ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

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Medical Services Along Alaska's Highways: 1980 through 1984, prepared by the Alaska EMS Section of H & SS. A copy of the complete report is available in the Committee master file.)

In carrying out its responsibility, the Alaska EMS Section of the Department of Health and Social Services works in conjuction with various other groups and agencies, including Highway Safety Planning Agency of the Alaska Department of Public Safety. (The EMS Section assists Highway Safety in developing the EMS component for the Highway Safety Program. In return the HSPA helps EMS via financial assistance available through the federal Highway Safety Act Program.)

Emergency Medical Services: Structure

The Emergency Medical Services Section provides technical assistance and awards grants to the three (soon to be four: see Appendix II) EMS regions within Alaska. In general, state EMS fills a coordinating function, as described in the previous section. A diagram, taken from page 15 of the Five Year Plan, might best serve to illustrate the EMS Section's relationship to other elements of state goverrment. (See Figure I on following page.)

In addition to the staff of the EMS Section (see Appendix III), a physician, Dr. Tim Samuelson, State EMS Medical Director, is employed part-time to provide overall medical direction. (Also, all regional programs have medical directors working at the regional and local levels to provide additional medical supervision and direction.)

In any discussion of EMS mention must also be made of the State Advisory Council on Emergency Medical Services (ACEMS), referenced in the diagram cited above. ACEMS was established in 1977. It is mandated to:

1) Advise the Commissioner of Health and Social Services with regard to the planning and implementation of a statewide emergency medical services system;

2) Assist the Statewide Health Coordinating Council in performing its duties under AS 18.07.011 relating to emergency medical services.

The purpose of ACEMS is to:

"1. Bring together technical resources, experience and knowledge to assist the development of an EMS system in Alaska;

2. Advise the State EMS staff and Regional Coordinators regarding public education and generation of broad community support for the goals of the EMS program;

3. Recommend EMS program policy;

4. Provide guidance and direction to State EMS staff;

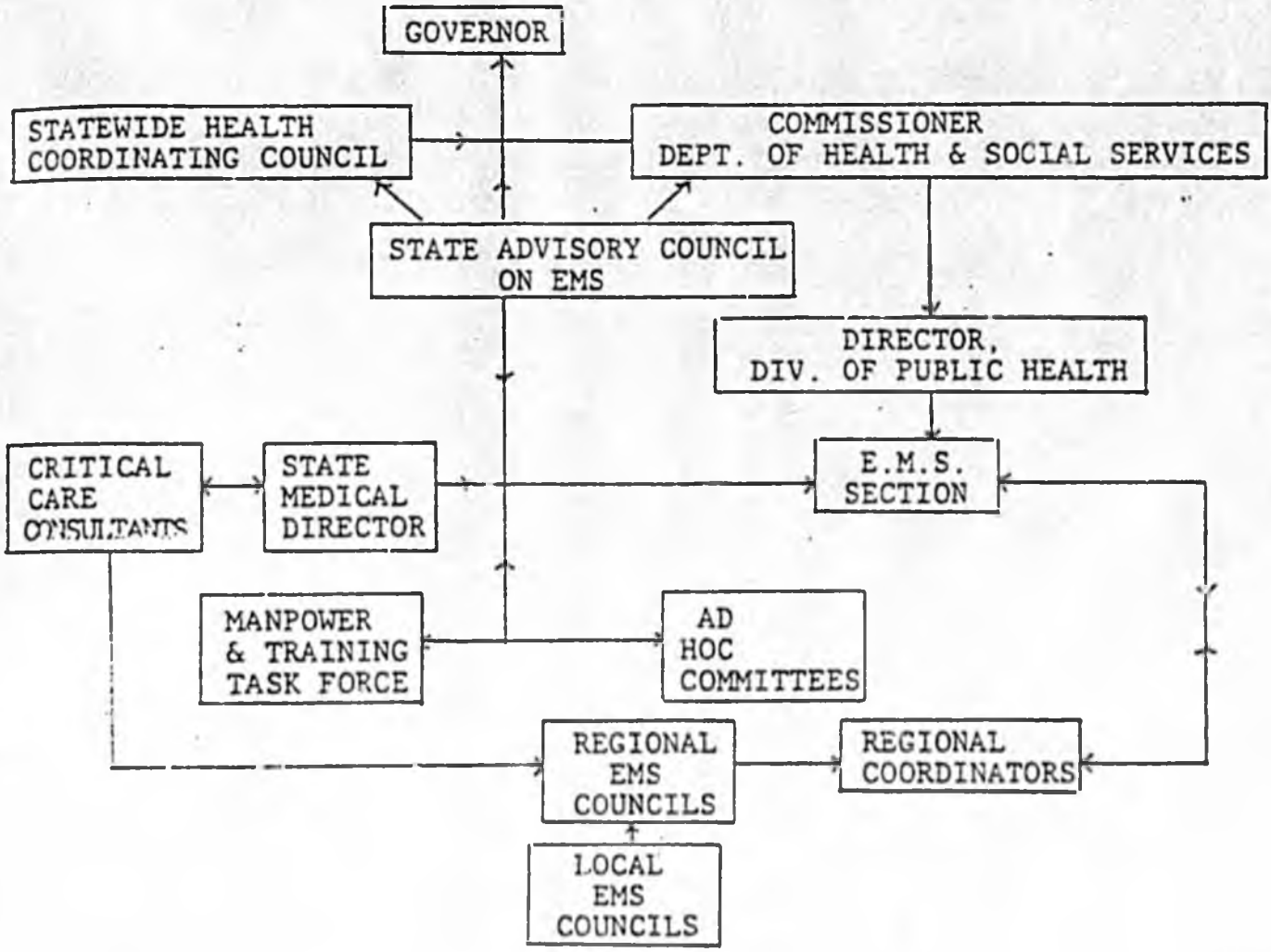

Figure I:
Relationships Between EMS Officials and EMS Advisory Bodies

Figure reproduced from page 15, "Five Year Plan for EMS Along Alaska's Highways: 1980 - 1984."

5. Review EMS or EMS-related program proposals per request of the Statewide Health Coordinating Council (SHCC) and the EMS staff;

6. Review EMS budgetary allocations and program priorities and advise the Commissioner on these matters."

(Quoted from Page 12 of A Five Year Plan for EMS Along Alaska's Highways: 1980 through 1984. Additional information on ACEMS, its composition and some of its accomplishments, may be found in Appendix IV.)

Emergency Medical Services are delivered on a local level within the state. Planning for and coordination of delivery of these services is currently carried out under the oversight of three EMS regional councils. (See Figure II, map.) In addition, each council is composed of membership from many local advisory groups. The relationship of the regional and local advisory groups might best be summarized as follows:

"EMS systems development in all three regions is coordinated through nonprofit incorporated Councils: the Northern Region EMS Council, Inc.; the Southern Region EMS Council, Inc.; and the Southeast EMS Council, Inc. All three Councils, in addition to carrying out their powers and functions as boards of directors, provide advisory council functions as well. They represent professional, consumer and geographic interests, including representation from each sub-area or major community in each region. All Native organizations active in EMS are also represented.

In addition to the region-wide councils, most sub-areas also now have active advisory councils. In some sub-areas associated with Native Health Corporations, the Boards of these corporations also serve as the EMS Board. Others have separate EMS advisory groups.

Currently, there are three sub-regional councils in Northern Region; seven sub-regional councils in Southern Region; and in Southeast, there are active local EMS councils in eight communities." (Quoted from Page 18, A Five Year Plan For Emergency Medical Services Along Alaska's Highways: 1980 through 1984.)

Lists of EMS Coordinators, Medical Advisors, Regional Council Membership, the ACEMS Board, etc., may be obtained in the 1981 Alaska EMS Directory, prepared by the EMS Section, and available in the Committee master file.

Emergency Medical Services: Goals and Problems

The overall goal of the EMS program is to "establish a comprehensive, coordinated system of emergency medical services which assures that citizens and visitors gain easy access to services; that initial response is expeditious; that appropriate life saving and stabilization measures are rendered at the scene; and that patients are transported or transferred in a timely and efficient manner to facilities capable of effecting maximum recovery and rehabilitation." (Quoted from Page

1. *NORTHERN*
   - *a. North Slope*
   - *b. N.A.N.A.*
   - *c. Interior*

2. *SOUTHEAST*

3. *SOUTHERN*
   - *a. Norton Sound*
   - *b. Yukon-Kuskokwim*
   - *c. Mat-Su*
   - *d. Anchorage*
   - *e. Copper River*
   - *f. Prince William Sound*
   - *g. Kodiak*
   - *h. Aleutian/Pribilof*
   - *i. Bristol Bay*
   - *j. Kenai Peninsula*

* *The three EMS regions are contiguous with the three HSA's (Health Systems Areas) in Alaska.*

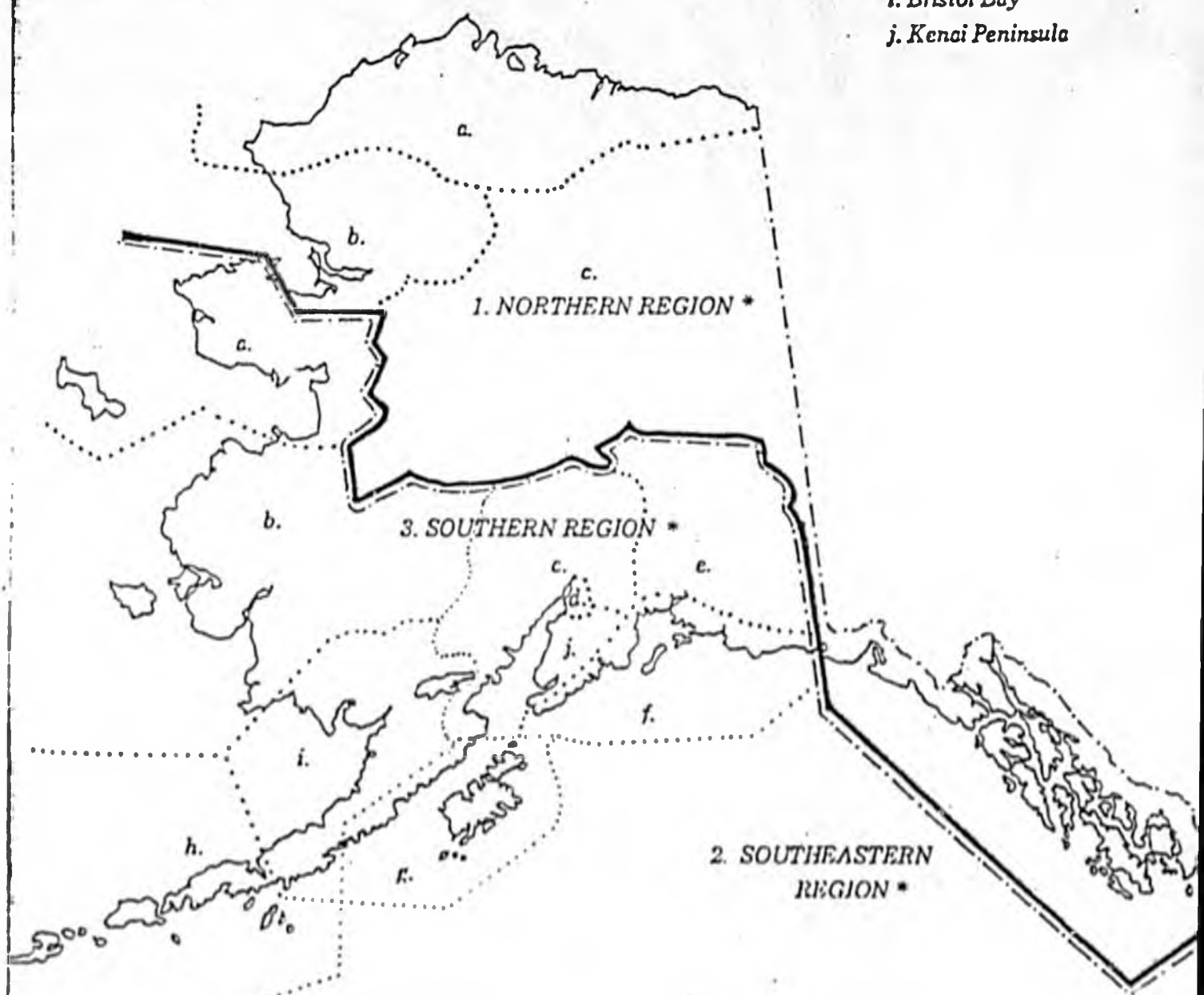

Figure II:
ALASKA EMS REGIONS & SUB – AREAS
FY 81
Copied from: "A Five Year Plan for EMS Along Alaska's Highways: 1980 - 1984."

VI-11, Alaska EMS Goals, A Guide for Planning Alaska's Medical Services System, printed in 1981, by the EMS Section, Alaska DHSS.)

Nationally, fifteen components have been identified as essential in establishing a comprehensive EMS system. Goals for state and local EMS programs in Alaska are grouped according to these fifteen components. (See Appendix V for a list of these goals.)

Whatever the stated goals, because of the large size of Alaska, small population and many scattered rural communities, Alaska EMS has its work cut out for it in attempting to organize a comprehensive and quality emergency medical service program statewide. In a draft copy of the Department of Public Safety Highway Safety Plan for FY 82 the situation is summed up as follows:

"Large areas have no communications either by telephone, radio or any other rapid means. This prevents the few existing ambulance services from being notified of accidents. Dispatch services are often non-existent.

The few sparsely inhabited communities that are located along the highway system lack a tax base to support EMT training, purchase equipment and supplies, or provide anything else to implement viable EMS services.

Existing ambulance services often have no agreements covering procedures for back-up support, patient transfer from service to service, or equipment compatability and retrieval. Protocol for air evacuation has not been developed.

Public awareness of the nearest emergency medical services and the means to access them must be developed and expanded. In 1978, the number of travelers entering Alaska at the Alaska-Canadian Border Station was 109,621; in 1979 slightly fewer travelers entered the state. These persons particularly need information before traveling on the Alaskan highway system.

