

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1586 SHESS HB 357 - (HB 464 & HB 465) ✓

ATTACHMENT II

Base Rates at the Governor's Budget Level Less (-943,700)

Region/Facility	Negotiated Rate	x	Estimated Census (FTE's)	=	FY 83 Estimated Cost
<u>RESIDENTIAL CARE II</u>					
<u>Southcentral</u>					
Jesse Lee	127.00		13,323 36.5		1,692,021
Rabbit Creek	127.00		2,957 8.1		375,539
Booth Memorial Home	127.00		4,818 13.2		611,886
<u>Southern</u>					
Ketchikan Int.	127.00		1,460 4.0		185,420
			<u>22,558</u> <u>61.8</u>		<u>\$2,864,866</u>
<u>RESIDENTIAL CARE I</u>					
<u>Southcentral</u>					
Turning Point	90.50		13,140 36.0		1,189,170
Kodiak Baptist	90.50		4,709 12.9		426,164
Aquarius	90.50		1,825 5.0		165,162
Colletti	90.50		1,679 4.6		151,949
North Star	90.50		1,679 4.6		151,949
Alaska Baptist	90.50		3,139 8.6		284,079
Hilltop	90.50		5,986 16.4		541,733
Kenai	90.50		2,519 6.9		227,969
<u>Southeastern</u>					
Juneau Receiving	90.50		4,271 11.7		386,525
<u>Southern</u>					
Ketchikan I & II	90.50		5,476 15.0		495,578
<u>Northern</u>					
North Star	103.50		4,234 11.6		438,219
Presbyterian	103.50		3,103 8.5		321,160
<u>Western</u>					
Bethel Group Home	119.50		1,351 3.7		161,444
			<u>53,111</u> <u>145.5</u>		<u>\$4,941,101</u>
<u>EMERGENCY SHELTER</u>					
<u>Southcentral</u>					
ACS Receiving	90.50		5,146 14.1		465,713
Kodiak Baptist	90.50		1,533 4.2		138,736
<u>Southeastern</u>					
Sitka Receiving	90.50		1,679 4.6		151,949
St. Judes	90.50		73 .2		6,606
<u>Northern</u>					
"R" House	103.50		5,256 14.4		543,996
<u>Western</u>					
Bethel Receiving	119.50		1,314 3.6		157,023
<u>Northwestern</u>					
Nome Receiving	123.50		1,241 3.4		153,263
North Slope	123.50		2,372 6.5		292,942
Kotzebue	123.50		1,825 5.0		225,387
			<u>20,439</u> <u>56.0</u>		<u>\$2,135,615</u>
					<u>\$9,941,582</u>

ATTACHMENT III

Base Rates at the Governor's Budget Level Less (-2,000,000)

<u>Region/Facility</u>	<u>Negotiated Rate</u>	x	<u>Estimated Census (FTE's)</u>		= <u>FY 83 Estimated Cost</u>
<u>RESIDENTIAL CARE II</u>					
<u>Southcentral</u>					
Jesse Lee	114.50		13,323	36.5	1,525,483
Rabbit Creek	114.50		2,957	8.1	338,576
Booth Memorial Home	114.50		4,818	13.2	551,661
<u>Southern</u>					
Ketchikan Int.	114.50		1,460	4.0	167,170
			<u>22,558</u>	<u>61.8</u>	<u>\$2,582,890</u>
<u>RESIDENTIAL CARE I</u>					
<u>Southcentral</u>					
Turning Point	80.50		13,140	36.0	1,057,770
Kodiak Baptist	80.50		4,709	12.9	379,074
Aquarius	80.50		1,825	5.0	146,912
Colletti	80.50		1,679	4.6	135,159
North Star	80.50		1,679	4.6	135,159
Alaska Baptist	80.50		3,139	8.6	252,689
Hilltop	80.50		5,986	16.4	481,873
Kenai	80.50		2,519	6.9	202,779
<u>Southeastern</u>					
Juneau Receiving	80.50		4,271	11.7	343,815
<u>Southern</u>					
Ketchikan I & II	80.50		5,476	15.0	440,818
<u>Northern</u>					
North Star	92.00		4,234	11.6	389,528
Presbyterian	92.00		3,103	8.5	285,476
<u>Western</u>					
Bethel Group Home	107.00		1,351	3.7	144,537
			<u>53,111</u>	<u>145.5</u>	<u>\$4,395,609</u>
<u>EMERGENCY SHELTER</u>					
<u>Southcentral</u>					
ACS Receiving	80.50		5,146	14.1	414,253
Kodiak Baptist	80.50		1,533	4.2	123,406
<u>Southeastern</u>					
Sitka Receiving	80.50		1,679	4.6	135,159
St. Judes	80.50		73	.2	5,876
<u>Northern</u>					
"R" House	92.00		5,256	14.4	483,552
<u>Western</u>					
Bethel Receiving	107.00		1,314	3.6	140,598
<u>Northwestern</u>					
Nome Receiving	111.00		1,241	3.4	137,751
North Slope	111.00		2,372	6.5	263,292
Kotzebue	111.00		1,825	5.0	202,575
			<u>20,439</u>	<u>56.0</u>	<u>\$1,906,462</u>
					<u>\$8,884,961</u>

ATTACHMENT IV

INSTITUTIONAL RATE COMPARISONS

Senate figure

House fig

<u>Region/Facility</u>	<u>FY 82</u>	<u>FY 83 Gov. Budget</u>	<u>FY 83 Gov. (943.7)</u>	<u>FY 83 Estimated Cost</u>
<u>RESIDENTIAL CARE II</u>				
<u>Southcentral</u>				
Jesse Lee	165.46	140.00	127.00	114.50
Rabbit Creek	166.40	140.00	127.00	114.50
Booth Memorial	146.90	140.00	127.00	114.50
<u>Southern</u>				
Ketchikan Int.	152.56	140.00	127.00	114.50
<u>RESIDENTIAL CARE I</u>				
<u>Southcentral</u>				
Turning Point	105.37	98.50	90.50	80.50
Kodiak Baptist	61.61	98.50	90.50	80.50
Aquarius	107.60	98.50	90.50	80.50
Colletti	117.51	98.50	90.50	80.50
North Star	103.55	98.50	90.50	80.50
Ak. Baptist	117.02	98.50	90.50	80.50
Hilltop	85.53	98.50	90.50	80.50
Kenai	91.74	98.50	90.50	80.50
<u>Southeastern</u>				
Jureau Rec.	106.17	98.50	90.50	80.50
<u>Southern</u>				
Ketchikan	74.26			
I and II	81.61	98.50	90.50	80.50
<u>Northern</u>				
North Star	62.25	114.00	103.50	92.00
Presbyterian	111.98	114.00	103.50	92.00
<u>Western</u>				
Bethel Group	59.06	131.00	119.50	107.00
<u>EMERGENCY SHELTER</u>				
<u>Southcentral</u>				
ACS Receiving	149.85	98.50	90.50	80.50
Kodiak Baptist	61.61	98.50	90.50	80.50
<u>Southeastern</u>				
Sitka Rec.	40.66	98.50	90.50	80.50
St. Judes	72.33	98.50	90.50	80.50
<u>Northern</u>				
"R" House	111.98	114.00	103.50	92.00
<u>Western</u>				
Bethel Rec.	75.52	131.00	119.50	107.00
<u>Northwestern</u>				
Home Rec.	116.97	135.30	123.50	111.00
North Slope	168.35	135.30	123.50	111.00
Kotzebue	NEW	135.30	123.50	111.00

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

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

March 24, 1982

DOCUMENT NO. 111-82

The Honorable Mike Beirne
Representative
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

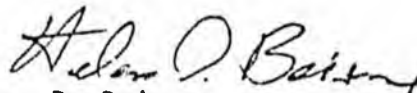
Dear Representative Beirne:

You recently inquired about the probable effects of a reduction of \$2 million in the proposed budget for residential care in the Division of Family and Youth Services. This reduction has been proposed by the HESS Subcommittee of the House Finance Committee.

I am enclosing for your information a letter which was sent to Representative Carney describing the types of care and reimbursement levels which would be considered with budgets set at the Governor's level, at a reduction of \$943,700 as submitted by this Department at the Subcommittee's request and at a reduction of \$2 million as proposed by the Subcommittee. All three levels assume the repeal or amendment of the full cost of care provisions of AS 47.40.

If there is no change in AS 47.40, we would expect to have to close about 44 beds with a reduction of \$943,700 and about 67 beds at the \$2 million reduction level.

Sincerely,



Helen D. Beirne
Commissioner

Enclosure

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

May 12, 1982

SUBJECT: Effect of SCS HB 357 (HESS) on pending litigation

TO: Senator Vic Fischer
Attn: Nancy Groszek

FROM: Thomas A. Sofo *AS*
Legislative Counsel

You have inquired concerning the effect of SCS HB 357 (HESS) on pending litigation. Although SCS HB 357 (HESS) involves revisions to the state law concerning the payment of public assistance, the question is one which can be answered generally. AS 01.10.100(a) provides:

The repeal or amendment of any law does not release or extinguish any penalty, forfeiture, or liability incurred or right accruing or accrued under such law, unless the repealing or amending act so provides expressly. The law shall be treated as remaining in force for the purpose of sustaining any proper action or prosecution for the enforcement of the right, penalty, forfeiture or liability.

The Alaska statutory rule comports with the general common law rule to the effect that ~~rights and liabilities are not affected by the passage of subsequent legislation unless that legislation expressly provides for such effect.~~ A review of the effective date clause for SCS HB 357 (HESS) reveals that the act is to take effect on July 1, 1982. The ~~act makes no overt attempt to be retroactive~~ and therefore is subject to the general rule. Litigation concerning issues which are addressed by the amendments to the state public assistance laws stands or fails on its own merits based on those laws at the time the litigation was instituted rather than being subject to later legislative action. However, on a practical level, ~~when faced with~~

Senator Vic Fischer

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May 12, 1982

~~statutes which are ambiguous a number of courts will look to recent legislative activity as an interpretative tool in trying to ascertain the legislature's original intent.~~

Where a former statute is amended, or a doubtful meaning of a former statute rendered certain by subsequent legislation, a number of courts have held that such amendment or subsequent legislation is strong evidence of what the legislature intended by the first statute. But, a subsequent legislative construction of a statute is not conclusive of the meaning of the former statute. Sutherland, Sec. 49.11.

Whether or not a court will decide to look to recent law in litigation that is ostensibly controlled by prior statutes seems to depend upon a number of circumstances. The types of circumstances which seem to bear most heavily on the propensity of a court to review recent legislative action are reflected by the statement in an old New York case.

The force which should be given to subsequent, as affecting prior legislation, depends largely upon the circumstances under which it takes place. If it follows immediately and after controversies upon the use of doubtful phraseology therein have arisen as to the true construction of the prior law, it is entitled to great weight . . . if it takes place after a considerable lapse of time and the intervention of other sessions of the legislature, a radical change of phraseology would indicate an intention to supply provisions not embraced in the former statute. People ex rel. Westchester Fire Insurance Co. v. Daveport, 91 N.Y. 574, 591 - 592 (N.Y. 1883)

Strictly speaking, ~~the enactment of SCS HB 357 (HES)~~ should have no effect on pending litigation. Realistically speaking, ~~a court in this state may consider the content of that bill if an issue in the current litigation is the ambiguity of or the legislative intent behind the current law.~~ It would be merely a guess as to the amount of weight which the court would give to this bill. But it would be impossible to state with certainty that the passage of SCS HB 357 (HES) would have completely no effect on court cases under the former law.

TAS:ljb

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
SHOULD TAKE ADDITIONAL ACTIONS TO REDUCE PAYMENT
OF PUBLIC ASSISTANCE FUNDS TO INELIGIBLE PERSONS

STATE OF ALASKA
OFFICE OF THE GOVERNOR
DIVISION OF INTERNAL AUDIT



06-47

SUMMARY

Public Assistance programs provide financial aid, food purchasing assistance, and medical payment assistance to eligible individuals. Over \$100 million is spent on public assistance programs in Alaska each year. The Department of Health and Social Services administers these programs through their Division of Public Assistance. To prevent erroneous payments of public assistance money, the Department has established a Quality Control Unit and a Fraud Investigation Unit.

ERRONEOUS PAYMENTS ADD TO THE COST OF THE PROGRAMS

Erroneous payments occur through the payment of public assistance benefits to persons who do not meet the eligibility criteria, or through overpayments to persons who are eligible, but for a lesser amount.

In a recent twelve month period over \$7 million of Public Assistance funds were paid in error in the State of Alaska. Errors in Public Assistance cases could also add to the state's cost through a reduction of federal assistance that will occur if federally established target error rates are not met. The Division of Public Assistance estimates that federal assistance could be reduced by \$716,000 if the state error rates are not reduced to federally mandated levels for the October 1980 - March 1981 review period.

