ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4616 HHES SB 195 - SB 228

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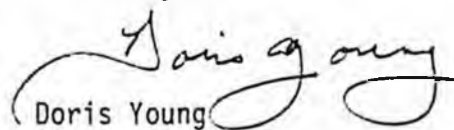
Public Health that Alaskans are misinformed about the AIDS virus and its transmission and that most Alaskans are afraid of contracting AIDS. In brief the survey showed that 61% of Alaskans would not eat in a restaurant that employs a person who has AIDS, 25% would not allow their child to attend school with a child diagnosed with AIDS, 28% believed that AIDS could be contracted from a shared drinking glass and 15% believed that the disease can be spread by mosquitos. Although the survey showed that 98% of Alaskans understand that AIDS can be transmitted through sex it did not ask Alaskans what sexual practices they consider to be "safe". 44% of all surveyed said that they are afraid of contracting the disease. The survey did not reflect how these people thought they could contract it.

At this time there are two very disconcerting facts about the future of the AIDS epidemic: 1) it is 100% FATAL; 2) there is no indication that a vaccine or cure is forthcomming within the next century or two. AIDS is a syndrome, which means that it is more of a condition than a specifically targeted and treatable disease. AIDS is a disease that creates a <u>body condition</u> that allows other more common diseases, diseases that can <u>normally</u> be treated and cured, to get the upper-hand. Presently, only means of prevention we have is behavior modification. If Alaskans know more about how AIDS is transmitted they can protect themselves and thus prevent further spread of the virus.

The prevention of AIDS in Alaska is an Alaskan challenge. Currently, Alaska does not have a program dedicated to the prevention of AIDS. The Department of Health and Social Services does not have enough funds nor enough staff to initiate a full and effective AIDS program. SB 195 would appropriate $498,000 to DHSS to develop a program to conduct certain amounts of testing and to provide appropriate levels of education for care givers, high risk groups, and the public at large. Alaska is now faced with difficult financial times and unavoidable budgetary cuts. This is the worst time to also be faced with additional burdens within the state's operating structure. However, passage of SB 195 (or HB 191) is crutial to heading off the AIDS epidemic in Alaska. There are no alternatives.

Thank you for considering passage of SB 195 or HB 191.

Sincerely,



Doris Young

Surgeon General's Report on

Acquired Immune Deficiency Syndrome

Surgeon General's Report on

ACQUIRED IMMUNE DEFICIENCY SYNDROME

U.S. Department of Health
and Human Services

Foreword

This is a report from the Surgeon General of the U.S. Public Health Service to the people of the United States on AIDS. Acquired Immune Deficiency Syndrome is an epidemic that has already killed thousands of people, mostly young, productive Americans. In addition to illness, disability, and death, AIDS has brought fear to the hearts of most Americans – fear of disease and fear of the unknown. Initial reporting of AIDS occurred in the United States, but AIDS and the spread of the AIDS virus is an international problem. This report focuses on prevention that could be applied in all countries.

My report will inform you about AIDS, how it is transmitted, the relative risks of infection and how to prevent it. It will help you understand your fears. Fear can be useful when it helps people avoid behavior that puts them at risk for AIDS. On the other hand, unreasonable fear can be as crippling as the disease itself. If you are participating in activities that could expose you to the AIDS virus, this report could save your life.

In preparing this report, I consulted with the best medical and scientific experts this country can offer. I met with leaders of organizations concerned with health, education, and other aspects of our society to gain their views of the problems associated with AIDS. The information in this report is current and timely.

This report was written personally by me to provide the necessary understanding of AIDS.

The vast majority of Americans are against illicit drugs. As a health officer I am opposed to the use of illicit drugs. As a practicing physician for more than forty years, I have seen the devastation that follows the use of illicit drugs – addiction, poor health, family disruption, emotional disturbances and death. I applaud the President's initiative to rid this nation of the curse of illicit drug use and addiction. The success of his initiative is critical to the health of the American people and will also help reduce the number of persons exposed to the AIDS virus.

Some Americans have difficulties in dealing with the subjects of sex, sexual practices, and alternate lifestyles. Many Americans are opposed to homosexuality, promiscuity of any kind, and prostitution. This report must deal with all of these issues, but does so with the intent that information and education can change individual behavior, since this is the primary way to stop the epidemic of AIDS. This report deals with the positive and negative consequences of activities and behaviors from a health and medical point of view.

