D. Lan
CHAIRMAN'S SIGNATURE

DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

HB175 POSITION PAPER

For: An Act making an appropriation for a grant for construction of the Women in Military Service Memorial

Background: The Women in Military Service for America Memorial Foundation, Inc. has undertaken a project to develop a memorial to women in military service to be placed at the gateway to Arlington National Cemetery. Funding for this memorial must be provided by non-federal donations, according to federal law. The Foundation has requested individual states to contribute to the construction fund, and has requested the State of Alaska to contribute the amount of $15,000 for the construction of the memorial.

Department Position: The Department of Military and Veterans Affairs feels that women in military service deserve special recognition, and that the proposed memorial is an appropriate way to provide that recognition. The question of whether or not the state should provide funding for a contribution to the construction of the memorial, and the amount of that contribution, is one of fiscal policy, which is the prerogative of the legislative branch.

for [signature], ASST. COMM. Date: 13-22-93
Hugh L. Cox III, Commissioner

[File: PPHB175]

Women In Military Service For America
Memorial Foundation, Inc.
Dept. 560
Washington, D.C. 20042-0560
(703) 533-1155 1-800-222-2294 (703) 9[illegible]208 (FAX)

March 1, 1993

Representative Cliff Davidson
State Capitol
Juno, Alaska 99801

Dear Representative Davidson:

I am writing to request your assistance in a vital project that will directly benefit the 5,000 women veterans who live in the state of Alaska. The Women In Military Service Memorial, to be built at the gateway to Arlington National Cemetery, will pay tribute to these women and the other 1.8 million who have served throughout history. We are delighted that you have agreed to sponsor an appropriation of $15,000 for the construction of this Memorial, joining the states of Florida, Montana, and Arkansas in supporting this worthy effort. Similar bills are also pending in South Dakota, Hawaii, Georgia, New Jersey, Virginia, and New York.

This will be the first major national memorial recognizing the contributions of women, and telling their stories for future generations. Many great women hail from the state of Alaska, including Colonel Mary Louise Rasmusen, US Army, Retired, former Director of the Women's Army Corps from 1957 - 1962, a critical period for women's continued service in the military.

By law, the Memorial must be funded through non-Federal donations. Sufficient funds to complete the project and provide for maintenance must be on hand before construction can begin. The fundraising goal is $14 million and authority expires on November 5, 1993.

A contribution from the state of Alaska at this stage could provide tremendous momentum and lead to support from many other states. Additionally, this contribution can help sponsor the 5,000 women veterans who do not have sufficient funds for the $25 registration donation for their names and record of service to be included in the Memorial's register. All states making contributions will be permanently recognized in the Memorial.

Support for the Memorial has already come from a variety of sources within the state of Alaska. Our National Tribute Committee includes Senators Frank Murkowski, who sponsored the original legislation, and Ted Stevens. In fact, Senator Murkowski is expected to assist us by sponsoring a bill in the Senate that would authorize the minting of a Women In Military Service coin, to benefit the Foundation.

Please feel free to call us if we can do anything to assist your efforts. Again, thank you for your efforts to honor the women who have served, in Alaska and nationwide, with valor and dedication.

Sincerely,

Wilma L. Vaught
Brigadier General, USAF (Ret.)
President

FOR THE BOARD OF DIRECTORS:

Connie L. Slewitzke
Brigadier General, USA, NC (Ret.)
Vice President

Sara J. Pritchett
Colonel, USMC (Ret.)
Secretary

Myrna H. Williamson
Brigadier General, USA (Ret.)
Member

Women In Military Service For America
Memorial Foundation, Inc.
Dept. 560
Washington, D.C. 20042-0560
(703) 533-1155 1-800-222-2294 (703) 931-4208 (FAX)

ABOUT THE MEMORIAL

WHAT: Women In Military Service Memorial to honor the more than 1.8 million women who have served or are serving in the armed forces starting with the American Revolution.

WHERE: The gateway to Arlington National Cemetery.

WHEN: Construction to start in December, 1993.

WHO: Spearheaded by the Women In Military Service For America Memorial Foundation (WIMSA).

THOSE TO BE HONORED: All U. S. servicewomen. WIMSA is seeking names, addresses, photos and memorable experiences of women who have served. Descendents of deceased servicewomen are asked to register them.

HISTORY: Bill to honor military women introduced by Congresswoman Mary Rose Oakar (D-Ohio) and Senator Frank Murkowski (R-Alaska). Signed into law by President Reagan in November, 1986.

DESIGN: Ms. Marion Gail Weiss and Mr. Michael Manfredi of Weiss/Manfredi, New York City, winners of national competition.

The Memorial features an upper terrace with views of Arlington National Cemetery and the monuments of Washington. On the terrace, there will be an arc of glass "pages" in which quotations from servicewomen are etched. This arc of glass also introduces natural light into the Memorial's visitor center. At the lower terrace in front of the Hemicycle wall are the reflecting pool and Court of Honor. The visitors center located behind the Hemicycle houses a Hall of Valor, theater, and a computer Register of servicewomen. Through the data base, visitors may access photos, military histories, and individual stories of registered women.

