ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1396 HHESS HB 834 - HB 854

1396

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution Number: HB 834

Title: Establishing the Housing Assistance Payment Program
Requested by: House, Education & Social Services and Finance Date: 3/16/82

II. FISCAL DETAIL
Agency Effected: Revenue
Program Category Effected: Administrative and Public Services
BRU, Program, or Subprogram(s) Effected: Administrative and Public Services
(Note: If more than one budget component is effected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	9.3	374.4	400.6	428.7	458.7	490.8
200 TRAVEL	-	-	-	-	-	-
300 CONTRACTUAL	-	415.5	444.6	475.7	509.0	544.6
400 COMMODITIES	-	5.0	5.4	5.7	6.1	6.6
500 EQUIPMENT	-	125.0	-	-	-	-
600 LAND & STRUCTURES	-	-	-	-	-	-
700 GRANTS,CLAIMS,ETC	-	-	-	-	-	-
800 MISCELLANEOUS	-	-	-	-	-	-
TOTAL	9.3	919.9	850.6	910.1	973.8	1,042.0

FUNDING (Thousands of Dollars)

GENERAL FUND	9.3	919.9	850.6	910.1	973.8	1,042.0
FEDERAL FUNDS	-	-	-	-	-	-
OTHER (Specify Source)	-	-	-	-	-	-

POSITIONS

FULL TIME	1/3 mm	3/36mm	3/36mm	3/36mm	3/36mm	-
PART TIME	-	21/135mm	21/135mm	21/135mm	21/36mm	-
TEMPORARY	-	-	-	-	-	-

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)
See attached analysis.

IV. DATE: 3/18/82 PREPARED BY: P.A. Wall
AGENCY: Revenue
PHONE: 465-2393

Original: Legislative Finance
cc: Budget and Management

HB 834

ANALYSIS

Allows claims and distribution of housing assistance payments on a calendar year or month by month basis.

ASSUMPTIONS

Claim's period begins January 1 for the preceeding calendar year, 420,000 claims for 1981. Parents can claim minor children; guardians can claim incompetent person in their care; married persons can make a joint claim for themselves and their minor children.

170,000 annual and 120,000 monthly (10,000 per month) payments for 1981. (Joint claims - 80,000, children under 18 - 160,000, individuals - 100,000). 50,000 address change, name change and miscellaneous transactions. Payments will be made monthly or on an annual basis. Supervision provided by existing staff.

PROGRAM SUMMARY:

Regulations must be developed and promulgated which define eligibility for housing assistance payments, the filing deadline date, the procedure for insuring that payments are used to pay for housing expenses and related processing procedures. Design, have printed, and distribute application forms and instructions. Provide assistance to applicants in filling out the forms and answering inquiries. Design, develop and implement the required processing procedures and computer forms. Receive applications at field counters and through the mail. Open mail, assign document control numbers, batch documents and establish batch controls, data capture documents for computer processing, audit computerized data and correct as required, audit warrant payment controls, correct as required and release warrants. Receive returned, undelivered and unclaimed warrants, file, data capture new addresses when received and send the payment to the new address.

POSITIONS

FY82

ADMINISTRATIVE SERVICES

PFT systems Analyst R 18 0 $2,838 mo
plus 32% const for 3 mos = 9.3

Design computerized distribution system for processing and payment of housing assistance claims.

Total FY82 positions for Administrative Services = 9.3

FY83

ADMINISTRATIVE SERVICES

1 PPT Personnel Assistant R 12 @ $1,889 mo
plus 32% costs for 6 mos = 15.0

Recruitment, hiring, EEO and contract administration, leave accounting and related personnel/payroll services.

1 PFT Systems Analyst R 18 @ $2,838 mo
plus 32% costs = 45.0

Complete design of computerized system for processing and payment of housing assistance claims.

2 PPT Clerk Typists R 7 @ $1,487 mo
plus 32% costs for 6 mos each = 23.6

Forms ordering and distribution, accounts payable including voucher preparation. Supply services.

10 PPT Tax Scanners R 7 @ $1,487 mo
plus 32% costs, for 6 mos each = 117.8

2 PFT Tax Scanners R 7 @ $1,487 mo
plus 32% costs = 47.1

Open mail, assign document control number, audit applications for completeness and required information, batch and batch control, data capture, audit of data capture and correction as necessary, preparation of monthly and annual housing assistance payment warrants, pull warrants which have garnishments or other attachments.

Total FY83 positions for Administrative Services = 248.5

PUBLIC SERVICES

3 PPT Tax Examiners R 10 @ 1,673 mo
plus 32 % costs, 9 mos each = 59.6

5 PPT Tax Examiners R 10 @ $1,673 mo
plus 32% costs, 6 mos each = 66.3

Application assistance and phone, letter and counter response to inquiries at Juneau, Anchorage, and Fairbanks. Receipt, filing and re-issue of returned, undeliverable and unclaimed housing assistance payments. Furnish copies of applications upon authorized request.

Total FY83 positions for Public Services = 125.9
Other TY83 positions 374.4

OTHER EXPENDITURES

FY83

ADMINISTRATIVE SERVICES

Contractual

Forms and Instructions:		
550,000 for handout and response to requests @ $20M	=	11.0
290,000 warrants @ $35 M	=	10.2
290,000 warrant envelopes @ $12.43 M	=	3.6
Postage		
Public Services correspondence - 15,000 @ .25	=	3.8
Forms and instructions - 180,000 @ .25	=	45.0
Housing assistance payment warrants 290,000 @ .25	=	72.5
Data Processing (Includes Development, Data Capture, and Production)		
Computer Resource Units: 85,000 @ 1.25 per unit	=	106.3
Common Output Units: 235 @ $31 (reports, warrants, COM)	=	7.3
Storage Units: Master and Payment file: 3,500 @ $14 disk	=	49.0
Miscellaneous Files including garnishments: 500 @ $14 disk	=	7.0
Backup - Tape	=	.1
Terminals		
Data Capture CRT's: 4 @ 3,900 each	=	15.6
Data Management CRT's: 4 @ 4,600 each	=	18.4
Printer: 1 @ $7,026	=	7.0
Controller: 1 @ $4,679	=	4.7

Toll calls including Zenith:			
Administrative Services	=	4.0	
Public Services	=	20.0	
Public Services Advertising: Radio, TV, Newspaper	=	20.0	
Miscellaneous Contractual:			
Administrative Services	=	5.0	
Public Services	=	5.0	
Total Contractual Services	=		415.5
Commodities - Administrative Services	=	2.0	
Public Services	=	3.0	
Total FY83 Commodities			5.0
Equipment - Microfilm System			125.0
Total FY83 Equipment			125.0

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution Number: HB 834
Title: An Act establishing the housing assistance payment program.
Requested by: House Health, Ed. & Social Services Committee Date: 03/18/82

II. FISCAL DETAIL
Agency Effected: Department of Revenue
Program Category Effected:
BRU, Program, or Subprogram(s) Effected:
(Note: If more than one budget component is effected, separate line item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	-	-	-	-	-	-
200 TRAVEL	-	-	-	-	-	-
300 CONTRACTUAL	-	-	-	-	-	-
400 COMMODITIES	-	-	-	-	-	-
500 EQUIPMENT	-	-	-	-	-	-
600 LAND & STRUCTURES	-	-	-	-	-	-
700 GRANTS,CLAIMS,ETC	-	-	-	-	-	-
800 MISCELLANEOUS	-	-	-	-	-	-
TOTAL	-	-	-	-	-	-

FUNDING (Thousands of Dollars)

GENERAL FUND	-			(See Below)	-	-
FEDERAL FUNDS	-	-	-	-	-	-
OTHER (Specify Source)	-	-	-	-	-	-

POSITIONS

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

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

If HB 834 is enacted, the General Fund would be negatively impacted. However, the amount of money available from the General Fund for the housing assistance payment program is undeterminable at this time.

IV. DATE: 03/18/82

PREPARED BY: Robert W. Elliott
AGENCY: Revenue
PHONE: 465-2173

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

33-001 (Rev. 12/81)

HB
844

COMMITTEE REPORT

HOUSE

(5) FURTHER: FINANCE

2/16/82

Date: 2-17-82

Mr. Speaker:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had CS HB 844(H&SS)

"An Act relating to the financing of rural health facility improvements and maintenance."

under consideration and ~~(a majority of the committee)~~ (the committee) reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for _____ [X] same title [ ] new title

and recommends _____

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

_____ CHAIRMAN

H 60 (Rev. 12/78)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

DOCUMENT NO. 81-82

March 9, 1982

The Honorable Michael F. Beirne
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Beirne:

Enclosed is our report on the physical plant condition of Alaska's rural hospitals and nursing homes. This report complements our initial report on construction needs among the state's 200 clinics which we recently provided to you. Both inventories were supported by a capital appropriation made to the Department by the Legislature for fiscal year 1982.

These reports were prepared to assist us in our long range planning as well as to guide the state in considering resource allocations for health facility construction. This increasing trend toward state assistance in health facility construction underscores the need for a systematic approach to allow the most urgent needs to be met in a timely manner.

A complete set of the individual inventories is being placed on file with the State Library, the Legislative Library, and a full set of reports is also available for review in the Division of State Health Planning and Development. We are providing to your committee a full set of the individual inventories for use by committee members and other members of the House.

If you have any questions or comments on this report, you may wish to contact Phoebe A. Lindsey, Director of the Division of State Health Planning and Development at 465-3038.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure

DB-F3:LH

REPORT ON RURAL ALASKA HOSPITALS AND NURSING HOMES

INVENTORY AND EVALUATION

SURVEY

PREPARED FOR

ALASKA LEGISLATURE

BY

DIVISION OF STATE HEALTH PLANNING AND DEVELOPMENT

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

HELEN D. BEIRNE, COMMISSIONER

MARCH 8, 1982

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INTRODUCTION

Ensuring access to and availability of care is an important planning responsibility of the State of Alaska. The needs for and adequacy of health care facilities, manpower, services and equipment are all important considerations in determining an appropriate health care delivery system for Alaska.

With the support of a 1981 legislative appropriation, the Department of Health and Social Services has conducted an inventory of 15 rural hospitals and nursing homes and a survey of more than 200 clinics in the State to assess their physical plant condition and functional adequacy. This report describes the inventory design and process, the findings, and alternative construction funding sources. In a separate effort, the Department surveyed all health clinics in the State and has provided an initial report on the needs for clinic construction to the legislature.

Information provided in these reports is intended to serve as a guide in determining an appropriate level of State support for health facility construction, since the number and size of construction aid requests and/or appropriations are increasing each year. Cost estimates are provided to outline the dimension of construction need, but cannot be interpreted as a recommended level of State support.

I. HEALTH FACILITY INVENTORY DESIGN AND IMPLEMENTATION

The Need for a Health Facility Inventory

The Department of Health and Social Services has become increasingly aware that many health care facilities, particularly rural hospitals and nursing homes,

are in need of renovation or replacement. This awareness has sharpened as the Department fulfills its responsibilities for review and approval of facility construction plans, for issuing construction licenses, for annual operational licensure surveys, for certification for Medicare and Medicaid reimbursement and in analyzing applications for certificate of need. Knowledge that there were significant needs for upgrading facilities was accompanied by an awareness that many communities were unable to undertake hospital or nursing home renovations because the community's economic base could not support the total costs. The Department initially outlined its concerns related to health facility construction and operation in a 1981 report to the Legislature on health facility revenue sharing.

Designing the Inventory

As a result of an appropriation by the 1981 Legislature to inventory health facilities, the Department defined its scope as those rural hospitals and nursing homes designated as Level III facilities in the State Health Plan. This designation includes communities with sufficient population and health care services, manpower, equipment and facilities to provide basic hospital services and long term care services. The inventory was limited to these communities because construction, licensing and certification staffs had identified major deficiencies in these facilities which communities had been unable to correct. These deficiencies included:

- Building, fire and life safety code violations;
- Lack of adequate mechanical ventilation to patient care areas;
- Mechanical and electrical inadequacies resulting from acquisition and use of modern equipment which places higher demands on original mechanical and electrical systems;

- Structural constraints which inhibit facility flexibility to respond to changes in health care practices, patterns of use, medical technology and community attitudes;

- Space shortages resulting from increased complexity of information processing and records storage requirements;

- Space shortages resulting from more medical equipment;

- Storage shortages related to greater use of disposables rather than reuseable items.

Changes in service area populations (growth or decreases) modifying needs for space.