In summary, the major problems are: 1) lack of communication; 2) lack of EMS services, and 3) lack of consumer awareness of EMS services."

In addition "...emergency medical services are inadequate because of antiquated or lack of equipment, insufficient communication networks and lack of initial and standardized training of personnel."

Emergency Medical Services: Problems and Solutions

Having outlined the major basic problems facing EMS in Alaska, it might be appropriate to outline some of the plusses. The following comments are taken from Mark Johnson, Alaska EMS Coordinator, in the EMS-Alaska Response publications, for May/June/July 1981, page 3 and4:

"Now that the Alaska EMS program is 100 percent funded by the state, it may be a good time to reflect on what has been accomplished, and to decide future priorities...

Since the first EMTs were trained more than a decade ago at the Public Safety Academy, there has been phenomenal progress in EMS in Alaska. At last count, there were at least 65 ambulance services statewide, with 14 new services organized within the past year. Virtually all of these services have basic or advanced trained EMTs with modern vehicles, equipment, and radio communications. There also are more military and civilian helicopters, and other aircraft, available for medical transportation. Throughout the state, there now are more than 3,000 certified EMTs with many more people trained as EMTs, but not certified. This gives Alaska the distinction of having more EMTs per capita than any other state. In urban areas, there are 47 licensed paramedics, with 6 more soon to be licensed.

We have seen the birth of emergency medicine as a board certifiable medical specialty, and a few urban hospitals in Alaska now are employing emergency physicians to staff emergency departments. In addition to the array of medical specialities and specialized critical care units now available in our urban areas, we have seen large numbers of physicians, nurses, and mid-level practitioners throughout the state certified in the American Heart Association Advanced Cardiac Life Support course. Numerous other courses on emergency medical topics also have been offered to hospital and pre-hospital personnel, and recently a course adopted by the American College of Surgeons, called Advanced Trauma Life Support, has been offered to physicians, primarily from rural areas, who often don't have surgeons and other specialists immediately available.

Thousands of citizens and first responders, statewide, have been trained with assistance from the Red Cross, Heart Association, and EMS providers in first aid, CPR, or emergency trauma training, with increased efforts directed to training in remote areas, including logging camps and other high risk occupation sites. Successful efforts also have been made in many communities to get some of these courses offered in schools.

Emergency communications have improved greatly, although much more still needs to be done. By the end of next year, most ambulance services along major highways will be able to talk to their base stations, troopers, and hospitals. However, gaps continue to exist in some places. Communications also have improved in many bush areas, but reliability continues to be a problem in many villages. In urban areas over 80% of the population now can access emergency services by dialing the universal access number 911. This means that a larger of Alaska's population is covered under a 911 central access number than any other state. A few major communities still need to upgrade to the 911 system, which has been proven through numerous studies to reduce response times from the onset of medical emergencies until medical responders arrive at the scene.

Disaster planning also has been given increased attention in many communities. Emergency services personnel throughout the state have had training in aircraft and other mass casualty disaster response,

and disaster drills have been conducted with involvement of military and civilian personnel. An example of the pay-off of these cooperative efforts was the fantastic rescue of all passengers and crew from the burning ship "Prinsendam" in the Gulf of Alaska last fall.

Given the tremendous progress that has been made so far, any consideration of future priorities should not hinder progress in these essential program areas. Rather, we should endeavor to continue the progress which already has been made in addition to adopting any new priorities."

In the same article, after summarizing program accomplishments, Johnson continues by discussing EMS priorities for the near future.

"Some new priorities of the State EMS Office are based on legislative mandate, such as standardizing the certification of EMTs These regulations soon will be adopted and have involved input from dozens of EMTs, physicians, and ambulance services during the past three years. During the next few months, this office will begin all certification of EMT-Is, IIs, IIIs and Instructors. To assist us in this effort, a training committee has been established by the State Advisory Council on EMS; a state training coordinator position is being established; and a computerized system to keep track of each EMTs certification status will become operable, with one one of its main functions being to notify EMTs in a timely fashion of their recertification requirements.

We also hope to use the new, statewide instructional television network to provide training and continuing education programs to EMS responders and citizens throughout the state, and we plan to work with EMS experts in developing more definitive, up-to-date field treatment guidelines for especially difficult medical conditions. This year the emphasis will be on hypothermia and cold water near-drowning.

Other priorities include increased attention to evaluation of programs to determine their potential impact on saving lives and reducing disability; imporved coordination between EMS responders and accident prevention programs; and more communication between all levels of EMS professionals and volunteers.

Public information and education programs also should be given major emphasis. As a beginning toward this effort, we recently have developed two brochures - one titled "EMS on Alaska's Highways" and the other titled "Welcome to Alaska - Have a Safe Trip!" which provides safety tips for tourists planning to visit our state. Another program we hope to initiate during the coming year, in cooperation with the Alaska Division of Emergency Services, is a public education program on what to do, or what not to do, during a major earthquake."

(Note: the regulations referred to in this article become effective January 1, 1982. Please see Committee master file for a copy. The two brochures are included in the Committee master file.

Emergency Medical Services: Observations and Recommendations

For purposes of discussion emergency medical services can be broken down into several categories: personnel, communications, equipment and transportation. The following is a summary of these categories, plus some recommendations for possible Committee action.

Personnel

People are the underpinning of EMS. Many emergency medical technicians (EMTs) are volunteers, members of volunteer ambulance departments, volunteer fire departments, or just people who want to be ready to help others in a medical emergency should the need arise. Other EMTs are paid professional members of police or fire departments, the military, village health aides, etc. EMT training emphasizes emergency (not routine) medical procedures designed primarily to provide prehospital stabilization and immediately needed medical assistance to people involved in accidents or experiencing a medical crisis. The skill classifications of EMTs are defined as follows:

ETT (Emergency Trauma Training): A 40-hour course developed by the Public Safety Academy and the Southeast Region EMS Council, especially for workers at isolated high risk occupation sites, which emphasizes emergency care for trauma victims, as well as medical communications and med vac preparations.

EMT-I (Emergency Medical Technician I): An EMT-I, as certified by the Alaska Department of Health and Social Services, has successfully completed a course, at least 81 hours in length, which incorporates the in-classroom objectives of the U.S. Department of Transportation, Basic Training Course/Emergency Medical Technician, plus knowledge and skills of pneumatic anti-shock device application. To be certified, the EMT-I may perform basic life support and emergency care, and apply pneumatic anti-shock devices (MAST suits).

EMT-II (Emergency Medical Technician II): An EMT-II, as certified by the Alaska Department of Health and Social Services, may perform the activities of an EMT-I, and under verbal or written orders of a supervising physician, insert esophageal obturator airways, apply rotating tourniquets, start peripheral IVs and use D5 & W, Ringers lactate, sodium bicarbonate, 50% glucase, and Narcan. The certified EMT-III must have sucessfully completed a Department-approved 50 hour course based on the appropriate modules of the U.S. Department of Transportation's National Training Course/EMT Paramedic; and must have six months experience as an EMT-I; and must pass a written and practical examination.

EMT-III (Emergency Medical Technician III): An EMT-III, as certified by the Alaska Department of Health and Social Services, may, in addition to performing the activities of an EMT-I and EMT-II, apply electrodes and monitor cardiac activity; defibrillate life threatening arrhythmias; use lidocaine, morphine for severe pain in trauma of the extremities, and epinephrine 1:1000 for anaphylaxis. The EMT-III must work under supervision and written or verbal orders of a sponsor physician; must have successfully completed a Department-approved course

of 24 or more hours; and must pass a written and practical examination.

Regulations governing training and certification of EMTs will go into effect on January 1, 1982. (See Committee master file for a copy of the regulations.) Within six months of this date all currently certificated EMTs must begin recertification, meeting standards set forth in the new regulations.

The state EMS Section, as well as each regional and local EMS advisory group, has medical advisory personnel whose purpose is to provide medical oversight and help provide training to Alaska EMTs. (Among other duties these medical providers devise "protocols" for EMTs to refer to in order to provide standardized treatment in particular types of medical emergencies. See Appendix VI for an example of such protocol.)

A frequent comment made to the Committee during interim hearings and during the course of research preparing this paper was the need for training EMTs. This need is expressed not only as a desire to train new EMTs to fill "holes" in the system, but also as a necessity to improve EMT skills through ongoing education, and to help prevent "skill decay".

Skill decay in EMTs was a topic mentioned with concern. Skill decay is loss of expertise in certain areas of medical practice not often called upon for use. Lack of use of various techniques leads to poor retention of skill in these areas. One method of skill retention is, of course, to see more patients with conditions requiring practice of these skills. This solution is usually impractical in a small and relatively scattered population. Another method is constant retraining of EMTs in order to retain and upgrade all skills, with special emphasis on strengthening these skills called upon less frequently in common practice.

One controversial area in the providing of emergency medical service in Alaska that will probably be brought to the legislature's attention again this session is the question of paramedics.

A paramedic is someone who has obtained EMS training over and above that of an EMT-III, with special emphasis on advanced assistance given to victim with cardiac problems. At least one volunteer fire department in Alaska now has on staff paramedics trained outside the state with state funds, and whose salaries are being paid with state monies. There are indications that at least two or three additional requests for funding paramedic training will be made to the legislature this session.

The controvery over paramedics revolves primarily over the issue of whether or not paramedical skills are needed in Alaska. Although the EMS state goals aim for paramedics in large, urban communities, testimony has been received that such skills cannot be kept upgraded by the few opportunities for their practice in Fairbanks. This may also be true of the situation in Anchorage. This argument views paramedics essentially as emergency care personnel whose main value lies in being able to provide immediate response (within minutes) primarily to victims of heart conditions (mainly elderly), and preferably while keep-

ing in radio communication with a physician while speeding the victim to a hospital. Others, however, argue that the greater skills of a paramedic make him/her a more valuable emergency medical care provider all around, and highly suitable as a trainer for other, lower skill grade, EMTs.

Other areas worth consideration while on the topic of paramedics are availability of training and funding. If the state deems paramedic skills worthy of encouragement and funds individuals to train for them, should the state also look at the possibility of setting up a source of paramedic training here in the state? And , once trained, should the state follow the precedent already set and plan to fund salaries for some or all paramedics working in Alaska? (For further information and background on the controversy over paramedics, please see Appendix VII.)

Currently, the state EMS Section is in the process of hiring an EMS training/coordinator. Some of the other needs expressed in the area of training at the local level have been the desire in some areas for Alaska-specific (and sometimes regional-specific) training manuals for EMTs, the need for new and replacement training equipment, and the need for a training building in the Interior region.

In order to provide training for EMTs, regional EMS councils employ training personnel who offer classes for teaching and upgrading of EMS skills. (To become certified, EMTs must pass nationally prepared exams.) In addition, the state EMS Section provides additional opportunities to upgrade skills through sponsoring a yearly symposium in Anchorage. The symposium features as speaker experts in various areas of emergency medicine and also an EMS skills competition. This year's symposium, held in mid-November, drew several hundred emergency medical personnel form all over the state. (A copy of the program guide for the symposium is in the Committee master file.)

The question has arisen of providing EMTs with legal protection from law suits. There are presently three versions of Good Samaritan legislation in Alaska statute. While some feel there is adequate protection for EMTs under present law, others do not. Early this summer draft legislation designed to deal with this problem was drawn up for the Department of Health and Social Services. The Department planned to offer this draft as a bill to the legislature during the second session. Since that time, on advice of the attorney general, the decision has been made not to offer the proposed bill to the legislature on the basis that such legislation, if ever challenged in court, would likely prove unconstitutional. A copy of this draft legislation plus much additional material on this subject can be found in the Committee master file. Other references on the topic are available through a small library on the subject at the state EMS office. A draft position paper from the EMS Section appears in Appendix VIII.

The question of providing insurance for Alaska EMTs has also been raised. The little testimony received on this topic is contradictory. The Committee may, however, wish to pursue the topic with the state EMS Section this coming session.

In the area of personnel, final mention might be made of the recently published Alaska EMS Goals: A Guide for Planning Alaska's Emergency

Medical Services, published by the EMS Section of the Department of Health and Social Services in 1981. This document lists ultimate EMS manpower goals according to a breakdown of communities bases on the "levels of care" system presented in the Alaska State Health Plan. Excerpts from this report are included in Appendix IX.

Communications

Many comments pointed out communications as a general problem area in EMS. However, aside from a few specific suggestions, the general feeling seemed to be that the problem was being worked on and that what was needed for the present was time to fully develop a communications plan for EMS. Work is proceeding on this plan with the newly organized Division of Communications in the Department of Administration.

Each Regional EMS council has a communications committee working in conjunction with the state, and with the communities within the region.

A compilation of material on EMS communications needs was made last session by Brad Brooks on behalf of Representative Brian Rogers. This compilation is available in the Committee master file.

Two communications areas that might require legislative assistance are continued funding of repair of present EMS communications equipment and possible pick-up of funding for village health aide (also used for EMS) phone lines, where such funding has been dropped by Indian Health Service. (See transcription of comments made at Nome HESS interim hearing in Appendix X.) Further information on these needs will probably be presented directly to the Finance Committees, along with requests for funds in these areas.

A final mention under communication might be made of the value to EMS of a centralized, coordinated dispatch system, especially the "911" system. Legislative encouragement of as many communities as possible adopting this system statewide would do much to expedite faster delivery of emergency medical services in Alaska. This could probably best be done by appropriations to assist communities in adopting or adapting to the 911 central dispatch system.

Equipment

The most frequently made comments regarding EMS equipment were those emphasizing need for funds to purchase new and replacement training equipment for the various regions, remarks about the difficulties in retrieving equipment (stretcher, etc.) sent in with a patient to a central hospital, and the need for medical oversight of major equipment requests made by local and regional EMS organizations to the legislature.

Theoretically, requests for capital monies for equipment purchases are made through the EMS Section's official presentation to the legislature. The equipment requested in this fashion has been screened through examination of the requests at the local, regional and state levels by medical and communications consultants and vetted for need and suitability. In actuality, while many requests do come in this

fashion, others are made by local or regional EMS groups directly to individual legislators. The main problem with this failure to go through "channels" is the increased likelihood of state funds being spent for inappropriate equipment. However, there does not seem to be an immediate solution to this problem. The Advisory Council on Emergency Medical Services (ACEMS) has expressed to the governor a willingness to review the appropriateness of any request for EMS equipment that might come to him from the legislature.