EFFORTS TO REDUCE ERRORS NEED CLOSER MONITORING

The Department's Quality Control Unit is responsible for controlling unnecessary expenditures of Public Assistance funds. The Quality Control Unit has not controlled unnecessary expenditures because their time is essentially taken up in performing federal reporting requirements.

The Department has taken other action to control unnecessary expenditures by forming a corrective action committee that is coordinated by the Chief of the Quality Control Unit. This committee has developed an error reduction plan that is now being implemented, but monitoring of the plans implementation has been limited.

To assure the success of this plan the Department should better monitor implementation and impact on error rates. In addition, the Department needs to improve efforts to collect overpayments and efforts to refer potential fraud cases to the proper authorities.

MORE EFFECTIVE FRAUD CONTROLS ARE NEEDED

Available evidence indicates that public assistance fraud is a significant problem in Alaska. The Department established a Fraud Investigation Unit to investigate fraud cases and recover money

erroneously paid as a result of fraud. Because the Department does not consider fraud control a priority effort the Fraud Unit does not receive the resources needed to operate effectively. Few cases result in prosecution and little money is recovered. In addition, the Fraud Unit does not meet the federal requirements.

RECOMMENDATIONS

The Commissioner of Health and Social Services should take the following actions.

To assure that the error rate is reduced:

- more closely monitor the implementation of the error reduction plan,
- obtain periodic reports on the plan's impact on error rates, and
- If the error rate is not reduced, take additional action to reduce the rate to an acceptable level.

To improve efforts to collect overpayments of public assistance:

- notify clients of their obligations in a timely manner,
- strengthen efforts to collect on past due accounts, and
- implement a mandatory payback system for fraud related overpayments.

To assure that all potential fraud cases are referred to the Fraud Investigation Unit:

- provide prompt feedback to employees making the referrals.

To assure effective control of fraud in public assistance programs:

- develop a plan to provide the state with an effective means of controlling and deterring public assistance fraud,
- provide the resources necessary to implement this plan, and
- obtain periodic reports showing how the effectiveness of the program is being improved.

DEPARTMENT COMMENTS

The Commissioner of Health and Social Services generally agreed with the conclusions and recommendations and outlined corrective actions that are being taken to address the conditions described. However, the need for additional corrective action in the area of collections is discussed on page 11. A complete copy of the Commissioner's response is provided as Appendix I.

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PUBLIC ASSISTANCE IN THE
STATE OF ALASKA

Public Assistance programs are State or state-federal programs providing temporary or long-term financial aid, food purchasing assistance, or medical payment assistance to eligible individuals. These programs are intended to assist deprived, disabled, or low-income individuals in maintaining a reasonable living standard.

Financial Aid programs like Aid to Families with Dependent Children (AFDC), provide assistance to needy children because of an absent, disabled or deceased parent. Adult Public Assistance provides assistance to disabled, blind, or adults over 65 years old who are unable to provide for their own basic needs.

The Food Stamp program provides assistance to low-income household with the objective of raising the nutrition level of recipients.

Medical payment assistance is implemented through programs like Medicaid, a joint federal-state program providing payments to providers of medical care for eligible low-income residents of the State.

The State of Alaska, through the Division of Public Assistance, provides aid to about 6,100 families each month through the AFDC program. Each month an estimated 36,600 individuals receive aid through the food stamp program, and about 4,600 through the medical program.

STATE FINANCIAL INVOLVEMENT

In Fiscal Year 80 about \$103,128,300 was spent on public assistance programs in Alaska. About 43 percent, or \$43,910,000 of this was provided by the State of Alaska with the balance coming from the Federal government. Funding for individual public assistance programs is shown below:

Cost of Public Assistance Programs
in Alaska for Fiscal Year 80
(in thousands)

<u>Program</u>	<u>Federal</u> <u>Funding</u>	<u>State</u> <u>Funding</u>	<u>Total</u> <u>Cost</u>
AFDC	\$12,005.9	\$12,005.9	\$24,011.9
Medicaid	16,649.9	14,347.9	30,997.8
Food Stamps	28,036.8		28,036.8
Energy Assistance	2,525.7		2,525.7
Aid to the Blind		119.8	119.8
Aid to the Disabled		3,743.2	3,743.2
General Relief - Cash		797.7	797.7
General Relief - Medical		9,513.3	9,513.3
Old Age Assistance		3,382.2	3,382.2
TOTAL	<u>\$59,218.3</u>	<u>\$43,910.0</u>	<u>\$103,128.3</u>

Public Assistance programs in Alaska have increased dramatically in recent years. In fiscal year 1980 the total cost and average number of cases for the two major public assistance programs (AFDC and Food Stamps) was more than double what it had been in fiscal year 1978, as shown below:

Growth in Major Public Assistance Programs
(dollars in thousands)

<u>Program</u>	<u>FY 1978</u>		<u>FY 1979</u>		<u>FY 1980</u>	
	<u>Total Cost</u>	<u>Average Cases</u>	<u>Total Cost</u>	<u>Average Cases</u>	<u>Total Cost</u>	<u>Average Cases</u>
AFDC	\$16,018	4,672	\$21,277	5,502	\$24,011	6,122
Food Stamps	<u>7,741</u>	<u>3,376</u>	<u>11,304</u>	<u>5,854</u>	<u>23,871</u>	<u>11,110</u>
TOTAL	<u>\$23,759</u>	<u>8,048</u>	<u>\$32,581</u>	<u>11,356</u>	<u>\$47,882</u>	<u>17,232</u>

STATE RESPONSIBILITY FOR
PROGRAM MANAGEMENT AND CONTROL

Alaska Statute 47.05.010 authorizes the Department of Health and Social Services to administer public assistance programs. The statutes also provide that the department "cooperate with the federal government in adopting state plans to make the state eligible for federal matching in appropriate categories of assistance, and in all matters of mutual concern, including adoption of the methods of administration which are found by the federal government to be necessary for the efficient operations of welfare programs."

Federal regulations require that the Department of Health and Social Services submit a state plan for public assistance programs receiving federal matching funds. The Federal regulations require that the state plan provide for both quality control and fraud control. To comply, the Department has established the Quality Control Unit in the Division of Public Assistance, and the Fraud Investigation Unit in the Division of Administrations Services, as shown on the organization chart on the following page:

DEPARTMENT OF HEALTH
AND SOCIAL SERVICES

DIVISION OF PUBLIC
ASSISTANCE

DIVISION OF ADMINIS-
TRATIVE SERVICES

CASH/FOOD
PROGRAMS

FIELD OPERATIONS

MEDICAL PROGRAMS

QUALITY CONTROL/
CORRECTIVE ACTION

FRAUD INVESTIGA-
TION SECTION

FOOD STAMP POLICY

REGIONAL OFFICES

MEDICAL PROGRAM
POLICY

SPECIAL REVIEW
SECTION

ADMINISTRATION

AFDC/APA POLICY

SOUTHEAST-JUNEAU

SOUTHCENTRAL-ANCH

STAFF TRAINING

SOUTHWEST-BETHEL

NORTHERN-FAIRBANKS

NORTHWEST-KOTZEBU

QC FIELD OFFICES

JUNEAU

ANCHORAGE

FAIRBANKS

*
OTHER COMMITTEE
DIVISIONS OR
SECTIONS

APA: ADULT PUBLIC ASSI
TANCE

ERRONEOUS PAYMENTS ARE A SIGNIFICANT
COST OF STATE'S PUBLIC ASSISTANCE PROGRAM

Erroneous payments occur through the payment of public assistance benefits to persons who do not meet the eligibility criteria, or through overpayments and underpayments to eligible persons.

In a recent twelve month period over \$7 million of Public Assistance funds were paid in error in the State of Alaska. Errors in Public Assistance cases could also add to the state's cost through a reduction of federal assistance that will occur if federally established target error rates are not met. The Division of Public Assistance estimates that federal assistance could be reduced by \$716,000 if the state error rates are not reduced to federally mandated levels for the October 1980 - March 1981 review period.

EXPLANATION OF ERROR RATES

Error rates are derived from quality control data that is gathered in accordance with the prescribed federal regulations. An erroneous payment is the payment of public assistance benefits to persons who do not meet the program eligibility criteria or an underpayment or overpayment to eligible program participants.

According to officials in the Division of Public Assistance error statistics are defined as follows:

- (1) Case Error Rate - Total number of incorrect cases for a review period in relation to total cases reviewed in that period.
- (2) Payments Error Rate - Total dollars errors in relation to the total dollars expended in review sample.
- (3) Client Error - Those errors attributable to non-reporting or incorrect reporting of actual circumstances by the client. This includes intentional as well as unintentional failure to report circumstances.
- (4) Agency Error - Those errors attributable to mistakes made by the eligibility technician. For example, a math error made in calculating a clients benefits.

PAYMENT ERRORS

Payments in error are a significant cost to the Public Assistance programs. Based on data for a recent twelve month period, it was projected that 26.5 percent of AFDC cases and 32.3 percent of food stamp cases contained errors which effected payment. These errors effected 13.3 percent and 14.6 percent of the total dollars spent in AFDC and food stamps respectively. The projected dollar loss of these two programs for the twelve month period was \$7 million, as shown below:

Error Rates and Projected Dollar Loss
October 1979 through September 1980

	<u>Case Error Rate</u>	<u>Payment Error Rate</u>	<u>Total Program Dollar</u>	<u>Projected Dollar Loss</u>
AFDC	26.5%	13.3%	\$25,578,000	\$3,401,874
Food Stamps	32.3%	14.6%	\$26,351,757	\$3,834,180
				<u>\$7,236,054</u>

These rates reflect both intentional and unintentional errors. They are not a measure of the loss caused by public assistance fraud since only intentional errors are fraudulent.

FISCAL SANCTIONS

To encourage states to reduce error rates, the Federal government establishes target payment error rates for each six month review period. If a state fails to meet the established rate, federal matching funds will be reduced in proportion to the difference between the targeted rate and the actual rate.

A Quality Control Official told us that to date no fiscal sanctions have been imposed on the State of Alaska. However, the likelihood of a fiscal sanction in excess of \$700,000 for the October 1980 - March 1981 review period was addressed in a recent memo of the Director of Division of Public Assistance as a very real possibility if the present payment error rate for the food stamp program remains constant. The target error rate for the October 1980 - March 1981 period is 12.6 percent but with 63 percent of the sample data completed the error rate is projected at 19.2 percent. The state would therefore be liable for 6.6 percent of the total dollar issuance for food stamps during the six month review period. This potential sanction is presently estimated at \$716,000.

EFFORTS TO REDUCE ERRORS
NEED CLOSER MONITORING

The Department's Quality Control Unit is responsible for controlling unnecessary expenditures of Public Assistance funds. The Quality Control Unit has not controlled unnecessary expenditures because their time is essentially taken up in performing federal reporting requirements.

The Department has taken other action to control unnecessary expenditures by forming a corrective action committee. This committee has developed an error reduction plan that is now being implemented, but monitoring of the plans implementation has been limited.

To assure the success of this plan the Department should better monitor implementation and impact on error rates. In addition, the Department needs to improve efforts to collect overpayments and efforts to refer potential fraud cases to the proper authorities.

QUALITY CONTROL RESPONSIBILITY

The Department developed a state plan and established a Quality Control Unit as required by federal regulations.

According to the Executive Budget it is the role of the Quality Control Unit to monitor and evaluate the appropriateness of payments to public assistance clients in order to reduce unnecessary and unauthorized expenditures of state and federal funds. The Budget also states that when quality control activities disclose areas in which expenditures are being inappropriately made or denied one or more corrective actions are initiated, such as:

- recommendations for procedural changes,
- collection actions for cases where funds are judged to be recoverable, or
- referral to the proper authorities when there is an indication of willful misrepresentation.

According to the Quality Control Supervisor, present efforts of the Quality Control Unit are limited to complying with federal sampling and reporting requirements. Quality Control case reviews are performed only on programs receiving federal funding and according to federally prescribed methods. Federal forms are completed for each of these cases and periodic reports are submitted to the federal government.

According to the Quality Control Supervisor, the present workload does not allow them to perform corrective actions.

CORRECTIVE ACTIONS ARE IN PROCESS

The Department has taken action to reduce errors. According to the Director of Public Assistance the following actions have been taken since 1979:

- The Quality Control Unit was transferred to the Division of Public Assistance, placed directly under the Director, and the Quality Control Manager's role was expanded to include development and monitoring of corrective action;
- Federal agencies were invited to participate in the Alaska error reduction effort;
- An ad hoc Corrective Action Committee was created;
- Division staff were advised that error levels were a serious problem that everyone should work to solve;
- Primary error reduction efforts were focused on the AFDC program;
- Eligibility worker and managerial positions were reclassified;
- Funding was secured for a computer system, and
- Steps were taken to assure that client records included social security numbers.

