

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 86/2

1438 SHESS 1981 INTERIM: FAIRBANKS 9/12/81 - NOME 11/7/81

Miss Kupperly

Homemakers -- travel should be operating east and not taken out of homes. Not allowed to carry wood or stove fires - prob for some

info & referral - lists from Gov. Office of agencies does not tell what services are provided.

In Arch. - Quality of Life Service - supposed to be a state-wide service, just funded. (Voc Rehab)

\* active funding -> INDEP LIV. FOR DEV. DISABLED

got a mini-grant from state but id more for referring. Voc Rehab. no money for Indep. Living.

- covering home for wheelchair etc. so stay out of institution.

- equipment

- vehicle modifications (money only for working)

Active Indep living Center - info & referral (Arch)  
Indep. Optical Nord - hearing - full service access

Carrier removal/access happening in Barouq. and peer counseling

(9)

Transportation - none for handicapped in FTBKE.  
Some nurses cannot drive pt. except in show (st.)  
Car if incur is provided.

Housing - no accessible housing except home  
for the elderly. (only 10 units - 1 bedroom) Those  
w/ children cannot find a place. low-income  
housing are not accessible (two story) and  
cannot be modified. Waiting list for show.

Advocacy - legal aide for the disabled. Statutes guarantee  
advocacy but they do not exist. P.A., D.T.  
only assists Develop. Disabled. Legal aide  
not taking more cases but you must  
financially qualify - not experts in hands.  
Clients do not know rights.

Social Security - gap in system must qualify  
for SSI or you cannot get medical care.  
Can't get insurance. People being cut  
off w/o notice or explanation. System  
is haphazard.

Handicapped Car Plates - no info available. Must have an  
M.D. cert. to get free plates. - even if you  
display a disability. Certificate for car  
needs to be sturdy / more visible.

Also need a temporary handicap placard for  
space w/ temp. disability for parking.

Handicapped person w/ job must make a good  
wage because employment will cause all  
services to cease. Cannot get insurance,  
but any that will insure will exclude  
all medical costs related to disability  
(previously existing conditions)

Social Security takes at least 1 yr to settle

David Mather Health Dir - Tanager Chiefs  
30 CHA Pract. in villages - primary  
and emerg. care unit. Mid-levels  
train and supervise. Supported  
by PHS (20 yrs).  
Other support  
- leases for clinics  
- emerg. med. communications  
serve all people in level I + II Comm.

Fed support:

- no leases for clinics as of March 8,
- Communications - additional phones or planned phones canceled
- CHA program inc. 0-3%
- MH, EMS, Home maker rely on CHA - only rec'm w/ facilities, and communication.

Salaries not competitive (40% of state prison) <sup>100 hrs training (\$11,500 yr)</sup>  
 Money from IHS too can serve all people.  
 Losing older, better qualified CHT because  
 they are leaving village to get better urban  
 jobs.

Health care is not under trust responsibilities.  
 applied for Hammermaker contract but had  
 to provide for N. Side too - unable to do that.  
 Contracted to Corp. on East Coast who cannot  
 possibly provide services.

— support training - statewide proposal coming  
 in for next session.

Barbara ~~Dahl~~ <sup>Dahl</sup> - disabled. Charles Pickett. Solicitor FRAS (H+SS)  
 you handicapped while  
 determination for S.S. went on. No idea  
 when it will run out. Turned down 3  
 times for S.S. - state grant goes with S.S.  
 and is cancelled if S.S. denied.

HSS unresponsive, confusing info by  
 mail. Lack of communication / confused.  
 Don't know what benefits will be - must  
 have complete reevaluation by SSI and  
 state.

1. STATE PROGRAM - state doesn't make own determination  
 but relies on SSI

Chief Medic w/ VFD.


Mr. Arturo Frasca - Training Coordinator EMT

EMT REGS - about 3,000	I
	300 II
	100 III
10 med EMT Para-med	35

wants a state trainer and a 1 person staff without a bureaucracy. Can work with all three regions, Regional offices work well together.

Cost to volunteer EMT has gone up drastically. Departments have some funds for training but can't cover costs of training facility. Thinks it's cheaper to bring rural folks to stores. Mean to transport instructor & equip.

Central Dispatch - improves time / less confusion for all services. No funding specified in 113314 (MAST)

 Military Asst Safety & Traffic - helicopter squad 283 for med. evac. like to include Paul Rd. in service area

Charles Kaltenbach - Dir. NARA - rep. Board of Directors (Paul Sherry pres) 1974 - started HSA's

Dr. Michael Druff - <sup>or statewide Health Care Council</sup> Tanana Chief MH Prog. Dir.  
 State Alcohol / Drug Abuse Prog.  
 needs more staff. SODA staff  
 doing best possible but need Northern  
 Regional Office.

### ⊗ Occupational Licensing

- no enforcement
- staff slow etc.
- people being licensed blame Board rather than O.L. generally.

Problem w/ State Programs (DHSS req. for grant funds)  
 Gov. generally signs budget in Aug.  
 though fiscal yr. ends June 30. and all  
 funds must be spent in fiscal year.  
 Some programs have State - Fed. but  
 no funding source programs have severe  
 problems.

⊗ Accountability - Small programs in rural  
 area feel that accountability  
 evaluations cannot relate to both  
 urban and rural.

Position paper will be sent.  
 - functions in Cm. Comm. could be expanded  
 to other areas ie prevention etc.

Dr. Wayne Meyers - U of A

World Health Organization - said rural Ak. health delivery best in the world for isolated areas.

CHA - not eligible for 3rd party reimbursement. No official recognition by State. State pharmacy reg. do not approve the CHA's dispensing Rx's. (but they do). Only an M.D. who is a Fed. employee can supervise a CHA. SOCC asked Helen Bierre to implement reg. to deal w/ liability, etc. ignored.

HSA may need to vested interest in health.

Health Research almost non-existence in Ak. Nalistic Health - Alcoholism do. Cost approx. \$500,000 approx. for research. Where ???, Should go to Council on Science & Technology.

Frank Cook - Bry Lake, Ak.

HB 4 - good idea

Jean Kingray - needs ~~to~~ correct treatment in FBIKES. She has cancer and must be treated in Anch. but there are no support groups in

Alaska. Many people go to Seattle / Calif. etc. People in FBKS. may look for home "cures" rather than travel. There are 5 people currently in FBKS. She knows of who need cobalt in

Mary Carey - retired health nurse.

Holistic Health - studied this at Yale.

Arturo Frezura (again)

RE: Air Quality Research

would like to see a follow-up on carbon monoxide & other chemicals (research) in Alaska where properties act differently because of climate etc. Because of Petro-Chemical development etc. to evaluate these before develop.

Suibanks - Sept 12

Charlie  
Dinger for Vic  
Sandra  
Nancy  
Fred Brown  
Yvonne for Mike Biern

Sally Smith

Saldana Sept. 25

Charlie  
Mike Callotta  
Sandra  
Nancy

Wade Malone  
Sally Smith  
Terry Martin  
Jody Luckland for M. Biern

Wome Nov 7

Charlie  
Mike Callotta  
Dinger for Vic

Sandra  
Nancy  
Jody & Petra for M. Biern  
Barbara Wilkins

Bethel Nov 14

Charlie  
Mike Callotta  
Sandra  
Nancy

Yvonne & ~~Alta~~ for M. Biern  
Barbara Wilkins

Nancy L. Raymond, Ketchikan. Box 2335 Homer  
Karen S. Carpenter ST Rt Box 40 Anchorage 99556  
James E. Johni Box 1918 Soldotna

Senate Health, Ed. & Social Services sheet #2  
Com. meeting - Soldotna

name	address
Burton Pfane Jr.	Box 3202 Soldotna AK
Debbie Rediske	Box 2885 Soldotna, AK
Justie Keala	467 " "
Aziah Bates	Box 544 Homer -
Mike Herring	Box 2007 Homer AK
Viviana Kieser	CPGN. Soldotna
Elizabeth Jaeschner	Box 56 Soldotna 99669

(1)

KENAI HEARING  
Sept. 26

MRS Raymond -

Home facility, a new profession called Kenlin. NO limit on consumers open to all. Detente in Home is an alternative - family atmosphere for physical disability; short term; provides homemaker services.

requires that they are lucid and not bedridden.

Applying for non-profit corp. Capacity of 4. Maximum of \$6.

Pilot Detente program in McLean, Va. Philosophy is that the person remains in control of self.

Cost of care \$300.00/wk for complete care.

Nelen Bieme has visited Detente. said it was a step forward in care of the elderly.

Staff has a nursing background. Kenlin philosophy - power of person to act in their own behalf. 8 step process (pattern of ownership)

Want eligibility determination for funding for care of low income

(2)

Karen Carpenter - Anchor Pt. Nurse since 1966. School Nurse, hosp. nurse. wants to support legislation which leaves decisions to the individual. Concerning all institutions (health, ed. etc.) Served on <sup>SC</sup> HSA '76-'78 but felt she had no real opportunity to give an opinion. Health # limited at illness. Studied Klein Profession

Jim Jolin - Chairman hosp. Bd. of Dir. S.C. Hosp Expansion \$5.7 million 1977- Long range study on hosp. options - relocate & build  
- expand  
- nothing

Potential growth of Community decided to expand. 67% Occup. rate (52% avg.)

Coastal Energy Impact funds from feds. \$5.7 million needed. Want grant monies to support bonding. Rural hosp. have vast

service area in Peninsula. 16,000 pop.  
will run mill rate from 5/10 to 1  
to retire two bonds. Expense from  
tax payers. 66-70% of revenue  
come from oil industry.

Phase #1 has expanded (outpatient &  
inpatient. More services locally.  
Operational budget shows profit (small)  
try to at least break even.

\$100/day Patient cost - projected for '82  
\$95/day bed

Lutheran Home Hosp. Soc. - manages  
Hosp. does all bookkeeping, purchase  
on ly. Scale reduces cost.

Occup. rate seasonal - 59% summer  
Projected 50% O.R. this winter.

Bwet Josey - N/Anesthetist at hosp.

Nurse Practice Act - nurse-anesth.  
not included. Now to be in article 5  
as certified Nurse Anesth. Group are  
not happy.

Changes are acceptable except

non-renewable - before passing Nat'l Exams  
must practice under supervision

of anesthesiologist - only one in FBKS.

Must graduate from an accredited school. Must pass nat'l exam within 18 mos. (given every 6 mos.)

Debbie Rediske - Admin. Dir. of CMHC.

