ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1439 SHESS 1981 INTERIM: NOME 11/7/81

program and in comparison with a typical urban mental health center.

The functions that follow are presented not as an exhaustive listing of all possible service activities, but rather are a set of common CMHC functions. These CMHC functions include:

1. Outreach: Identifying and making purposeful contacts with people in need of mental health services.

2. Brokerage and Advocacy: Facilitating access to and usage of existing services; actively pursuing appropriate services, policies, rules and regulations; advocating and modeling healthy values, behaviors, attitudes and decisions. At times this may include such activities as assisting with tax and other business forms, filling grocery orders, etc.

3. Assessment and Evaluation: Assessing individual, family, and community needs, and providing evaluation services.

4. Teaching and Education: Providing a range of instructional and informational services. This includes developing and training local resource persons.

5. Community Resources/Alternatives Development: In collaboration with other community groups planning and developing needed programs and services; insuring the local availability of recreational, vocational, educational, and cultural activities and alternatives; promoting networking.

6. Consultation: Providing technical input to other providers and agencies concerning problems, needs, and programs.

7. Direct Service Provision: Providing counseling, psychotherapy, crisis intervention, and supportive services to identified persons and groups in need, sometimes of necessity such services are provided on an informal basis in an informal setting.

8. Data Management: Performing all aspects of data handling, gathering, tabulating, analyzing, and program monitoring.

9. Administration: Activities aimed at maintaining the agency or institution rather than activities directed to community or client services.

10. Visibility/Acceptability Promotion: Advertising the availability and promoting the acceptability of mental health services in the community through highly visible physical presence in the community, newletters, sponsorship of community functions and active participation in community life, not limited to professionally-related activities, etc.

PROGRAM MONITORING

The existing procedures for program monitoring do not adequately reflect what rural programs do, why they do it or how they do it. The following breakdown is a beginning effort at re-thinking one of these measures--the staff log. A workable, realistic procedure for program monitoring will require effort on the part of Division staff and program directors if the format is to be equitable to both rural and urban efforts.

A Categorical Break-Down by Service Function
For Reporting and Measurement

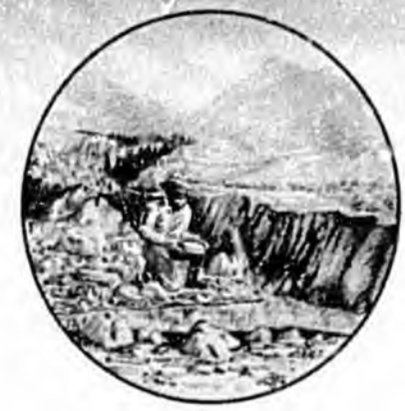
I. Services
   - A. Community-Oriented
     1. Community Resources/Alternative Development
   - B. Client/Community
     1. Evaluation
     2. Teaching/Education
     3. Consultation
   - C. Direct Client-Centered Services
     1. Brokerage/Advocacy
     2. Direct Treatment
     3. Outreach

II. Visibility/Acceptability Promotion

III. Administration
   - A. Data Management
   - B. Administrative Services

SUMMARY STATEMENT

In summary, a set of common CMHC functions has been identified which are readily applicable to the activities of both rural and urban programs. Characteristics of rural Alaskan communities have been presented. Program planning, monitoring, and evaluation as well as the selection, orientation and training of service providers can be enhanced by an appreciation of the factors discussed. These characteristics dictate that rural programs will differ substantially from more urban programs in the emphasis placed on the various program functions.



CITY OF NOME

P.O. BOX 281 - NOME, ALASKA 99762
TELEPHONE (907) 443-5242

80th ANNIVERSARY CITY OF NOME 1901 1981

November 10, 1981

Senator Charles H. Parr, Chairman
Health & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

At a recent Senate HESS hearing in Nome, there was a great deal of discussion about rising crime and alcohol problems.

We recently received a letter (copy enclosed) from one of the finest District Attorney's we have had in Nome in a long time who has addressed these issues. Sadly, he is leaving Nome to work in Anchorage. It is difficult to see him go. However, Mr. White clearly states the magnitude of the problems we face here in Nome. This is especially true with many of the neighboring villages opting to go "dry". As more of these problems ' inkers gravitate to our city, we shall be hard pressed to keep up with them and the problems they cause.

My intent is not to ask for assistance to upgrade the Police Department, but to impress you with the idea that more money is needed to deal with alcohol and its attendent problems.

Thank you for your concern.

Sincerely,

Ivan L. Widom

Ivan L. Widom
City Manager

cc: Governor Hammond
Senator Frank Ferguson
Representative Jack Fuller
Mayor & Council
Dr. Bob Johnson, Kodiak

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599
Fairbanks, Alaska 99701
(907) 456-5029

Fairbanks Interim Office
545 Third Avenue, Suite D
Fairbanks, Alaska 99701
(907)456-8925

Pouch V
Juneau, Alaska 99811
(907) 465-4907

DATE: October 19, 1981

TO: Senator Colletta, Senator Fischer, Senator Kelly and Senator Stimson

FROM: Senator Charlie Parr, Chairman
Senate HESS Committee

SUBJ: Flight info and hotel accomodations for Nome and Bethel hearings

* *

November 7, 1981
Saturday

Wien Flt. 61 departs Anchorage at 8:50 a.m.
arrives Nome at 9:25 a.m. (daily)
Alaska Flt. 51 departs Anchorage at 8:30 a.m.
arrives Nome at 8:55 a.m. (daily)
Wien Flt. 61 departs Nome at 10:05 a.m. (via Fairbanks)
arrives Anchorage at 1:55 p.m. (daily)
Alaska Flt. 51 departs Nome at 9:40 a.m. (via Fairbanks)
arrives Anchorage at 1:15 p.m. (daily)

The Nugget offers single rooms for approximately $75.00 a night.

November 14, 1981
Saturday

Wien Flt. 31 departs Anchorage at 7:45 a.m.
arrives Bethel at 9:00 a.m. (daily)
Wien Flt. 35 departs Anchorage at 5:40 p.m.
arrives Bethel at 6:55 p.m. (daily)
Wien Flt. 36 departs Bethel at 7:45 p.m.
arrives Anchorage at 8:45 p.m. (daily)

The Kuskokwim Inn offers single rooms for approximately $55.00 a night

CHP:dm

✓ Jeanette Morton	Norton Sound Health Corp. 443-9661
✓ Connie Hollenbeck	Norton Sound Comprehensive Alcohol Program
Sharon Wallulis	Norton Sound Family Services Box 966 [illegible]
✓ [illegible]	[illegible]
✓ FRED ANGLETON	EMS ADVISORY COUNCIL Pres.
✓ Robb Stokes	Self
✓ Nancy H. Mendenhall	Norton Sound Health Corp.
✓ Geoff LANGER	" "
✓ Frank D. Costanzo	Chairman Norton Sound Comp. Alcohol Counsels
✓ Doreen Dailey	
✓ VERNON KUGZRUK	SEL (Staff Kawerak, Inc. Board Member BSNC Nome)
✓ DICK BULLOCK	N.S. EMS
✓ FRANK J. POPLAWSKI	BERING SEA WOMEN'S GROUP
✓ IVAN L. WIDOM	CITY OF NOME
✓ LaVonne Hendricks	NORTON SOUND HEALTH CORP. - NOME TEEN HEALTH DIRECTOR
✓ R. R. "BOB" Blodgett	Bering Strait REAA & Coastal Resource Planning Board

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF LAW

DISTRICT ATTORNEY – SECOND JUDICIAL DISTRICT

BOX 160 – NOME 99762

November 4, 1981

Mr. Ivan Widom
City Manager
Nome, AK 99762

Dear Ivan:

As you may be aware, I will be leaving my position as District Attorney for the Second Judicial District (Nome and Kotzebue), on November 24, 1981.

I take this opportunity to point out the high level of police work I have encountered in your city, and to make some observations of trends I have observed regarding crime in the Second Judicial District.

There has been a sharp increase of violent crime in the Second Judicial District.* Between 1979 and 1981, there has been more than a 300% increase in felony cases filed in the Superior Courts. In 1979, there were 31 felony cases filed; in 1981, 109. To this date in 1981, there have been many more felony convictions than in the entire years of 1979 and 1980. This increase is all the more significant when it is considered that in 1981 a Pre-Trial Intervention Program was initiated which has diverted cases from the Court system.

It seems to me that the character of crime has changed also. Where in the past there were 'acquaintance' sexual assaults, this office is now deluged with violent 'attack' type sexual assaults. In the past year there have been at least two such assaults or attempts, on elderly women in their homes. This office has been vigorously prosecuting such cases and the Superior Courts have been issuing stiff sentences, however, it has done little to prevent such acts by others. It surely will get worse in Kotzebue and Nome, as village "problems" are increasingly transferred into the cities due to the village movement to get "drier" and "drier" with the new local option provisions.

* Statistics in this letter relate to crimes upon which a felony charge has been filed in Court. In other words, crimes reported in which a charge has not been filed are not considered. The statistics are derived from Department of Law internal statistics as well as from those published by the Court system. Statistics for 1981 are projected based on actual figures through Sept. 30, 1981.

NORTON SOUND
HEALTH CORPORATION

P.O BOX 966
NOME, ALASKA 99762
(907) 443-5411

STATE TO SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

November 7, 1981

Sharon Walluk, Director NSFS

I would like to speak to issues in the areas of the delivery of Mental Health Services. We are greatly concerned with the methods currently being used by the State to determine levels of funding for programs around the State.

Last June at the Governor's Advisory Council for Mental Health meeting in Anchorage it became apparent to those of us from the Bush that some of our programs were being cut to fund programs in larger more urban areas. The basis for this action was evaluating all programs by a model of mental health service delivery that is questionnable not only in the bush but also in more urban and even lower '48 areas. What was happening was that unless we were pushing numbers through our doors and seeing people in one to one therapy sessions we weren't doing any work.