Adolescents and pre-adolescents are those whose behavior we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual and homosexual) and perhaps experimenting with drugs. Teenagers often consider themselves immortal, and these young people may be putting themselves at great risk.

Education about AIDS should start in early elementary school and at home so that children can grow up knowing the behavior to avoid to protect themselves from exposure to the AIDS virus. The threat of AIDS can provide an opportunity for parents to instill in their children their own moral and ethical standards.

Those of us who are parents, educators and community leaders, indeed all adults, cannot disregard this responsibility to educate our young. The need is critical and the price of neglect is high. The lives of our young people depend on our fulfilling our responsibility.

AIDS is an infectious disease. It is contagious, but it cannot be spread in the same manner as a common cold or measles or chicken pox. It is contagious in the same way that sexually transmitted diseases, such as syphilis and gonorrhea, are contagious. AIDS can also be spread through the sharing of intravenous drug needles and syringes used for injecting illicit drugs.

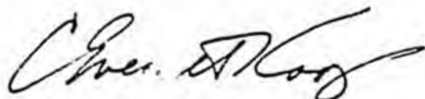
AIDS is *not* spread by common everyday contact but by sexual contact (penis-vagina, penis-rectum, mouth-rectum, mouth-vagina, mouth-penis). Yet there is great misunderstanding resulting in unfounded fear that AIDS can be spread by casual, non-sexual contact. The first cases of AIDS were reported in this country in 1981. We would know by now if AIDS were passed by casual, non-sexual contact.

Today those practicing high risk behavior who become infected with the AIDS virus are found mainly among homosexual and bisexual men and male and female intravenous drug users. Heterosexual transmission is expected to account for an increasing proportion of those who become infected with the AIDS virus in the future.

At the beginning of the AIDS epidemic many Americans had little sympathy for people with AIDS. The feeling was that somehow people from certain groups "deserved" their illness. Let us put those feelings behind us. We are fighting a disease, not people. Those who are already afflicted are sick people and need our care as do all sick patients. The country must face this epidemic as a unified society. We must prevent the spread of AIDS while at the same time preserving our humanity and intimacy.

AIDS is a life-threatening disease and a major public health issue. Its impact on our society is and will continue to be devastating. By the end of 1991, an estimated 270,000 cases of AIDS will have occurred with 179,000 deaths within the decade since the disease was first recognized. In the year 1991, an estimated 145,000 patients with AIDS will need health and supportive services at a total cost of between $8 and $16 billion. However, AIDS is preventable. It can be controlled by changes in personal behavior. It is the responsibility of every citizen to be informed about AIDS and to exercise the appropriate preventive measures. This report will tell you how.

The spread of AIDS can and must be stopped.

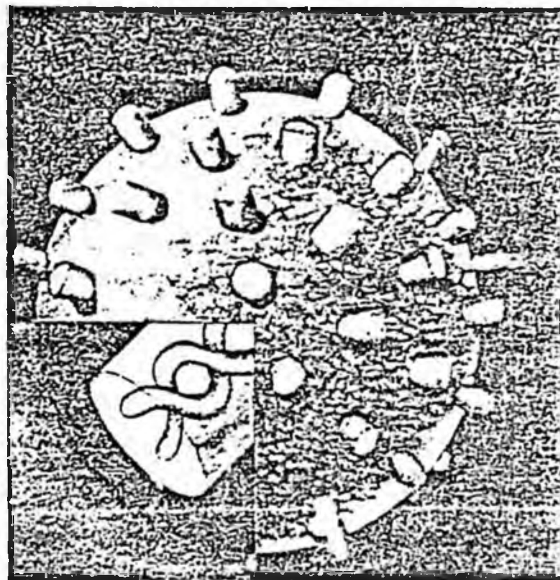


C. Everett Koop, M.D., Sc.D.
Surgeon General

AIDS

AIDS Caused by Virus

The letters A-I-D-S stand for Acquired Immune Deficiency Syndrome. When a person is sick with AIDS, he is in the final stages of a series of health problems caused by a virus (germ) that can be passed from one person to another chiefly during sexual contact or through the sharing of intravenous drug needles and syringes used for "shooting" drugs. Scientists have named the AIDS virus "HIV or HTLV-III or LAV"[1]. These abbreviations stand for information denoting a virus that attacks white blood cells (T-Lymphocytes) in the human blood. Throughout this publication, we will call the virus the "AIDS virus." The



