ALASKA ASSOCIATION OF SCHOOL ADMINISTRATORS

MEMORANDUM

TO: Representative Thelma Buchholdt, Chairman
House HESS Committee

DATE: March 19, 1979

FROM: Ronald W. Hohman, President
Alaska Association of School Administrators

SUBJECT: Superintendent's Annual Legislative Fly In, Legislative Position Profile

PUBLIC SCHOOL FOUNDATION FORMULA

1. The Alaska Association of School Administrators voted without opposition to support the Finance Committee Substitute for Senate Bill 199 as offered by the Finance Committee on March 15, 1979. CS SB 199 (Finance) 3/15/79

2. The group also expressed concern about power equalization in any new bill before a statewide study could be completed.

3. The A.A.S.A. supports the concept of area differentials with a need for costs to be justified locally.

STUDENT TRANSPORTATION

A.A.S.A. supports 100% funding of D.O.E. approved transportation contracts between local education agencies and bus contractors.

IN LIEU OF LOCAL TAXES

51 school districts

The equity of State funding to school districts must be addressed. Reducing in lieu of local taxes compresses disparity.

Reducing in lieu of local taxes this year destroys forward funding concept.

Support existing in lieu of local taxes 100% with study to promote equity for action for next session.

UNEMPLOYMENT COMPENSATION

Most school classified employees are seasonal workers. As such the positions are advertised and filled on the knowledge that they exist from late August until early June. Allowing for the fringe benefits of this labor group is inconsistent with the certificated staff, and creates an inappropriate expenditure burden on the district and state budgets.

WORKMANS COMPENSATION

Large need for a definition of work related ailments.

TAX CREDITS

The association recognizes the dangers of any efforts which detracts from the principle of "Separation of church and state".

Tax credit for education is viewed as an encroachment upon is principle.

The association believes that the State meets its obligation to provide education through its system of public schools.

The association is opposed to any program of Tax Credit for education.

RECALL OF PUBLIC OFFICIALS

We support the original draft of HB 245 revising state statutes on the recall of public officials. Legislation is needed to:

1) balance the right of recall against a public official's right to defend their position,
2) make all state recall provisions more compatible with one another.

Specifically, any petition for the recall of a public official should clearly show:

1) that a successful recall will result in the removal of that official from office,
2) that only registered voters may sign the petition,
3) the charge against the public official, clearly stated,
4) the response of the public official to the charge,
5) by affidavit that the contents of the petition were not misrepresented by the person circulating it.

Such provisions would still preserve the right of recall. The public official, however, would have a fair opportunity to explain their position prior to the election. Such a law would be more consistent with some of the requirements for initiatives in Alaska and recall provisions in other states.

COMMUNITY SCHOOLS

The current law should at least be extended past July 1, 1979. Current funding levels enable districts to only help minimal programs operating, but at least current funding levels will keep community schools from dying in Alaska. We support the concept that the original community education legislation should be extended and that efforts should continue to fund community schools at the 2% of foundation level.

ACTIVITIES ASSOCIATION

The Activities Association needs to be a seperate and independent agency because:

1. Operating costs of the association will be lower without the control of state public employee rules.
2. Member schools and their school districts control the association. Thus, district control can be utilized in making policy.
3. An appeals committee of a cross section of interested persons can be developed rather than the State School Board acting as the appeals committee.
4. The new bill does clean up the language used in the present regulations.

GENERAL FUND BALANCE

School districts, as well as any monetary based organization, need an operating surplus. There are numerous logical and rationale arguements to support this principle. During recent months much review has been made on the school districts general fund balance surpluses. This review has allowed some to make an interpretation conflicting with successful and prudent management. Space here does not allow for explanations of each case. However, we do hope you will ask for our interpretations and explanations when the issue is timely. Audit reports can best be used as a drunk uses a lamp post, "for support rather than illumination", and that, "what a bikini bathing suit reveals is very suggestive - but what it hides is vital".

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER / POUCH H-01 – JUNEAU 99811

February 9, 1978

Document# House HESS #1

Honorable Charlie Parr
Chairman
HESS Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Chairman Parr:

This letter is in reply to your request for information regarding the Emergency Medical Services (EMS) program dated January 16, 1978.

The majority of the information which you requested can be found in the attachments. The Emergency Medical Services Section, Division of Public Health coordinates a statewide program that is attempting to improve EMS on a regional basis. The Regional Coordinators are responsible for the planning and implementation of improvements in their regions. Broad input is gained from regional and sub-regional EMS Advisory Councils. (Attachment number one indicates the regional boundaries and the name and address of each Regional Coordinator.)

In order to have the most comprehensive reply possible to your hypothetical cases, we asked the appropriate Regional EMS Coordinator to respond to the situations located in that region. Attachment number two is the response from the Southern EMS Region. It addresses situations 1, 2, 6, and 7. Attachment number three addresses those cases from the Interior EMS region, numbers 3 and 4. The Southeastern region response for case number 8 is attachment number four. The Southeast Coordinator added a ninth hypothetical case to your list, a broken femur and ruptured spleen in a logging camp. This was done because it is a significant problem for Southeast Alaska. Attachment number five describes situation number 5.

It is apparent from these responses that the major areas for improvement are the isolated places in Alaska. The current efforts and future plans of the program identify the rural and bush areas of the State as foci of funding.

The specific components of the EMS System that are or will be receiving priority attention include:

1. Training

   Good pre-hospital care has been shown in other state EMS programs to significantly impact on death and disability. The pre-hospital providers, including volunteer ambulance personnel and community health aides, have shown an unprecedented degree of enthusiasm for more training. This is proving to be a monumental task because the skills being taught need to be practiced in order to maintain proficency. In the sparsely populated areas, virtually every place outside of Fairbanks and Anchorage, there is simply not enough "business" to maintain the skills. Consequently, refresher training is extremely important on at least an annual basis, with monthly one-day seminars to supplement.

2. Communications

   In communications, the most serious shortcoming is citizen access. The second most important problem is ambulance to hospital communications. This fiscal year the Governor's Office of Telecommunications, using funds from EMS and the Criminal Justice Planning Agency, has contracted with a consultant to develop a statewide public safety communications plan. The consultant has some innovative ideas for improving access with greater use of CB channel 9.

3. Transportation

   By far and away the greatest problem in transportation is providing medically adequate air transport. Two distinct phases need to be dealt with: (a) village evacuations, and (b) hospital to hospital transfer of the critically ill. This is a very complex area and an in-depth study is needed before any solution can be reached. The other transportation problem is placing and replacing ground ambulances on the isolated highway sections.

4. Recordkeeping

   In order to realistically make decisions about resource allocation for a large program such as this accurate data is needed about the types of patients that are being encountered, where, and what is happening to them. A coordinated recordkeeping system is needed to provide that information.

As mentioned before, the program is impacting these problems on a regional basis. In the three years of the program's existence three regions have been funded: Southeastern, Nana, and Interior. The Interior program will probably be defunded during the next fiscal year due to the

federal funding strategy which places the type of planning grant they will be applying for as the lowest priority. Southeastern and Nana will probably be approved for second-year implementation grants. And, given adequate funding, the Southcentral part of the State (includes Southern, Bristol Bay, Bering Straits and Yukon Kuskokwim Regions) will undertake an intensive planning effort in preparation for implementation in the following year. For more detailed information on the history of the program, I've included a brief State program overview and a description of the federal program as attachments 6 and 7.

I hope this information is adequate. The Department welcomes the HESS Committee's interest in the EMS program and will be prepared for your planned hearings.

Sincerely yours,

Helen D. Beirne

Helen D. Beirne
Commissioner

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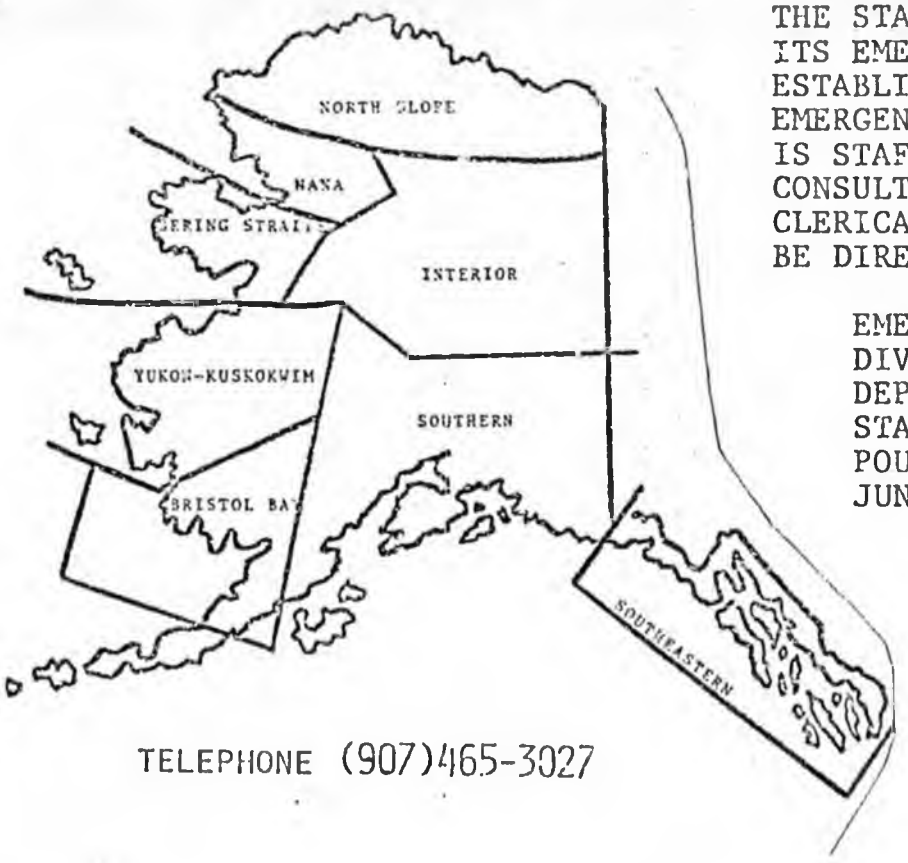
ALASKA EMERGENCY MEDICAL SERVICES



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

EMERGENCY MEDICAL SERVICES SECTION
DIVISION OF PUBLIC HEALTH
DEPT. OF HEALTH & SOCIAL SERVICES
STATE OF ALASKA
POUCH H-06C
JUNEAU, ALASKA 99811

TELEPHONE (907)465-3027

STAFF:

THOMAS D. SCOTT
COORDINATOR

PEGGY A. ZUFELT
ASSOCIATE COORDINATOR

LYNNE QUIST
PROGRAM CONSULTANT

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

REGIONAL COORDINATORS & CONTRACTORS

LAUREL PARKER
SOUTHEASTERN ALASKA EMS COUNCIL
P.O. BOX 2170
SITKA, ALASKA 99835 (747-8005)

BOB ALOYSIUS
YUKON KUSKOKWIM HEALTH CORP.
P.O. BOX 528
BETHEL, ALASKA 99559 (543-2506)

CONNIE RYAN
BRISTOL BAY AREA HEALTH CORP.
P.O. BOX 233
DILLINGHAM, ALASKA 99576 (842-5266)

FRAN McAFEE
NORTON SOUND HEALTH CORP.
P.O. BOX 966
NOME, ALASKA 99762 (443-2261)

SALLY JACOBY
NORTH SLOPE BOROUGH
P.O. BOX 69
BARROW, ALASKA 99723 (852-2611)

JEFF SMITH
MAUNELUK ASSOCIATION
P.O. BOX 256
KOTZEBUE, ALASKA 99752 (442-3311)

RICHARD PAULEY
SOUTHERN REGION EMS COUNCIL
1135 WEST 8TH - SUITE #7
ANCHORAGE, ALASKA 99501 (274-3651)

JOE MARZUCCO
FAIRBANKS PHYSICIAN SERVICES
711 GAFFNEY ROAD - SUITE #202
FAIRBANKS, ALASKA 99701 (456-3978)

Transportation to more definitive treatment is normally provided by the local commercial air carrier. Agreements have been established, but there are times when aircraft are not available. Commercial air ambulance services in Anchorage are then contacted, although the Air Force Air Rescue Service must sometimes be used. Weather, such as high winds or clouds in the pass, greatly restrict inter-hospital transfers at times.

State, local, and commercial agencies are working closely to improve EMS activities. There is little federal activity in the area.

Situation #2 - Kodiak

A commercial fisherman problem would be reported on marine radio. The Coast Guard Rescue Center on Kodiak monitors this frequency and would launch a helicopter to bring in the sick fisherman. Of course, weather would be a limiting factor. The Coast Guard personnel are well trained but could not provide any surgical care for an appendicitis.

The Kodiak Hospital is well equipped and could preform this type of surgical procedure. Nursing staff is on full time and doctors are on call. There is a commercial activity in Kodiak called Alaska Emergency Medical Services, which offers medical equipment sets for fishing ships. They also have the capability of physician communication with ships, if necessary.

If more extensive treatment is required, the patient would be transported by air to Anchorage. The weather at Kodiak often restricts air evacuation, and the Mayor of Kodiak recently had to wait three days to be transported for cardiac problems. Transport to Anchorage is a frequent occurrence, but to the best of our knowledge, formal written transfer agreements are not prepared.

Certain agreements between Coast Guard and Kodiak activities have been developed. Federal, State, local, and commercial agencies are working together to improve the EMS system.

Situation #6 - Denali Highway

Communications along the Denali Highway are extremely poor. An emergency problem would be taken by messenger to Cantwell where the nearest phones are available. The Alaska State Troopers would receive the notification. There is a single EMT at Cantwell who has some medical equipment and tries to respond to local emergencies. The nearest ambulance service is at Healy, 40 miles to the north of Cantwell. This service is in the Interior Region and our knowledge is limited, but we believe they are well equipped and can provide certain Advanced Life Support techniques. There is also a Physician Assistant in Healy, while the closest doctors are in Fairbanks 149 miles north, or Wasilla 170 miles south. Obviously, communication with a doctor would be practically impossible. If State Trooper radios are available, they could operate through their repeater system and achieve a phone patch to the physician in Fairbanks. This would be a complex procedure and would "tie-up" the State Trooper system.

If the accident occurred a substantial distance off the highway, the evacuation would be considerably more difficult. Back country injuries would normally require a helicopter. This could be obtained from the Air Force, but again, communications would hinder the response time. If AF helicopters were used, the patient would be evacuated to Anchorage where the State's most sophisticated medical resources are available. Air Force pararescue personnel are well trained and equipped, and should be able to stabilize the patient while transporting. Ground transport would deliver the patient to Fairbanks, which also has a well equipped hospital.

Weather could delay transportation by ground or air. This hypothetical case takes place in a very lightly populated area on the border between two EMS regions. Little if any agreement exists.

Situation #7 - Sand Point

This patient would be taken directly to the local Baptist Mission Clinic where there is a registered nurse and some equipment. With only four miles of roads, there is little requirement for an ambulance, and transportation is provided by AST carryall or other available private vehicles. Most homes have telephones and almost three-quarters of the homes also have CB radios. Weather would have little effect on communications, but could complicate ground transportation.

The limited capability of the clinic, and seriousness of the patient, would require evacuation to the Thermal Unit at Providence Hospital in Anchorage. There are several small planes available at Sand Point which could be used to evacuate to Anchorage, or the patient could be taken to Cold Bay where the runway is large enough to receive jet ambulances. If a small private plane is utilized, treatment enroute would be minimal unless the nurse accompanied the patient. The availability of air transport equipment would also limit treatment. If a jet ambulance is used, treatment would be better since the aircraft would have nursing personnel and advanced medical equipment. Either plane could talk to a doctor through an FAA patch, which would take time to set up. Weather could greatly restrict air transportation.

Due to funding limitations and the huge area of the Aleutians, we have done very little to improve this area. Working agreements are unknown.

All of these cases demonstrate the lack of EMS facilities and the problems to be solved, before our citizens can depend on a truely effective EMS system. Great advances have been made, but even in the more densely populated areas, there are serious deficiencies.

Improvement of the system will require vast expenditures of money and the dedication of many persons. Given the premise that funds and personnel are available, I would envision a future EMS to include the following improvements.

MANPOWER/TRAINING

Without well trained manpower, no system will ever be adequate. We must continue to provide training for our volunteers and develop a professional body of personnel to provide Advanced Life Support (ALS) in remote areas. Skill decay will be a serious problem, which could be solved by rotating paramedics through the Anchorage EMS where there are significant numbers of responses. These paramedics could serve one week in a remote area, one week in Anchorage, and one week off. Paramedics should also receive training on air evacuation techniques and be available for air transports.

COMMUNICATIONS

The communication system must be improved, but this will be expensive. Initial access to the system should include the use of the nation-wide 9-1-1 emergency number in all telephone systems. Public safety agencies should monitor CB channel 9 to respond quickly to emergencies. Alaska has an unusually large number of CB radios and we should encourage their use. The current VHF system is already becoming crowded and in time will become overloaded. We should establish a UHF system with eight channels available for emergency traffic. Dispatch, ambulance/hospital, and hospital/hospital communications must be separated. A series of radio relay sites similar to the AST system must be established to insure communication along the highway system. Similar radio service should be available through a satellite relay system to provide communication with remote areas. If such a reliable communications system is developed, cardiac telemetry should be considered for use by advanced trained volunteer ambulance services and physician extenders in remote areas. Cardiac telemetry would also be useful between physicians in the smaller hospitals and specialists at the major hospitals. Of course, this could be accomplished over current land lines at considerably less cost.

TRANSPORTATION

Rapid evacuation to suitable care facilities is crucial to the patient. Current ambulance services sometimes take hours to transport a patient to health care facilities. Additional ambulance services must be established to provide 30 minute response time throughout the highway system. This will probably require the use of professional crews, since numerous areas do not have a population base large enough to establish volunteer crews. The ground ambulance service must be supported by a substantial air evacuation fleet. Both helicopters and fix wing aircraft should be located so that they could provide air evacuation from remote areas. Fast jet aircraft capable of operating on short runways should be available to transport from distant areas. All of these aircraft must be fully equipped and staffed by competent technicians.

FACILITIES

Foul weather often makes any type of transportation impossible. Health facilities should be upgraded to provide stabilization and care for at least three days. Even on the highway system, there are areas where it is 200 miles between health care facilities.