Mini-grants of $2,500 per year have recently been made available through the EMS Section to volunteer EMS groups for upkeep of equipment.

Little can be done externally about the problem of equipment retrieval other than to keep in mind that the situation does drive up the costs of EMS equipment by making purchases of extras of various "vanished" items necessary.

Some EMS groups have established a local share policy for purchase of emergency equipment. While this practice may work in some areas and for some types of equipment purchases, other groups with a lesser tax base or less community EMS involvement have expressed fears that should such a policy become mandatory statewide it would seriously hamper their ability to purchase needed equipment.

Transportation

The major problems mentioned under the heading of transportation are accessibility and cost. Many small community EMS groups are now obtaining ambulances. However, with few roads and great distances between communities air transport is frequently (or in many cases always) a necessity in rural areas of Alaska. Many times chartered aircraft are necessary to evacuate critically ill or injured people, and this drives the cost of medical transportation even higher. In the past, Indian Health Service funds have been used to help underwrite at least a portion of EMS transportation costs, but with federal cutbacks these funds are increasingly unavailable. If the situation continues to deteriorate, the legislature may have to look at methods of funding some EMS transportation in rural areas.

Another difficulty mentioned under the general heading of transportation is the problem of volunteer ambulance services and air taxi operators have being reimbursed for their services. In the case of ambulance services, in an area with little or no tax base to help cover costs the ambulance must depend upon patient reimbursals to defray expenses. Where these are not forthcoming the costs must be met through some other means. A resolution from the Tanana Chiefs Conference, passed by the recent AFN Convention, addresses the legislature on this topic. (See Appendix XI.)

The air taxi operators have a somewhat different problem. Often they do not know the name or address of the patient they are transporting on an emergency evacuation. If the patient is critically ill or injured they may not be able to obtain this information from him or her

before offloading the patient at an airfield nearest the hospital to which he or she is being taken. Privacy considerations currently prevent hospitals from later releasing this information from their files to air taxi operators. Therefore, unless the patient contacts the air taxi operator there is no way for the operator to present, let alone collect, a bill for transportation services rendered. As many such patients may be out of state residents who return home after their recovery, the likelihood of the air taxi operator ever receiving payment under these circumstances is very slight. The Committee may wish to look at means of legalizing the release of information on air evacuated patients to air taxi operators to help alleviate this situation.

Emergency Medical Services: Summary

As a final observation, it might be noted that the emergency medical services programs in the state received excellent reviews in the returned health systems survey questionnaires sent to health care providers around the state (See Appendix XII). Comments made during testimony to the Committee, while focused on problems facing EMS, were also generally positive in tone, and the EMTs and others contacted during the course of this research were to a person enthusiastic about the functions of Alaska EMS. It should be remembered that many of the EMTs associated with the emergency medical service system in the state have volunteered considerable amounts of their time and a fair amount of money to learn and practice their skills. For a program with such ambitious goals, serving a large and geographically diverse state with a significant portion of its personnel comprised of volunteers, Alaska EMS appears to be operating very well.

The final appendix to this report (Appendix XIII) contains a brief review of some of the activities of each major EMS region during the past few years.

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SECTION 7

Appendixes:

Emergency Medical Services

APPENDIX I: Statutory Authority for Alaska EMS (Title XVIII, Chapter VIII).

Chapter 08. Emergency Medical Services.

Sec. 18.08.010. Administration. The department is responsible for the development, implementation and maintenance of a statewide comprehensive emergency medical services system and, accordingly, shall

(1) coordinate public and private agencies engaged in the planning and delivery of emergency medical services to plan an emergency medical services system;

(2) assist public and private agencies to deliver emergency medical services through the award of grants in aid. (§ 1 ch 100 SLA 1977)

Sec. 18.08.020. Advisory Council on Emergency Medical Services. There is established in the department an Advisory Council on Emergency Medical Services. The council shall

(1) advise the commissioner with regard to the planning and implementation of a statewide emergency medical services system;

(2) assist the Statewide Health Coordinating Council in performing its duties under AS 18.07.011 relating to emergency medical services. (§ 1 ch 100 SLA 1977)

Sec. 18.08.030. Composition. The council shall consist of 11 members appointed by the governor. Four of the members shall be consumers of emergency medical services, and one from each judicial district in the state. (§ 1 ch 100 SLA 1977)

Sec. 18.08.040. Term of office. (a) Members of the council shall be appointed for overlapping terms of four years.

(b) Of the 11 initial appointments to the council, two shall be appointed for one-year terms, three for two-year terms, three for three-year terms, and three for four-year terms. A consumer shall be appointed to each of these overlapping terms. Appointments made on the expiration of the initial appointments shall be made for four years.

(c) A vacancy occurring in the membership of the council shall be filled by appointment by the governor in the same manner as original appointments, and when a seat is vacated before expiration of a term, the vacancy shall be filled for the unexpired portion of the vacated term. (§ 1 ch 100 SLA 1977)

Sec. 18.08.050. Compensation and per diem. Members of the council receive no salary, but are entitled to per diem, reimbursement

for travel, and other expenses authorized by law for boards and commissions. (§ 1 ch 100 SLA 1977)

Sec. 18.08.060. Meetings. The council shall meet at the call of the chairman not less frequently than twice a year. A majority of members constitutes a quorum. (§ 1 ch 100 SLA 1977)

Sec. 18.08.070. Special committees. The council may create special committees or task forces outside its membership and may appoint persons who are not members of the council to serve as advisors or consultants to any committee created to carry out the purposes of the council. (§ 1 ch 100 SLA 1977)

Sec. 18.08.080. Regulations. The department shall adopt, with the concurrence of the Department of Public Safety, regulations establishing standards and procedures for the issuance, renewal, reissuance, revocation, and suspension of certificates required under AS 18.08.084, as well as other regulations necessary to carry out the purposes of AS 18.08.010 — 18.08.090. (§ 1 ch 100 SLA 1977; am § 1 ch 78 SLA 1978)

Cross references. — As to the power of a municipality to provide emergency medical services and facilities, see AS 29.48.030 (a)(23). As to the authority of a municipality to provide emergency medical services outside its boundaries and to regulate their use and operation, see AS 29.48.037(a).

Effect of amendments. — The 1978 amendment rewrote this section.

Sec. 18.08.082. Issuance of certificates. (a) The department shall prescribe by regulation a course of training or other requirements prerequisite to the issuance of certificates which provide for the following:

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

(2) authorizes an emergency medical technician certified under AS 18.08.010 — 18.08.090 to provide under the written or oral direction of a physician those advanced life support services enumerated on the certificate;

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

(4) authorizes an emergency medical service certified under AS 18.08.010 — 18.08.090 to provide under the written or oral direction of a physician those advanced life support services enumerated on the certificate.

(b) The department shall be the central certifying agency for personnel certified under (a)(1) and (2) of this section and under regulations adopted under AS 18.08.080. (§ 2 ch 78 SLA 1978)

Sec. 18.08.084. Certificate required. (a) No person may represent himself, nor may an agency or business represent an agent or employee

of that agency or business, as an emergency medical technician certified by the state unless the person represented is certified as an emergency medical technician under AS 18.08.082.

(b) No person, organization, or government agency may represent itself as an emergency medical service or ambulance service certified by the state unless the person, organization, or government agency is certified as an emergency medical service under AS 18.08.082.

(c) No person may provide, offer, or advertise to provide advanced life support services outside a hospital unless authorized by law.

(d) No person, organization, or government agency which provides, offers, or advertises to provide an emergency medical service may provide advanced life support services unless authorized under AS 18.08.082. (§ 2 ch 78 SLA 1978)

Sec. 18.08.086. Immunity from liability. (a) No person certified under AS 18.08.082, or person or public agency which employs, sponsors or controls the activities of persons certified under AS 18.08.082, who administers emergency medical services to an injured or sick person may be liable for civil damages as a result of an act or omission in administering those services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude liability for civil damages which is the proximate result of gross negligence or intentional misconduct, nor preclude imposition of liability on a person or public agency which employs, sponsors, or controls the activities of persons certified under AS 18.08.082 if the act or omission is a proximate result of a breach of duty to act created under AS 18.08.010 — 18.08.090. For the purposes of this subsection, "gross negligence" means reckless, wilful, or wanton misconduct.

(b) No physician who in good faith arranges for, requests, recommends, or initiates the transfer of a patient from a hospital to another hospital may be liable for civil damages as a result of arranging, requesting, recommending, or initiating the transfer if

(1) in the exercise of that degree of knowledge or skill possessed, or that degree of care ordinarily exercised by physicians practicing the same specialty in the same or similar communities to that in which the physician is practicing, the physician determines that treatment of the patient's medical condition is beyond the capability of the transferring hospital or the medical community in which the hospital is located;

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

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

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

liability for civil damages which are the result of gross negligence or intentional misconduct. (§ 2 ch 78 SLA 1978)

Sec. 18.08.088. Penalty. Any person who violates a provision of AS 18.08.010 — 18.08.090 is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000, or by imprisonment for not more than 90 days, or by both. Each violation is a separate offense. (§ 2 ch 78 SLA 1978)

Sec. 18.08.090. Definitions. In AS 18.08.010 — 18.08.090,

(1) "commissioner" means the commissioner of health and social services;

(2) "consumer of emergency medical services" means a person who is not a provider of emergency medical services as defined in this section;

(3) "department" means the Department of Health and Social Services;

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

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

(6) "Statewide Health Coordinating Council" means the council created under AS 18.07.011;

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

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

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

(10) "emergency medical technician" means a person trained in emergency medical care and certified in accordance with the regulations prescribed under AS 18.08.080;

(11) "emergency medical service" means the provision of emergency medical care and transportation of the sick and injured. (§ 1 ch 100 SLA 1977; am § 3 ch 78 SLA 1978)

Effect of amendments. — The 1978 amendment added paragraphs (7) through (11).

Chapter 15. Disease Control.

Article
2. Physical Examination of Nonresident Employees (Repealed)

Article 2. Physical Examination of Nonresident Employees.

Section
60—110. [Repealed]

Secs. 18.15.060 — 18.15.110.

Repealed by § 1 ch 130 SLA 1976.

Editor's notes. — The repealed article derived from §§ 1 — 5, ch. 103, SLA 1949.

Chapter 16. Regulation of Abortions.

Section
10. Abortions

Sec. 18.16.010. Abortions. (a) No abortion may be performed in this state unless (1) the abortion is performed by a physician or surgeon licensed by the State Medical Board under AS 08.64.200; (2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Welfare or a hospital operated by the federal government or an agency of the federal government; (3) consent has been received from the parent or guardian of an unmarried woman less than 18 years of age; and (4) the woman is domiciled or physically present in the state for 30 days before the abortion. "Abortion" in this section means an operation or procedure to terminate the pregnancy of a nonviable fetus. Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section.

(b) A person who knowingly violates a provision of (a) of this section, upon conviction, is punishable by a fine of not more than $1,000, or by imprisonment for not more than five years, or by both. (§ 65-4-6 ACLA 1949; am § 1 ch 103 SLA 1970; am § 22 ch 166 SLA 1978)

APPENDIX II: Formation of New EMS Regional Alignments.

Northern Region Emergency Medical Services Council, Inc.

P.O. Box 2120 Fairbanks, Alaska 99707 (907)456-3970

STATUS REPORT
on the
NORTHERN, INTERIOR, NANA REGION, AND NORTH SLOPE
EMERGENCY MEDICAL SERVICES PROGRAMS

by

Jennifer A. Gleason, RN, Exec. Director

The Northern Region EMS Council was incorporated two years ago to address the clinical training needs of the three subregions, to provide technical assistance as needed, and to be better aligned for federal funding and evaluation. Since that time the focus of the director has been to bring clinical specialists into the region to provide physician and nursing workshops, workshops for the outlying physicians' assistants and nurse practitioners, and provide on-site technical assistance as requested. Each of the hospitals has had yearly Advanced Cardiac Life Support training and the Council has provided equipment and organizational assistance for physician Advanced Trauma Life Support training.

Equipment needs for both hospital training and patient care have been identified and funded this year. Due to severe cuts in IHS funds, one might expect to see increased needs for rural hospital and clinic equipment and professional education support.

The Northern Region EMS Council remains committed to seeing that professional level emergency education and equipment receive the same degree of support that all of the first responder and ambulance programs do. The prehospital phases of the EMS program are carried out under the three subregional councils and their advances are described within this packet. The Northern Region Council feels, however, that the clinical goals of the program will best be carried out with a different organizational structure. At their Board meeting a few weeks ago, they took the recommendation of their director, Jennifer Gleason, and decided to dissolve at the end of the fiscal year.

All clinical goals described in last year's request will be carried out, and the clinical needs of each subregion will be clearly identified so that they might contract with their own clinical resource people next year. This local control in identifying clinical resource people should enhance all three programs.

APPENDIX II

Daily News-Miner, Fairbanks, Alaska, Thursday, Dec. 10, 1981—5

Medical Council to end clinical organization

The clinical organization of the Northern Region Emergency Medical Service Council Inc. will phase out by June 30, following the council's board vote Monday on that action.

According to Jeanne Ostness, the Interior, North Slope and NANA northern regions voted to phase out the organization. Plans for the phase out should be complete by March. Ostness is executive director of the Interior Region Emergency Medical Services Council.

The northern region provided clinical support, Ostness said, supplying physican's assistants, nurses, initial health education, refresher training and equipment purchases. They provided clinical direction necessary in all three regions, Ostness said.