RELY ON STATE/LOCAL SUPPORT.

NEEDS:

- 1. Preventative
- 2. OUTREACH / Education.

- 1 staff - 3 Admin
- 2 PhD Psych.
- 2 MSW
- 1 Consulting Psychiatrist.

Inpatient in S.C. hosp.

Patient load 320-350 / yr.

very few are chronic mentally ill (about 10)  
not alc/drug related.

\$181,000 - State '80 (75% of money from state)  
 250,000 state '81

Local funds, Client fees, 3rd party.  
 Revenue sharing, Voc. Rehab. (10,000), Family & Youth Services Contracts and School (\$9,000)  
 (39% local this yr)

# Support Mental Health Lands Bill.

Justin Maile - Hosp. Bd.  
OPPOSED to 168'  
per-capita ignores need.

Asaya Botes - Homer - since 1959.  
Gov. Council of Acc. / Drugs.

- NEED hosp. expansion. Bond issue on ballot this election.

- NEED Detox Center on Peninsula  
Pop. must go to Anch. or Kodiak.  
Cook Inlet Council on Anch. tried,  
Borough granted money.

- HB ? - Ad in Anch. paper that bill would make M.D. a murderer who did abortion. Abortion should be personal choice.

Bob Cowles - coord-eval. alcohol programmes. <sup>good</sup> job.

"Here's looking at you" should be mandatory in all schools.

Revolving door - continuous treatment

of the same people. How to evaluate?

Michael Herring - Admin. of S. Pen. Hosp - Honored

Share expansion plans. Rec. C.O.N.  
for Exp. \$7,150,000 Cost: \$3,150,000 Bonds  
on Oct. ballot. Need state asst  
for remainder of \$.

T. Martin - 29.90 State aide for local hosp. financing.

Current - 13 acute + long term

4p. - 24 acute 15 L.T.C.

1980 - 4,162 patient Days or 12 1/2/day  
fluctuating 2 to 30. Nat'l Stand. for sm.  
hosp is 60-65% occupancy

Operating grant received from service area  
enabled hosp. to remain in the black.  
Not enough financial stability to  
sustain debt service for entire cost  
of construction.

Not adding any new services/equip.  
expect better utilization of existing services

pull out patient referrals to check. to remain the same.

Rev. Shoro. (131)

Virginia Rivers - Acting Admin. of S.C. Hoop. kitchen etc.

Beth Fairman - Provider. - Bd. Member of S.C. HSA

SEND QUEST.

HEB 41 - SCHOOL NURSE 12 yrs. 1 3 yrs. - well abth. to Comm. H's 22

Interest to Health Planning.  
Pl 96 79. Health Planning shouldn't be in spirit because of influence of jobbuying. Need local input. MUST contribute.  
Health Promotion  
School health ed.

please sign up

I

name	address
Jeanne E. Jones	P.O. Box 2120 Fairbanks AK 99707 - Intensive Reg EMS
Jeffrey [unclear] MD	1919 Lathrop St (State Med Board)
Patti August	1919 Lathrop St. Room 1, 1st fl. at. Nursing School
Martin Becker	S.R. 20122 Fairbanks 99701
Tom Minger	116 Craig St Fairbanks 99701 Fairbanks Memorial Hospital
Wayne Myers	P.R. Box 40017 " " WAMI Program, UAF
Patricia J. Rogers	1919 Lathrop St., Suite 223, 1st fl. Division of Nursing

I  
Foy Ann MacPhee 1/4 mi Selma Rd.

Div. of Family Support  
Services

Rose Lawson 621 Northward Bldg. MARRA Board

Jennifer Graham Box 2120 Fairbanks, Ak. Emergency Mgr. Sen  
State Bd of Nursing

✓ Shelia Kelly 714 Kennedy  
PO Box 1544

FBKS

NASW Rep

Director of FBS Community  
& Adoption

sign up sheet #3

✓ Glenda Moore - must leave by 11:30

✓ Theresa Dyles

✓ Laverdi Lafferty

DAVID MATHER

Health Director - Tanager Chiefs Conf. Inc.

Doan Bldg FBES.

17, 23, 16

7  
sign up sheet # 4

name	address
Barbara Doble - Social Services 155 1551	1-C-1 Dixie apt FBK 5
ARTURO FIZZERA	DIRECTOR REGION S.M.S.C
	P.O. 1207 2120 FBK 6, AK 99707

sign up sheet #5 Theresa Dykes 456-1612  
home  
2-6367

name

address

CHARLES KALTENBACH

SR 20130

1/2 mile Gold-Town Rd.



\* Charlie  
This is the  
only

new sign up

HSA's passed 1976

Polish Div Dec fee,  
per boards in approp dept.

I - afternoon

Sign up sheet - afternoon  
Name address

- ① <sup>Dr.</sup> Michael Graf - Dir Mental Health Ser  
Tanana Clinic Conf. Trce
- ② Wayne Meyers WAMI
- ③ FRANK COOK Po Box 17-926 BILAKE 99667
- ④ Gene Kujala 68 E St 456 8500

afternoon sign up sheet II

NAME  
May Cany

ADDRESS  
Box 1259 - PKC

sep 12, 1981 - Fairbanks

## Part now -

Med Bd no position on HB 41. Ap indiv against further Medicaid bureaucracy - may have problems with HB 41 as stands. Canadian doctor - had to get dr to brush even w/ money high. Ft Yukon PHS ca. I get dr, use PA. Canadian using clinics with nurses.

Control needed on lay midwives by somebody. Easier to deal w/ private carriers than w/ gov't. MD's won't go broke getting 60% for 15% of patients, but might repeat Arch experience w/ obstetrics.

Arctic Village & Venetie - usually see about 1/2 village - minor problems. Maybe people feel drs will pick up something missed by health aids. Few major problems.

Astrea - <sup>improves</sup> reqs for EMT - II & III acting as PA's, in regional areas.

- reqs in draft amb certification. Eielson AFB will stop going off-base if reqs adopted as are.

- ~~Fed money~~ where funds allocated may be problem (e.g. Public Safety) - should go to HHS.

- payment for transportation (air or ambulance) not coming through. Tok needs money or will have to stop.

Ostres - equipment retrieval problem. Need more  
back up equipment in villages.  
- state wide insurance package possible?  
- microwave system needed - funding =  
to Tok and up Dalton Hwy.  
- need ~~training~~ training site - this area.  
- MAST now past 100<sup>th</sup> mission - area cut  
somewhat.

Mingen - what direction is state going? Not  
opposed to HB 41 - some people not getting  
care - but COMPASS study of Medicaid -  
Battelle study - Helen Burns re catastrophic  
illness program. Are all the coordinated &  
what's bottom line for state costs?  
Medicaid cap 9% -  
- if shortfall where does money come from?  
- FMH wrote off last year - because  
not fully paid for Medicaid & Medicare -  
- CON needs to be modified - dollar limits un-  
realistic - no problem w/ regional rec or state  
decision. Need crowd planning (Fed, state &  
private sector)  
- study of hosp capital needs due Dec -  
- hospital should have its share lined up before  
state kicks in.  
- Revenue sharing changes good. Don't tie it  
to specific activities of hospital.

Mungen (cont) Average 85 day wait to get paid  
(incl private ins cov) - part of problem is  
everybody outside. Can state help?

Gleason - EMS & ch Board of Nursing -

- will need people to enforce regs for EMT

- main EMS need is on-going training, esp in

\* rural areas (pre-hospital training)

- HB 314 (Hugh) - central dispatch -

- main need training of mid-level practitioners

- hosp emergency room needs to know level  
of training of EMT's in field.

- programs for advanced life support system  
needs go through HHS -

\* - could be circuit-rider training

- liability - good samaritan -

Osborne - Title 18 - 1977 -

- Nurses - competency - mandatory continuing  
education - UA project MEDIA - ends in Oct.

Need to package refresher course for RN's -

- Next mtg Nursing Bd in Nov, Oct - get  
reports - may be rec -

- Turnover in rural areas 1/2 year -

Glenda Moore - on behalf on handicapped - home  
health aide & homemaker programs good.

- handicapped people being talked down to - not  
being treated with dignity - by supervisors operating  
Program

Glenda Moore - continued -

- state pay for travel time to client's house and subtract from client's time -

McC Smithy - NASSW - 160 members in AR

HTS 41 - some health care regis. specific attend after results of Battelle study.

- ad (in FBI counseling + adoption) individual - HTS HTS 41 leaves out social workers

- no reg yet on (counseling + adoption) non-party agencies - <sup>some</sup> state should 1st contract w/ unlicensed agencies. <sup>some</sup> third-party payor won't pay - can't contract w/ some (state?) agencies.

Theresa Dykes - handicapped -

- DMV - license plate -

- need info + referral service for all handicapped people. (ARIC)?

I'm parking spaces at College PD

- need still fine if non-handicapped wear space (Fred - taxi drivers like them)

Lorelei Lafferty - ARIC - Rts PD says spaces going in.

- Memoranda not allowed to carry work on put in into above

- list of agencies doesn't say what they provide or what ~~of~~ the qualified for.

Lafferty - continued

info referral

- Quality of Life Center, Anch (funded thru DVR) supposed to be statewide. Hasn't seen local presence.

- Need to look at funding for ACIL or similar orgn. DVR has no funding for equipment, to remodel for wheelchair use (e.g), car modifications such as hand controls.

- Anch has Independent Living Now, full service center for handicapped.

- no transportation for handicapped in Ftks now - buses coming. Home maker can't transport, but can drive client's car.

- no accessible housing except Golden Towers which is and stays full. Low-cost projects don't have any.

- no advocacy (see AS 47.80) -

- social security (SSI) qualified nec to get assistance, fall through cracks. May not be able to get \* Medicaid or insurance. Check into this.

- may cost doctor's fee to get free handicapped plates

- placard needs to be better (in plastic?)

- need temporary placard for temp disability

- Jobs Service not offering enough help, DVR doesn't offer enough counseling. Job needs to pay enough to take care of all needs - sometimes can't get insurance.

- Aid to Disabled supposed to supplement SSI. Long time to get it - what bridges gap?

not long a  
Mather — TCC

Comm health aides (about 30) — plus mid-level people, plus PHS supervision. Leases clinics, furnishes communications.

State reluctant to fund any part of system. Feds no more leases for comm clinics. Six additional phones cancelled. Expect 0-3% for comm health aide socs.

Reagan budget cuts —

Comm health aides paid less than comparable state positions, i.e. assistants to PH nurse <sup>\$11,500</sup>

Understands that state funding must ~~be~~ not be restricted to Al Natives.