FUNDING: The cost for building the Memorial -- an estimated $14 million -- must be raised through non-Federal funds. This sum must be available by November, 1993. So far, more than $1 million is committed to the building fund.

DONATIONS AND REGISTRATIONS: Donations and histories of servicewomen can be sent to: Women In Military Service Memorial, Dept. 560, Washington, D. C. 20042-0560. Toll-free telephone: 1 - 800 - I - SALUTE (1-800-472-5883.)

The Memorial is a registered member of the Combined Federal Campaign, the annual workplace fundraising drive conducted by the U. S. Government for all military, civilian agency and postal workers worldwide. In state and corporate campaigns, donors should designate "Women In Military Service For America Memorial" on their pledge card.

As of: Jan. 1, 1993

Women In Military Service For America
Memorial Foundation, Inc.
Dept. 500
Washington, D.C. 20042-0560
(703) 533-1155 1-800-222-2294 (703) 931-4208 (FAX)

April 1, 1992

For more information, contact: Rae Lee
Fay Fulton
703/533-1155

WOMEN IN MILITARY SERVICE MEMORIAL
TO HONOR AMERICA'S SERVICEWOMEN THROUGHOUT THE AGES

The Women In Military Service For America Memorial Foundation (WIMSA) was founded to create a Memorial to honor the 1.8 million women who have served in the U.S. military services throughout history, from the American Revolution through Operation Desert Storm and beyond. Authorized by Congress in 1986, the Women in Military Service Memorial will provide a legacy to future generations by capturing the undocumented history of our American servicewomen. It will be unique in that it will be a place of honor for both the living and deceased; those who served in the past, those who serve today, as well as those who will serve in the future.

This Memorial is unique in other ways. It will use an existing site and its structures at the gateway to Arlington National Cemetery, our most honored military resting ground. The wall there, or Hemicycle, suffers from years of neglect and is badly in need of repair. The Hemicycle will be restored and modified to add four stairways to the upper level of the wall, a walkway with views of Arlington National Cemetery and monumental Washington. A key feature of the terrace will be an arc of glass tablets bearing quotations of servicewomen etched theron. These glass tablets will also form a series of skylights into the Memorial's interior Visitors Center. The Visitors Center will house an underground theater and a computerized data base where the public can access the photos, military history and individual stories of the women who have served. The Foundation relies on servicewomen, veterans and their descendants to "Register" their stories and photos so that the history of women in the military is brought to light for all Americans.

Support for the Memorial has come from a number of sources. The governments of Kuwait, Saudi Arabia and Qatar announced their support, in honor of the women who served in the Persian Gulf. State governments also provided financial support in 1991, including Montana, Florida and Arkansas. Corporations which contributed include: The Coca-Cola Company, Martin Marietta Corporation, RJR Nabisco, Northrop Corporation, Raytheon Company, Xerox Corporation and Tambrands Corporation. A number of veterans and service organizations have supported the project in a variety of ways, many through publicity to their membership and group registration of their female members. The Veterans of Foreign Wars Auxiliary voted last year to accept WIMSA as a group project. Each activity and contribution brings this tribute closer to reality for the many women who have served throughout the years.

-more-

The cost for building this Memorial — an estimated $12 million - must be raised through non-Federal funds. Public Law #102-216, passed in November 1991, extended by two years WIMSA's deadline for raising the remaining monies needed to build the memorial. With 20 months remaining in the deadline, this project needs the support and help of all Americans.

One example of how women have fought for their country is Deborah Sampson Gannett. Gannett disguised herself as a man to serve in the Army in the Revolutionary War. She was shot in battle and escaped detection by removing the musket ball from her thigh by herself. Some two years later, when she was hospitalized with a fever, the attending doctor found that this soldier was a woman. She is one of thousands of women whose story will be told through the Memorial Register.

Today's heroine does not have to disguise herself, but the dangers are just as real. Major Marie Rossi, who became a familiar sight on television screens during the Persian Gulf War when CNN broadcast an interview with her, was killed one day after the cease fire while operating a supply helicopter. There are many more women who have contributed in defense of our nation that deserve our recognition, too.

Now all of these women, veterans, active duty, Guard and Reservists, will receive the honor and recognition they have earned.

Those wanting more information on how to register for the Memorial or support this tribute to military women, please call **1-800-4-SALUTE** or write to Women In Military Service Memorial, Department 560, Washington, DC 22042-0560.