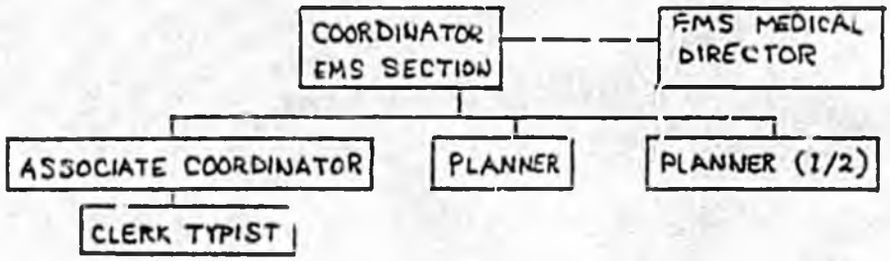
However, Barrow and Kotzebue populations usually refer their patients to Anchorage rather than Fairbanks. Therefore, the North Slope and NANA regions may form another emergency medical services unit to fill their needs.

Meanwhile, the Interior Region Emergency Medical Services Council plans to hire someone to carry on clinical services for Fairbanks.

In other business, the Interior council voted to share office space with the local Red Cross chapter in the Emergency Medical Services building at 1881 Marika. Red Cross closed its downtown office recently due to lack of funding. Red Cross programs to be lodged at the EMS office include water safety and first aid.

APPENDIX III: List of Staff in EMS Section Office.

STAFFING PLAN AND DUTIES OF KEY PERSONNEL



EMS Coordinator — Mark S. Johnson, B.A.: Coordinates and administers the development of EMSS throughout the State, secures and administers grants; integrates state and regional EMS Systems; interagency liaison.

Health & Social Services Planner II — Gloria Houston Way, M.P.H: Primarily responsible for short and long-range EMS plan development in accordance with State health policy; responsible for areas of data, evaluation, and systems management; public information and education; staffs the Advisory Council on EMS; writes and edits RESPONSE, the bi-monthly newsletter.

Associate Coordinator — Carol A. Taplin, M.A.: Administers grants from federal EMS, writes, negotiates and administers grants to Regions and contracts for specific tasks; prepares fiscal part of state budget; responsible for all fiscal activities; supervises support staff; responsible for office management; staffs the Manpower & Training Task Force of the Advisory Council on Emergency Medical Services. Prepares drafts of certification standards for EMT's and regulations; collects information on specific issues for the Task Force.

Health & Social Services Planner I (1/2 time) — Under supervision of the Planner II, researches and analyzes data; develops systems for standardized data collection and evaluation; identifies program needs on data analysis.

Clerk Typist III — : Performs varied typing and clerical work, directs work production and flow, operates office machines, etc.

APPENDIX IV: Composition and Accomplishments of the Advisory Council on Emergency Medical Services (ACEMS).

D. Composition

Four of the members appointed are consumers and represent each of Alaska's judicial districts. Two members are Alaska Natives and one member is a consumer member of the Statewide Health Coordinating Council (SHCC). The remaining seven provider categories represent two physicians, two nurses, a hospital administrator, a Native Health Corporation Director, and an EMT-Paramedic.

Ex officio membership includes a State of Alaska Senator and Representative, the State EMS Medical Director, a representative from the Alaska Area Native Health Service, the Department of Public Safety and the Division of Emergency Services, Department of Military Affairs.

E. Some Council Accomplishments During 1978 and 1979, its First Two Years of Operation

1. Established By-laws; roles & responsibilities document; policies & procedures manual;

2. Established Manpower & Training Task Force to set standards for training, curriculum, qualification for certification and recertification of all levels of emergency care personnel.

3. Established Critical Care Committee of physicians specializing in six critical care areas to develop standards for critical patient care, including transport and transfer standards. This Committee is not formally functional at State level; however, most of these physicians are serving regional Councils and act as consultants to the state medical director.

4. Established Annual Governor's EMS Award Program and set criteria for selection of three categories of recipients. Two annual awards banquets have been sponsored.

5. Instrumental in first-time appropriation of State funds for EMS, and in assuring continuation of funding.

6. Reviewed and recommended modification in proposed State Health Plan, re. "Levels of Care" conceptual model.

7. Established a permanent working relationship with SHCC.

8. Each year, reviewed and prioritized EMS and EMS-related applications for state and regional funding and recommended approval/disapproval to the Commissioner, DHSS.

9. Assisted in development of long-range planning document, "Standards and Goals for EMS in Alaska."

10. Sponsored resolutions on state funding; gas pipeline specifications; inter-departmental coordination in communications planning; clarification of state EMS leadership role.

11. Established a Task Force to develop long-term funding strategy for statewide EMS.

F. Some Current Council Projects for Remainder of FY 80

1. Review of grant applications, budgets and objectives of regional and state programs for recommendations to SHCC and the Commissioner of DHSS.

2. Review and approval of EMT, and EMT Instructor standards and draft regulations.

3. Adoption of "Standards and Goals for EMS in Alaska" for recommended incorporation into State Health Plan.

4. Task Force on long-term funding strategy for Statewide EMS.

G. Some Council Projects for FY 81

1. Adoption of EMT regulations.

2. Review, approval/modification, adoption of standards for remaining prehospital personnel standards.

3. Adoption of ambulance regulations.

4. Annual Governor's EMS Awards Program.

5. Implementation of long-term funding strategies.

APPENDIX V: List of Alaska EMS Goals.

Appendix V

THE MISSION OF THE ALASKA EMERGENCY MEDICAL SERVICES PROGRAM

The mission of the Emergency Medical Services (EMS) program in Alaska is to reduce both the human suffering and economic loss to society resulting from premature death and disability due to accidents and sudden illness.

GOALS OF THE EMERGENCY MEDICAL SERVICES PROGRAM

The overall goal of the Alaska Emergency Medical Services (EMS) program is to establish a comprehensive, coordinated system of emergency medical services which assures that citizens and visitors gain easy access to services; that initial response is expeditious; that appropriate life-saving and stabilization measures are rendered at the scene; and that patients are transported or transferred in a timely and efficient manner to facilities capable of effecting maximum recovery and rehabilitation.

Fifteen components have been identified by the national EMS program as essential in establishing a comprehensive EMS system. Systems goals for state and regional EMS programs in Alaska are grouped according to these fifteen components:

1. Manpower

   A. The number of qualified EMS administrators, clinical experts and technical specialists should be adequate to provide the necessary direction and assistance to regional EMS systems development.

   B. An adequate supply of trained EMS prehospital and hospital personnel to provide quality 24-hour-a-day, 7-day-a-week coverage of emergency medical services appropriate to each "level of care" should be maintained throughout the state.

2. Training

   A. Basic and advanced trained EMTs and paramedics should be certified according to state statute and regulations.

   B. Recommended standards for training, continuing education, certification and curricula for all other categories of emergency care personnel should be established to assure quality of patient care throughout the state.

   C. Training programs and resources within Alaska should be adequate to meet all EMS prehospital manpower needs.

   D. Continuing education and specialized EMS training for hospital personnel should be provided within Alaska to the greatest extent possible.

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3. Communications

A. Local and regional EMS communication systems should be established and maintained which will assure residents and visitors easy access into a medically controlled system and which will assure the most rapid dispatch of appropriate personnel and transportation vehicles, assure coordination among public safety agencies, and provide flexibility to handle emergencies of any magnitude.

B. All EMS communications systems development should be in keeping with an overall state EMS communications plan, utilizing existing systems and resources in a cost efficient, practical manner.

C. All EMS communications systems should maintain a minimum of 95% reliability and be provided with back-up systems in event of primary systems failure.

4. Transportation

A. There should be available an adequate number of air or surface vehicles, suitably staffed and equipped, to ensure timely response and transport to medical facilities in order to minimize personal injury and loss of life for accident and illness victims.

B. Ambulance services in Level II, III and IV communities and on highways receiving state financial assistance should be certified according to state statutes and regulations.

5. Facilities

A. There should be an adequate number of accessible medical facilities - clinics, emergency departments and critical care units - to provide service on a 24-hour-a-day, 7-day-a-week basis, which maintain state recommended standards, and which are coordinated with other health care facilities within the system.

6. Critical Care

A. The treatment and transfer of the critically ill or injured patient, from the point of systems entry through rehabilitation, should be carried out according to protocols appropriate for regional capabilities, designed for maximum recovery.

B. All critically ill or injured patients should receive care at the most appropriate facility the regional system offers for their condition, or if necessary, should be transferred in a stabilized condition to an appropriate facility outside the region.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

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7. Public Safety Agencies

A. All public safety agencies involved in emergency response should be coordinated to provide the most effective utilization of appropriately trained personnel and equipment for emergency patient care.

8. Consumer Participation

A. Consumer participation in all aspects of EMS systems planning and policy setting should be encouraged through a policy of responsiveness and accessibility, and assured through the mechanism of local, regional and state EMS Councils.

9. Accessibility to Care Without Ability to Pay

A. Services should be financed so that ability to pay or economic status of the consumer does not interfere with delivery of needed services at the time of need and does not affect the quality of health service provided.

10. Transfer of Patients

A. The transfer of patients to facilities offering the definitive follow-up care and rehabilitation necessary for maximum recovery should be facilitated through established transfer mechanisms, with recommended protocols available.

11. Coordinated Recordkeeping

A. There should be a coordinated EMS patient recordkeeping system which follows the patient from initial entry into the EMS system through discharge and follow-up and which is consistent with other medical recordkeeping within the state.

B. All regional EMS systems development data should be in keeping with a coordinated State EMS information system.

12. Public Education and Information

A. Alaska residents should know how to access their local EMS system and should know how to render appropriate first aid in a medical emergency.

B. Visitors to Alaska should know how to access the EMS system and how to take appropriate action in time of emergency.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

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13. Evaluation

A. There should be a functioning system for periodic and objective review of the quality and extent of EMS systems development at both state and regional levels, for the purposes of evaluation and needs assessment.

14. Disaster Response

A. Local, regional and statewide EMS disaster planning and emergency medical resources should be adequate to deal effectively with any major disaster situation and should be coordinated with the Division of Emergency Services, Dept. of Military Affairs.

15. Mutual Aid Agreements

A. Necessary back-up and support services in time of emergency should be assured through mutual aid agreements between inter-regional, state and federal agencies.

THE ROLE OF THE EMERGENCY MEDICAL SERVICES SECTION

The Emergency Medical Services Section seeks to fulfill its mission and goals by:

1. Coordinating federal, state and regional official and voluntary agencies involved in Alaska's EMS system.

2. Recommending standards for EMS which are appropriate for Alaska.

3. Providing overall medical direction for statewide EMS systems development.

4. Certifying personnel and services according to legislative mandates to assure certain minimum standards of emergency medical care.

5. Providing and administering financial assistance for regional EMS system development.

6. Providing technical assistance to regional and local EMS agencies.

7. Educating the public on appropriate action in emergencies and on emergency procedures.

8. Seeking improved emergency medical services through legislative action.

9. Monitoring and evaluating EMS systems development throughout the state.

10. Planning and prioritizing continued program development based on systematic needs assessment, and epidemiological research.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

THE ROLE OF THE REGIONAL EMS COUNCILS

1. Facilitating the development and maintenance of local and regional emergency medical services to provide a continuum of patient care.

2. Coordinating regional, subarea and local official and voluntary agencies involved in EMS.

3. Assisting local emergency medical services and facilities to meet recommended standards and regulations of the statewide EMS program.

4. Providing technical assistance and medical consultation to regional and local EMS agencies and medical facilities.

5. Administering funds granted by the Emergency Medical Services Section, as well as income derived from other sources.

6. Providing financial assistance to local emergency medical services.

7. Coordinating and providing training of EMS personnel within the region.

8. Educating the public on appropriate action in emergencies and on emergency preparedness.

9. Monitoring and evaluating regional EMS development.

10. Planning and prioritizing continued regional program development based on systematic needs assessment.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

Appendix VI: Sample Medical Protocol for Use by EMTs

RESULTS OF A CONFERENCE ON HYPOTHERMIA AND COLD WATER NEAR DROWNING

July 11 and 12, 1981 in Anchorage, Alaska
Participants: William Doolittle, M.D.
John Haywa-d, Phd.
William Mills, M.D.
Martin Nemiroff, M.D.
Tim Samuelson, M.D., Moderator

HYPOTHERMIA

I. General Points

A. The evaluation and treatment of hypothermia whether wet or dry, on land or water, is essentially the same. Ther fore, we do not specifically distinguish between chronic and acute, or wet and dry in the following discussion.

B. In the setting of the cold patient, a rectal temperature is one of the vital signs. In terms of the ABC's it would be -

A. Airway
B. Breathing
C. Circulation
D. Degrees

C. "Low Reading" thermometers are important in the care of the hypothermic patient. Regular thermometers are useless and probably dangerous in this setting. (SF is going to purchase and distribute)

D. Obtaining a temperature is important and useful for treating hypothermia. However, there is tremendous variability in individual physiologic responses at specific temperatures. In addition, there will frequently be times when a low reading thermometer is not available. Therefore, these guidelines are not based on the patient's measured temperature.

E. Axiom: With the hypothermic patient, THINK HEAT.

1. No cold IV's.
2. No cold ventilation therapy.
3. No cold treatments of any kind.

F. We must, at least, <u>prevent further heat loss at the core</u>. This can only be done by insulating the entire patient plus adding heat to the "core areas" (head, neck, chest, and groin.)

G. <u>Adding heat</u> gradually and gently implies:

1. External warm objects - hot water bottles, "warm packs", (e.g. chemical heat packs, etc.), warm rocks (wrapped in towels), warm bodies, etc. - applied to the head, neck, chest and groin.

2. Breathing warm, moist air or oxygen.

* The term "adding heat" is used rather than "rewarming" because often the patient is not actually any warmer with the addition of heat, but rather only a further loss of heat is prevented.

H. Do not ever try to cool the extremities or use tourniquets or other occlusive dressings.

I. Be wary of statements or actions while working on patients who are unconscious or requiring CPR. These patients frequently remember what is done and said and it can produce severe psychological problems later on. This statement applies equally well to warm and cold patients.

J. Preplanning regarding how you will handle these problems, who will be in charge, and being familiar with the appropriate equipment is absolutely necessary.

K. A note on transport: Air travel in Alaska is obviously favored. But if air travel is not possible, other types of transport should be utilized, such as snowmachine, dog team, cars, and especially boats in areas with water access.