Artists drawing of AIDS virus with cut away view showing genetic (reproductive) material

[1]These are different names given to AIDS virus by the scientific community:

HIV	— Human Immunodeficiency Virus
HTLV-III	— Human T-Lymphotropic Virus Type III
LAV	— Lymphadenopathy Associated Virus

AIDS virus attacks a person's immune system and damages his/her ability to fight other disease. Without a functioning immune system to ward off other germs, he/she now becomes vulnerable to becoming infected by bacteria, protozoa, fungi, and other viruses and malignancies, which may cause life-threatening illness, such as pneumonia, meningitis, and cancer.

No Known Cure

There is presently no cure for AIDS. There is presently no vaccine to prevent AIDS.

Virus Invades Blood Stream

When the AIDS virus enters the blood stream, it begins to attack certain white blood cells (T-Lymphocytes). Substances called antibodies are produced by the body. These antibodies can be detected in the blood by a simple test, usually two weeks to three months after infection. Even before the antibody test is positive, the victim can pass the virus to others by methods that will be explained.

Once an individual is infected, there are several possibilities. Some people may remain well but even so they are able to infect others. Others may develop a disease that is less serious than AIDS referred to as AIDS Related Complex (ARC). In some people the protective immune system may be destroyed by the virus and then other germs (bacteria, protozoa, fungi and other viruses) and cancers that ordinarily would never get a foothold cause "opportunistic diseases" — using the *opportunity* of lowered resistance to infect and destroy. Some of the most common are *Pneumocystis carinii* pneumonia and tuberculosis. Individuals infected with the AIDS virus may also develop certain types of cancers such as Kaposi's sarcoma. These infected people have classic AIDS. Evidence shows that the AIDS virus may also attack the nervous system, causing damage to the brain.

Signs and Symptoms

No Signs

Some people remain apparently well after infection with the AIDS virus. They may have no physically apparent symptoms of illness. However, if proper precautions are not used with sexual contacts and/or intravenous drug use, these infected individuals can spread the virus to others. Anyone who thinks he or she is infected or involved in high risk behaviors should not donate his/her blood, organs, tissues, or sperm because they may now contain the AIDS virus.

ARC

AIDS-Related Complex (ARC) is a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms. However, ARC patients' symptoms are often less severe than those with the disease we call classic AIDS. Signs and symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistance to infection, or swollen lymph nodes. These are also signs and symptoms of many other diseases and a physician should be consulted.

AIDS

Only a qualified health professional can diagnose AIDS, which is the result of a natural progress of infection by the AIDS virus. AIDS destroys the body's immune (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These opportunistic diseases would not otherwise gain a foothold in the body. These opportunistic diseases may eventually cause death.

Some symptoms and signs of AIDS and the "opportunistic infections" may include a persistent cough and fever associated with shortness of breath or difficult breathing and

may be the symptoms of *Pneumocystis carinii* pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of Kaposi's sarcoma. The AIDS virus in all infected people is essentially the same; the reactions of individuals may differ.

Long Term

The AIDS virus may also attack the nervous system and cause delayed damage to the brain. This damage may take years to develop and the symptoms may show up as memory loss, indifference, loss of coordination, partial paralysis, or mental disorder. These symptoms may occur alone, or with other symptoms mentioned earlier.

AIDS: the present situation

The number of people estimated to be infected with the AIDS virus in the United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Of these, an estimated 100,000 to 200,000 will come down with AIDS Related Complex (ARC). It is difficult to predict the number who will develop ARC or AIDS because symptoms sometimes take as long as nine years to show up. With our present knowledge, scientists predict that 20 to 30 percent of those infected with the AIDS virus will develop an illness that fits an accepted definition of AIDS within five years. The number of persons known to have AIDS in the United States to date is over 25,000; of these, about half have died of the disease. Since there is no cure, the others are expected to also eventually die from their disease.

The majority of infected antibody positive individuals who carry the AIDS virus show no disease symptoms and may not come down with the disease for many years, if ever.

No Risk from Casual Contact

There is no known risk of non-sexual infection in most of the situations we encounter in our daily lives. We know that family members living with individuals who have the AIDS virus do not become infected except through sexual contact. There is no evidence of transmission (spread) of AIDS virus by everyday contact even though these family members shared food, towels, cups, razors, even toothbrushes, and kissed each other.