###

Women In Military Service For America
Memorial Foundation, Inc.
Dept. 560
Washington, D.C. 20042-0560
(703) 533-1155 1-800-222-2294 (703) 931-4208 (FAX)

NUMBER OF FEMALE VETERANS IN EACH STATE*

State	Female Veterans	State	Female Veterans
Alabama	17,000	Montana	4,700
Alaska	5,000	Nebraska	6,900
Arizona	25,000	Nevada	9,200
Arkansas	9,800	New Hampshire	7,200
California	146,200	New Jersey	26,000
Colorado	21,000	New Mexico	9,600
Connecticut	14,100	New York	56,300
Delaware	3,600	North Carolina	30,600
Dist. of Columbia	3,700	North Dakota	2,600
Florida	85,400	Ohio	40,500
Georgia	31,000	Oklahoma	13,800
Hawaii	7,100	Oregon	17,000
Idaho	4,600	Pennsylvania	46,300
Illinois	34,800	Rhode Island	4,600
Indiana	19,500	South Carolina	16,800
Iowa	8,600	South Dakota	3,000
Kansas	9,300	Tennessee	17,000
Kentucky	11,900	Texas	72,800
Louisiana	14,300	Utah	4,800
Maine	7,400	Vermont	3,400
Maryland	28,900	Virginia	42,900
Massachusetts	26,500	Washington	33,500
Michigan	33,100	West Virginia	5,700
Minnesota	15,100	Wisconsin	17,400
Mississippi	9,100	Wyoming	2,300
Missouri	19,800		
		TOTAL	**1,106,600**

*Information courtesy of the Department of Veterans Affairs (1992).

These numbers are exclusive of the number of women on active duty and in the national Guard, Reserves and Coast Guard in each state.

Women In Military Service For America
Memorial Foundation, Inc.
Dept. 560
Washington, D.C. 20042-0560
(703) 533-1155 1-800-222-2294 (703) 931-4208 (FAX)

STATISTICS ON WOMEN IN THE MILITARY

Number of Women on Active Duty as of March 31, 1992

Active Duty		Reserve and Guard
Army	76,887	62,954
Navy	54,849	22,007
Air Force	70,917	15,567
Marine Corps	8,643	1,524
Total DoD	211,364	102,052
Coast Guard	2,776	1,393
Total	214,140	103,445

Number of women who served in Operation Desert Storm, by Service

Army	26,000
Navy	2,600
Air Force	3,800
Marine Corps	952
Coast Guard	13
Total	33,365

Number of women held Prisoners of War during individual military conflicts

World War II	88	(all officers, all nurses)
Desert Storm	2	(one doctor; one, the first, enlisted woman)

Number of women who served in the military conflicts

Civil War	6,000
Spanish/American War	1,500
World War I	34,000
World War II	400,000+
Korea	22,000
Vietnam	7,500
Grenada	116
Panama	1,200
Desert Storm	33,365

Women In Military Service For America
Memorial Foundation, Inc.
Dept. 560
Washington, D.C. 20042-0560
(703) 533-1155 1-800-222-2294 (703) 931-4208 (FAX)

A SUMMARY HISTORY OF WOMEN'S SERVICE IN THE MILITARY

The history of America's military women begins with the birth of our nation. It is a dramatic story of persistence, courage and foresight in the face of repeated frustrations and the built-in institutional resistance of the tradition-bound military subculture. It is set against the background of peace and war, of social evolution and of advancement in the technology of warfare.

During the 18th and 19th centuries, women were routinely present with the armies in battle. Indeed, with constant manpower shortages, sustaining Washington's army during the American Revolution in field or in garrison would have been next-to-impossible without women. Women also were hired employees, and the medical service, for example, was allowed one matron and ten nurses per hundred wounded.

It was common and accepted practice for poor but respectable wives, mothers and daughters to go along with their men when they went off with the army; often, they had no practical alternative. Women also served in less-conventional capacities, and in their little-known history are many stories of women masquerading successfully as male soldiers until wounded and medical attention revealed their deception. In the War of 1812, the "first girl Marine" is reputed to have served for three years on the USS Constitution as George Baker.

During the Civil War, women on both sides became active on an unprecedented scale, as many of the social conventions were set aside. In addition to their usual functions of nursing, cooking, sewing and foraging for supplies, many women -- both black and white -- served a saboteurs, scouts and couriers. They led troops into battle as color bearers, blew up bridges, cut telegraph wires, burned arsenals and warehouses, and help prisoners and slaves escape. One woman, Dr. Mary Walker, was awarded the Congressional Medal of Honor for her contributions.

In the Spanish-American War of 1898, an epidemic of typhoid fever forced the recruitment of women by the Army under a civilian contract. Eventually, 1,500 served, leading initially to the formation of the Army Nurse Corps in 1901, and later to the formation of the Navy Nurse Corps in 1908. When involvement in World War I became inevitable, the nursing services were organized and ready to serve, but full military status would not be accorded women until 1948.

During World War I, both the Navy and Marine Corps enlisted women as clerks, translators, and radio electricians, with about 12,000 serving, along with a few in the Coast Guard. About 23,000 Army and Navy nurses served in field hospitals and in mobile, evacuation, base, and convalescent hospitals, on troop trains and transport ships. Some died, some were wounded and many were decorated, including three who received the Distinguished Service Cross, a combat medal second only to the Congressional Medal of Honor.