CRITICAL CARE UNITS

Most of Alaska is at least 1,500 miles from any other critical care facilities. Anchorage should develop units capable of caring for any of the critical situations. As our population continues to grow, the need for these units will expand.

OTHER

The other components of the EMS system will need to be addressed. This will require sufficient staffing of the State and Regional EMS Offices.

We are discussing a multimillion dollar program for the State, but I firmly believe this is what is necessary to assure our residents of adequate emergency care.

Sincerely,

Richard E. Pauley,
Executive Administrator

REP/sk

EMERGENCY MEDICAL SERVICES COUNCIL
INTERIOR REGION

c/o Dr. James Borden
Medical & Dental Arts Bldg.
1919 Lathrop Street

c/o Tanana Chiefs Health Authority
Doyon Building
First & Hall Street

FAIRBANKS, ALASKA 99701

February 1, 1978

Mr. Tom Scott, Coordinator
Emergency Medical Services
Department of Health & Social Services
Pouch H-06C
Juneau, Alaska 99811

Dear Tom:

This letter is in response to Charlie Parr's request to gather data on the Emergency Medical systems present and future capabilities for responding to critically injured or ill patients. The Interior Region's response is to Mr. Parr's hypothetical case No. 3 and 4.

An elderly person in Allakaket suffers a heart attack.

Question: How is the emergency reported and to whom?

Answer: Allakaket is a small community in the northwest interior region. It has no internal system of telephones. When an emergency occurs, either in the town or in the bush, the village health aide or alternate is contacted by messenger in person. In town, of course, the messenger would simply run to the village health aide's home, however, from the bush, they would probably either get the village health aide to come to the scene of the accident by snow-go, or if the patient was immediately transportable, ship the patient in to the village health aide.

Question: Are the means of communication adequate?

Answer: In the case of this community, the means of communications are quite adequate. The only addition to this service could be the use of citizen's band radios that could be mounted on the snow-gos with a bay station in the village health aide's home.

Question: What is the anticipated date of upgrading?

Answer: There is no anticipated upgrading of the system in this community.

Question: Would bad weather reduce or nullify the adequacy of communications?

Answer: Only in the ability for the messenger to find his way to the village health aide's office.

Question: Where is the injured or sick person taken and by what means?

Answer: The injured or sick person is taken to the village health aide's home or the alternate village health aide's home.

Question: Are the means of transportation adequate?

Answer: For a community this small, the injured person is transported by carrying through the village or by snow-go from the bush. Adequacy of transportation is difficult to assess. This community is not large enough to make an ambulance useful or the upkeep justified.

Question: What is the anticipated date of upgrading the transportation system?

Answer: There is no anticipated upgrading of this system.

Question: Would bad weather reduce or nullify the adequacy of transportation?

Answer: The only problem with weather in this case would be the amount of time that an injured person could survive in sub-zero weather while being transported by litter or snow-go.

Question: If appropriate, can emergency medical care be given before or during transportation?

Answer: If the village health aide is not the initial responder, there is probably no ability to give other than basic first aid before transportation. Once the patient has been transported to the village health aide's clinic, the village health aide can give adequate advanced first aid care. This falls short of what is typically considered paramedical care.

Question: Are qualified personnel available?

Answer: The only qualified personnel in this village is the village health aide.

Question: Can the person giving the emergency medical care communicate with a physician while giving it?

Answer: Yes, by satellite to Tanana Hospital.

Question: If equipment (respirator, monitoring devices) is needed, is it available?

Answer: None of this equipment is available because this does not fall under the realm of the village health aide's training program.

Question: If not, what is the anticipated date of availability?

Answer: This is a very difficult question. Alaska Federation of Natives is now exploring the possibility of producing its own physician assistant training program to update medical services in the bush. However, there is a heated debate on the problem of skill decay rate in the field, i.e., can an individual trained to a high level of medical care be expected to retain his ability to do those procedures with an extremely low case load. Decay rate of medical skills in an underpopulated area is exceedingly high.

Question: Does the facility to which the injured or sick person is taken have qualified personnel or necessary equipment to give the required treatment?

Answer: The facility to which a patient would be taken from Allakaket would either be Tanana or Fairbanks. If the patient is taken to Tanana, most assuredly if this individual has a heart attack, his initial care and stabilization could be managed. They have doctors, a defibrillator and monitoring devices for electrocardiograph tracings. If the patient is to die ultimately, there would be no difference in outcome if the patient were sent to Tanana or Fairbanks for immediate care. More extensive follow-up care can be managed by sending the patient from Tanana to Fairbanks Memorial Hospital. In the renovations of the Fairbanks Memorial Hospital, we are anticipating the use of the Schwongantz Pulmonary Artery Wedge Pressure Monitoring devices. This would be an exceeding development in the management of failure related to a myocardial infarction.

Question: If not, have provisions been made for subsequent transfer to a facility which has capabilities?

Answer: Transfer agreements from Allakaket to Tanana and Fairbanks and the Anchorage Native Health Center have been worked out. These agreements are not purely medical. They primarily exist for financial reasons between the private sector and Alaska Native Health Service.

Question: Have all necessary agreements been made between agencies involved (federal, state, community, local, private)?

Answer: See previous question.

A child in Fairbanks suffers burns over most of the body.

Question: How is the emergency reported and to whom?

Answer: In the Fairbanks metropolitan area, the prefixes 452 and 456 are covered with the 911 emergency access code. Other prefixes in the area have their own emergency telephone number which dial directly to an emergency dispatcher.

Question: Are the means of communication adequate?

Answer: Yes.

Question: Would bad weather reduce or nullify adequacy of communication?

Answer: No.

Question: Where is the injured or sick person taken and by what means?

Answer: The sick person would be taken to Fairbanks Memorial Hospital Emergency Department. The patient would primarily be taken by ambulance and in the hypothetical case discussed above would be taken in the mobile intensive care unit ambulance.

Question: Are the means of transportation adequate?

Answer: Yes.

Question: Would bad weather reduce or nullify adequacy of transportation?

Answer: It would probably reduce the response time somewhat, however, bad weather does not negate the use of these emergency transportation vehicles.

Question: If appropriate, can emergency medical care be given before or during transportation?

Answer: Yes. Qualified EMT's and paramedics are available around the clock through the Fairbanks Fire Department. On a run such as the one described above, a paramedic would always be in charge.

Question: Can the person giving emergency medical care communicate with a physician while giving it?

Answer: Yes. Adequate means of communication through the ambulance to the hospital are tested and proven. Means of communication to individual physician's offices over special communication nets are available and have been used, however, are not used very frequently.

Question: If equipment (respirator, monitoring devices) is needed, is it available?

Answer: Yes.

Question: If not, what is the anticipated date of availability?

Answer: The mobile intensive care ambulance is well equipped and the only anticipated upgrading would be with change in types and methods of treating patients.

Question: Does the facility to which the injured or sick person is taken have qualified personnel or necessary equipment to give the required treatment?

Answer: Yes. Fairbanks Memorial Hospital has profiled itself at Level 3 for burn care. It has a qualified plastic surgeon who is in charge of the burn team. It has qualified nursing personnel for burn management also. It now has rooms which are available to be used for isolation for burn victims, however, after the renovations which are underway are finished, there will be a specific burn unit available. All necessary equipment is available for the treatment of this burn with the exception of hemodialysis. In the place of this, peritineal dialysis is used when necessary.

Question: Have provisions been made for subsequent transfer to a facility which has the capabilities?

Answer: No formal transfer agreements exist at this time, however, transfers for burns have occurred in the past. Informal transfer agreements do exist.

Question: Have all necessary agreements been made between agencies involved (federal, state, community, local, private)?

Answer: No.

Sincerely,

Joseph Marzucco, PA-C
EMS Coordinator

JM/aw

#4

Southeast Region Emergency Medical Services Council

GENERAL DELIVERY
SITKA, ALASKA 99835

TELEPHONE 747-8005

February 5, 1978

Tom Scott, Acting Coordinator
State Office of Emergency Medical
Services
Pouch H
Juneau, Alaska 99801

Dear Tom:

Enclosed is the description of the current and future system response to hypothetical case #8 as requested by Commissioner Bierne. Since this case represents one for which we are already fairly well prepared and for which major changes are not planned, I have taken the liberty of adding a ninth hypothetical case. The area I have chosen, logging camp emergencies, is one in which changes are sorely needed and on which EMS will have a significant impact.

Yours Truly,

Laurel

Laurel Parker
Executive Director

#8. A premature baby, (term 27 weeks) apparently suffering from congenital malformation is born in Juneau.

Present: While Bartlett Memorial medical staff perform an umbilical catheritization and take other measures to stabilize the infant, plans are made for transfer to another facility, Children's Orthopedic in Seattle or sometimes to Providence Hospital in Anchorage. This depends partly upon Alaska Airline's schedules and sometimes upon the parent's preference. The infant is transferred in a special infant transport incubator with oxygen, provided through the State Division of Public Health, and is accompanied en route by nurses and physicians as his condition requires.

Future: It is unlikely that Bartlett would aim to treat such a premature infant with congenital malformation in the foreseeable future. Cost for maintenance of an infant intensive care unit and availability of a perinatologist would not be justified by the incidence of cases. Transfer would therefore continue to be the general protocol, and changes in the above description would be limited to improved stabilization capability and to strengthened relationships with frequently used medical centers.

Efforts to improve stabilization capabilities include Bartlett's plans to procure an infant heart monitor; and by EMS, the provision of nursing in-service modules including one in neonatal emergencies, and physician exchange programs with frequently used medical centers such as Children's Orthopedic. This exchange program will also serve to strengthen relationships with referral centers along with provision to all Southeast physicians of the treatment protocols used by those centers. Such information will allow physicians to judge appropriate treatment techniques prior to transfer in accordance with the treatment the infant will be receiving after transfer. With the assistance of the physicians represented on our Board, we hope to publish transfer guidelines describing critical care services available within reasonable transportation time from our hospitals, specialists to be contacted, and ideal pre-transfer treatment protocols to be provided to all Southeast's physicians as an informational service.

At 10pm, at a small logging camp in Southeast Alaska, a man riding on a motorbike crashes into a log lying across the road, ruptures his spleen, and breaks his leg.

Since there is nobody with any more than very basic first aid training in camp, it is essential that the man be transported for medical help immediately. Although his broken leg is obvious, responders do not have the skills to assess that he has internal injuries to his abdomen. Since the fracture is to his femur, a traction splint should be applied but such a splint is not available anyplace in camp. OSHA requires that certain first aid supplies be kept in camp, but these requirements are extremely minimal and resupply throughout the season is uncertain. Traction splints are not included.

One logger tries to secure a piece of board to the leg, but feels extremely uneasy about this as he has never tried it before. Since a fractured femur causes the bone ends to push against one another, the man is in intense pain which will not be alleviated without traction. His internal bleeding, meanwhile, is causing him to go into progressively worsening shock, and his blood pressure falls dangerously. There is no blood pressure cuff in camp, so those trying to help are not aware of this drop.

While this is going on, two other loggers are trying to reach help over the radio. During the day, communication is possible through the Logger's Association radio system, but at night this is not monitored. It becomes apparent that communication is not possible and other measures must be taken.

Although the night is rainy and windy, these two men decide to risk taking a boat to a nearby community where there is a single side band base station with the Coast Guard frequency. As usual, atmospheric disturbance makes transmission very poor, but they are able to make contact. Meanwhile, the victim in the camp has become unconscious but this is not known to the two callers. When the Coast Guard operator asks what is the patient's condition, they respond that his leg is broken. They are not able to provide vital signs or other indicators which would have alerted the operator that the situation was critical.

Now the Coast Guard is in a quandary. If the man has an uncomplicated fracture, he will be safe until morning. Flying in such inclement weather, however, would be extremely risky to both crew and victim. Knowing, however, that when loggers get hurt they are generally very badly hurt and that they tend to understate problems, it is decided that a medical evacuation will be performed. If the call were coming from a village, the decision may have been otherwise as these requests tend to be overstated, and the Coast Guard pilots have performed life-threatening evacuations to find the "victim" waiting with baggage packed and an appointment for a routine physical.

When the Coast Guard chopper reaches the camp, they can find nowhere to land. They need a cleared area about 120' long, and after 30 minutes of searching, finally find a possible, though far from ideal, landing area almost half a mile away. Until they land, they cannot be sure that the surface is safe for their 22,050 lb. machine.

By the time the victim is loaded onto the helicopter, he is, needless to say, in extremely critical condition. (In reality, he probably would have died, but this would make too depressing a story). The corpsman on board removes the soggy blanket covering the victim and replaces it with a dry one. He has so much to do in trying to deal with the man's condition that he wishes he had additional medically trained men on board.

Once the plane finally lands in town, the victim is handed over to the ambulance service, who in turn, bring him to the hospital emergency room. By this time, however, information on the patient's condition has passed through several hands, and since the man is unconscious, the physician finds out nothing about the cause of injury. He wishes that someone would do something about the logging camps. If he weren't so busy dealing with cases such as this, he would like to do something himself.

EMS Impact On This System:

1. Lack of trained manpower in camp: We are providing logging camps with an intensive 40 hour Emergency Trauma Training course which covers not only stabilization techniques, but physical assessment. The man's leg would have been properly splinted, a pressure bandage would have been placed over his abdomen to retard internal bleeding, he would have been treated for shock, and the Coast Guard would have received more definitive medical information (history, vital signs, etc.).

2. Lack of equipment: We have put together trauma kits which contain the equipment essential to stabilization and for which training is given in the above mentioned course. These kits, specially designed for logging camps, fit on a yarder and are watertight. The blanket, therefore, would not have been soggy.

3. Communication: We are investigating two means whereby radio coverage could be extended to 24 hours a day, using the existing VHF system. One alternative would be to install a base station with the logger's frequency at the Coast Guard base which would be used after the Logger's Association receiving station closed in the evening and would be restricted to emergency use. Another alternative is to install a remote receiver at the local fire department/rescue service where calls are monitored already at all times. At night, calls would be automatically relayed here and again restricted to emergencies. Cost for either alternative would be surprisingly low.

4. Heliports: In order to land an HH3F helicopter, an area about 120' long needs to be cleared and kept free from obstruction. We have supplied information on landing requirements for these choppers to the State Division of Aviation with a prioritized list of communities and camps where needed for inclusion in their transportation plan.

5. Pre-hospital forms: We have designed, and had printed, forms to be used by first responders in out-lying communities. The forms include simple checklists which provide information on patient condition and action taken which medical providers need to know, and which serve as reminders to the responder. A carbon copy would accompany the patient through transfer and be provided to the physician upon ER arrival.

6. Training for Coast Guard Crew: We are presently giving an EMT course for

Coast Guard personnel at Air Station Sitka, and plan another. A PHS physician has agreed to write standing orders for those Coast Guard crew members who we will train in IV therapy.

Situation #5 A blue baby is born in Nome.

A so called "blue baby" born in the Norton Sound Regional Hospital in Nome would set in motion a pre-established system of life support and transportation to the Newborn Special Care Nursery at Providence Hospital. The attending physician would immediately follow the treatment protocols outlined in the High Risk Infant Transport Manual written by the Alaska Newborn Project and published by the State EMS Office in 1976. Simultaneously, a call would be placed via telephone to the head nurse of the Special Care Nursery. The head nurse would be prepared to give immediate advice on further care, notify the pediatrician on call and notify the transport coordinator who is jointly funded by the Indian Health Service and State Maternal and Child Health program.

The transport coordinator would assemble the transport team, arrange for the transfer to the airport of the transport incubator and team, and arrange the air transportation. Depending on how critical a factor time is, transport will be via either a commercial carrier such as Wien or Great Northern, or by charter jet, usually Troy air. The only weather that will affect the transport will be below IFR minimums at either Anchorage or Nome.

While the transport arrangements are being made, the pediatrician will be advising the Nome physician on proper stabilization techniques and gather patient information so that all appropriate resources will be ready to care for the infant upon its arrival at Providence.

The transport team will consist of at least a nurse from the special care nursey and in some instances the on-call pediatrician. The Anchorage Paramedics will transport the transport incubator and the team to the airport. Upon arrival in Nome one of the two commercial ambulances in Nome will pick up the team and take them to the hospital. The team will prepare the infant for transport and do some teaching of the local physician and nurses in the process

During the return flight the transport incubator will be positioned in the plane and draw power from the plane's power systems according to directions in The Transport Manual. There are directions for each type of aircraft normally used. The plane will be met by Anchorage Paramedics who will provide assistance as necessary. Upon arrival in the Special Care Nursery definitive treatment will begin, in this case blood transfusion.

Because of the Alaska Newborn Project there is a very well organized system of emergency care for newborns in distress. It is actually a model for what needs to be done in other areas of critical care. It is a truly cooperative effort of the State Division of Public Health, the Indian Health Service and the private medical community.

The major discrepancy that now exists is the lack of guaranteed availability of an adequately equipped jet for transport. The other area of need is training for rural hospital personnel in the care of the infant while awaiting the transport team.

This report was prepared by State Staff due to illness of Fran McAfee, the Regional Coordinator in Nome.

EMERGENCY MEDICAL SERVICES
PROGRAM OVERVIEW

January 1978

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

1. Insure that an ambulance can be easily summoned in need. The primary focus here is to develop a 911 emergency phone number in every community in the State for the dispatch of all public safety elements.

2. Insure that once a call is received an ambulance can be quickly dispatched, and that provisions have been made for backup service if the primary unit is on a call. This is usually accomplished by means of a regional dispatch center and signed mutual aid agreements among operators.

3. Under medical direction insure that the victim's condition is stabilized at the scene and maintained during transport. This is accomplished by training all ambulance personnel to the Emergency Medical Technician (EMT) level and insuring that their vehicle is adequately equipped with medical supplies, rescue equipment, and 2-way voice communications with a hospital. In the rural communities the EMT is being given advanced training in how to start intravenous (IV) fluids for the control of shock due to blood loss. In these cases direct radio contact with a physician for medical control is the ideal. In larger communities the EMT-Paramedic is the preferred training level because they can treat heart attack victims with electric shock and controlled drugs.