Health Workers

We know even more about health care workers exposed to AIDS patients. About 2,500 health workers who were caring for AIDS patients when they were sickest have been carefully studied and tested for infection with the AIDS virus. These doctors, nurses and other health care givers have been exposed to the AIDS patients' blood, stool and other body fluids. Approximately 750 of these health workers reported possible additional exposure by direct

contact with a patient's body fluid through spills or being accidentally stuck with a needle. Upon testing these 750, only 3 who had accidentally stuck themselves with a needle had a positive antibody test for exposure to the AIDS virus. Because health workers had much more contact with patients and their body fluids than would be expected from common everyday contact, it is clear that the AIDS virus is not transmitted by casual contact.

Control of Certain Behaviors Can Stop Further Spread of AIDS

Knowing the facts about AIDS can prevent the spread of the disease. Education of those who risk infecting themselves or infecting other people is the only way we can stop the spread of AIDS. People must be responsible about their sexual behavior and must avoid the use of illicit intravenous drugs and needle sharing. We will describe the types of behavior that lead to infection by the AIDS virus and the personal measures that must be taken for effective protection. If we are to stop the AIDS epidemic, we all must understand the disease — its cause, its nature, and its prevention. *Precautions must be taken.* The AIDS virus infects persons who expose themselves to known risk behavior, such as certain types of homosexual and heterosexual activities or sharing intravenous drug equipment.

Risks

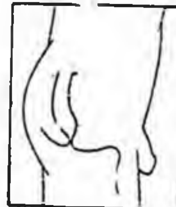
Although the initial discovery was in the homosexual community, AIDS is not a disease only of homosexuals. AIDS is found in heterosexual people as well. AIDS is not a black or white disease. AIDS is not just a male disease. AIDS is found in women; it is found in children. In the future AIDS will probably increase and spread among people who are not homosexual or intravenous drug abusers in the same manner as other sexually transmitted diseases like syphilis and gonorrhea.

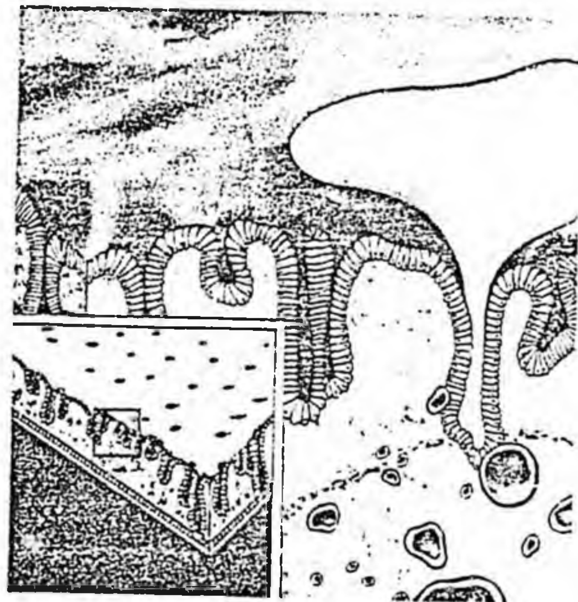
Sex Between Men

Men who have sexual relations with other men are especially at risk. About 70 percent of AIDS victims throughout the country are male homosexuals and bisexuals. This percentage probably will decline as heterosexual transmission increases. *Infection results from a sexual relationship with an infected person.*

Multiple Partners

The risk of infection increases according to the number of sexual partners one has, *male or female.* The more partners you have, the greater the risk of becoming infected with the AIDS virus.





Vulnerable rectum lining provides avenue for entry of AIDS virus into the blood stream.

How Exposed

Although the AIDS virus is found in several body fluids, a person acquires the virus during sexual contact with an infected person's blood or semen and possibly vaginal secretions. The virus then enters a person's blood stream through their rectum, vagina or penis.

Small (unseen by the naked eye) tears in the surface lining of the vagina or rectum may occur during insertion of the penis, fingers, or other objects, thus opening an avenue for entrance of the virus directly into the blood stream; therefore, the AIDS virus can be passed from penis to rectum and vagina and vice versa without a visible tear in the tissue or the presence of blood.