World War II saw the first class of female officers in the history of the U.S. Armed Forces assembled for training at Fort Des Moines, Iowa, in July of 1942. Eventually, more than 400,000 women -- all volunteers -- served in all branches and in all military theaters. The casualties, more than 200, included Army nurses and members of the Women Airforce Service Pilots, and there were 88 women held as prisoners of war.

Until demobilization began in 1945, women's service in the military had followed much the same pattern as Washington's army in the American Revolution. When the war was over, the Continental Army disbanded, leaving a force the size of a Corporal's guard -- some 80 men. Women were not granted full and permanent military status in the U.S. Armed Forces until that attitude toward preparedness changed. At the close of World War II, when the exodus home began, military leaders began to have second thoughts about letting all the women go. At General Dwight D. Eisenhower's direction, legislation was drafted to establish a Women's Army Corps in the Regular and Reserve of the peacetime Army. It died in controversy but led to the Integration Act, passed by Congress as the Women's Armed Services Act of 1948. On June 12 of that year, President Harry S. Truman signed the measure that finally established a permanent place for women in the Army, Navy, Air Force and Marine Corps.

The Integration Act did not guarantee equity for military women, and after the debacle of an ill-planned recruiting program during the Korean War, women's programs in the subsequent Cold War years barely survived. Women's roles in the military, once a route to education and jobs previously reserved for men, became token in the fifties and early sixties -- tolerated but not take seriously. Instead of serving as a springboard for further integration and equality for woman, the Act had become the base of a system of institutional segregation and unequal treatment. Unlike their predecessors in World War II and Korea, American servicewomen were not taxiing aircraft, running motor pools or teaching aerial gunnery. The Pentagon's official attitude was that women would not be employed at jobs that "are not in conformance with the present cultural pattern of utilizing women's services in this country." This situation, however, changed when the demand for recruitment for the war in Vietnam could not be met with available manpower of acceptable quality and ultimately resulted in a renewed expansion of roles for woman.

The next step was real integration: the abolition of separate services for women military members. The Army's Chief of Staff, General Bernard W. Rogers, recognized that support was necessary from the top to the very bottom of the organization and sent a message to his commanders in Mary, 1978, emphasizing the Army"s commitment to integration of women and to accomplishing it "smoothly and rapidly:"

> Qualified women now have the opportunity to serve in all but a few specific combat units and combat specialties. In availing themselves of the opportunity, women, like their male counterparts, must accept the responsibility for sharing all risks and enduring all hardships inherent in their specialty. Some people believe that women soldiers will not be deployed in the event of hostilities, that they are only to be part-time soldiers -- here in peace, gone in war. Some women are being used in skills other than those for which they were trained and some are being excused from performance of unit duties. The Army cannot operate effectively in this manner. Women are an essential part of the force; they will deploy with their units and they will serve in the skills in which they have been trained... The first considerations in the assignment of women in the Army have been, and will continue to be, the mission of the Army itself, and the uniquely demanding nature of Army service in wartime. Within that context, women can make many important contributions; indeed they are doing so now. The burden which rests on leaders at every level is to provide knowledgeable, understanding, affirmative and even-handed leadership to all our soldiers.

Clearly, women are and continue to be an essential factor in the volunteer services, qualitatively and quantitatively. In 1979 for example, had the services not enlisted some 42,000 women, recruiting shortfalls would have been even larger. Their ability to meet 1980 recruiting goals was due in large part to the enlistment of 50,000 women, the largest number of women since World War II.

In 1988, the Secretary of Defense wrote to the Service Secretaries that decisions that military women could be assigned to missions and units under the combat exclusion laws but only with the understanding that they would be assigned to them both in peacetime and during conflict. He said they should not be assigned duties which they could not fulfill during mobilization or national emergency since there would be no plans or instructions to remove or evacuate them

Recent history has raised the awareness of American public about women in the military. A few women had deployed with their units to the island of Grenada. However, when some commanders realized they were there, the women were ordered back to their United States bases. Eventually, that order was lifted and the women continued their duties without fanfare. Women servicemembers also deployed to Panama although the stories of their performance tended to overshadow their actual contributions.

It was Operation Desert Storm in the Persian Gulf, however, which proved to be a determining factor in women's futures as members of the military. According to the Women's Research and Education Institute, more than 33,300 U.S. military women served in key combat-support positions. They piloted and crewed planes and helicopters, directed artillery, drove trucks, ran prison-of-war facilities, served on support and repair ships and in port security units and construction battalions, and did a myriad of other jobs crucial to the success of Operations Desert Shield/Desert Storm. And, of course, many women served in the vital medical and administrative jobs where women always have been well-represented.

As a result of their performance, both the Senate and the House of Representatives passed legislation lifting the combat exclusion laws as they pertain to women serving in aviation.