To determine interest in participating in the survey, the Department contacted all rural hospitals and nursing homes to advise them of the survey and to request their participation. Anchorage and Fairbanks hospitals were not included as they are not considered rural facilities and were not experiencing code compliance correction issues faced by rural facilites. For-profit facilities such as Nakoyia Health Care Center in Anchorage and Careage North in Fairbanks were also excluded since they are not eligible for State assistance. All rural hospitals and nursing homes elected to participate in the inventory with the exception of Valley Hospital in Palmer, since financing had been secured for renovation/replacement of the facility and project design was in progress. Sitka Community Hospital also declined to participate since construction of a replacement facility was underway.

Conducting the Inventory

Once the listing of facilities to be inventoried had been finalized, the Department of Health and Social of Services issued a Request for Proposal to architectural firms for the completion of an on-site inventory and evaluation survey of fifteen rural health care facilities in the State.

The purpose of the survey is two-fold: 1) to develop a detailed record of the current condition of each subject facility, emphasizing physical condition and functional adequacy; and, 2) based on an analysis of those current conditions and any anticipated future developments (expressed in long-range plans, and certificate of need applications, for example), to formulate recommended activities for the correction of noted deficiencies and provide preliminary cost estimates for the recommended activites.

The inventory and condition survey was organized into three basic phases:

Phase One: Pre-inventory Activity

The first phase consisted of pre-inventory activity including:

- preparation of request for proposals
- selection of architectural firm
- initial consultation with selected firm
- collection and review of available documents/plans
- confirmation of site visit schedule
- development of forms and questionnaires
- final coordination meeting between architectural firm and DHSS

Phase Two: On-site Inventory

The second phase included all the on-site inventory activity. To accomplish this portion of the work in the limited time available, two survey teams were formed, each with a hospital systems planner, an architectural investigator, a mechanical investigator, and an electrical investigator. The facilities surveyed were divided into an eastern region and a western region with one survey team assigned to each region. Pre-determined survey formats were used to assure consistency between the two regions.

Each site survey consisted of the following steps:

Document Review:

Examination of existing documents including plans, code reviews, pertinent facilities board actions, pending physical plant changes, fire marshal reports, licensing agency recommendations and long range plans.

Staff Interview:

An interview session including representatives from the facility's administration and medical staff (as deemed appropriate by the facility's administrator).

Facility Examination:

The survey team inspected all portions of the facility to gather first-hand information on all systems. Standardized forms and checklists were used to assure thorough investigation and standardized reporting. Field notes were used to itemize deficiencies not covered by the standardized forms and checklists.

Final Meeting:

A final meeting was held with the facility's administrator to communicate the results of the facility examination, preliminary findings of the team, and to discuss the nature of the report.

Phase Three - Evaluation of Reports

The third phase of the inventory and condition survey included the evaluation of collected data, and preparation and submission of draft reports. The Health Resources Development Section of the Division of State Health Planning and Development, DHSS analyzed several drafts and worked with the consulting architectural firm toward the completion and printing of the report.

II. OVERVIEW OF SURVEYED FACILITIES

During its evaluation of the physical facilities of each hospital/nursing home the architectural team discovered a number of serious deficiencies. Generally, the deficiencies result from advances and changing techniques in the medical field, coupled with more stringent building, fire and life safety codes which have been adopted over the years since construction of the facilities. Space and flexibility limitations in the facilities were also judged to be important deficiencies and were considered in arriving at the recommendations for corrective measures.

The majority of nursing units were found to lack required electrical capacity, mechanical ventilation systems and nurse call systems. Surgical units

in some hospital facilities were found not to meet minimum area requirements and to be poorly ventilated. Often the surgical areas were laid out in a manner providing undesirable circulation patterns which created cross-contamination problems.

Advanced laboratory and treatment equipment is increasingly being placed in service at the facilities. Usage of the radiology and laboratory units of the facilities is also increasing. These areas require large amounts of mechanical and electrical service to accommodate these increases. Most of the facilities surveyed were drastically short on space in these areas. Most of the older facilities provide insufficient waiting areas for outpatients, causing the use of corridors, foyers, and other access areas for waiting areas. These conditions result in Life Safety Code violations.

Many facilities have found it necessary to store medical equipment in corridors due to the lack of storage space, thus compounding circulation problems.

New obstetrical practices such as "birthing rooms" and "rooming in" have become popular in recent years causing changes in space requirments for obstetrical areas.

Administration areas in most facilities are cramped, with records storage space lacking. As these facilities convert to the use of computerized data storage systems, this problem will increase due to the sophisticated mechanical and electrical requirements for this equipment. Retrofitting most facilites to handle this type of equipment will be costly and difficult.

Bringing some of the surveyed facilities into compliance with the governing

mechanical and electrical codes is expected to be more costly than new construction. This is due, in part, to a lack of physical space in which to install the required systems. Examples of this are:

The existence of concrete floor slab-on-grade construction, where the floor would have to be removed to install new plumbing or mechanical systems; and,

Buildings that have little or no space between ceilings and the roof framing for the installation of mechanical systems.

Although, in some instances the report recommends facility replacement based upon the conclusion that it would not be cost-efficient to attempt to bring the facility up to current hospital construction standards by remodeling or renovation, many of those facilities may still be useful for non-hospital programs.

The reports do not recommend the correction of noted deficiencies when the costs involved appear to outweigh the benefits. In such instances replacement is suggested. In other instances the reports recommend immediate remedial action to correct hazards even though the final conclusion is for replacement of the facility.

III. PRIORITIZATION OF SURVEY FACILITIES

In conducting the inventory and evaluation study of the fifteen hospitals and long-term care facilities, the architectural consultants identified six facilities which are in greater need of immediate attention than others, due

to their more severe physical and functional deficiencies. To arrive at a ranking of all surveyed facilities based upon relative need for construction to correct noted deficiencies, the Department assembled a committee to review the report. This committee consisted of one member of:

The Alaska Medical Facility Authority;
The Alaska State Hospital Association
Southeast Alaska Health Systems Agency, Inc:
South Central Health Planning and Development, Inc.;
The Medical Care Advisory Committee, and
The Statewide Health Coordinating Council.

The ranking provided by this committee was based only upon the relative severity of all physical and functional deficiencies found at each facility and did not consider other factors such as facility utilization or population trends: The committee ranking was as follows:

1.) Cordova Community Hospital and Long-Term Care Facility
2.) Petersburg General Hospital and Long-Term Care Facility
3.) Seward General Hospital
4.) Kodiak Island Hospital and Long-Term Care Facility
6.) Wesleyan Nursing Home
7.) Wrangell General Hospital
8.) South Peninsula General Hospital and Long-Term Care Facility
9.) Ketchikan General Hospital and Island View Manor
10.) Central Peninsula General Hospital
11.) Bartlett Memorial Hospital
12.) Valdez Community Hospital

13.) St. Ann's Nursing Home

14.) Norton Sound Regional Hospital

To develop a construction plan for addressing the need for correcting the noted deficiencies, the Department considered the recommendations given in the report and the recommended ranking provided by the review committee in light of factors other than physical characteristics such as occupancy rates, population trends, accessibility, and alternative sources of health care. The construction plan (attached as an appendix) recognizes the need for an orderly progression for each facility on a year to year basis from preparation of long-range planning to design and then to construction. The plan also recognizes the fact that some of the facilities have completed the planning phase or design phase and are prepared to proceed with the correction of deficiencies. For these reasons the construction plan is not entirely consistent with the prioritized listing which was based only upon the severity of deficiencies. The plan also spreads the estimated costs for planning and construction over a five year period.

For some facilities the consultants report provided estimated costs for correcting deficiencies. For other facilities where estimated costs were more difficult to assess the report recommended long-range planning before establishment of cost estimates. Readers of this report should note that the estimated costs have been proposed without the benefit of detailed long-range planning and should only be viewed as guidelines. The costs shown in the report and construction plan are estimated 1982 values without projection for inflation and do not include other project costs such as fees, equipment, or site acquisition. More accurate figures have been presented for the Petersburg facility since that facility is nearing the end of the design phase.

The estimated costs shown are provided as a guideline in determining the dimensions of a given community's need. No estimates have been made or indeed can be made from this inventory as to the level of State assistance appropriate to any one community.

The construction plan emphasises the need for long-range planning prior to construction. The consultant report indicates that sufficient long-range planning was not done before construction of several of the facilities surveyed. The Department recommends a requirement for formal long-range planning for those facilities which have not begun or have not have adopted a long-range plan before any State funding is provided. One important aspect of long-range planning is to identify possible future expansion and thereby, avoid "boxing in" service areas which can reasonably be expected to require more space in future years. Long-range planning and State policy development should also consider both Pioneers and non-Pioneers requiring long-term nursing care. The expected growth of the age group of Alaskans eligible for Pioneer services, which include skilled nursing care, make this an important consideration.

IV. ALTERNATIVE SOURCES OF CONSTRUCTION FUNDS

Possible sources for construction funds are limited and apparently do not meet the needs of most of the surveyed facilities. Existing sources are:

Revenue Sharing

Under AS 29.90 municipalities or other hospital or health facilities sponsors may receive reimbursement for up to 25% of total project costs. This partial reimbursement is available only to those facilities which have successfully secured financing and have completed a health facility construction project. Most rural facilities do not have the capacity for debt required to secure

financing for completion of a facility. For this reason access to the partial reimbursement is essentially denied to those facilities.

Alaska Medical Facility Authority

Under AS 18.26 medical facilities may apply to the Alaska Medical Facility Authority for State backing relative to the sale of tax-exempt bonds for the purpose of financing medical facility construction. One project has been financed through this program to date -- a 1978 Fairbanks Memorial Hospital expansion project in the amount of approximately $12 million. Alaska Hospital and Medical Center, Anchorage, is presently working with the Authority for the refinancing of that facility and the acquisition of the adjacent professional office building.

One determination which the Authority must make before bonds may be issued under this statute is that the lease or operator agreement for the medical facility being financed by that issue is at least sufficient to meet all obligations in connection with the lease or operator agreement, including all costs necessary to service the bonds. This prerequisite essentially disallows use of the program by rural facilities, most of which do not have more than a minimal capacity for servicing bonds.

Federal Funding

Federal funding for health facility construction provided under the Hill-Burton program is no longer available.

Congress has approved a program which may provide construction funds for the purpose of converting existing hospitals and long-term care facilities to

other uses. The intent of this program is to provide for an orderly closure of an unneeded hospital or long-term care facility. This program has not been funded and would not serve the needs of Alaskan facilities which are seeking funds for renovation or replacement.

The only Federal funds which are available for health facility construction are esentially limited to construction or renovation of Federally owned facilities such as Public Health Service hospitals or Veterans hospitals.

Municipal or Borough Bonds

The issuance of municipal or borough bonds is a possible source of funds for community hospitals. Most of the surveyed facilities are, however, located in municipalities or boroughs which do not have the bond capacity necessary to meet more than a portion of estimated construction costs.

Direct Legislative Funding

Direct legislative funding through the sale of bonds or from general funds has been an important source of State support for health facility construction, particularly for rural facilities. There are, however, several problems which may result from a direct legislative appropriation to a named recipient. This method of funding has provided excess funding in some instances, and insufficient funding in other instances, since, under this method, funding levels are necessarily set before reliable cost estimates are available. An excess of funds usually results in additions to the original building concept such as additional administrative space, another operatory or another feature which may not be essential. Insufficient funding either causes delays

in project construction, incomplete projects, or the construction of a facility which is reduced in scope from the original design.

Conventional Loans

Conventional loans from lending institutions may be another source of construction dollars for hospitals; however, lending institutions usually have more stringent requirements and higher interest rates than previously mentioned alternatives.

V. DETERMINING A STATE ROLE IN HEALTH FACILITY CONSTRUCTION

The question of the appropriate state role in assisting construction needs of existing facilities is a complex one. This report has noted that the State and Federal Government have previously had roles in establishing and/or assisting with the construction of many health care facilities. With the discontinuation of Federal funds which had previously supported construction of health care facilities, the State's role has become less clear and in need of further exploration and definition. Regardless of the extent of the State's role, the fact remains that many of Alaska's health care facilities, which are deemed to be needed facilities by virtue of access to the services they provide, are in need of renovation, modernization or replacement in order to continue to make quality health care reasonably accessible to Alaskans as well as to the many visitors to this State.

Health facility construction funding is presently limited to the aforementioned alternatives. The likelihood of Federal assistance for which Alaska facilities would be eligible any time in the near future is remote. Health facility construction need not be bound by current programs if it is determined that the State has a role in assisting with systematic health facility upgrading and construction.