As the result of this a group of bush program directors met in August in McGrath to discuss and evaluate what we are doing out here, why we are doing it and why we feel it works. The result of this meeting is what is now being called the McGrath paper which is a beginning step in defining a more functional service delivery system for the bush/rural areas of the State. We went back to the Advisory Council in September with this paper and after spending a full day of their two day meeting discussing the paper the Council voted to support this concept paper and recommended to the Staff in Juneau to take this paper into account when making any future plans for service delivery, program planning, etc., in the State. When I have this statement typed I will attach a copy of the McGrath paper.

The reason I'm presenting this issue is to make you people aware of the situation that is beginning to occur more and has been unlying the system for as long as I have been here. Mental Health and from my experience Alcohol too, in the State feels hard pressed to justify their existence so in order to do this they have grabbed on to models of programs, treatment services, delivery systems that belong maybe in L.A. but certainly not in Stebbins or Diomede. Since I've been here, 6 years, we have burnt out 1 Psychiatrist, and 5 PhD. psychologists. The reasons for this are many but probably the biggest is simply that their skills, what they know how to do simply doesn't work with our people, in our situation. The problem is that this model of service-delivery is the only one that the State sees as legitimite (or at least is strongly moving in that direction as of last June) and thus will fund. The result is if this occurs is a system of delivery that for this area has not worked in the past, won't work in future but which we will have to at least pretend to use if we expect any State funding.

Three to four years ago the only people being served by our clinic were those from the lower '48 that had moved up here. The local people would come once or twice and never return. Since then we've developed for the villages an alternative model that seems to be working. Our problem is getting State support of this system to develop it further, to get evaluation criteria etc. We have what we feel works, what we need is back-up from the State to evaluate it and make it legitimate, to get rid of the bugs. We have at this time a choice, either accept a model that fits only a small minority of people who come and go from our area or to develop a system that will work for everyone here.

I'm asking you as legislatures to be aware of these issues that the Mental Health and again I include Alcohol programs are in danger, because of the need to justify themselves, of accepting systems that don't work just so they can get money now. The result will be - when it doesn't work monies will be cut, programs will disappear and the people won't have any help. We need the chance, the expertise, to develop Alaskan based systems.

founded 1970

NSHC

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-5411

HEALTH CORPORATION

COMPREHENSIVE ALCOHOL PROGRAM (CAP) 7 November 81
PUBLIC TESTIMONY ON HEALTH CARE

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 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 "bush" Alaska as it was sixteen years ago.

Overview of the Norton Sound CAP Project

The Norton 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 Norton 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 Nome 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

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-5411

HESS COMMITTEE HEARING

November 7, 1981

At the last NSHC Board of Directors' meeting in October, the need for adequate Water & Waste Systems were called out as the top priorities of village needs.

Since the early 1960's when the 1st 86-121 projects were constructed by PHS in Alaska, many problems have been encountered which has affected the type and design of sanitation facilities built today. Before, systems were constructed in villages without any thought as to how the villages were to operate, maintain and manage these systems. However due to many complicated factors and to what has been learned from past mistakes it has become necessary to place more emphasis on the operation and maintenance and management of the systems constructed and those to be constructed.

The construction of sanitation facilities, especially in Alaska, is not an easy task to say the least. All of the "bush" villages would like to have not only a safe water supply, but also a sanitary and safe means for the disposal of both sewage and solid wastes. They want this not only for convenience, but also for the health and safety of their families. These needs are real, but due to a combination of various factors, the fulfillment of these needs is rather difficult to say the least. Even so, these needs (safe water and disposal of wastes) are real and essential at any cost - as essential as schools, safe airports, health clinics and other public facilities.

Some factors which result in inadequacies in both the quality and quantity of facilities and service are:

1. severe cold climates
2. permafrost and cold stress
3. swampy soil conditions
4. no economic base (subsistence, welfare, etc.)
5. inflation (fuel, electricity, everything has increased)
6. inadequate cold region technology
7. inadequate transportation & communications
8. lack of coordination of efforts among the different agencies involved
9. lack of materials for repairs
10. lack of skilled manpower and lack of training for local manpower
11. lack of community organization and/or council development
12. small populations
13. beliefs, culture, habits & lifestyle
14. in some cases, shortage of water & land availability
15. economic feasibility
16. the capability of communities to operate, maintain, and support facilities

In summary, it is most difficult if not impossible, for most communities to financially support systems constructed with current technology. Facilities

can no longer be constructed with tools and methods borrowed from the lower 48. Facilities need to be custom designed to truly meet the sanitation needs of Alaskans.

No project should be approved for construction until both the funding for construction and the funding for continuing operation and maintenance can be assured.

The efforts by PHS and DEC of designing and constructing present day systems are commendable but problems with the lack of operation, maintenance, management and support of these systems is unreliable to say the least. The problems involved are social as well as economical; physical as well as technical.

In addition, the majority of the villages in the Norton Sound area are in drastic need for funds to correct disposal problems of sewage and solid waste. Due to saturated soil conditions and the high costs for haul systems, conventional "lower 48" methods are obsolete in the "bush". These reasons are valid, but something still needs to be done now.

Communites, which are aware of the seriousness of the problem, that are trying to solve the solid waste/honeybucket disposal problems are:

Savoonga
Elim
St. Michael
Shishmaref
Stebbins

The lack of funding is the main barrier against solving their problems.

SUMMARY:

The problems of obtaining safe water supplies and for disposing of honeybucket and solid waste are unique to the "bush"areas; unlide populated areas as Anchorage and Fairbanks where these needs are more easily met.

The "bush" area communities account for a small percentage of the state population, but their basic needs in areas of water and waste disposal should be a higher priority than funding some the nicer conveniences such as new offices in Anchorage and Fairbanks.

Past inequities to the "bush" are reflected in the present conditions of the villages and in the high incidence of water and skin related diseases as hepatitis, dysentery, scabies, impetigo, etc. Also, failure to pass House Bill No. 334 support this statement.

Bush life can hazardous to one's health as well as life threstening. The problems for obtaining safe water and a safe means for the disposal of sewage and solid wastes is not an unusual encounter.

For example, last year a man from Shishmaref was caught in a storm in the middle of winter while traveling nearly 20 miles to obtain potable water for his family. He nearly died doing so. This is only one example to how basic the need is for the villages. I realize the bush is easier to ignor since we are so inaccessible, but please be aware that even the most basic needs are still out there and still need to be met.

208 Village Facilities Assistance Grant

Because the operation, maintenance and management of sanitation facilities is a major undertaking for most villages, and is a combination of complex factors, the 208 Grant was developed to:

1. Study and analyze with the community the potential of those communities to provide long range support for the operation and maintenance of existing facilities.

2. Provide emergency technical assistance on maintenance.

3. Provide O-J-T training for the water operators.

4 Council development and management training

5. Provide training to the village public on the correct use of facilities and the prevention of water/wastes related diseases.

6. In those communities to get new systems, try to coordinate planning with the city councils, PHS, and other involved agencies to get a feasible system in those communities.

This grant is not for a new water project or facilities, but rather it is a project or facilities, but rather it is a planning grant to study, and analyze the problems encountered, make recommendations, and to provide technical assistance and training unique to each village, with each village.

Recommendations will come from the villages themselves as well as from the Norton Sound staff. Recommendations will go to PHS, DEC, and any other agencies involved in the design and/or construction of water and waste disposal systems. Recommendations will be geared towards customizing systems to the unique needs of each village in terms of environmental factors affecting design, operation & maintenance needs, feasibility of existing system and areas needing improvements, economic support of existing or planned systems and training needs for village operators of each village.

It would behoove the State to consider the recommendations coming out of this project, as they come from the village and regional prospectus. If this project is successful, I would recommend that the necessary funding be allocated to expand this project into other villages in the region as well as statewide. Successful coordination of this project may not only mean having more feasible systems in each village, but could also mean savings in actual cost for operation and maintenance of these systems, as the villages begin

to feel more responsible towards the planning and use of their water and wastes disposal systems.

In other words, the benefits would not only be to the villages in getting more feasible systems, but to the State, as well, as reflected in the money saved on possible replacement and/or renovations to existing systems, as well as reduced State assistance needed for operation and maintenance costs, i.e., fuel, electricity, etc.

Needless to say, more research is needed to find practical, feasible and economical answers.

1135 West Eighth Avenue, Suite 7 • Anchorage, Alaska 99501 • (907) 274-3651

Southern Region
EMERGENCY
Medical Services Council, Inc.

PRESIDENT'S REPORT

November 12, 1981

Since becoming involved with the Southern Region E.M.S. in 1976, I have seen it grow from:

Approximately a $50 000 contract to $826,429 presently

Serving a

Population in 1976 of 205,681 to 266,037

And from

100,000 square miles to 260,000 square miles.

From an original staff of 2 to a present staff of 10.

This past year has been one to remember. Our third Executive Director, Tom Scott, was hired, replacing Richard Pauley. Rich replaced Maurice Messer. I was on the hiring committee for each and each has been special in his own way.

As the old saying goes, "a new broom sweeps clean", is probably true of Tom. He has been cleaning house ever since he started.

This also has been our first year of only State funding. Although no Federal Funds have been funneled through Southern Region's office, each of the Native Corporations has received funding through their Indian Health Service grants and in most cases have a very workable relationship.

As taken from the Quarterly Progress Report, I have found the following information not only interesting, but informative:

Since inception in December of 1975, the SREMS has been promoting the development of EMS Systems in the geographical areas that make up the region. During fiscal years 76-78, the primary emphasis was on providing EMT training statewide and developing advanced life support training programs for the rural parts of Alaska. In FY 79, we received a 1202(1) Grant and followed that in sequence with 1203(1) and 1203(2) grants in FY 80 and FY 81 respectively. At the same time we continued EMT training with funds appropriated by the Alaska Legislature.