Today, more than 400,000 women are on active duty, and in the National Guard and the Reserves of the Army, Marine Corps, Navy, Air Force and Coast Guard, and comprise more than 11 percent of the active duty personnel and 13 percent of the ready reserves of the country's armed forces. It is estimated that there are more than 1.2 million living women veterans.

It is intended that the Women In Military Service For America Memorial, the first to honor women's contributions in the defense of our nation, will help write their history for all to read. The memorial's unique inclusion of all the women, in all the wars faced by the country -- from the American Revolution through the Persian Gulf -- and in peacetime, is an opportunity for the public recognition of a part of our collective heritage that has gone unnoticed for too long. The location of the memorial, at the ceremonial entrance to the nation's most-hallowed resting place for its military and national heroes, is the appropriate setting. The goal of the memorial's cultural and educational center is to tell the history of the dedication, commitment and sacrifice of women in partnership with men in service to their country, and to inspire our youth to emulate these women, to follow and to surpass them.

USA TODAY

Women's role in U.S. military saluted today

By Tracy Walmer
USA TODAY

Forty-seven years ago today, Staff Sgt. Paula Burrows was nervously waiting and watching as the D-day invasion unfolded in France, carrying out plans she had carefully helped orchestrate.

She stood watch from an office outside London — behind the scenes and away from the battle lines, like most of the 400,000-plus U.S. women who served in World War II. Burrows received a Bronze Star for her work.

Today, her fellow female soldiers get their due when luminaries join military women and families at ceremonies at the Capitol in Washington.

The celebrators hope to erect a memorial to honor the estimated 1.6 million women who have served in the U.S. military since the Revolutionary War.

When Chinook helicopter pilot Marie Rossi died a day after the Persian Gulf war ended — and a week after she captured the hearts of many Americans through a CNN interview — her parents decided to turn their loss into a gift to military women.

They'll be on hand at today's tribute, where Marie will be honored as a highly visible symbol of women who for so long have been largely invisible to the public.

"It's not just about my daughter. It's about all the women who served," says Gertrude Nolan Rossi.

Agnes Jensen Mangerich, 76, is one.

A World War II Army flight nurse, her tour nearly ended in disaster, when a cargo plane carrying Mangerich and 29 other nurses, medics and crew was shot down over Albania in November 1943.

The next two months were a horror of dysentery, typhoid, malnutrition and midnight hikes through German lines as the group was guided by frightened, hungry Albanian sympathizers to a rescue boat on the Adriatic coast.

"When I think about it now, the hairs just stand up on my head," says Mangerich. "You know, when you're 20 you just think you're invincible."

Betsy Ross Menin, 58, liked her Korean War service.

"I'd do it again if I was young enough," says Menin, who joined the Marines when she was 19. She spent eight years working the jobs available to women — stenographer, clerk, court reporter and drill instructor.

In Vietnam, between being a female and dealing with widespread anti-war feelings at home, it was hard to feel appreciated, says Carol Kenefick DeMeo, 47.

"You just buried your feelings. It was a time you didn't talk about," says DeMeo, now a civilian nurse. "The memorial is important. It will help."

▶ Snapshot, 1A

Photos by Women in Military Service Memorial

IN VIETNAM: Carol Kenefick DeMeo, now 47, says it was especially hard for women to feel appreciated for serving in that war.

BURROWS: Worked behind the scenes in World War II

ROSSI: Helicopter pilot died day after gulf war ended

50-state tribute for the women of Desert Storm

Today's tribute in Washington kicks off a 50-state campaign to honor the women who served in Operation Desert Storm, and to raise money to build a memorial to all U.S. military women.

Authorized by Congress in 1986, the memorial is slated to go up in Arlington National Cemetery by 1993. Plans call for a computer database with photographs and information on every woman who has served.

About 60,000 of the estimated 1.6 million military women are in the database so far.

The privately funded memorial will cost $25 million. Raised so far: $3 million.

For more information, call Women in Military Service for America Memorial Foundation at 800-472-5883.

Memorial created for women's role in armed services

By NANCY PRICE
TIMES WRITER

Wilhelmina Daniels left her New Orleans home at the age of 20 to enlist in the Coast Guard during World War II, crisscrossing the United States as a radio operator.

The east Anchorage resident describes her career in the Coast Guard as "two really nice years of my life" but thinks it is time women vets had more than their memories to commemorate their service in the U.S. armed forces.

She and 60,000 other women vets want a permanent registry and memorial for the women who have served in the country's military.

"I think it's a great idea, I really do," she said. "An awful lot of women in the service went overseas (during World War II).

"I think we did our part, we did the same things in my department that the men did. I think we deserve a memorial."

Daniels is one of more than 60,000 women vets who have registered with the Women In Military Service Memorial. The register will be housed eventually in a memorial center to be constructed at the Arlington National Cemetery's Hemicycle and marked by 10 glowing glass spires.

> 'I think we did our part, we did the same things in my department that the men did. I think we deserve a memorial.'
>
> — Wilhelmina Daniels
> Anchorage resident

The Women In Military Service Memorial Foundation hopes to register the nation's estimated 1.6 million servicewomen who have served from the Revolutionary War to the present. Their histories and photographs will be entered in a computer register that will be accessible to the memorial's visitors.