Two legislative proposals address the need for a statutorily established health facility construction program. House Bill 844 and the identical Senate Bill 782 pose one possible format for a program adressing health facility construction. These bills would create a fund within the Department of Health and Social Services for plant improvements and maintenance at rural health facilities. The bills provide that the Statewide Health Coordinating Council will make recommendations to the Commissioner of the Department of Health and Social Services as to the prioritization of projects. Under these bills the priorization of projects would be based upon:

1) The condition of the existing physical plant of a rural health facility (as determined by an annual inventory prepared by the Department of Health and Social Services);

2) The ability of the rural health facility to continue to provide quality health services;

3) The need in the community for additional services; and

4) The ability of the rural health facility to meet current licensure standards.

Although the concept of providing state assistance to rural health facilities as outlined in these bills appears valid, the bills do have some shortcomings. The bills apparently provide for total State funding of construction of rural health facilities. It can be argued that the State has a responsibility for ensuring access to quality health care facilities by its citizens by providing

grant funds when other sources of funding are non-existent or insufficient; however, the Department does not believe the State has a responsibility to totally fund health facility construction. Some level of local support for health facility construction is essential.

The Department has historically supported the establishment of a formalized health facility construction program in Alaska to better guide the allocation of limited resources. The completed rural hospital and nursing home inventory and condition survey and the committee's review comments described in this report are viewed as the first step in the development of a systematic approach to state assistance for health facility construction. Such an approach should include the following components as well:

- a Statewide Medical Facilities Plan
- certificate of need review
- a funding mechanism
- construction progress assessments

A proposed format and discussion of these components follows:

Statewide Medical Facilities Plan

A hospital construction assistance program should be based upon a Statewide Medical Facilities Plan which sets out the future needs for medical facilities in the State. This plan may be included as a part of the State Health Plan prepared on a regular basis by the Department of Health and Social Services and the Statewide Health Coordinating Council. The purpose of the Statewide Medical

Facilities Plan would be to orderly set forth and prioritize the need for construction of health facilities. The format of such a plan should be determined by the Department of Health and Social Services; however, the development and approval of the plan would involve the individual hospital, the Statewide Health Coordinating Council, the Alaska State Hospital Association, the State Health Planning and Development Agency, and the health systems agencies or successor organizations. To provide a data base for the plan, each facility would be requested to submit, on a voluntary basis, a long-range plan. The long-range plan would, at a minimum, anticipate the facility's program needs and construction needs for the current year and the next five years. These institution-specific plans would be included and prioritized in the Statewide Medical Facilities Plan by the Division of State Health Planning and Development and approved by the Statewide Health Coordinating Council (SHCC). In its consideration for approval of the Statewide Medical Facility Plan the SHCC would consider public input, certification and licensure reports, the State Health Plan, and other pertinent information.

Funding Mechanism

The funding mechanism should allow sufficient flexibility to permit non-grant financing to be used in conjunction with grant funds. Planning and design of a hospital construction project should be completed to the degree necessary to establish reliable construction cost estimates before construction funding levels are determined. The mechanism might also serve to reduce the inaccuracy of funding levels by providing separate allocations for 1) planning and design, and 2) construction. Although some adjustments to cost estimates will occur during construction, this method of determining funding levels

will reduce the excess funding and funding shortfalls which have resulted from current methods of funding hospital construction.

The first step in any building program is the perception that a need exists. Typically, the perception of the need for a building program results from observable facility inadequacies: The facility is too small, too old, does not provide sufficient space for a recently perceived need such as birthing room, long-term care rooms, ultra-sound services, for example. As such, the need for a building program is generally perceived on a local level by physicians, facility staff, the community served by the facility and is subsequently brought before the facility's board of directors for approval. The State may point out the need for a building program as a result of licensure or architectural surveys; however, it is essential that the people who work in the facility and are served by the facility be involved in the development of a solution to an identified need if the solution is to be acceptable.

Once a need has been perceived, active planning begins with a need survey and feasibility evaluation. The work required by the need survey will depend upon the specific points of the perceived need. If the perceived need is to meet a code requirement, the need survey may simply be a statement of the facts. If the perceived need is for a new facility, the need survey would be more extensive, identifying what services the community desires, what services may reasonably be offered in the community, and workloads for those services. The most important point to determine with the need survey is whether the <u>perceived</u> need is an <u>actual</u> need.

Certificate of Need Review

The certificate of need review is essential to any process whereby State funds are provided for hospital and nursing home construction. It is this review which offers a safeguard against the proliferation of health care beds, avoids unnecessary duplication of facilities, and gives assurance that the size and cost of facilities are reasonable.

The above noted need survey and feasibility evaluation are the major components of a certificate of need application. A positive indication by the need survey and feasibility evaluation usually result in the issuance of a certificate of need approving the requested construction project. (When a negative indication results from the need survey or feasibility study the facility's board generally does not proceed with the submission of an application for a certificate of need. As such, few certificate of need applications are disapproved.)

Where construction of a health facility is proposed the certificate of need review addresses considerations such as:

1. The relationship of the project to the State Health Plan;

2. The relationship of the proposed project to the long-range plan of the facility;

3. The relationship of the proposed project to the Health Systems Plan and Annual Implementation Plan of the Health Systems Agencies;

4. The need of the population to be served served by the facility;

5. The availability of less costly or more effective alternative methods of meeting the needs of the area to be served by the facility;

6. The immediate and long-term financial feasibility of the proposed facility;

7. The relationship of the facility to other existing health care facilities in the area;

8. The availabiltiy of resources including health manpower, management personnel and the availability of funds needed for construction or those funds needed for operating costs;

9. The probable impact of the construction project on the cost of providing health services to the citizens to be served.

Level of State Assistance

Assuming certificate of need approval, one major decision regarding a proposed health facility project would remain: the appropriate level of state assistance for the project. The appropiate level could be determined in a simple and straight forward manner by the provision of a ratio of State assistance to local assistance, such as 70% State funding and 30% local match. Obviously several variations in the ratio are possible. An important consideration which this simple formula would overlook is the capability of the community served to provide the matching funds. The discontinued Federal Hill-Burton program for health facility construction worked on this basis; however, in Alaska the local match was provided by the State.

It may be more appropriate to establish an application process by which the facility would request an amount of State assistance with accompanying justification to support the request. Department of Health and Social Services staff or an advisory committee would review the application for State assistance and provide to the Commissioner a recommended level of State participation in the form of a grant, loan, loan guarantee or a combination. In this model a proceedure would be established to coordinate the expenditure of grant funds with lenders, the Alaska Medical Facility Authority, and other possible funding sources.

Once any level of State funding has been established, the recipient should be required to demonstrate the availability of total construction funds neccessary for the completion of the project before the expenditure of State funds. Such a demonstration will help avoid situations where funding is depleted before the project is completed or where the scope of a project is reduced to the point where the completed facility will be inadequate to fulfill needs and requirements for which it was originally planned.

Construction Progress Assessments

To give further assurance that funds will be sufficient to complete the project, it is advisable for the disbursement of funds to be made in phases according to the percentage of work completed. The Department of Health and Social Services currently reviews plans and specifications for hospital construction and intermittently visits construction sites to assure that the completed facility meets codes and it is acceptable for Medicare and Medicaid certification and State licensure. Under this program the Department of

Health and Social Services representatives would have the added responsibilities of verifying the percentage of project completion and reporting that percentage to the disbursement officer in charge of State funds for each project.

APPENDIX

FIVE-YEAR CONSTRUCTION PLAN FOR STATE HEALTH PLAN LEVEL III

HOSPITALS AND NURSING HOMES

Notes to Five-Year Construction Plan for State Health Plan Level III

Bartlett Memorial Hospital

A long-range plan has recently been completed. Preparation of plans and specifications for the correction of deficiencies may begin once the facility's board has assessed the long-range plan. The five year plan indicates $2,000,000 for design during FY 85 with construction costs determined thereby in FY 86. The source of financing has not been identified.

Central Peninsula General Hospital

Facility operations have recently expanded into a major addition for outpatient and administration departments. Another addition for needed beds and surgery department improvements is in the contracting phase. A borough bond issue has been approved for the purpose of financing the project and a certificate of need has been issued.

Cordova Community Hospital and LTC Facility

Has recently completed a certificate of need application for a new structure. A bill for funding of the design phase is currently before the legistature. A decision regarding this application is expected in late March. The five-year plan indicates an estimated $1,000,000 for design during FY 83 and $13,000,000 toward construction in FY 84.

Faith Hospital

Has completed preliminary drawings for an addition and renovation project. Funding has not been arranged. This facility's board has in the past indicated reluctance to accept State funding. The five-year plan suggests a sum of $1,200,000 as needed for this project.

Ketchikan General Hospital and Island View Manor Nursing Home

Has recently completed an extensive addition and renovation project. Funds shown anticipate future needs of $50,000 in FY 84 for planning and $1,000,000 in FY 85 for design. Construction costs as determined during these phases would follow in FY 86.

Kodiak Island Hospital and LTC Facility

Is currently completing long-range planning and program work and has submitted a certificate of need application. $1,000,000 for design and $10,000,000 for construction are estimated for FY 84 and FY 85.

Norton Sound Community Hospital

Recently occupied a new hospital wing and remodeled facility. $50,000 for formal long-range planning is estimated for FY 85 with funds required for subsequent phases to follow in succeeding years. Long-range planning should consider both Pioneer and non-Pioneer long-term nursing care.

Petersburg General Hospital and LTC Facility

$10,000,000 is before the legislature. Planning and design has ben completed with funds provided from previous state grants.

Seward General Hospital and Wesleyan Nursing Home

Should be encouraged to join in cooperative planning at an early date in order to maintain quality standards consistent with recognized goals. Long-range planning funds of $40,000 for each facility are scheduled in FY 84 and design funds of $1,500,000 in FY 85. Approximate construction costs for joint usage are shown at $15,000,000 in FY 86. Long-range planning should consider both Pioneer and Non-Pioneer long-term nursing care.

Sitka Community Hospital

A new Facility is under construction.

South Peninsula Hospital

Has completed some preliminary planning and has been granted a certificate of need for an addition. A bill for funding has been introduced into the legislature to provide $4,000,000 for construction in FY 83.

St. Ann's Nursing Home

Occupies quarters which were remodeled and expanded in the late 1970s. Establishment of a Pioneer Home providing other nursing home services in Juneau would profoundly affect this facility. The five-year plan schedules long-range planning funds of $40,000 in FY 84 and design funds of $500,000 in FY 85. Construction funds as necessary would be designated in FY 86 following the design phase.

Valdez Community Hospital

Is deficient in certain respects and should be studied particulary in regard to overall Harborview Developmental Center relationship and future need. Long-range planning funds of $50,000 in FY 85 would establish probable costs to be considered in FY 86 and 87.

Valley Hospital

Is currently completing construction drawings in accordance with the certificate of need issued. Construction is expected to begin in early summer of 1982

Wrangell General Hospital and LTC facility

Has expressed a need for additional space to satisfy current standards and goals. Design funds of $1,000,000 are indicated for FY 83 with construction funds of $8,000,000 in FY 84.