4. Insure that the local medical facilities are adequately equipped and staffed with personnel trained to further stabilize the patient and when necessary, transfer to the most appropriate critical care facility, be it to a hospital, another institution in the state, or outside the state. This is achieved by categorizing facilities according to their ability to handle different types and severities of injuries, i.e. Homer Hospital can care for the moderately burned patient, and the burn center at Harborview Hospital in Seattle is the nearest facility to take care of major burns. The facilities are identified and a list of protocols are in place so that, hypothetically, a patient with a major burn in Homer would be treated according to burn care procedures developed by specialists and then transferred directly to Seattle (because the Anchorage hospital can only care for moderate burns). This hypothetical protocol would be accepted previously by each of the physicians involved as the best procedure to follow.

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

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

1. Ongoing basic training programs to insure an adequate supply of personnel, as well as refresher training programs to maintain high quality service delivery. Refresher and Continuing Education programs are especially important in Alaska. This is because our widely scattered population does not have enough serious accidents in any one locality for the providers to maintain high levels of skill. All of our providers, physicians, nurses and emergency medical technicians, need formal continuing education in the care of the critically ill and injured.

2. Public Information and Education programs are needed for two purposes. The first is to insure that people know how to call for help in the area where they live or are traveling. The second purpose is to provide information about what people can do for themselves and others when they are in need, e.g. first aid courses.

3. An important element in support is a good record-keeping and evaluation system. The systems approach requires that each element of the system is continually being evaluated as to its effectiveness in order to suggest areas for improvement. An example is evaluating EMT performance by analyzing ambulance run reports. EMT's are trained to follow certain protocols for certain types of injuries. By checking their performance areas of need for refresher training can be more easily identified. A computerized system that does this has been in operation for several years in western Pennsylvania with great success and low cost.

4. Finally, coordination efforts of the various state (Public Safety, Disaster Office, Community and Regional Affairs, Education, National Guard) and federal (Park Service, BLM, Coast Guard, Military branches, Indian Health Service) agencies that are directly involved in EMS activities in Alaska is vitally important to efficient utilization of resources.

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

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

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

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

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

1971 EMS planner established in Office of Comprehensive Planning

Apr. 1974 Department of Health and Social Services applied for 1202 grant for planning;
AFN applied for 1202 grant for planning;
Mauneluk Association applied for 1204 grant for Search and Rescue.
All were not accepted based on lack of comprehensiveness. However, DHEW offered assistance for future grant application development.

Jan. 1975 Dr. David Boyd, National Director of EMS, and several other nationally recognized speakers attended meeting in Anchorage with interested groups.

Apr. 1975 Department of Health & Social Services submitted a 1203 grant. Tanana Chiefs Conference submitted a 1203 grant for Interior Region. Region X suggested that the applications be combined with State acting as lead agency for regional programs. Thus, funds for state office and EMT training were made available.

Jul. 1975 Department of Health & Social Services received grant ($450,000) to establish state office, statewide EMT training, provide implementation grant (first year 1203) to Tanana Chiefs Conference ($220,000), and provide salaries and travel for EMS coordinators in the other 7 EMS regions.

Nov. 1975 Legislative Budget and Audit approved revised program, and contracts were let. With three positions, Office of Planning & Research was charged with administering programs.

Jan. 1976 Charles Ramage was hired as Associate Coordinator. State submitted grant request for second year funding of Tanana Chiefs Conference Interior program, and first year funding of 1203 programs in six other regions. Ad hoc Advisory Council met.

Jul. 1976 State received a grant of $725,000 which provided funds for State office, EMT training, Tanana Chiefs Conference, and regional coordinator. Funds for the additional 1203 programs were not available due to the failure of Congress to extend the 1973 law. Charles Ramage became Coordinator,

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

Aug. 1976 Congress passed $1.35 million appropriation for FY77 to Alaska Area Native Health Service for EMS implementation in the native health corporation regions.

Nov. 1976 Tanana Chiefs Conference turned Interior program back to State.

Jan. 1977 Using AANHS EMS money, corporations covered half of the coordinators' salaries in six regions. Northern Region Office, Divison of Public Health began administering Interior program for an interim period.

Apr. 1977 State submitted grant application for first year 1203 grants for seven regions and 1202 grant for Advanced Life Support planning for the Interior region.
Charles Ramage resigned as Coordinator. Thomas Scott appointed Acting Coordinator. Lynne Quist hired as Health Planner - temporary status.

May 1977 Legislature passed HB407 establishing the Department as the state agency responsible for developing emergency medical services in the state and establishing an eleven member advisory council consisting of seven providers and four consumers.

Jun. 1977 Program transferred from Office of Planning and Research to Division of Public Health

Jul. 1977 State was awarded $698,000 to support state office, EMT training and first year 1203 grants for Southeast ($175,000) and Maneluk Association ($68,000). The Interior program was extented one year in order to complete implementation of Basic Life Support using unexpended funds from FY77.

Aug. 1977 Dr. William Mills of Anchorage accepted position of EMS Medical Director.

Nov. 1977 State EMS Symposium drew over 150 participants. Mrs. Hammond announced Governor's appointments to new Advisory Council. Symposium provided stronger direction to program.

Accomplishments

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

- 90% of all ambulance personnel are trained to at least the basic Emergency Medical Technician level. Three years ago it was less than 30%.

- A need for greater emphasis on emergency care skills has been recognized for the Community Health Aides. Thus, their training and equipment have been improved substantially.

- MAT-SU Borough has adopted Borough-wide ambulance powers, established new services at Talkeetna and Willow, purchased new vehicles, and has increased cooperation with services in Anchorage.

- Kenai Borough is considering following same direction as MAT-SU.

- An advanced EMT course aimed at the rural EMT has been developed and is in use statewide. This course teaches the administration of IV fluid therapy for control of shock.

- A substantial video tape library has been established by the Alaska Hospital Research and Education Foundation of continuing education materials in emergency and critical care medicine for circulation among all hospitals in the state.

- An Artic First Aid Film strip and accompanying printed materials have been developed. This resulted from the need to develope a first aid training medium that Alaska Natives can relate to. American Red Cross materials are based on verbal learning skills whereas Alaska Natives are more visually oriented.

- EMS subsidized the Alaska Emergency Department Nurses Association for their last two annual clinical symposia.

- EMS assisted the U of A school of Nursing in its successful efforts to develop and have funded a 40 hour emergency care course that will be taught in almost every rural hospital in the State.

- EMS has started the installation of an areawide communications system for the Interior road system. When completed all ambulances, including military vehicles, on the Interior Region highway system will have two way voice communication with Fairbanks Memorial Hospital.

- We are jointly funding with the Criminal Justice Planning Agency through the Governor's Office of Telecommunications a Communication Consultant who is developing a statewide Public Safety Communications Plan that will be area specific.

Problem Areas

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

(a) The sheer magnitude of the program requires very careful understanding of the problems and the solutions, and requires individuals who can relate to volunteer EMT's as well as to physicians.

(b) The vast majority of people think EMS is pre-hospital and that the only thing needed is the upgrading of training and equipment. The total systems concept and the team approach is difficult to understand, especially because traditionally there has been little if any communication or involvement between pre-hospital providers and in-hospital providers. Another problem is communication between rural physicians and specialists in the major centers regarding appropriate care for the critically injured.

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

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

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

Finally, there is a lack of data for planning and evaluation. The EMS program is one federal program that realizes the importance of systematically evaluating how the system is functioning as well as planning the expenditure of funds based on demonstrated need. The development of a coordinated patient record keeping system is one of the mandated 15 components that has received little more than lip service. Planning is hampered by this lack of data.

Prospects

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

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

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

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

Emergency Medical Services Systems Development: A National Initiative

DAVID R. BOYD

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

INTRODUCTION

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

It is now quite apparent that significant improvements in emergency and critical care of all types of emergency patients can be realized if a sound integration of all of the essential components of an EMS system are logically structured and directed towards delivering ideal care to "real" *patients in need.* Heretofore, some debate has existed as to which component, or subsystem, is the most important. However, current consensus is that only a comprehensive EMS program, logically planned and staged, will develop and mature so that all patients in need will receive the most appropriate care in the prehospital, hospital, interhospital, critical care, and rehabilitative phases. An EMS system must then develop a sound sequence of comprehensive program activities on a regional basis if the needs of all potentially emergent patients are to be properly anticipated and receive adequate response.

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The author is with the Department of Health, Education, and Welfare, Hyattsville, MD 20782.

THE EMERGENCY MEDICAL SERVICES SYSTEMS ACT OF 1973

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

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

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

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

EMERGENCY MEDICAL CARE ISSUES

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

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

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

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

EMS SYSTEMS DEVELOPMENT

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

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

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

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

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

BASIC LIFE SUPPORT SYSTEM

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

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

ADVANCED LIFE SUPPORT SYSTEM

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

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

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

REGIONALIZATION OF EMERGENCY MEDICAL SERVICES

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

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

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

EMERGENCY MEDICAL SERVICES SYSTEM COMPONENTS

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

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

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

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

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

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

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

The EMS communications system should include a command and control center which is responsible for establishing those communications channels and allocating those public resources essential to the most effective and efficient EMS management of the immediate problem. The center should have the necessary equipment and facilities to permit immediate interchange of information essential for the system's resource management and control. The essentials of such a command and control center are that a) all requests for system response are directed to the center; b) all system response is directed from the center; and c) all system liaison with other public safety and emergency response systems is coordinated from the center.

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

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

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

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

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

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

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

The communications element should include the following.

Access providing public interface system to emergency resource system:

- 911.
- Alternative single access number.

Resource management function:

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

Medical Control:

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

Hospital to Mobile Unit:

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

Hospital to Hospital Unit:

- Basic voice.
- Relayed biomedical telemetry.

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

The elements of transportation should include the following.

Ground—Basic Life Support Elements:

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

Ground—Advanced Life Support Elements:

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

Air:

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

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

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

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

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

Elements for facilities consideration include the following.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13) Independent Review and Evaluation—Each EMS system must provide for a) periodic, comprehensive, and independent review and evaluation of the extent and quality of the emergency health care services provided in the system's service area and b) submission to the Secretary of the reports of each such review and evaluation.

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

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

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

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

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

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

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

EMS SYSTEMS MANAGEMENT

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

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

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

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

EMS LEGISLATION

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

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

- Definition of an areawide EMS system.
- Creation of a state governmental unit to plan, develop, and coordinate EMS activities in the state, emphasizing areawide systems with intersystem cooperation and including interstate cooperation.
- Ambulance services, including licensing of ambulances and ambulance services; standards for vehicle design, equipment for medical care and for communication; and personnel.
- Personnel, including definition of categories of personnel involved in EMS, training, and certification requirements, and explicit definitions of which services the various categories are authorized to perform under specific circumstances.
- Emergency medical facilities, including a requirement for participation in areawide systems and a requirement for systemwide categorization of hospitals by the level of care they can provide.
- "Good Samaritan" legislation.
- Responsibility for providing care, including responsibility of the general public, health professionals, ambulance services, and hospital emergency facilities.
- Financial responsibility for care, defining who is responsible for paying for care provided.

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

EMS SYSTEM EVALUATION

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

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

The following are basic to an evaluation strategy.

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

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

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

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

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

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

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

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

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

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

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

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

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

4. And finally, the evaluation of treatment effects, therapy alternatives, program options, phases of implementation, and other experimental studies, will be possible in regional programs as the level of maturity and sophistication progresses, sound BLS and ALS systems.

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

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

DEVELOPMENT OF REGIONAL EMS SYSTEMS

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

A year-by-year summary of activity follows.

Fiscal Year 1974

Eighty-five grants covering 126 regions and serving a population of 88 200 000 were awarded in the amount of $17 000 000.

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

Fiscal Year 1975

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

Section of Act	Number of Grants	Number of Regions	Dollar Amount	Population Served
1202	56	82	$ 4 617 800	57 400 000
1203	49	66	19 500 000	46 200 000
1204	11	26	8 125 000	18 200 000
Total	126	174	$32 242 800	121 800 000

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

Fiscal Year 1976

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

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

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

Training

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

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

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

Research

In fiscal year 1974, five grants and 14 contracts were awarded in the amount of $3 311 000 under Section 1205. In fiscal year 1975, 14 grants and four contracts were awarded in the amount of $4 444 474 under Section 1205. These awards supported research in the four major categories described in Section 1205 (a).

Category	Dollar Amount
I. Medical Techniques	$1 022 766
II. Methods	3 657 995
III. Devices	2 181 326
IV. Delivery	892 476
Total	$7 754 474

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

DISCUSSION

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

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

ORGANIZATIONAL RESPONSIBILITIES

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

CRITIQUE OF EMERGENCY AND CRITICAL CARE DELIVERY

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

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

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

FEDERAL INVOLVEMENT IN EMS DEVELOPMENT

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

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

EMS AS A COMPONENT OF THE TOTAL HEALTH CARE DELIVERY SYSTEM

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

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

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

REFERENCES

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[2] Public Law 93-154: *Emergency Medical Services Systems Act of 1973*. 93rd Congress, S.2410. 1973.

[3] *Emergency Medical Services Systems: Program Guidelines*. U.S. Department of Health, Education, and Welfare, Health Services Administration, Division of Emergency Medical Services. Revised 1975. (HSA-75-2013)

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[5] *Training of Ambulance Personnel and Others Responsible for Emergency Care of the Sick and Injured at the Scene and During Transport*. National Research Council, National Academy of Sciences, 1968. (HSA-74-2027)

[6] *Federal Specifications—Ambulance - Emergency Medical Care Vehicle*. U.S. General Services Administration. January 2, 1974 (with revision). 1974. (Specification KKK-A-1822)

[7] *Medical Communications Services*. U.S. Federal Communications Commission. Federal Register 39:26116-26126, July 16, 1974, also, *Emergency Medical Services Communication Systems*. U.S. Department of Health, Education, and Welfare, Emergency Medical Services Program. 1972 (HRA-74-3209)

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COMPUTER PRINT FOR BILLS IN H. HESS

HOUSE HESS

NUMBER	ABBREVIATED TITLE / SPONSOR / REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 12	LONGEVITY BONUS; MEDICAL ABSENCE MILLER	IN (H) FINANCE	01/25/77		127	01/25/77	DNP02, CS06.
HB 13	LONGEVITY BONUS PHILLIPS	IN (H) FINANCE	02/18/77		330	02/18/77	DP06, DNP01.
HB 16	INSTRUCTIONAL UNITS-SCHOOL FOUNDATION MILLER	IN (H) FINANCE	01/25/77		127	01/25/77	DP06, DNP02.
HB 58	VILLAGE SAFE WATER ACT RULES GOVERNOR	IN (H) FINANCE	01/24/77		115	01/24/77	DP07, NR01.
HB 59	HANDICAPPED INDIVIDUALS RULES GOVERNOR	CHAPTER 0005 SLA 78	02/07/78	* AM	77	01/19/77	DP(AM)08.
HB 60	COMPULSORY SCHOOL ATTENDANCE RULES GOVERNOR	CHAPTER 0010 SLA 77	03/23/77	CS *	77	01/19/77	DP07.
HB 63	GUARDIANS FOR INCAPACITATED PERSONS RULES GOVERNOR	IN (H) JUDICIARY	01/31/77		170	01/31/77	DP(AM)07, NR01.
HB 65	ADOPTING INTERSTATE CORRECTIONS COMPACT RULES GOVERNOR	IN (H) JUDICIARY	02/14/77		288	02/14/77	CS06.
HB 74	CHILD CARE CENTERS IN STATE OFFICE BUILDINGS DUNCAN	IN (H) FINANCE	02/11/77	SS *	271	02/11/77	DP01, DNP04, NR02.
HB 78	APPROPRIATION; SEWARD SKILL CENTER; DEPT OF EDUCATION SPECKING	CHAPTER 0119 SLA 77	06/13/77	CS * AM S	113	01/26/77	DP04, NR04.
HB 89	STATE AID FOR SCHOOL CONSTRUCTION COTTEN	CHAPTER 0120 SLA 77	06/14/77	FCCS SCS CS *	419	03/01/77	DP(AM)02, CS05.
HB 99	HOSPITALIZATION OF MENTALLY ILL, LIAB. FOR EXPENSE OF RULES GOVERNOR	IN (H) RULES	04/27/77		407	02/28/77	DP01, DNP01, NR06.
HB 125	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM DUNCAN	IN (S) HESS	04/29/77	CS SS *	580	03/18/77	DNP02, CS04.
HB 126	APPROP AK COM ON POSTSECONDARY ED DUNCAN	IN (H) FINANCE	03/18/77	SS *	580	03/18/77	DP02, DNP01, DP(AM)01, NR02.
HB 130	PUBLIC EMPLOYMENT RELATIONS ACT HESS	IN (H) JUDICIARY	03/30/77		702	03/30/77	DNP02, CS05.
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM PARR	IN (S) HESS	05/14/77	CS *	407	02/28/77	CS08.
HB 135	APPROP-DEPT H&SS SENIOR CITIZEN NUTRITION FACILITY FBKS PARR	IN (H) FINANCE	02/11/77		272	02/11/77	DP07.
HB 136	WICHE STUDENT EXCHANGE PROGRAM PARR	CHAPTER 0085 SLA 77	06/03/77	* AM S (RE-ENG)	240	02/09/77	DP(AM)05, NR01.
HB 142	AK HISTORICAL COMMISSION- TRANSFER TO DEPT NAT RESOURCE RULES GOVERNOR	IN (H) RULES	05/03/77		849	04/13/77	DP(AM)04, NR02.
HB 146	SCHOLARSHIP LOAN PROGRAM PARR	IN (H) RULES	02/23/77		372	02/23/77	DP04, DNP04.
HB 152	MENTAL HEALTH ADVISORY COUNCIL RULES GOVERNOR	CHAPTER 0040 SLA 77	05/19/77		289	02/14/77	DP05, NR01.
HB 161	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES PARR	IN (H) FINANCE	02/15/77		297	02/15/77	DP04, DNP04, NR01.
HB 179	APPROP DEPT EDUC - COMMUNITY SCHOOLS DUNCAN	CHAPTER 0121 SLA 77	06/14/77		309	02/16/77	DP07.