But the memorial still faces a few hurdles, spokeswomen Rae Lee said Friday.

Times photo by MICHAEL DINNEEN

Wilhelmina Daniels is registered for the Women's Veterans Memorial in Washington, D.C.

The foundation, headed by retired Air Force Brig. Gen. Wilma L. Vaught, is trying to raise $15 million toward the memorial's construction and still must win approval of its design from three Washington committees, Lee said.

The memorial's establishing legislation expires in November, but legislation already has been introduced to extend the congressional mandate for two more years, she said.

Women veterans and their families are being asked to contribute $25 toward the registry, but registrations are accepted regardless of ability to pay, Lee said.

The foundation even has a toll-free number — 1-800-222-2294 — for registrations and contributions.

Carolyn Van Laar of Ketchikan is trying to locate Alaska's estimated 4,000 women vets.

Van Laar, herself a World War II vet who served as a Navy WAVE, is one of the memorial's 570 field representatives. She has kept busy lately, contacting television and radio stations to get public service announcements broadcast, getting announcements posted in retirement homes and organizing booths in a Ketchikan mall.

The search for women veterans has not been easy, Van Laar said.

"They're all hiding, but I'm finding them," the Ketchikan lodge owner said.

The Washington Post

en's Memorial: Stunning Surprise

ton, It's a Splendid Addition, but Dollars Are Scarce as Deadline Looms

njamin Forgey
ton Post Staff Writer

in Military Service for ial, like so many others, nd downs. Conceived by a s from New York, it start- nded up short, began high low, originated as a se- als and finished as flat as Washington skyline.

g is a happy surprise: As ehest of the Washington olishment, the design is hrough a splendid one.

ated at the entrance to Ar- l Cemetery, the memorial nstitute a significant addi- s catalogue of special plac-

The if factors are big. After the second of two triumphant design review hearings this week, retired Air Force Brig. Gen. Wilma L. Vaught, president of the memorial foundation, pointed out that with $1 million in hand, the foundation remains $13 million short of the amount needed to build the structure A congressionally mandated deadline looms. Vaught and colleagues have but 15 months to raise the hefty sum.

And despite conceptual approvals by the National Capital Planning Commission on Wednesday and the Commission of Fine Arts on Thursday, the design still faces preservation reviews. The federal Advisory Council on Historic Preservation and Virginia's historic preservation officer have yet to utter their critical judgments.

But the memorial clearly deserves broad support. Symbolically it is a perfect gesture in a proper place at a fitting moment. Women have served this country in the military from the Revolutionary War to the present day, and have done so against major odds and obstacles. But their contributions have gone vastly underrecognized in the national pantheon that is Washington. By prominently honoring all who served, and not just this or that branch in this or that conflict, the memorial finally would correct a long-lasting mistake.

Aesthetically, the design is a gem. Encompassing the neoclassical, semicircular wall at the entrance to the cemetery, the memorial as designed by architects Marion Gail Weiss and Michael Manfredi would positively transform the wall and the space around it.

As it now stands, the 60-year-old retaining wall admirably if grandiloquently performs a single function: It is the end piece of the visual axis linking the Lincoln Memorial across Washington's prettiest bridge to the cemetery and Arlington House (the Custis-Lee Mansion) up above. The beauty and symbolic resonance of this view rarely fail to impress. Connecting north and south of a once-divided republic, the vista embodies the nation's profound collective memories and its high aspirations.

But the role of the granite hemicycle, with its blind niches and its tall central apse, is best appreciated from a distance. Up close, shrouded by haphazard plantings at its base, it is an unvisited and almost unvisitable dead space. Up very close, it is obvi-

Finds the design for the Women in Military Service a Memorial a perfect gesture in a proper place at a ment.

ously a wreck, its heavy stones discolored and chipped, its joints caked with rock-hard calcified salts.

It may be, as Vaught believes, that the initial, competition-winning Weiss-Manfredi design did not receive a fair hearing. Featuring 10 39-foot-tall, translucent, inner-lit glass pylons set in an arc on the terrace atop the hemicycle, it was opposed from the outset by the National Park Service, Arlington Cemetery's caretaker, and the pylons were negotiated out of existence behind closed doors. Whether justified or not, this kind of opposition usually produces unsatisfactory design results, the sorts of compromises we've witnessed in the designs of the memorials to the veterans of the Vietnam and Korean wars.

Not this time. To their everlasting credit, Weiss and Manfredi jettisoned their disappointment and went back to basics, focusing again on the fundamental purposes of the memorial and their own deep responses to the site. The relative merits of the two designs are of course debatable, but the fortunate outcome is not. The revised design is sensitive, internally consistent and subtly poetic. It offers a wonderful opportunity to fix what is broken at this important spot, physically and symbolically.