The major achievements of the last year of federal funding are as follows:

-Gaining the financial support of the Alaska Legislature to continue funding SREMSC at a level consistent with federal funding levels assuring not only maintenance of the improved levels of care achieved with federal funds, but providing support for continued development and improvement of a total EMS system.

-Complete a comprehensive assessment of the status of each community in the region relative to the new Alaska EMS goals which provides the planning foundation for future activities.

-Administer the purchase and distribution of $188,000 in communications, medical, and training equipment for the EMS providers in the region. The funds were state funds obtained by the Highway Safety Planning Agency.

-Contributed to a training program that put on some 69 EMT courses (EMT-A, Refresher, EMT-II and EMT-III) that trained 636 individuals during the year.

-Provided travel for continuing medical education in each of the hospitals in the region.

-Conducted and supplemented an additional $800,000 plus of Indian Health Service EMS funds used to improve care in those villages and communities that are predominately Alaska Native.

-Anticipating end of federal funding, converted evaluation specialist position to clinical specialist to coordinate continuing education for hopsital and clinical staffs.

-Provided travel funds for the Outreach Worker from the Providence Hospital Thermal Unit to do continuing education programs in care of the burn victim, air transport, and care of the frostbite patient to hospital, ambulance service, schools, and industry in communities in the region. Program was highly rated by all participants.

-Assisted with the development of a new ambulance service at Glacier View on the Glenn Highway. Trained new responders at Cold Bay and Sand Point will receive new ambulances from the Alaska Legislature in FY 82.

-Conducted system design to improve ambulance to hospital communications on the highways of the Central Kenai Peninsula.

The federal funds provided under the EMS System Act of 1973 and subsequent amendments have enabled the Southern Region to make significant progress in the development of Basic Life Support Systems in the region. In 1975, there were eleven ambulance services in the region which were manned by EMT-As. Today there are twenty-nine such services, most of which are trained to at least the EMT-II level with physician control.

In 1975, only Anchorage had a 911 telephone number with central dispatch. Today, 10 of the 13 other major communities in the region have 911, including the Copper River area's which works at long last.

In 1975, there were no special care units other than ICU/CCU's in the region. Today there is a regional Thermal (Burn & Cold) Unit, a statewide perinatal unit, and a statewide Poison Control Center. More importantly, however, is that transfer agreements between these units and the federal (IHS-military) hospitals have been developed and implemented.

In 1975, there were no ACLS trained personnel in the region's hospitals. Today, there are ACLS providers in each facility in the region. Furthermore, each facility either has physicians in the ER [illegible] a day or the on-call physician has VHF radio contact with the hospital and the ambulance.

In short, the support of the federal government has enabled the Southern EMS Region to bring most of the populated portions of the region to a true BLS capability and has enabled us to demonstrate our viability to the Alaska Legislature to assure continued programs towards the national goals of developing true systems.

FY 81 TRAINING

EMT-III Date	Location	Students	Completed	Certified	Total Yearly To Date	Total to Date	Total Certified Year/Total	
Total FY 80					NA	NA		
March	Kodiak	8	8	8	8	19	8	19
April	Homer	6	6	6	14	25	14	25
	Barrow	3	3	-	17	28	-	-
May	Kenai	5	5	4	22	33	18	29
	Alyeska Pipe.	16	16	-	38	49	-	-
EMT-I.I/R								
April	Homer	3	3	3	3	3	3	3

FY 81 TRAINING

EMT-II Date	Location...	Students	Completed	Certified	Total Yearly To Date	Total to Date	Total Certified Year/Total	
Total FY 80					128	417		
July	Valdez	15	15	9	15	432	9	190
	Homer	5	5	2	20	437	11	192
	Ft. Rich	5	5	2	25	442	13	194
August	Unalaska	9	9	7	34	451	20	201
	Pond Reef	7	7	6	41	458	26	207
October	Nome	6	5	5	46	463	31	212
November	Barrow	5	5	1	51	468	32	213
	Girdwood	11	10	4	61	478	36	217
	Seldovia	4	4	2	65	482	38	219
December	Talkeetna	3	3	3	68	485	41	222
January	Willow	8	7	3	75	492	44	225
	Chugiak	4	4	2	79	496	46	227
	Palmer	7	7	7	86	503	53	234
February	Soldotna	4	4	4	90	507	57	238
	Willow	8	7	4	97	514	61	242
March	Dillingham	6	6	-	103	520	-	-
	Port Graham	6	5	-	108	525	-	-
April	Alyeska Pipe	19	19	1	127	544	62	243
	Homer	5	5	1	132	549	63	244

FY 81 TRAINING

EMT-R Date	Location	Students	Completed	Total Yearly To Date	Total To Date	Passed NREMT Took/Pass/%
Total FY 80				100	284	
October	Glacier View	15	11	11	295	
	Willow	15	14	26	309	
November	Barrow (II/R)	2	2	28	311	
	Seldovia	7	7	35	318	
	Kotzebue	11	11	46	329	
	Chugiak	15	14	60	343	
	Chugiak (II/R)	8	8	68	351	
December	Trapper Cr.	11	11	79	362	
January	Alyeska Pipe	17	17	96	379	
February	Willow	14	13	109	392	
March	Dillingham	6	6	115	398	
	Cantwell	4	3	118	401	
	St. Paul Is.	4	4	122	405	
April	Seward Inst. Wkshp.	20	20	142	425	
May	McKinley	13	13	155	438	

FY 81 TRAINING

EMT-I Date	Location	Students	Completed	Total Yearly To Date	Total To Date	Passed NREMT Took	Pass	%
Total FY 80				198	1014			
October	Wasilla	8	8	8	1022	4	4	100%
	Nome	11	6	14	1028	-	-	-
	Barrow	17	15	29	1043	15	13	87%
November	Iliamna	10	10	39	1053	10	7	70%
	Nikiski	12	11	50	1064	11	11	100%
	Ninilchik	13	9	59	1073	8	8	100%
December	Talkeetna	7	7	66	1080	7	7	100%
	Trapper Cr.	4	4	70	1084	4	4	100%
	Seldovia	13	13	83	1097	12	12	100%
January	Cold Bay	11	11	94	1108	11	11	100%
	Whittier	11	11	105	1119	11	10	91%
	Evans Island	7	7	112	1126	7	7	100%
February	Port Graham	6	6	118	1132	6	5	83%
	Port Alcan	5	5	123	1137	-	-	-
	So. Naknek	6	6	129	1143	6	6	100%
	Naknek	8	6	135	1146	6	5	83%
	Kodiak	15	15	150	1161	6	4	67%
March	St. Paul Is.	9	9	159	1170	9	7	78%
	Cantwell	7	6	165	1176	5	3	60%
	Copper River	8	8	173	1184	6	6	100%
April	Prudhoe Bay	37	37	210	1221	35	32	91%
	Homer	18	18	228	1239	18	18	100%
	Chugiak	10	7	235	1246	7	7	100%
May	Dillingham	12	7	242	1253	-	-	-
	Kotzebue	14	14	256	1267	-	-	-
June	Barrow	18	14	271	1282	-	-	-
	Prudhoe Bay	37	37	308	1319	37	-	-

SOUTH CENTRAL HEALTH PLANNING & DEVELOPMENT, INC.
"A Health System Agency"

Lynne Johnson-Joseph
Health Promotion

Phone (907) 278-3631

1135 W. Eighth Ave. Suite 1 Anchorage, Alaska 99501

TOPICS OF DISCUSSION

I. Transportation:

A) Medicaid travel to ANS facilities

B) Emergency travel - authorized at local level

II. Communication:

A) Need for greater coordination in communities planning between IHS, Regional Corporations and State, to provide low maintenance cost, highly reliable, comprehensive EMS communication system in bush Alaska.

B) Assumption of responsibility for black phone medical communication system.

III. Clinic Operation & Maintenance Support:

Regs require to be 2nd class city
Rev. Share money inadeq. to even maintain
heat for clinic. Clinics leased frozen
- no operation funds

A) Revise clinic revenue sharing regs to allow village to apply to increase amount and to require maintenance of environmental standards.

IV. Environmental Health:

Indian Health Service Programs are being cut - Regional Corporations can provide infrastructure to deliver these services in rural areas.

V. Community Health Aide Program

Federal reductions threaten to seriously erode the quality and scope of services provided on training a supervision of CHA's is curtailed to preserve funds for salary maintenance.

Legislation should be drafted to provide training support for CHA services.

3rd Pty. / licensure to support CHA & Clinic
Community Health Representative - outreach worker - many do alcohol clinic, mental health, ADD, ser., WIC etc. Environ. health - very flexible by village
these responsibilities go to CHA - 30% cut this yr.

VI. Need for a formal review of State statutes and administrative regulations that prevent Regional Corporations from acting as comprehensive health service provider in rural areas.

Dr. Rabeau Req. Abs. opinions

1) PHN Service - Contractibility of functions that are provided for under statutory authority.

AG opinion asked for.

2) Board requirements that are inconsistent or unclear; ie: Mental Health/Alcohol Program, etc.

3) Medicaid reimbursement for IHS clinical facilities in Juneau, Fairbanks, and Ketchikan.

asked for admin. Review by HHSS.

reimburse. denied to IHS Clinics because of definition of clinic in statute.

4) Various enforcement authorities in Environmental Health.

5) Various regulations governing facility ownership and construction, etc.

insurance regulation prevents collection of reimbursement because facility is owned by Feds.

VII. General discussion of successes and failures of alcoholism programs in rural areas.

VIII. Additional Areas of Interest:

Support HSA's?

Dennis Kelso - Anch. - Alcohol Prog. Evaluation.

Community Mental Health Board - waiting for reps for 4 years.