Barbara Dable (pronounced Dail) —

— became disabled, for year never knew how she stood (would continue or not) —

— turned down for 50% three times, each time lost state grant — re-opened when applied again.

— didn't get 11% increase in state funding —

— five wks. first turn down

Arturo Frizzera — EMS

— about 3000 EMT I, 1500 EMT II, 100 EMT III (35 paramedics licensed). Need state trainer plus one-person staff, coordinate regional trainers.

— need training facility — \$1300 - 3000 per class for use school space

Fruzzera (continued) -

- HB 314 - thank to Hugh (centr / dispatch)
- pushing limits on ambulance times
- prob only Troopers (of state agencies) involved
- MAST limited to Flks vic - Ostros says working thru Stevens & military. 29,000 veh over border this year. 37,000 going other way.
- personal (w/ Steve VFO) - thank.

Kaltenbach - Ex Dir NAHRA

- Fed over-structured HSA's, expected too much
- additional funds not in HHS policy budget
- functions: comm organ & resource development  
(under state rec on policy questions of lg funding) review req for fund allocations  
research health issues  
health promotion
- NAHRA Bd unanimous that CON limit too low
- agrees that fresh look needed -
- involved w/ setting up N. region EMS
- reviewed \$10 million in health facility requests (s. ved \$300-400,000 in alcohol grant funds)

Graf - need person in N. region for alcoholism programs

- advocate of HSA - doesn't apply for funds w/o checking with HSA staff
- some dissatisfaction w/ HSA because it says "no"

Graf (continued) -

- As member of SHCC knows how much state agencies  
to rely on HSA info.

- Services from Dec Licensing & Law abysmal.

No successful pursuit of person practicing psych  
w/o license in four years, as far as he knows.

\* - req. requiring self-generated funds be spent  
in same FY - HHS req for all Dept grant funds

- small programs problems on accountability-  
position paper

- CMHC - take over allied (?) functions, esp in  
small rural communities - mini block grant  
program (?)

Myers -

- World Health Orgn - says HK system best, now  
being replicated in Brazil & studied in Mexico. WHO  
delegation here 1<sup>st</sup> wk Nov.

- comm health aides & most vulnerable part of  
system. Poorly paid - not eligible for 3<sup>d</sup> party payments.  
State pharmacy regs re drugs problem.

- MD can't supervise health aide because subject  
to liability, must be PHS. Helen B. asked to look at  
problem.

- sees \$1.5 million to non-vested-interest group (HSA's)  
worthwhile when figure spending \$400 million year.

- Murkowski bill - \$25 million for research,

Myers (continued)

- research money should go to ~~AST~~ Council on Science & Technology.

Frank Cook -

Supports concept of HB 41. Take worry about catastrophe away. People now having to choose between medical care & food.

Jean Kingra - speaking as a citizen

- has cancer, need cobalt machine in Folsom - no emotional support in Arch, greater cost.
- no plans in expansion of FMH for cobalt
- knows of four others in inner circle who need cobalt

Mary Carey -

- holistic health - not new concept
- what's happening is bunch people getting into Arch
- conf Arch 2 yrs ago - Sheraton - farce
- Norman Cousins - do not interested in taro cards, cosmology, etc

Fruzzia - (for self) -

- research on air conditions in sub-arctic and effects on health.

Jean Kohler - (wife of Bill) (Chena Ridge)

Health education - controversy - problems over curriculum  
see Paul Frith - \$20-30,000 for ad campaign - sex ed, self-concept  
from Pub Health - talked to Kattenbach

Sep 17 health ed seminar - all day

Partnow - speaking for himself  
st. medical bd  
st. medical assn.

difficult to obtain physicians  
who want to go to the  
brush

Calibre of health aids

Jeanne Ostress - EMS

difficulty in retrieval  
communications

4B 519 ex older 50

training facility

M.A. S. T. area covered  
ent

Tom Mingen - administrator FMH hospital  
laws in some states require  
something like 90% of claims  
in state x

Jennifer Glenson - EMS & st. bd of nursing  
training for EMS  
single largest need for  
continuing funding

(2)

Jennifer Gleason cont - more info  
on nurse practitioner act - presently  
in House HES3

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Ms. Moore - speaking on behalf of the  
handicapped - Home Health Care  
aides - Program Resources  
honorarium services - travel time  
deducted from health time with  
those who need assistance

Homemaker Home Health Aid supervisors  
very condescending

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Sister Kathy social workers

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Ms. Dykes prob. obtaining a handicapped  
license plate  
started information referral service -  
makes ref to ACIL - joined  
with them

fed post  
11/1/80  
college  
P.O.

also - suggests possibility of a  
stiff fine for parking in a handicapped  
parking spot

Fred - suggests City council action  
against cars

La Veda Lafferty — ACIL

cheaper to provide some equipment  
to provide essentials remodel kitchen  
& bathroom than put in careage. d.

Independent Living Centers - 2 in Park.  
ACIL acting as a consumer group

\$ to DVR for independent living

no handicapped units in low  
cost housing - closest to it  
is ~~in~~ Park West

Advocacy for the disabled

PADD exists for the  
developmentally disabled -  
not for the phys. cally disabled

"Package" for the hand'capped

\* has info from eq. lit. on  
how to obtain handicapped  
plate

afternoon V

Frank Cook - Big Lake - everyone  
wants to build  
supports HB 41

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Gene Kuyera - speaking of a private  
citizen - ref. need  
for a cobalt machine  
in TX

Cobalt machine -  
travel, apartment,  
plus food & transportation  
23 1/2 hours per day

Lack of cobalt in TX  
leads people to seek  
cure in TX

would like

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Mary Carey - retired  
ex community health  
nurse

Consider  
the anatomy  
of an illness

holistic health

↳

afternoon VI

Arturo F. again -  
speaks on Correlation  
CO & health - makes  
point of Dow Schell  
& possible illnesses

Frances Bremer  
Kenai Boss Clerk

Sheila Cross

9-27  
9-31  
Nov

Foot  
1st  
Thurs  
29-1

edu  
education  
information

11 am 1st lib.  
Conf. room

Caren  
McPherson  
455

PR - Voters  
Forum

B+M  
Sheila Cross\*

~~John~~ Fern Orton 356-2025  
2-6941

Christine Thorsen 479-2835

1981

LAUTRIM

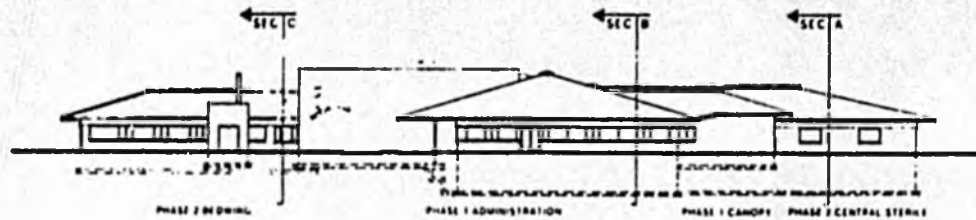
SOLDOTWA

9/26/81

Mr. Mary E. Raymond, Keilbair. Box 1335 Alaska  
Fransburg Carpenter Sitka Box 40 Anchorage 99552  
James E. Johni Box 1918 Soldotna

Com. meeting - Soldotna

name	address
Burtan Pfane Jr.	Box 3202 Soldotna AK
Debbie Rediske	Box 2885 Soldotna, AK
Justie Keala	467 " "
Aziah Bates	Box 544 Homer -
Mike Herring	Box 2007 Homer AK
Viviana Kiesel	CPGH. Soldotna
Elyzeth Jasschner	Box 56 Soldotna 99669

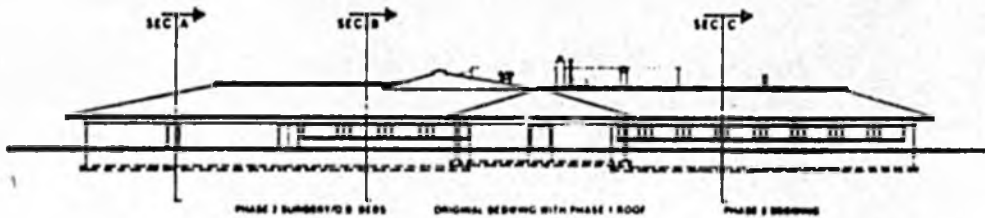


NORTH

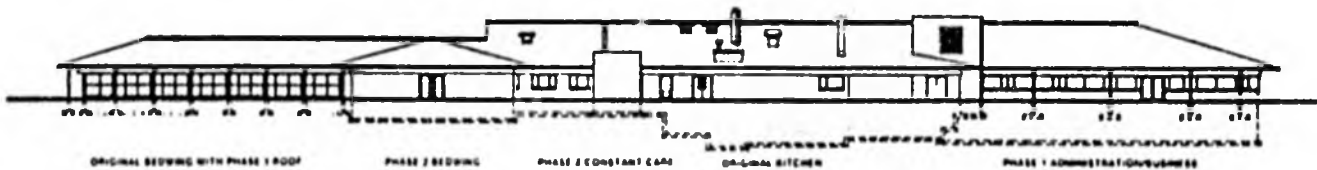
THE PROPOSED

\$5.7 MILLION EXPANSION BOND ISSUE

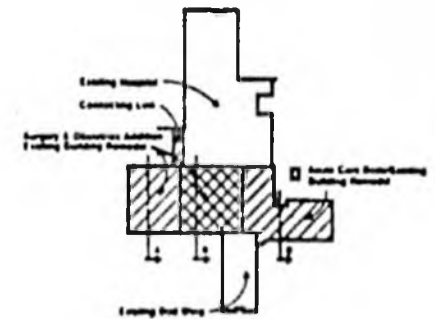
FOR THE CENTRAL PENINSULA GENERAL HOSPITAL



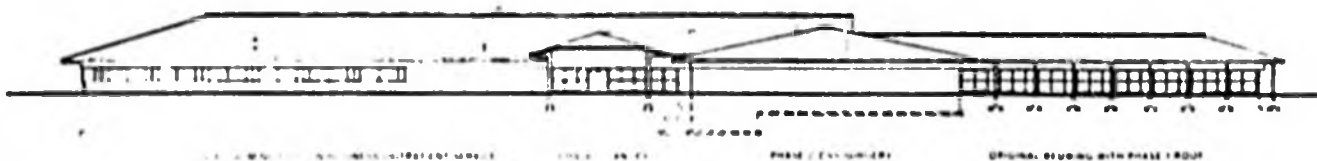
SOUTH



EAST



KEY PLAN



WEST

CENTRAL PENINSULA  
GENERAL HOSPITAL  
PHASE 2

ELEVATIONS

ORIGINAL DOCUMENT SCALE 1/16" = 1'-0"



CIA ARCHITECTS ENGINEERS  
JULY 2, 1981

## INFORMATION ABOUT THE PROPOSED \$5.7 MILLION EXPANSION BOND ISSUE FOR THE CENTRAL PENINSULA GENERAL HOSPITAL

The Central Peninsula General Hospital proposes to remodel and expand its current surgical, obstetrical, and central sterile supply areas in accordance with the Long Range Hospital Plan.