In fact, it promises great improvement, changing a passive place to an active one, transforming a retaining wall into a handsome building facade, and resurrecting for public enjoyment an exhilarating view of monumental Washington, on the one side, and of the great cemetery on the other.

The crucial decision was to eliminate the pylons altogether, rather than to try some stubby in-between. Instead, the architects created a slightly tilted bank of cast-glass "pages" or "tablets," each inscribed with a fitting quotation from a woman veteran, and running the entire length of the high terrace behind the hemicycle. At the base of the hemicycle will be a paved "Court of Honor" with a centered, circular reflecting pool, framed by formal bosques of trees. Generous openings will be cut in the northern and southern extremities of the wall; behind the wall will be a curved gallery and a sequence of rooms—a 250-seat auditorium, a "register room" containing computerized information on individual veterans, a special exhibition hall and offices.

Water plays a major part. It will flow continuously over the tablets, symbolizing "singular voices," to be gathered as a "chorus of voices" in a sheetlike waterfall at the central apse, and from there to flow in a narrow channel into the reflecting pool, completing the story. Likewise, the role of light is intrinsic. The translucent pages will softly illuminate the interior spaces during the day; the shadowy inscriptions, moving in sundial fashion, will play mysteriously on interior surfaces. At night the subtly lit niches and pages will contribute a fitting new note to the stunning view from across the Potomac.

Critical to the success of the design is the idea of ascension. In a bold move, the architects propose to place stairwells in four of the hemicycle niches. If there is a stumbling block in the historic preservation review process, this is likely to be it—the stairwells are a major change. But the benefits are immense. These passages, visible through glass panels in the gallery, unify the space inside and outside. And they tie the memorial together bottom to top, thereby reclaiming that magnificent, still perspective up to Arlington House and the dynamic view back to the always moving city. Reviewers are strongly urged to consider the stairwells as a completion of the architecture, a brilliant, up-to-date realization of its full potential.

As to the comparative qualities of the two designs, well, something may have been lost in the change. The "candles," as the competition jurors so nicely called the pylons, possessed an undeniable, poetic power. They could have been lit oh-so-softly, like a necklace on the plush darkness of the Arlington hill.

But something definitely was gained. It's not simply that Vaught had the tactical sense to realize the argument would have gone on and on, though that she did. It's that Marion Weiss and Michael Manfredi, by rethinking the entire design, were able to produce a wholly satisfying substitute. The second design is safer than the first, in some particulars more unified, and, in all respects save one, as evocative.

Dept. 560
Washington, D.C. 20042-0560

Women In Military Service For America Memorial

Design Concept

The Women in Military Service for America Memorial will honor all servicewomen, past and present. The data register, in the Memorial's educational center, will tell their stories of service, sacrifice, and achievement in the defense of our country.

The Memorial site, the main gate of Arlington National Cemetery, is defined by an existing hemicycle wall completed in 1932 by the renowned architectural firm of McKim, Meade & White.

A broad and simply landscaped plaza forms the front of the Memorial. The circular reflecting pool in the forecourt marks the beginning of the journey for the visitor. An amphitheater of stone terraces extends to the face of the hemicycle wall and connects to a public terrace above by a series of ascending stairs which pass through arches in the hemicycle wall, framing views into the cemetery and toward the city.

The upper public terrace is marked by an arc of glass "pages" bearing inscriptions by and about the women who have served. Their words are etched upon the individual pages of glass, bearing witness to the history of women's contributions from the American Revolution through Desert Storm. A number of pages will remain unmarked, awaiting the contributions of future generations.

During the day, the sunlight passing through the arc of glass will cast the shadow of the inscriptions onto the walls of the gallery in the Memorial Center behind the hemicycle wall. Like the shadow of a sundial, the shadow of quotes will change with every passing hour, marking the continuous passage of time.

A thin veil of water descending over the inscriptions "carries" their singular voices to a collecting pool behind the central niche; the "voices" pass together through the niche forming a collective voice symbolized by the sound of the falling water. These voices finally come to rest at the reflecting pool, signaling the completion of their story.

HB 178

HOUSE COMMITTEE REPORT

(11)
Date Referred: March 22, 1993 FURTHER REFERRALS:

Date of Committee Action: 3/29/93

The FINANCE Committee considered: HB 178

HOUSE BILL NO. 178 MEDICAID FOR CERTAIN CHILDREN
"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title
[ ] have attached amendments(s)
[✓] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal impact _____ 2 [X] fiscal note(s) H&SS 3/22/93

[ ] zero fiscal note _____ [ ] zero fiscal note(s) _____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*DNP*	*NR*	*AM*
E.P. MacLean					
Ronald D. Larson	X				
Mark Hanley	X				
Terry Martin	X				
Carol R. Farnell Farnell	X				
Ben Gryggendorf	X	/			
Mike Navarre	✓				
Tom Harrington	X				
Richard Foster	?				