#3-8 million shortfall in FHS this yr. (Reflects 10 2018 reductions in staff)

Testimony Offered before the
Senate Health, Education and Social Service Committee

December 15, 1981

As the Chairperson of the Alaska Statewide Health Coordinating Council, probably better known as SHCC, I am here to represent that 30 member body to express to you our concerns on how to facilitate the best health care possible for all citizens of Alaska. Specifically, we wish to indicate our support of the regional entities described here earlier today by the ~~Northern~~ Alaska Health Consortium, ~~Kotzebue Association, South Central Health Planning & Development and Southeast Alaska Health System Agency~~. Their evolution into State and locally supported entities specifically charged to perform health promotion, technical assistance to communities in the development of local health programs, and data collection and analysis is one which will preserve and strengthen the functions most needed now out of all those presently performed by the Health System Agencies.

Before elaborating on why we give support to this changed functional emphasis, I shall review briefly the function, makeup, and, therefore, perspective of SHCC on this issue. The Alaska SHCC is authorized under Alaska Statute 18.07.011 to establish priorities for the orderly development and implementation of health care delivery in Alaska. The expression of those priorities is found in the State Health Plan, a document authored by the Council. Because the State Health Plan is based upon regional plans developed by the individual health system agencies, the State Plan is a result of regional and local perspectives put into an expression of priorities with a statewide outlook. In conducting all secondary functions of SHCC, including review and comment or approval activities, the State Health Plan is used as the basis for decision making. Likewise, SHCC membership, a majority of whom are not providers of health care, consists of individual citizens from all over the State: 60% nominated by the Health Systems Agencies and the remaining 40% directly appointed by the Governor. The result is statewide expression on health delivery issues with a local and regional foundation.

Federal support for health planning, as we have known it for the past six years, is being discontinued. Given the size of Alaska and the magnitude of resources presently being spent on health facility and program development, coupled with the present concerns for long range health policy issues now before the citizens and legislature of Alaska, it seems most logical and reasonable that local and regional voices of concern continue to have a means by which those concerns can be expressed.

Alaskans are committed to local input on statewide issues. It would be a shame to totally discard the valuable resources which have been built at a regional level in the form of the three Health Systems Agencies. Those resources are human in the for of well-qualified, respected and knowledgeable professionals as well as knowledgeable lay board members who have freely given thousands of hours to the goal of better health care for their fellow citizens; those resources also include non-human resources in the form of extensive dat., profiling regional health delivery capability and shortcomings.

You are urged to take these valuable resources and give them a new charge to function as regional health resource organizations. They should be responsible to: (1) promote the develoment and maintenance of health education and self-care programs; (2) coordinate and facilitate local and regional participation in identifying and then responding to health care delivery needs; and (3) maintain the capability to provide local and regional current, accurate health related data for planning, review and resource development activities.

In summary, the Alaska Statewide Health Coordinating Council urges your thoughtful support of the proposal for establishing regional health resource organizations to preserve and maintain local and regional voices committed to the facilitation of the best health care possible for our citizens.

James M. Armbrust
Chairperson
Alaska Statewide Health
Coordinating Council

Proposed legislation relating to the Medicaid budget review process.

First Draft, December 11, 1981

Section _____. FINDINGS AND DECLARATION OF POLICY. The legislature finds and declares that health facilities are an integral part of the infrastucture of the State of Alaska. Accordingly, it acknowledges the need to reimburse health facilities for services provided beneficiaries of state programs at a level which will meet the true financial requirements of the institutions. In order to accomplish this end in a prudent fashion it is necessary that rates of reimbursement to be paid to health facilities by the Medicaid and General Relief/Medical program should be prospectively negotiated so that appropriate and equitable funding decisions can be made.

SECTION _____. REIMBURSEMENT FOR COST SETTLED PROVIDERS. The payment rate for health facilities shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Reimbursement shall reflect a reasonable return on investment in addition to the other financial needs of the facility. Reimbursement shall be made for, by way of example and not by limitation, the following:

(a) Costs of current operating requirements, including but not limited to:

(1) Health facility operating expenses such as wages and salaries, purchased services,

supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and minor remodeling;

(2) Bad debts;

(3) Education;

(4) Research; and

(5) All costs associated with preparing budgets and negotiating rates under this section.

(b) A reasonable operating margin, in order to provide for:

(1) Working capital necessary to meet current obligations as they come due; and

(2) Capital necessary for

(i) Major renovations and repairs;

(ii) Replacement of plant and equipment;

(iii) Expansion; and

(iv) New technology.

(c) A reasonable return on equity.

SECTION _____. BUDGET DETERMINATION. (a) No less ninety 90 before the start of the health facility's fiscal year, the Division of Public Assistance shall provide it with an estimate of its volume for that fiscal year.

(b) No less than 60 days before the start of the health facility's fiscal year, the health facility shall submit its proposed rates for Medicaid reimbursement and its budget projections on forms prescribed by the commission.

(c) Within 45 days after the proposed rates and budget projections are submitted, the commission shall review the proposed rates and the budget projections and shall, in accordance with section _____, issue a written decision. Reimbursement shall be made in accordance with the rates established in that written decision. The health facility shall be permitted to present oral testimony and a documentation in support of its proposed rates and budget projections. If the commission fails to issue a written decision within that period, the health facility's rates will be deemed approved.

(d) Within 30 days of issuance of the decision, the health facility may request the commission to reconsider the decision. Whether or not reconsideration is requested the health facility has the right to de novo judicial review of the decision by the superior court under the Rules of Appellate Procedure. During any reconsideration or appeal the health facility shall receive payment according to the rates approved by the commission.

(e) Any health facility may submit amended proposed rates and an amended budget during its fiscal year. Within 60 days of submission the commission shall review the amended proposed rates and amended budget and shall issue a written decision. If the commission fails to issue a

written decision within that period, the health facility's amended rates and amended budget shall be deemed approved.

(f) Within 90 days after the close of the health facility's fiscal year, it shall submit to the commission, on forms prescribed by the commission, which forms shall be consistent with the budget projection forms, a report on its financial performance during that fiscal year.

SECTION _____. AUDIT AND INSTITUTIONAL REVIEW.

(a) As a condition of participation in the Medicaid program, health facilities must provide the division reasonable access to fiscal records of all Medicaid beneficiaries.

(b) Health facilities must allow inspection of fiscal records by the division and other state and federal agencies to the extent required by federal law and regulation.

SECTION ____. REIMBURSEMENT TO HEALTH FACILITIES UNDER GENERAL RELIEF/MEDICAL PROGRAM. (a) Reimbursement to health facilities under the General Relief/Medical program shall be made at the same rates as those established for Medicaid reimbursement.

(b) Health facilities shall submit all claims for reimbursement on invoices prescribed by the division and in accordance with its provider manuals.

(c) Claims for reimbursement must be filed promptly following the provision of care, and reimbursement shall be promptly made.

SECTION ____. MEDICAID BUDGET REVIEW COMMISSION. There is created in the Governor's Office the Medicaid Budget Review Commission.

SECTION ____. COMPOSITION OF COMMISSION. The Commission consists of the following persons:

(1) The chief executive officer of a health facility which is licensed by the state but not owned or operated by the state or federal government and which is subject to the budget review process as prescribed in section _____ through _____;

(2) A person with a professionally relevant background appointed to represent the insurance industry;

(3) A physician licensed by the state and actively engaged in the practice of medicine in the state who is not employed by the state or federal government;

(4) A person with a professionally relevant background appointed to represent the business community; and

(5) A person appointed to represent consumers of health services who does not have an interest, direct or indirect, in an entity engaged in health care delivery.

SECTION ____. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and shall serve at his pleasure.

SECTION ____. TERM OF MEMBERSHIP. Members shall be appointed for terms of three years, and they may not be appointed to successive terms. Terms shall be staggered. The initial terms shall be two members serving for three years, two serving for two years and one serving for one year. For purposes of initial appointments, appointing successors or filling vacancies, all terms shall be measured from January 1 of the year in which the term of the vacant position began, regardless of when the vacancy is filled. A member appointed to fill a vacancy serves for the unexpired term of the member he succeeds.

SECTION ____. COMPENSATION. The members of the commission serve without compensation but are entitled to per diem and travel expenses authorized by law for other boards and commissions.

SECTION ____. OFFICERS. At the first meeting of each year, the commission shall elect a chairman from among its members.

SECTION ____. MEETINGS AND QUORUM. The commission shall meet as frequently as necessary to conduct its business efficiently and expeditiously. Three members of the commission constitutes a quorum.

SECTION ____. DUTIES OF THE COMMISSION. The commission shall have sole responsibility to review proposed rates and

budgets of health facilities and establish Medicaid and General Relief/Medical reimbursement rates for health facilities pursuant to Sections ____ through _____.

SECTION _____. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. The executive director may, with the approval of the commission, select and employ additional staff as necessary. The executive director and all employees of the commission are in the exempt service under AS 39.25.

SECTION ____. AS 47.07.070 is repealed.

SECTION ____. AS 47.07.080(1) is repealed.

SECTION ____. DEFINITIONS. In this chapter,

(1) "health facility" shall include hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities/mentally retarded, inpatient psychiatric facilities, home health agencies, rural health clinics, and out patient surgical clinics and any other entity which receives Medicaid or General Relief/Medical reimbursement for services traditionally provided in health facilities;

(2) "commission" shall mean the commission created pursuant to Section _____;

(3) "division" means the Division of Public Assistance of the Department of Health and Social Services; and

(4) "volume" means the total services provided to Medicaid and General Relief/Medical beneficiaries.

SECTION ____. This act takes effect January 1, 1983.

ALASKA STATE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811

DEC 18 1981

REGIONAL INFORMATION OFFICE
1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

12-16

Senator Pars,

This was brought in today the gentleman asked that I foiward it to you.