Payment error rates in the AFDC program decreased significantly when client records were corrected to include social security numbers. During the period 10/78 - 3/79 all AFDC cases that did not have a social security number were technically ineligible according to federal regulations, and were counted as payment errors. After client records were corrected they were no longer counted as errors and the payment error rate dropped substantially in the next reporting period (4/79 - 9/79) as shown below:

	<u>10/78 - 3/79</u>	<u>4/79 - 9/79</u>
State-calculated error rate	22.7%	13.1%
Federally- calculated error rate	28.8%	16.5%

Federally calculated error rates are not yet available for periods subsequent to 9/79, but the state calculated rate has declined from 13.1 percent to about 12 percent for the period ending 3/81.

The Corrective Action Committee is chaired by the Director of Public Assistance, with the Quality Control Supervisor serving as the coordinator. The committee is responsible for developing an error reduction plan designed to identify reasons for errors and corrective actions needed.

The plan is developed primarily from the result of Quality Control reviews. Other sources include weekly management reports, federal reviews and input/feedback from Field Office Staff. The Committee is responsible for reviewing and updating the plan at least quarterly.

The error reduction plan identifies problems contributing to the error rate and indicates a corresponding corrective action to reduce or eliminate the problem.

BETTER MONITORING IS NEEDED

The Corrective Action Coordinator has delegated responsibility for implementation of corrective actions specified in the error reduction plan to individuals in the Division of Public Assistance. We discussed monitoring efforts with these individuals and found that their efforts to monitor implementation are generally quite limited. For example, one official stated that monitoring efforts are limited to weekly phone calls to the Regional Assistance Payment Managers and a monthly narrative report.

For several of the problems noted the plan indicates that the Quality Assurance or Quality Control staff will monitor and evaluate the corrective action. But, we found that while they do consider this in their normal course of duty, they are taking no specific action to monitor implementation of the corrective action.

The organization chart for the Quality Control Unit includes a special review group, and according to the Corrective Action Coordinator, this group will be responsible for monitoring the implementation of corrective action. But, at the present time there is no staff assigned to this group. The Director of Public Assistance said that one staff was assigned to this group, but was reassigned to a higher priority area.

COLLECTION EFFORTS HAVE LIMITED SUCCESS

Present efforts to collect overpayments of public assistance funds are divided between the Food Stamps section in the Division of Public Assistance and the Fiscal Section in the Division of Administrative Services. The Food Stamps section is responsible for collecting overpayments on those cases where there was no fraud involved, and the Fiscal section handles those cases that result from fraud investigations.

Clients are not advised in a timely manner that they are expected to pay back the money that was erroneously paid to them. For example, as of April 2, 1981 there were forty AFDC claim determinations dating as far back as January 1981 that had been reviewed and determined to be overpayments, but no letters had been sent to the client demanding repayment. Food stamp claim determination was about two months behind schedule, with about fifty claims pending.

Collection efforts are limited to processing payments received. Follow-up letters for outstanding AFDC payback agreements were last sent in November 1980. The Fiscal section has made no follow-up efforts on delinquent accounts since they assumed the responsibility in July 1980.

Collections are limited. At the time of our review no payment had been received on 76 percent of the outstanding payback agreements, as shown below.

Type of Payback Agreement	Number of Cases	Cases With No Payment Received	% Cases With no Payment Received
Non-Fraud	304	254	84
Fraud	<u>100</u>	<u>54</u>	54
Total	<u>404</u>	<u>308</u>	<u>76</u>

These 404 cases represent \$391,400 owed to the state. Only 10.7 percent of this, or \$22,600 had been collected as of February 1981.

Some clients continue to receive public assistance even after defaulting on payback agreements, as shown below.

	Amount to Payback	Amount Paid	Date of Payback Agreement	Date Last Public Asst. Benefits Rec'd
Client A	\$ 542	\$ 114	1978	April 1981
Client B	524	35	1978	April 1981
Client C	2,729	650	1979	April 1981
Client D	6,099	10	1980	April 1981

Public Assistance officials said part of this problem could be solved by instituting a mandatory payback agreement. Under this type of regulation any client who willfully withholds information concerning their income or resources would be required to have future assistance payments reduced by a specific amount until the debt was paid. This method of collecting payments of fraud claims is optional under federal regulations for the AFDC and Food Stamps programs, but Alaska uses a voluntary payback system.

FRAUD REFERRALS ARE LIMITED

Division of Public Assistance Employees have been instructed to report all suspected fraud cases. A Fraud Complaint form has been established for this purpose. According to Chief Fraud Investigator, about 90 percent of their cases come from referrals by the Division of Public Assistance employees. However, it appears that potential fraud cases are not always reported.

For example, a January 1981 quality control review of an AFDC case found a client had been ineligible for over nine months because of a change in

income status, but had not reported the change to the Division of Public Assistance. The quality control review also disclosed that:

- The client was receiving Social Security checks that were being deposited directly to a bank in Florida,
- The clients AFDC checks were being sent to a post office box in Alaska, and then being deposited in a local bank without signature,
- The residence address shown by the client had been occupied by someone else for over one year, and the current occupant had never heard of the client, and
- The local school district had no record of a school age child shown in the case file.

According to the quality control investigator, this case had not been referred to the Fraud Unit as a potential fraud case.

Employees in the Division of Public Assistance are sometimes reluctant to report potential fraud cases because of a concern that no action will be taken anyway. A recent federal review on the Alaska AFDC program found that:

"There was concern expressed in nearly every office visited that once a fraud referral was made there was never any feedback. As a result, local office personnel are almost always unsure of the status of their fraud referrals that had been referred to the investigative unit. This creates a severe attitudinal problem for workers. If workers feel the state is indifferent to their fraud referrals, they are less apt to continue making them."

This review also found that:

- A worker in Sitka had never received a response on suspected fraud cases that had been referred to Juneau.
- The Wasilla office had sent fraud reports to the regional office, but no response was received and they were told that the fraud investigators are too busy; and
- The Juneau Office staff was neither aware of cases brought to prosecution, nor were they aware of the disposition of any cases that had been referred to the Fraud Investigation Unit.

CONCLUSIONS

The Department has taken action to reduce erroneous public assistance payments by developing an error reduction plan, but monitoring the implementation of specific actions to reduce errors is limited. A Special Review group will be responsible for monitoring implementation of the corrective actions, but the unit has not been staffed. Because the error rate is still very significant, it is important to monitor

implementation of the actions. Closer monitoring of corrective actions is needed so the Department can determine whether the action is properly implemented, and whether any additional actions are needed.

The Department's efforts to collect overpayments of public assistance funds have limited success because clients are not being advised of their obligation in a timely manner, efforts to collect past due accounts are almost non-existent, and there is no mandatory payback agreement.

The Department has instructed employees to refer potential fraud cases to the Fraud Investigation Unit, but the employees often do not make the referrals because they get little feedback on the results of their referrals.

RECOMMENDATIONS

The Commissioner of Health and Social Services should take the following action to assure that the error rate is reduced:

- more closely monitor the implementation of the error reduction plan, and
- obtain periodic reports on the plans impact on error rates, and
- if the error rate is not reduced, take additional action to reduce the rate to an acceptable level.

The Commissioner should take the following action to improve efforts to collect overpayments of public assistance:

- notify clients of their obligations in a timely manner,
- strengthen efforts to collect on past due accounts, and
- implement a mandatory payback system for fraud related overpayments.

The Commissioner should take the following action to assure that all potential fraud cases are referred to the Fraud Investigation Unit by:

- provide prompt feedback to employees making the referrals.

DEPARTMENT COMMENTS

The Commissioner agreed with the recommendation to expand monitoring efforts. However, the Commissioner's response did not fully address the recommendations concerning collection of overpayments and fraud referrals.

Collection of Overpayments

Our report points out three problems in the Department's collection

efforts--not notifying clients of their obligation to repay in a timely manner, not adequately attempting to collect on past due accounts, and not having a mandatory payback system for fraud-related overpayments.

The Commissioner's response does not address the problem of notification of clients of their obligations in a timely manner. We believe the clients must be notified of their obligation in a timely manner, if there is to be timely recovery of overpayments.

The Commissioner stated that the Department is instituting a mail follow-up procedure in an attempt to obtain more repayments of fraud-related overpayments. We believe a mandatory repayment system should be implemented for collection of fraud-related overpayments. We believe the mail follow-up procedure will improve collections, and should also be instituted for non-fraud overpayments.

Fraud Referrals

The Commissioner stated that the Department is preparing a plan for more effectively controlling and deterring public assistance fraud. However, the Commissioner did not specifically address our recommendation that action be taken to assure that all potential fraud cases are referred to the Fraud Investigation Unit. To assure effective fraud control, we believe it is important that all potential fraud cases are referred to the Fraud Unit.

MORE EFFECTIVE FRAUD CONTROLS ARE NEEDED

Available evidence indicates that public assistance fraud is a significant problem in Alaska. The Department established a Fraud Investigation Unit to prosecute fraud cases and recover money erroneously paid as a result of fraud. Because the Department does not consider fraud control a priority effort, the Fraud Unit does not receive the resources needed to operate effectively. Few cases result in prosecution and little money is recovered. In addition, the Fraud Unit does not meet federal requirements.

PUBLIC ASSISTANCE FRAUD IN ALASKA

The Department does not maintain statistics on the estimated total loss through public assistance fraud.

We discussed the significance of the fraud problem with officials in the Fraud Unit and the Division of Public Assistance. While their estimates of the exact extent of the problem varied considerably, the consensus was that public assistance fraud is a significant problem in Alaska.

Department error rate data provides another indication of the significance of the fraud problem. For a recent twelve month period the data shows that 68 percent of the errors in the AFDC program and 54 percent of the errors in the food stamps program were the result of client errors. Client errors are those attributable to non-reporting or incorrect reporting of actual circumstances by the client. These error rates include both intentional and unintentional failure to report circumstances. The errors are not fraudulent unless the incorrect reporting is intentional, and some Department officials believe that most client errors are unintentional, but this data provides an indication of the potential significance of the problem.

RESPONSIBILITY FOR CONTROLLING PUBLIC ASSISTANCE FRAUD

Federal regulations require that the "state plan" must provide:

- Methods and entries for identifying situations in which a question of fraud in the program may exist.
- Procedures developed in cooperation with State's legal authorities for referring to law enforcement officials.

The Department has established a Fraud Investigation Unit in the Division of Administrative Services and has charged them with the investigation and administrative adjudication of recipient and provider fraud cases.

According to their policy statement, the Department is committed to:

- removing all ineligibles from the public assistance rolls
- prosecuting fraud to the fullest extent of the law, and
- recovering all monies erroneously paid as a result of fraud.

The unit consists of a Chief Investigator, two Fraud Investigators, and one secretary. All are located in Anchorage.

FRAUD CONTROL IS A
LOW PRIORITY

To allocate limited resources the Department must prioritize their efforts. The Department prioritizes its resources to: (1) cope with rising caseloads; (2) assure timely delivery of eligibility and payment services; (3) provide effective quality controls to minimize underpayments and overpayments through error; and, (4) provide fraud control. The Fraud Unit falls in the last priority and operates with limited resources.

The staff of the Fraud Unit has remained constant for the past five years while the programs they monitor and the staff level in the Division of Public Assistance have increased significantly, as shown on the chart on the following page. The fraud investigators stated that they cannot handle the existing caseload with current staffing, and we noted that many of the potential fraud cases are never investigated because there is no staff available to conduct the investigation.