FIVE-YEAR CONSTRUCTION PLAN FOR STATE HEALTH PLAN LEVEL III

HOSPITALS AND NURSING HOMES

FACILITY	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987
Bartlett Memorial Hospital Juneau	long-range plan is complete	———	$2,000,000 for design	const. cost to be determined during design phase	———
Central Peninsula General Hospital Soldotna	Addition & remodel design is complete and construction to begin in 1982	construction is to be completed in FY 84 with borough funds	———	———	———
Cordova Community Hospital & LTCF Cordova	$1,000,000 for design of new facility	$13,000,000 for construction of new facility	———	———	———
Faith Hospital Glennallen	Addition & remodel $1,200,000 for construction of new facility	———	———	———	———
Ketchikan General Hospital and Island View Manor Ketchikan	new addition & remodeling has been completed	$50,000 for long-range planning	$1,000,000 for design	construction costs to be determined during design phase	———
Kodiak General Hospital & LTCF Kodiak	———	$1,000,000 for design	$10,000,000 for construction	———	———
Norton Sound Hospital & LTCF Nome	———	———	$80,000 for long range planning	design costs to be determined in planning phase	construction costs to be determined in planning
Petersburg General Hospital & LTCF Petersburg	$10,000,000 for construction design to be comp. w/state grant fund	———	———	———	———
Seward General Hospital Seward	———	$40,000 for long range planning	$1,900,000 for design	$15,000,000 for construction	———
Wesleyan Nursing Home Seward	———	$40,000 for long range planning (cooperative program)			
Sitka Community Hospital Sitka	A new facility is under construction	———	———	———	———
South Pen. General Hospital & LTCF Homer	$4,000,000 for construction	———	———	———	———
St. Ann's Nursing Home Juneau	———	$40,000 for planning	$500,000 for design	Construction costs to be determined in design phase	
Valley Hospital & LTCF Palmer	Addition & remodel design is complete to be under construction in 1982	———	———	———	———
Valdez Community Hospital Valdez	———	———	$50,000 for long-range planning	design costs to be determined in planning phase	const. costs to be determined in design phase
Wrangell General Hospital & LTCF Wrangell	$1,000,000 for design	$6,000,000 for construction	———		
OTHER	———	———	———	unknown	unknown
TOTAL	$17,000,000	$27,170,000	$15,100,000	$15,000,000 plus	$15,000,000 plus

* LTCF = Long-Term Care Facility

APPROXIMATE COSTS SHOWN ARE ESTIMATED 1982 VALUES WITHOUT PROJECTIONS FOR FUTURE INFLATION AND DO NOT INCLUDE OTHER PROJECT COSTS SUCH AS FEES, EQUIPMENT, SITE ACQUISITION, ETC. THE ESTIMATED COSTS SHOWN ARE PROVIDED AS A GUIDELINE IN DETERMINING THE DIMENSIONS OF A GIVEN COMMUNITY'S NEED. NO ESTIMATES HAVE BEEN MADE OR INDEED CAN BE MADE FROM THIS INVENTORY AS TO THE LEVEL OF STATE ASSISTANCE APPROPRIATE TO ANY ONE COMMUNITY.

POSITION PAPER

HOUSE BILL NO. 844

For an Act entitled: "An Act relating to the financing of rural health facility improvements and maintenance."

House Bill 844 creates a fund in the Department of Health & Social Services for the purpose of providing grant funds for improvement and maintenance of rural health facilities.

The Department has historically supported the establishment of a formalized health facility construction program in Alaska to better guide the allocation of limited resources. The recently distributed reports on the physical condition of the 200 + clinics in the state and on 15 rural hospitals and nursing homes are a first step in the development of a systematic approach to health facility construction. Other components of a system for health facility construction should include:

facility long range plans
a statewide plan for medical facilities
certificate of need review
a funding mechanism
periodic inventories of health facility physical plants

House Bill 844 would create a fund within the Department of Health and Social Services for plant improvements and maintenance at rural health facilities. The bill provides that the Statewide Health Coordinating Council will make recommendations to the Commissioner of the Department as to the prioritization of projects and that the Commissioner would make grants to rural health facilities based on those recommendations.

Although the concept of providing state assistance to rural health facilities is strongly supported by the Department, the bill would benefit from further clarification. The bill as outlined would provide total state funding of improvements and maintenance at rural health facilities. It can be argued that the state has a responsibility for ensuring access to quality health care facilities to its citizens by providing grants funds when other sources of funding are non-existent or insufficient; however, the Department does not believe the state has a responsibility to totally fund all health facility improvement or maintenance, whether rural or urban. In this regard the bill could be improved by a change in section 18.25.140(d) indicating assistance is to be given in areas which would otherwise be denied adequate facilities, because community tax bases are limited and an attempt at total community financing of a project would cause hardship or prevent its realization.

The bill also would make improvement and maintenance funds available regardless of ownership of the facility. The Department believes the bill would be improved by limiting distribution of state funds to only non-profit and community owned facilities.

Health Facilities currently receive construction and operating assistance under the health facility revenue sharing statute (AS 29.89 and AS 29.90). The revenue sharing statutes provide for this assistance to a broad range of health facilities including hospitals, public health centers, maternity homes, community mental health centers, facilities for the mentally or physically handicapped, nursing homes and convalescent centers. House Bill 844 should define the types of health facilities to be covered by this act. A definition section should also include definitions for the scope of "maintenance" and "improvements."

The Department supports the use of a review body in recommending priorities for making grants. The Department recommends expansion of this concept to include review by experts knowledgeable in health facility financing and community support capabilities. This review body would evaluate proposals for health facility improvements and maintenance, determine whether current financing mechanisms such as revenue sharing, the Alaska Medical Facilities Authority, bond sales or other financing mechanisms are available to the health facility and what level of state support is needed. On the basis of this review and recommendation the Commissioner of Health and Social Services could then make grants from the fund established under AS 18.25.130.

Under the bill the Statewide Health Coordinating Council (SHCC) is required to recommend priorities for making grants. The bill limits the considerations of the SHCC to four points:

1) the condition of the existing physical plant of a rural health facility;

2) the ability of the rural health facility to continue to provide quality health services;

3) the need in the community for additional services; and

4) the ability of the rural health facility to meet current licensure standards

Other considerations may impact a decision of prioritizing the need for grant funds. The body which is to make those prioritizations should not be restricted to these four points. The Department suggests that fifth consideration should be added:

5) Other considerations such as those addressed in the certificate of need review

The question may arise as to whether a program of this type would encourage the proliferation of unneeded facilities. The certificate of need program will serve to limit the development of these facilities covered by the program such as hospitals and nursing homes but would not restrict the construction of other facilities such as birthing centers and health clinics.

The certificate of need review addresses the following aspects of proposed health facility construction which are pertinent to a consideration of state financial assistance:

- the need for additional acute care beds in the hospital service area;
- the relationship of the project to other health care providers in the area;
- the anticipated impact of the project on hospital operating costs, revenues, and patient charges;
- the financial feasibility of the project;
- the cost-effectiveness of constructing shelled-in space for future use

With requests for health facility assistance increasing in number and in scope, the establishment of a systematic approach to health facility construction can guide the allocation of limited state resources.

Recommended by: Phoebe A. Lindsey
Phoebe A. Lindsey, Director
State Health Planning
& Development

Date: March 10, 1982

Approved by: Helen D. Beirne
Helen D. Beirne, Commissioner
Department of Health
& Social Services

Date: 3-10-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

I. REQUEST
Bill/Resolution No. House Bill 844
Title An Act Relating to the Financing of Rural Health Facility Improvements
Requested by

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES	57.0	62.7	69.0	75.0	83.0	91.9
200 TRAVEL	30.0	33.0	36.0	40.0	44.0	48.4
300 CONTRACTUAL	300.0	330.0	360.0	400.0	440.0	484.0
400 COMMODITIES	1.0	1.1	1.2	1.3	1.5	1.7
500 EQUIPMENT	1.5	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	389.5	426.8	466.2	517.1	569.0	626.0

FUNDING (Thousands of Dollars)

GENERAL FUND	28,400	36,600	24,900	30,000	30,000	30,000
FEDERAL FUNDS	-0-	-0 -	-0-	-0-	-0-	-0-
OTHER (Specify Source)	-0-	-0-	-0-	-0-	-0	-0-
	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	--0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	1	1	1	1	1	1
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-

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

(See Attached)

IV. DATE March 8, 1982 PREPARED BY Dave W. Williams
AGENCY State Health Planning & Development
PHONE 465-3015

fcc

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

III Analysis

The fiscal note has been prepared considering the maximum impact which can be expected under this bill, given the possible coverage of all rural health facilities (private, municipal, state or federal, psychiatric hospitals, tuberculosis hospitals, skilled nursing facilities, ambulatory surgical centers, health centers, health clinics, birthing centers,...)

An inflation rate of 10 percent has been assumed. The figures reflect the cost of having a consultant firm provide annual inventory of all rural health facilities.

Expenditures

Line 100 indicates the equivalent of salary and benefit costs for one staff position with appropriate qualifications. Duties of the proposed staff would include oversite of the required annual inventory of rural health facilities.

Line 200 reflects necessary travel to widely scattered areas for oversite of the consulting firm providing the inventory. Also included is the cost of periodic review of numerous on going and extensive construction projects.

Line 300 shows probable consultant requirements for engineering speciality investigation, travel, land etc. The inventory would result in reports not unlike the inventory of facilities accomplished in 1981. Telephone office rental and maintenance would be included.

Line 400 would provide for office supplies involved.

Line 500 would be necessary expenditures for office equipment.

General fund costs assume current estimates for actual surveyed facility needs spread over six years and extended to include approximately 200 health facilities in remote locations.

The costs of this program would be sharply reduced if "rural health facility" was defined to include only hospitals and nursing homes. The cost of providing an inventory would be substantially reduced if hospitals/nursing homes were required to submit annually updated long-range plans for each facility.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
WORK DRAFT PAPER
CS HOUSE BILL NO. 844 (HESS)

For an Act entitled: "An Act relating to the financing of rural health facility improvements and maintenance."

Committee Substitute for House Bill 844 creates a fund in the Department of Health & Social Services for the purpose of providing grant funds for improvement and maintenance of rural health facilities.

The Department has historically supported the establishment of a formalized health facility construction program in Alaska to better guide the allocation of limited resources. The recently distributed report on the physical condition of 15 rural hospitals and nursing homes is a first step in the development of a systematic approach to health facility construction. Other components of a system for health facility construction should include:

facility long range plans
a statewide plan for medical facilities
certificate of need review
a funding mechanism
periodic inventories of health facility physical plants

The CS for House Bill 844 would create a fund within the Department of Health and Social Services for plant improvements and maintenance at rural health facilities. The bill provides that the Statewide Health Coordinating Council will make recommendations to the Commissioner of the Department as to the prioritization of projects and that the Commissioner would make grants to rural health facilities based on those recommendations.

Although the concept of providing state assistance to rural health facilities is strongly supported by the Department, the bill would be improved with further clarification.

The bill would make improvement and maintenance funds available regardless of ownership of the facility. The Department believes the bill would be improved by limiting distribution of State funds to only non-profit and community owned facilities.

It can be argued that the state has a responsibility for ensuring access to quality health care facilities to its citizens by providing grants funds when other sources of funding are non-existent or insufficient; however, the Department does not believe the state has the responsibility stated in section 18.25.40(d) of assuring that state grants are sufficient to enable a facility to satisfy the financial requirements of the physical plant improvement or maintenance recommended by the Statewide Health Coordinating Council. The responsibility of assuring that sufficient funds are available to meet total project costs properly lies with the municipality or local administrative entity which desires State assistance. In this regard, a grantee should be required to demonstrate the availability of total project funding before any state grant funds are expended, but the balance of the project costs sought from other sources would probably be more readily found once a commitment is made for the State grant.

To increase accountability for the use and disbursement of grant funds, a provision should be included in the bill which would permit the Department to provide grant funds for health facility improvement and maintenance to a municipality (or local administrative entity) where a rural health facility is located. Experience gained under the Hill-Burton program indicates that this step provides a form of local audit responsibility and a valuable neutral link for necessary administrative transactions without undue cost or delay.

To address these concerns the Department suggests revising the language in section 18.25.140(d) of CS HB 844 as follows:

> 18.25.140(d) The commissioner of Health and Social Services shall review the recommendations of the Statewide Health Coordinating Council and may make grants from the fund under AS 18.25.130 to a municipality (or local administrative entity) for physical plant improvements and maintenance. The local match for improvements and maintenance shall be sufficient to enable the municipality or local administrative entity to satisfy the remaining balance of total financial requirements of the physical plant improvement or maintenance supported by a State grant made under this section.

CS HB 844 provides a definition of the scope of the term "rural health facilities." The Department believes the bill should be further clarified by including definitions for the scope of the terms "maintenance" and "improvements."

The Department supports the use of a review body in recommending priorities for making grants. The Department recommends expansion of this concept to include review by experts knowledgeable in health facility financing and community support capabilities. This review body would evaluate proposals for health facility improvements and maintenance, determine whether current financing mechanisms such as revenue sharing, the Alaska Medical Facilities Authority, bond sales or other financing mechanisms are available to the health facility and what level of state support is needed. On the basis of this review and recommendation the Commissioner of Health and Social Services could then make grants from the fund established under AS 18.25.130.

The question may arise as to whether a program of this type would encourage the proliferation of unneeded facilities. The certificate of need program would serve to limit the development of hospitals, psychiatric hospitals, tuberculosis hospitals, skilled nursing facilities, kidney disease treatment centers, intermediate care facilities, and ambulatory surgical facilities, whether private, municipal, state or federal. Although the CSHB 844 definition of rural health facilities is not entirely consistent with the coverage of the certificate of need program, there are very few facilities eligible for grants under CSHB 844 which are not required to obtain a certificate of need and this is not seen as a significant problem.