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NUMBER	ABBREVIATED TITLE / SPONSOR / REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 205	LICENSING OF CARE PROVIDERS FOR DEPENDENT ADULTS MILES BY REQUEST	CHAPTER 0045 SLA 77	05/20/77	CS * AM S	772	04/05/77	CS05.
HB 212	STATE AID FOR SCHOOLS SCHAEFFER	CHAPTER 0090 SLA 77	06/03/77	SCS CS *	849	04/13/77	CS03, NR02.
HB 224	POSTSECONDARY EDUCATION RULES GOVERNOR	CHAPTER 0099 SLA 77	06/09/77	CS * (FIN)	570	03/17/77	CS08.
HB 228	TEACHERS ENGAGED IN COLLECTIVE BARGAINING DUNCAN	IN (S) HESS	05/05/77	CS * (FIN) AM	674	03/28/77	DNP03, DP(AM)01, CS03, NR02.
HB 242	STATE SOCIAL SERVICES PLAN MALONE	IN (H) FINANCE	04/06/77		787	04/06/77	CS05.
HB 251	APPROP; PUBLIC WORKS; RECONSTRUCTION OF TWIN HILLS SCH SEVERSEN	IN (S) FINANCE	05/14/77		462	03/07/77	DP05.
HB 270	APPROP; DEPT OF PUBLIC WORKS; PIONEERS HOME AT HOMER RHODE	IN (H) FINANCE	04/07/77		810	04/07/77	DP05, NR03.
HB 271	MOTOR VEHICLE LICENSE TAX BUCHHOLDT	IN (S) HESS	04/06/77	CS * AM	713	03/31/77	CS06.
HB 284	SERVICE CREDIT IN TRS AND PERS RULES GOVERNOR	IN (H) FINANCE	03/29/77		688	03/29/77	DP07.
HB 287	PROHIBIT SEX DISCRIMINATION IN EDUCATION RUDD	IN (S) HESS	04/14/77	CS * AM	734	04/01/77	DNP02, CS06.
HB 312	POSTSECONDARY EDUCATION HESS	CHAPTER 0050 SLA 77	05/25/77	FCCS SCS *	556	03/16/77	DP06.
HB 343	TEACHERS & PUBLIC EMPLOYEES RETIREMENT MILLER	CHAPTER 0128 SLA 77	06/14/77	SCS CS * (FIN) AM S	688	03/29/77	DP07, DNP01.
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES BRADLEY,R.	IN (S) HESS	01/16/78	CS *	940	04/21/77	CS07.
HB 361	ACCOUNTING & FISCAL MATTERS-U OF A MILES	IN (H) FINANCE	04/13/77		849	04/13/77	DP(AM)01, CS02, NR02.
HB 362	APPROP; U OF A BOARD OF REGENTS MILES	IN (H) FINANCE	04/05/77		773	04/05/77	DP04, NR01.
HB 363	APPROP; U OF A FISCAL MGMT COMMITTEE MILES	IN (H) FINANCE	04/05/77		773	04/05/77	DP05.
HB 365	REVOLVING LOAN FUND FOR RESIDENTIAL CARE FACILITIES MILES	IN (S) FINANCE	02/02/78	CS * AM	736	04/01/77	DP(AM)07, NR01.
HB 366	APPROP; COM & ECON DEV; RESIDENTIAL CARE FACIL. R.L.F. MILES	IN (S) FINANCE	02/02/78	CS * AM	736	04/01/77	DP(AM)07, OTHER01.
HB 379	BOARD OF NURSING HOME-MEMBERSHIP ELIASON	CHAPTER 0077 SLA 77	06/03/77		861	04/14/77	DP07.
HB 381	APPROP-DEPT EDUC; COMFORT STATION AT COLONY VILLAGE BUCHHOLDT	IN (S) FINANCE	04/25/77	CS * (HESS)	714	03/31/77	CS08.
HB 390	APPROP; ANCH LITERACY PROJECT; DEPT OF EDUCATION LETHIN	IN (H) FINANCE	04/06/77		790	04/06/77	DP07.
HB 395	COMMUNITY MENTAL HEALTH SVCS ACT EXPENDITURES MALONE	IN (H) FINANCE	04/04/77		754	04/04/77	DP(AM)04, NR01.
HB 407	EMERGENCY MEDICAL SERVICES-ADVISORY COUNCIL MCKINNON	CHAPTER 0100 SLA 77	06/09/77	* AM	1043	04/27/77	DNP01, DP(AM)05.

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NUMBER	ABBREVIATED TITLE	SPONSOR	REQUESTEE	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 408	APPROP; ANCH NEIGHBORHOOD HEALTH CENTER; H & SS, DEPT	MILES		IN (H) FINANCE	04/26/77		1030	04/26/77	DP05.
HB 409	CATASTROPHIC ILLNESS	BUCHHOLDT		IN (S) FINANCE	05/24/77	CS * (FIN)	1262	05/09/77	CS09.
HB 413	APPROP; CITY OF NENANA HEALTH SVC CENTER	SWANSON		IN (H) FINANCE	04/23/77		987	04/23/77	DP04, NR01.
HB 418	DE NOVO HEARINGS IN SUPERIOR COURT	JUDICIARY		IN (S) HESS	04/21/77		903	04/19/77	DP06.
HB 421	APPROP-ADMIN DEPT ADVANCES TO U OF A	RULES	GOVERNOR	IN (H) FINANCE	04/20/77		923	04/20/77	CS06.
HB 432	SVCS FOR PERSONS UNDER STATE RESPONSIBILITY	HESS		IN (H) FINANCE	05/05/77		1227	05/05/77	CS05.
HB 435	APPROP - C&RA DEPT; RURALCAP PROGRAM	COWPER		CHAPTER 0134 SLA 77	06/14/77		1055	04/27/77	DP04, NR03.
HB 439	AK LONGEVITY BONUS; DEPT HEARING	GUY		IN (S) FINANCE	05/26/77	CS *	1193	05/04/77	CS07.
HB 460	APPROP; LAKE PENINSULA REGIONAL EDUC ATTENDENCE AREA	ANDERSON		IN (H) FINANCE	05/18/77		1389	05/18/77	DP03, NR05.
HB 463	APPROP; SHELTER FOR ASSAULTED WOMEN & CHILDREN	MALONE		CHAPTER 0072 SLA 77	05/28/77	* AM	941	04/21/77	DP(AM)05, NR02.
HB 465	EQUAL TREATMENT OF PERSONS; REGULATIONS OF HESS DEPT	PARR		IN (S) HESS	04/29/77	CS * AM	1030	04/26/77	CS05.
HB 589	AK NAT GUARD SENIOR ROTC SCHOLARSHIP PROGRAM	RULES	GOVERNOR	IN (H) FINANCE	01/23/78		131	01/23/78	DP05, NR02.
HB 608	SUPPL APPROP; DEPT OF ED; PUPIL TRANSPORTATION; COMPUTR	RULES	GOVERNOR	IN (H) FINANCE	01/30/78		173	01/30/78	DP04.
HB 618	STATE COMMISSION FOR HUMAN RIGHTS ANNUAL REPORT	MALONE		IN (H) FINANCE	02/01/78		198	02/01/78	DP(AM)06.
HB 660	COST OF LIVING ALLOWANCE IN TRS	RULES	LEG. CNCL.	IN (H) FINANCE	02/14/78		301	02/14/78	DP05, DNP01, OTHER01.
HB 698	TEACHERS RETIREMENT	DUNCAN		IN (H) FINANCE	02/10/78		278	02/10/78	DP03, DNP01, NR03.
HCR 7	PRISON SYSTEM INVESTIGATION BY JUDICIAL COUNCIL	BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		143	01/27/77	DP04, DNP04, OTHER01.
HCR 26	ELIGIBILITY FOR FOOD STAMPS, DETERMINATION OF	MALONE		READ BY GOVERNOR	05/19/77	CS *	872	04/15/77	CS06.
HCR 35	HEALTH CARE FACILITIES IN KING SALMON	SEVERSEN		READ BY GOVERNOR	04/27/77		520	03/14/77	DP09.
HCR 44	BOARD OF REGENTS; LEGISLATIVE FINDING-U OF A	RUDD		EXPIRD 1ST SESS (H)	05/30/77		923	04/20/77	DNP02, CS02, NR02.
HCR 55	STATISTICS-TREATMENT OF MENTALLY ILL	MALONE		EXPIRD 1ST SESS (H)	05/30/77	CS *	1410	05/19/77	CS05.
HCR 56	STATISTICS-WOMEN IN AK LABOR FORCE	MALONE		EXPIRD 1ST SESS (H)	05/30/77	* AM	1332	05/13/77	DP(AM)06, NR01.
HCR 65	AK PIONEER HOME-SITKA; SUPERINTENDENTS QUARTERS	ELIASON		READ BY GOVERNOR	05/27/77	* AM	1318	05/12/77	DNP01, DP(AM)03, NR01.

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NUMBER	ABBREVIATED TITLE / SPONSOR	REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HJR 9	NATIONAL HEALTH INSURANCE BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		407	02/28/77	DNP04, CS04.
HJR 17	SOCIAL SECURITY ACT; PUBLIC HEARINGS MALONE		EXPIRD 1ST SESS (H)	05/30/77		516	03/11/77	DP07.
HJR 36	WELFARE REFORM STUDY BY US PRESIDENT PARR		READ BY GOVERNOR	05/11/77	* AM	807	04/07/77	DP(AM)08.
HJR 47	BILINGUALISM IN FEDERAL PROCEEDINGS BUCHHOLDT		CHAPTER 0000 SLA 78	02/17/78	* AM S	172	01/30/78	DP06.
HR 17	RURAL AREA FOOD STAMP ALLOTMENTS ANDERSON		READ BY GOVERNOR	02/07/78		198	02/01/78	DP06.
SB 45	RADIATION PROTECTION RULES	GOVERNOR	IN (H) FINANCE	05/14/77		1352	05/14/77	CS07.
SB 46	STUDENT REGENT, UNIV. OF ALASKA CROFT		CHAPTER 0013 SLA 77	04/04/77	CS *	470	03/08/77	DP07.
SB 51	HOSPITALS RULES	GOVERNOR	IN (H) RULES	03/17/77		569	03/17/77	DP(AM)04, NR04.
SB 54	ADOPTION ASSISTANCE -- FOSTER HOMES, AND EFF. DATE RULES	GOVERNOR	CHAPTER 0036 SLA 77	05/16/77		448	03/04/77	DP06, NR01.
SB 110	STATE PHYSICAL THERAPY BOARD RULES	GOVERNOR	CHAPTER 0043 SLA 77	05/19/77		1317	05/12/77	DP05.
SB 129	MEDICAL ASSISTANCE FOR NEEDY PERSONS RULES	GOVERNOR	IN (H) RULES	02/16/78		98	01/18/78	DP05, NR03.
SB 226	TERMS OF REGIONAL SCHOOL BOARD MEMBERS FERGUSON		CHAPTER 0112 SLA 77	06/13/77		1283	05/10/77	DNP03, CS05.
SCR 32	ANNULLING STUDENT LOAN INDEBTEDNESS REGULATION KERTTULA		READ BY GOVERNOR	05/25/77		1425	05/20/77	DP04, NR01.
SJR 33	THE HEAD START PROGRAM CROFT		IN (H) RULES	02/16/78		330	02/16/78	DP06.

NUMBER	ABBREVIATED TITLE	CURRENT STATUS	STATUS DATE	REQUESTER	AMENDED NAME
	PRIME SPONSOR: HESS				
HB 130	PUBLIC EMPLOYMENT RELATIONS ACT	IN (H) JUDICIARY	03/30/77		
HB 312	POSTSECONDARY EDUCATION	CHAPTER 0050 SLA 77	05/25/77		FCCS SCS *
HB 432	SVCS FOR PERSONS UNDER STATE RESPONSIBILITY	IN (H) FINANCE	05/05/77		
	CS ADOPTED: HESS				
HB 125	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM	IN (S) HESS	04/29/77		CS SS *
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM	IN (S) HESS	05/14/77		CS *
HB 205	LICENSING OF CARE PROVIDERS FOR DEPENDENT ADULTS	CHAPTER 0045 SLA 77	05/20/77	BY REQUEST	CS * AM S
HB 271	MOTOR VEHICLE LICENSE TAX	IN (S) HESS	04/06/77		CS * AM
HB 287	PROHIBIT SEX DISCRIMINATION IN EDUCATION	IN (S) HESS	04/14/77		CS * AM
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES	IN (S) RULES	05/28/77		CS *
HB 381	APPROP-DEPT EDUC; COMFORT STATION AT COLONY VILLAGE	IN (S) FINANCE	04/25/77		CS * (HESS)
HB 439	AK LONGEVITY BONUS; DEPT HEARING	IN (S) FINANCE	05/26/77		CS *
HB 465	EQUAL TREATMENT OF PERSONS; REGULATIONS OF HESS DEPT	IN (S) HESS	04/29/77		CS * AM
HCR 26	ELIGIBILITY FOR FOOD STAMPS, DETERMINATION OF	READ BY GOVERNOR	05/19/77		CS *
HCR 55	STATISTICS-TREATMENT OF MENTALLY ILL	EXPIRD 1ST SESS (H)	05/30/77		CS *

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BILL *	ABBREVIATED TITLE	SPONSOR	DATE	REFERRALS
HB 28	PUBLIC EDUCATION FUNDING	SWANSON	1/12/77	FINANCE
HB 41	GO BOND $5,000,000 PIONEERS HOME KETCHIKA	GARDINER	1/12/77	FINANCE
HB 109	BOROUGH SCHOOL DISTRICTS	DUNCAN	1/25/77	-----
HB 183	STATE BOARD OF EDUCATION - MEMBERSHIP	SCHAEFFER	2/08/77	-----
HB 206	PUBLIC HEALTH SERVICES IN MUNICIPALITIES	RULES	2/11/77	FINANCE
HB 207	CONTRACTS FOR LOCAL HEALTH SERVICES	RULES	2/11/77	FINANCE
HB 290	HOSPITAL & HEALTH CARE CENTER FUND	SWANSON	3/01/77	FINANCE
HB 291	BONDS FOR CONSTRUCTION OF HOSPITALS & HEA	SWANSON	3/01/77	FINANCE
HB 296	CIVIL LIABILITY OF HEALTH CARE PROVIDERS	BEIRNE	3/03/77	JUDICIARY
HB 340	ALCOHOL & DRUG ABUSE TREATMENT	RULES	3/11/77	JUDICIARY
HB 344	CONFIRMATION OF U OF A PRESIDENT	MALONE	3/14/77	-----
HB 360	U OF A MANAGEMENT COMMITTEE	MILES	3/16/77	FINANCE
HB 410	ESTAB AK COMMUNITY COLLEGES	MCKINNON	3/29/77	FINANCE
HB 415	DECENTRALIZATION OF UNIV OF ALASKA	MEEKINS	3/30/77	-----
HB 428	TEACHER CERTIFICATION	OSTERBACK	4/04/77	-----
HB 429	DISPOSAL OF SCHOOL LANDS	OSTERBACK	4/04/77	FINANCE
HB 430	' NIVERSITY' & ' OLLEGE'	OSTERBACK	4/ ./77	-----
HB 431	AK COMM ON POSTSECONDARY ED	OSTERBACK	4/04/77	-----
HB 441	TRS-MILITARY SERVICE CREDIT	MALONE	4/06/77	FINANCE
HB 450	REGIONALIZATION OF HEALTH & SS DEPT	ANDERSON	4/07/77	FINANCE

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BILL *	ABBREVIATED TITLE	SPONSOR	DATE	REFERRALS
HB 464	CREATE DEPT OF HEALTH	MCKINNON	4/12/77	FINANCE
HB 472	SERVICES FOR MENTALLY ILL PERSONS	FARR	4/14/77	FINANCE
HB 475	COCA LEAVES	DANKWORTH	4/15/77	JUDICIARY
HB 489	LABOR RELATIONS-SCHOOL BOARDS & EMPLOYEES	MALONE	4/21/77	FINANCE
HB 492	ARBITRATION IN TEACHER NEGOTIATIONS	FARR	4/21/77	-----
HB 493	ORGANIZATION OF THE U OF A	FARR	4/20/77	FINANCE
HB 519	PERSONS WITH DEVELOPMENTAL HANDICAPS	RULES	5/02/77	FINANCE
HB 534	APPROP-CONSTRUCT SCHOOL AT NEWHALEN, EDUC	ANDERSON	5/11/77	FINANCE
HB 535	STATE AID TO LOCAL SCHOOL DISTRICTS	NAKAK	5/12/77	FINANCE
HB 536	STATE SHARED REVENUES-SUPPORT OF HEALTH S	DEIRM	5/12/77	FINANCE
HB 548	EDUCATION OF EXCEPTIONAL CHILDREN	RUDD	5/21/77	FINANCE
HB 552	CONSTRUCTION & REPAIR OF EDUCATIONAL FACI	MALONE	5/28/77	FINANCE
HB 553	LICENSING SPEECH PATHOLOGISTS AND AUDIOLO	PHILLIPS	1/09/78	-----
HB 561	SPECIAL APPROP: PUBLIC WORKS; HLTH CENTER	ANDERSON	1/09/78	FINANCE
HB 570	SPECIAL APPROP; DEPT OF H&SS; ALCOHOLISM	OSTERBACK	1/09/78	FINANCE
HB 571	SPECIAL APPROP; DEPT OF ED; SWIMMING POOL	OSTERBACK	1/09/78	FINANCE
HB 586	ADULT EDUCATION	RULES	1/10/78	-----
HB 587	CORRECTIONAL INDUSTRIES	RULES	1/10/78	FINANCE
HB 589	AK NAT GUARD SENIOR ROTC SCHOLARSHIP PROG	RULES	1/10/78	-----
HB 598	SPEC APPROP, DEPT HEALTH & SS; WOMENS CEN	SNIDER	1/11/78	FINANCE

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BILL *	ABBREVIATED TITLE	SPONSOR	DATE	REFERRALS
HB 605	SPECIAL APPROP; DEPT OF ADMIN; PIONEERS H	RULES	1/11/78	FINANCE
HB 608	SUPPL APPROP; DEPT OF ED, PUPIL TRANSPORT	RULES	1/11/78	FINANCE
HB 616	SPEC APPROP; DEPT/EDUC, CONSTRUCT SCHOOL,	HAUGEN	1/11/78	FINANCE
HCR 84	ALCOHOLISM TREATMENT FACILITY ON UMNAK IS	OSTERBACK	1/09/78	FINANCE
HJR 37	AMEND CONSTITUTION - PRIVATE EDUC INSTITU	ELIASON	3/25/77	FINANCE
HJR 38	AMEND AK CONST-UNIV OF ALASKA	MALONE	3/31/77	FINANCE
SB 129	MEDICAL ASSISTANCE FOR NEEDY PERSONS	RULES	4/07/77	FINANCE
SB 323	ACCREDITATION OF PRIVATE SCHOOLS	SUMNER	5/17/77	JUDICIARY