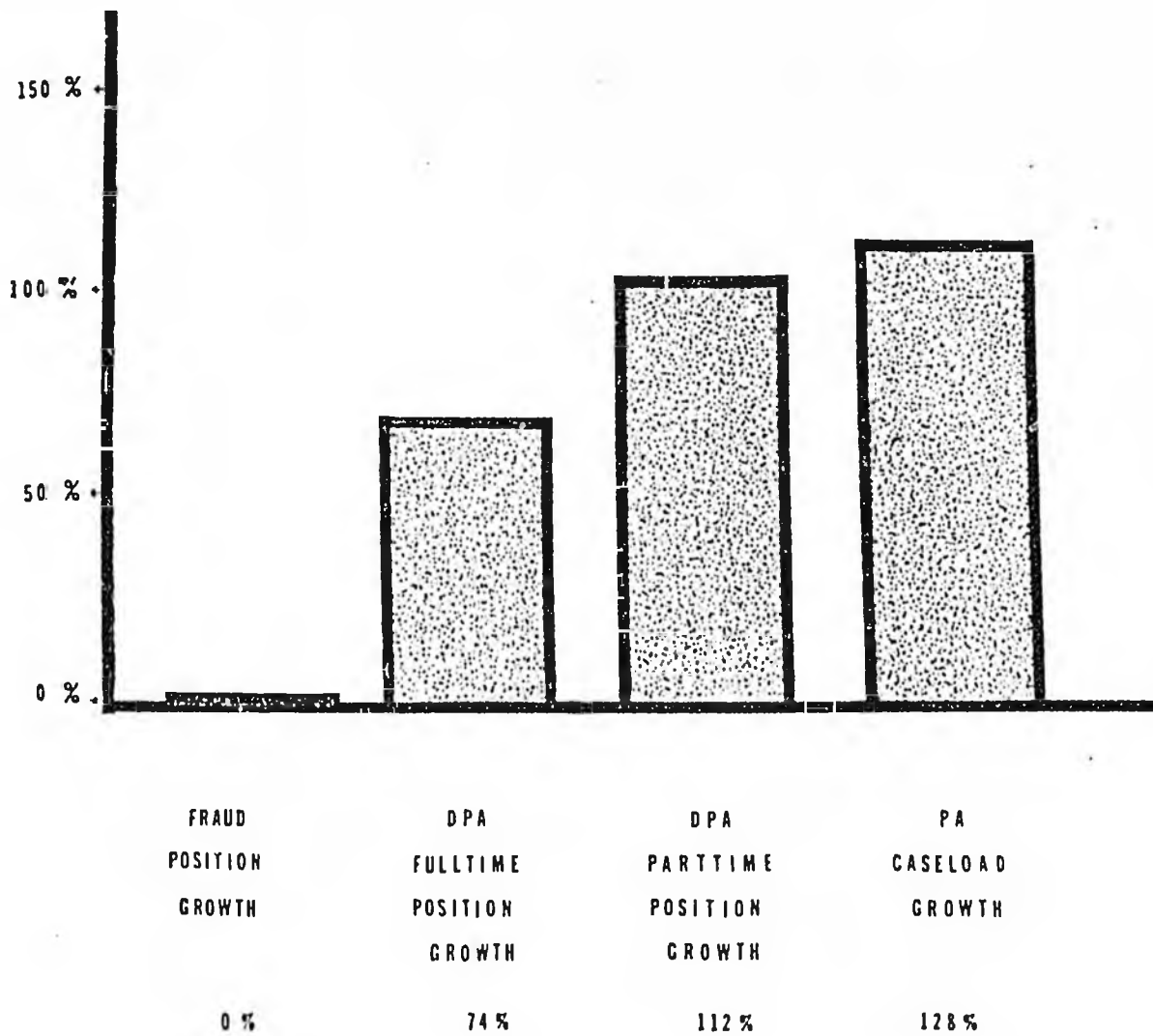
The Fraud Unit is responsible for the entire state, but because of limited travel funds they seldom do fraud investigations outside of Anchorage. The Units total travel budget for fiscal year 1981 was \$9,200. Fraud investigators say there is welfare fraud throughout the state, but because they have limited travel funds they seldom investigate cases outside of the Anchorage area.

When travel funds are available the units effort appear to be productive. The major out-of-town effort in fiscal year 1981 was a four week investigation in the Fairbanks area conducted by two investigators. The results of this effort are summarized below:

- 5 cases prepared for the District Attorney	\$40,064
- 1 lump sum payment in lieu of prosecution	20,975
- 15 payback agreements	<u>36,400</u>
	<u>\$97,439</u>

Another indication of the Unit's lack of resources is the absence of basic equipment needed to conduct fraud investigations. For example, the Assistant District Attorney suggested that they obtain and utilize a camera in their investigative efforts, but they have no photographic equipment and no funds of the purchase of photographic equipment. In another instance the District Attorney advised the fraud investigators that in order to prove fraud in court they must be able to identify in a evidentiary way persons who have committed fraud. He suggested that they have documents fingerprinted and they keep the documents and fingerprints in plastic or other ways in a manner consistent with good law enforcement practice. But, the Unit's total annual budget for supplies is \$400.00 and according to the fraud investigators this does

**FIVE YEAR GROWTH PATTERN FOR DPA / FRAUD STAFFING
AND RELATED PROGRAM GROWTH**



not allow them to purchase the plastic containers referred to by the District Attorney.

FRAUD UNIT IS NOT EFFECTIVE

When potential fraud cases are reported to the Fraud Unit most of the cases are not investigated. In addition, the cases investigated by the Unit usually do not result in payback of overpayment or prosecution.

Cases Closed by the Fraud Unit in 1980

During 1980 the Fraud Unit closed 195 cases, as shown in the following table:

FRAUD CASES CLOSED IN 1980

	<u>No. of Cases</u>	<u>Percent of Total</u>
Closed by Review	102	52.3
Closed by Admin. Action	53	27.2
Closed as Unfounded	19	9.7
Payback Agreement*	17	8.7
Prosecuted	<u>4</u>	<u>2.1</u>
TOTAL	<u>195</u>	100.0

* Only indicates a payback agreement, not actual payback.

Most Fraud Cases Are Closed Without Being Investigated

In 1980, 52 percent of the fraud cases referred to the Fraud Unit were closed by review. Cases closed by review are not investigated but are sent back to the Division of Public Assistance.

The Chief Fraud Investigator told us that the criteria used to determine which cases can be closed by review are as follows:

- The loss is less than \$400
- The information does not substantiate the allegation, or
- The case is more than one year old.

We reviewed 23 fraud cases that were closed by review and found that 20 should have been investigated based on the above criteria. These 20 cases alone represented an alleged loss of \$66,200.

Most Fraud Cases Investigated are Closed Without Obtaining a Payback or Prosecution

In 1980 the Fraud Unit investigated 93 cases, but 72 or 77 percent were

closed by "Administrative Action," or were closed as "Unfounded".

A case is closed by Administrative Action when, after investigation, it is determined that the case does not have fraud potential. A case is closed as Unfounded when, after investigation, it is determined that there is no support for the allegation of fraud. In 1980 the Fraud Unit closed 53 cases by Administrative Action and 19 cases as Unfounded.

Fraudulently Received Payments are Seldom Recovered

In 1980 there were 17 cases closed by "payback". These are cases where the client agreed to pay back to the state money that was received fraudulently. In some cases a lump sum payment was received. In some cases the client signed an agreement to pay back the amount owed on an installment basis, but these agreements were seldom honored. Installment payback agreements were signed for nine of the seventeen cases mentioned above, but only one client had complied with the terms of the agreement.

Few Cases are Prosecuted

In 1980, the Fraud Investigation prosecuted four fraud cases or 2.1 percent of the cases closed that year. The result of these cases are as follows:

- Case No. 1 - The client pleaded "no contest" to 15 counts of welfare fraud. The client was sentenced to 10 days in jail on two counts, with seven days suspended on each count. Client was ordered to make restitution of \$4,599 within 180 days, and to make restitution of \$1,500 within one year.
- Case No. 2 - Client did not appear for trial, was subsequently arrested and trial has been rescheduled.
- Case No. 3 - Client pleaded guilty to 3 counts of welfare fraud. Sentenced to 120 days in jail on each count, with 99 days suspended on each count - sentenced to run concurrently. Ordered to pay restitution of \$993 within two years.
- Case No. 4 - Client pleaded "no contest" to 2 counts of welfare fraud. Ordered to pay \$236 to the state and pay a fine of \$300. Sentenced to 60 days in jail with all suspended.

FRAUD UNIT DOES NOT MEET FEDERAL REQUIREMENTS

The federal regulations that the State has agreed to comply with specify that the State will have established procedures and methods for the prevention and control of program fraud and abuse.

A recent federal examination of Alaska's fraud and abuse program, as it relates to the Medicaid program, concluded that the State's program is not in compliance with federal regulations. A summary of the findings of this report is shown below.

<u>Criteria</u>	<u>Finding</u>
The State Agency must have procedures and methods for detection of fraud situations.	The State does not meet this requirement.
The State must have a method for verifying with recipients whether services billed by providers were received.	The State does not meet this requirement.
The State must have methods for investigating situations of fraud and abuse.	The State partially meets this requirement.
The State must have procedures for the referral of fraud and abuse cases for criminal and civil action.	The State does not meet this requirement.
The State must resolve all full-scale investigations.	The State partially meets this requirement.
Fraud and abuse information must be reported to the appropriate federal official.	The State partially meets this requirement.
The State must include a fraud on all provider claims forms or on the claimant endorsement block of the reverse of all checks.	The State meets this statement requirement.
Providers and recipients must be informed of penalties for Fraud.	The State partially meets this requirement.

CONCLUSIONS

The Department's Fraud Investigation Unit is not effective. The Unit prosecutes few fraud cases and recovers little of the money erroneously paid as a result of fraud. Department priorities focus on providing direct service to clients so only limited resources have been available for fraud control. Because there is a significant amount of fraud in public assistance programs, the Department needs to place more emphasis and resources on fraud control.

RECOMMENDATIONS

The Commissioner of Health and Social Services should take the following action to assure effective control of fraud in public assistance programs:

- develop a plan to provide the state with an effective means of controlling and deterring public assistance fraud,
- provide the resources necessary to implement this plan, and
- obtain periodic reports showing how the effectiveness of the program is being improved.

DEPARTMENT COMMENTS

The Commissioner outlined several actions planned or in process that are consistent with our recommendations for improving the effectiveness of the Fraud Investigation Unit.

PURPOSE AND SCOPE OF REVIEW

Because public assistance programs are rapidly growing this review was conducted to determine what actions the Department of Health and Social Services is taking to prevent misuse of public assistance funds. Specifically, we conducted the review to determine what actions are being taken to reduce erroneous public assistance payments, and what impact these actions are having on the error rate. We also sought to determine what actions are being taken to reduce fraud in public assistance programs.

The following review steps and procedures were used:

- Review of applicable statutes, regulations, codes and administrative procedures;
- Interviews with Department personnel, and with appropriate Federal officials;
- Examination and analysis of Department reports, documents, and statistical data.

Proposed APA regulations August 1979 -

not yet been validly promulgated pursuant to Administrative Procedures Act, but Dept. uses these proposed regulations: Count As Available income SSI payments during the time of eligibility determination & appeals process (6 mos. to 2 yrs.) even though this is not real income

AS 47.05.010 (a) states: "... the amount of assistance is sufficient... to provide the individual with a reasonable subsistence compatible with health and well being..."

the Social Security Administration developed a program to provide interim payment reimbursement to States (20 C.F.R. 55 416.525 AND .1901 et seq.) but the Department does not participate in the program.

Sec. 5

New Section 47.25.252 DISCRETIONARY
RELIEF

Full Cost of Care

Carney called all providers - all agreed they were for
the compromise.

with suspension require the legislature to pay raises
that would have been incurred in 83-84?

* no retroactive clause.

1981 audited rates.

APA

move to adopt Senate CS for working document (Bilman)
Section 9 - Contracting - deleted on House floor, added on

line 4, page 4 - take out "local"

H B

4 6 4 8

4 6 5

A M E N D M E N T

Offered in the SENATE

By Parr

TO:

Page , line :

Insert the following new section:

* Sec. . AS 24.15.020 is amended to read:

Sec. 24.15.020. SALARY OF LEGISLATORS. The monthly salary for each member of the legislature is \$1,564 [EQUAL TO STEP A, RANGE 10 OF THE SALARY SCHEDULE IN AS 39.27.011(a) FOR JUNEAU, ALASKA]. The president of the senate and the speaker of the house of representatives are each entitled to an additional \$500 a year during tenure of office.

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HB 176

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Offered in the SENATE

By Parr

TO:

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Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

February 22, 1982

The Honorable Al Adams, Chairman
House Committee on Finance
Alaska State Legislature
Pouch V
Juneau, Alaska 99811


Dear Mr. Chairman:

The House Committee on Health, Education and Social Services is referring House Bills 464 and 465 to your committee with the recommendation that the scope of the bills be broadened to include private school children as candidates for vision and hearing examinations. These examinations will be funded through the Department of Health and Social Services.

The Committee did not amend these bills in this respect because they were awaiting legal clarification of the constitutionality of this point. This opinion is attached for your reference.

The Committee feels that preventive examinations should be made available to the full range of children in the school system. Children in private schools also need this preventive care and might miss their opportunity if they move from one system to another. In order to enhance the health of the state's residents as a whole, the recommendation for amendment is offered.

Sincerely,


Representative Mike Beirne
Chairman
House Committee on Health, Education
and Social Services

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

February 17, 1982

SUBJECT: Constitutionality of providing state-sponsored
 vision and hearing examinations to private
 school pupils (CSHB 464 (HESS))

TO: Representative Michael F. Beirne
 Chairman, House Health, Education
 and Social Services Committee

FROM: Edward H. Hein *EHA*
 Legislative Counsel

You have asked whether it would be constitutional to extend to private school children the state sponsored vision and hearing examinations proposed for public school children in CSHB 464 (HESS).

Under both the federal and Alaska constitutions the legislature is prohibited from making laws "respecting an establishment of religion". U.S. Constitution, Amendments I, XIV; Alaska Constitution, Article I, Sec. 4. State aid to private schools does not violate the establishment clause if the aid is for a clearly secular purpose, neither advances nor inhibits religion, and does not foster excessive entanglements by the state with religion. Committee for Public Education v. Nyquist, 413 U.S. 756 (1973). Under this test, providing funds for vision and hearing examinations for all school children would not violate the establishment clause.