Nicki Hattenbey

LAA 11
(1-26-79 M)

Nancy To be
This seems to be
written version of
oral testimony by
Miss Burrell in
Anch on Dec 15.
Thanks

Hearing Dec. 15, 1981
Hastily made notes
with appologies.

Sen. Parr
Dr. Beirne

Request ; catastrapic Insurance or
State provide Major Medical
and Doctors care to those
who have applied to various
insurance companies and have
been refused because of major
health problems. State Insurance premium
to be based on individuals income.
and in line with charges made to
individuals buying insurance and
not repeated coverage.

Request: also Temporary medical coverage to
(middle aged) divorced ~~woman~~ people who have not
worked in the marriage or not for
years; has no individual Insurance
plan and small income below poverty level must
or has temporary restraints & liens by court order
on property and bank accounts.
Can not qualify for perverty assistance
because of existing real property in addition
to ~~the~~ other home. NO children in household.
There are also medical coverage.

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/367-1000

Please attach this Endorsement to your Group Conversion Certificate. Your hospital in-patient benefits will be increased for hospital admissions on or after the date your new rates become effective, provided you are admitted to the hospital on or after your effective date of coverage.

Endorsement
to
Hospital Service Surgical and Medical Certificate
Group Conversion

Maximum Room Allowance of $75.00

In consideration of the advance payment of the required subscription charges, the Certificate to which this Endorsement is attached is amended.

Part V, Benefits, paragraph A.1.a is amended as follows: the reference to a maximum room allowance is hereby modified to provide up to seventy-five dollars ($75.00) per day.

Blue Cross of Washington and Alaska

President

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361-3000

November 30, 1981

Ms. [redacted]
37 [redacted]
Anchorage, Alaska >>504

Dear Ms. [redacted]

Every application for transfer from our Group Conversion Program to our Individual Program must meet membership requirements and be reviewed by our Underwriting Committee. The Committee carefully reviews each health statement and membership records.

After reviewing your application and membership records it is the Committee's decision that the medical underwriting requirements have not been met because of your combined medical history of arthritis, [redacted], residuals of polio including tendon transplants and spinal fusion, a lumpectomy with atypical cell growth and menopausal syndrome. Although we are unable to accept you for our Individual Program, we are pleased to continue your coverage on our Group Conversion Program. Our records show that you are currently paid to December 1, 1981.

Blue Cross of Washington and Alaska has established medical underwriting guidelines. We screen each application for the Individual Program according to these guidelines. We would like to offer coverage to everyone who applies. However, in order to offer coverage to people at a cost that most people can afford, some restrictions are occasionally necessary. This means, of course, that some applicants cannot qualify.

Although you may not perceive the conditions to be acute or a threat to good health, our determination was consistent with rating provisions for the Individual Program.

Thank you for your interest in the Individual Program.

Sincerely,

Sharon S. Thompson R.N.

Sharon S. Thompson, R.N.
Individual Underwriting

cc: 18A/15

446
1-800-6400

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361-3000

September 1, 1981

[redacted]ive
Anchorage, Alaska 99504

Was fully covered thru husband, by Blue Cross State of Alaska. Lost this coverage at divorce, put in Group Conversion refused adequate coverage offered in Individual Program

Dear Ms. [redacted]

Every application for transfer from our Group Conversion Program to our Individual Program must meet membership requirements and be reviewed by our Underwriting Committee. The Committee carefully reviews each health statement and membership records.

After reviewing your application and membership records it is the Committee's decision that the medical underwriting requirements have not been met because of your combined medical history. Although we are unable to accept you for our Individual Program, we are pleased to continue your coverage on our Group Conversion Program. Our records show that you are currently paid to August 1, 1981.

Blue Cross of Washington and Alaska has established medical underwriting guidelines. We screen each application for the Individual Program according to these guidelines. We would like to offer coverage to everyone who applies. However, in order to offer coverage to people at a cost that most people can afford, some restrictions are occasionally necessary. This means, of course, that some applicants cannot qualify.

Your application is enclosed. Thank you for your interest in the Individual Program.

P.S. Your money will be applied toward your current group conversion program.

Sincerely,

Sharon S. Thompson R.N.

Individual Underwriting

lk

Enclosures

age 57½

Group # cost #120 - 770 a year
75 a day allowed
no doctors in Hosp
up to #125 total in hospital Doctor
total - small - ridiculous surgery fee schedule

Individual # 654
109 x a
full hospital room coverage
Doctor office, after $200 deductible
Full fee paid doctors in hospital
full fee surgery

(1)

Crash Sale

Government cruel & ruthless
When comes to forced disposal
of land. 50% of value
to discount Fair Market Value
Land least fluid asset, yet
best investment for someone
who cannot ~~ear~~ earn a current
cost of living wage. Part time, good
paying jobs not available.
Temporary poverty or permanent
poverty, the elder divorced women
goes without medical attention.
A Widow receives possibly a pension for
24 years a marriage. The elder woman

divorced has nothing. Small Bank account eaten up by attorney fees. Husband has been running up bills & taking away assets before leaving the woman. If there are children, there is "aid to dependant children", rarely support ordered to the older now single woman. It is uncollectable except by private attorney; the woman has to have money up front, or sign away over $\frac{1}{2}$ if collected & still pay Court costs. She goes without food & medical care to "save her home". While trying to adjust to the totally unfamiliar work world

& Compete ∈ women just out of school & 30 years younger - an old arthritic condition or a major stroke occurs. Her mental health from sheer terror & lack of family makes her prey to every sharpie in town, She needs financial & medical help now. The criteria for qualifying for medical care favors the very poor with no assets other than a home & a long history of receiving Government aid. The woman must meet requirements of Bankruptcy

before she can received medical help. She must "liquidate" her assets she held to prevent her from being a permanent welfare recepient. If she has no idea of market value or is so sick she sells ~~for a penny~~ for a penny on the dollar. Her nest egg gathered in 24 years of marriage is gone. In a state that allows a mate to walk out, mostly with no strings, why isn't there medical care available for an abandoned mate, when needed?

We spend millions in amusement, leisure time helping; the artscenter, the

sports arenas; a huge covered dome stadium — all of the expense & upkeep will move that woman out of her home faster. State income tax relief benefits the rich in a great & grand proportion and ignores the sick, the old, & the abandoned. In Canada, medical care is available to everyone. Its available to the rich & the poor here.

Major medical Insurance is denied the person who needs it the most. We allow the insurance companies to skim the cream of the milk they choose the well & the employed to insure, & refuse to insure the seriously ill. Or if through previous insurance, they a husband, they set up a conversion

appendectis cost $1200 for doctor only (6) - not complicated $285.00 allowed by Blue Cross $75 - a day for Hospital No office calls

plan, which they say is meant only to cover the employable while they are between jobs." The rates are a rip-off. $110 every 2 months, with no doctors office fees paid. $450.00 allowed in the hospital for $2600.00 doctors fees charged. For a major surgery: Example

$75.00 for a Hospital room that costs the patient $240.00 a day. A normal hysterectomy would cost the patient $2966.00 plus the $720.00 paid yearly to Blue Cross for a total of $3686.00 or more. Without this "insurance" ie no Cheerium rights it would cost $5,400. It takes a year to adjust to that surgery. If you sick, how can you pay it off? Meanwhile the ex husband goes back to job-employed, with all benefits for $109 or for less payment than a sick plan. Complete Coverage

If the husband is military; he has medical coverage, free, for life & the of military wife has nothing — not even a pot hole plan. Your lack of and in these circumstances causes life long hardship, break down in the individuals ability to adjust & an ongoing folt into into the world of poverty.

Arent people more important than the Hotels & Sullivans Convention center?

Why is health care a luxury & Project 80 a necessity?

TESTIMONY BEFORE THE SENATE, HEALTH & SOCIAL SERVICES COMMITTEE

NOME, ALASKA

November 7, 1981

By: William M. Dann
Former Executive Director of
Norton Sound Health Corporation

I appreciate the opportunity to submit testimony to you and regret that I am unable to be in attendance during the hearings. I understand you wish to hear testimony on categories that you have previously publicized and I will try to address those areas.

HOUSE BILL 41:

Over the last four years, the Norton Sound Health Corporation has been receiving approximately a 10% annual cost of living increases in its contract with the Indian Health Service. Whereas the actual cost of doing business has gone up about 15% annually, we have therefore had a 20% reduction in real dollars available for services over the last four years prior to any impact of the Reagan budget cutting process. We have absorbed this impact through elimination of our Planning Office (which prevents us adequately planning and documenting health problems in our area and services to meet them), elimination of training positions for development of local manpower, reduction of patient travel, failure to keep pace with comparable salaries in the region and throughout the state, reduction of training opportunities for our employees, reduction of the manpower available to train our Community Health Aides, reduction or elimination of training available to Alternate Health Aides to provide coverage to the villages during weekends and leave for educational and other purposes of the primary Community Health Aides. These are specific examples.

At the present time, the salaries of Norton Sound Health Corporation employees are approximately 30% below comparable state salaries. Anticipated salaries for State employees in the Fall will further widen this gap. We have experienced instances in which a number of our employees have left the Corporation in order to seek State employment. Continuity of personnel for purposes of learning the unique aspects of our delivery system and cross-cultural communication with patients is critical to maintain and improve the quality of health services delivery, therefore failure to keep pace with salaries poses a real problem. This will worsen significantly with the impact of the Reagan budget cuts.

Throughout the budget cutting process over the last four years, contrary to practice of Indian Health Service, the Board of Directors of the Norton Sound Health Corporation who are consumers throughout the region and represent village or city constituencies, have consistently chosen to maintain services and cutback in administrative and benefits areas. This has hindered our ability to attract personnel and additional funding as well as to effectively plan, however, we are now at the point where further reductions in these categories are no longer possible and the impact of future Reagan cuts will adversely impact services.