Ronald D. Larson E.P. MacLean
CHAIRMAN'S SIGNATURE

FISCAL NOTE

1

Bill Version: HB 178

(H) Publish Date: 3/22/93

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Revision Date:

Dept. Affected: Health and Social Services

Title: "An Act adding children under the age of 21 who are eligible for adoption....to the optional Medicaid

BRU: Purchased Services

Component: Foster Care

Sponsor: HOUSE LABOR & COMMERCE

Requestor:

COMPONENT SERIAL NO. 0252

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	-35.4	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	(35.4)	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(35.4)	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	(35.4)	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: $0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note represents a one-time transfer of funding responsibility from DFYS component #0252 to DMA component #0229. See attached analysis for more.

Prepared by: for Deborah R. Wing, Director (Randall E. Hines, acting)

Phone: 465-3191

Division: Family & Youth Services

Date: 03/03/93

Approved by Commissioner: Theodore A. Mala, MD, MPH

Date: 3/4/93

Agency: Department of Health and Social Services

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information call the Governor's Legislative Office

COMMITTEE COPY

Fiscal Note Analysis continuation
HB 178

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

The Division of Family and Youth Services currently pays a direct monthly subsidy to adoptive parents of hard-to-place children. A hard-to-place child is a child who is not likely to be adopted or to obtain a guardian by reason of physical or mental disability, emotional disturbance, recognized high risk of physical or mental disease, age, membership in a sibling group, racial or ethnic factors, or any combination of these.

The monthly subsidy is considered a reimbursement for costs of supporting hard-to-place children. AS 25.23.190 provides for continuation of the subsidy if necessary to assure placement of a hard-to-place child. The subsidy covers many ongoing maintenance costs including, food, shelter, clothing, school supplies, recreation and transportation costs, counseling or other types of therapy, as well as medical costs.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the fiscal note only considers the coverage available for future adoptions of hard-to-place children with special medical needs.

The experience under the program shows that the number of new subsidy agreements have begun to lessen. For FY91 new agreements for children with special medical needs totaled 46. After FY92 there have been 14 placements that have special medical needs. The projected number of special needs placements and the associated medical cost is anticipated to show only slight growth in future years.

A December 1992 review of DFYS files established a FY 93 base year average medical cost per child of $2,400. The current medical inflation rate of 5.5% is assumed to continue. Medical costs for FY94 are calculated to be 35.4 (14 placements X $2,400 X 1.055 medical inflation rate = $35,448). There will be a one time transfer of funding for medical costs associated with subsidized adoptions.

FISCAL NOTE

No. 2
Bill Version: HB 178
(H) Publish Date: 3/22/93

STATE OF ALASKA
1993 LEGISLATIVE SESSION

Revision Date:
Title: An Act adding children under the age of 21 who are eligible for adoption....to the optional Medicaid
Sponsor: House Labor & Commerce
Requestor:

Dept. Affected: Health and Social Services
BRU: Medial Assistance
Component: Medicaid Non Facility
COMPONENT SERIAL NO. 0229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	35.4	40.2	43.0	48.2	53.2	58.2
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	35.4	40.2	43.0	48.2	53.2	58.2
CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	17.7	20.1	21.5	24.1	26.6	29.1
1003 GF Match	17.7	20.1	21.5	24.1	26.6	29.1
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	35 4	40.2	43.0	48.2	53.2	58.2

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: $0.0

ANALYSIS: (Attach a separate page if necessary)

See attached for more.

Prepared by: Dave W. Williams
Division: Medical Assistance
Phone: 907-465-5826
Date: 3/2/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date: 3/4/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information call the Governor's Legislative Office

COMMITTEE COPY

Fiscal Note Analysis continuation
HB 178

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

The Division of Family and Youth Services currently pays a direct monthly subsidy to adoptive parents of hard-to-place children. A hard-to-place child is a child who is not likely to be adopted or to obtain a guardian by reason of physical or mental disability, emotional disturbance, recognized high risk of physical or mental disease, age, membership in a sibling group, racial or ethnic factors, or any combination of these.

The monthly subsidy is considered a reimbursement for costs of supporting hard-to-place children. AS 25.23.190 provides for continuation of the subsidy if necessary to assure placement of a hard-to-place child. The subsidy covers many ongoing maintenance costs including, food, shelter, clothing, school supplies, recreation and transportation costs, counseling or other types of therapy, as well as medical costs.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the fiscal note only considers the coverage available for future adoptions of hard-to-place children with special medical needs.

The experience under the program shows that the number of new subsidy agreements have begun to lessen. For FY91 new agreements for children with special medical needs totaled 46. After FY92 there have been 14 placements that have special medical needs. The projected number of special needs placements and the associated medical cost is anticipated to show only slight growth in future years.

A December 1992 review of DFYS files established a FY 93 base year average medical cost per child of $2,400. The current medical inflation rate of 5.5% is assumed to continue. Medical costs for FY94 are calculated to be 35.4 (14 placements X $2,400 X 1.055 medical inflation rate = $35,448). There will be a one time transfer of funding for medical costs associated with subsidized adoptions.