The Alaska Constitution, Article VII, Sec. 1 also provides that "no money shall be paid from public funds for the direct benefit of any religious or other private educational institution". The test under this section is whether the aid would directly benefit the private school. As our Supreme Court has stated,

Representative Michael F. Beirne
Page 2
February 17, 1982

Though any state assistance that relieves the burden on a private school to provide for the health and welfare of its students will free the school to concentrate its funds on its private educational mission, numerous delegates (at the constitutional convention) voiced their understanding that the direct benefit clause would not bar such incidental support.

Sheldon Jackson College v. State, 599 P.2d 127, 130 (Alaska 1979).

Providing for vision and hearing exams would clearly be for the health and welfare of students. Under the proposed plan, schools and school districts would merely be the conduit for providing this benefit to the students. The students, and not the schools, would directly benefit from the examinations.

Thus, providing for vision and hearing examinations for both public and private school children would violate neither the federal nor the Alaska Constitutions.

EHH:ljb

Enclosure

HOUSE HEALTH, EDUCATION & SOCIAL SERVICES
STANDING COMMITTEE
February 12, 1982
3:08 p.m.

Members Present: Rep. Beirne, Chairman
Rep. Malone
Rep. Cato
Rep. Smith
Rep. Martin

COMMITTEE CALENDAR

HB 464/465 Relating to vision/hearing screening for children.
HB 210 Relating to child custody.
HB 225 Relating to the Parole Board
HB 261 Relating to the continuation of the Parole Board.
HB 293 Relating to the Parole system, furloughs, etc.
HB 679 Relating to imitation controlled substances.

WITNESS REGISTER

Rep. Zharoff
Position Statement: Testified in favor of HB 464/465.

Dr. E.S. Rabeau, Dept. of Health and Social Services
Position Statement: Supported HB 464/465/

Susan Leach, Speech Pathologist
Position Statement: Testified support for HB 464.

Diane Schmeling, Gov. Council on Handicapped
Position Statement: Support for HB 464.

Don Oberg, NEA, Juneau
Position Statement: Support for HB 464.

Dean Guaneli, Dept. of Law
Position Statement: Testified on HB 293.

Charles Campbell, DHSS
Position Statement: Testified on Parole Bills.

PREVIOUS ACTION

HB 464/465 Hearing on May 14, 1981.
HB 210 Hearings on 3.26.81, 4.22.81, and 1.29.82.
HB 225, 261,293 Hearings on 3.23.81, 2.8.82.

ACTION NARRATIVE

Tape #16
Recording
Number 0000

Chairman Beirne opened the committee meeting at 3:08 p.m.. The first bill discussed were HB 464 and HB 465. Rep. Zharoff expressed his support for these bills, pointing out the need for these services especially in the rural areas. Dr. Rabeau stated the Depts. strong support for these bills, explaining 33,000 students would be screened annually by trained lay people. He suggested the committee consider adding non-public students to the program and having the funds in DHSS, not Dept. of Ed.

Number 0110

Discussion was held on desirability of having the School District responsible to providing these tests. Rep. Cato objected, saying some districts would misuse the funds, but Rep. Smith thought the school district should pay for these screenings. The cost of each screening is set at \$3.00.

Number 0355

Don Oberg stated the N.E.A.'s strong support. Susan Leach also testified to the need for these early screenings, stating the importance of detecting problems before they become learning disabilities. Diane Schmeling also gave support as a priority item from the Governor's Council on the Handicapped.

Number 0502

Rep. Malone moved the amendment suggested on the position paper be adopted: HB 464, line 16, pg. 1, addition of "...and Social Services shall set standards for performance of vision and hearing screening, shall train..." and the addition to pg.1, line 14, of "...and at regular intervals as specified by regulation (considered available)...". Discussion was also held on extending to non-public schools, but question on the constitutionality was brought up. Rep.

Malone questioned wording on Pg. 1, line 21. Rep. Malone motioned to have the amendments adopted and the bill passed out with these amendments. There were no objections. Rep. Cato moved to change the effective date to 1982. Rep. Malone motioned to delete Sec. 2. Rep. Cato withdrew her motion. Rep. Smith moved to change the title and drop the effective date. This motion carried. Rep. Cato moved to delete Dep. of Ed. and insert DHSS on line 16, Sec. 2, in HB 465. There were no objections. Rep. Malone moved to pass the bill, HB 465 from the committee. There were no objections. HB 464 and HB 465 were passed out of committee as amended.

Number 0770

Next, the Parole Bills were taken up, HB 225, 261 and 293. Committee staff had prepared a list of desirable items from HB 293 to be added to HB 225. Rep. Smith asked for more time to consider these bills and any changes. So did Rep. Malone. Rep. Martin asked if the committee wanted the Parole Board to continue or not. Dean Guaneli spoke for the Dept. of Law, saying HB 293 was an effort to sunset the parole board, as asked for by the Governor, but that the Dept. of Law was not for or against the bill. Rep. Martin asked if the parole board must be carried over or could it be abolished immediately? Mr. Guaneli stated it could be dropped this year. HB 293 would cause increase in jail population. Mr. Campbell urged some of the reforms in HB 293, concerns over presumptive sentencing. Rep. Malone and Rep. Martin set up a meeting to go over parole bills and materials. Rep. Smith asked to be a part of the meeting, set for Sat. 13th.

Number 1158

HB 679 was brought up next. There were no witnesses present.

Number 1189

HB 210 was the last bill discussed. The committee had several changes to be made in the bill and a CS prepared. Rep. Malone wanted the language concerning joint and physical custody to be cleared up. Rep. Malone also brought up awarding custody to non-parent and preference of the child as points to look at. Rep. Martin stated the intent of the bill was to stress responsibility of the child to the natural parents. HB 210 will be discussed again.

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

February 23, 1981

LEGISLATIVE PROPOSAL

VISION AND HEARING SCREENING OF SCHOOL-AGE CHILDREN

PURPOSE: The State of Alaska should insure that adequate resources are provided so that all school-age children receive periodic vision and hearing screening.

NEED: There is a definite relationship between a child's physical well-being and his/her readiness to learn. Seventy-five per cent of all learning is attained through the sense of vision. A great deal of learning is obtained by auditory means. Undetected vision and hearing difficulties can and do adversely affect a child's school adjustment, learning, and health.

While many school districts (22 of 33 districts which responded to a 1980 survey) conduct some type of vision and hearing screening, other districts do not. There is presently no requirement for all children to receive vision and hearing screening.

OBJECTIVES:

School vision and hearing screening programs should be required to:

1. Identify children who may have vision or hearing problems.
2. Inform parents of each child who fails screening of the possibility of a problem.
3. Recommend to the parents, when appropriate, that professional examination and/or treatment be sought and instituted.
4. Refer children who have a vision or hearing impairment (as identified by a physician, audiologist or eye specialist) for evaluation of the educational and communication implications of the hearing loss or vision impairment.
5. Inform the child's teacher of the vision or hearing difficulty.
6. Maintain records of the status of children referred to insure that needed services are obtained whenever possible.
7. Maintain records of the over-all screening program activities and complete and transmit reports of these activities at the close of each school year.

PROGRAM: A statewide screening system must include the following:

1. Regulations, program standards and guidelines adopted by the Department of Health and Social Services in conjunction with the Department of Education.
2. General supervision of school district screening programs by the Department of Health and Social Services:

Vision Consultant Public Health Nurse in the Division of Public Health for vision screening.

Communicative Disorders Program in the Division of Public Health for hearing screening.

3. Training and certification of screening personnel by the Department of Health and Social Services.
4. Funding for local school districts on a cost per child basis and funding for general statewide program supervision and training of screening personnel.

RATIONALE: The Department of Health and Social Services position states that:

Screening to detect vision and hearing impairments is a valuable and cost-effective preventive health measure. Simple tests can effectively and efficiently screen large numbers of children at minimal cost in order to identify those children in need of further treatment or intervention. Early identification is critical in order to provide an opportunity for each child to maximize his/her learning experience.

The initiation of periodic vision and hearing screening of school children has been uniformly supported by the Departments of Education and Health and Social Services, local school districts, public health nurses, native corporations, the Governor's Council for the Handicapped and Gifted, and the private medical community.

With the dramatic rise in health costs in Alaska and the United States, efforts are increasingly being directed to preventive services and to the use, where possible, of non-medical personnel. Screening examinations which can identify children with vision or hearing impairments can be performed effectively, rapidly, and inexpensively by appropriately trained lay personnel. Children who fail the initial screening are referred for further evaluation, diagnosis, treatment, and remediation. Children with chronic or permanent impairments will be identified so that remedial or special education programs can be appropriately provided.

LEGISLATIVE OPTIONS:

PRIORITY 1: New legislation under educational statutes, Section 14 as follows:

"An Act relating to vision and hearing screening in the schools,
and providing for an effective date."

Section 14.30.080. Vision and hearing screening required. Vision and hearing screening shall be required for all school children.

(a) Screening shall be done in accordance with regulations promulgated by the Department of Health and Social Services in cooperation with the Department of Education.

(b) The Department of Health and Social Services shall train local school district screening personnel, assist with referral and follow-up of children needing professional examination or treatment, and assist with maintenance and repair of screening equipment.

(c) Local personnel conducting vision and hearing screening shall be trained and certified by the Department of Health and Social Services.

(d) School districts shall receive funds for screening from the Department of Education on the basis of cost per child per screening event.

(e) This Act takes effect July 1, 1981.

PRIORITY 2: Amend existing physical examination statute as follows:

Section 1. AS 14.30.070 is amended by adding a new sub-section to read:

(d) Vision and hearing screening examinations required by regulations promulgated under AS 14.30.065 shall be made by a competent individual authorized by the commissioner of health and social services to perform such tests.

Section 2. This Act takes effect immediately in accordance with AS 01.10.070(c).

FUNDING: The fiscal note for a proposed new statute or an amendment to existing statute for vision and hearing screening is as follows:

DEPARTMENT OF EDUCATION;

Funds to school districts based on \$3.00 per screening per child.

1980-81 enrollments in grades to be screened in public schools:

Vision grades		Hearing grades	
K or 1	6,700	K or 1	6,700
3	6,725	2	6,737
5	7,049	3	6,725
7	6,385	7	6,385
11	6,603	11	6,603
	<u>33,462</u>		<u>33,150</u>

Total children eligible = 66,612 x \$3/child = \$199,836

DEPARTMENT OF HEALTH AND SOCIAL SERVICES;

Vision Consultant Public Health Nurse Position

Anchorage based	
Range 18, PHN III	
Salary \$31,680	
Benefits 8,479	
Total	<u>40,159</u>
	\$40,159

Travel for both vision and hearing consultants (hearing personnel already employed by the Communicative Disorders Program of the Division of Public Health) to train school district and REAA personnel and Public Health Nurses to do screening:

	20,000
Contractual	9,100
Commodities	4,750
Equipment	2,450
	<u>\$76,459</u>

TOTAL FISCAL NOTE: \$276,295



GOVERNORS COUNCIL FOR THE HANDICAPPED AND GIFTED

UNIVERSITY PLAZA OFFICES WEST SUITE C • 600 UNIVERSITY AVENUE • FAIRBANKS, ALASKA 99701
PHONE (907) 479-6507

February 23, 1981

- * During the past two years the Governor's Council for the Handicapped and Gifted established a Vision and Hearing Screening Committee which studied the need for a statewide vision and hearing screening program for all school-age children and developed comprehensive vision and hearing screening standards and guidelines. The committee members included a wide range of community members, physicians, vision and hearing specialists, public health nurses, educational specialists, and representatives of the Departments of Health and Social Services and Education as well as school administrators.
- * The Committee finalized its comprehensive report in October 1981 and presented recommendations to the Departments of Health and Social Services and Education. The Department of Health and Social Services attempted to institute vision and hearing screening in place of the presently required physical examinations (AS 14.30.070). Proposed regulations to this effect went to public hearing in December 1980. Due to the amount of testimony received in favor of retaining physical examination requirements, the Department abandoned this effort in favor of supporting statutory change which would include vision and hearing screening and allow persons other than physicians or nurses to conduct the screening.
- * The Council believes that vision and hearing screening is important to the school-age community and that every effort should be made to institute the vision and hearing screening programs according to the standards recommended by the Committee. Both the Department of Health and Social Services and the Department of Education are in agreement with the Council.

It is the Council's hope that legislators will support introduction of this important legislation, enact the legislation, and institute statewide vision and hearing screening programs in local school districts during the 1981-82 school year.

John Nuttall

John Nuttall

Council Chairperson-elect
Chairman, Legislative Committee

STATE OF ALASKA

JAY S. HAYMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF FAMILY HEALTH

POUCH H 05B
JUNEAU, ALASKA 99811
PHONE: 465-3100

April 16, 1981

The Honorable Fred Sharoff
House of Representatives
Pouch V
Juneau, Alaska 99811

Re: HB 464 & 465

Dear Mr. Zharoff:

The following information is provided as guidance material on the hearing portion only of the proposed vision-hearing screening legislation. We have this information readily available on hearing because our Communicative Disorders Program deals with this sphere of problems. Similar information can be gathered on the vision portion but this would take more effort since that program is not yet as well established.