Prevention of Sexual Transmission – Know Your Partner

Couples who maintain mutually faithful monogamous relationships (only one continuing sexual partner) are protected from AIDS through sexual transmission. If you have been faithful for at least five years and your partner has been faithful too, neither of you is at risk. If you have not been faithful, then you and your partner are at risk. If your partner has not been faithful, then your partner is at risk which also puts you at risk. This is true for both heterosexual and homosexual couples. Unless it is possible to know with *absolute certainty* that neither you nor your sexual partner is carrying the virus of AIDS, you must use protective behavior. *Absolute certainty* means not only that you and your partner have maintained a mutual faithful monogamous sexual relationship, but it means neither you nor your partner has used illegal i[illegible] drugs.

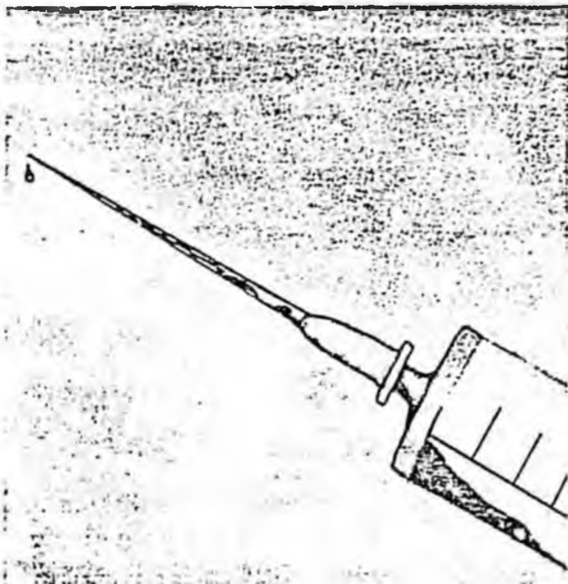
AIDS: you can protect yourself from infection

Some personal measures are adequate to safely protect yourself and others from infection by the AIDS virus and its complications. Among these are:

- If you have been involved in any of the high [illegible] sexual activities described above or have injected illicit intravenous drugs into your body, you should have a blood test to see if you have been infected with the AIDS virus.
- If your test is positive or if you engage in high risk activities and choose not to have a test, you should tell your sexual partner. If you jointly decide to have sex, you must protect your partner by always using a rubber (condom) during (start to finish) sexual intercourse (vagina or rectum).

- If your partner has a positive blood test showing that he/she has been infected with the AIDS virus or you suspect that he/she has been exposed by previous heterosexual or homosexual behavior or use of intravenous drugs with shared needles and syringes, a rubber (condom) should always be used during (start to finish) sexual intercourse (vagina or rectum).

- If you or your partner is at high risk, avoid mouth contact with the penis, vagina, or rectum.
- Avoid all sexual activities which could cause cuts or tears in the linings of the rectum, vagina, or penis.
- Single teen-age girls have been warned that pregnancy and contracting sexually transmitted diseases can be the result of only one act of sexual intercourse. They have been taught to say *NO* to sex! They have been taught to say *NO* to drugs! By saying *NO* to sex and drugs, they can avoid AIDS which can *kill* them! The same is true for teenage boys who should also not have rectal intercourse with other males. It may result in AIDS.
- Do not have sex with prostitutes. Infected male and female prostitutes are frequently also intravenous drug abusers; therefore, they may infect clients by sexual intercourse and other intravenous drug abusers by sharing their intravenous drug equipment. Female prostitutes also can infect their unborn babies.



Dirty intravenous needle and syringe contaminated with blood that may contain the AIDS virus.

Intravenous Drug Users

Drug abusers who inject drugs into their veins are another population group at high risk and with high rates of infection by the AIDS virus. Users of intravenous drugs make up 25 percent of the cases of AIDS throughout the country. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug related implements and the virus is injected into the new victim by reusing dirty syringes and needles. Even the smallest amount of infected blood left in a used needle or syringe can contain live AIDS virus to be passed on to the next user of those dirty implements.