Also, in accordance with the plan a ten-room patient ward and a two-room intensive care unit will be added in line with demand.

The remodeling, expansion and addition will accomplish the following:

The current surgical suite includes one operating room and small changing rooms for physicians and nurses. Surgical utilization has increased both on an inpatient and outpatient basis. As this trend continues it becomes extremely difficult to adequately schedule all cases. A new surgical suite containing two operating rooms will be added. Unlike the present operating room, the new rooms will properly handle orthopedic and other specialized surgery.

A new central sterile supply will be part of the new surgical addition. Much time and consideration has been given to determine the proper flow of supplies in and out of surgery.

The present surgery area will be changed by remodeling to an obstetrical area that will include birthing facilities and rooming in-rooms. The Central Peninsula General Hospital has not been able to offer these services due to limited and cramped facilities. The remodeling proposes a delivery room, a birthing room, a two-bed labor room, a one bed labor room, two obstetric bed rooms and two rooming in-rooms plus male and female changing rooms.

The addition of a ten room hospital is necessary to meet the present and projected use of the inpatient facility. Occupancy has been 60% or better for most of 1981. Occupancy will continue to rise with the arrival of an orthopedical surgeon, an internist, and other physicians.

Hospital use forecast for 1986 has occurred in late 1980 and 1981 making the expansion necessary now.

Passage of the bond proposal will make possible bidding in April of 1982 and building completion in October 1983.

The expansion will remove the need for transfers and transports to Anchorage except in unusual cases.

A bond proposal of 5.7 million at a municipal bond interest rate of 10.5% for 15 years on a Hospital Service Area tax base of \$1,934,136,000 would be .4 of a mill. This means \$20 on a \$50,000 piece of property or \$40 on a \$100,000 piece of property. *now .5 mill on existing bonds -*

The project is eligible for a sizable State grant that will allow the Hospital Board to retire the entire debt or substantially reduce the amount owed in a year's time.

Passage of the hospital expansion bond proposal will aid in meeting the medical and health needs of our community in a timely and orderly fashion.

Prepared and paid for by the committee for Hospital Expansion.

Justin Maile, Treasurer

Malone  
Smith  
Martin

Soldotna 9/26/81

Jody Sutherland (for Mike Berine)

Mary Raymond - Kinlein - Homer - Detente  
Detente - family atmosphere - people now ~~paying~~ paying -  
State support for those unable to pay  
Capacity now four - limited to 10 max. Wants 6 total.  
Now \$300 - week - not sure how much of capacity  
Kinlein - self-care

Karen Carpenter - since 1970 in Rk - nurse -  
- wants support of decisions <sup>left</sup> to individuals  
- finds it difficult to ~~get~~ have a say  
- on HSA 1176-78 (Southcentral) -  
- Kinlein new, indiv knows what best for him/her  
- doctors lacking in ed as to letting patients decide  
- need more emphasis on preventive health

Jolin -  
James ~~Jolin~~ - Chairman, Central Peninsula Hosp Bd.  
- long-range plan - was 30% occ, now 52%,  
expect 67% finally  
- \$5.7 million bonds - want 100% state grant  
- 33 physicians on register  
- May-Aug ca 59% - expects 50% winter

Bert Fossey - ~~an~~ an aesthetist -  
- nurse practice act - deleted from nurse practitioner  
act because didn't apply -  
- Board of Nursing gave temp permit ->

Bert Fossey (cont) -

- nurse - anaesthetist - now allowed to practice w/o passing nat'l exams, but only in Ak.
- wants all allowed to practice or no one - until passed exam
- nat'l exams every 6 mos - 25% fail first exam, 3% fail 3<sup>rd</sup>. Cannot skip exam - must take <sup>in</sup> succession

Debbie Rediski - Kenai Pen Mental Health Center

- 7 staff (4 prof (2 Ph psych, 2 MA level))
- 320-350 patients year
- Last yr \$1,000,000 from state, this yr \$200,000
- " " 38% budget-local

Justin Maile - Treas hospital board

- doesn't like SB 168 system

Hozea ~~\_\_\_\_\_~~ Bates - Homer -

- need expand hosp in Homer
- " detox center in Soldotna, Kenai or Homer
- HB 180 - abortion - bad bill
- consider mandatory 6-mos after 3 detox sessions

Michael Haring (sp) - Homer - admin hosp

- 17 beds (13 acute, 4 long-term) - 13 → 24, 4 → 15
  - \$7,100,000 cost of expansion (bond issue local 3,150,000)
  - doesn't want double-dip (25%)
  - av 12 patients day in 1980
- } all patients intermed.

Michael Haring (sp) (cont)

- 60-65% optimal occupancy -
- now in good financial shape
- doesn't plan any new services
- half of Jan couldn't get med-evac  
(Collette - share services w/ Soldotna?) - reply:  
probably incomplete range of services at other hosp
- most members Hosp Assn question need for 3 HSA's
- wasteful process CON - maybe OK for capital projects vs equipment (Hosp assn split) -

Vivianne Reaser (sp) - admin Central Pen. Hosp

- Elizabeth (Beth) Kashner - health provider, member <sup>3 yrs</sup> SC HSA
- HB 41 puts burden on & gives auth to Comm H&W
  - health planning needs to continue - but set apart from govt
  - HSA's have provided for input - raised consciousness
  - not sure as of today whether should be dif system

(1)

Sept. 26, 1981  
Sen HESS meeting  
Soldatna

Colletta  
Parr - martin  
Malone  
Smith  
Jody

---

Ms. Raymond

"Kentine" self-care agency -  
Homer  
"detente"  
rest home? 3 elderly people,  
needs mostly physical

group home for people who  
are physically or mentally  
disabled needing care -  
capacity is 4 - 10 max.  
(?) 6 aimed for

6 sleeping  
rooms

\$300.00 week for complete care -  
based on 4 paying family

Dr. Annable - ref.  
letter to the leg.

②

HESS meeting - Soldatna

'Detente' intermediate care

71% of all medicare \$  
being spent going to nursing  
homes

Person eligible to receive the \$

~~it~~ wants the state to look at  
Detente to see if state \$ could  
be available for people who  
need this service

board members almost all  
nurses

Kenline - philosophy of  
self-care

---

Karen Carpenter - lives Anchor Pt now -  
Speaks in favor of legislation "leaving  
decisions to the individual person"

HSA - 1976 - 1978 - She served on the  
board

feels individuals should be informed

(3)

NESS meeting - Soldotna

of the choices, then left to make  
their own choices



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Pert Fossey - Senior anesthetist -  
nurse practitioner

(cert. reg. nurse anesthetist -  
Ch. 5?)

OBX memorial - employs a  
physician anesthetist

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Debbie Rediski - Ad. Director Cent.

Pen. Mental Health Center  
about 22 com. mental health  
centers in Alaska - many  
rely on state grant funds

Debbie Redeske, cont'd



320 <sup>per yr</sup> - only about 10 chronically ill

\$182,000 from state last year  
250,000 " " " " this year  
Also, other \$ from charts, etc.  
r.w. showing city of Kenai, etc.



Mental Health hands bill

R

Justin Malley - Soldotna - served with  
Jim John on the hospital. -



he was against SB168 - didn't  
think it fair on the pen. because  
it was based on pop. rather  
than an areas problems

SB164

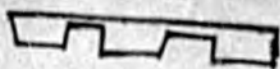
didn't  
move because  
of the  
"iniquity with"

asking for 100% grant for 5.7 million  
dollar expansion - surgery 9 06



5

NR233 meeting  
Soldatna



Asseya Bates - Homer - no need funds  
for expansion of hospital in Homer

state health - need a detox center on  
the peninsula - either Kenai, Soldatna  
or Homer

NR - 180 - ? - ref. considering any  
doctor carrying out an abortion would  
be considering a murder - very much  
against this bill - pro choice - issue  
should be between M.D. & the mother  
involved

5 bed detox maybe

K-12 "Here's Looking at You" - mandatory?

40 evaluations made by Cole's office in  
the past 6 months -

---

Michael Herring - S. Pen. Hosp. Homer

17 bed, 13 acute & long term care -  
had to keep patients in the hall

7.15

(C) HESS meeting,  
Soldotna

ballot issue this fall, would also  
like assistance from the state

ref AS 29.90 - st. aid to

local hosp. for construction & financing

expand to 30

"leap frogging" - if prob. can't be  
handled locally, go directly to Anch.

Homer }  
Soldotna } 3 Kenai Pen. hosp. -  
Seward } little exchange of patients  
among all 3

Q ref HSA  
meet members of the hosp. assn.  
questions the need for 3 HSA's in Alaska,  
& their budget

Q ref EMS prob of air carriers in  
collecting \$ from patients - excellent EMS assoc.  
with fire dept - call large service dept

① HESS meeting, Soldatna

equipment retrieval problems

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Viviane Reaser - acting admin.  
Soldatna Hosp - ~~has~~ <sup>has</sup> been here  
5 months

is impressed with the hospital here

FEEL

---

HSA's - health promotion & wellness -  
neutral forum - 51,070  
consumer based

Both?  
~~Age 60+~~ - 3 yrs on 5 Cent HSA 60

school health education

? N. Mexico mandated health ed in  
schools

SCA  
SCA affidavits not to take positions in  
my new health planning agency

1981

ENTRIM

NOME

11/7/81

Original sponsors: Buchholdt, Gardiner,  
Clocksin, et al

Offered: 4/16/81  
Referred: Rules

1 IN THE HOUSE . BY THE FINANCE COMMITTEE  
2 CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 41 (Finance) (efd failed)  
3 IN THE LEGISLATURE OF THE STATE OF ALASKA  
4 TWELFTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the health of residents of the  
7 state."