This legislation will establish a uniform hearing screening program Statewide for school children to be conducted by trained lay personnel. Training will be provided by the Communicative Disorders Program (H&SS) staff according to standards established by the Vision and Hearing subcommittee of the Governor's Council for the Handicapped and Gifted. Efforts to date to initiate such screening have resulted in sporadic compliance due to lack of standards, poor funding and a confused role/responsibility for this task. This legislation addresses each of these issues. Through such a screening program approximately 41,300 children would be screened annually. A conservative estimate of a 10% failure rate statewide would mean that 4,130 students at high risk would be identified each year. Of the 4,130 students failing screening, approximately half would be referred for medical attention, one fourth would be found to need other non-medical services (such as counseling concerning noise exposure, hearing aid management, preferential seating in school, etc.) and one fourth would be subsequently found to have normal hearing and would not need further services.

Hearing loss continues to be one of the major health problems in Alaska. Statistics from other states indicate that a hearing screening failure rate of 5% is usually anticipated. In Alaska when the same screening procedures are employed the failure rate ranges between 10.3% and 36.6%. The highest failure rate is found in the remote areas (especially in the rural villages of northern and western Alaska).

April 16, 1981

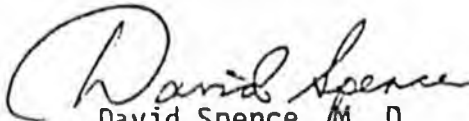
Cases of hearing loss identified by these screening procedures vary from mild transitory ear infections to severe sensory damage. Otitis media (middle ear infection) is by far the most common condition identified prior to grade three. Cases of otitis media will be referred to a physician, public health nurse or health aide who will administer medications, monitor the case over a period of time, and refer for more specialized attention when indicated.

Hearing loss due to noise exposure is also found commonly in older students through screening. High school students at Mt. Edgecumbe have had their hearing routinely checked for several years. This type of hearing loss has been discovered on 9 to 17% of the student population each year. It is believed that this high prevalence of noise induced hearing loss is caused by excessive exposure to high intensity noise from rifle fire, light aircraft, snow mobiles and motor boats. Once incurred, this condition is permanent and may be progressive with continued exposure. Early identification is important so that ear protection, counseling and hearing health education material may be provided.

The implementation of a uniform hearing screening effort in Alaska is a necessary part of developing a preventative program. Cases identified can be: (1) referred for prompt medical attention, (2) counseled concerning prevention of further hearing loss, and (3) monitored on an ongoing basis. Without prompt and systematic identification many of these cases will no doubt go undetected until corrective procedures are less effective.

Should you wish further information concerning hearing loss in Alaska please contact me.

Sincerely yours,



David Spence, M. D.
Chief
Section of Family Health



GOVERNORS COUNCIL FOR THE HANDICAPPED AND GIFTED

UNIVERSITY PLAZA OFFICES WEST SUITE C • 600 UNIVERSITY AVENUE - FAIRBANKS, ALASKA 99701
PHONE (907) 479-6507

April 1, 1981

Representative Fred F. Zharoff
Pouch V
Juneau, Alaska 99811

Dear Fred:

Enclosed are copies of the Council's recommended Vision and Hearing Screening Standards.

The standards are for your information should there be questions about what is involved in screening and how screening would take place under the Council's proposed legislation.

The Department's of Health and Social Services and Education were involved in their development and have agreed to utilize these standards and procedures once enabling legislation is enacted.

Thank you for your willingness to sponsor this important legislation. Please give me a call if you have additional questions.

Sincerely,

John Nuttall
Legislative Committee Chairperson

Enclosure

JN/lsl

RECOMMENDED

ALASKA
VISION SCREENING STANDARDS

OCTOBER 1980

DEVELOPED BY THE VISION/HEARING SCREENING COMMITTEE
OF THE
GOVERNOR'S COUNCIL FOR THE HANDICAPPED AND GIFTED

These Vision and Hearing Screening Standards have been developed through the diligent efforts of the following individuals who represented their respective professions and/or organizations on this subcommittee of the Alaska Governor's Council for the Handicapped and Gifted.

Ms. Jean Lucius	Public Health Nursing
Dr. David Spence	MCH-CCS-Pediatrics
Mr. Tom Buckner	State Department of Education Special Education Section
Dr. Marj Robinson	Rural Special Education Admin.
Dr. Thomas Harbour	Alaska Optometrists Assoc.
Dr. James Patterson	Alaska Ophthalmologists Assoc.
Mr. Carl Dixon	Alaska Native Medical Center
Dr. Richard Raugust	Alaska Otolaryngologists
Mrs. Barbara Seidl	School Nursing
Ms. Ann Rogers	N.E.A. Alaska
Mr. Carl Pohjola	School Superintendent
Dr. Jim Ayers	Head Start Program
Dr. David Canterbury (Co-chairperson)	Communicative Disorders Program
Mrs. Jane Brodic (Co-chairperson)	Blind/Visually Impaired Program

Consultants:

Miss Elizabeth Field
Vision Screening Consultant
Arizona Dept. of Health

Mr. Jim Nelson
Child Health Section
Illinois Department of Health

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1.0 INTRODUCTION

The State of Alaska is committed to the belief that each child has a right to an equal opportunity for a quality education. Research has shown that there is a relationship between a child's physical well-being and his or her readiness to learn. Since up to 75% of all learning is attained through the sense of vision, vision difficulties can adversely affect a child's learning. High quality vision screening programs identify those children who need diagnostic attention by an eye specialist (ophthalmologist/optometrist) in order that their visual condition is treated and/or corrected to the best possible status.

Effective screening involves implementing uniform policies and methods by trained personnel using appropriate equipment; and adhering to well organized referral; follow-up; and reporting procedures. Programs of high quality can be established through the cooperative efforts of (1) school personnel, i.e., school nurses, teachers, teacher aides; (2) health personnel, i.e., public health nurses, community aides, physicians, ophthalmologists and optometrists; and (3) appropriately trained volunteers.

Two things need to be emphasized in screening programs. The first is that screening procedures are not intended to be diagnostic. It is improper to conclude that persons who fail screening procedures have vision loss. Screening selects the population that needs further, more refined evaluations. Parents and visual screeners should be instructed to seek a professional visual evaluation by an eye specialist (ophthalmologist/optometrist) whenever they have any doubt about any child's vision, regardless of any recent vision screening with normal results.

Secondly, the diagnostic process which follows screening may identify those youngsters who after best correction still have a vision impairment to such an extent that they meet the eligibility criteria for special education. At this time, the educational implications of a vision loss need to be added to the medical implications. Too often the sole goal is referral of medical needs of those who fail screening procedures.

Objectives of a School Vision Screening Program are:

1. To identify the children who may have eye problems.
2. To inform parents of each child who fails the screening of the possibility of a problem.
3. To recommend to the parents, when appropriate, professional visual evaluation and care be sought for children with possible visual problems.

1.0 INTRODUCTION (Continued)

4. To pursue the matter until an examination is made and appropriate evaluation and/or treatment is instituted.
5. To inform teachers of their students' visual difficulties and its resolution.
6. To refer children who have a vision impairment (as identified by an eye specialist), for evaluation in the unique educational implications of the vision impairment.
7. To maintain records of the status of children referred to insure that needed services are obtained whenever possible.
8. To maintain records of the overall screening program activities and complete and transmit as required annual reports of this activity at the close of each school year.

2.0 SCREENING PROCEDURES

Vision screening involves testing in an abbreviated way, large numbers of children. The main purpose is to identify children who are in need of a diagnostic visual examination and to refer them for professional diagnosis.

From the following screening schedule it is apparent that the specific screening tests used will vary from one grade to another. It is recommended that the age appropriate battery of tests be administered at one time. The frequencies of screening stated below are minimal standards state-wide for Alaska. More frequent screening may be justifiable based on local circumstances.

2.1 POPULATIONS TO BE SCREENED

2.1.1 SCREENING SCHEDULE

SCREENING PROCEDURE	GRADES							ALL SPEC ED STUDENTS ANNUALLY	ALL NEW STUDENTS
	*Preschoolers	K and/ or 1	3	5	7	11			
Observation	At all grade levels - P-12							X	X
Distance Visual Acuity	X	X	X	X		X	X	X	
Cover/Uncover	X	X		X			X	X	
Color Deficiency	Once after grade six for all students								After Grade six

2.1.2 Waivers

A child is exempt from screening or testing if a parent, guardian, or person in loco parentis of the child presents a written statement or given verbal notification to the administration of the child's school that the parent, guardian, or person in loco parentis does not wish the child to be screened.

2.2 TYPES OF SCREENING

2.2.1 Observation

Observation of visual behavior is one of the most important means of determining potential visual problems. Observation

- *Preschoolers
- (1) Ages 2 1/2, 3 or 4.
 - (2) School districts are not required to screen preschoolers until school entry.
 - (3) Other agencies who are involved in children of this age should adhere to these standards.

2.2 TYPES OF SCREENING (Continued):

2.2.1 Observation (Continued):

should be an ongoing activity and performed by all persons who are in contact with children, i.e., teachers, aides, volunteers, parents, relatives, and other health personnel. See "Observation--Signs of Eye Trouble" - Appendix A.

2.2.2 Distance Visual Acuity:

Distance Visual Acuity is the most important single test of visual function. Distance Visual Acuity tests the individual's ability to see and to report correctly forms seen under standards testing conditions. The following screening test symbols are recommended and are ranked in decreasing order of difficulty and effectivity.

1. Snellen Letter - may be used for 1st grade and above.
2. E Chart - may be used with pre-school, K, and special education students.
3. Hand Chart - may be used with pre-school, K, and special education students.
4. Picture Chart - reliability less refined as with above tests useful with pre-school and special education students.

2.2.3 Cover/Uncover Test:

The cover/uncover test will determine any abnormality of muscle imbalance or ocular alignment. The eyes must be properly aligned to have binocular vision. Muscle balance screening is especially important in young children to detect such conditions as strabismus which may produce amblyopia. If muscle imbalance is detected and properly treated before the age of 4 to 6, visual prognosis is good.

2.2.4 Color Test:

Assessment of color vision does not need to be made until a student has reached grade 6 and need be made only once. Deficiency in color vision is not correctable, but is important for the individual and his parents, and appropriate personnel to be aware of such a deficiency. A knowledge of color deficiency is important in art, science, safety, and vocational counseling. Color vision can be screened by using appropriate sets of color plates. (See Section 6.2)

2.3 RESCREENING OF FAILURES

If a child fails one or more of the tests (except color) he/she should be rescreened with the failed test on a subsequent day,

2.3 RESCREENING OF FAILURES (Continued)

optimally about one week later. If the student again fails, he/she should be referred under the criteria and methods listed in Section 3.0 - Referrals. This rescreening procedure is necessary to prevent over-referrals. It should be noted that in remote areas rescreening may have to be done on the same day.

2.4 SCREENING OF CHILDREN WHO WEAR GLASSES OR CONTACT LENSES

Vision of children who wear glasses or contact lenses should be tested with their glasses or contact lenses in place. The determination of the need for a referral should be based on levels of referral delineated in Section 3.0.

2.5 TEST ENVIRONMENT

It is recommended that an isolated area at least 20 feet long be made available to conduct vision screening with Snellen charts. Room lighting recommended is 10 to 30 foot candle power. Where equipment is not available to determine this, normal lighting for school work will provide adequate illumination to conduct vision screening. Be sure there is no glare or shadows on the charts.

2.6 VISION SCREENING MACHINES

If your district is considering using vision screening machines, it is recommended you contact the Maternal and Child Health Department of Public Health for information on these machines. The vision consultants on this committee discourage their use.

3.0 REFERRALS

One of the most crucial aspects of vision screening is referral for a professional diagnostic visual evaluation of those students who fail any area of the vision screening after rescreening. The referral for a professional visual evaluation should be initiated and monitored by the school district; however, ultimate responsibility for follow through rests with the parents. It is important therefore to involve the parents in the process at the earliest possible time. (See Figure 1 on page 7.)

3.1 CRITERIA FOR REFERRAL

SCREENING PROCEDURE	AGE	CRITERIA
Distance Visual Acuity	3, 4, or 5 year olds	Two lines of difference in acuity between the Right and Left Eye CR, 20/50 or Less in one or both eyes
	6 year olds and above - including students wearing glasses, and contact lenses	20/40 or Less in one or both eyes
Cover/Uncover	All Ages	Any movement indicative of a tropia or large phoria
Observation	All Ages	Any child who has an obvious sign of eye defect or valid eye complaints

3.2 REFERRAL FOR PROFESSIONAL DIAGNOSTIC VISUAL EVALUATION

Any individual who fails one vision screening test on two occasions should be referred for a professional diagnostic visual evaluation by an eye specialist. Figure 1 on page 7 diagrams the referral process.