The certificate of need review addresses the following aspects of proposed health facility construction which are pertinent to a consideration of state financial assistance:

- the need for additional acute care beds in the hospital service area;

. the relationship of the project to other health care providers in the area;

. the anticipated impact of the project on hospital operating costs, revenues, and patient charges;

. the financial feasibility of the project;

. the cost-effectiveness of constructing shelled-in space for future use.

With requests for health facility assistance increasing in number and in scope, the establishment of a systematic approach to health facility construction can guide the allocation of limited state resources.

Recommended by: Phoebe A. Lindsey

Phoebe A. Lindsey, Director
State Health Planning
& Development

Date: March 25, 1982

Approved by:

Helen O. Beirne, Commissioner
Department of Health
& Social Services

Date: 3/30/82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

I. REQUEST
Bill/Resolution No. CS House Bill 844
Title An Act Relating to the Financing of Rural Health Facility Improvements
Requested by HESS

II. FISCAL DETAIL
Agency Affected Department of Health & Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88
100 PERSONAL SERVICES	57.0	62.7	69.0	75.0	83.0	91.0
200 TRAVEL	30.0	33.0	36.0	40.0	44.0	48.4
300 CONTRACTUAL	150.0	165.0	180.0	200.0	220.0	242.0
400 COMMODITIES	1.0	1.1	1.2	1.3	1.5	1.7
500 EQUIPMENT	1.5	-0-	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.	22704.0	32191.0	24118.0	26354.0	33565.0	36921.0
TOTAL	22943.5	32454.8	24404.0	26670.0	33913.5	37304.1

FUNDING (Thousands of Dollars)

GENERAL FUND	22943.5	32454.8	24404.0	26670.0	33913.5	37304.1
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER (Specify Source)	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS

FULL TIME	1	1	1	1	1	1
PART TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-
	-0-	-0-	-0-	-0-	-0-	-0-

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

(See Attached)

IV. DATE March 9, 1982 PREPARED BY Dave W. Williams
AGENCY State Health Planning & Development
PHONE 465-3015

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

33-001 (Rev. 12/81)

This fiscal note has been prepared considering the full impact which could be expected under this CSHB 844. Even though not all rural health facilities eligible for state assistance under CSHB 844 will necessarily desire state assistance. This fiscal note assumes that all facilities eligible under CSHB 844 would desire and recieve state assistance. This may not necessarily be true. Assumptions regarding expenditure levels made by the Department in preparing this fiscal note are as follows:

Line 100
This line indicates the equivalent of salary and benefit costs for one staff position with appropriate qualifications. Duties of the proposed staff would include oversight of the required annual inventory of rural health facilities, review of requests for state assistance, and the research or and preparation of reports regarding grant requests as necessary under provisions with in this Bill.

Line 200
This line reflects necessary travel to rural health facility sites during the update of the annual inventory of rural health facilities and the cost of periodic review of rural health facility construction projects.

Line 300
This line shows probable costs for consultants for mechanical, electrical, and structural engineers required for undating the the annual inventory of rural health facilities.

Line 400
This line shows expenditure for necessary office supplies.

Line 500
This line shows necessary expenses for office eqiopment.

Line 700
The estimated grant expenditures shown on this line are provided to outline the dimension of need, but cannot be interpreted as a recommended level of state support.

These expenditures for grants are based upon the recent inventory of 15 rural hospitals and nursing homes. The inventory found numerous and serious deficiencies at the surveyed facilities. The fiscal note shows the probable grant expense to the state for correcting the noted deficiencies spread over the next six years. Grant expenses for subsequent years (1989 and beyond) should decline once the noted deficiencies are corrected.

The inventory report gave estimated 1982 construction costs for the correction of deficiencies which were noted at each facility. The inventory report cost estimates do not include costs for fees, equipment, inflation, site acquistion, and other project costs. To arrive at total project costs, the inventory report cost estimates must be adjusted by a factor between 125% and 160%. In preparing this fiscal note the Department has used a factor of 150% with inflation calculated at 10% a year. In estimating the grant expendtures under this bill the Department

has assumed each rural health facility would bear 20% of the total project costs. Under the provisions of CSHB 844 the local portion of costs may be adjusted to meet the needs of each facility and, therefore, may be higher or lower than the assumed 20%.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 18, 1982

AGENDA

HB 695/696 Vocational Education/ Approp. Voc. Ed.

HB 844 Financing of Rural Health Facility Improvements

HB 327 Naturopathy SB 214

HB 357 Adult Public Assistance

HB 307 Pioneer's Homes

844 3/30

Ann:

① news sect.:
"Eligible for.": defined as
mp or ~~Pol~~ municipally owned rural
health fac.

② population?

HB
650

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 850 "An Act relating to the licensing
Title of clinical social workers; and providing for an effective date."
Requested by Carney Date 2-16-82

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, Or Subprogram(s) Affected Regulation & Licensing of professions; admin
(Note: If more than one budget component is affected, separate line-item invest., &
amounts and funding for each component in the analysis section.) boards.

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		27.9	27.9	27.9	27.9	27.9
200 TRAVEL		9.6	9.4	10.3	11.3	12.4
300 CONTRACTUAL		10.4	11.1	12.3	13.4	15.0
400 COMMODITIES		.5	.5	.5	.5	.5
500 EQUIPMENT		2.8	0	0	0	0
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		50.1	49.1	51.0	53.1	55.8

FUNDING (Thousands of Dollars)

GENERAL FUND		50.1	49.1	51.0	53.1	55.8
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

PERSONAL SERVICES - FY'82 salary schedule plus benefits.
1 Licensing Examiner, range 12, gen. govt., 12 mos. 27.9

TRAVEL - 10% inflation factor projected.

Board of Clinical Social [illegible], 5 members. Travel and per diem for 4 meetings annually to conduct board business, regulation projects and administer examinations. Anticipate meetings in Anchorage, Fairbanks, Southeast, Kodiak or Nome; 2 days each. 6.6

Travel and per diem for dept. staff; 1 regulations specialist, and 1 management analyst to attend at least 2 meetings per year. 2.0

Total 8.6

IV. DATE March 19, 1982 PREPARED BY Marjorie Doland
AGENCY Division of Occupational Licensing
PHONE [illegible]

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

33-001 (Rev. 12/81)

- CONTRACTUAL

Duplicating and mailing costs of applications and statute booklets; registration and renewal forms; publication costs for proposed regulations and meetings; gerneral operating and computer costs . 7.0

Rental Space - 1 licensing examiner.
60 sq.ft X $1.70 X 12 mos. 1.2

Professional examination service costs 1.5
National Association dues .5

Hearings - licensing/disciplinary hearings. Costs estimated from past Guide Board hearings held in December 1981. Anticipate 3 hearings per year. In estimating one day hearings, the following costs are considered:

- Average 6 hour days:

Hearing officer @ $75/hr	450.00
Court Reporter @ $25/hr	150.00
10 exhibits, $.45 ea.	4.50
3 witnesses, 1/2 day ea., @ $12.50/day	37.50
1 expert witness, 2 hours, @ $150/hr	300.00
Transcript. avg.210 pages @ $4.50/page	945.00
	1,887.00
	X3
	$5,661.00

** Other costs such as transportation of witnesses, taking of depositions and other special handli , can increase cost of hearings.

COMMODITIES

General supplies needed by licensing examiner such as tapes for meetings, file folders, paper etc. .6

EQUIPMENT - one time cost in FY'83.

1 desk ,double pedestal 60" x 30"	426.92
1 chair, posture without arms (contour)	170.57
1 typewriter, correcting selectric, dual pitch	1,028.81
1 typewriter table	101.92
1 credenza, 90" x 62"	470.90
1 side chair	96.16
2 file cabinets, 4 drawer legal	505.20
	$2,799.48

LANGDON PSYCHIATRIC CORPORATION
A PROFESSIONAL CORPORATION

PSYCHIATRY
ARON S. WOLF, M.D., F.A.P.A.
JAMES HARRIS, M.D.
JERRY DONAHOE, M.D.
CLINICAL PSYCHOLOGY
JAMES HARRIS, Ph.D.
BRUCE R. SMITH, Ph.D.
PSYCHIATRIC SOCIAL WORK
PEGGY J. NELSON, M.S.W., A.C.S.W.
HELEN CRAIG, M.S.W., A.C.S.W.
DONALD MADSEN, M.S.W., A.C.S.W.
MARSHALL JONES, M.A.
ELIZABETH ROBINSON, M.S.W., A.C.S.W.
READING THERAPY
TROY SULLIVAN, M.Ed.

Anchorage Office
4001 Dale Street
Anchorage, Alaska 99504
(907) 279-0461

Valley Office
Wasilla Village Center
Suite 202
Wasilla, Alaska 99687
MAILING ADDRESS
P. O. Box 540
(907) 376-2447

March 26, 1982

The Honorable Mike Beirne, M.D., Chairman
House Committee on Health, Education and Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Dr. Beirne:

I am writing to urge your support for House Bill #850, pertaining to licensure of clinical social workers.

Both as a practicing psychiatrist in Alaska, and as president of the corporation for the Langdon Psychiatric Clinic, I am in a position to recognize the importance of setting standards through licensure for clinical social workers, who carry important responsibility for service to disturbed people.

We believe that social workers doing psychotherapy, such as the social work members of our own Clinic staff, need to have the professional training and supervised experience specified in House Bill #850. These standards have been recognized by licensure by a number of other states, which I feel Alaska should join.

Currently health insurance carriers will not reimburse for services by social workers unless they are licensed or registered, and this is important to psychiatric service agencies, both private and public, such as the Community Mental Health Centers in Alaska. We believe that licensure of clinical social workers would make psychiatric services more widely available, through at least partly resolving payment problems, as well as relieving budget problems of psychiatric agencies.

Hoping that you will take this step toward better mental health services for Alaska citizens, I am

Sincerely yours,

Aron S. Wolf, M.D.

cc: Terry Martin
Betty Cato
Sally Smith
Hugh Malone

March 26, 1982

The Honorable Mike Beirne, M.D., Chairman
House Committee on Health, Education & Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Dr. Beirne:

I am writing to urge your support for passage of House Bill 350, which would establish licensure of clinical social workers.

As a clinical social worker of many years' experience, both in Alaska and Outside, in direct service, supervision, administration, teaching, consultation, I am convinced that it is to the advantage of Alaska citizens in need of psychotherapeutic services to have state definition, through a licensure statute, of the standards necessary for persons who are to practice here as clinical social workers. A number of other states have established such licensure, and I feel Alaska should follow suit.

At the present time health insurance carriers will not reimburse for services by social workers unless they are licensed or registered, and this is a matter of importance to psychiatric agencies and personnel, whether private or public, such as Community Mental Health Centers in Alaska. Licensure of clinical social workers in this state could make psychotherapeutic services more widely available, through in part at least resolving payment problems, and so helping to relieve budget problems of psychiatric agencies.

I hope that you will take this step toward improved mental health services for Alaska citizens.

Sincerely,

Elizabeth M. Robinson

Elizabeth M. Robinson ACSW
2961 Cliffside Drive
Anchorage, AK 99501

cc:
Terry Martin
Betty Cote
Sally Smith
Hugh Malone

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 850

"An Act relating to the licensing of clinical social workers; and providing for an effective date."

This Bill provides for the licensing of clinical social workers and the creation of a Board of Clinical Social Worker Examiners. In addition, it provides for privileged communication and defines the scope of practice. The Department of Health and Social Services supports the concept of licensing clinical social workers.

The Department has one recommendation with respect to this Bill. Page 4, Lines 16-21, Section 08.87.080(3) addresses exemptions to privileged communication when the client is a minor. This section, however, does not provide for mandatory reporting of harm as a result of child abuse and neglect. Under AS 47.17.020 of the Child Protection Act, social workers are listed among those professionals required to report. This Bill, by definition, distinguishes between clinical social workers and other social work professionals. Given the scope of clinical social work practice as defined in the Bill, clinical social workers should be required to report harm as a result of child abuse and neglect.

RECOMMENDATION:

The Department recommends that Section 08.87.080 be amended to comply with the Child Protection Act.

In conclusion, the Department supports passage of this Bill and recommends that consideration be given to our proposed amendment.