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SUMMARY OF BILLS

NUMBER	ABBREVIATED TITLE	CURRENT STATUS	STATUS DATE	REQUESTER	AMENDED NAME
	PRIME SPONSOR: PARR				
HB 75	MUNICIPAL TAX ON NET INCOME	IN (H) C&RA	05/25/77		SS *
HB 76	ADULTRY & FORNICATION, REPEALING STATUTORY REFERENCES	IN (H) RULES	01/31/77		
HB 108	THIRD-PARTY BENEFICIARIES, WARRANTIES	FAILD (S) ON RECONS	05/06/77		SCS *
HB 131	FREEDOM OF PUBLIC INFORMATION	IN (S) JUDICIARY	04/15/77		CS * (JUD)
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM	IN (S) HESS	05/14/77		CS *
HB 133	STATE LAND SELECTION BY MUNICIPALITIES	IN (H) FINANCE	05/04/77		
HB 134	PENALTIES FOR MUNICIPAL ORDINANCE VIOLATIONS	IN (S) C&RA	03/03/77		CS *
HB 135	APPROP-DEPT H&SS SENIOR CITIZEN NUTRITION FACILITY FBKS	IN (H) FINANCE	02/11/77		
HB 136	WICHE STUDENT EXCHANGE PROGRAM	CHAPTER 0085 SLA 77	06/03/77		* AM S (RE-ENG)
HB 146	SCHOLARSHIP LOAN PROGRAM	IN (H) RULES	02/23/77		
HB 160	FALSE CERTIFICATE OF RESIDENCY	IN (H) L&M	02/03/77		
HB 161	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES	IN (H) FINANCE	02/15/77		
HB 174	RIGHT TO CRIMINAL ACCUSATION BEFORE GRAND JURY	IN (H) JUDICIARY	02/04/77		
HB 182	TAX CREDITS UNDER AK NET INCOME TAX	CHAPTER 0028 SLA 77	05/06/77		FCCS CS *
HB 202	ASSESSMENT & TAXATION ON DEVELOPED LAND	IN (H) C&RA	02/10/77		
HB 219	SHORE FACILITIES FOR OFFSHORE RESOURCE EXTRACTION	IN (H) C&RA	05/28/77		SS *
HB 273	THIRD CLASS BOROUGHS	CHAPTER 0093 SLA 77	06/03/77		CS * AM
HB 405	EQUAL TREATMENT OF PERSONS; REGULATIONS OF H&SS DEPT	IN (S) HESS	04/29/77		CS * AM
HB 471	DECENTRALIZATION OF EXECUTIVE BRANCH OF STATE GOVERNMNT	IN (H) STATE AFF.	04/14/77		
HB 472	SERVICES FOR MENTALLY ILL PERSONS	IN (H) HESS	04/14/77		
HB 491	PROHIBITED USE OF SOCIAL SECURITY ACCOUNT NUMBERS	IN (H) JUDICIARY	04/21/77		
HB 492	ARBITRATION IN TEACHER NEGOTIATIONS	IN (H) HESS	04/21/77		
HB 493	ORGANIZATION OF THE U OF A	IN (H) HESS	04/20/77		
HCR 15	COMMENDING ATTORNEYS; VIOLENT CRIMES COMPENSATION BOARD	READ BY GOVERNOR	02/11/77		
HCR 16	AK AMER REVOLUTION BICENTENNIAL COMMISSION	READ BY GOVERNOR	02/11/77		
HCR 53	ALASKA SPECIAL OLYMPICS	READ BY GOVERNOR	05/02/77		
HCR 76	NAME NO SLOPE HAUL RD THE DALTON HIGHWAY	READ BY GOVERNOR	06/10/77		
HCR 79	COST ANALYSIS-KEEPING THE CAPITAL IN JUNEAU	EXPIRD 1ST SESS (H)	05/30/77		
HCR 87	ANNULLING DEPT/PUBLIC SAFETY REG; UNATTENDED CARS	IN (H) STATE AFF.	01/12/78		
HJR 18	AMEND AK CONST - ELECTION DISTRICTS & STATE SENATORS	IN (H) STATE AFF.	02/14/77		
HJR 36	WELFARE REFORM STUDY BY US PRESIDENT	READ BY GOVERNOR	05/11/77		* AM
HR 6	NORTH SLOPE HAUL ROAD	READ BY GOVERNOR	02/11/77		* AM
HR 14	MAINTENANCE OF NORTH SLOPE HAUL ROAD	READ BY GOVERNOR	05/27/77		
HR 15	ALCAN GAS PIPELINE ROUTE	EXPIRD 1ST SESS (H)	05/30/77		
	CO-SPONSOR: PARR				
HB 2	HOMESITE LAND AVAILABLE FROM STATE	CHAPTER 0142 SLA 77	06/18/77		SCS CS * (RES) AM S
HB 47	UTILITY CORRIDOR - RAILROAD	CHAPTER 0145 SLA 77	06/18/77		
HB 48	AK RAILROAD-APPROP HIGHWAYS - RIGHT-OF-WAY	CHAPTER 0150 SLA 77	06/16/77		* AM
HB 49	STATE EMPLOYMENT CONTROL COMM - NUMBER OF EMPLOYEES	IN (H) STATE AFF.	01/13/77		
HB 51	VETERANS' LOANS	IN (H) FINANCE	04/12/77		
HB 72	CREATE HISTORICAL & TOURISM REVOLVING LOANS	CHAPTER 0139 SLA 77	06/16/77		CS * AM S
HB 89	STATE AID FOR SCHOOL CONSTRUCTION	CHAPTER 0120 SLA 77	06/14/77		FCCS SCS CS *
HB 91	EMERGENCY RESIDENTIAL RENT, REGULATION & CONTROL	IN (S) COMMERCE	03/17/77		
HB 125	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM	IN (S) HESS	04/29/77		CS SS *
HB 178	NEW CAPITAL SITE AT WILLOW - PLANNING & DEVELOPMENT	IN (H) STATE AFF.	02/09/77		
HB 179	APPROP DEPT EDUC - COMMUNITY SCHOOLS	CHAPTER 0121 SLA 77	06/14/77		
HB 198	BOARD OF GOVERNORS - AK BAR	IN (S) JUDICIARY	03/31/77		CS *
HB 220	SUPPL APPROP TO NAT RESOURCES DEPT; IDITAROD TRAIL RACE	CHAPTER 0011 SLA 77	03/28/77		CS *
HB 228	TEACHERS ENGAGED IN COLLECTIVE BARGAINING	IN (S) HESS	05/05/77		CS * (FIN) AM
HB 239	STATE ELECTION CAMPAIGNS	IN (H) STATE AFF.	02/21/77		
HB 290	HOSPITAL & HEALTH CARE CENTER FUND	IN (H) HESS	03/01/77		
HB 291	BONDS FOR CONSTRUCTION OF HOSPITALS & HEALTH CARE CENTR	IN (H) HESS	03/01/77		
HB 316	SALE OF ALCOHOL - CLUB LICENSES	CHAPTER 0032 SLA 77	05/11/77		* AM S
HB 333	FOSTER CARE FOR CHILDREN	CHAPTER 0126 SLA 77	06/14/77		SEE BILL HISTORY
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES	IN (S) RULES	05/28/77		CS *
HB 352	STATE LAND FOR AGRICULTURAL HOMESITES	IN (S) RESOURCES	05/14/77		CS * AM
HB 353	AGRICULTURAL DEVELOPMENT PROJECTS	VETOED BY GOVERNOR	06/23/77		SCS CS * AM S
HB 371	FIRE INSURANCE RATES	CHAPTER 0034 SLA 77	05/16/77		CS *
HB 373	TAX DEDUCTION FOR CHILD ADOPTION	IN (H) FINANCE	03/18/77		
HB 480	TRADE ASSOC NEGOTIATE WORKMENS COMP PLANS	IN (H) L&M	04/15/77		
HB 511	AK HORSE RACING COMMISSION	IN (H) STATE AFF.	04/27/77		
HB 512	COMPETITIVE BIDDING-FISCAL PROCEDURES ACT	IN (H) STATE AFF.	04/28/77		
HB 523	REDUCING TAX RATES - AK NET INCOME TAX ACT	IN (H) FINANCE	05/04/77		
HB 544	LOCAL HIRE UNDER STATE LEASES	IN (H) L&M	05/19/77		
HB 548	EDUCATION OF EXCEPTIONAL CHILDREN	IN (H) HESS	05/21/77		
HB 559	SUPPL APPROP; DEPT OF TRANSPORTATION; AK RAILROAD	IN (H) STATE AFF.	01/09/78		
HB 563	CONNECTIONS & INTERCHANGE FACILITIES IN PIPELINES	IN (H) RESOURCES	01/09/78		
HB 624	TAX ON MOTOR FUEL FOR WATERCRAFT	IN (H) RESOURCES	01/13/78		
HCR 1	HONORING RALPH J. RIVERS	READ BY GOVERNOR	01/24/77		

NUMBER	ABBREVIATED TITLE	CURRENT STATUS	STATUS DATE	REQUESTER	AMENDED NAME
	CO-SPONSOR: PARR (CONTINUED)				
HCR 3	FAREWELL TO RICHARD A. GUTHRIE	READ BY GOVERNOR	01/24/77		
HCR 4	HONORING VIDE G. BARTLETT	READ BY GOVERNOR	01/24/77		
HCR 14	HONORING LANGHORNE A "TONY" MOTLEY	READ BY GOVERNOR	02/03/77		* AM S
HCR 17	EVENING BUSINESS IN THE DISTRICT COURTS	READ BY GOVERNOR	03/31/77		CS *
HCR 30	NORTH SLOPE HAUL RD	READ BY GOVERNOR	06/03/77		
HCR 49	CONGRATULATING RICK SWENSON	READ BY GOVERNOR	04/14/77		
HCR 61	HONORING KEITH SPECKING	READ BY GOVERNOR	05/02/77		
HCR 64	HONORING RICHARD A. FREER	READ BY GOVERNOR	05/11/77		
HCR 71	HONORING JAMES DALTON	EXPIRD 1ST SESS (H)	05/30/77		
HCR 73	HONORING EMERY F. TOBIN	READ BY GOVERNOR	05/25/77		SCS *
HCR 78	HONORING R ANDERSON, B SHEPARD & H TRIVETTE	READ BY GOVERNOR	05/25/77		
HJR 8	PRES OF US TO ADDRESS AK LEGISLATURE	READ BY GOVERNOR	02/03/77		
HJR 9	NATIONAL HEALTH INSURANCE	EXPIRD 1ST SESS (H)	05/30/77		
HJR 10	PUBLIC LAND FOR HOMESTEADING	EXPIRD 1ST SESS (H)	05/30/77		CS *
HJR 42	CITIZENS FOR MANAGEMENT OF ALASKA LANDS	EXPIRD 1ST SESS (H)	05/30/77		
HR 1	SUSITNA VALLEY BAND TO INAUGURATION	READ BY GOVERNOR	01/20/77		
HR 2	SENATOR TED STEVENS - CONGRATULATIONS	READ BY GOVERNOR	01/28/77		
HR 8	COMMENDING WARREN BUD WOODS	READ BY GOVERNOR	02/24/77		
HR 9	AK RAILROAD EXTEND TO CANADIAN BORDER	READ BY GOVERNOR	03/23/77		
HR 11	HONORING MARTIN SEVERSEN	READ BY GOVERNOR	03/23/77		

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NUMBER	ABBREVIATED TITLE / SPONSOR / REQUESTER / CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 12	LONGEVITY BONUS; MEDICAL ABSENCE MILLER IN (H) FINANCE	01/25/77		127	01/25/77	DNP02, CS06.
HB 13	LONGEVITY BONUS PHILLIPS IN (H) FINANCE	02/18/77		330	02/18/77	DP06, DNP01.
HB 16	INSTRUCTIONAL UNITS-SCHOOL FOUNDATION MILLER IN (H) FINANCE	01/25/77		127	01/25/77	DP06, DNP02.
HB 58	VILLAGE SAFE WATER ACT RULES GOVERNOR IN (H) FINANCE	01/24/77		115	01/24/77	DP07, NR01.
HB 59	HANDICAPPED INDIVIDUALS RULES GOVERNOR IN (S) FINANCE	02/07/77	* AM	77	01/19/77	DP(AM)08.
HB 60	COMPULSORY SCHOOL ATTENDANCE RULES GOVERNOR CHAPTER 0010 SLA 77	03/23/77	CS *	77	01/19/77	DP07.
HB 63	GUARDIANS FOR INCAPACITATED PERSONS RULES GOVERNOR IN (H) JUDICIARY	01/31/77		170	01/31/77	DP(AM)07, NR01.
HB 65	ADOPTING INTERSTATE CORRECTIONS COMPACT RULES GOVERNOR IN (H) JUDICIARY	02/14/77		288	02/14/77	CS06.
HB 74	CHILD CARE CENTERS IN STATE OFFICE BUILDINGS DUNCAN IN (H) FINANCE	02/11/77	SS *	271	02/11/77	DP01, DNP04, NR02.
HB 78	APPROPRIATION; SEWARD SKILL CENTER; DEPT OF EDUCATION SPECKING CHAPTER 0119 SLA 77	06/13/77	CS * AM S	113	01/26/77	DP04, NR04.
HB 89	STATE AID FOR SCHOOL CONSTRUCTION COTTEN CHAPTER 0120 SLA 77	06/14/77	FCCS SCS CS *	419	03/01/77	DP(AM)02, CS05.
HB 99	HOSPITALIZATION OF MENTALLY ILL, LIAB. FOR EXPENSE OF RULES GOVERNOR IN (H) RULES	04/27/77		407	02/28/77	DP01, DNP01, NR06.
HB 125	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM DUNCAN IN (S) HESS	04/29/77	CS SS *	580	03/18/77	DNP02, CS04.
HB 126	APPROP AK COM ON POSTSECONDARY ED DUNCAN IN (H) FINANCE	03/18/77	SS *	580	03/18/77	DP02, DNP01, DP(AM)01, NR02.
HB 130	PUBLIC EMPLOYMENT RELATIONS ACT HESS IN (H) JUDICIARY	03/30/77		702	03/30/77	DNP02, CS05.
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM PARR IN (S) HESS	05/14/77	CS *	407	02/28/77	CS08.
HB 135	APPROP-DEPT H&SS SENIOR CITIZEN NUTRITION FACILITY FBKS PARR IN (H) FINANCE	02/11/77		272	02/11/77	DP07.
HB 136	WICHE STUDENT EXCHANGE PROGRAM PARR CHAPTER 0085 SLA 77	06/03/77	* AM S (RE-ENG)	240	02/09/77	DP(AM)05, NR01.
HB 142	AK HISTORICAL COMMISSION- TRANSFER TO DEPT NAT RESOURCE RULES GOVERNOR IN (H) RULES	05/03/77		849	04/13/77	DP(AM)04, NR02.
HB 146	SCHOLARSHIP LOAN PROGRAM PARR IN (H) RULES	02/23/77		372	02/23/77	DP04, DNP04.
HB 152	MENTAL HEALTH ADVISORY COUNCIL RULES GOVERNOR CHAPTER 0040 SLA 77	05/19/77		289	02/14/77	DP05, NR01.
HB 161	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES PARR IN (H) FINANCE	02/15/77		297	02/15/77	DP04, DNP04, NR01.
HB 179	APPROP DEPT EDUC - COMMUNITY SCHOOLS DUNCAN CHAPTER 0121 SLA 77	06/14/77		309	02/16/77	DP07.