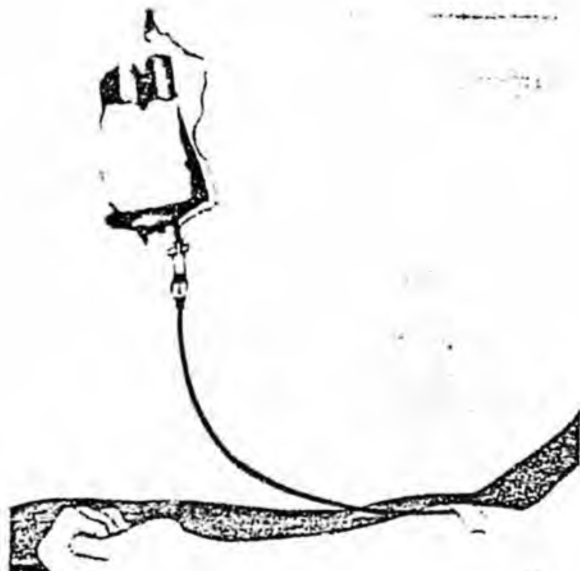
No one should shoot up drugs because addiction, poor health, family disruption, emotional disturbances and death could follow. However, many drug users are addicted to drugs and for one reason or another have not changed their behavior. For these people, the only way not to get AIDS is *to use a clean, previously unused* needle, syringe or any other implement necessary for the injection of the drug solution.

Hemophilia

Some persons with hemophilia (a blood clotting disorder that makes them subject to bleeding) have been infected with the AIDS virus either through blood transfusion or the use of blood products that help their blood clot. Now that we know how to prepare safe blood products to aid clotting, this is unlikely to happen. This group represents a very small percentage of the cases of AIDS throughout the country.

Blood Transfusion

Currently all blood donors are initially screened and blood is *not* accepted from high risk individuals. Blood that has been collected for use is tested for the presence of antibody to the AIDS virus. However, some people may have had a blood transfusion prior to March 1985 before we knew how to screen blood for safe transfusion and may have become



infected with the AIDS virus. Fortunately there are not now a large number of these ca[illegible] With routine testing of blood products, the blood supply for transfusion is now safer than it has ever been with regard to AIDS.

Persons who have engaged in homosexual activities or have shot street drugs within the last 10 years should *never* donate blood.

Mother Can Infect Newborn

If a woman is infected with the AIDS virus and becomes pregnant, she is more likely to develop ARC or classic AIDS, and she can pass the AIDS virus to her unborn child. Approximately one third of the babies born to AIDS-infected mothers will also be infected with the AIDS virus. Most of the infected babies will eventually develop the disease and die. Several of these babies have been born to wives of hemophiliac men infected with the AIDS virus by way of contaminated blood products. Some babies have also been born to women who became infected with the AIDS virus by bisexual partners who had the virus. Almost all babies with AIDS have been born to women who were intravenous

drug users or the sexual partners of intravenous drug users who were infected with the AIDS virus. More such babies can be expected.

Think carefully if you plan on becoming pregnant. If there is any chance that you may be in any high risk group or that you have had sex with someone in a high risk group, such as homosexual and bisexual males, drug abusers and their sexual partners, see your doctor.

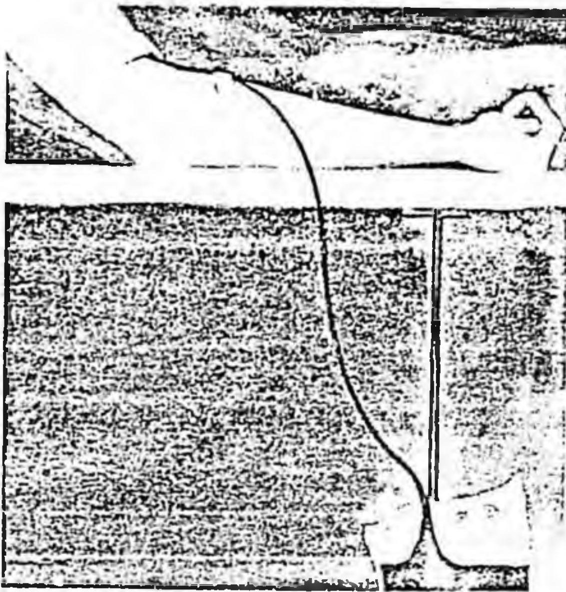
Summary

AIDS affects certain groups of the population. Homosexual and bisexual males who have had sexual contact with other homosexual or bisexual males as well as those who "shoot" street drugs are at greatest risk of exposure, infection and eventual death. Sexual partners of these high risk individuals are at risk, as well as any children born to women who carry the virus. Heterosexual persons are increasingly at risk.