RECOMMENDED BY: John R. Pugh

John R. Pugh, Director
Division of Family and Youth Services

DATE: 3/17/82

APPROVED BY: Helen D. Beirne

Helen D. Beirne
Commissioner

DATE: 3-21-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House Bill No. 850
Title "An Act relating to the licensing of clinical social workers;....."
Requested by _____ Date _____

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected _____
BRU, Program, Or Subprogram(s) Affected _____
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100	PERSONAL SERVICES		-0-	-0-	-0-	-0-	-0-
200	TRAVEL		-0-	-0-	-0-	-0-	-0-
300	CONTRACTUAL		-0-	-0-	-0-	-0-	-0-
400	COMMODITIES		-0-	-0-	-0-	-0-	-0-
500	EQUIPMENT		-0-	-0-	-0-	-0-	-0-
600	LAND & STRUCTURES		-0-	-0-	-0-	-0-	-0-
700	GRANTS, CLAIMS, ETC.		-0-	-0-	-0-	-0-	-0-
			-0-	-0-	-0-	-0-	-0-
	TOTAL		-0-	-0-	-0-	-0-	-0-

FUNDING (Thousands of Dollars)

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

POSITIONS

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

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

House Bill No. 850 has no fiscal impact on the Department of Health and Social Services.

IV. DATE 3/8/82 PREPARED BY John R. Pugh, Director
AGENCY Division of Family and Youth Services
PHONE 465-3170

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

33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 850 "An Act relating to the licensing
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Requested by Carney Date 2-16-82

II. FISCAL DETAIL
Agency Affected Department of Commerce & Economic Development
Program Category Affected Public Protection
BRU, Program, Or Subprogram(s) Affected Regulation & licensing of professions; admin
(Note: If more than one budget component is affected, separate line-item invest., &
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600 LAND & STRUCTURES						
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PART TIME						
TEMPORARY						

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

PERSONAL SERVICES - FY'82 salary schedule plus benefits.
1 Licensing Examiner, range 12, gen.govt., 12 mos. 27.9

TRAVEL - 10% inflation factor projected.

Board of Clinical Social Worker Examiners, 5 members. Travel and per diem for 4 meetings annually to conduct board business, regulation projects and administer examinations. Anticipate meetings in Anchorage, Fairbanks, Southeast, Kodiak or Nome; 2 days each. 6.5

Travel and per diem for dept. staff; 1 regulations specialist, and 1 management analyst to attend at least 2 meetings per year. 2.0

Total 8.5

IV. DATE March 19, 1982 PREPARED BY Marjorie Odland
AGENCY Division of Occupational Licensing
PHONE 465-2535

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

CONTRACTUAL

Duplicating and mailing costs of applications and statute booklets; registration and renewal forms; publication costs for proposed regulations and meetings; gerneral operating and computer costs	7.0
Rental Space - 1 licensing examiner. 60 sq.ft X $1.70 X 12 mos.	1.2
Professional examination service costs	1.5
National Association dues	.5

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* Average 6 hour days:

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3 witnesses, 1/2 day ea., @ $12.50/day	37.50
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** Other costs such as transportation of witnesses, taking of depositions and other special handling can increase cost of hearings.

COMMODITIES

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EQUIPMENT - one time cost in FY'83.

1 desk, double pedestal 60" x 30"	426.92
1 chair, posture without arms (contour)	170.57
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1 typewriter table	101.92
1 credenza, 90" x 62"	470.90
1 side chair	95.15
2 file cabinets, 4 drawer legal	505.20
	$2,799.48

TESTIMONY OF HARRY D. TREAGER

BEFORE THE HOUSE HESS COMMITTEE

MARCH 22, 1982

THANK YOU FOR THE OPPORTUNITY TO COMMENT ON HB 850, "AN ACT RELATING TO THE LICENSING OF CLINICAL SOCIAL WORKERS..." THE DEPARTMENT HAS REVIEWED THE PROPOSED LEGISLATION AND WOULD LIKE TO MAKE THE FOLLOWING OBSERVATIONS FOR THE CONSIDERATION OF THE COMMITTEE.

FIRST, WHILE THE DEPARTMENT HAS NO OBJECTION TO THE LICENSING OF CLINICAL SOCIAL WORKERS, WE DO QUESTION WHETHER REGULATION OF THE SCOPE OF PRACTICE OF CLINICAL SOCIAL WORKERS IS NECESSARY IN ADDITION TO REGULATION OF THE TITLE ITSELF. THE DEPARTMENT BELIEVES THAT THE BENEFICIAL EFFECTS OF LICENSURE FOR THE PUBLIC SHOULD RESULT FROM TITLE PROTECTION ALONE AND THAT PROHIBITION OF UNLICENSED PRACTICE MAY NOT NECESSARILY AFFORD ANY ADDITIONAL PUBLIC PROTECTION.

THE PRINCIPAL PUBLIC BENEFITS THAT WE ANTICIPATE FROM LICENSURE ARE:

1. BETTER ACCESS TO THIRD PARTY REIMBURSEMENT;
2. REASONABLE ASSURANCE FOR THE PUBLIC THAT A LICENSED PRACTITIONER IS QUALIFIED AND HAS NOT ENGAGED IN UNETHICAL AND IRRESPONSIBLE ACTIVITIES, AND

3. THE DISCOURAGING OF CHARLETONS FROM PRACTICING THE ENABLING OF THE PROFESSION TO BETTER POLICE ITSELF AND THE PROVISION OF CERTAIN LEGAL GUARANTEES FOR THE PUBLIC (E.G. CONFIDENTIALITY).

THE DEPARTMENT FEELS THAT TITLE PROTECTION ITSELF IS SUFFICIENT TO BRING ABOUT THESE BENEFICIAL EFFECTS AND THE PROHIBITION OF UNLICENSED PRACTICE MAY ONLY CONFUSE ISSUES. FOR EXAMPLE, WOULD AN UNLICENSED STATE SOCIAL WORKER I BE VIOLATING THE PROPOSED STATUTES IF HE OR SHE WERE PROVIDING DIRECT PREVENTATIVE SERVICES TO A CLIENT? THE ANSWER APPEARS TO BE YES. A SIMILAR CONCERN IS THAT THERE APPEAR TO BE NO CLEAR LINES DISTINGUISHING THE SCOPE OF PRACTICE OF CLINICAL SOCIAL WORKERS FROM OTHER MENTAL HEALTH PRACTITIONERS (BOTH PROFESSIONAL AND PARAPROFESSIONAL).

IF PRACTICE IS TO BE RESTRICTED THROUGH THIS LEGISLATION, THEN THERE IS PROBABLY A NEED TO BETTER DEFINE THE PRINCIPAL EXEMPTION "QUALIFIED MEMBER OF ANOTHER PROFESSION." THERE IS PROBABLY ALSO A NEED TO BETTER DEFINE THE ACTUAL SCOPE OF PRACTICE WHICH IN ITS PRESENT FORM GIVES CLINICAL SOCIAL WORKERS THE RIGHT TO PRACTICE MEDICINE.

AS 08.87.010 PLACES NO LIMIT ON THE NUMBER OF REAPPOINTMENTS OF BOARD MEMBERS. WHILE THERE IS NO DOUBT THAT THE CONTINUOUS REAPPOINTMENT OF AN EFFECTIVE MEMBER CAN BE EXTREMELY BENEFICIAL, IT IS GENERALLY CONSIDERED BETTER PRACTICE TO LIMIT THE NUMBER OF CONSECUTIVE TERMS TO 2. THIS IS ESPECIALLY SO WHEN INDIVIDUAL TERMS ARE FOR 5 YEARS. PERHAPS 3 YEAR TERMS WOULD BE MORE REASONABLE.

AS 08.87.020(5) REQUIRES THE BOARD TO PREPARE AND ADMINISTER AN EXAMINATION AND AS 08.87.030(4) REQUIRES AN APPLICANT TO PASS SUCH AN EXAMINATION IN ORDER TO BE ELIGIBLE FOR LICENSURE. IT IS NOT CLEAR WHY SUCH AN EXAMINATION IS NECESSARY GIVEN THE OTHER PROPOSED EDUCATION AND EXPERIENCE REQUIREMENTS. THE DEPARTMENT WOULD URGE THAT THE CLEAR NEED FOR AN EXAMINATION BE ESTABLISHED BEFORE IT IS MADE A STATUTORY REQUIREMENT FOR LICENSURE. EXAMINATIONS ARE COSTLY AND TIME CONSUMING FOR THE APPLICANT, THE BOARD AND THE DIVISION OF OCCUPATIONAL LICENSING. AS A GENERAL RULE, A GOOD OBJECTIVE EXAMINATION IS DIFFICULT TO DEVELOP AND ADMINISTER BY A BOARD OF THIS NATURE. IN FAIRNESS TO BOTH THE BOARD AND APPLICANTS, ADDITIONAL RESOURCES MAY BE NEEDED FOR ASSISTANCE IN THE DEVELOPMENT OF PROPER EXAMINATION BY AN APPROPRIATELY QUALIFIED INDIVIDUAL OR ORGANIZATION.

WHILE WE DO RAISE THIS ISSUE AS A CONCERN BASED ON SIMILAR EXPERIENCES ELSEWHERE, WE MUST NOTE THAT WE HAVE NOT RESEARCHED THIS ISSUE WITH RESPECT TO THE SOCIAL WORK PROFESSION PER SE. WE SHOULD ALSO NOTE THAT OUR PRELIMINARY RESEARCH INDICATES THAT ALL TWENTY-ONE STATES THAT LICENSE SOCIAL WORKERS AT THE LEVEL PROPOSED IN THE PRESENT BILL REQUIRE SOME FORM OF EXAMINATION AS A CONDITION FOR LICENSURE.

AS 08.87.030(1) AND (5). THE DEPARTMENT WOULD RECOMMEND THAT THE PHRASES "GOOD PROFESSIONAL STANDING" AND "ACCEPTABLE TO THE BOARD" BE FURTHER DEFINED IN EITHER STATUTE OR REGULATION TO AVOID CONFUSION AND INCONSISTENCES. TERMS SUCH AS "GOOD PROFESSIONAL STANDING" AND "MORAL TURPITUDE" (SEE AS 08.87.060(2)) ARE GENERALLY CONSIDERED BY LEGISLATIVE AUDITORS, INVESTIGATORS AND THE COURTS TO BE TOO VAGUE AND GENERAL TO BE ENFORCEABLE UNLESS THEY ARE FURTHER QUALIFIED IN STATUTE OR REGULATIONS. SIMILARLY, OBJECTIVE STANDARDS SHOULD BE DEVELOPED BY THE BOARD WITH RESPECT TO WHAT IS AND IS NOT ACCEPTABLE IN TERMS OF LETTERS OF REFERENCE. THIS IS NECESSARY TO ASSURE FAIRNESS AND CONSISTENCY IN THE EVALUATION OF APPLICANTS.

AS 08.87.060(4) MAY GIVE THE IMPRESSION THAT NEGLIGENCE IS PERMISSIBLE IF IT RESULTS IN NO INJURY OR ONLY MINOR INJURY TO A CLIENT. PERHAPS BETTER WORDING WOULD BE DESIRABLE HERE.

AS 08.87.070 CALLS FOR THE RENEWAL OF LICENSES EVERY TWO YEARS. UNLESS NECESSARY FOR REASONS NOT PRESENTLY APPARENT TO US, THE DEPARTMENT WOULD RECOMMEND A FOUR-YEAR RENEWAL CYCLE IN THE INTEREST OF EFFECTIVE UTILIZATION OF STAFF AND MINIMAL BUREAUCRATIC INFRINGEMENT UPON THE LIVES OF THE LICENSEES.

CLEARER AND MORE COMPREHENSIVE WORDING REGARDING THE APPLICABILTIY OF THE ADMINISTRATIVE PROCEDURES ACT SHOULD REPLACE THE PROPOSED WORDING IN AS 08.87.020(1). ALTERNATE WORDING SHOULD READ:

> THE BOARD SHALL COMPLY WITH THE ADMINISTRATIVE PROCEDURES ACT (AS 44.62) BOTH AS TO ENACTMENT OF REGULATIONS AND ADJUDICATIONS.

AS 44.62.330 SHOULD ALSO BE AMENDED TO INCLUDE SPECIFIC REFERENCE TO CLINICAL SOCIAL WORKERS.