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SPONSOR	REQUESTER CURRENT STATUS	STATUS DATE	BILL ID.	
HB 205	LICENSING OF CARE PROVIDERS FOR DEPENDENT ADULTS	772	04/05/77	CS05.
MILES	BY REQUEST CHAPTER 0045 SLA 77	05/20/77	CS * AM S	
HB 212	STATE AID FOR SCHOOLS	849	04/13/77	CS03, NR02.
SCHAEFFER	CHAPTER 0090 SLA 77	06/03/77	SCS CS *	
HB 224	POSTSECONDARY EDUCATION	570	03/17/77	CS08.
RULES	GOVERNOR CHAPTER 0099 SLA 77	06/09/77	CS * (FIN)	
HB 228	TEACHERS ENGAGED IN COLLECTIVE BARGAINING	674	03/28/77	DNP03, DP(AM)01, CS03, NR02.
DUNCAN	IN (S) HESS	05/05/77	CS * (FIN) AM	
HB 242	STATE SOCIAL SERVICES PLAN	787	04/06/77	CS05.
MALONE	IN (H) FINANCE	04/06/77		
HB 251	APPROP; PUBLIC WORKS; RECONSTRUCTION OF THIN HILLS SCH	462	03/07/77	DP05.
SEVERSEN	IN (S) FINANCE	05/14/77		
HB 270	APPROP; DEPT OF PUBLIC WORKS; PIONEERS HOME AT HOMER	810	04/07/77	DP05, NR03.
RHODE	IN (H) FINANCE	04/07/77		
HB 271	MOTOR VEHICLE LICENSE TAX	713	03/31/77	CS06.
BUCHHOLDT	IN (S) HESS	04/06/77	CS * AM	
HB 284	SERVICE CREDIT IN TRS AND PERS	688	03/29/77	DP07.
RULES	GOVERNOR IN (H) FINANCE	03/29/77		
HB 287	PROHIBIT SEX DISCRIMINATION IN EDUCATION	734	04/01/77	DNP02, CS06.
RUDD	IN (S) HESS	04/14/77	CS * AM	
HB 312	POSTSECONDARY EDUCATION	556	03/16/77	DP06.
HESS	CHAPTER 0050 SLA 77	05/25/77	FCCS SCS *	
HB 343	TEACHERS & PUBLIC EMPLOYEES RETIREMENT	688	03/29/77	DP07, DNP01.
MILLER	CHAPTER 0128 SLA 77	06/14/77	SCS CS * (FIN) AM S	
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES	940	04/21/77	CS07.
BRADLEY,R.	IN (S) RULES	05/26/77	CS *	
HB 361	ACCOUNTING & FISCAL MATTERS-U OF A	849	04/13/77	DP(AM)01, CS02, NR02.
MILES	IN (H) FINANCE	04/13/77		
HB 362	APPROP; U OF A BOARD OF REGENTS	773	04/05/77	DP04, NR01.
MILES	IN (H) FINANCE	04/05/77		
HB 363	APPROP; U OF A FISCAL MGMT COMMITTEE	773	04/05/77	DP05.
MILES	IN (H) FINANCE	04/05/77		
HB 365	REVOLVING LOAN FUND FOR RESIDENTIAL CARE FACILITIES	736	04/01/77	DP(AM)07, NR01.
MILES	IN (H) RULES	05/10/77		
HB 366	APPROP; COM & ECON DEV; RESIDENTIAL CARE FACIL. R.L.F.	736	04/01/77	DP(AM)07, OTHER01.
MILES	IN (H) RULES	05/10/77		
HB 379	BOARD OF NURSING HOME-MEMBERSHIP	861	04/14/77	DP07.
ELIASON	CHAPTER 0077 SLA 77	06/03/77		
HB 381	APPROP-DEPT EDUC; COMFORT STATION AT COLONY VILLAGE	714	03/31/77	CS08.
BUCHHOLDT	IN (S) FINANCE	04/25/77	CS * (HESS)	
HB 390	APPROP; ANCH LITERACY PROJECT; DEPT OF EDUCATION	790	04/06/77	DP07.
LETHIN	IN (H) FINANCE	04/06/77		
HB 395	COMMUNITY MENTAL HEALTH SVCS ACT EXPENDITURES	754	04/04/77	DP(AM)04, NR01.
MALONE	IN (H) FINANCE	04/04/77		
HB 407	EMERGENCY MEDICAL SERVICES-ADVISORY COUNCIL	1043	04/27/77	DNP01, DP(AM)05.
MCKINNON	CHAPTER 0100 SLA 77	06/09/77	* AM	

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HB 408	APPROP; ANCH NEIGHBORHOOD HEALTH CENTER; H & SS,	MILES		IN (H) FINANCE	04/26/77	DEPT	1030	04/26/77	DP05.
HB 409	CATASTROPHIC ILLNESS	BUCHHOLDT		IN (S) FINANCE	05/24/77	CS * (FIN)	1262	05/09/77	CS09.
HB 413	APPROP; CITY OF NENANA HEALTH SVC CENTER	SWANSON		IN (H) FINANCE	04/23/77		987	04/23/77	DP04, NR01.
HB 418	DE NOVO HEARINGS IN SUPERIOR COURT	JUDICIARY		IN (S) HESS	04/21/77		903	04/19/77	DP06.
HB 421	APPROP-ADMIN DEPT ADVANCES TO U OF A	RULES	GOVERNOR	IN (H) FINANCE	04/20/77		923	04/20/77	CS06.
HB 432	SVCS FOR PERSONS UNDER STATE RESPONSIBILITY	HESS		IN (H) FINANCE	05/05/77		1227	05/05/77	CS05.
HB 435	APPROP - C&RA DEPT; RURALCAP PROGRAM	COWPER		CHAPTER 0134 SLA 77	06/14/77		1055	04/27/77	DP04, NR03.
HB 439	AK LONGEVITY BONUS; DEPT HEARING	GUY		IN (S) FINANCE	05/26/77	CS *	1193	05/04/77	CS07.
HB 460	APPROP; LAKE PENINSULA REGIONAL EDUC ATTENDANCE	ANDERSON		IN (H) FINANCE	05/18/77	AREA	1389	05/18/77	DP03, NR05.
HB 463	APPROP; SHELTER FOR ASSAULTED WOMEN & CHILDREN	MALONE		CHAPTER 0072 SLA 77	05/26/77	* AM	941	04/21/77	DP(AM)05, NR02.
HB 465	EQUAL TREATMENT OF PERSONS; REGULATIONS OF HESS DEPT	PARR		IN (S) HESS	04/25/77	CS * AM	1030	04/26/77	CS05.
HCR 7	PRISON SYSTEM INVESTIGATION BY JUDICIAL COUNCIL	BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		143	01/27/77	DP04, DNP04, OTHER01.
HCR 26	ELIGIBILITY FOR FOOD STAMPS, DETERMINATION OF	MALONE		READ BY GOVERNOR	05/19/77	CS *	872	04/15/77	CS06.
HCR 35	HEALTH CARE FACILITIES IN KING SALMON	SEVERSEN		READ BY GOVERNOR	04/27/77		530	03/14/77	DP09.
HCR 44	BOARD OF REGENTS; LEGISLATIVE FILING-U OF A	RUDD		EXPIRD 1ST SESS (H)	05/30/77		923	04/20/77	DNP02, CS02, NR02.
HCR 55	STATISTICS-TREATMENT OF MENTALLY ILL	MALONE		EXPIRD 1ST SESS (H)	05/30/77	CS *	1410	05/19/77	CS05.
HCR 56	STATISTICS-WOMEN IN AK LABOR FORCE	MALONE		EXPIRD 1ST SESS (H)	05/30/77	* AM	1332	05/13/77	DP(AM)06, NR01.
HCR 65	AK PIONEER HOME-SITKA; SUPERINTENDENTS QUARTERS	ELIASON		READ BY GOVERNOR	05/27/77	* AM	1318	05/12/77	DNP01, DP(AM)03, NR01.
HJR 9	NATIONAL HEALTH INSURANCE	BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		407	02/28/77	DNP04, CS04.
HJR 17	SOCIAL SECURITY ACT; PUBLIC HEARINGS	MALONE		EXPIRD 1ST SESS (H)	05/30/77		516	03/11/77	DP07.
HJR 36	WELFARE REFORM STUDY BY US PRESIDENT	PARR		READ BY GOVERNOR	05/11/77	* AM	807	04/07/77	DP(AM)08.
SB 45	RADIATION PROTECTION	RULES	GOVERNOR	IN (H) FINANCE	05/14/77		1352	05/14/77	CS07.
SB 46	STUDENT REGENT, UNIV. OF ALASKA	CROFT		CHAPTER 0013 SLA 77	04/04/77	CS *	470	03/08/77	DP07.

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	SPONSOR	REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.			
SB 51	HOSPITALS					569	03/17/77	DP(AM)04, NR04.
	RULES	GOVERNOR	IN (H) RULES	03/17/77				
SB 54	ADOPTION ASSISTANCE -- FOSTER HCMES, AND EFF. DATE					448	03/04/77	DP06, NR01.
	RULES	GOVERNOR	CHAPTER 0036 SLA 77	05/16/77				
SB 110	STATE PHYSICAL THERAPY BOARD					1317	05/12/77	DP05.
	RULES	GOVERNOR	CHAPTER 0043 SLA 77	05/19/77				
SB 226	TERMS OF REGIONAL SCHOOL BOARD MEMBERS					1283	05/10/77	DNP03, CS05.
	FERGUSON		CHAPTER 0112 SLA 77	06/13/77				
SCR 32	ANNULLING STUDENT LOAN INDEBTEDNESS REGULATICN					1425	05/20/77	DP04, NR01.
	KERTTULA		READ BY GOVERNOR	05/25/77				

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NUMBER	ABBREVIATED TITLE	SPONSOR	REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 12	LONGEVITY BONUS; MEDICAL ABSENCE	MILLER		IN (H) FINANCE	01/25/77		127	01/25/77	DNP02, CS06.
HB 13	LONGEVITY BONUS	PHILLIPS		IN (H) FINANCE	02/18/77		330	02/18/77	DP06, DNP01.
HB 16	INSTRUCTIONAL UNITS-SCHOOL FOUNDATION	MILLER		IN (H) FINANCE	01/25/77		127	01/25/77	DP06, DNP02.
HB 58	VILLAGE SAFE WATER ACT	RULES	GOVERNOR	IN (H) FINANCE	01/24/77		115	01/24/77	DP07, NR01.
HB 59	HANDICAPPED INDIVIDUALS	RULES	GOVERNOR	IN (S) RULES	01/20/78	* AM	77	01/19/77	DP(AM)08.
HB 60	COMPULSORY SCHOOL ATTENDANCE	RULES	GOVERNOR	CHAPTER 0010 SLA 77	03/23/77	CS *	77	01/19/77	DP07.
HB 63	GUARDIANS FOR INCAPACITATED PERSONS	RULES	GOVERNOR	IN (H) JUDICIARY	01/31/77		170	01/31/77	DP(AM)07, NR01.
HB 65	ADOPTING INTERSTATE CORRECTIONS COMPACT	RULES	GOVERNOR	IN (H) JUDICIARY	02/14/77		288	02/14/77	CS06.
HB 74	CHILD CARE CENTERS IN STATE OFFICE BUILDINGS	DUNCAN		IN (H) FINANCE	02/11/77	SS *	271	02/11/77	DP01, DNP04, NR02.
HB 78	APPROPRIATION; SEWARD SKILL CENTER; DEPT OF EDUCATION	SPECKING		CHAPTER 0119 SLA 77	06/13/77	CS * AM S	113	01/26/77	DP04, NR04.
HB 89	STATE AID FOR SCHOOL CONSTRUCTION	COTTEN		CHAPTER 0120 SLA 77	06/14/77	FCCS SCS CS *	419	03/01/77	DP(AM)02, CS05.
HB 99	HOSPITALIZATION OF MENTALLY ILL, LIAB. FOR EXPENSE OF	RULES	GOVERNOR	IN (H) RULES	04/27/77		407	02/28/77	DP01, DNP01, NR06.
HB 125	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM	DUNCAN		IN (S) HESS	04/29/77	CS SS *	580	03/18/77	DNP02, CS04.
HB 126	APPROP AK COM ON POSTSECONDARY ED	DUNCAN		IN (H) FINANCE	03/18/77	SS *	580	03/18/77	DP02, DNP01, DP(AM)01, NR02.
HB 130	PUBLIC EMPLOYMENT RELATIONS ACT	HESS		IN (H) JUDICIARY	03/30/77		702	03/30/77	DNP02, CS05.
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM	PARR		IN (S) HESS	05/14/77	CS *	407	02/28/77	CS08.
HB 135	APPROP-DEPT H&SS SENIOR CITIZEN NUTRITION FACILITY FBKS	PARR		IN (H) FINANCE	02/11/77		272	02/11/77	DP07.
HB 136	WICHE STUDENT EXCHANGE PROGRAM	PARR		CHAPTER 0085 SLA 77	06/03/77	* AM S (RE-ENG)	240	02/09/77	DP(AM)05, NR01.
HB 142	AK HISTORICAL COMMISSION- TRANSFER TO DEPT NAT RESOURCE	RULES	GOVERNOR	IN (H) RULES	05/03/77		849	04/13/77	DP(AM)04, NR02.
HB 146	SCHOLARSHIP LOAN PROGRAM	PARR		IN (H) RULES	02/23/77		372	02/23/77	DP04, DNP04.
HB 152	MENTAL HEALTH ADVISORY COUNCIL	RULES	GOVERNOR	CHAPTER 0040 SLA 77	05/19/77		289	02/14/77	DP05, NR01.
HB 161	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES	PARR		IN (H) FINANCE	02/15/77		297	02/15/77	DP04, DNP04, NR01.
HB 179	APPROP DEPT EDUC - COMMUNITY SCHOOLS	DUNCAN		CHAPTER 0121 SLA 77	06/14/77		309	02/16/77	DP07.

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NUMBER	ABBREVIATED TITLE / SPONSOR	REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 205	LICENSING OF CARE PROVIDERS FOR DEPENDENT ADULTS MILES	BY REQUEST	CHAPTER 0045 SLA 77	05/20/77	CS * AM S	772	04/05/77	CS05.
HB 212	STATE AID FOR SCHOOLS SCHAEFFER		CHAPTER 0090 SLA 77	06/03/77	SCS CS *	849	04/13/77	CS03, NR02.
HB 224	POSTSECONDARY EDUCATION RULES	GOVERNOR	CHAPTER 0099 SLA 77	06/09/77	CS * (FIN)	570	03/17/77	CS08.
HB 228	TEACHERS ENGAGED IN COLLECTIVE BARGAINING DUNCAN		IN (S) HESS	05/05/77	CS * (FIN)	674 AM	03/28/77	DNP03, DP(AM)01, CS03, NR02.
HB 242	STATE SOCIAL SERVICES PLAN MALONE		IN (H) FINANCE	04/06/77		787	04/06/77	CS05.
HB 251	APPROP; PUBLIC WORKS; RECONSTRUCTION OF TWIN HILLS SCH SEVERSEN		IN (S) FINANCE	05/14/77		462	03/07/77	DP05.
HB 270	APPROP; DEPT OF PUBLIC WORKS; PIONEERS HOME AT HOMER RHODE		IN (H) FINANCE	04/07/77		810	04/07/77	DP05, NR03.
HB 271	MOTOR VEHICLE LICENSE TAX BUCHHOLDT		IN (S) HESS	04/06/77	CS * AM	713	03/31/77	CS06.
HB 284	SERVICE CREDIT IN TRS AND PERS RULES	GOVERNOR	IN (H) FINANCE	03/29/77		688	03/29/77	DP07.
HB 287	PROHIBIT SEX DISCRIMINATION IN EDUCATION RUDD		IN (S) HESS	04/14/77	CS * AM	734	04/01/77	DNP02, CS06.
HB 312	POSTSECONDARY EDUCATION HESS		CHAPTER 0050 SLA 77	05/25/77	FCCS SCS *	556	03/16/77	DP06.
HB 343	TEACHERS & PUBLIC EMPLOYEES RETIREMENT MILLER		CHAPTER 0128 SLA 77	06/14/77	SCS CS * (FIN) AM S	688	03/29/77	DP07, DNP01.
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES BRADLEY,R.		IN (S) HESS	01/16/78	CS *	940	04/21/77	CS07.
HB 361	ACCOUNTING & FISCAL MATTERS-U OF A MILES		IN (H) FINANCE	04/13/77		849	04/13/77	DP(AM)01, CS02, NR02.
HB 362	APPROP; U OF A BOARD OF REGENTS MILES		IN (H) FINANCE	04/05/77		773	04/05/77	DP04, NR01.
HB 363	APPROP; U OF A FISCAL MGMT COMMITTEE MILES		IN (H) FINANCE	04/05/77		773	04/05/77	DP05.
HB 365	REVOLVING LOAN FUND FOR RESIDENTIAL CARE FACILITIES MILES		IN (S) HESS	01/17/78	CS * AM	736	04/01/77	DP(AM)07, NR01.
HB 366	APPROP; COM & ECON DEV; RESIDENTIAL CARE FACIL. R.L.F. MILES		IN (S) HESS	01/17/78	CS * AM	736	04/01/77	DP(AM)07, OTHER01.
HB 379	BOARD OF NURSING HOME-MEMBERSHIP ELIASON		CHAPTER 0077 SLA 77	06/03/77		861	04/14/77	DP07.
HB 381	APPROP-DEPT EDUC; COMFORT STATION AT COLONY VILLAGE BUCHHOLDT		IN (S) FINANCE	04/25/77	CS * (HESS)	714	03/31/77	CS08.
HB 390	APPROP; ANCH LITERACY PROJECT; DEPT OF EDUCATION LETHIN		IN (H) FINANCE	04/06/77		790	04/06/77	DP07.
HB 395	COMMUNITY MENTAL HEALTH SVCS ACT EXPENDITURES MALONE		IN (H) FINANCE	04/04/77		754	04/04/77	DP(AM)04, NR01.
HB 407	EMERGENCY MEDICAL SERVICES-ADVISORY COUNCIL MCKINNON		CHAPTER 0100 SLA 77	06/09/77	* AM	1043	04/27/77	DNP01, DP(AM)05.

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NUMBER	ABBREVIATED TITLE / SPONSOR	REQUESTER	CURRENT STATUS	STATUS DATE	BILL ID.	JOURNAL PAGE	JOURNAL DATE	COMMITTEE RECOMMENDATIONS
HB 408	APPROP; ANCH NEIGHBORHOOD HEALTH CENTER; H & SS, DEPT MILES		IN (H) FINANCE	04/26/77		1030	04/26/77	DP05.
HB 409	CATASTROPHIC ILLNESS BUCHHOLDT		IN (S) FINANCE	05/24/77	CS * (FIN)	1262	05/09/77	CS09.
HB 413	APPROP; CITY OF NENANA HEALTH SVC CENTER SWANSON		IN (H) FINANCE	04/23/77		987	04/23/77	DP04, NR01.
HB 418	DE NOVO HEARINGS IN SUPERIOR COURT JUDICIARY		IN (S) HESS	04/21/77		903	04/19/77	DP06.
HB 421	APPROP-ADMIN DEPT ADVANCES TO U OF A RULES	GOVERNOR	IN (H) FINANCE	04/20/77		923	04/20/77	CS06.
HB 432	SVCS FOR PERSONS UNDER STATE RESPONSIBILITY HESS		IN (H) FINANCE	05/05/77		1227	05/05/77	CS05.
HB 435	APPROP - C&RA DEPT; RURALCAP PROGRAM COWPER		CHAPTER 0134 SLA 77	06/14/77		1055	04/27/77	DP04, NR03.
HB 439	AK LONGEVITY BONUS; DEPT HEARING GUY		IN (S) FINANCE	05/26/77	CS *	1193	05/04/77	CS07.
HB 460	APPROP; LAKE PENINSULA REGIONAL EDUC ATTENDENCE AREA ANDERSON		IN (H) FINANCE	05/18/77		1389	05/18/77	DP03, NR05.
HB 463	APPROP; SHELTER FOR ASSAULTED WOMEN & CHILDREN MALONE		CHAPTER 0072 SLA 77	05/28/77	* AM	941	04/21/77	DP(AM)05, NR02.
HB 465	EQUAL TREATMENT OF PERSONS; REGULATIONS OF H&SS DEPT PARR		IN (S) HESS	04/29/77	CS * AM	1030	04/26/77	CS05.
HCR 7	PRISON SYSTEM INVESTIGATION BY JUDICIAL COUNCIL BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		143	01/27/77	DP04, DNP04, OTHER01.
HCR 26	ELIGIBILITY FOR FOOD STAMPS, DETERMINATION OF MALONE		READ BY GOVERNOR	05/19/77	CS *	872	04/15/77	CS06.
HCR 35	HEALTH CARE FACILITIES IN KING SALMON SEVERSEN		READ BY GOVERNOR	04/27/77		530	03/14/77	DP09.
HCR 44	BOARD OF REGENTS; LEGISLATIVE FINDING-U OF A RUDD		EXPIRD 1ST SESS (H)	05/30/77		923	04/20/77	DNP02, CS02, NR02.
HCR 55	STATISTICS-TREATMENT OF MENTALLY ILL MALONE		EXPIRD 1ST SESS (H)	05/30/77	CS *	1410	05/19/77	CS05.
HCR 56	STATISTICS-WOMEN IN AK LABOR FORCE MALONE		EXPIRD 1ST SESS (H)	05/30/77	* AM	1332	05/13/77	DP(AM)06, NR01.
HCR 65	AK PIONEER HOME-SITKA; SUPERINTENDENTS QUARTERS ELIASON		READ BY GOVERNOR	05/27/77	* AM	1318	05/12/77	DNP01, DP(AM)03, NR01.
HJR 9	NATIONAL HEALTH INSURANCE BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		407	02/28/77	DNP04, CS04.
HJR 17	SOCIAL SECURITY ACT; PUBLIC HEARINGS MALONE		EXPIRD 1ST SESS (H)	05/30/77		516	03/11/77	DP07.
HJR 36	WELFARE REFORM STUDY BY US PRESIDENT PARR		READ BY GOVERNOR	05/11/77	* AM	807	04/07/77	DP(AM)08.
SB 45	RADIATION PROTECTION RULES	GOVERNOR	IN (H) FINANCE	05/14/77		1352	05/14/77	CS07.
SB 46	STUDENT REGENT, UNIV. OF ALASKA CROFT		CHAPTER 0013 SLA 77	04/04/77	CS *	470	03/08/77	DP07.