L. The inside of the ambulance and any rooms where such patients are treated should be "room temperature" (approximately 65 to 72 degrees F.[18 to 22 degrees C.]).

II. Evaluation and Treatment

GENERAL PUBLIC/FIRST RESPONDER

A. If the patient is cold and has any of the following signs or symptoms:

1. Depressed vital signs.
2. Altered level of consciousness, including slurred speech, staggering gait, decreased mental skills.
3. Temperature = 90 degrees F. (32 C.) or less.
4. No shivering in spite of being very cold (the presence of alcohol intoxication throws this sign off).
5. Associated significant illness or injury that is present or that may have permitted the hypothermia to develop.

....He is considered to have <u>severe hypothermia</u>.

If he is cold and does not have severe hypothermia, as defined above, he has <u>mild to moderate hypothermia</u>.

B. Basic Treatment

1. Treat very gently. (rough handling releases detrimental chemicals from the muscles)
2. Remove wet clothing. Replace with dry clothing or dry coverings of some kind.
3. Insulate from the cold.
4. Add heat to the head, neck, chest and groin externally (See G. under General Points on Page 1.), or internally, if a system for breathing warm moist air is available. Avoid attempts to warm the extremities.
5. When the first responder adds heat to the very cold patient (temperature less than 75 degrees F.[24 degrees C.]) the idea is to prevent further heat loss, <u>not</u> raise the core temperature which will cause electrolyte, acid-base and hydration that the first responder will not be able to treat.

(this assumes a better quality of help is on hand or is available)

HYPOTHERMIA - GENERAL PUBLIC/FIRST RESPONDER - BASIC TREATMENT (Con't.)

6. No rubbing or manipulation of the extremities.
7. No coffee or alcohol.
8. Do not put patient in a shower or bath.
9. Warm fluids can be used only after uncontrolled shivering stops with a clear level of consciousness, with the ability to swallow, and evidence of rewarming already.
10. If severe hypothermia is present, treat as above and transport to a higher medical facility.
11. If there is no way to get to a higher medical facility, rewarm the patient slowly, cautiously and gradually with the methods indicated in G. under General Points on Page 1.

C. Severe hypothermia with no life signs (CPR required).

1. Basic treatment as indicated above.
2. Carefully assess the presence or absence of pulse or respirations for one to two minutes.
3. If no pulse or respirations, start CPR.
4. Use mouth-to-mouth rather than bag/mask breathing.
5. Obtain a rectal temperature if possible.
6. If you are than less than 15 minutes to a higher medical facility, do not bother trying to add heat.
7. If you are greater than 15 minutes to a higher medical facility, add heat gradually and gently.
8. Reassess the physical status periodically.
9. Transfer to a higher medical facility in all cases.

D. Severe hypothermia with signs of life (i.e. pulse and respirations present).

1. Basic treatment. (Do not use CPR.)
2. Add heat with the methods indicated in G. under General Points on Page 1 if you are greater than 15 minutes from a higher medical facility.
3. Transfer to a higher medical facility.

EMERGENCY MEDICAL TECHNICIAN I*

A. Treat as the GENERAL PUBLIC/FIRST RESPONDER with the following additional guidelines:

1. Do not use oxygen unless you are performing CPR or you are specifically told to do so.
2. Pneumatic antishock trousers are not indicated for hypothermia, but may be used to treat hypovolemic shock in a hypothermic patient.
3. The indications for oral airways are the same in the hypothermic and the warm patient.
4. Communicate with a higher medical facility.

* Note: Alaska Native Village Health Aids are, for purposes of these protocols, considered to fall into this category.

HYPOTHERMIA (Con't.)

EMERGENCY MEDICAL TECHNICIAN II

A. Treat as an EMERGENCY MEDICAL TECHNICIAN I, with the following additional guidelines:

1. IV therapy (Note: Do not delay transport, communications, or other therapy by taking a long time to start an IV. IV's are difficult to start in cold patients):
   a. All patients with severe hypothermia should have an IV started after other stabilization.
   b. Use D5W at a rate of 75 cc. per hour.

B. Additional medications: (Note: Medications are inefficient and are metabolized much more slowly in the hypothermic patient.)

1. Narcan and 50% Dextrose are not to be used unless specifically instructed to do so by a physician.

C. The Esophageal Airway Device: The indications and contraindications for the esophageal airway device are the same in the hypothermic and the warm patient.

D. Communicate with a higher medical facility.

EMERGENCY MEDICAL TECHNICIAN III

A. Treat as an EMERGENCY MEDICAL TECHNICIAN II, with the following additional guidelines:

1. In cardiac arrest:
   a. Attention to the ABC's.
   b. CPR.
   c. Attempt defibrillation once with 400 w/s's if the patient is in ventricular fibrillation or ventricular tachycardia. (Note: Shivering can mimic ventricular fibrillation.)
   d. Add heat if greater than 15 minutes from the hospital.
   e. Repeat defibrillation may be attempted only if the core temperature is 85 degrees F.(30 degrees C.) or higher.
   f. If cardioversion is successful, give Lidocaine, approximately 1 mg. per kilogram IV bolus, followed in 15 minutes by a second bolus at 0.5 mg. per kilogram.
   g. If heart rhythm is asystole: Do not attempt defibrillation and treat as an EMT II.
2. Morphine is contraindicated in the hypothermic patient.
3. Cardiac monitoring is indicated in all hypothermic patients as long as its use does not unnecessarily delay other or further care.

PARAMEDICS

A. Treat as an EMERGENCY MEDICAL TECHNICIAN III with the following additional guidelines:

1. Paramedics in isolated areas in Alaska should function as an EMT III in regards to the hypothermic patient, unless they are under the specific on-line direction of a physician, or until a patient reaches a level of adequate physiological response (temperature higher than approximately 90 degrees F.)
2. Endotracheal intubation: The indications and contraindications for ET tube placement are the same in the hypothermic and the warm patient.
3. Cardiac arrest: Treat as an EMT III.
4. Additional medications: Since medications are inefficient and also poorly metabolized in the hypothermic patient, no additional medications are indicated.

SMALL/BUSH CLINICS

A. The extent of the evaluation and treatment in small/bush clinics is defined by the training of the personnel and the available equipment as outlined in the foregoing guidelines.

For transfer to a higher medical facility, the patient must be stabilized in the clinic rather than transferred as an unstable patient. Therefore, if the patient is requiring CPR or is otherwise with unstable vital signs, necessary equipment and trained personnel, if not already at the clinic, should be sent to the clinic in order to stabilize the patient enough for transfer to a higher medical facility.

Once the rewarming process has started in the clinic, it should be continued with slow, gradual techniques until transfer is possible and appropriate.

HOSPITALS

A. Some general points:

1. Treat to the level of your ability as your hospital equipment, staff, and skills dictate.
2. All patients should be stabilized before any transport to another facility. The patient should be kept in the sending hospital until the patient is stable.

B. Evaluation

1. Initial attention to the ABC's and CPR as needed.
2. Vital signs, including rectal temperature.
3. Brief history.

4. Brief physical exam: Feel for skin coldness or warmth, level of consciousness, shivering, cardiopulmonary exam, and associated trauma.

Then:

5. Chest x-ray.
6. 12 lead electrocardiogram.
7. Urine for urinalysis, sodium and osmolality.
8. Blood for CBC, BUN, creatinine, electrolytes, sugar, platelets, PTT, Prothrombin Time, Liver Function Tests, amylase.
9. Arterial blood gases.
10. Weight.

C. Monitoring and Treatment

1. Cardiopulmonary monitoring.
2. An IV and/or central venous pressure line (in the superior vena cava, not the right heart), with D5W at 75 cc. per hour. IV fluid and rate of infusion will vary depending on the patient's level of hydration and laboratory data.
3. Urinary bladder catheter.
4. Nasogastric tube, if the patient is unconscious and the airway is protected.
5. Endotracheal/Nasotracheal tube is indicated in the unconscious patient after careful neck evaluation.
6. Daily weights; I&O.
7. Always ventilate with warm, moist air or oxygen (typical unwarmed ventilation is approximately 72 degrees F.[22° C.]).
8. Sodium bicarbonate administration is based on arterial blood gases.
9. Adding heat: The recommended possibilities include:

External Methods	Internal Methods
1. Gradual spontaneous rewarming.	1. Warm steam inhalation/ ventilation.
2. Warming blankets, warming mattresses, etc.	2. Peritoneal lavage.
3. Tub bath.	3. Warm IV fluids.
	4. Extracorporeal circulation (AV shunt).

General notes about rewarming techniques:

1. Regardless of the method chosen for adding heat, the patient must be under total physiologic control, to allow you to deal with the metabolic needs of the patient.
2. Tub bath is the most rapid method and requires immediate laboratory results and extremely close physiological monitoring to maintain control of the situation.
3. Do not compromise extremity circulation by using tourniquets, MAST pants or ice packs.

4. The recommended temperature is about 105 to 110 degrees F. (40 to 43 degrees C.) for all methods.

   a. For severe hypothermia without signs of life (requiring CPR):

      1. Warm the core as rapidly as you can handle, using one or more of the methods. (For example, warming mattress, warm steam inhalation, and peritoneal lavage), trying to get the patient greater than approximately 85 degrees F., (30 degrees C.)
      2. For severe hypothermia with life signs: Use your judgement, utilizing one or more of the methods.

10. Continue monitoring until stable and warm.

D. Most common problems

Note: Drug therapy should be moderated because in the cold patient medications are both inefficient and poorly metabolized.

1. Arrhythmias - these are usually atrial arrhythmias.

   a. If very cold, these atrial arrhythmias will usually convert spontaneously with rewarming.
   b. If the temperature is rising and the arrhythmia does not convert, you may want to use the usual medications. (Inderal may be the drug of choice in atrial arrhythmias in this setting.)
   c. If the treatment is not working, add more heat.
   d. Ventricular fibrillation in the very cold patient is treated with CPR, adding heat, AND after the temperature reaches approximately 85 degrees F. (30 degrees C.), defibrillation.

      In the patient whose temperature is rising, the standard (AHA, others) treatment for ventricular fibrillation should be utilized.

2. Dehydration - monitor and treat accordingly.
3. Hyperkalemia - monitor and treat accordingly (do not infuse potassium in IV's).
4. Hyperglycemia - monitor and treat accordingly.

E. Transferring Patients to Tertiary Care Facilities

The indications to transfer the patient from a smaller hospital to a tertiary care facility are:

1. In general, lack of nursing and support staff and equipment to properly provide for a critically ill patient, requires that the patient be transferred, once that patient is stable.

2. Specifically, the patient should be transferred if:

   a. There is no capability for rapid arterial blood gas results.
   b. There is profound neurological depression.
   c. There is associated significant trauma.

COLD WATER NEAR DROWNING

A. General Comments

1. Anyone submerged long enough to be unconscious and/or require CPR, who has been under water less than one hour, should be sent to the hospital.
2. If under water for more than one hour, no attempt at resuscitation should occur.
3. If we do not know how long the person has been under water, we err on the side of considering them under one hour.
4. There is no difference between fresh and salt water near drowning in regards to outcome or treatment.
5. These principles apply to any near drowning, not just those in cold water. The difference between warm and cold water is that in long submersions (greater than 6 minutes), survival in warm water is 50% at best. Therefore, attempt to get a temperature of the water at some point in time primarily for prognostic purposes. Obviously the colder the water, the better the chance for survival.
6. The level of coldness is rarely profound (below 85 degrees F.[30°C.]) in cold water near drowning, so the hypothermia aspect of the problem is less critical than the pulmonary or hematology aspects. Thus, rewarming is done very cautiously and gradually, without the need for invasive techniques such as peritoneal lavage or AV shunts.
7. Many near drowning victims die of a particular type of Disseminated Intravascular Coagulation, not from their pulmonary problems.

B. Evaluation and Treatment

For the general public/first responder, Emergency Medical Technician I, Emergency Medical Technician II, Emergency Medical Technician III, and the Paramedic, the treatment is the same as indicated for hypothermia, plus:

1. It is very important to clear the airway with any of the standard maneuvers, but no specific maneuvers are mandatory to expel water from the lungs. Do not do the Heimlich maneuver on these patients.
2. CPR must be started immediately.
3. Assess carefully for associated injuries.

HOSPITAL CARE

1. The evaluation is generally the same as for hypothermia, except for the laboratory evaluation which in near drowning should be, in order:

   a. Arterial blood gases.
   b. Chest x-ray.
   c. 12 lead electrocardiogram.
   d. Electrolytes, BUN, CBC.
   e. Scan the serum for pinkness (indicating hemolysis).
   f. Institute cadiorespiratory monitoring.
   g. IV therapy - D5W at keep open levels. (In children, ¼ - ½ mainterance rate).

2. Therapy:

   a. Attention to the ABC's, with respiratory support, intubation, etc., as needed.
   b. Rewarming. Active rewarming methods (warm air inhalation, external heat sources, etc.) should be used only while CPR is required.

      Once circulation has been established, do only passive rewarming (light sheets or light blankets, room temperature). Note that these patients often become hyperthermic.
   c. Aspiration pneumonitis and pulmonary edema may be treated with:
      1. Corticosteroids.
      2. Penicillin.
      3. Lasix.
   d. Profound neurological depression: Recommend cerebral resuscitation, as per CONN* with intraventricular pressure monitoring, diuretics, and barbiturates.
   e. Hemolysis - Treat as with any patient with hemolysis.
   f. Disseminated Intravascular Coagulation - treat as with any patient with DIC.
   g. Renal insufficiency - Treat as with any patient with renal insufficiency.

3. Transferring the near drowning patient to a tertiary care facility.

   a. The indications to transfer the patient from a small hospital to a tertiary care facility are:

      Note: The patient should be stabilized at the nearest hospital with intubation as necessary and ventilation.

      1. Lack of nursing and support staff and equipment to properly provide ongoing care for a critically ill patient requires that the patient be transferred, once the patient is stable.
      2. Specifically, the patient should be transferred if:

         a. There is no capability for rapid arterial blood gas results.
         b. There is deterioration of pulmonary status.
         c. There is renal insufficiency.
         d. There is hemolysis.
         e. There is profound neurological depression.
         f. There is significant associated trauma.