The minimal impact that I foresee of the Reagan budget cuts would be as follows:

1. Elimination of laboratory technician position
2. Elimination of inservice training
3. Elimination of the Respiratory Therapy and Respiratory Thereapy Dept.

4. Reduction in travel of the sanitarian to the villages for inspection of water supplies, provision of rabies clinics, inspection of village clinic facilities, inspection of school food handling, etc.
5. Reduction in eye care services to the villages so that about 25% of the villages will receive no eye glass diagnostic and prescription services each year.
6. Continued elimination of the Planning Office
7. Elimination of the Boarding Home program (this program houses patients while they are awaiting delivery and/or return to village after having been seen in the hospital.
8. Reduction in patient travel. We have reduced patient travel over the last year by virtue of a 30% reduction in travel to Anchorage. This is either due to a change in the pattern of disease being seen at the hospital or a change in the pattern of practice by physicians. Unfortunately, lack of a Planning Office makes it difficult us to diagnose this.
9. Elimination of filing of village community health aide encounters in patients charged here at the hospital.
10. Elimination of training for the Board of Directors.
11. Provision of primary community health aide training only once every two years. This would mean we would fall far short of the State Health Plan and South Central Health Planning & Development, Inc. plan of having a certified Community Health Aide in each village.
12. Elimination of a clerical position in our Outpatient Dept. eliminating the ability to track chronic disease patients to call them in for follow-up, adequatrack chronic patients in the village, [illegible] examples of the impact of further budget cuts.

It is possible that the ultimate impact this year of the Reagan budget cuts depending how Congress and the President choose to make those cuts may additionally result in:

1. Elimination of additional position including direct care position in the hospital.
2. Downgrading other positions to nine month positions.
3. Reduction in salaries with the result we will fall critically below salaries needed for recruitment and retention.
4. Elimination of annual village meetings in which consumers provide input into our planning and prioritizing process
5. Elimination of travel to the villages by the Emergency Medical Services Dept. to establish Search & Rescue teams, training school children and adults in First Aid, etc.

As you know, the proposed cuts in fiscal year '82 are only the first of a four year plan for a massive reduction in Federal effort. The potential impact on the Indian Health Service would be disastrous. It was learned that during this year's appropriations process in the Senate, there was introduction of an amendment to completely eliminate the community health aide program in Alaska. This program provides more than half of the total ambulatory care in our region and would set health care in rural Alaska back 20 years. The purpose in reviewing this information with you is to point out that it is imperative that the State of Alaska now establish a policy as to what responsibility it will take for provision of health services to its citizens. Like the commitment that the State has made in education, a similar commitment will need to be made for health services. With the oil wealth available to us, there should be some consideration of investment in human resources of the State and

not merely development of renewable and non-renewable natural resources. The Medicaid program must be expanded and a health security program provided to insure that those who are unable to access services due to the high cost of travel and using those services will not be prevented from receiving medical care that is required. Principal problems in the health delivery system of Alaska is accessibility. The cost now of a trip from an outlining village to Nome to acccess can run up to a $100 one-way. With the cutbacks in the BIA Social Services and other social programs, it is becoming an increasingly difficult for patients to come up with funds to meet these needs.

I would propose that the State of Alaska establish a policy whereby a minimum benefit package not unlike that in House Bill 41 would be provided to all citizens. A sliding fee scale would be established, that takes into account regional differences in costs, and has the State participating for its percentage of those costs. Policies would have to include whether or not employers could meet that need directly or would buy into that same program administered by the State and/or have other options. The State of Alaska could then seek to negotiate with the Federal government a commitment so that the Federal government will meet the on-going costs of a certain basic minimal set of services as part of its obligation to Native Americans. The legal obligation of the Federal government in its press for responsibility to provide these services is very clouded. The Snyder Act which is the enabling act for the Indian Health Service, says only that Congress has the option to provide funds for provision of health services. The original treaty agreement between Russia and the United States stipulated that the United States must continue to provide services to Alaska Natives. It may be that if negotiations between the the State and Federal government fall down, a legal effort could be

initiated to have the United States honor its original treaty responsibility. At any rate, the Federal government is likely in such a negotiated agreement to reduce the services well below what is being provided now. This short-range cost only speaks to the inevitable long-range cost and would allow the State to prevent short-range drastic cuts to come from the Reagan budget cuts.

House Bill 41 must treat all Alaskans alike. Differences should be drawn based on income levels and costs in accessing as well as utilizing health services. That is, a deductible, based on the total amount that would be paid out on behalf of any individual for services in a given year should he stipulated and maintained across the State.

In the negotiations with the Federal government, I believe the State should begin taking full responsibility for mental health services as well as environmental health services. The part of the Indian Health Services that has going to this purpose should be shifted into medical services.

HEALTH PLANNING:

Evidence prior to the establishment of health systems agencies in Alaska has proven that the development of accurate and respected State health plans that have positive impact on moving the health systems forward cannot be created on a Statewide basis. The existing State health plan which is well respected, is the result of massive input from the health systems agencies. The function of the State office is merely one of coordination as called for under Federal planning legislation. I believe the State of Alaska must provide funds to continue the health planning effort for the following reasons:

1. Regional priorities and input are necessary in order that a realistic and respected State health plan can be developed.
2. State health policy, which has been woefully absent, must be guided by such a plan. This would include the allocation of resources by the Legislature and the Administration.
3. Data cannot be collected on a Statewide basis without its filtering through a regional planning effort that can test that data. The need of the State to contract out an inventory of clinic facilities and accurate hospital information bespeaks my point.
4. The Legislature and the Administration need comment from regional planning groups regarding proposed programs and policies to improve the health status of Alaskans. Again, I do not feel that the Statewide form is sufficient in this regard.
5. The State should provide seed funds for the establishment of a public interest consulting firm that would work with communities to develop strategies for impacting Alaska's major health status problems. The major health status problems of Alaska are those resulting from decisions Alaskans make as to how they live their lives. That is the decision to consume alcohol, smoke cigarettes, overeat, fail to get exercise, fail to practice accident preventive practices, etc., and are not amendable to solutions by the medical care system. The educational process and/or community and peer pressure are necessary to exert changes. Alaskans must have an informed choice as to how to live their lives. Persons should be taught through community or educational system mechanisms the effects of lifestyle decisions upon their future health. Further, many communities, wish to on their own initiative, develop services in their communities. They need expertise on how to apply for grants, how to work within commu-

nities to gain support for programs, etc. The cutbacks in funding to the regional health corporations will make it very difficult for them to provide the kind of technical assistance to communities to meet these needs. Where the State of Alaska to fund HSA's on a minimal basis to provide the above functions, they could then offer services to communities and/or providers on a consulting non-profit basis to perform the following:

a. Training of staff or Board Members
b. Development of long-range plans
c. Development of short-range plans
d. Grant writing
e. Systems analysis
f. Development of local resources and community action for preventive and educational services

Essentially my proposal is a compromise. It provides the needed seed money for HSA's who have interest in resource development to maintain an office and avail themselvs to communities for that purpose. If they are not successful in marketing their services, then their staff will be severely limited and provide only the data input.

DEVELOPMENT OF REGIONAL HEALTH CORPORATION:

I believe the State must streamline the contracting process to enable services to be contracted to regional health entities. The State will need to look at its need for representation from all aspects of the community and the regional health corporations need to abide by the regulations of the Indian Self-

Determination Act which requires representation only from tribes. I believe this could be worked out with the Indian Health Service.

Presently the regions are pulling away from increased responsibility for provision of services to populations in their regions. The reason for this is the cutback in Federal funds. If the State is going to be supportive to the forthcoming cutbacks in services by the Federal government, it will need to have regional non-profit entities operating those services. I don't believe the State will be inclined to provide direct or insurance assistance to a Federally operated facility. Therefore, the State has some interest in the development of the regional health corporation's ability to provide services. This could take the place of provision of additional training through the community colleges or the universities, the provision of grants for development purposes (these were formally provided by the Indian Health Service but has since then been largely eliminated), seminars, etc.

George Petkovich

MARIGAL OHOHANEY, M.D.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Bethel Hearing
Nov. 14, 1981
(1)

George Kratovich - HSA - Southcentral Bethel rep.

concern over future of HSA. Nov 6-7 met in Anch. all three. Provided much technical assistance in Bethel. Looking at forming a coalition - reducing board members, changing types of service given

alcoholism program - need more co-ordination between agencies/ funding mechanisms. Could not have local input on grants coming to Bethel - not enough money to travel to regional meetings. Block grant money now

Marilyn Chohaney MO - Med. Direct. YKHC

Elimination of travel funding (50-70,10[2] sq miam[illegible]

The reason health care has worked in this area is because of CHA. Average CHA - woman in 30's h.s. education, bilingual, [illegible] children [illegible] training key person in community, daily radio contact w/ physician in Bethel. Travel fund cut makes CHA more resp. for primary care.

Clinic (heat, lights, communication, Rx storage) problems with all of these physical structures in [illegible]. Have been federally funded, staffed, training. Village Council has lease w/ PHS - funds frozen, no inflation increase

DHS funding a flat amt. per village with the community expected to make up the difference.

Betsy Weiss - keep.

gradual increments in improvement in communications, even an imperfect system.

Dr. John Heavenrich -

many villages have phone in public place, no privacy with charts - sometimes phones don't work. Emergencies can generally be handled, but routine care has prob. of comm. with physician on a daily basis.

15 villages with phones in clinics. 48 have side band radio - communicate mainly w/ these.

TRAVEL FUNDING - Some villages (in St. Marys) using 638 monies for health travel ($5,000)

Joe Ryan - Loop Admin - $32,000 travel for St. Mary's

Emergency travel (charters) are the most expensive

Priority Issues:

- Resources of CHA -
- Travel & Communication

Gina Pattee - Pub. Health Nurse

per capita funding not high, costs extreme. ($550/per head) Compensation not bad for rural area.