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

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

10 CHAPTER 27. STATE HEALTH INSURANCE.

11 Sec. 18.27.010. STATE COMPREHENSIVE HEALTH PLAN. (a) The com-  
12 missioner shall establish minimum benefit standards for the state  
13 comprehensive health plan and shall provide for the underwriting and  
14 administration of the state comprehensive health plan.

15 (b) A resident of the state is entitled to enroll in the state  
16 comprehensive health plan.

17 (c) The state comprehensive health plan shall provide for copay-  
18 ments and deductibles, and shall provide an annual limit on the total  
19 amount of copayments and deductibles for each enrolled resident and the  
20 covered dependents of the resident for each year. The annual limit  
21 shall be the same regardless of family size. ?

22 (d) The commissioner shall contract for the administration and  
23 may contract for the underwriting of the state comprehensive health  
24 plan. A contract entered into under this subsection shall be based on  
25 competitive bids and shall be for a three-year period.

26 (e) Notwithstanding the provisions of (c) of this section and the  
27 limitations in AS 18.27.020(b), an individual eligible for a permanent  
28 fund dividend under AS 43.23.010 may, to the extent of his eligibility  
29 under AS 43.23.010,

Kuzruk  
6

Trigg  
(Xomb)

Kuzruk  
don't cut  
dividend

1 (1) enroll in the state comprehensive health plan or in an  
2 individual health insurance plan certified under AS 18.27.020(a)(1);

3 (2) direct the commissioner of revenue to use as much of the  
4 permanent fund dividend to which the individual is entitled under  
5 AS 43.23.010 as is necessary to pay a cost of the individual incurred  
6 in participation in the state comprehensive health plan or in an indivi-  
7 dual health insurance plan certified under AS 18.27.020(a)(1).

8 Sec. 18.27.020. STATE HEALTH INSURANCE COST SHARING PROGRAM. (a)  
9 A resident of the state is entitled to cost sharing under the state  
10 health insurance cost sharing program if

11 (1) the resident is enrolled in the state comprehensive  
12 health plan or an individual health insurance plan which the insurance  
13 company has certified to the commissioner as equivalent to or exceeding  
14 the benefit standards of the state comprehensive health plan estab-  
15 lished by the commissioner under AS 18.27.010(a);

16 (2) the resident is not enrolled in a group health insurance  
17 plan or in a federal health plan; and

18 (3) the resident qualifies for cost sharing under (b) of  
19 this section.

20 (b) The commissioner shall pay the state share of the costs of  
21 health insurance incurred by a resident of the state and his covered  
22 dependents qualifying for cost sharing under the following formula:

23 (1) if the total adjusted gross income of the resident and  
24 his dependents is at or below 75 percent of the base income, 100 per-  
25 cent of the premium cost of health insurance;

26 (2) if the total adjusted gross income of the resident and  
27 his dependents is between 75 percent of the base income and 125 percent  
28 of the base income, a graduated percentage of the premium cost of  
29 health insurance between 100 percent and zero percent;

*Kugzruk -  
revis according  
to region*

1 (3) if the total adjusted gross income of the resident and  
2 his dependents is at or below 45 percent of the base income, 100 per-  
3 cent of copayments and deductibles;

4 (4) if the total adjusted gross income of the resident and  
5 his dependents is between 45 percent of the base income and 95 percent  
6 of the base income, a graduated percentage of the copayments and de-  
7 ductibles from 100 percent and zero percent;

8 (5) if a resident is enrolled in an individual health insur-  
9 ance plan certified to the commissioner under (a) of this section, the  
10 state share of the cost of health insurance for the resident is limited  
11 to the amount that the state's share would have been if the resident  
12 had been enrolled in the state comprehensive health plan.

13 (c) The commissioner shall adopt minimum benefit standards and  
14 guidelines for determining benefit equivalence for the certification of  
15 plans under (a)(1) of this section.

16 (d) Notwithstanding the provisions of an individual health insur-  
17 ance plan, a plan certified by an insurance company to the commissioner  
18 under (a)(1) of this section provides the minimum benefits and the  
19 equivalent benefits required for certification.

20 Sec. 18.27.030. DEFINITIONS. In this chapter

21 (1) "adjusted gross income" means the adjusted gross income  
22 of the resident determined under the regulations of the commissioner;

23 (2) "base income" means

24 (A) family median income for Alaska determined by the  
25 federal Office of Human Development Service; and

26 (B) regional adjustments established by the commis-  
27 sioner to the family median income for Alaska determined by the  
28 federal Office of Human Development Service which are based on  
29 relative costs of living in the state;

1 (3) "benefit equivalence" means that the benefits provided  
2 in an individual health insurance plan and certified to the commis-  
3 sioner under AS 18.27.020(d) are equivalent to benefits provided under  
4 the state comprehensive health plan;

5 (4) "commissioner" means the commissioner of administration;

6 (5) "copayment" means the portion of covered expenses pay-  
7 able by the resident after the deductible has been met;

8 (6) "insurance" means prepaid plans or indemnity plans.

9 \* Sec. 2. The commissioner of administration shall report by the 30th  
10 day of the Second Session of the Twelfth Legislature on

11 (1) proposed minimum benefit standards and estimated actuarial  
12 costs of the state comprehensive health plan (AS 18.27);

13 (2) the anticipated number and characteristics of participants in  
14 the state health insurance cost sharing program (AS 18.27.020) and the  
15 projected cost to the state;

16 (3) a proposed plan for

17 (A) implementation of AS 18.27;

18 (B) eligibility determinations under AS 18.27; .

19 (C) payment of the state share of premium costs and copay-  
20 ment and deductibles incurred under AS 18.27; and

21 (D) informing the public of benefits under AS 18.27;

22 (4) recommendations for amendments to AS 18.27.

23 \* Sec. 3. Coverage under the state comprehensive health plan (AS 18.27.-  
24 010) and the state health insurance cost sharing program under AS 18.27.020  
25 begins on July 1, 1982.

26 \* Sec. 4. AS 21.54.060 is amended by adding a new paragraph to read:

27 (7) under a policy issued to the state to insure residents  
28 of the state under AS 18.27.

29 \* Sec. 5. AS 39.30.090(1) is amended to read:

1 (1) A group insurance policy shall provide one or more of  
2 the following benefits: life insurance, accidental death and dismem-  
3 berment insurance, weekly indemnity insurance, hospital expense insur-  
4 ance, surgical expense insurance, dental expense insurance, audio-  
5 visual insurance, alcoholism and drug dependency insurance, or other  
6 medical care insurance.

7 \* Sec. 6. AS 39.30 is amended by adding a new section to read:

8 Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a)

9 The group insurance policy under AS 39.30.090(1)

10 (1) shall provide coverage for alcoholism and drug depen-  
11 dence to include

12 (A) inpatient detoxification benefits for not less than  
13 14 days of benefit each calendar year in a state-approved treat-  
14 ment facility or licensed hospital; payment of institutional and  
15 professional benefits shall be equal to and payable as any other  
16 covered condition, except a covered condition which, by the terms  
17 of the policy, has an internal restriction;

18 (B) inpatient treatment coverage benefits for not less  
19 than 30 days of benefit each calendar year in a state-approved  
20 treatment program; payment of institutional and professional bene-  
21 fits shall be at the same level as any other covered condition,  
22 except a covered condition which, by the terms of the policy, has  
23 an internal restriction; and

24 (C) outpatient treatment coverage benefits of not less  
25 than 30 visits each calendar year if treatment is provided by a  
26 licensed physician, state-approved treatment program, or state-  
27 certified professional substance abuse counselor; coverage shall  
28 include individual, family or group therapy; benefits shall be  
29 paid at least 75 percent of the usual, customary and

Kuzruk  
29 Feb  
with  
this

1 reasonable charge for a medical procedure, treatment or service in  
2 the geographic area;

3 (2) may not exclude dependents otherwise covered and may not  
4 limit coverage for alcoholism or drug dependence because of age, sex or  
5 state of illness;

6 (3) may not apply preexisting or named condition exclusions  
7 to deny coverage for alcoholism or drug dependence; and

8 (4) may require a physician's certification of necessity as  
9 a condition of payment for alcoholism or drug dependence treatment.

10 (b) The provisions of this section apply to group health insur-  
11 ance contracts and group service or indemnity type contracts issued to  
12 provide coverage for employees of the state and may apply to contracts  
13 for the benefit of employees of other participating governmental units  
14 only if the governing body of the governmental unit elects to have the  
15 provisions apply.

16 (c) In (a) of this section,

17 (1) "alcoholism" means an illness or condition characterized  
18 by the habitual lack of self control in the use of alcoholic beverages,  
19 or use of alcoholic beverages to the extent that health is substantial-  
20 ly impaired or endangered, or social or economic function is substan-  
21 tially disrupted;

22 (2) "drug dependence" means the condition of being physi-  
23 cally or psychologically addicted to an opiate, opiate derivative,  
24 tranquilizer, amphetamine, barbiturate, or similar substance, but  
25 excluding nicotine, caffeine and alcohol;

26 (3) "state" means any state in the United States and in-  
27 cludes the District of Columbia.

28 \* Sec. 7. AS 39.30.100 is amended to read:

29 Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-

1 30.090]

2 (1) "eligible employee" means

3 (A) an employee who has served in permanent full-time  
4 or part-time employment with the same governmental unit for 30  
5 days or more, except an emergency or temporary employee, and

6 (B) an elected or appointed official of a governmental  
7 unit, effective upon taking the oath of office;

8 (2) "governmental unit" means the state, a borough, municipi-  
9 pal corporation, or other political subdivision of the state, and the  
10 North Pacific Fishery Management Council;

11 (3) "insurance", "insurance carrier" and "insurance policy"  
12 include health care services, health care service contractors and con-  
13 tracts.

14 \* Sec. 8. The provisions of secs. 5 - 7 of this Act apply to group poli-  
15 cies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and  
16 which are delivered, issued for delivery, or renewed in this state after the  
17 effective date of this Act. A policy or contract providing coverage for  
18 eligible employees in this state under AS 39.30.090 - 39.30.100 delivered,  
19 issued for delivery, or renewed after the effective date of this Act provides  
20 the minimum coverage required by this Act even if the language of the policy  
21 or contract does not specifically so provide.

22 \* Sec. 9. AS 47.05 is amended by adding new sections to read:

23 Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CON-  
24 TRACTS. (a) The commissioner shall use medical assistance funds to  
25 purchase and pay premiums on policies of insurance or pay the expenses  
26 on health care service contracts that provide one or more of the ser-  
27 vices available under state medical assistance programs.