IN CLOSING, THE DEPARTMENT WOULD LIKE TO NOTE THAT WHILE IT DOES NOT OBJECT TO THE PRESENT APPROACH TO LICENSING CLINICAL SOCIAL WORKERS, IT DOES FEEL THAT MORE COMPREHENSIVE MEANS EXIST TO ACHIEVE THE SAME ENDS. AT PRESENT, THE STATE CONTROLS BOTH TITLE AND PRACTICE FOR PSYCHOLOGISTS AND PSYCHOLOGICAL ASSOCIATES. TO THE PROPOSED REGULATION OF SOCIAL WORKERS ONE MIGHT LEGITIMATELY ADD OTHER MENTAL HEALTH PROFESSIONALS SUCH AS MARRIAGE AND FAMILY COUNSELORS. IF THE PURPOSE OF

LICENSURE IS TO PROTECT AND BENEFIT THE PUBLIC IN THE WAYS LISTED ABOVE, THEN IT WOULD PROBABLY BE MORE EFFECTIVE TO LICENSE ALL APPROPRIATELY QUALIFIED PROFESSIONAL MENTAL HEALTH PRACTITIONERS THROUGH A CONSISTENT AND COORDINATED SYSTEM STANDARDS ADMINISTERED BY A SINGLE BOARD. SUCH AN APPROACH WOULD PROBABLY ALSO WORK TO REDUCE THE RISK OF THE LICENSURE PROCESS BEING USED FOR ENHANCEMENT OF THE PROFESSION RATHER THAN THE PROTECTION AND BENEFIT OF THE PUBLIC.

Introduced: 2/16/82
Referred: Health,Education & Social Services, Judiciary and Finance

IN THE HOUSE BY CARNEY

HOUSE BILL NO. 850

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - SECOND SESSION

A BILL

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

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

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

CHAPTER 87. CLINICAL SOCIAL WORKERS. — Sets 5 people.

ARTICLE 1. BOARD OF CLINICAL SOCIAL WORKER EXAMINERS.

Sec. 08.87.010. BOARD OF CLINICAL SOCIAL WORKER EXAMINERS. (a) There is created a Board of Clinical Social Worker Examiners.

(b) The board consists of five members appointed by the governor. Three of the board members shall be clinical social workers eligible for licensing under this chapter. All board members shall be citizens of the United States and residents of the state.

(c) The board members serve at the pleasure of the governor for five-year terms. Each board member shall hold office for the term of his appointment and until his successor is appointed and qualified. A board member is qualified for ~~reappointment~~ one consecutive term. A vacancy on the board shall be filled in the same manner as the original appointment but only for the unexpired term.

(d) Board members serve without compensation, but are entitled to travel and per diem expenses as provided in AS 39.20.180.

Sec. 08.87.020. DUTIES OF THE BOARD. The board shall

(1) adopt regulations in accordance with the Administrative Procedure Act (AS 44.62) to administer and carry out the provisions of this chapter;

(2) establish a code of professional ethics based on nationally accepted standards in social work;

(3) establish, in consultation with the department, application fees, examination fees, credential review fees, out-of-state endorsement fees, initial license fees, and biennial renewal fees;

(4) conduct hearings and keep records and minutes necessary for carrying out the purpose of this chapter in an orderly manner;

(5) prepare and administer an examination;

(6) annually publish a list of the names and addresses of all persons licensed under this chapter.

ARTICLE 2. LICENSURE AND PRACTICE.

Sec. 08.87.030. LICENSURE AS CLINICAL SOCIAL WORKER. A person is eligible for licensure as a clinical social worker if the person

(1) is in good professional standing; — define?

(2) holds a master's or doctoral degree in social work from a graduate school of social work accredited or recognized by the Council on Social Work Education;

(3) has had two years or 3,000 hours of post-master's degree supervised clinical social work practice under supervision as determined to be appropriate by the board in review of the applicant's qualifications;

(4) has passed an examination prepared by the board; and

(5) provides three references acceptable to the board.

Sec. 08.87.040. SCOPE OF PRACTICE OF CLINICAL SOCIAL WORKER. A clinical social worker may provide direct diagnostic, preventative, psychotherapeutic, and treatment services to individuals, families, and groups whose functioning is threatened or affected by social and psychological stress or health impairment.

Sec. 08.87.050. LICENSURE BY ENDORSEMENT. A person who is

licensed as a social worker by an authority other than the state may be licensed as a clinical social worker in the state if the board determines that the person's requirements for the out-of-state license or certificate at the time the individual was licensed are similar to the requirements of AS 08.87.030 or the National Association of Social Workers.

Sec. 08.87.060. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The board may deny, suspend, or revoke the license of a person who

(1) has obtained or attempted to obtain a license to practice under this chapter by fraud or deceit;

(2) has been convicted of a felony involving moral turpitude;

(3) is habitually intoxicated or is addicted to the use of depressant, hallucinogenic, narcotic, or stimulant drugs;

(4) is found by the board to have been negligent, resulting in serious injury to a client;

(5) has wilfully or repeatedly violated a provision of this chapter.

Sec. 08.87.070. EXPIRATION AND RENEWAL OF LICENSE. A license issued under this chapter expires two years after it is issued unless the board establishes a biennial date when all licenses issued under this chapter expire. A license may be renewed by making an application for renewal to the board and by meeting the requirements of this chapter.

Sec. 08.87.075. PROBATIONARY PRACTICE FOR NEW EMPLOYEE. A person exempt from the licensing provisions of this chapter under AS 08.87.110 may practice for a period not to exceed six months under the direct supervision of a clinical social worker licensed under this chapter. As used in this section, direct supervision includes at least one hour a week of personal consultation with a supervisor who is licensed as a

clinical social worker under this chapter. If geographical distance precludes personal weekly consultation between a person and his supervisor, supervision may be maintained through weekly written or telephone communication as prescribed by regulation of the board.

Sec. 08.87.080. PRIVILEGED COMMUNICATION. A clinical social worker licensed under this chapter may not disclose information acquired from a client if that information was necessary to enable the clinical social worker to render professional services to the client, except

(1) with the written consent of the client, the client's personal representative or other person authorized to sue on behalf of the client, or the beneficiary of an insurance policy on the client's life, health, or physical condition;

(2) that a clinical social worker licensed under this chapter is not required to treat as confidential communications that reveal the contemplation or execution of a crime or harmful act;

(3) when the client is a minor under 18 years of age and the information acquired by the clinical social worker indicates that the minor was the victim of a crime or harmful act, the clinical social worker may testify at an examination, trial, or other proceeding in which the commission of the crime or harmful act is the subject of the inquiry;

(4) when the client commences a legal proceeding against the clinical social worker.

ARTICLE 3. PROHIBITIONS AND PENALTIES.

Sec. 08.87.090. LICENSE REQUIRED. A person may not engage in the practice of clinical social work unless the person is licensed under this chapter or is exempt from the requirements of this chapter under AS 08.87.110.

Sec. 08.87.100. VIOLATIONS. It is unlawful for a person to

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

(2) aid and abet a person not licensed under this chapter;

(3) use the title "clinical social worker" or a title or designation indicating or tending to indicate that the person is a clinical social worker, if the person is not licensed under this chapter; or

(4) wilfully violate a provision of this chapter.

Sec. 08.87.110. EXEMPTIONS. The following persons are exempt from the licensing provisions of this chapter:

(1) a qualified member of another profession if he does not hold himself out to the public by title or description of service as being engaged in clinical social work practice;

(2) a person newly employed on probationary status as a clinical social worker.

Sec. 08.87.120. PUNISHMENT FOR MISDEMEANOR. A person who violates a provision of this chapter is guilty of a class A misdemeanor.

Sec. 08.87.130. EQUITABLE RELIEF. The board may bring an action in the superior court to enjoin or restrain a violation of the provisions of this chapter.

Sec. 08.87.140. DEFINITIONS. In this chapter

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

(2) "department" means the Department of Commerce and Economic Development;

(3) "psychotherapeutic" means the use of psychosocial and social methods within a professional relationship to assist a person or persons to achieve a better psychosocial adaptation; forms of psychotherapy include but are not restricted to individual psychotherapy;

conjoint marital therapy, family therapy, and group psychotherapy.

* Sec. 2. AS 08.01.010 is amended by adding a new paragraph to read:

(24) Board of Clinical Social Worker Examiners.

* Sec. 3. AS 08.03.010(a) is amended by adding a new paragraph to read:

(21) Board of Clinical Social Worker Examiners (AS 08.87.010) -- June 30, 1996.

* Sec. 4. APPOINTMENT OF FIRST MEMBERS OF BOARD OF CLINICAL SOCIAL WORKER EXAMINERS. (a) The governor shall designate the terms of the members of the Board of Clinical Social Worker Examiners first appointed under AS 08.87.010.

(b) Of the two members who are not licensed or eligible to be licensed as clinical social workers

(1) one shall serve a term of one year; and

(2) one shall serve a term of two years.

(c) Of the three board members first appointed who are licensed or eligible to be licensed as clinical social workers

(1) one shall serve a term of [illegible] years;

(2) one shall serve a term of [illegible] years; and

(3) one shall serve a term of [illegible] years.

* Sec. 5. TEMPORARY EXEMPTION FROM EXAMINATION REQUIREMENTS. A person who is, or is eligible to be, registered by the register of clinical social workers of the National Association of Social Workers is considered by the Board of Clinical Social Worker Examiners as meeting the requirements for a licensed clinical social worker and shall be issued a license under this Act. This provision is effective until one year after the effective date of this Act. Thereafter, all new applicants for a license must meet the licensing requirements of AS 08.87.

* Sec. 6. This Act takes effect July 1, 1992.

COMMITTEE REPORT

HOUSE

(5)

FURTHER: JUDICIARY
FINANCE

2/16/82

Date: _____

Mr. Speaker:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had HB 854

"An Act relating to protection of the elderly."

under consideration and ~~(a majority of the committee)~~ ~~(the committee)~~ reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for 0854Y [ ] same title [ ] new title

and recommends _____

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

Jane Martin - Repeal

CHAIRMAN

■ 60 (Rev. 12/78)

Municipality of Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502-0650
(907) 264-6720

TONY KNOWLES, MAYOR

DEPARTMENT OF SOCIAL SERVICES
Senior Citizens Program

March 26, 1982

M.F. Beirne, Chairman
HESS Committee
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Dr. Beirne:

It has been requested that I write to you and inform you of action taken at the March meeting of the Municipal Senior Citizens Advisory Commission.

The meeting agenda included a discussion of HB 854 and 855 as drafted. Some members of the Commission had specific ideas or suggestions which they shared with the HESS committee during the recent teleconference. Other members may send written comments. A motion was made and passed that the Municipal Senior Citizens Advisory Commission endorses the Concept of both HB 854 and 855.

Thank you for the opportunity to share action taken by this body on legislation which is directed towards improving the quality of life for all older Alaskans.

Sincerely,

Norma Lundy

Norma Lundy, Manager
Senior Citizens Division

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 5, 1982

AGENDA

HB 854 Protection of the Elderly

HB 855 Right to a Natural Death

alaska state hospital association
319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

March 15, 1982

The Honorable Donald E. Clocksin
State House of Representatives
Pouch V, State Capitol Building
Juneau, ALaska 998811

Dear Don:

The Alaska State Hospital Association must respectfully inform you of our opposition to House Bill 854.

We believe that the listing of those required to report elderly abuse is far too broad and is duplicative of processes currently in place which provide protection to elderly patients of nursing homes in Alaska. We believe that House Bill 854 should be modified so as not to include those persons now included under proposed Section 47.24.010 (a)(11) nursing home administrator, (12) a nurse's aide or orderly in a nursing home facility, (13) a person paid to care for a patient in a nursing home facility, and (14) a staff person employed by a nursing home facility. We do not believe that the mere fact of employment in a nursing home confers any expertise on a clerk-typist or a maintenance engineer to assess elderly abuse nor should persons be subject to fines for failing to report what they are not qualified to judge.

Further, this legislation ignores the fact that nursing home patients are admitted to nursing homes by a physician's order (see 7 AAC 12.010(d)(3)) and remain the patient of the admitting physician. Nursing homes are licensed pursuant to 7 AAC 12.040 and may have that license revoked pursuant to 7 AAC 12.040(a)(8)(B) if "any illegal act affecting the welfare of a patient in the institution has been permitted".

The Division of Licensure and Certification has the power to respond to any complaint about the care and treatment of nursing home patients and indeed has responded to such complaints. I must note, however, that they rarely find merit to the complaints. In addition to this activity, the state has created a Senior Citizen Ombudsman who has

authority to investigate complaints, except for those elderly persons in Pioneer's Homes. While this program is in its infancy, we believe that the working relationship between that office and members of this Association is developing well and in a nature beneficial to elderly patients.

Aside from the inappropriateness of including nursing homes and their employees, we would suggest that the structure of this bill only serves to further fragment services for the elderly. We have in the Department of Health and Social Services, a Division of Adult and Aging Services, the nursing home licensing in the Division of Licensing and Certification and payment for services in the Division of Public Assistance, a state office of Senior Citizen Ombudsman, and in the Department of Administration we have a Division of Pioneer's Benefits and the Older Alaskans Commission. Now enter into this morass the Division of Family and Youth Services in the Department of Health and Social Services. One must wonder how much paper gets shuffled and how many elderly concerns get resolved.