      3. Air transport should be in an aircraft pressurized to sea level or flying at sea level. You may need to increase oxygen supplementation depending on the level of pressurization.

*"Cerebral Salvage in Near Drowning following Neurological Classification by Triage," A. W. Conn, Canadian Anesthesia Society Journal, Volume 27, No.3, May, 1980.

Appendix VII: Background Information on Paramedics

MEMORANDUM State of Alaska

TO: William Wermen, M.D., Chairman
Advisory Council on Emergency Medical Services

DATE: October 20, 1981

FILE NO:

TELEPHONE NO: 465-3027

FROM: Mark S. Johnson, Coordinator
Emergency Medical Services Section

SUBJECT:

We missed you at the ACEMS meeting in Sitka. There was some discussion about the proposed use of the excess FY82 EMS funds for Northern Region, but some members were frustrated that they didn't have advance notice to review the requests. While I sympathize with this concern, there was nothing we could do about it, because the Interior and Northern Region Boards had just approved these requests one week prior to the ACEMS meeting.

The one funding request which generated the most discussion was the proposal to send EMTs from Nenana and Healy outside the state for paramedic training. As I see it, there are pros and cons to this proposal. I have listed some of these below:

Pros	Possible Cons
1) Advanced medical training is probably needed more in rural areas because of the long distances to acute care centers.	1) If we approve paramedic training for Healy & Nenana how many other rural services will request similar funding assistance in the future?
2) At least one of the EMTs desiring paramedic teaching is an instructor. Paramedic training will enhance this person's instructor capabilities.	2) Will there be enough calls to maintain skill levels?
3) Proximity to Mt. McKinley means that large numbers of tourists pass through the area in the summer.	3) Will these people be content with their current volunteer or low pay status after paramedic training?

Due to the complexity of the issue, some members of ACEMS would prefer that the decision be made at the regional level. ACEMS also voted to review this request again at their next meeting.

Therefore, I suggest that you bring this up at the next Interior Region Medical Advisory Board meeting. Also, if they endorse this request, I think it would be a good idea to set up a formal evaluation to determine the benefits of paramedic training in rural areas. This information would be especially useful because Senator Charlie Parr has suggested that Alaska should train paramedics in all subregional centers who could also assist with medevacs.

please see following letter

If there is, in fact, a growing demand for paramedic training, should we consider providing some or all of this training in-state?

I'll appreciate hearing your views on this subject.

MSJ/bb

cc: James Borden, M.D.
Tim Samuelson, M.D.
Jeanne Ostnes

CHARLIE PARR

ALASKA LEGISLATURE

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December 14, 1981

Tim Samuelson, M.D.
Medical Director, State EMS Office
Pouch H-06C
Juneau, Alaska 99811

Dear Dr. Samuelson:

I have recently seen a copy of your letter of November 2 to Dr. Wennen regarding paramedics in sub-regional centers in the rural part of the state. Unfortunately, someone has misinformed you as to my ideas on the subject.

I have never suggested paramedic staffing. Instead, I have suggested that we might consider the assignment of physician assistants to regional offices. This idea has never been advanced as something the state should do, only as an idea that should be considered. (After all, the Russians did it in Siberia thirty or more years ago!)

Scrry for the misunderstanding.

Sincerely,

Charlie Parr by dm

Charles H. Parr

P. S. The information about skill decay in your letter was quite helpful.

CHP:dm

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
EMERGENCY MEDICAL SERVICES SECTION

POUCH H-06C
JUNEAU, ALASKA 99811

EMS MEDICAL ADVISORS REPORT

November 12, 1981
Anchorage, Alaska

Present: Bill Dahl, M.D., Kotzebue
Dave Lonsdorf, M.D., Bethel
Stan Jones, M.D., Haines
Bill Wennen, M.D., Fairbanks
Jim Borden, M.D., Fairbanks
Bernard Gerard, M.D., Valdez
Myron Bloom, M.D., Ketchikan
Floyd Elterman, M.D., Tanana
George Garnett, M.D., Soldotna
Ron Gould, M.D., Tanana Chief's Conference
Tim Samuelson, M.D, State EMS Medical Director
Jennifer Gleason, EMS Coordinator, Fairbanks
Susan Ash, EMS Clinical Coordinator, Southern Region EMS
Susan Clark, EMS Clinical Coordinator, Southeast EMS
Susan Super, State EMS Staff
Mark Johnson, State EMS Coordinator
Laurel Anderson, Southeast Region EMS Council
Ross Van Camp, M.D., Glennallen

The meeting was held at the Anchorage Westward Hilton, and lasted from 9:00 a.m. to 2:00 p.m.

Hypothermia Protocols recently developed through the offices of the State EMS offices were presented by Dr. Samuelson. The group had a number of useful and helpful suggestions and these were incorporated into changes on a revised set of protocols. In particular, there seemed to be concern in regards to the medical/legal aspects of these protocols and several physicians felt that the way that certain parts of these protocols were written might be fuel for lawyers to produce successful suits against doctors.

The EMT Regulations were presented by Dr. Samuelson. Those parts of the EMT Regulations that impact on physicians and medical advisors were discussed and pointed out to those present. Several in the group expressed happiness that these regulations were finally coming to fruition while others in the group were concerned about them causing complications in regards to providing Emergency Medical Services. The regulations were discussed in detail.

The concept of Medical Control was discussed by the group and each of those present described how they provide leadership and quality control

in their respective pre-hospital Emergency Medical Services. In this regard, the concept of bush or very rural paramedics was discussed and the group felt that the use of paramedics in such situations was generally inappropriate. What was needed in these areas, they believe, is someone with more general knowledge such as a Physician's Assistant rather than someone with very specialized knowledge involving only emergency care as is the case with the paramedics. In addition, the group felt that it may be difficult to find ~~a Physician's Assistant or~~ physicians willing to spend the time necessary to provide effective and proper medical control of such individuals. And finally, the group was concerned about the best use of money in that they felt that for the cost of providing paramedic services, the benefits to the population in general were quite low.

The document produced by the State EMS Office called "EMS Goals for the State of Alaska" was introduced to those present and discussed. The orientation of the document and the uses of the document were discussed and Dr. Samuelson stressed that it was merely a guide and not a document that rigidly instructed people in how to provide Emergency Medical Services. The document can be very useful in planning Emergency Medical Services in both small and large communities.

Prepared by Tim Samuelson, M.D.

TS:rlt

Appendix VIII: Draft Position Paper from EMS Section on Question of Good Samaritan Laws

POSITION PAPER

DRAFT

Liability of EMTs and Supervising Physicians

Alaska Statute 8.08.086 - IMMUNITY FROM LIABILITY

(a) No person certified under Section 82 of this Chapter (EMTs and Instructors) or persons or public agency which employs, sponsors or controls the activities of persons certified under Section 82 of this Chapter, who administers emergency medical services to an injured or sick person may be liable for civil damages as a result of an act or omission in administering those services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude liability for civil damages the proximate result of gross negligence or intentional misconduct, nor preclude imposition of liability on a person or public agency which employs, sponsors, or controls the activities of a person certified under Section 82 of this Chapter if the act or omission is a proximate result of a breach of duty to act created under this Chapter. For purposes of this Section, "gross negligence" means reckless, willful, or wanton misconduct.

Section 08.64.366 - Liability for services rendered by a physician-trained mobile intensive care paramedic. No act or omission of a physician-trained mobile intensive care paramedic done or omitted in good faith while rendering emergency lifesaving service to a person who is immediate danger of loss of life shall impose any liability upon the physician-trained mobile intensive care paramedic, the supervising physician, a hospital, the officers, members of the staff, nurses or other employees of a hospital or upon a federal, state, borough, city or other local government unit or upon other employees of a governmental unit; however, this section does not relieve a physician or a hospital of a duty otherwise imposed by law upon the physician or hospital for the designation or training of a physician-trained mobile intensive care paramedic or for the provision or maintenance of equipment to be used by the physician-trained mobile intensive care paramedic.

The above statutes address the concerns, expressed by numerous emergency medical technicians, paramedics, ambulance service chiefs, and physician supervisors, about potential liability in rendering emergency medical care in a field setting. Since both of these statutes only address immunity from liability in life-threatening emergencies, the Emergency Medical Services Section and the State Advisory Council on Emergency Medical Services recommended that these statutes be amended to include any situation whereby the patient was in danger of "loss of life or serious harm." This, in effect, would cover all situations requiring the assistance of EMTs or paramedics. Unfortunately, the adiminisration chose not to sponsor this suggested legislative amendment.

However, based on the advice of Jim Page, a nationally noted EMS legal expert, any statute which attempts to grant immunity from liability to a specific group may ultimately be judged unconstitutional by the courts. Whether or not this is true, the statutes themselves do not preclude someon from filing a suit, which could result in costly legal expenses for the defendents, even if they are found not guilty.

Currently a law suit is pending against some Juneau Fire Department EMTs, physicians, Bartlett Memorial Hospital, and the City of Juneau regarding a 3-year-old cold water near-drowning case. While the City and Borough of Juneau can probably afford to cover its own legal defense, many volunteer EMTs, and rural physicians in Alaska may not be able to afford the legal expenses of such a case.

A recent report from the Emergency Medical Services Committee, National Research Council, National Academy of Sciences, also addresses legal issues in EMS:

4. Legal Considerations

"Experience of various EMS systems with and without medical control strongly suggests that a firm system of medical control, with treatment, triage, and transport protocols accepted by the medical community and enforced by the system's medical director is the best insurance against legal action. It does not appear that Good Samaritan laws, designed originally to protect lay persons offering assistance at an emergency, should be applied to professionally trained EMS

personnel. In any event, malpractice lawsuits involving EMS personnel are so rare that the question of legal liability does not appear to be a major barrier to the development of an ALS (advanced life support) system."

A."All persons within an EMS system who directly provide emergency medical care should be legally responsible for providing care appropriate to their training and skills. However, we recommend that the EMS system itself, or its parent body, such as a municipality, should bear insurance costs entailed in the legal liability of EMTs, paramedics, and of medical supervisors in their exercise of medical control functions. State Good Samaritan laws should apply only to lay persons providing aid at the scene of an emergency."

B."The responsibility to attempt resuscitation exists as long as there is possibility of brain life; once begun, resuscitation should be terminated only on order of the supervising physician. The question of possible liability for resuscitation after brain damage is unresolved, but does not appear to differ in kind from the more general questions related to artificial prolongation of life."

The key legal issue in the National Academy of Sciences report seems to be the recommendation that "the EMS system itself, or its parent body, such as a municipality, should bear insurance costs entailed in the legal liability of EMTs, paramedics, and of medical supervision in their exercise of medical control functions."

Given the fact that most EMTs in Alaska are volunteers, and the fact that physician supervisors often do not even reside in the same community, perhaps the question of state sponsored liability insurance for EMTs, paramedics, and physician supervisors should be explored. While it doesn't seem unreasonable to expect physicians to carry malpractice insurance for themselves, it also does not seem unreasonable that the state would provide insurance coverage for EMTs or paramedics under the supervision of these physicians. Of course, strict quality control must be a consideration. Otherwise EMTs in the field may not feel the need to continually train and update their skills.

The question of liability for emergency care is especially difficult because there often is not clear evidence of appropriate treatment for various types of emergency medical situations. Depending upon distance from a hospital and skill levels of personnel, treatment may differ. Furthermore, the patient may have undiagnosed complications which could result in unanticipated outcomes. Lawsuits stemming from these situations may discourage volunteers from getting involved in the system, or may result in an overly conservative approach to treatment. Perhaps state certified EMTs and paramedics could be extended the privileges of state employees for the purposes of insurance coverage.

In summary, the entire issue of potential liability for EMTs, paramedics, ambulance agency chiefs, and physician supervisors is extremely complex, and should be studied throughly by the state.

The EMS Section of the Division of Public Health and the State Advisory Council on Emergency Medical Services will be more than willing to offer additional assistance in exploring this issue.

Appendix IX: Excerpts from Alaska EMS Goals Outlining Ultimate, Ideal Deployment of EMS and Other Medical Personnel and Facilities in Alaska

LEVELS OF CARE:

ALASKA'S APPROACH TO ORGANIZING A HEALTH CARE SYSTEM

Organization of the Alaska health care system, as conceptualized in the Alaska State Health Plan, utilizes a regional approach, identifying appropriate health resources and services for five community levels. These levels are categorized as:

Level I	Village
Level II	Sub-Regional Center
Level III	Regional Center
Level IV	Urban Center
Level V	Metropolis

Health services, manpower and facilities generally appropriate for each of the five levels are recommended in the Plan. However, specific resources to be provided in any individual community are to be determined by considering such factors as population characteristics, health status, anticipated frequency that the service will be required, and economic feasibility of providing the service. Regardless of the level in which a community may be classified, economic realities may not permit provision of all recommended health resources in each community. Compromises also must be made with respect to time and distance from services as well as with the scope of services available.

The "levels of care" concept encompasses the elements of continuity, coordination and a continuum of service delivery and referral patterns, generally from one level to the next highest level. However, there will be times when a community will relate directly to the level which can provide appropriate care in the most expeditious and convenient manner.

Services for Level I Communities — Villages

Level I Communities are those equated with primary health care, those elements of health care that people use most frequently. Services allocated to Level I Communities generally meet one or more of the following criteria:

1. Services that can be provided conveniently at that level on a continuing basis.

2. Services designed primarily for ambulatory care.

3. Emergency measures that must be provided in a timely matter.

Primary health care in Level I Communities includes the range of services that will adequately provide for most daily personal health care needs. It includes continuing evaluation and management of conditions of general discomfort, early complaints and symptoms, problems and chronic aspects of disease. It also includes preventive health maintenance — health measures designed to reduce the incidence of sickness and disease, such as periodic health surveillance, immunizations, education and promotion of positive health habits.

Direction of patients to specialized health care is a major function of primary health care. Primary health care does not in itself provide total or comprehensive care. It does, however, have a unique potential for becoming the key element in a comprehensive community health care system.