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SB 51	HOSPITALS	RULES	GOVERNOR	IN (H) RULES	03/17/77		569	03/17/77	DP(AM)04, NR04.
SB 54	ADOPTION ASSISTANCE -- FOSTER HOMES, AND EFF. DATE	RULES	GOVERNOR	CHAPTER 0036 SLA 77	05/16/77		448	03/04/77	DP06, NR01.
SB 110	STATE PHYSICAL THERAPY BOARD	RULES	GOVERNOR	CHAPTER 0043 SLA 77	05/19/77		1317	05/12/77	DP05.
SB 129	MEDICAL ASSISTANCE FOR NEEDY PERSONS	RULES	GOVERNOR	IN (H) FINANCE	01/18/78		98	01/18/78	DP05, NR03.
SB 226	TERMS OF REGIONAL SCHOOL BOARD MEMBERS	FERGUSON		CHAPTER 0112 SLA 77	06/13/77		1283	05/10/77	DNP03, CS05.
SCR 32	ANNULLING STUDENT LOAN INDEBTEDNESS REGULATION	KERTTULA		READ BY GOVERNOR	05/25/77		1425	05/20/77	DP04, NR01.

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HB 12	LONGEVITY BONUS; MEDICAL ABSENCE MILLER	IN (H) FINANCE	01/25/77		127	01/25/77	DNP02, CS06.
HB 13	LONGEVITY BONUS PHILLIPS	IN (H) FINANCE	02/18/77		330	02/18/77	DP06, DNP01.
HB 16	INSTRUCTIONAL UNITS-SCHOOL FOUNDATION MILLER	IN (H) FINANCE	01/25/77		127	01/25/77	DP06, DNP02.
HB 58	VILLAGE SAFE WATER ACT RULES GOVERNOR	IN (H) FINANCE	01/24/77		115	01/24/77	DP07, NR01.
HB 59	HANDICAPPED INDIVIDUALS RULES GOVERNOR	CHAPTER 0005 SLA 78	02/07/78	* AM	77	01/19/77	DP(AM)08.
HB 60	COMPULSORY SCHOOL ATTENDANCE RULES GOVERNOR	CHAPTER 0010 SLA 77	03/23/77	CS *	77	01/19/77	DP07.
HB 63	GUARDIANS FOR INCAPACITATED PERSONS RULES GOVERNOR	IN (H) JUDICIARY	01/31/77		170	01/31/77	DP(AM)07, NR01.
HB 65	ADOPTING INTERSTATE CORRECTIONS COMPACT RULES GOVERNOR	IN (H) JUDICIARY	02/14/77		288	02/14/77	CS06.
HB 74	CHILD CARE CENTERS IN STATE OFFICE BUILDINGS DUNCAN	IN (H) FINANCE	02/11/77	SS *	271	02/11/77	DP01, DNP04, NR02.
HB 78	APPROPRIATION; SEWARD SKILL CENTER; DEPT OF EDUCATION SPECKING	CHAPTER 0119 SLA 77	06/13/77	CS * AM S	113	01/26/77	DP04, NR04.
HB 89	STATE AID FOR SCHOOL CONSTRUCTION COTTEN	CHAPTER 0120 SLA 77	06/14/77	FCCS SCS CS *	419	03/01/77	DP(AM)02, CS05.
HB 99	HOSPITALIZATION OF MENTALLY ILL, LIAB. FOR EXPENSE OF RULES GOVERNOR	IN (H) RULES	04/27/77		407	02/28/77	DP01, DNP01, NR06.
HB 125	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM DUNCAN	IN (S) HESS	04/29/77	CS SS *	580	03/18/77	DNP02, CS04.
HB 126	APPROP AK COM ON POSTSECONDARY ED DUNCAN	IN (H) FINANCE	03/18/77	SS *	580	03/18/77	DP02, DNP01, DP(AM)01, NR02.
HB 130	PUBLIC EMPLOYMENT RELATIONS ACT HESS	IN (H) JUDICIARY	03/30/77		702	03/30/77	DNP02, CS05.
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM PARR	IN (S) HESS	05/14/77	CS *	407	02/28/77	CS08.
HB 135	APPROP-DEPT HESS SENIOR CITIZEN NUTRITION FACILITY FBKS PARR	IN (H) FINANCE	02/11/77		272	02/11/77	DP07.
HB 136	WICHE STUDENT EXCHANGE PROGRAM PARR	CHAPTER 0085 SLA 77	06/03/77	* AM S (RE-ENG)	240	02/09/77	DP(AM)05, NR01.
HB 142	AK HISTORICAL COMMISSION- TRANSFER TO DEPT NAT RESOURCE RULES GOVERNOR	IN (H) RULES	05/03/77		849	04/13/77	DP(AM)04, NR02.
HB 146	SCHOLARSHIP LOAN PROGRAM PARR	IN (H) RULES	02/23/77		372	02/23/77	DP04, DNP04.
HB 152	MENTAL HEALTH ADVISORY COUNCIL RULES GOVERNOR	CHAPTER 0040 SLA 77	05/19/77		289	02/14/77	DP05, NR01.
HB 161	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES PARR	IN (H) FINANCE	02/15/77		297	02/15/77	DP04, DNP04, NR01.
HB 179	APPROP DEPT EDUC - COMMUNITY SCHOOLS DUNCAN	CHAPTER 0121 SLA 77	06/14/77		309	02/16/77	DP07.

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HB 205	LICENSING OF CARE PROVIDERS FOR DEPENDENT ADULTS	MILES	BY REQUEST	CHAPTER 0045 SLA 77	05/20/77	CS * AM S	772	04/05/77	CS05.
HB 212	STATE AID FOR SCHOOLS	SCHAEFFER		CHAPTER 0090 SLA 77	06/03/77	SCS CS *	849	04/13/77	CS03, NR02.
HB 224	POSTSECONDARY EDUCATION	RULES	GOVERNOR	CHAPTER 0099 SLA 77	06/09/77	CS * (FIN)	570	03/17/77	CS08.
HB 228	TEACHERS ENGAGED IN COLLECTIVE BARGAINING	DUNCAN		IN (S) HESS	05/05/77	CS * (FIN) AM	674	03/28/77	DNP03, DP(AM)01, CS03, NR02.
HB 242	STATE SOCIAL SERVICES PLAN	MALONE		IN (H) FINANCE	04/06/77		787	04/06/77	CS05.
HB 251	APPROP; PUBLIC WORKS; RECONSTRUCTION OF TWIN HILLS SCH	SEVERSEN		IN (S) FINANCE	05/14/77		462	03/07/77	DP05.
HB 270	APPROP; DEPT OF PUBLIC WORKS; PIONEERS HOME AT HOMER	RHODE		IN (H) FINANCE	04/07/77		810	04/07/77	DP05, NR03.
HB 271	MOTOR VEHICLE LICENSE TAX	BUCHHOLDT		IN (S) HESS	04/06/77	CS * AM	713	03/31/77	CS06.
HB 284	SERVICE CREDIT IN TRS AND PERS	RULES	GOVERNOR	IN (H) FINANCE	03/29/77		688	03/29/77	DP07.
HB 287	PROHIBIT SEX DISCRIMINATION IN EDUCATION	RUDD		IN (S) HESS	04/14/77	CS * AM	734	04/01/77	DNP02, CS06.
HB 312	POSTSECONDARY EDUCATION	HESS		CHAPTER 0050 SLA 77	05/25/77	FCCS SCS *	556	03/16/77	DP06.
HB 343	TEACHERS & PUBLIC EMPLOYEES RETIREMENT	MILLER		CHAPTER 0128 SLA 77	06/14/77	SCS CS * (FIN) AM S	688	03/29/77	DP07, DNP01.
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES	BRADLEY,R.		IN (S) HESS	01/16/78	CS *	940	04/21/77	CS07.
HB 361	ACCOUNTING & FISCAL MATTERS-U OF A	MILES		IN (H) FINANCE	04/13/77		849	04/13/77	DP(AM)01, CS02. NR02.
HB 362	APPROP; U OF A BOARD OF REGENTS	MILES		IN (H) FINANCE	04/05/77		773	04/05/77	DP04, NR01.
HB 363	APPROP; U OF A FISCAL MGMT COMMITTEE	MILES		IN (H) FINANCE	04/05/77		773	04/05/77	DP05.
HB 365	REVOLVING LOAN FUND FOR RESIDENTIAL CARE FACILITIES	MILES		IN (S) FINANCE	02/02/78	CS * AM	736	04/01/77	DP(AM)07, NR01.
HB 366	APPROP; COM & ECON DEV; RESIDENTIAL CARE FACIL. R.L.F.	MILES		IN (S) FINANCE	02/02/78	CS * AM	736	04/01/77	DP(AM)07, OTHER01.
HB 379	BOARD OF NURSING HOME-MEMBERSHIP	ELIASON		CHAPTER 0077 SLA 77	06/03/77		861	04/14/77	DP07.
HB 381	APPROP-DEPT EDUC; COMFORT STATION AT COLONY VILLAGE	BUCHHOLDT		IN (S) FINANCE	04/25/77	CS * (HESS)	714	03/31/77	CS08.
HB 390	APPROP; ANCH LITERACY PROJECT; DEPT OF EDUCATION	LETHIN		IN (H) FINANCE	04/06/77		790	04/06/77	DP07.
HB 395	COMMUNITY MENTAL HEALTH SVCS ACT EXPENDITURES	MALONE		IN (H) FINANCE	04/04/77		754	04/04/77	DP(AM)04, NR01.
HB 407	EMERGENCY MEDICAL SERVICES-ADVISORY COUNCIL	MCKINNON		CHAPTER 0100 SLA 77	06/09/77	* AM	1043	04/27/77	DNP01, DP(AM)05.

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HB 408	APPROP; ANCH NEIGHBORHOOD HEALTH CENTER; H & SS, DEPT MILES		IN (H) FINANCE	04/26/77		1030	04/26/77	DP05.
HB 409	CATASTROPHIC ILLNESS BUCHHOLDT		IN (S) FINANCE	05/24/77	CS * (FIN)	1262	05/09/77	CS09.
HB 413	APPROP; CITY OF NENANA HEALTH SVC CENTER SWANSON		IN (H) FINANCE	04/23/77		987	04/23/77	DP04, NR01.
HB 418	DE NOVO HEARINGS IN SUPERIOR COURT JUDICIARY		IN (S) HESS	04/21/77		903	04/19/77	DP06.
HB 421	APPROP-ADMIN DEPT ADVANCES TO U OF A RULES	GOVERNOR	IN (H) FINANCE	04/20/77		923	04/20/77	CS06.
HB 432	SVCS FOR PERSONS UNDER STATE RESPONSIBILITY HESS		IN (H) FINANCE	05/05/77		1227	05/05/77	CS05.
HB 435	APPROP - C&RA DEPT; RURALCAP PROGRAM COWPER		CHAPTER 0134 SLA 77	06/14/77		1055	04/27/77	DP04, NR03.
HB 439	AK LONGEVITY BONUS; DEPT HEARING GUY		IN (S) FINANCE	05/26/77	CS *	1193	05/04/77	CS07.
HB 460	APPROP; LAKE PENINSULA REGIONAL EDUC ATTENDENCE AREA ANDERSON		IN (H) FINANCE	05/18/77		1389	05/18/77	DP03, NR05.
HB 463	APPROP; SHELTER FOR ASSAULTED WOMEN & CHILDREN MALONE		CHAPTER 0072 SLA 77	05/28/77	* AM	941	04/21/77	DP(AM)05, NR02.
HB 465	EQUAL TREATMENT OF PERSONS; REGULATIONS OF H&SS DEPT PARR		IN (S) HESS	04/29/77	CS * AM	1030	04/26/77	CS05.
HB 589	AK NAT GUARD SENIOR ROTC SCHOLARSHIP PROGRAM RULES	GOVERNOR	IN (H) FINANCE	01/23/78		131	01/23/78	DP05, NR02.
HB 608	SUPPL APPROP; DEPT OF ED; PUPIL TRANSPORTATION; COMPUTR RULES	GOVERNOR	IN (H) FINANCE	01/30/78		173	01/30/78	DP04.
HB 618	STATE COMMISSION FOR HUMAN RIGHTS ANNUAL REPORT MALONE		IN (H) FINANCE	02/01/78		198	02/01/78	DP(AM)06.
HB 637	CREDITABLE OUTSIDE SERVICE AND TRS RULES	LEG. CNCL.	IN (H) FINANCE	02/22/78		373	02/22/78	CS07.
HB 660	COST OF LIVING ALLOWANCE IN TRS RULES	LEG. CNCL.	IN (H) FINANCE	02/14/78		301	02/14/78	DP05, DNP01, OTHER01.
HB 680	BILINGUAL PUBLIC HEARINGS; ADMINISTRATIVE PROCEDURE ACT BUCHHOLDT		IN (H) FINANCE	02/22/78		374	02/22/78	CS06, NR01.
HB 698	TEACHERS RETIREMENT DUNCAN		IN (H) FINANCE	02/10/78		278	02/10/78	DP03, DNP01, NR03.
HB 726	SPEC APPROP; DEPT/EDUC; AK PUBLIC BROADCASTING CMSN NAKAK		IN (H) FINANCE	02/24/78		394	02/24/78	DP03, NR02, OTHER02.
HCR 7	PRISON SYSTEM INVESTIGATION BY JUDICIAL COUNCIL BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		143	01/27/77	DP04, DNP04, OTHER01.
HCR 26	ELIGIBILITY FOR FOOD STAMPS, DETERMINATION OF MALONE		READ BY GOVERNOR	05/19/77	CS *	872	04/15/77	CS06.
HCR 35	HEALTH CARE FACILITIES IN KING SALMON SEVERSEN		READ BY GOVERNOR	04/27/77		530	03/14/77	DP09.
HCR 44	BOARD OF REGENTS; LEGISLATIVE FINDING-U OF A RUDO		EXPIRD 1ST SESS (H)	05/30/77		923	04/20/77	DNP02, CS02, NR02.

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HCR 55	STATISTICS-TREATMENT OF MENTALLY ILL MALONE		EXPIRD 1ST SESS (H)	05/30/77	CS *	1410	05/19/77	CS05.
HCR 56	STATISTICS-WOMEN IN AK LABOR FORCE MALONE		EXPIRD 1ST SESS (H)	05/30/77	* AM	1332	05/13/77	DP(AM)06, NR01.
HCR 65	AK PIONEER HOME-SITKA; SUPERINTENDENTS QUARTERS ELIASON		READ BY GOVERNOR	05/27/77	* AM	1318	05/12/77	DNP01, DP(AM)03, NR01.
HJR 9	NATIONAL HEALTH INSURANCE BRADLEY,R.		EXPIRD 1ST SESS (H)	05/30/77		407	02/28/77	DNP04, CS04.
HJR 17	SOCIAL SECURITY ACT; PUBLIC HEARINGS MALONE		EXPIRD 1ST SESS (H)	05/30/77		516	03/11/77	DP07.
HJR 36	WELFARE REFORM STUDY BY US PRESIDENT PARR		READ BY GOVERNOR	05/11/77	* AM	807	04/07/77	DP(AM)08.
HJR 47	BILINGUALISM IN FEDERAL PROCEEDINGS BUCHHOLDT		CHAPTER 0000 SLA 78	02/17/78	* AM S	172	01/30/78	DP06.
HR 17	RURAL AREA FOOD STAMP ALLOTMENTS ANDERSON		READ BY GOVERNOR	02/07/78		198	02/01/78	DP06.
SB 45	RADIATION PROTECTION RULES	GOVERNOR	IN (H) FINANCE	05/14/77		1352	05/14/77	CS07.
SB 46	STUDENT REGENT, UNIV. OF ALASKA CROFT		CHAPTER 0013 SLA 77	04/04/77	CS *	470	03/08/77	DP07.
SB 51	HOSPITALS RULES	GOVERNOR	IN (H) RULES	03/17/77		569	03/17/77	DP(AM)04, NR04.
SB 54	ADOPTION ASSISTANCE -- FOSTER HOMES, AND EFF. DATE RULES	GOVERNOR	CHAPTER 0036 SLA 77	05/16/77		448	03/04/77	DP06, NR01.
SB 110	STATE PHYSICAL THERAPY BOARD RULES	GOVERNOR	CHAPTER 0043 SLA 77	05/19/77		1317	05/12/77	DP05.
SB 129	MEDICAL ASSISTANCE FOR NEEDY PERSONS RULES	GOVERNOR	PASSED (H)	02/24/78		98	01/18/78	DP05, NR03.
SB 226	TERMS OF REGIONAL SCHOOL BOARD MEMBERS FERGUSON		CHAPTER 0112 SLA 77	06/13/77		1283	05/10/77	DNP03, CS05.
SCR 32	ANNULLING STUDENT LOAN INDEBTEDNESS REGULATION KERTTULA		READ BY GOVERNOR	05/25/77		1425	05/20/77	DP04, NR01.
SJR 33	THE HEAD START PROGRAM CROFT		CHAPTER 0000 SLA 78	02/24/78		330	02/16/78	DP06.