3.3 REFERRAL FOR SPECIAL EDUCATION PLACEMENT

A child with a visual impairment may be eligible for special education placement in accordance with the eligibility guidelines in the current Alaska Special Education Handbook of the Department of Education.

Initial Screening

Distance Visual Acuity

Cover/Uncover

Color Deficiency
(after grade 6)

Pass

Meets criteria
in 3.1

Fail

Fails to meet
criteria in 3.1

Pass

No deviant-
eye movement

Fail

Any movement indi-
cating of a tropia
or large phoria

Pass

Passes all
items on test

Fail

Fails 1 or more
items on test

Rescreening

Use same test(s) failed
first time with same
procedure.

Pass

Meets criteria
in 3.1

Fail

Fails at least one
vision screening test
on two occasions

Advise Parent
& Student

Send notice of
color deficiency

Advise Appropri-
ate School
Personnel.

Referral

Advise parent and/or proper health
authority that child needs profes-
sional diagnostic vision exam

Diagnostic
Evaluation

Child is OK, or
receives corrective
treatment

1. Teacher advised
2. Student health card and other records completed

Child after treatment has
disability to warrant meeting
criteria for special education

1. Student referred to Special Education
2. Teacher advised
3. Student health card and other records completed

FIGURE 1
-7-

4.0 RECORDKEEPING, REPORTING, AND FORMS

A vital component of the vision screening program is the recordkeeping and reporting process. The individual in each district who has been designated to coordinate vision screening activities should also be responsible for recordkeeping and reporting as is stipulated below:

4.1 CONFIDENTIALITY

Individual screening and testing records shall be confidential as required by district policy. The records shall be available to health agencies to assist in obtaining proper and necessary health and educational care.

4.2 MANAGEMENT

The following forms should be used in the manner recommended below when conducting the vision screening process.

4.2.1 Reporting Observations

At the outset of each school year the information sheet Observation--Signs of Eye Trouble and the Student Observation Form should be distributed to each teacher in the district. The Observation--Sign of Eye Trouble is meant to inform teachers of the types of behavior exhibited in the classroom which might indicate a vision disorder. The Student Observation Form comes in duplicate and is used for referring those students to the individual responsible for screening. The second copy is to be kept by the teacher for classroom records. Samples of these forms are in Appendix A and B.

4.2.2 Recording Daily Screening Activities

The form Vision Screening Worksheet should be used by the screener to record the daily screening activities. Data from these forms will be used in the Annual Vision Screening Report submitted at the end of each school year. A sample of the Vision Screening Worksheet is in Appendix C.

4.2.3 Referrals to Parents

4.2.3.1 Professional Diagnostic Visual Evaluation

When, as a result of vision screening, it is determined that a professional diagnostic visual evaluation is needed, the parents should be notified by mail, by telephone, or by parent conference. Use of the Parents Referral Form is

4.2.3.1 Professional Diagnostic Visual Evaluation (Cont.)

recommended. This form informs the parent of the reason for the referral and has a "tear off" portion which the eye specialist can use to report findings back to the schools. The form comes in duplicate, one copy to be kept by the referring party. See sample in Appendix D.

4.2.3.2 Color Vision

When color deficiency has been detected the parents should be notified by sending them the form Parents Notification of Color Deficiency or by direct parent contact. A sample of this form is in Appendix E. The appropriate school personnel should also be notified.

4.2.4 Exam Results and Recommendations

When the results of the professional diagnostic visual evaluation are returned to the coordinator of vision screening, these results should 1) become part of the individual's school health record, 2) be communicated to the individual's teacher(s), and 3) be considered if a child study team is reviewing a child for special educational services.

4.2.5 School Health Records

School health records will exist in varying form from district to district. Entry should be made in the health record whenever the child has failed screening and rescreening tests. The subsequent referral for professional diagnostic visual evaluation should be traceable in the record.

4.2.6 Annual Report

During April or May of each year an annual report of vision screening activities should be completed using the screener's copy of the Screening Worksheet, Parent Referral Form, Parent Notification of Color Deficiency, and professional diagnostic evaluation reports as sources of input. A sample of the Annual Vision Screening Report is included in Appendix F. A copy of this report should be sent to Vision Screening Consultant, Department of Health & Social Services, Section of Family Health.

5.0 PERSONNEL AND TRAINING

5.1 PERSONNEL

State: Coordination and administration of vision screening at a state level should be the responsibility of a full time Vision Screening Consultant from the Department of Health & Social Services. The Vision Screening Consultant shall develop and conduct training programs, monitor compliance to standards, coordinate screening services performed by various agencies in the state, keep all state records and reports regarding vision screening, and disseminate information about vision screening.

Local: The administration of vision screening should be the responsibility of superintendent of the school district. The superintendent should designate the management or direction of the vision screening program to a local health care provider such as a school nurse or public health nurse. This individual should be certified in vision screening by the State Vision Screening Consultant to assure that districts' standards and procedures for follow-up activities are known and followed.

Alaska school districts may employ or contract personnel for this purpose. The needs of some districts may be best served by establishing an agreement with the appropriate local public health nurse's office or regional public health agency to provide the supervisory and consultative function.

In managing the vision screening program the local health care provider should perform the following duties:

- a) Arrange a screening schedule and notify all involved.
- b) Administer screenings and rescreenings.
- c) Notify parents of referrals.
- d) Follow-up on referrals.
- e) Complete recordkeeping and reporting.

The local health care provider may arrange for the training of other individuals such as teachers, aides, volunteers (to be known as screeners) to administer the vision screenings and rescreenings. School districts should make an effort to employ reasonable permanent screeners; persons who understand that they carry screening responsibility over a period of time and thereby have an opportunity to accumulate knowledge and develop necessary skills.

5.2 TRAINING

It is recommended that the State Vision Screening Consultant of the Department of Health & Social Services, develop the curriculum for a training program for vision screeners and that this program also establish certification and recertification procedures for such personnel, including the use of a competency based test. A minimum of eight hours of training, including practicum is

suggested for new screening team members. A minimum of two hours refresher training should be provided by or under the direction of the State Vision Screening Consultant. Training procedures for vision screening should be designed to provide personnel with basic knowledge of vision and its effect on learning and with technical skills adequate to perform the screening task properly. Training should ensure that screeners develop competencies in:

1. Operation of screening equipment.
2. Identification of improperly functioning equipment.
3. Instruction-giving.
4. Conditioning techniques.
5. Eliminating inappropriate cues.
6. Evaluating the reliability of responses.
7. Making pass/fail judgements.
8. Identifying the difficult-to-test child.
9. Follow-up procedures.
10. Accurate recording of data.

Additionally, training should include a competency based evaluation of the knowledge and skills acquired by the screener to ensure that he/she meet minimum competencies. Evaluation should be done annually.

6.0 MATERIALS AND EQUIPMENT

Each local education agency should provide and make available for its vision screening program those testing materials recommended in the Screening Procedures Section 2.2 and 2.4. Sources for those materials are listed below.

6.1 Tests for Screening Visual Acuity

Snellen Letter & E Charts with Cover Cards

National Society for the Prevention of
Blindness
79 Madison Avenue
New York, N.Y. 10016

Snellen Letter & E Charts, Picture Charts

The Lighthouse
New York Association for the Blind
111 E. 59th Street
New York, N.Y. 10022

Snellen Letter & E Charts, Picture Charts

American Optical Company
312 Dexter Avenue North
Seattle, Washington 98109

Sjogren Hand Test

The House of Vision, Inc.
135-137 N. Wabash Avenue
Chicago, IL 60602

Stycar Screening Tests

National Foundation for Education Research
in England
London, England

6.2 Tests for Screening Color Vision

Guy's Color Test for Children

Western Optical Corporation
1200 Mercer
Seattle, Washington 98109

Ishihara Test

The Good-Lite Company
7426 W. Madison Street
Forest Park, IL 60130

Pseudo-Isochromatic Plates

American Optical Company
312 Dexter Avenue North
Seattle, Washington 98109

6.3 Stereoscopic and other machines for screening various components of vision:

American Optical Child's Vectrograph and Project-O-Chart

American Optical Company
14 Mechanic Street
Southbridge, MA 01550

Bausch and Lomb School Vision Tester

Bausch and Lomb
635 St. Paul Street
Rochester, NY 14602

Good-Lite Vision Screener

Good-Lite Company
7426 W. Madison Street
Forest Park, IL 60130

Keystone Telebinocular (Keystone Preschool Test used for young children with the No. 46 Telebinocular available)

Keystone View Company
Meadville, PA 16335

Titmus Vision Tester

Titmus Optical Company, Inc.
1015 Commerce Street
Petersburg, VA 23803

APPENDIX A

OBSERVATION -- SIGNS OF EYE TROUBLE

Observation of a pupil's behavior and appraisal of a pupil's achievement are exceedingly important as unusual behavior, poor school performance, and reduced rates of learning may indicate visual problems.

Signs and symptoms of visual problems:

1. Viewing Behavior

- a. Holds work too close or too far.
- b. Asks for special seating.
- c. Thrusts head forward to see distant objects.
- d. Holds body tense when reading or looking at distant objects.
- e. Frowns or squints when regarding or when trying to see distant objects.
- f. Attempts to brush away a blur.
- g. Rubs eye frequently.
- h. Blinks continually when reading.
- i. Tilts head.
- j. Covers or closes one eye.
- k. Exhibits poor muscle coordination.

2. Complaints

- a. Eyes are sensitive to light, photophobia.
- b. Eyes or lids burn or itch.
- c. Images appear blurred or doubled.
- d. Letters and lines run together.
- e. Words seem to jump.
- f. Frequent headaches associated with visual tasks.

3. Appearance

- a. Eyes water or appear bloodshot.
- b. Eyes that are not properly aligned are crossed or turned out.
- c. Eyes in constant motion, nystagmus.
- d. Eyes with pupils of different sizes and reaction to light and accommodation.

The above symptoms or signs constitute reasons for special vision screening.

VISION SCREENING REFERRAL

SCHOOL DISTRICT

To the parents of: _____ Date of Birth _____

School: _____ Date _____

As a result of a recent vision screening at school, we believe that your child should have a complete professional eye examination. Please give this form to your ophthalmologist/optometrist to complete and then return it to school. We urge you to give this your prompt attention.

Your child's performance on vision screening:

Snellen Test for Distance Vision .

R eye _____ ; L eye _____ ; Both eyes _____

Cover/Uncover

Right eye OK _____ Deviation _____

Left eye OK _____ Deviation _____

Observation of symptoms and/or comments: _____

Signature of Tester

Signature of Duly Authorized
School Personnel

PROFESSIONAL EYE EXAMINATION

Note to the ophthalmologist/optometrist:

The above child has not passed the vision screening. Please complete this form for parents to return to the school. Thank you.

Visual Acuity	Distance Vision		Near Vision	
	without correction	with correction	without correction	with correction
Right Eye (O.D.)	_____	_____	_____	_____
Left Eye (O.S.)	_____	_____	_____	_____
Both Eyes (O.U.)	_____	_____	_____	_____

Field of Vision:

Diagnosis and Prognosis:

Treatment (if any):

When should glasses be worn:

Re-examination recommended:

Date of Examination

Signature of Eye Physician.

A P P E N D I X E

PARENT NOTIFICATION REGARDING COLOR DEFICIENT TEST

SCHOOL DISTRICT

To the parents of: _____ Date of Birth _____

School: _____ Date _____

During a recent vision screening, results indicate that your child has some degree of color deficiency. Although this problem cannot be corrected, and usually does not affect how a person sees, it is important that the student and people close to the student are aware of this color deficiency.

The main reason for color deficiency testing is to alert the student and his/her parents about the color deficiency since in the future there may be implications in planning or preparing for certain jobs or careers.

Information regarding results of the color deficiency test will be recorded on his health record, and education record, to alert school personnel who work with, or counsel, your child.

If you have any questions regarding results of this screening, please feel free to contact the school nurse or to consult an eye specialist.

Additional remarks.

Health Screener: _____

School: _____

ARE COMPLETED, BUT PRIOR TO SUMMER VACATION.

ANNUAL VISION SCREENING REPORT

SCHOOL: _____ DISTRICT _____ SCREENER _____ DISCIPLINE _____

ADDRESS: _____ CITY _____ AVERAGE ENROLLMENT _____

GRADE	NUMBER SCREENED	# of Failures on Each Test After Rescreening			TOTAL REFERRED	RECEIVED EVALUATION	SAW EYE SPECIALIST		REFERRALS NOT YET COMPLETED
		Visual Acuity	Cover/Uncover	Color			No Treatment	Received Treatment, Medication, Lenses	
Pre-K									
p. Ed.									
K									
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
TOTAL									

APPENDIX F

Shaded Areas are recommended for annual screening.