Services for Level II Communities — Sub-Regional Centers

Level II Communities are also equated with primary health care. Generally, a broader range of services than those provided in Level I Communities would be available to the residents of Level II Communities. The additional services are not generally of an emergency nature, but include those that must be reasonably close to consumers to assure availability, accessibility and use as needed and appropriate.

Services for Level III Communities — Regional Centers

Level III Communities provide expanded services which can be equated with secondary health care. Services are extended to include basic hospital services and bed care in a facility which can provide for diagnostic workup, routine laboratory services, services for normal obstetrical cases, general surgery as appropriate and other hospital inpatient episodic care.

Services for Level IV Communities — Urban Centers

To Level IV Communities are allocated a larger range and scope of services, including those that do not need to be as close to people. These additional services tend to be institutionally related, more specialized and less frequently used than the services provided in Levels I, II, and III.

In addition to providing primary and secondary services, Level IV Communities act as a focal point for economically feasible specialized health services for a wide geographic area. Certain recognized centers for specialized services, such as those for neonatal intensive care, open heart surgery, treatment of head and spinal injury and of thermal injury, generally require a significant population base to justify their establishment and maintenance, according to national guidelines. The economic viability of these centers and the provision and maintenance of clinical expertise and technology are largely dependent on an appropriate population base which may not exist in each Level IV Community.

Services for a Level V Community — Metropolis

Presently within Alaska, no Level V Community exists. While future growth may foster a Level V Community in Alaska, the closest and most frequently used Level V is now Seattle, Washington. This is the Level which would encompass highly advanced, specialized and technologically sophisticated care. Alaska's population currently does not justify the expense of providing the type of care envisioned within this Level. Equally important is that this aspect of tertiary care often deals with entities of relatively low incidence in the general population, so that centralization is necessary for a sufficient case load to maintain the technical proficiency of the staff. Economics and quality thus warrant provision of Level V services outside of the state.

ON THE FOLLOWING PAGES ARE DEPICTED THE FIVE COMMUNITY LEVELS CATEGORIZED IN THE ALASKA STATE HEALTH PLAN. FOR EACH LEVEL THERE ARE LISTED THE CRITERIA CONSIDERED FOR DESIGNATING A COMMUNITY AT THAT LEVEL. LISTED ALSO ARE THE SERVICES, FACILITIES AND MANPOWER WHICH SHOULD BE PRESENT AT THAT "LEVEL OF CARE", INCLUDING THOSE RELATING TO EMERGENCY MEDICAL SERVICES.

THE RECOMMENDATIONS OUTLINED ON THE COLORED PAGES OF THIS EMS PLANNING GUIDE ARE AN EXPANSION OF THE RECOMMENDED SERVICES, FACILITIES AND MANPOWER GUIDELINES FOR EACH OF THESE COMMUNITY "LEVELS OF CARE". THE RECOMMENDATIONS FOCUS ON EMERGENCY MEDICAL SERVICES APPROPRIATE FOR EACH "LEVEL OF CARE".

LEVEL I

VILLAGE

CRITERIA

Population.....25 - 750, immediate community

Proximity*.....more than 30 minute access to a higher level (of care) by year-round surface transportation.

GUIDELINES

SERVICES

.Primary Care for common acute illness

.Reception, System entry

.Referral services

.Diagnostic screening, preliminary workup

.Preventive services

.Limited formulary pharmacy services

.Education, counseling

.Health Promotion Services

.Itinerant Services

- -Dental
- -Eye
- -Behavioral Health
- -Physician
- -Audiology
- -Preventive

.Home Health Aide/Homemaker Services

.Basic Life Support System

FACILITIES

.Space that can be used for Clinic purposes. As possible the space should be provided with:

- -Electricity
- -Water
- -Heat
- -Private Examination Area with Examination Table
- -Secure Storage
- -Reliable Communications Line to a Referral Center (Radio and/or Telephone)

MANPOWER

.Community Health Aide and Alternate Person, trained at EMT I level

.Homemaker

.Itinerant Public Health Nurse

.Itinerant Behavioral Health Worker

.Itinerant Health Specialist(s)

* Proximity refers to a given community's nearness to another community of the same and/or higher level. Proximity criteria are intended to prevent unnecessary duplication of resources.

LEVEL II

SUB-REGIONAL CENTER

CRITERIA

Government (or Social Organization).....	preferably incorporated government; de facto town council; active formal community organizations, especially those with human services orientation.
Population	500 - 2500 in immediate community or a service area population of at least 1000.
Proximity*	generally should be more than 30 minutes by year-round surface transportation from another community providing a Level II or higher level of services.
Accessibility**.....	generally should be within 30 minutes access time to outlying villages.
Transportation.....	transportation network to outlying villages and to a Level III or IV Community.
Communications.....	a reliable radio or phone service to a Level III or IV Community.
Economic Development.....	basic services to outlying villages.

GUIDELINES

SERVICES

- .All Services proposed for Level I
- .Consultation to Providers in Level I
- .Ambulatory Medical & Surgical Procedures
- .Supervised overnight Patient Care
- .Itinerant Dental Services
- .Basic Diagnostic Services Including Limited X-ray & Lab Capability
- .General Pharmaceutical Services
- .Education, Counseling, Promotive Services
- .Support, Supply, Administrative Services for Level I Communities
- .Long Term Care Alternatives
- .Nutrition Services
- .Advanced Life Support System without cardiac capability

FACILITIES

Health Center

MANPOWER*

- .Physician assistant or nurse practitioner
- .Public Health Nurse
- .EMT II
- .Behavioral Health Counselor
- .Home Health Aide(s)/Homemakers (as appropriate)

*(Manpower should be available as appropriate to the particular community)

** Accessibility refers to the ease with which a given community can be reached from outlying areas. Accessibility criteria are intended to foster access to resources.

LEVEL III

REGIONAL CENTER

CRITERIA

Government.....should be incorporated

Population .....1500 - 50,000 in immediate community and greater than 3,000 in Primary Service Area

Proximity*.....Should be more than 30 minutes by year round surface transportation from another community providing a level III or higher level of services.

Accessibility**.....Immediate community should be within 60 minutes travel time for at least 90% of population in Primary service area.

Transportation.....should have daily scheduled airline, rail, marine, or bus services to a Level IV or V Community, or should have less than 60 minutes travel time by private auto to a Level IV or V Community.

Communications..... Statewide phone network; radio, some T.V.

Economic Development..... serve as a service center (maintenance services, commodities, financial, transportation) to Level I and II Communities within its primary service area.***

GUIDELINES

SERVICES

.All Services Proposed for Level II
.Consultation to Level I & II Providers
.Short Stay Institutional Services
.Chronic Care & Long-Stay Institutional Services
.Pharmacy Services
.Optometrist Services
.Diagnostic X-ray Services
.Support, supply & Administrative Services to Level II
.Community Based:
  -Mental Health
  -Substance Abuse/Alcohol Rehab.
.Mobile EMS Capacity
.Short Term Shelter Care
.Detox. Capabilities
.Dental Services
.Clinical Laboratory Services including:
Walk-in Blood Bank
.Advanced Life Support Systems with Cardiac Capabilities

FACILITIES

.Hospital:
  -general surgery as appropriate
  -acute & long term beds
  -class 3 emergency care

.Health Center
.Community Mental Health Ctr.
.Physician Clinic(s)
.Dental Clinic(s)
.Nursing Home or LTC nursing beds associated with hospital

MANPOWER

.Same as Level II plus:
.Primary Care Physician(s)
.Itinerant Specialist Physicians.
.Hospital Support Staff:
  -X-Ray Technician
  -Medical Technologist
  -Lab Technician
.Dentist(s)

FACILITIES Con't.

- .Optometrist(s)
- .Pharmacist(s)
- .Psychologist/Mental Health Clinician(s)
- .MSW/Social Worker(s)
- .Sanitarian

***Primary service area refers to that area which rationally relates to the community for most of the services not provided elsewhere in that area and includes that population within the immediate and surrounding area.

LEVEL IV

URBAN CENTER

CRITERIA

Government	be incorporated and either be a unified home rule municipality (preferably having health powers and providing health services' or be located in an organized borough.
Population	30,000 - 750,000 immediate community.
Transportation.....	daily scheduled transportation services to Level III Communities within its health service area and to closest Level V Community.
Communications.....	statewide phone network; radio, T.V.
Economic Development.....	serve as a commercial service center including specialty health services to Level III Communities within its secondary service area (generally, a health service area); preferably some industrial activity

GUIDELINES

SERVICES

- .All Services Proposed for Levels 1, II, and III Communities
- .Consultation to Level 1, II, III Providers
- .Specialized Major Medical Services
- .Class II Emergency Services Capability (Hospital)
- .Major Diagnostic Services
- .Clinical Laboratory Services including Blood Bank
- .Basic Rehabilitation Services
- .Opthalmic Care Services
- .Center for a Uniform Health Information System
- .Communication Linkages to all Levels
- .Mechanisms for Mobilizing EMS Services for Catastrophic Disasters involving mass casualties
- .Therapeutic Radiation Capability
- .Pathology and Autopsy Capability
- .State designated Capacity for Mental Health & Alcoholism inpatient committal.

FACILITIES

See discussion of services on previous pages. Appropriateness in general will be determined on the basis of population and expected utilization of such facilities as well as economic & practical feasibility. Delineation of such facilities (or portions thereof) will occur through the review of new & existing institutional health services.

MANPOWER

To be determined according to services.

LEVEL V

METROPOLIS *

Government	Incorporated, within a higher level sub-state entity (county equivalent) having health powers and providing health services and/or health industry regulation.
Population	450,000 +, immediate community
Accessibility	daily major airline service to Level IV Communities.
Communications	sophisticated and comprehensive communications network.
Economic Development	major trade and service center; stable industry.

RECOMMENDATIONS

Highly advanced specialized care is recommended for Level V, including the following examples:

SERVICES	FACILITIES
Organ transplants Complex Pediatric Heart Surgery Burn Center	Medical/Dental School Facility

The SHCC will develop other recommendations to influence decisions concerning Level V services which serve as multistate resources.

* There are no Level V Communities in Alaska at present.

Appendix X: Transcript of EMS-related Testimony Presented at Senate HESS Interim Hearings

Senate HESS Committee Hearing in Fairbanks, September 12, 1981.

Jeanne Ostnes, Interior Sub-region EMS Coordinator: She spoke on several issues related to EMS problems in the Interior. Equipment retrieval (back to villages from hospitals) a continuing problem. More backup equipment is needed in the villages. Payment for transportation costs to private air ambulance carriers is a problem (no method of ensuring payment from private citizens, especially those who may reside Outside). Stresses all EMS funds should be funneled through the same department -- suggest H & SS. Pointed out deficiencies in EMS communications. Statewide insurance package a possibility for ambulance services? (Insurance comes through fire departments at present...all except those of largest towns are volunteer. Stressed the need for an EMS training center in the Fairbanks area, where equipment could be stored and EMT training classes held. Discussed MAST (Military Assistance to Safety and Traffic) helicopter medivac.

Jennifer Gleason, EMS Northern Region Director: She touched on the need for someone to enforce the new EMS regulations when they come into effect in January 1982. She emphasized EMS on-going training was the biggest need, especially in rural areas, also the coordination between hospitals and EMT expertise in the field needed to be better. EMT training in field could be accomplished by "curcuit riders". She also pointed out that a central dispatch (911) was very helpful. She also felt liability insurance must be given consideration - Alaska has three sets of "Good Samaritan" laws. (Conflicting Attorney General opinion on this.)

Arturo Frizzera, Interior Region EMS: He said there were about 3,000 EMT-I, 1,500 EMT II, 100 EMT III and 35 licensed paramedics in the state at this time. He felt the state needed a trainer plus one staff person to coordinate regional trainers. The Interior needs a training facility (building) of its own, they are presently spending from $1,300 - 3,300 per class on renting school space. He praised the central dispatch system being set up in other communities and stressed the need for same in Fairbanks. Mentioned MAST helicopter service provided by the military to points in the Interior, and some problems with coverage of wide area.

Senate HESS Committee Hearing in Soldotna, September 26, 1981.

Michael Herring, South Peninsula Hospital Coordinator: In response to a question he stated that there were excellent EMTs associated with the fire department (in Homer? Peninsula wide?), but that their service district was very large... and also mentioned the problems the carriers had collecting from the emergency patients they hauled.

Senate HESS Committee Hearing in Nome, November 7, 1981.

Dick Bullock, Norton Sound EMS: Only 7 villages of 16 have phones (specifically) for health aides. Indian Health Service has stopped

funding the $850 per month to subsidize these phones. No privacy in discussion of patient's problems on public phone located in the store...also difficulties in access sometimes. NSEMS trained National Guard last year, eight of whom qualified as EMT-I. There are about ten EMTs in Nome at present, but there is a high turnover. Problems experienced with payment for ambulance. Equipment retrieval from Anchorage a problem. Problems with maintenance of EMS communications single sideband radios...equipment old. Trained village health aides in EMS techniques. Problems with funding - lost federal funding to travel to the villages to give instruction this past year. Hard to maintain enough EMTs to man the ambulance in Nome because of turnover in people. EMS trains for medical care (emergency) in the area, while the troopers provide search and rescue training. Disaster preparedness is not dealt with at all, funds being the big problem.

Fred Angleton, Alaska State Trooper, President of EMS Advisory Council: Air costs are going up and often must charter, trip from a village to Nome can run $300 - 500 for a round trip. Most single sideband communications equipment about 12 years old and in need of frequent repair. A study is being done at present to make plans for a communications network on the west coast to serve EMS, search and rescue, troopers, etc. The intent is to put together material from many sources into a packet before attempting to upgrade communcations.

Comments on EMS from Jeanette Morton, Norton Sound Hospital, during tour of hospital prior to public hearing: The Nome ambulance service is run by volunteers. The ambulance is owned by the Norton Sound Regional (Native) Corporation, which rents it back to the volunteers for a dollar a year.

Senate HESS Committee Hearing in Bethel, November 14, 1981.