28 (b) The policy of insurance or the contract financed under this  
29 section must guarantee to

1 (1) provide services and supplies under policies of insur-  
2 ance or contracts under AS 21;

3 (2) provide the statistical data, records, and reports  
4 relating to the provision, administration, and costs of providing  
5 services and supplies as required by the commissioner.

6 Sec. 47.05.080. IMPLEMENTATION. The commissioner shall implement  
7 the provisions of AS 47.05.070 when he determines that comparable  
8 benefits are available at equal or less cost than direct payments by  
9 the department to the providers of services and supplies.

10 Sec. 47.05.090. INTERIM PAYMENT. If the commissioner determines  
11 under regulations adopted by him that a provider of medical services is  
12 expected to serve a large volume of medical assistance clients, he may  
13 make an interim payment before receipt of billing for services to the  
14 provider.

15 Sec. 47.05.100. INTEREST ON LATE PAYMENTS. When presented by a  
16 provider of medical services with a clean claim, the commissioner shall  
17 pay

18 (1) interest at the rate of one percent per month when  
19 payment is delayed more than 45 days after presentation of the clean  
20 claim;

21 (2) interest at the rate of two percent per month when  
22 payment is delayed more than 90 days after presentation of the clean  
23 claim; and

24 (3) the interest for a full month if the overdue clean claim  
25 is not paid by the 15th day of a calendar month.

26 Sec. 47.05.110. DEFINITIONS. In AS 47.05.070 - 47.05.110

27 (1) "clean claim" means a claim for payment which can be  
28 processed without obtaining additional information from the provider of  
29 the service or from a third party; it includes a claim with errors

1 originating in the department's claims processing system, but does not  
2 include claims from a provider who is under investigation for fraud or  
3 abuse, or a claim under review for medical necessity;

4 (2) "commissioner" means the commissioner of health and  
5 social services;

6 (3) "health care service contract" means a contract with a  
7 nonprofit corporation which accepts prepayment for health care services  
8 and is sponsored by or associated with a group of physicians or a group  
9 of hospitals or both or by a health maintenance organization recognized  
10 under federal law;

11 (4) "medical assistance" means Medicaid (AS 47.07), general  
12 relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and  
13 crippled children's and maternal and child health programs (AS 18.05.-  
14 010).

15 \* Sec. 10. AS 47.07.020(b) is repealed and reenacted to read:

16 (b) A resident of the state for whom the provisions of the Social  
17 Security Act in effect on March 1, 1981, allow optional medical cover-  
18 age qualifying for federal financial participation is eligible for  
19 medical assistance. A resident of the state qualifying as medically  
20 needy is not eligible for medical assistance.

21 \* Sec. 11. AS 47.07.030 is repealed and reenacted to read:

22 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical ser-  
23 vices to be offered to eligible persons include those services eligible  
24 for federal financial participation under the provisions of Title XIX  
25 of the federal Social Security Act in effect on March 1, 1981.

26 \* Sec. 12. AS 47.07.080 is amended by adding new paragraphs to read:

27 (5) "medically needy" means a person who meets the categori-  
28 cal requirements of eligibility for medical assistance but whose income

29 (A) exceeds the income standard for categorical assist-

1           ance; and

2                   (B) is less than the medically needy income standard  
3           after the deduction of allowable medical expenses;

4                   (6) "categorical requirements of eligibility" means the  
5           standards established under 42 C.F.R., secs. 435.500 - 435.541;

6                   (7) "medically needy income standard" means the standards  
7           established under 42 C.F.R., secs. 435.800 - 435.816.

8       \* Sec. 13. (a) By the 30th day of the Second Session of the Twelfth  
9       Legislature the Legislative Council shall study and make recommendations to  
10      the legislature

11           (1) for federal improvements in the Indian Health Service  
12      delivery system;

13           (2) on the alternatives available to the state to complement the  
14      funding of the Indian Health Service;

15           (3) on the alternatives available to the state to complement  
16      services available to the senior citizens of the state under Medicare.

17      (b) The Legislative Council shall seek participation in the study by

18           (1) the Health, Education, and Social Services Committees of the  
19      legislature;

20           (2) the Alaska Native Health Board;

21           (3) regional health organizations;

22           (4) other providers and consumers of health care;

23           (5) the Department of Health and Social Services;

24           (6) the Alaska Area Native Health Service, United States Public  
25      Health Service.

26      \* Sec. 14. AS 47.07.020(d) is repealed.



# NORTON SOUND HEALTH CORPORATION

Testimony to HESS Committee

by

Nancy M. Mendenhall, Community Health Services Director

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11/7/81

Thank you for the opportunity to testify at this hearing. I will address two areas of health care delivery today: Dental Services and Eye Care. *To this date both have been funded through our contract w/ IHS, have never actually met the need.*

Eye Care services in the region presently are very limited. Norton Sound Health Corp. employs a trained Eye Care technician who is able to do refractions for eye glasses, eye glasses repair, some eye disease screening. She maintains an office in Norton Sound Hospital and makes her services available to the public in Nome. People pay for the actual purchase of the glasses themselves. She also assists ophthalmologists who come to Nome to do speciality clinics.

There are two serious problem with this service delivery which we are going to be unable to resolve using I.H.S. money. First, being a one person office, with the loss of her CETA assistant this year, she is unable to keep up with the need here in Nome and is beginning to experience a back log of patients. Second, she ~~and~~ the PHS ophthalmologists are scheduled to travel to each of the 15 outlying communities of the region only once a year.

This year, there is a strong possibility that area office IHS staff will not be able to cover their share of the villages, which is normally one half.

This would leave some villages without eye services for the year. As you are probably aware, there is a lot of need for vision correction in Arctic Alaska. We are especially concerned about the effect of budget reductions on services to school children. The technician has already informed us that if she has no assistant next year, she will be unable to cover school screening on her trips to the villages. This function can be covered by P.H.Ns but expansion of state eye services to outlying communities to include eye glass refractions would appear to be a very needed function soon.

Another area of even more critical concern is dental disease. Norton Sound Board of Directors recognizes dental disease as one of our major health problems, and it is an established fact which Norton Sound acknowledges that we are falling behind in the larger villages in our attempt to overcome this health problem.

Norton Sound provides that each village in the region is visited ~~one~~ or twice a year, either by our own PHS dentists or by private dentists which we contract to cover PHS eligible patients. This field trip is of one week duration in the smaller villages, two weeks in the larger. Because of size, nine of our villages get only a one week trip once a year. Our budget will not permit more than this. Some villages attempt to supplement the days by contributing to dentists' per diem costs from their own city accounts. The two weeks allowed to the larger villages is not enough to cover the extent of disease, and the dentists report that in some sites the condition of childrens teeth is getting worse not better. Many children by the time they reach school age have not a usable tooth left in their head.

The present benefits offered through our IHS contract have been: general routine care to recipients under 20 years of age, but no dentures or other prosthetics; this plus prosthetics to medicaid eligible over 55 years or under 20; emergency care only to other adult recipients.

Two private dentists reside in Nome who can provide dentures at market cost, but this is extremely expensive, out of reach for most village families, when you consider the travel costs involved in getting this prolonged work done.

This fall for the first time we are opening up our benefits to include non-emergent routine care to adults on a cash market-price basis. The purpose is to try to do more to get the maintenance level up. However, many families will not be able to afford this, and the village trips will still be limited to the one or two a year.

Another effort by NSHC has been in the area of prevention, specifically fluoride treatments, which are managed through the health aide program. But much more needs to be done in the way of dental education and prevention. For the last year Norton Sound has employed a dental hygienist whose position is presently on the budget "cut list". The person attempts to work with patients directly and with Nome schools, but has no travel funds for village work.

Clearly dental services to remote communities is an area of health which the state needs to involve itself immediately in, with the contraction of services by Indian Health Services threatened. I.H.S. has never met the need even in its better funded days.

A need implied in my comments on dental and eye care needs is a third serious area of deficiency which we face in the reduction of our IHS Contract, and this is patient travel costs. The average one way fare from a village into Nome for treatment at our hospital is \$75.00. For the last four years we have asked the patient to pay one way while NSCH picks up the return trip. We are now looking at the very real possibility that NSHC may not be able to cover this half of the travel costs. For most families this type of expense will be difficult and may result in them delaying necessary treatment. A similar situation prevails in travel between NSBH and ANS in Anchorage, in which case we pay one way and ANS the other. ANS informs us as of this week that they will not be able to cover their half except in emergency cases, and as stated above, we will have the same problem.

In order for rural populations to have equity of access to health services with urban populations, it may be necessary for the State to consider subsidizing travel costs to medical facilities.

Thank you for considering this testimony.

RECEIVED 11-7-81  
CHISHAM

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FORATION

COMPREHENSIVE ALCOHOL PROGRAM (CAP)  
PUBLIC TESTIMONY ON HEALTH CARE

7 November 81

The Comprehensive Alcohol Program (CAP) recommends that in all considerations before the Senate Committee concerning Health Care that persons suffering from alcoholism or other medical conditions arising from alcohol abuse be given equal treatment as a patient presenting symptoms of any other disease. This includes the availability and accessibility of services, health planning (HSA), and prevention and education information.

We specifically request that the treatment of alcohol and drug abuse not be considered as a separate issue in House Bill 41. The State Comprehensive Health Plan as described in HB41 appears to be meant for all eligible Alaska residents who wish to enroll. We would like an explanation of two specific items:

- page 5      Why is there a separate section dealing specifically with alcohol and drug abuse?
- page 6      Why does this section appear to be meant for only state employees?

In this remote area of Alaska alcohol is the major contributing factor to a series of illnesses, diseases, and injuries which, as a whole, is the number one public health problem for our population. In addition to alcoholism as a disease and the related diseases such as liver cirrhosis, pancreatitis, gastric ulcers, and the like, there are many debilitating illnesses which are brought about or worsened by alcohol abuse. Further, there are almost no violent crimes and assaults in this area which are not alcohol related. There is child abuse and neglect and spouse battering which damages both bodies and minds.

The philosophy of CAP is that alcoholism is a treatable disease. It is our opinion that cultural stress plays a significant role in the causal factors of alcoholism in the Norton Sound and Bering Straits region of

northwest Alaska. We believe that prevention is the highest level of alcohol abuse treatment and, therefore, emphasize concentrating efforts on a strong foundation of alcohol abuse prevention education. Included in our philosophy is a belief that a health systems approach is critical to the solutions desired in the area of alcohol abuse as it affects our region. Planning must be at the least regionwide and long-term, wherein the whole rather than the individual is stressed.