We believe more elderly Alaskans will be served and more needs met by organizing the current chaos than by adding a new head to this multi-headed beast. If it is your position that these other avenues have failed in their missions, let us dismantle them and clear the way for addressing the needs of elderly Alaskans. Perhaps what we need is a Department on Aging with a defined mission and the ability to accomplish that mission.

Sincerely,

Dennis L. DeWitt
President

DLD:bf
cc: Senate HESS Committee Members

Alaska State Legislature

House of Representatives

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

TO: Rep. Mike Beirne, Chair
House Health, Education & Social Services Committee

FROM: Rep. Don Clocksin

SUBJECT: HB 854/Protection of the elderly from abuse

DATE: March 3, 1982

Enclosed are materials relating to HB 854, which provides for protecting elderly Alaskans from abuse. The bill mandates the reporting and investigation of suspected cases of elder abuse and makes protective services available to elderly persons if they want them.

Three national studies and one recently completed in Anchorage all conclude that elder abuse, both physical and psychological, is a very serious problem. The Anchorage study was done by the Anchorage Community Mental Health Center and the results correspond closely to the national studies.

National studies indicate that in 95% of the cases of elder abuse, some effort has been made to report the abuse. That effort, unfortunately, is often unsuccessful and indicates a failure of social service systems to respond.

According to the Anchorage study, 76% of the reported elder abuse cases involved a woman victim, many of whom are the frail elderly unable to defend themselves. National studies indicate that 80-90% of the abusers are related to the victim, who resides with the relative who is also the elder's caretaker. The abuse is often a response to stress which may be a result of lack of income, crowded living conditions, and the high level of physical and emotional care required of the abuser. In a sense, the abuser is also a victim of a difficult situation.

HB 854 is based on draft legislation produced by the Elder Abuse Task Force, a coalition of over thirty agencies in Anchorage that has voluntarily studied the problem for the past year. Similar legislation based on that draft has also been introduced in the Senate by Sen. Bertoula (SB 773).

Enclosed is a bill summary, statistical findings of the Anchorage study, and an excerpt from a monograph on elder abuse.

Please contact this office if you need further information concerning this bill and the general problem of elder abuse. I urge early and favorable action to address this serious problem.

FINDINGS OF A.C.M.H.C. - 1981 - Alaska

In the study conducted by A.C.M.H.C. of 75 cases documented, 34 cases (43.3%) of physical abuse were found. A breakdown of the abuse sustained follows:

lack of personal care	17.3% •
bruises and welts	13.3%
lack of food	10.7%
medicines withheld	8.0%
freezing	6.7%
malnutrition	6.7%
direct beatings	5.3%
abrasions and lacerations	2.6%
bone fractures	2.6%
sexual assault	1.3%
imprisonment	1.3%

Psychological abuse was sustained by 53 elders (70%)

fear	46.7% •
verbal assault	28.7%
threat	18.7%

Material abuse occurred in 43 cases (57.3%)

misuse of money or property	45.3% •
theft of money or property	26.7%

• categories are not mutually exclusive

Here was violation of rights in 18 cases (24%)

forced social isolation	16.0% •
forced from home	6.7%
forced into nursing home	5.3%

STATISTICS ON VICTIM

Age of abused elder at the time of the abuse

60 - 70	41.3%
70 - 80	41.3%
80 - 90	13.3%
90 •	4.0%

Sex of Victim

Female	76.0%
Male	22.7%
Couple	1.3%

Race or Ethnic Group

White	69.3%
Native	18.7%
Black	9.3%
Hispanic	1.3%
Unknown	1.3%

STAISTICS ON VICTIM (continued)

Economic Status of Victim

Low	54.7%
Middle	29.3%
High	12.0%
Unknown	4.0%

Degree of Physical or Mental Impairment

Physically or mentally disabled to a great degree	38.7%
Need some assistance with Activities of Daily Living (ADL's)	21.3%
Physically self-sufficient	40.0%

Resides at the same address as victim

Alone	17.3%
Family member(s)	41.3%
Husband/wife	14.7%
Girl/boyfriend	8.0%
Boarding home	4.0%
Nursing home	4.0%
Housekeeper	5.3%
Friend(s)	4.0%
Unknown	1.3%

STATISTICS ON ABUSER

Relationship to victim

Daughter	22.7%
Son	21.3%
Husband	10.7%
Granddaughter	1.3%
Grandson	1.3%
Girlfriend	4.0%
Boyfriend	1.3%
Son-in-law	1.3%
Daughter-in-law	9.3%
Hired caretaker/housekeeper	6.7%
Entire family	5.3%
Boarding home	4.0%
Friend	10.7%

Age of abuser

20's	6.7%
30's	22.7%
40's	36.0%
50's	12.0%
60's	14.7%
70's	2.7%
80's	1.3%
Unknown	4.0%

Ethnic Group of Abuser

White	65.3%
Native	20.0%
Black	8.0%
Hispanic	1/3%
Unknown	5.3%

Economic Status of Abuser

Low	44.0%
Middle	22.7%
High	16.0%
Unknown	17.3%

Does the Abuser Live With the Victim?

Yes	69.0%
No	22.7%
Unknown	1.3%

OTHER INFORMATION

Is alcohol a factor in this situation?

Yes	49.3%
No	41.3%
Unknown	9.3%

Has this mistreatment happened before?

No	2.7%
Once	9.3%
2 - 3 times	8.0%
4 or more	74.7%
Unknown	5.3%

How did you know about it?

Self report	49.3%
Private M.D.	5.3%
Hospital	22.7%
Police	0
Public Social Service Agency	5.3%
Private Social Service Agency	6.7%
Public Health	2.7%
Neighbor	1.3%
Professionals Observation	6.7%

Did the victim seek help?

Yes	53.3%
No	43.7%
Unknown	4.0%

Developing New Laws and Servic s

Studies by the UCLA/USC Long Term Care Gero tology Center, the House Select Committee on Aging (U.S. House of Representatives) and the Senate Special Committee on Aging (U.S. Senate) reveal that the States have greatly varyin powers of authority for elderly protective services. Many have almost no authority. Almost all States, in one way or another, have an office with responsibility to provide protective services to some segment of the population. The House Select Committee on Aging Survey identified 26 States which have some type of adult protective services legislation. The provisions and coverage of these services and laws vary widely in scope. The following specifics of State laws and services are from the above-mentioned studies.

States may provide services under general health and welfare authorities and/or specific adult protective services legislation. The scope of their efforts and of their capabilities in addressing the problem depends on the shape of these laws. The House Committee on Aging found that the reports from its survey provided a very mixed picture. It is, however, evident that States have just begun to recognize the growing importance of this problem. The majority of the adult protective service laws have been passed in the last 5 years. Only one State reported having an adult protective service law in place prior to 1973.

There are many necessary provisions that these laws may or may not have. Some are as follows: (1) aid provided without regard to income, (2) reporting provisions, (3) provisions to enter and investigate, (4) provision to e in the caretaker from interfering, (5) provisions for guardianship or conservatorship, (6) in untary or emergency service pro ions, (7) voluntary services provisions, (8) mandated me period for investigation or report, (9) case review mechanisms, (10) due process safeguards, (11) penalty provisions for failure to report and/or caretaker maltreatment, and (12) specific adult population groups covered.

Both studies looked at the specific authority for elderly protective services conferred by State statutes. They both found that the States have widely varying powers. The majority of State adult protective service divisions do have the authority to receive complaints and investigate them. However, some States have no provisions for investigations without the consent of the abused adult or guardian. In some States, services must wait until there is a request from the victim or his or her guardian. Other States have "voluntary" adult protective services. A few States (Oklahoma, Kentucky, Nebraska, and Colorado) reported having statutory authority not only to receive complaints but also to open investigations as well as following up on complaints without the prior consent of either party. It is apparent that State actions and capacity for action vary greatly.

The States also vary as to whom they service. Some have restrictions as to age and/or disability. Some also have restrictions as to income. In response to the House survey, which asked if services were provided without regard to income, all States said yes, with exception of Missouri and South Dakota which both reported applying the Title XX income test to determine eligibility. In the case of others, a sliding fee scale keyed to income may be used such as in the case of Massachusetts and Wisconsin. Virginia offers optional service free for 10 days, with services based on income eligibility criteria after that. In some instances, clients must be in the care or custody of the appropriate State agency. And, some, such as New Hampshire, provide services regardless of income when the victim is incapacitated as well as abused. In terms of money spent, according to the House Committee survey, the nationwide average is a modest $679,354 for elderly protective services. Only 20 of the States had the necessary data to respond to this question, and the range went from a low of $4,950 in Utah to a high of $3,088,399 in New York.

It is apparent that State actions and capacity for action vary greatly. Some States have laws authorizing the provision of services to abused adults, but do not require that abuse cases be reported. Other States with adult protective service laws require the reporting of abuse, but do not provide for the delivery of services after the abuse has been cited. Sixteen of the 26 States with adult protective service laws (Alabama, Arkansas, Connecticut, Florida, Kentucky, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, Oklahoma, South Carolina, Tennessee, Utah, Vermont, and Virginia) indicated that they also require mandatory reporting of elderly abuse cases. Required reports, point of handling reports, and the penalties for failure to report and caretaker maltreatment vary widely.

Many States which do not have laws are providing protective services on a voluntary basis for adults under funds they receive under Title XX of the Social Security Act. Ten States (Arizona, Kansas, Maine, Maryland, Massachusetts, Michigan, Montana, New York, Rhode Island, and Wisconsin) have adult protective service laws enacted, but do not require individuals who suspect abuse has occurred to report the incident. Of the States without adult protective service bills and/or mandatory reporting requirements, 20 have sponsored bills and/or mandatory reporting requirements. Only 10 States (Alaska, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Nevada, South Dakota, and Texas) have neither adult protective service statutes nor mandatory reporting requirements, nor any legislation pending consideration before their State legislature.

It was apparent from the House Committee Survey that most of the States have little data on elderly abuse or their response to the problem. Although data were too incomplete to draw any conclusions, States reported that prime sources of complaints about elderly abuse are hospitals or clinics, police, lawyers, or public service agencies. Respondents from 23 States said that their State has standardized forms for reporting elderly abuse. Slightly over one-half of the States have specific written instructions or procedures concerning intervention when elderly abuse is found to have occurred. When asked what was the most common course of action, the States said that the most common action was to call the police or to relocate the victim to another setting. They also felt that these methods of intervention were probably the least effective, preferring counseling and provision of services. Most of the States thought that the needs of the elderly in abuse situations were being met only occasionally to infrequently. Several were unsure due to lack of data. In total, 63 percent of the States said they lack appropriate statutory authority to adequately help the abused elderly. A frequently cited problem was the lack of authority to begin investigation unless requested to do so by the abused or his family—which often means the abuser. This places the protective service worker in a classic Catch 22 situation. The other problem most often cited was the lack of properly trained staff and other resources.

Excerpt from: "Abuse of the Elderly"
Human Services Monograph Series
Number 27, September 1981
Publication No. OS-76-130

Alaska State Legislature

House of Representatives

Rep. Don Clocksin
Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

SUMMARY OF HOUSE BILL 854

Protection of Elderly from Abuse

Purpose: To protect the elderly from harm resulting from abuse, neglect, exploitation, and abandonment, and to make protective services available to prevent or alleviate harm.

Reports of Harm: Requires health professionals, nursing home staff and others to report cases of harm to elderly persons which come to their attention in their work. Reports of harm are made to the division of family and youth services in the Department of Health and Social Services.

Action on Reports: Requires that the division promptly investigate reports of harm and determine what, if any, action o services are needed for the protection of the elderly person. Requires that the division prepare a written report of its investigation.

Protective Services: Provides for making protective services available to elderly persons if they consent. Outlines procedures for providing services if the caretaker is interfering in their provision.

Review and Referral: Requires regular review and evaluation of cases until closed.

Confidentiality: Makes investigative reports and reports of harm confidential and exempt from public inspection and copying. Makes special provision for judicial proceedings.

Annual Report: Provides for annual statistical report on cases of elder abuse to the legislature.

Regulations: Specifies that regulations adopted to implement the law be jointly approved by the division and the Older Alaskans Commission.

Definitions: Defines "abandonment," "abuse," "exploitation," "neglect," and other special terms used in the law.