Joe Ryan, IHS Hospital Administrator: Emergency charters are the most expensive forms of air travel, which is tremendously increasing in cost . Travel and communication a priority in area.

Dr. John Weatherby: Many villages have a phone in public places, 15 villages have phones in clinics, 48 have side-band radio communications. Emergencies can generally be handled with system, although phones sometimes don't work, privacy is a problem.

Joe Friedman: EMS does patient education in the villages occasionally.

Notes on the Senate HESS Committee Hearing in Anchorage, on December 15, 1981, will be available to the Committee at the start of the legislative session in January.

Appendix XI: Tanana Chiefs Conference Resolution, Presented at the 1981 AFN Convention

TANANA CHIEFS CONFERENCE, INC.

EMERGENCY MEDICAL ASSISTANCE

RESOLUTION NO. 81-08

WHEREAS, The State of Alaska bears the responsibility for emergency medical assistance for residents and visitors to the State, and

WHEREAS, currently State financial support for ambulance services in rural communities is not adequate to assist in offsetting costs incurred in responding to emergencies occurring inside/outside of their usual service areas, and

WHEREAS, reimbursement by consumers for the costs of these responses has been historically low, placing a financial burden on the ambulance services, and

NOW, THEREFORE BE IT RESOLVED that the Alaska Federation of Natives, Inc. hereby urges the Alaska State Legislature and the Division of Emergency Medical Services to provide adequate continuing supplemental financial assistance to ambulance services in rural communities to support their responses to remote emergencies.

APPROVED:

_____

Appendix XII: EMS Related Responses from Health Systems Questionnaire Sent Out By Senate HESS Committee to Health Care Providers

Health, Education and
Social Services Committee

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

Official Business

Alaska State Legislature

Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4906

June 1981

Dear Sir or Madam:

Health care issues and the cost of providing health services has become a national concern. Proposed changes in Federal funding and regulations makes this an appropriate time to reconsider the health systems in Alaska.

To this end, the Senate HESS Committee is investigating many health issues in preparation for the 1982 Legislative Session.

The Committee would appreciate your cooperation in promptly returning this questionnaire to the above address. Any further comments you wish to make on any health care topics will be welcomed and fully considered.

Sincerely,

Charles H. Parr
Chairman

THIS COVER LETTER ACCOMPANIED HEALTH CARE QUESTIONNAIRES SENT TO HEALTH CARE PROFESSIONALS STATEWIDE. SUMMARIZED RESPONSES FROM THOSE WHO RETURNED QUESTIONNAIRES FOLLOWS.

PROFESSIONAL

6. Are there conditions effecting your profession that you think are unique to Alaska?

Yes	272
No	66
No response	73
Unknown	14

COMMENTS	TIMES REPORTED
1. Continuing Education not local, travel, expense. time off	56
2. Isolation/rural	51
3. Travel for health care	50
4. Lifestyle-violence, accidents, alcoholism, transience	31
5. Rural professionals more responsibility, distance from supervisor	23
6. Travel to give care, itinerant	19
7. Weather	14
8. Difficult to continue patient follow-up	12
9. Socio-cultural differences, dual system-native/non-native	11
10. Overhead/cost of living	11
11. Isolated, lack of professional stimulation	8

Do you see an increased need for Para-professionals?

Yes	154
No	145
No response	26
Unknown	9

COMMENTS	TIMES REPORTED
1. Mid-level practitioners needed for rural	58
2. Too many health care providers at present	26
3. Need to sponsor training for ANP and family practice RN	20
4. EMS/EMT special training	11
5. Routine Primary care.	11
6. Prevention/Education	9
7. Efficient, cost effective, immediate care	8
8. Poorly trained, dangerous	8

All physicians were sent a copy of HB 327, concerning the licensing of Naturopathic Practitioners, and the questionnaire asked for comments. Those received were:

4	Favor
57	Opposed
5	Unknown
12	No comment

Remarks:	Number of respondents
Quackery	25
Poorly trained, inadequate for duties in bill	18
Licensing would mislead public, danger to citizens	15
May delay needed treatment	9
No surgery, x-ray	9
No obstetrics	9
No prescription capabilities	8
Fraudulent, life threatening	8
State cannot legislate hospital privileges	7
State should investigate practitioners for education/ preparation; followup on fraud and incompetence	4
Responsibilities too broad	4
Waste of state money	2

All Physicians were asked if they had any contact with the rural health delivery system, and for comments

45	Yes
25	No
44	No response
2	Unknown

Comments	Number of respondents
System in good balance, appropriate, constantly upgraded	18
Health Aides work well, need more financial support, skill upgrading	10
Need alcohol abuse education	7
Need EMS communications upgrading	5
Need more health promotion, prevention	5
Expensive	5

Need more Mental Health Services(violence, lifestyle)	4
Travel greatest problem	4
Unsophisticated, minimal care	3
PHS should not compete with private practice	3
Need survival techniques	3
Need more school health education	3
Abolish AANHS/IHS	2
No payment mechanism for M.D. fees	2
Need rehabilitative medicine, specialists	2

Other comments:

The state needs to promote older, more experienced physicians looking for a change in lifestyle to work in rural alaska.

Federal and state regulations are incompatible for rural health and hospitals.

Travel and lodging payments to physicians would encourage more to have rural clinics, as fees do not meet expenses.

State needs to assist Native Corporations as they assume health care responsibilities, and local control.

Need strict penalties for alcohol related crime.

EMT skill, improved communication and transportation have greatly upgraded care in the Fairbanks area

Community Anchorage Number of respondents 183

		Yes	No	Unknown
1.	Is health care accessible in your area?	169	4	
2.	Is transportation to facilities a problem?	24	164	
	Comments old, handicapped and poor 7 poor public transportation 2			
3.	Are Emergency Medical Services available?	182	1	
	Do they function efficiently?	182	1	
4.	Does your area have an alternative birthing center?	157	7	19
	Is there a demand for one?	18	8	5
5.	Does any doctor in your area do home births?	28	56	76
6.	Is there a lay midwife in your area?	27		
	Is there a nurse midwife in your area?	93		
	Should the state license lay midwives?	70	80	18
6.	Have you had contact with Home Health?	83	73	10
	Is there a demand for this service?	50	3	6
	Comments good program 78 need more funds/staff 36 need RN 4 cost effective 21 preserve dignity at home 17 local control 2			
7.	Does your area have mental health services?	151	3	3
8.	Does your area have alcohol/drug abuse services?	165	1	2
9.	Is Family Planning available?	92		8
10.	Is health education in your school curriculum?	119	3	35
11.	Does your area have hospice services?	56	64	43
	Is there an interest in services for the terminally ill?	69	2	9

12. What services and providers are needed in your area?

Nurse 16
OB-GYN 13
Surgeons 16
Long term care 4
high quality mental health 6
specialists 17
prevention/adult screening 18
child protection 4
sheltered care 11
transition care 7
therapists 4

Community Fairbanks Number of respondents 67

		Yes	No	Unknown
1.	Is health care accessible in your area?	66		
2.	Is transportation to facilities a problem?	15	43	
	Comments distance/rural 14 expense 3 weather 4			
X	Are Emergency Medical Services available?	62		
	Do they function efficiently?	61	3	3
4.	Does your area have an alternative birthing center?	24	19	11
	Is there a demand for one?	19	5	9
5.	Does any doctor in your area do home births?	10	32	19
6.	Is there a lay midwife in your area?	1/		
	Is there a nurse midwife in your area?	16		
	Should the state license lay midwives?	26	21	7
6.	Have you had contact with Home Health?	33	24	
	Is there a demand for this service?	21		
	Comments: good program 28 contract locally 1			
7.	Does your area have mental health services?	44	4	1
8.	Does your area have alcohol/drug abuse services?	47	2	3
9.	Is Family Planning available?	33	1	2
10.	Is health education in your school curriculum?	1		9
11.	Does your area have hospice services?	3	15	9
	Is there an interest in services for the terminally ill?	10	1	2

12. What services and providers are needed in your area?

Nurse 10
specialists 12
ancillary services 4
long term care

mental health follow up/sheltered living 15
rehabilitation facility 5
alcohol halfway house 8
radiation therapy 2

Community Juneau Number of respondents 30

	Yes	No	Unknown
1. Is health care accessible in your area?	28	1	
2. Is transportation to facilities a problem?	10	16	1
Comments expense 3 rural non-natives served in Juneau			
3. Are Emergency Medical Services available?	29		
Do they function efficiently?	24		
4. Does your area have an alternative birthing center?	13	18	2
Is there a demand for one?	14	3	2
5. Does any doctor in your area do home births?	2	25	2
6. Is there a lay midwife in your area?	4		
Is there a nurse midwife in your area?	10		
Should the state license lay midwives?	26	21	7
6. Have you had contact with Home Health?	23	7	
Is there a demand for this service?	12		
Comments good program 21 cost effective 6 better staff pay 7 expand to rural 2 need foster care 1			
7. Does your area have mental health services?	25	2	
8. Does your area have alcohol/drug abuse services?	29		
9. Is Family Planning available?	26		1
10. Is health education in your school curriculum?	18	10	2
11. Does your area have hospice services?	18	12	
Is there an interest in services for the terminally ill?	23	2	5

12. What services and providers are needed in your area?

General Practitioners 7
OB-GYN 15
nurse 4
specialists 10
Mental Health 8
halfway house 3
child protection 3
Accident prevention 3
adult screening 6
expand WIC 2
Prevention 8

Community Palmer-Wasilla Number of respondents 20

		Yes	No	Unknown
1.	Is health care accessible in your area?	17	3	
2.	Is transportation to facilities a problem?	12	8	
	Comments weather 3 distance, expense 5			
3.	Are Emergency Medical Services available?	18	1	1
	Do they function efficiently?	19		
4.	Does your area have an alternative birthing center?	1	15	1
	Is there a demand for one?	12	3	
5.	Does any doctor in your area do home births?	3	12	8
6.	Is there a lay midwife in your area?	6		
	Is there a nurse midwife in your area?	6		
	Should the state license lay midwives?	5	9	1
6.	Have you had contact with Home Health?	10	6	
	Is there a demand for this service?	9		
	Comments good program 9 expansion needed 5			
7.	Does your area have mental health services?	12	4	1
8.	Does your area have alcohol/drug abuse services?	15	2	1
9.	Is Family Planning available?	17		1
10.	Is health education in your school curriculum?	9	1	7
11.	Does your area have hospice services?	2	14	1
	Is there an interest in services for the terminally ill?	6	4	3

12. What services and providers are needed in your area?

Mental health counseling, residential 6
Nurse/mid-level 3
OB-GYN 2
Family planning(minimal, infrequent)
residential detox 2
health ed.(Palmer) 2
Dental/optical 3

Community Kenai Peninsula Number of respondents 22

		Yes	No	Unknown
1.	Is health care accessible in your area?	20	2	
2.	Is transportation to facilities a problem?	15	5	
	Comments expensive 2			
3.	Are Emergency Medical Services available?	22		
	Do they function efficiently?	22		
4.	Does your area have an alternative birthing center?		22	
	Is there a demand for one?	19	3	
5.	Does any doctor in your area do home births?	6	16	
6.	Is there a lay midwife in your area?	12		
	Is there a nurse midwife in your area?	9		
	Should the state license lay midwives?	9	12	1
6.	Have you had contact with Home Health?	15	6	1
	Is there a demand for this service?	12	1	3
	Comments good program 11 Need RN 4 More funding/staff 2			
7.	Does your area have mental health services?	21	1	
8.	Does your area have alcohol/drug abuse services?	20	2	
9.	Is Family Planning available?	20	1	1
10.	Is health education in your school curriculum?	14	3	5
11.	Does your area have hospice services?	2	26	
	Is there an interest in services for the terminally ill?	13	9	

12. What services and providers are needed in your area?

Nurse 4
OB-Gin 3
Mental Health 3
Specialities 16
Family planning(Homer)
Surgery 4
inpatient mental health 4
Detox 9
sheltered living 5
optical
diagnostic

Community Kodiak Number of respondents 10

	Yes	No	Unknown
1. Is health care accessible in your area?	10		
2. Is transportation to facilities a problem?	4	6	
Comments weather 1			
3. Are Emergency Medical Services available?	10		
Do they function efficiently?	10		
4. Does your area have an alternative birthing center?	6	4	
Is there a demand for one?		3	
5. Does any doctor in your area do home births?	5	5	
6. Is there a lay midwife in your area?	3		
Is there a nurse midwife in your area?			
Should the state license lay midwives?	2	7	
6. Have you had contact with Home Health?	8	1	
Is there a demand for this service?	3		1
Comments good program 8 needs expansion 6			
7. Does your area have mental health services?	8	1	
8. Does your area have alcohol/drug abuse services?	10		
9. Is Family Planning available?	9	1	
10. Is health education in your school curriculum?	6		4
11. Does your area have hospice services?	5	4	
Is there an interest in services for the terminally ill?	6		1

12. What services and providers are needed in your area?

Nurse 3
therapy 2
specialists 4
Home Health 2
OB-GYN 2
Mental health outpatient and follow-up 4
Psychiatrist 2
Prevention/adult screening 7

Community Valdez Number of respondents 3

		Yes	No	Unknown
1.	Is health care accessible in your area?	3		
2.	Is transportation to facilities a problem?	3		
	Comments weather 2			
3.	Are Emergency Medical Services available?	3		
	Do they function efficiently?	3		
4.	Does your area have an alternative birthing center?		3	
	Is there a demand for one?	2	1	
5.	Does any doctor in your area do home births?		2	1
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	2		1
6.	Have you had contact with Home Health?		3	
	Is there a demand for this service?		2	1
	Comments			
7.	Does your area have mental health services?	3		
8.	Does your area have alcohol/drug abuse services?	3		
9.	Is Family Planning available?	1		1
10.	Is health education in your school curriculum?	3		
11.	Does your area have hospice services?	3		
	Is there an interest in services for the terminally ill?	1	2	

12. What services and providers are needed in your area?

Surgery 2
specialists 2
alcohol crisis intervention
prevention
school health ed. inadequate 1