In 1956 the American Medical Association recognized alcoholism as a disease process. Like heart disease it can be triggered and worsened by an unhealthy lifestyle; unlike heart disease persons with alcoholism are often denied equal medical treatment as if the disease were a moral or character weakness. In 1965 the American Psychiatric Association issued a statement which included reference to the fact that general medical and psychiatric facilities commonly discriminate against the patient with alcohol problems:

"Such meager services as they do render are offered in a spirit of therapeutic pessimism. What is needed are properly equipped and adequately staffed wards prepared to offer prompt and adequate treatment of acute and chronic physiological, psychological, and social disturbances associated with alcohol problems, and all of this in close collaborative relationship with other community agencies concerned with the management of such problems. The principle of a continuum of services in the community applies here as well as to other disorders.

All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seek treatment in medical settings on the same basis as for other illnesses."

It is the CAP position that this is as true today in 1981 "lush" Alaska as it was sixteen years ago.

Overview of the Horton Sound CAP Project

The Horton Sound CAP is a department of the regional health corporation. It is funded almost entirely through a state grant with some in-kind match and cash grants from the city and the health corporation for other components of the project. The services are comprehensive and include emergency care, medical detoxification, intermediate care at a residential treatment center, outpatient services through the community mental health agency, outreach through the women's shelter and the court-referral program, village coordination and technical assistance program, aftercare, and consultation and education.

There arises the question of what model to adopt to measure success. Keeping in mind the disease process of alcoholism and the many interrelated factors, it becomes evident that the recovery process is also complex. Recovery from alcoholism or other alcohol-related health conditions must be accomplished with a change in lifestyle. In this part of Alaska if a person is to learn to abstain from or reduce alcohol consumption he must learn to do it in what was, at the height of the illness, an alcohol-filled environment. A person recovering from heart disease learns to eat healthier foods, seek less stress-filled employment, get routine medical checkups, quit smoking, and so forth. Similarly, the recovering alcoholic or alcohol abuser must build these healthier changes into his treatment plan. The heart patient sometimes has relapses, sometimes eats unhealthy food, sometimes sneaks a cigarette, sometimes indulges in stressful situations. The recovering alcoholic also relapses during the recovery process. Such relapses are predictable, are measurable, and should be considered in designing an evaluation model.

At Horton Sound CAP we believe that not all persons suffering from alcohol problems have the same affliction; however, we do believe that for those who have progressed to the stage of alcoholism, drinking alcohol is contraindicated. Therefore, for such persons success can be measured in increasing periods of sobriety between relapse until a state of relative "remission" is reached (most researchers tend to believe that to reach this state is a two- to three-year process). Other ways of measuring successful client outcomes include increased quality of life, better financial status, ability to seek and maintain employment, and the like.

For persons who have alcohol problems less severe, success can be measured in improved health, lowered consumption, better quality of life, improved attitudes. Ideally we will deliver services and health care for all patients with alcohol-related problems in a setting as close to their own environment as possible. In our case this means acute care at the regional hospital, intermediate care at the regional treatment center, aftercare at the village level or local level for Home residents. We tabulate patient contacts and operate on the principle of a continuum of services. If we can show ever-increasing levels of professionalism for our service providers, increasing hours of patient contact, better results from medical exams, increasing days of employment for active clients, positive reports from significant others in the clients' lives--we consider these to be measures of success which will ultimately move us toward the goal of reducing alcohol abuse in the region and thereby reduce the physiological, psychological, and social problems which it causes.

These physical and mental health care services attack only half of the cycle of alcohol abuse. The balance is education and prevention. Recovering alcoholics are sober role models and therefore treatment is needed for those suffering. Education is needed to remove the myths, teach coping skills for those in alcohol abusing situations, to reveal equally enjoyable alternatives to abusive drinking, and so on. Prevention can take many forms, and limiting availability is a significant one. This is something that the local option laws are addressing, as is other legislation enacted or under consideration, such as sanctions for serving inebriates and efforts to shorten serving hours for licensed premises.

We believe that money being filtered into "bush" programs such as ours is being carefully and frugally managed. We recommend that such "bush" programs be allowed to develop evaluation models unique to rural Alaska which will give the interpreters a truer picture of the progress being made with regional projects.

Submitted by:

*Constance L. Hollenbeck*  
Constance L. Hollenbeck  
Acting CAP Director



# NORTON SOUND HEALTH CORPORATION

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## Status of Water Projects

### Horton Sound Area

November, 1981

1. NOME: Year of last water project: Summer, 1981
  - Complete Water & Sewer System
  - Received +\$4 million for connecting existing housing units to city water and sewer
  - Existing sewage treatment plant is undersized and is presently being by-passed; discharging raw sewage into Snake River.
  - No plans for enlarging sewage treatment plant
  - Utilizes honeybucket haul service and water delivery
  - Community landfill and an aluminum recycling program
  - Plans to construct causeway at mouth of Snake River. May extend sewage discharge pipe along causeway for ocean disposal.
2. UNALAKLEET: Year of last water project: 1981
  - Complete Water & Sewer System (\$35/mo/home)
  - 30 new housing units present being connected
  - Community landfill
3. SAVOONGA: Year of last water project: 1980
  - Watering Points (3) and washeteria
  - Planning for a community landfill and honeybucket disposal site
  - City developing a water delivery and honeybucket disposal service
  - DIA operates and maintains pumpouse facility
  - Well source
4. GAMBELL: Year of last water project: 1980
  - Watering point and washeteria
  - (4) 4 kw-wind generators; inoperable
  - Shallow well (REAA H. School and washeteria and spring gallery (watering point) sources
  - Replaced gallery transmission line-summer, 1980

Gambell (cont)

- gallon steel water storage tank
- REAA feels that the H. School is not provided with an adequate water supply
- Fenced-in community landfill
- Community honeybucket waste disposal bunkers
- City to receive grant money for purchasing 3 windchargers
- Possible lead problem in H. School water system; recheck chemical samples will be collected to verify

5. SHISHMAREF: Year of last water project: 1977

- Watering Point
- Fill and draw system; pond source
- 300,000 gallon steel water storage tank
- REAA planning to construct new elementary school and swimming pool/ fire reservoir
- 16 HU housing units to be constructed - 1982
- PHS planning to upgrade existing water system
- REAA H. School presently utilizes half of community stored water supply
- City developing garbage pickup service
- Individual honey bucket disposal
- Community open dump
- New runway to be constructed - 1982
- REAA conducting feasibility studies for developing conceptual designs for new community sanitation facilities
- Residents do not utilize existing water system due to objections of the reservoir adjacent to the cemetery
- Proposal submitted for an erosion control project
- Proposal submitted for landfill equipment
- Was placed on the VSW priority list for improvements to existing water system. Was placed 7th on the PHS priority list for regular projects

6. STEBBINS: Year of last water project: 1981

- Watering point and washeteria
- Fill and draw system; pond source
- 500,000 gallon steel water storage tank
- 3.5 miles P.E. transmission water line
- New REAA H. School to be completed - 1982
- REAA to provide additional water storage for H. School
- PHS planning renovations to existing system - 1982
- CIA school does not drink school well water due to oil contamination
- City desires summer water line
- No primary water operator
- Has placed 11th on the PHS priority list for regular projects

7. ST. MICHAEL: Year of last water project: 1981

- Watering point
- Fill and draw system; pond source
- 3.5 mile 4" aluminum transmission line
- 400,000 gallon steel water storage tank under construction (VSW & PHS)
- EIA school connected to existing pump house; 100,000 gallon steel water storage tank.
- City submitted DEC application for community landfill and road development
- Lead problem in BIA school water system

8. ELIM: Year of last water project: 1981

- Complete water and sewer; spring gallery source
- Presently connecting 35 new housing units
- Sewage treatment plant being replaced with dual community septic tank systems
- City decided against a washeteria facility due to financial problems in 1980
- Community landfill site location under study by PHS
- City submitted grants for purchase of heavy equipment for road and landfill maintenance purposes
- City submitted grant for bulk fuel storage tanks

9. TELLER: Year of last water project: 1981

- No community water system
- City summer water haul service; Blueston River - 18 mi.
- Individual solid waste and honeybucket disposal
- REAA school well brackish; utilize hauled water for drinking purposes. No additional water storage
- Teller townsite located in flood plain
- REAA school district proposing to construct a one million gallon community water storage tank.
- PHS developed a watering point for new site. Marginal source due to freezing over of creek
- Placed as top priority on both the VSW & PHS priority lists

10. KOYUK: Year of last water project: 1981

- Watering point and washeteria - completed fall '81
- Well source - 90' deep
- Fenced-in community landfill disposal site
- Honeybucket disposal bunkers filled with water - useless
- Summer water distribution line
- DEC funded 4 x 4 truck for community garbage pickup service

11. SHAKTOOLIK: Year of last water project: 1980

- Watering point and washeteria
- Fill and draw system; creek source
- 2.5 mile transmission line

### Shaktoolik (cont)

- 800,000 gallon steel water storage tank
- REAA Elementary and H. School utilize community source
- Received emergency state funds Fall '81 due to backup of septic tank system for washeteria
- Tank did not get re-filled for this winter. Water to H. School was consequently cut off.

### 12. BREVIG MISSION: Year of last water project: 1979

- No existing community water system
- Watering point/washeteria facility destroyed by fire - Jan. 1980
- No water system for the REAA H. School
- REAA school district proposes to construct a community water system
- Extent of construction unknown. May receive additional funding from state.

### 13. WALES: Year of last water project: 1979

- Community washeteria and watering point
- Residents haul water from creek in summer; do not utilize watering point
- Individual garbage and honeybucket disposal
- Poor O & M of existing system
- Gallery water source

### 14. WHITE MOUNTAIN: Year of last water project: 1982

- Community washeteria and watering point under construction - PHS & VSW
- Well source
- 16 HUD housing units to be constructed - 1982

### 15. GOLOVIN: Year of last water project: 1979

- Community washeteria and watering point
- Fill and draw system; creek source
- 10,000 foot water transmission line
- 15 HUD housing units to be constructed - 1982
- 300,000 gallon wood-stave tank; residents complain of faulty tank: leaks
- Operation and maintenance of system unreliable; system has frozen almost every winter since its completion in 1977
- Fish Co-op utilizes existing system in summer months
- No trained water operator
- REAA H. School has no water system
- Community to be provided electricity - '82
- REAA submitted a budget for a community water system. Extent of construction activities unknown.
- BIA school well brackish; school utilizes hauled water for drinking purpose
- Residents utilize hauled water; do not trust quality of community water
- PHS is planning on renovating existing water facility in conjunction with new housing

16. DIOMEDE: Year of last water project: 1973-74

- Community watering point
- 150,000 gallon wood-stave tank; spring source
- BIA operates and maintain water system in return for water usage
- Existing tank undersized for both community and school usage
- Old summer transmission line and tank needs repairing
- New REAA H. School to be constructed - 1982
- REAA proposes a horizontal storage tank; size of tank unknown
- Washer, shower, and drier facilities available in the BIA school for community use

17. COUNCIL: Year of last water project: 1978

- VSW watering point
- Wind generator - presently inoperable
- Well source

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September 8, 1981

Enclosed is a paper put together by a committee of rural/bush mental health program directors. It is a beginning attempt to look at rural/bush mental health issues and needs and to come up with a plan for service delivery and outcome indicators.