Mary Pavlo - Director Y.KHC

Medicaid problems - Medicaid will not pay from village to Bethel - only Bethel to Anchorage. Need Medicaid access for air transportation. Agreement between AANHS & HSS.

IHS responsible for travel to their facility. YKHC are judged IHS resources & Medicaid will not pay. Only $70,000 IHS funds in M.H. (eye care maternal/child mental health)

Jeff Friedman - Dir. Mental Health YKHC

Mental Health not IHS through HSS considers it such. Psychiatric services in twice a month in Bethel from Anch. psychiatrist. Medicaid compass not cover travel

Helen Callens - PHS supervisor

Medicare pays for child for ESD 3-4 visits yearly in village. (4 to 5 days) doctor once a year.

Joe Ry... - always fear of present cuts create difficult time in cutting services people have come to expect.

Trust relationship not an entitlement. Lack of relationship between all those investigating Health Care and Native relationship.

Currently

avg. pt. load 33/day (60-80%)
14 doctors (1 ax administrator) 1 for radio comm/day
62 nurses 2 for inpatient
50,000 outpt. visits yr.

only 1/4 people who have to hospital have transportation fd. boarding home funds also cut, cut operating expenses for ambulance, money cut for village sanitation travel, may have to cut prematernal home.

Non-Natives (about 2,000) have no access to health care other than IHS. Hospital has no mechanism to collect money (Fed. Law)

Dina Pattier

need for Prevention - maternal & child. nutrition village must mobilize. access to good food. - stores don't carry the proper food, people can't afford to buy it.

Nancy Bill — Health Educator YKHC

school health, pr. ed, community health ed.

many outpatient visits are for infectious diseases tied to lifestyle, sanitation etc. Villages need education on basic areas — require deep personal habit change. health aides can be best utilized for prevention but are taken up w/ care.

Jeff Friedman – M.H.

primary prevention/ed.

facility being constructed in Mtn. Village as a district health center for villages in that area

State subsidy of health aide program. They make $12-14,000/yr. – sub standard care – your responsibility.

PHN only has time for mandated activities & Chronic pts. No time for education.

7 itinerant nurses, 3 for Bethel. Keep radio contact w/ CHA.

"Here's looking at you" should be mandated by State.

EMS does pt. ed in villages periodically – also MH/dental.

Village airports – runways poorly maintained, no lights

10 village-based alcohol programs. Others get only 3-6 days of program a year. Need more volunteer people

ANCP might have info.

Estimated that villages are growing and not dying. People migrate to Bethel but return for lack of jobs etc. Much dependency or subsistence. Few have any income from any industry. Only 5-6 villages have TV – potential for Ed??

Wally Richardson – LIO

teleconference network can be an educational tool

Can dial in to villages from Anch, Juneau, FBKS.
Could have speaker-phone in village to broadcast to a roomful of people.

Early Childhood programs important to villages —
Infant Learning, Parent-child (funded by RuralCap)
for 6 mos — 3 yrs. Stress on teaching
parenting — play, reading etc.

YKHC runs Ed. programs at yere-maternal home
Trying to implement WIC program in area

Mary has proposal for supplementing salaries
of CHA's in Bethel area. Also need to upgrade
skill-level — will have travel costs.
* Standardize health aide capabilities??

legal protection for CHA? under supervision of IHS physicians
covered by Fed. Torts — will provide defense but
no real statement of liability.

4 villages do not have clinics — use BIA schools,
so in summer, are locked and no access
to phone at some times.

Joe Ryan - Every 3 years — a comprehensive study of
the clinics. Issue of use from village council

64 primary CHA's
48 alternates

HB 41

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Discussion Paper

Development of Regional Health Resources Organizations

Prepared by

Alaska Health Coalition

November 6-7, 1981

Agreed To In Principle by:

Statewide Health Coordinating Council

Northern Alaska Health Resources Association, Inc.

South Central Health Planning and Development

Southeast Alaska Health Systems Agency

December 15, 1981

OVERVIEW

Members of the Board of Directors and Staff from each of the Health Systems Agencies (HSA's) in Alaska have been grappling for several months with the problem of how to maintain a regional health perspective or voice within the State when Federal support for health planning is discontinued. Early in 1981, the Commissioner of Health and Social Services expressed a desire to support the continuation of a regional health planning program. HSA's were invited to develop a proposal for her consideration as part of the Governor's budget for FY-83. After the HSA's agreed on a core of five functions, each developed a proposal for the Commissioner based on local needs and submitted them in August, 1981. After considering the proposals, the Commissioner elected not to include additional funds for HSA's in the Department of Health and Social Service budget basically because of other departmental priorities in the areas of corrections and mental health.

Following the Commissioner's decision the HSA's reassessed their position and agreed that if the worthwhile functions of the HSA's were to be maintained, an effort must be launched to gain legislative support. Subsequently, the Board Presidents, other board members, and staff from each of the Agencies met in Anchorage for a two-day session to develop a proposal and a strategy for approaching the State Legislature. We carefully examined all of the activities we have been engaged in over the past five years and compared them with what we believed to be the needs of the State. This led to the development of a proposal for regional technical assistance centers for health which would have as their core functions: 1) community assistance, 2) health promotion, and 3) regional perspective.

To promote the proposal within the State those present at the November 6-7, meeting elected to form a coalition with representation, at the present time, made up of HSA Board Presidents and Executive Directors, and the Chairman of the Statewide Health Coordinating Council. The primary mission of the Alaska Health Coalition - as it was named - is "to review the need for health planning, development, and promotion activities and to develop goals, describe functions and recommend structures to achieve optimal health for the citizens of the State of Alaska."

The core functions are outlined below with examples of activities which would be carried out within each of the functions.

1. COMMUNITY ASSISTANCE

   To assist communities in identifying problems and developing plans to solve them. Activities would include:

   A. Organizing key individuals within the community or region to address important health issues.

B. Gathering ideas/opinions from community members on specific issues or needs.

C. Analyzing problems and assisting in the development of local strategies for dealing with unmet needs.

D. Assisting communities to implement strategies.

E. Conducting public hearings on issues of local or regional concern.

F. Providing direct technical assistance to individuals, service programs, and communities in:

- defining needs
- identifying resources (manpower, financial, services)
- preparing grant applications
- assisting with program implementation
- assisting with program evaluation

II. HEALTH PROMOTION

To promote the development and maintenance of health promotion and prevention programs through:

A. Determining the prevention and health promotion needs of the region.

B. Assisting the currently existing programs to improve their effectiveness through coordination and cooperation with other programs.

C. Providing a forum for prevention and health promotion interests.

D. Developing new prevention or health promotion programs to meet the special health problems of Alaska.

III. REGIONAL PERSPECTIVE

A. To maintain a local/regional capability to provide current, accurate, health-related data for planning review, and resource development activities by:

1) Assisting individuals, communities, service programs, and the Department of Health and Social Services to define data requirements to support regional and statewide planning activities.

2) Maintaining a regional data library which would contain current information on the population, socioeconomic status, health status, and health care system for use by all citizens.

3) Coordinating data collection activities with local agencies, regional Native corporations, and statewide agencies and organizations.

B. To maintain coordination with State government by:

1) Providing a community/regional perspective to the Legislative and Executive Branches of State government on health-related issues.

2) Conducting local reviews of grant applications and proposals for local or State health-service funds in cooperation with the Commissioner of Health and Social Services.

3) Conducting local reviews of proposals for new institutional health services (hospitals, nursing homes) as required by the Alaska Certificate of Need Law.

4) Studying and developing recommendations on policy issues suggested by the State Legislature, the Department of Health and Social Services, or other policy setting bodies.

C. To conduct research activities and program evaluations in response to regional and State priorities by:

1) Conducting health-service and health-policy research on issues of local, regional or statewide interest.

2) Assisting health service programs to develop and implement program evaluation activities within their agencies.

3) Assisting local and State funding agencies in conducting evaluations of health service programs.

OTHER FUNCTIONAL CAPABILITIES

Another function currently performed by regional health systems agencies which is considered important, but which should be de-emphasized is plan development. After five years of developing and revising regional health systems plans, we believe that much less time should be spent on the paperwork of plan development. Instead more emphasis should be placed on implementation of existing plans.

Regional health systems plans are important especially as they relate to the State Health Plan and other State planning documents. We recommend a five-year planning cycle for the regional health plan interspersed with subject-specific plans such as mental health, facilities, manpower, etc.

GOVERNANCE

We propose that regional health resources organizations be private, non-profit corporations governed by a board of directors made up of consumers and providers from throughout the different regions. Appointment to the governing board would be by locally-elected officials, health boards, or by election of the general membership of the corporation.

The number of governing board members should not exceed 20 nor be fewer than 10.

SUNSET PROVISION

It is suggested that a "sunset provision" be included in any legislation or regulations which may come about as a result of this proposal. It seems reasonable to set a three-year time limit on the initial development of regional health resources organizations followed by a legislative review before additional funding could be forthcoming.

STRUCTURE

We propose that at least three regional health resources organizations be established along boundary lines which are coterminous with those of the regional Native corporations. Provisions should be included to allow further division of a region to recognize established health resource activities (municipalities with health powers, Native health authorities).

The uncertainty created by the Federal budget process has made it difficult to propose a formal working relationship between the State Department of Health and Social Services and the regional health resources organizations. At the present time, the Federal government mandates and funds the Division of State Health Planning and Development and the Statewide Health Coordinating Council (SHCC). Regional health systems agencies are formally linked to these two entities, as provided in PL 93-641 and PL 96-79 and would continue that relationship as long as Federal funds were supporting any part of the health planning and resources development network.