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HB 12	LONGEVITY BONUS; MEDICAL ABSENCE MILLER / IN (H) FINANCE	01/25/77		127	01/25/77	DNP02, CS06.
HB 13	LONGEVITY BONUS PHILLIPS / IN (H) FINANCE	02/18/77		330	02/18/77	DP06, DNP01.
HB 16	INSTRUCTIONAL UNITS-SCHOOL FOUNDATION MILLER / IN (H) FINANCE	01/25/77		127	01/25/77	DP06, DNP02.
HB 58	VILLAGE SAFE WATER ACT RULES / GOVERNOR / IN (H) FINANCE	01/24/77		115	01/24/77	DP07, NR01.
HB 59	HANDICAPPED INDIVIDUALS RULES / GOVERNOR / IN (S) FINANCE	02/07/77	* AM	77	01/19/77	DP(AM)08.
HB 60	COMPULSORY SCHOOL ATTENDANCE RULES / GOVERNOR / IN (S) HESS	03/01/77	CS *	77	01/19/77	DP07.
HB 63	GUARDIANS FOR INCAPACITATED PERSONS RULES / GOVERNOR / IN (H) JUDICIARY	01/31/77		170	01/31/77	DP(AM)07, NR01.
HB 65	ADOPTING INTERSTATE CORRECTIONS COMPACT RULES / GOVERNOR / IN (H) JUDICIARY	02/14/77		288	02/14/77	CS06.
HB 74	CHILD CARE CENTERS IN STATE OFFICE BUILDINGS DUNCAN / IN (H) FINANCE	02/11/77	SS *	271	02/11/77	DP01, DNP04, NR02.
HB 78	APPROPRIATION; SEWARD SKILL CENTER; DEPT OF EDUCATION SPECKING / IN (H) RULES	03/01/77		113	01/26/77	DP04, NR04.
HB 89	STATE AID FOR SCHOOL CONSTRUCTION, & EFF. DATE COTTEN / IN (H) FINANCE	03/01/77		419	03/01/77	DP(AM)02, CS05.
HB 99	HOSPITALIZATION OF MENTALLY ILL, LIAB. FOR EXPENSE OF RULES / GOVERNOR / IN (H) FINANCE	02/28/77		407	02/28/77	DP01, DNP01, NR06.
HB 132	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM PARR / IN (H) FINANCE	02/28/77		407	02/28/77	CS08.
HB 135	APPROP-DEPT H&SS SENIOR CITIZEN NUTRITION FACILITY FBKS PARR / IN (H) FINANCE	02/11/77		272	02/11/77	DP07.
HB 136	WICHE STUDENT EXCHANGE PROGRAM PARR / IN (S) HESS	02/11/77	* AM	240	02/09/77	DP(AM)05, NR01.
HB 146	SCHOLARSHIP LOAN PROGRAM PARR / IN (H) RULES	02/23/77		372	02/23/77	DP04, DNP04.
HB 152	MENTAL HEALTH ADVISORY COUNCIL RULES / GOVERNOR / IN (S) HESS	03/01/77		299	02/14/77	DP05, NR01.
HB 161	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES PARR / IN (H) FINANCE	02/15/77		297	02/15/77	DP04, DNP04, NR01.
HB 179	APPROP DEPT EDUC - COMMUNITY SCHOOLS DUNCAN / IN (H) FINANCE	02/16/77		309	02/16/77	DP07.
HCR 7	PRISON SYSTEM INVESTIGATION BY JUDICIAL COUNCIL BRADLEY,R. / IN (H) JUDICIARY	01/27/77		143	01/27/77	DP04, DNP04, OTHER01.
HJR 9	NATIONAL HEALTH INSURANCE BRADLEY,R. / IN (H) JUDICIARY	02/28/77		407	02/28/77	DNP04, CS04.
SB 54	ADOPTION ASSISTANCE -- FOSTER HOMES, AND EFF. DATE RULES / GOVERNOR / IN (H) RULES	03/04/77		448	03/04/77	DP06, NR01.

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	PRIME SPONSOR: HESS				
HB 130	PUBLIC EMPLOYMENT RELATIONS ACT	IN (H) HESS	01/28/77		

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HB 12	MILLER	LONGEVITY BONUS; MEDICAL ABSENCE	IN (H) FINANCE	01/25/77		127	01/25/77	DNP02, CS06.
HB 13	PHILLIPS	LONGEVITY BONUS	IN (H) FINANCE	02/18/77		330	02/18/77	DP06, DNP01.
HB 16	MILLER	INSTRUCTIONAL UNITS-SCHOOL FOUNDATION	IN (H) FINANCE	01/25/77		127	01/25/77	DP06, DNP02.
HB 58	RULES	VILLAGE SAFE WATER ACT / GOVERNOR	IN (H) FINANCE	01/24/77		115	01/24/77	DP07, NR01.
HB 59	RULES	HANDICAPPED INDIVIDUALS / GOVERNOR	CHAPTER 0005 SLA 78	02/07/78	* AM	77	01/19/77	DP(AM)08.
HB 60	RULES	COMPULSORY SCHOOL ATTENDANCE / GOVERNOR	CHAPTER 0010 SLA 77	03/23/77	CS *	77	01/19/77	DP07.
HB 63	RULES	GUARDIANS FOR INCAPACITATED PERSONS / GOVERNOR	IN (H) JUDICIARY	01/31/77		17	01/31/77	DP(AM)07, NR01.
HB 65	RULES	ADOPTING INTERSTATE CORRECTIONS COMPACT / GOVERNOR	IN (H) JUDICIARY	02/14/77		288	02/14/77	CS06.
HB 74	DUNCAN	CHILD CARE CENTERS IN STATE OFFICE BUILDINGS	IN (H) FINANCE	02/11/77	SS *	271	02/11/77	DP01, DNP04, NR02.
HB 78	SPECKING	APPROPRIATION; SEWARD SKILL CENTER; DEPT OF EDUCATION	CHAPTER 0119 SLA 77	06/13/77	CS * AM S	113	01/26/77	DP04, NR04.
HB 89	COTTEN	STATE AID FOR SCHOOL CONSTRUCTION	CHAPTER 0120 SLA 77	06/14/77	FCCS SCS CS *	419	03/01/77	DP(AM)02, CS05.
HB 99	RULES	HOSPITALIZATION OF MENTALLY ILL, LIAB. FOR EXPENSE OF / GOVERNOR	IN (H) RULES	04/27/77		407	02/28/77	DP01, DNP01, NR06.
HB 125	DUNCAN	AK NATIVE EDUC ADMIN INTERNSHIP PROGRAM	IN (S) FINANCE	03/02/78	CS SS *	580	03/18/77	DNP02, CS04.
HB 126	DUNCAN	APPROP AK COM ON POSTSECONDARY ED	IN (H) FINANCE	03/18/77	SS *	580	03/18/77	DP02, DNP01, DP(AM)01, NR02.
HB 130	HESS	PUBLIC EMPLOYMENT RELATIONS ACT	IN (H) JUDICIARY	03/30/77		702	03/30/77	DNP02, CS05.
HB 132	PARR	ESTAB STATE EDUCATIONAL INCENTIVE GRANT PROGRAM	IN (S) FINANCE	03/02/78	CS *	407	02/28/77	CS08.
HB 135	PARR	APPROP-DEPT H&SS SENIOR CITIZEN NUTRITION FACILITY FBKS	IN (H) FINANCE	02/11/77		272	02/11/77	DP07.
HB 136	PARR	WICHE STUDENT EXCHANGE PROGRAM	CHAPTER 0085 SLA 77	06/03/77	* AM S (RE-ENG)	240	02/09/77	DP(AM)05, NR01.
HB 142	RULES	AK HISTORICAL COMMISSION- TRANSFER TO DEPT NAT RESOURCE / GOVERNOR	IN (H) RULES	05/03/77		849	04/13/77	DP(AM)04, NR02.
HB 146	PARR	SCHOLARSHIP LOAN PROGRAM	IN (H) RULES	02/23/77		372	02/23/77	DP04, DNP04.
HB 152	RULES	MENTAL HEALTH ADVISORY COUNCIL / GOVERNOR	CHAPTER 0040 SLA 77	05/19/77		289	02/14/77	DP05, NR01.
HB 161	PARR	TEACHERS RETIREMENT CREDIT IN US MERCHANT MARINES	IN (H) FINANCE	02/15/77		297	02/15/77	DP04, DNP04, NR01.
HB 179	DUNCAN	APPROP DEPT EDUC - COMMUNITY SCHOOLS	CHAPTER 0121 SLA 77	06/14/77		309	02/16/77	DP07.

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HB 205	LICENSING OF CARE PROVIDERS FOR DEPENDENT ADULTS	MILES	BY REQUEST	CHAPTER 0045 SLA 77	05/20/77	CS * AM S	772	04/05/77	CS05.
HB 212	STATE AID FOR SCHOOLS	SCHAEFFER		CHAPTER 0090 SLA 77	06/03/77	SCS CS *	849	04/13/77	CS03, NR02.
HB 224	POSTSECONDARY EDUCATION	RULES	GOVERNOR	CHAPTER 0099 SLA 77	06/09/77	CS * (FIN)	570	03/17/77	CS08.
HB 228	TEACHERS ENGAGED IN COLLECTIVE BARGAINING	DUNCAN		IN (S) HESS	05/05/77	CS * (FIN) AM	674	03/28/77	DNP03, DP(AM)01, CS03, NR02.
HB 242	STATE SOCIAL SERVICES PLAN	MALONE		IN (H) FINANCE	04/06/77		787	04/06/77	CS05.
HB 251	APPROP; PUBLIC WORKS; RECONSTRUCTION OF TWIN HILLS SCH	SEVERSEN		IN (S) FINANCE	05/14/77		462	03/07/77	DP05.
HB 270	APPROP; DEPT OF PUBLIC WORKS; PIONEERS HOME AT HOMER	RHODE		IN (H) FINANCE	04/07/77		810	04/07/77	DP05, NR03.
HB 271	MOTOR VEHICLE LICENSE TAX	BUCHHOLDT		IN (S) HESS	04/06/77	CS * AM	713	03/31/77	CS06.
HB 284	SERVICE CREDIT IN TRS AND PERS	RULES	GOVERNOR	IN (H) FINANCE	03/29/77		688	03/29/77	DP07.
HB 287	PROHIBIT SEX DISCRIMINATION IN EDUCATION	RUDD		IN (S) HESS	04/14/77	CS * AM	734	04/01/77	DNP02, CS06.
HB 312	POSTSECONDARY EDUCATION	HESS		CHAPTER 0050 SLA 77	05/25/77	FCCS SCS *	556	03/16/77	DP06.
HB 343	TEACHERS & PUBLIC EMPLOYEES RETIREMENT	MILLER		CHAPTER 0128 SLA 77	06/14/77	SCS CS * (FIN) AM S	688	03/29/77	DP07, DNP01.
HB 351	SCHOOL OF JUSTICE & AMEND THE AK BAR RULES	BRADLEY,R.		IN (S) HESS	01/16/78	CS *	940	04/21/77	CS07.
HB 361	ACCOUNTING & FISCAL MATTERS-U OF A	MILES		IN (H) FINANCE	04/13/77		849	04/13/77	DP(AM)01, CS02, NR02.
HB 362	APPROP; U OF A BOARD OF REGENTS	MILES		IN (H) FINANCE	04/05/77		773	04/05/77	DP04, NR01.
HB 363	APPROP; U OF A FISCAL MGMT COMMITTEE	MILES		IN (H) FINANCE	04/05/77		773	04/05/77	DP05.
HB 365	REVOLVING LOAN FUND FOR RESIDENTIAL CARE FACILITIES	MILES		IN (S) FINANCE	02/02/78	CS * AM	736	04/01/77	DP(AM)07, NR01.
HB 366	APPROP; COM & ECON DEV; RESIDENTIAL CARE FACIL. R.L.F.	MILES		IN (S) FINANCE	02/02/78	CS * AM	736	04/01/77	DP(AM)07, OTHER01.
HB 379	BOARD OF NURSING HOME-MEMBERSHIP	ELIASON		CHAPTER 0077 SLA 77	06/03/77		861	04/14/77	DP07.
HB 381	APPROP-DEPT EDUC; COMFORT STATION AT COLONY VILLAGE	BUCHHOLDT		IN (S) FINANCE	04/25/77	CS * (HESS)	714	03/31/77	CS08.
HB 390	APPROP; ANCH LITERACY PROJECT; DEPT OF EDUCATION	LETHIN		IN (H) FINANCE	04/06/77		790	04/06/77	DP07.
HB 395	COMMUNITY MENTAL HEALTH SVCS ACT EXPENDITURES	MALONE		IN (H) FINANCE	04/04/77		754	04/04/77	DP(AM)04, NR01.
HB 407	EMERGENCY MEDICAL SERVICES-ADVISORY COUNCIL	MCKINNON		CHAPTER 0100 SLA 77	06/09/77	* AM	1043	04/27/77	DNP01, DP(AM)05.

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HB 408	APPROP; ANCH NEIGHBORHOOD HEALTH CENTER; H & SS, DEPT MILES — IN (H) FINANCE	04/26/77		1030	04/26/77	DP05.
HB 409	CATASTROPHIC ILLNESS BUCHHOLDT — IN (S) FINANCE	05/24/77	CS * (FIN)	1262	05/09/77	CS09.
HB 413	APPROP; CITY OF NENANA HEALTH SVC CENTER SWANSON — IN (H) FINANCE	04/23/77		987	04/23/77	DP04, NR01.
HB 418	DE NOVO HEARINGS IN SUPERIOR COURT JUDICIARY — IN (S) HESS	04/21/77		903	04/19/77	DP06.
HB 421	APPROP-ADMIN DEPT ADVANCES TO U OF A RULES — GOVERNOR — IN (H) FINANCE	04/20/77		923	04/20/77	CS06.
HB 432	SVCS FOR PERSONS UNDER STATE RESPONSIBILITY HESS — IN (H) FINANCE	05/05/77		1227	05/05/77	CS05.
HB 435	APPROP - C&RA DEPT; RURALCAP PROGRAM COWPER — CHAPTER 0134 SLA 77	06/14/77		1055	04/27/77	DP04, NR03.
HB 439	AK LONGEVITY BONUS; DEPT HEARING GUY — IN (S) RULES	03/08/78	CS *	1193	05/04/77	CS07.
HB 460	APPROP; LAKE PENINSULA REGIONAL EDUC ATTENDENCE AREA ANDERSON — IN (H) FINANCE	05/18/77		1389	05/18/77	DP03, NR05.
HB 463	APPROP; SHELTER FOR ASSAULTED WOMEN & CHILDREN MALONE — CHAPTER 0072 SLA 77	05/28/77	* AM	941	04/21/77	DP(AM)05, NR02.
HB 465	EQUAL TREATMENT OF PERSONS; REGULATIONS OF H&SS DEPT PARR — IN (S) HESS	04/29/77	CS * AM	1030	04/26/77	CS05.
HB 489	LABOR RELATIONS; SCHOOL BOARDS & OTHERS AND EMPLOYEES MALONE — BY REQUEST — IN (S) HESS	03/09/78	CS *	427	02/28/78	CS08.
HB 589	AK NAT GUARD SENIOR ROTC SCHOLARSHIP PROGRAM RULES — GOVERNOR — IN (H) FINANCE	01/23/78		131	01/23/78	DP05, NR02.
HB 598	SPEC APPROP; DEPT HEALTH & SS; WOMENS CENTER IN KODIAK SNIDER — IN (H) FINANCE	03/03/78		462	03/03/78	CS05, NR03.
HB 608	SUPPL APPROP; DEPT OF ED; PUPIL TRANSPORTATION; COMPUTR RULES — GOVERNOR — IN (H) FINANCE	01/30/78		173	01/30/78	DP04.
HB 618	STATE COMMISSION FOR HUMAN RIGHTS ANNUAL REPORT MALONE — IN (S) HESS	03/07/78	* AM	198	02/01/78	DP(AM)06.
HB 637	CREDITABLE OUTSIDE SERVICE AND TRS RULES — LEG. CNCL. — IN (H) FINANCE	02/22/78		373	02/22/78	CS07.
HB 660	COST OF LIVING ALLOWANCE IN TRS RULES — LEG. CNCL. — IN (H) FINANCE	02/14/78		301	02/14/78	DP05, DNP01, OTHER01.
HB 680	BILINGUAL PUBLIC HEARINGS; ADMINISTRATIVE PROCEDURE ACT BUCHHOLDT — IN (H) FINANCE	02/22/78		374	02/22/78	CS06, NR01.
HB 697	SPEC APPROP; DEPT/EDUCATION; COMMUNITY SCHOOLS DUNCAN — IN (H) FINANCE	02/28/78		427	02/28/78	DP(AM)07.
HB 698	TEACHERS RETIREMENT DUNCAN — IN (H) FINANCE	02/10/78		278	02/10/78	DP03, DNP01, NR03.
HB 726	SPEC APPROP; DEPT/EDUC; AK PUBLIC BROADCASTING CMSN NAKAK — IN (H) FINANCE	02/24/78		394	02/24/78	DP03, NR02, OTHER02.
HB 728	SPEC APPROP; DEPT/HEALTH & SS; MOBILE DENTAL CLINIC OSTERBACK — IN (H) FINANCE	03/08/78		510	03/08/78	DP04, NR01.