APPENDIX G

GLOSSARY

Amblyopia - Dimness of vision without any apparent disease of the eye.

Amblyopia ex anopsia - Dimness of vision due to disuse of an eye with no apparent physical abnormality.

Astigmatism - Defective curvature of the refractive surfaces of the eye as a result of which light rays are not sharply focused on the retina for either nearness or distance.

Binocular Vision - Using the two eyes simultaneously to focus on the same object and to fuse the two images into a single image.

Candle Power - or "Foot Candle" - Unit of measurement of light intensity. One foot-candle equals the amount of light cast by a standard candle at a distance of one foot from the light.

Color Vision - The ability to discriminate colors. *Color deficiency* - The inability to discriminate between certain colors, usually red-green, seldom blue-yellow. Pseudo-isochromatic plates are used for testing for color deficiency.

Cover/Uncover Test - A test which discloses whether or not the two eyes function together as they should.

E Chart - Chart with only the letter E of specified sizes and in various positions printed in rows.

Eye Specialist - Ophthalmologist or optometrist

Field of Vision - The entire area which can be seen at one time without shifting the head or eyes.

Glare - A quality of light which causes discomfort in the eye; it may result from a direct light source within the field of vision or from a reflection of a light source not in the field of vision.

Hand Chart - Chart with a picture of a hand of specified sizes and in various positions in rows. Also referred to as Sjogern Hand test.

In Loco Parentis - In place of the parent without formal legal custody.

Ophthalmologist - A physician who has specialized in the diagnosis and treatment of vision defects and diseases of the eye. He may prescribe glasses, contact lenses, and other corrective measures and may perform surgery. He uses the initials M.D. after his name.

Optician - A maker and dealer in optical instruments who fills prescriptions for glasses by grinding lenses, fitting them into frames, and adjusting frames to the wearer.

Optometrist - A person who has done advanced study on vision, vision problems, and visual performance. He is licensed by law to examine eyes and vision and to prescribe and provide glasses, contact lenses, and orthoptic training. He uses the initials O.D. after his name.

Phoria - A latent tendency toward crossed eyes. "Phoria" is used with a prefix to determine the direction of such deviation (Hyperphoria, up; esophoria, in; exophoria, out).

Picture Chart - Chart using symbols which conform to Snellen test sizes and are printed in rows.

Pre-Schoolers - Youngsters below kindergarten age. For screening purposes usually ages 2½, 3, and/or 4.

Professional Vision Evaluation - A complete examination of the visual system by an ophthalmologist or optometrist.

Screeners - A person trained and certified to administer vision screening to children in the school screening program.

Snellen Letter Chart - Chart with a number of letters of the alphabet of specified sizes printed in rows.

Strabismus - Failure of the two eyes to direct their gaze at the same object because of muscle imbalance; crossed-eyes or wall-eyes.

Tropia - A manifest or observable deviation of the eyes from normal position for binocular vision. "Tropia" is used with a prefix to denote a type of strabismus, as heterotropia, esotropia, exotropia.

20/20 Vision - The ability to correctly perceive an object or letter of a designated size from a distance of 20 feet; normal visual acuity.

Vision Screening - A procedure for detecting possible abnormality of the visual system with referral for correction, treatment, or appropriate school placement. This identification of possible vision problems shall not be considered diagnostic.

Visual Acuity - Sharpness of central vision for detail, as in reading.
Central visual acuity - Ability of the eye to perceive the shape and form of objects in the direct line of vision.

Visually Impaired Children (for purpose of special education) - Those children who are defined as blind or partially sighted in the Alaska Department of Education Special Education Handbook.

RECOMMENDED

ALASKA
HEARING SCREENING STANDARDS

OCTOBER 1980

DEVELOPED BY THE VISION/HEARING SCREENING COMMITTEE
OF THE
GOVERNOR'S COUNCIL FOR THE HANDICAPPED AND GIFTED

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1.0. INTRODUCTION

The State of Alaska is committed to the belief that each child has the right of an equal opportunity to a quality education. It has been shown that there is a relationship between a child's physical well-being and his or her readiness to learn. Since a good deal of learning is obtained by auditory means, hearing difficulties may adversely affect a child's school adjustment. High quality hearing screening programs identify those children who need diagnostic attention by a physician and/or an audiologist in order that their hearing loss is treated and/or corrected to the best possible status. Effective screening involves implementing uniform policies and methods by trained personnel using appropriate equipment; and adhering to well organized referral; follow-up; and reporting procedures. Programs of high quality can be established through the cooperative efforts of (1) school personnel, i.e., school nurses, educational audiologists, communicative disorders specialists, teachers, teacher aides; and (2) health personnel, i.e., public health audiologists, public health nurses, community health aides, and physicians.

Two things need to be emphasized in screening programs: The first is that screening procedures are not intended to be diagnostic. It is improper to conclude that persons who fail screening procedures have hearing loss. Screening selects the population that needs further, more refined evaluations. The audiological/medical process which follows screening provides the identification of hearing loss as well as diagnostic and habilitative information. Secondly, the educational and communication implications of hearing loss need to be balanced with the medical implications. "Too often the sole goal is referral of medical needs of those who fail screening procedures".

Objectives of a School Hearing Screening Program are;

1. To identify the children who may have hearing problems.
2. To inform parents of each child who fails the screening and subsequent threshold testing of the possibility of a problem and to recommend to the parents, when appropriate, that audiology and/or physician's examinations and care be sought for children with possible hearing deficits.
3. To pursue the matter until the appropriate evaluation and/or treatment is instituted.
4. To refer children who have a hearing deficit, (as identified by an audiologist or physician), for evaluation of the educational and communication implications of the hearing loss.
5. To inform the child's teacher of the hearing difficulty.
6. To maintain records of the status of children referred to insure that needed services are obtained whenever possible.
7. To maintain records of the overall screening program activities and complete and transmit as required annual reports of this activity at the close of each school year.

2.0 SCREENING

Screening audiometry involves testing in an abbreviated way, large numbers of pupils, resulting in the ready identification of those who have hearing sensitivity within normal limits and those tentatively identified as having hearing problems.

With respect to the number of professionals and paraprofessionals, equipment, time and financing available, an effective annual screening program should be initiated for the target populations described below:

2.1 POPULATIONS TO BE SCREENED

It is recommended that screening be provided for the following students on an annual basis.

2.1.1 Grades K, 1, 2, 3, 7, 11.

2.1.2 All Special Education students with conditions associated with a high prevalence of hearing loss.

2.1.3 New students.

2.1.4 Referrals from teachers and outside sources.

2.1.5 Preschool students.

Preschool children should be screened by technicians having special emphasis in this area or by school nurses, public health nurses, audiologists and communicative disorders specialists similarly trained. Supervision should be provided for screening by a fully qualified audiologist to insure valid results.

School districts are not required to screen preschoolers until school entry. Other agencies who are involved in screening children of this age should adhere to these standards.

2.1.6 Waivers

A child is exempt from screening or testing if a parent, guardian or person in loco parentis of the child presents a written statement or has given verbal notification to the administrator of the child's school that the parent does not wish the child to be screened.

2.2 TYPES OF SCREENING

2.2.1 Observations of Behavior

Certain behavior characteristics of the hearing impaired student may alert the teacher, parents or health personnel to possible hearing loss. A list of these observations is included in the Appendix.

3.0 REFERRALS

Referral procedures should be tailored to the specific locality in which the students reside. The referral for audiological, medical and rehabilitation should be initiated and monitored by the school district however, ultimate responsibility for follow through rests with the parents. It is important therefore to involve the parents in the process at the earliest possible time. A referral plan should be developed cooperatively with medical, audiological and educational entities in the area prior to the initiation of screening activities. This plan should be made available in written form so that all parties are familiar with the process and criteria for referral.

3.1 AUDIOLOGIC REFERRALS

3.1.1 Criteria for Audiologic Referral

Students should be referred for audiologic evaluation when any one of the following circumstances exist.

- 3.1.1.1 Puretone screening tests have been failed twice.
- 3.1.1.2 Impedance/immittance screening indicates persistent negative middle ear pressure, a persistently non-compliant ear drum or a large canal volume.
- 3.1.1.3 The student has a known hearing loss and is in need of recheck.
- 3.1.1.4 An audiologic evaluation has been requested by a Child Study Team, a health services provider or parent.

3.1.2 Purpose of Audiologic Evaluation

An audiologic evaluation provides minimal hearing sensitivity results for those pupils who failed the screening tests. Specialized tests such as bone conduction, speech audiometry, site of lesion, hearing aid evaluation, etc. and materials appropriate to the diagnostic process should be employed by audiologists.

Among the reasons for complete audiologic evaluation are:

- 3.1.2.1 Case finding to prevent the growth of diseases and conditions that lead to hearing loss.
- 3.1.2.2 Identification of pupils with hearing defects.
- 3.1.2.3 Referral for medical examination and treatment to restore hearing when possible.
- 3.1.2.4 Definition of the type and extent of hearing loss.
- 3.1.2.5 Monitoring the status of individuals with known hearing loss.

2.2.2 PURE TONE SCREENING - LEVELS AND FREQUENCIES

Pure tone screening at 20 dB for 1000, 2000 and 4000 Hz is required. If no response is obtained at 4000 Hz the level may be increased to 25 dB. Specific procedures for pure tone screening are in the pamphlet "Audiometric Screening - Procedures and Forms" available through the Communicative Disorders Program, Division of Public Health and is included in the Appendix.

2.2.3 IMPEDANCE/IMMITANCE SCREENING**

Impedance screening for middle ear disorders is required for children from preschool to third grade inclusively and for Special Education students as indicated in 2.1.2. This procedure is also useful with populations that are not testable by other means. Determination of the need for this type of testing should be made at the local level jointly by medical, school and speech & hearing personnel. Whenever such screening is conducted the following precaution should be taken:**

- A. Medical referral criteria, channels and protocol should be established prior to the initiation of any screening. These should be made available in writing for all participating parties. Individuals doing the screening should be trained and supervised by a certified audiologist.
- B. Medical referral protocol should include provision for test/retest prior to referral (at an interval from 4 - 12 weeks) to guard against over referral of transitory problems. (When screening is done with impedance failure results should not be viewed as an obvious reason for immediate medical referral but often as cause for follow-up testing which may or may not result in medical referral or developmental evaluation at a later date.)
- C. Impedance screening programs for middle ear pathology may be phased in over a 3 year period to allow screening programs to obtain the necessary instrumentation, training and to develop referral procedures. The efficacy of impedance screening should be evaluated and reported annually for at least the first 3 years of its implementation.

2.4 KNOWN HEARING LOSS

Students with known hearing loss should receive threshold tests of hearing sensitivity annually or on a scheduled periodic basis as needed. A retest schedule for high frequency losses should be established in consultation with the supervising audiologist.

2.5 TEST ENVIRONMENT

It is recommended that space used for screening be made as quiet as possible to insure that high ambient noise does not invalidate screening results. If noise levels are excessive, screening should not be attempted but deferred until a more quiet time or place can be identified.

** See majority and minority report on this issue in Appendix G

3.1.2.6 Aid in planning habilitation and rehabilitation programs for those with chronic or permanent hearing losses.

3.1.3 Procedure for Audiologic Referrals

3.1.3.1 If the pupil still cannot pass the screening test after the second screening, an audiologic evaluation including at least air and bone conduction threshold tests should be accomplished within an additional 7 to 10 day period. All of these tests should be conducted by appropriately trained personnel. (See Section 5.1 and 5.2)

3.1.3.2 If the school district has the services of an audiologist referrals should be made directly to him/her after the second screening.

3.1.3.3 If no school audiologist is available, especially in rural areas, referrals should be made to the community health aide and public health nurse or school nurse who will in turn refer to the Communicative Disorders Program when appropriate.

This model is the preferred procedure to be followed. However, the program which will best serve the pupils in a specific area with the available qualified personnel, both professional and paraprofessional, should be utilized.

3.2 MEDICAL REFERRAL

A medical referral and management protocol should be established and made available in written form prior to the initiation of any screening efforts. The exact referral system employed will depend upon the availability of physicians, nurses, audiologists, physician's assistants etc. The procedure shall follow the same basic format as is depicted on Page 7 however, personnel will vary according to region.

Cases needing prompt medical attention may be so referred without prior audiological evaluation by school or public health nurses as the need indicates.

3.3 REFERRAL FOR EDUCATIONAL PLACEMENT

A child with a hearing impairment may be eligible for special education placement in accordance with the eligible guidelines in the current Alaska Special Education Handbook.

Every child who has been identified as hearing impaired (2 frequency pure tone loss of 20 dBHL or more for the speech range) must be considered to be a possible candidate for educational programs for the hearing impaired. The immediate responsibility of the school system will then be to determine whether educational assessment of each child should take place. A standard district preassessment procedure should be followed. The decision concerning referral for educational assessment should be made in conjunction with the parents and the classroom teacher, on the basis of audiological information and a review of the child's school performance.