In the absence of Federal funds, which will most assuredly occur in the FY-83 Federal budget process, the State of Alaska must reassess the relationship between the State Department of Health and Social Services and its constituents. The regional health resources organizations will be prepared to work cooperatively with the Department of Health and Social Services and the State Legislature to develop a formal working relationship which maximizes the flow of information and resources throughout the health system in the most efficient and effective way possible.

Each center would be staffed by at least three professional people and additional clerical staff. Estimated budget would be $300,000 ± $50,000 for each center (about two-thirds the current level of funding for the Health Systems Agencies).

AUTHORITY

We are proposing that the regional health resources organization be vested with the authority to have "review and comment" and/or "review and approval/disapproval" responsibility over State funds which are awarded to health service programs within their jurisdiction. Although technical assistance provided to a potential applicant for State funds is believed to have the most impact on the final delivery of services, we also recognize that, without the authority which accompanies project review, health service agencies would have very little incentive to shape their programs to meet local needs.

Authority to review the expenditure of State funds for the development or expansion of health facilities, major medical equipment, and for operational costs associated with new services should also be included in legislation or regulations establishing health resources organizations. We propose that the threshold limits for "Certificate of Need" review be raised to at least $600,000 for capital expenditures; $400,000 for major medical equipment; and $250,000 for operational costs associated with new services.

Franz A. Stiegemeier
Box 302
Bethel, Alaska 99559
~~Pub. Cmnt.~~

18.27.020(a) 2: is IHS/PHS considered an adequate federal health program? ~~adequa~~
~~If it is not equal to~~

18.27.030 ~~Sec~~ Sec 2 P2 ~~if the area population~~ 15,000 Enrollees
15,000 enrollees for whom the state will bear 100% of copayments and deductible.
(Estimate $15,000,000?)

47.05.070(a): simply cannot be done with the feds lack of a billing procedure, there would be no assurance that moneys would be returned to ~~a~~ the utilized unit.

In regard to this I feel the best thing the legislature of the state of alaska could do for rural health care would be to help liberate the regional hospitals from the clutch of the federal government to the regional health corporation. As autonomous health organizations the would be eligible for a 100% return of their billings. And in a state with comprehensive health ~~ph~~ insurance, those revenues [going to PHS] will be considerable.

47.05.120 (1) the federal [IHS/PHS] health system, at the present time, is incapable of submitting a clean claim to third party insurance, due to their inability to break down, itemize, services on the bill

47.07.030 - Med services to be offered
noise about Medicaid travel, the hospital will ask that the ~~IHS~~ state pay for travel via TR mechanism. The ~~fee for travel portion~~ travel ~~portion~~ could as easily be an ~~itemized~~ item on a bill which is submitted for medicaid payment. Unfortunately the local hospital would lose 1/2 of the returns

funds ~~to medicaid~~ to AREA administration.

WHY DOES AREA administration keep 50% returned medicare money?

General observation re HB 41:
One can see the federal control rural health HB 41 will yield little to rural residents.

22. Any injury or illness resulting from war or any act of ware, declared or undeclared, or from commission of a felony by the covered person.

24. Expenses incurred prior to the effective date of this schedule of benefits or for services rendered after this schedule of benefits is terminated by contractual or Congressional Act or eligibility of a person terminates.

25. Inappropriate use of ER.

26. Inappropriate use of ambulance

27. Abortions: There is a strong likelihood that in the near future the IHS will not be able to pay for elective abortions.

14. Any mental health, alcoholism, or chemical dependancy services not specifically covered in the benefits described under Mental Health; Alcoholism, and Chemical Dependancy Services.

15. Any mental health Services.

15. Specialized evaluation and therapy to include: Speech therapy hearing therapy, therapy for learning disability, communicatic delay, perceptual disorders, mental retardation and related conditions, behavior disorders, mulitiple handicapped, hyperactivity, sensory deficit and motor dysfunction, developmental and neuroedurational testing or treatment, sleep therapy, hypetherapy and bio-feedback, behaviorial training, myofunctional therapy, neuromuscular rehabilitation and other special therapy.

16. Marriage counseling.

17. Vocational rehabilitation.

18. Acupuncture.

19. Procedures, services, and supplies related to sex transformation. Reversal of voluntary sterilization procedures and related procedures.

20. Surgical treatment for obesity.

21. Home delivery for child birth.

22. Artificial aids and external prosthetic devices, artificial limbs, corrective appliances, rental or purchase of durable equipment and supplies.

3. ~~Care in an Extended Care Facility~~, or Skilled Nursing ~~Facility~~;

4. Custodial care domiciliary care or nursing home care.

5. Home health services except as provided per professional judgment by the KANA physician or community health aide.

6. Audiological (hearing) screening, hearing aids, and the fitting of hearing aids.

7. Eyeglasses except as provided for under Special Services and Supplies.

8. Cosmetic surgery or conditions for which plastic surgery is indicated primarily for cosmetic purposes, except as provided for under Medical Services.

9. Dental care including dental x-rays except as provided for under Dental Care.

10. Third party physical examinations such as those for employment or for purchase of insurance, (except to the extent that the normal physical examination schedule is applicable). School physicals will be provided at the KANA medical clinic

11. Any procedures which can be classified by the Alaskan Medical Community as experimental, investigative, unusual, or not customary in Alaska medical practice.

12. Any out of Area Service.

13. Pediatric or chiropractic services.

Mary P.

EXCLUSIONS

All services for conditions within any of the following classifications shall be excluded from coverage:

1. Illness, injuries, or conditions covered by services, idemnification, or reimbursement available either:

   a. Pursuant to any federal, state, county, borough, or municipal workmen's compensation or employee's liability law or other legislation of similar purpose or import;

   b. Pursuant to benefits available from federal, state, county, municipal, or other governmental agencies, including the Veterans Administration for service connected disabilities or injuries; benefits available through the Indian Health Service and/or Alaska Area Native Health service are specifically excluded from this subpart;

   c. Pursuant to any federal, state, or other legislation, such as Medicare or Medicaid;

   d. Pursuant to benefits entitled to any covered person under any automobile liability or medical payments policy; and

   e. Services for bodily injury, illness, or disease arising out of motor vehicle accidents for which there is available other valid and collectable insurance under the provisions of Alaska statutes.

2. All medical specialty care except when cleared on a case-by-case basis through the Area

2nd copy of 12 Dunn's
test to Judy Sutherland

Bon Sloan Dir. Nort. Sound Hosp.

Nome hearing
Nov. 7, 1981

Charlie - introduction

Jeannette Morton - reading Bill Dunn's testimony

HB 41 - (for 4 yrs. been getting 10% C.O.L. increase from IHS. Have absorbed impact by:

Eliminating training/planning
reducing travel funds
30% below comp. State salaries for staff

Concern over further budget cuts. Can no longer cut admin. etc Will have to cut service:

lab tech
therapy
reduce village sanitarian travel
reduce training
village eye care
planning office
boarding home prog. (for villages)
reduce pt travel
CHA training every 2 yrs.
Elim. outpt. Clerical staff

potential impact on IHS in 4 yrs disasterous.

State needs to estab. policy for health services. Invest in human resources. Expand Medicaid travel services.

accessibility - major prob.

BIA Soc. Ser. cut - affects travel $

State needs to negotiate w/ Feds over obligation for health care

HB41 treat all Alaskans alike - sliding scale, income, C.O.L.

more resp. for mental health services.

Health Planning

Existing state health plan function of HSA -

1. regional priorities/input
2. need state policy
3. few data collected
4. need public interest consulting re: health care - prevention/education change lifestyle.
5. need grant assistance
6. state need monies for HSAs

Develop of Reg Health Corp

attitude of resp for IHS to serve only native pop need to change

Connie Nullenbuck – Coord for Alcohol Program.

Comprehensive Alcohol Program recs:
1. avail/access of services
2. included in planning/ed.
3. not a separate issue in HB 41

Alcohol not prob. in Nome).
Ins needs to cover alcohol like any other medical condition
State funded
Detox / medical (acute)
Rehab treat.
CMHC
Women's center
After care
Consult/Educ

Villagers come to Nome to drink w/ local options.
Need local treatment – learn to change life style in own environment.
measuring outcome
quality of life
financial status
ability to seek/hold job

CAP operates on a continuum of services
Ed. for coping skills

Link to limit alcohol availability – not serve inebriates, limit hours etc.

12 bed fac. 45 day program (1 yr. in after.) stays pvt.
80% villages 90% all court referrals - follow-up part of probation - volunteer after care in villages
pilot project - alcohol ed. sponsored by Court will share w/ Govern this year. Class for credit.

Sharon Wallace Director CMHC

M.H. hard to justify existence hooked into reg. programs through those skills are not applicable here. Head of service delivery is funded by State

McGrath Paper - alternative program need help from state to develop Evaluation.
service/delivery
Evaluation
One: one counseling does not work. Developing community support (extended family, elders, village council) for chronic M.H people in villages Community Model - peer pressure more relevant than counseling IHS no longer fund. Do not keep people on medication in villages, but nutrition/training

Darryl Tracy - Board Member Northern Tribal Health Centers w/ language re HB41
* "annual bond regardless of size of family;"

Insurance on alcohol needed in bush — object to giving it to State employees. Is it a pilot project / how long.

define "federal health plan"

Where natives lie in between IHS & NSHC? What is the relationship between them.

HB 151 - (Trust money into General fund for M.H.)
taken years to build MH trust funds, so much is needed, why deplete funds

Jeff Langer - Sanitarian NSHC

Top priority in villages - water & sewage.
more emphasis on operation & maintenance of facilities than in past.
Golovin - Brevig Mission need high schools with no running water. Golovin water ..... everywhere
Some villages have lead in water because of poor solder used in construction
Shishmaref has water supply next to cemetary - sewage
real problem with garbage - no funds to haul away.
208 grants by N.S.H.C to do feasibility,