This paper will be presented by one of our committee members at the Governor's Advisory Council meeting on September 25th. Rural program directors will attend this meeting and are willing to engage in a work session with the Council if they are interested.

We recognize that this is just a beginning effort toward the accomplishment of the goal of developing a solid, effective plan for rural mental health services through activities that can be quantified and assessed.

Your comments and suggestions would be appreciated.

Sincerely,

Nettie D. Scott, M.S.W.  
Clinical Director

COMMUNITY MENTAL HEALTH IN RURAL ALASKA

## INTRODUCTION

In response to a request from the Governor's Mental Health Advisory Council, the rural Community Mental Health Center (CMHC) directors met to formulate a statement defining and describing rural/bush services and service delivery models. The committee consisted of the following CMHC program administrators: Nettie Scott, Susan Soule, Daniel Bill, Jeff Friedman, Boy Collier, Sharon Walluk, Evelyn Wiszinckas, and Michael Graf. The document is an attempt to identify specific issues and circumstances common to Alaska's rural and urban community mental health programs. It is hoped that this document will be adopted by the Council and the Division of Mental Health in developing orientation materials, in establishing funding criteria, in developing a more meaningful management information system format, in evaluating program effectiveness, and in preparing statewide planning documents.

## MISSION STATEMENT

Community mental health programs in Alaska should provide a broad range of locally determined mental health services. These services should be accessible, responsive, adaptive, and should be founded upon a service philosophy, plan, and delivery system based upon local need. They should promote the well-being of the larger community, the family and the individual.

Planning, monitoring, and evaluating programs and services require criteria broad enough to encompass the various social and cultural contexts in which services are to be delivered, yet specific enough to provide clear direction. Following is a description of common rural community characteristics and a comprehensive listing of program functions, applicable not only to the rural program, but to more urban programs as well.

## CHARACTERISTICS OF SMALL COMMUNITIES

Small Alaskan communities have important characteristics which differ substantially from those of larger urban settings. These characteristics are not totally unique to rural communities and exist to a lesser extent in urban areas. In rural communities, because they predominate, they play a large role in program development, service delivery, and overall program activities. These characteristics derive from the healthy need of a small community to survive independently and they are necessary and adaptive in allowing the small community to sustain itself. The generalized conservatism associated with these characteristics imposes certain unique demands on any program which has potential impact on the social structure and social functioning of the community. Some of these characteristics are:

1. A conservative social system in which there is a slowness to accept new persons and new ideas in the community.
2. A sense of tradition and resistance to rapid change.
3. An investment of trust in individuals rather than in roles or agencies.
4. Homogeneity of life, people, activities and expectations.
5. A special relationship to the physical environment which may include a benign acceptance of natural phenomena.
6. A discrepancy between realistic lifestyle options of a small community and expectations aroused by exposure, often only media exposure, to urban styles and options.
7. Problems of transportation, communication, unavailability of materials, as well as the inaccessibility and high cost of goods and services.
8. A lack of employment opportunities.
9. No anonymity.
10. The ethic and historical necessity of community, familial and individual self-reliance.

Some of these general characteristics have clear implications for the acceptance of mental health services and interact with a variety of other specific characteristics, which include the following:

1. Conflicting and unclear expectations about services.
2. Frequently realistic expectations, based upon experience, that service may be erratic and providers transient.
3. Confusion about, and distrust of, mental health providers, agencies, and government organizations, based in part on past experience.
4. A proportionately greater stigma associated with the use of mental health services.
5. A lack of comprehensive or specialized services within the community or region.
6. Relative lack of access to services outside of the community or region.
7. Insufficient population to support community, district or regionally based specialized services.

8. A benign acceptance of physical phenomena which may be extended to a similar acceptance of human events.
9. A high tolerance for individual differences and eccentricities.
10. Confidentiality as an intensely significant issue in small communities where personal privacy is rare.

Culture-specific factors play a large part in determining the necessities of program style, goals, objectives, and activities. Rapid cultural change has led in some communities to factors including:

1. An erosion of traditional support systems.
2. Lowered self-esteem.
3. An attitude of learned dependency.
4. Changing attitudes toward both cash and subsistence economies.
5. Difference in language and in communication styles.
6. Identity confusion.
7. Shifting child-rearing practices.
8. Ambivalence and conflict about competition and individual achievement.

A rural CMHC service delivery system must be sensitive to characteristics inherent to the populations served. Population and area-specific characteristics create a particular set of needs and a particular climate, which, although not necessarily unique, require a variable degree of emphasis on locally determined approaches.

#### A RURAL MENTAL HEALTH DELIVERY SYSTEM

The achievement of CMHC goals in rural and bush areas is directly dependent upon the extent to which program development and activities are responsive to community characteristics. These communities lack specialty services, put little faith in roles or agencies, admit new people only after a period of trial and observation. These are culturally distinct populations. They resist rapid cultural change and embrace attitudes and values which differ substantially from those common to urban America.

Such communities will neither use nor likely benefit from a case-oriented urban service model. They demand instead a community-oriented, personal-involvement approach. The community itself is the object of intervention.

The intervenor to a large extent is not a program or an expert, but an individual. Resistance to case-oriented treatment typically stems from:

1. Mistrust of professionals and outsiders.
2. Unclear expectations about services to be provided.
3. Stigma associated with the use of mental health services.
4. The ethic of self-reliance
5. The tendency to accept as natural events that in other environments would provide motivation for change.
6. An intense fear of gossip.

Further, the traditional case oriented model relies to a greater or lesser extent on the client's ability to develop new support systems and new patterns for spending time. A small rural community where destructive patterns of living may be community-wide phenomena does not readily offer new, positive support systems nor a wide variety of ways to spend time. Out of this latter characteristic comes the need for the community itself to be the object of intervention.

Finally, the mistrust of professionals, programs and persons from outside the community, coupled with the homogeneity of life, people and activities within the community leads to the need for the intervenor both to work at a personal level and to make efforts in terms of his or her own life-style to become a community member both in actions and in understanding.

Both in terms of adequate local client treatment and the prevention and reduction of "casualties", effective community interventions are clearly the treatment of choice. This requires not that rural CMHCs ignore the full range of accepted services, but that a priority be given to the development and maintenance of village networks, advocacy of healthy attitudes and behaviors, and other interventions. Because of the complex variables involved in this social and cultural milieu, this method of intervention requires a proportionately higher expenditure of time as compared with the more traditional case services. It should be stressed that rural programs, while providing some individual case services, cannot be expected to fit or to evolve into an urban-style delivery system.

Numerous factors must be taken into account in the delivery of

rural services. Some of these factors are:

1. The program and its personnel must be prepared for a lengthy period of community scrutiny before being accepted. This process will be repeated with each change in program personnel.
2. Both the program and its personnel are faced with the task of offering diverse services. Although such services may or may not be typically regarded as community mental health services, they are critical to the ultimate acceptance of the program.
3. Service delivery must be informal and flexible if it is to succeed.
4. Professional staff members, particularly directors of one-person programs, must be willing and capable of accepting roles which include the following: visible and involved community member, outreach worker, broker, advocate, teacher, behavior changer, mobilizer, data manager, administrator, fiscal and personnel manager, secretary, grants-writer and grants manager, janitor, public relations officer, caregiver, community planner, consultant, and model.
5. The professional must be willing to develop and utilize both formal and personal community relationships as vehicles for change.
6. Professional and program staff must be capable of maintaining an effective program despite minimal ancillary services and limited levels of personal, social and material resources.
7. Program personnel must be prepared to cope with the length of time required to develop community relationships and the delays inherent in delivery of services on an itinerant basis.

#### RURAL COMMUNITY MENTAL HEALTH CENTER FUNCTIONS

Thus far, a descriptive set of community characteristics and factors has been presented which impinge upon community mental health program development. The nature of the situation in rural communities dictates the performance of certain service activities. The proportion of energy devoted to each activity varies according to the nature of the communities served as well as the program's current stage of development. For example, rural centers will devote more time to some activities than will urban centers.

Chart 1 on Page 6 graphically displays some of these differences in terms of the stage of development of a rural

CHART 1

AN ESTIMATE OF PROPORTIONATE PROGRAM EFFORT BY PROGRAM FUNCTION

Program Function	W E I G H T									
	1	2	3	4	5	6	7	8	9	10
Visibility	**** +++ #####	**** #####	**** #####	**** #####	**** #####	**** #####	**** #####	**** #####	**** #####	**** #####
Outreach	**** ++++ #####	**** #####	#####							
Brokerage/ Advocacy	**** ++++ #####	++++ #####	#####	#####	#####					
Assessment/ Evaluation	**** ++++ #####	**** ++++ #####	++++ #####	++++ #####	++++					
Teaching/ Educating	**** ++++ #####	**** #####	**** #####	**** #####	**** #####	****	****			
Community Re- sources Alter- natives Devel.	**** ++++ #####	**** #####	#####	#####	#####	#####	#####			
Consultation	**** ++++ #####	**** ++++ #####	**** ++++ #####	**** ++++ #####	**** ++++					
Direct Services	**** ++++ #####	**** ++++ #####	**** ++++ #####	++++ #####	++++ #####	++++ #####	++++	++++	++++	++++
Data Management	**** ++++ #####	**** ++++ #####	**** ++++ #####	++++ #####	++++					
Administration	**** ++++ #####	**** ++++ #####	**** ++++ #####	**** #####	**** #####	**** #####	**** #####	**** #####	**** #####	**** #####

KEY:   \*\*\*\* New Program - Rural  
       ++++ Urban Program  
       ##### +5-year Stage Rural Program