AIDS: what is safe

Most Behavior is Safe

Everyday living does not present any risk of infection. You *cannot* get AIDS from casual social contact. Casual social contact should not be confused with casual *sexual* contact which is a major cause of the spread of the AIDS virus. Casual *social* contact such as shaking hands, hugging, social kissing, crying, coughing or sneezing, will not transmit the AIDS virus. Nor has AIDS been contracted from swimming in pools or bathing in hot tubs or from eating in restaurants (even if a restaurant worker has AIDS or carries the AIDS virus.) AIDS is not contracted from sharing bed linens, towels, cups, straws, dishes, or any other eating utensils. You cannot get AIDS from toilets, doorknobs, telephones, office machinery, or household furniture. You cannot get AIDS from body massages, masturbation or any non-sexual contact.



Donating Blood

Donating blood is *not* risky at all. *You cannot get AIDS by donating blood.*

Receiving Blood

In the U.S. every blood donor is screened to exclude high risk persons and every blood donation is now tested for the presence of antibodies to the AIDS virus. Blood that shows exposure to the AIDS virus by the presence of antibodies is not used either for transfusion or for the manufacture of blood products. Blood banks are as safe as current technology can make them. Because antibodies do not form immediately after exposure to the virus, a newly infected person may unknowingly donate blood after becoming infected but before his/her antibody test becomes positive. It is estimated that this might occur less than once in 100,000 donations.

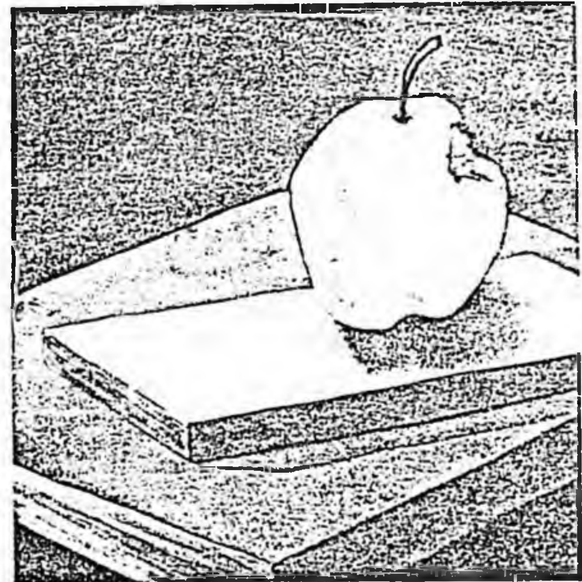
There is no danger of AIDS virus infection from visiting a doctor, dentist, hospital, hairdresser or beautician. AIDS

cannot be transmitted non-sexually from an infected person through a health or service provider to another person. Ordinary methods of disinfection for urine, stool and vomitus which are used for non-infected people are adequate for people who have AIDS or are carrying the AIDS virus. You may have wondered why your dentist wears gloves and perhaps a mask when treating you. This does not mean that he has AIDS or that he thinks you do. He is protecting you and himself from hepatitis, common colds or flu.

There is no danger in visiting a patient with AIDS or caring for him or her. Normal hygienic practices, like wiping of body fluid spills with a solution of water and household bleach (1 part household bleach to 10 parts water), will provide full protection.

Children in School

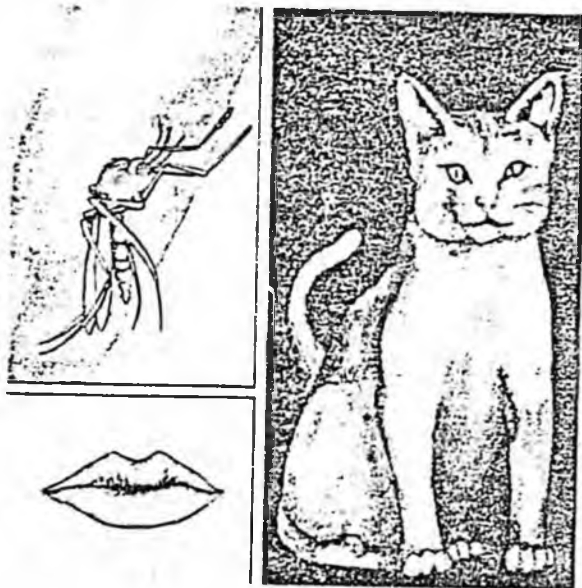
None of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to another in school, day care, or foster care settings. Transmission would necessitate exposure of open



cuts to the blood or other body fluids of the infected child, a highly unlikely occurrence. Even then routine safety procedures for handling blood or other body fluids (which should be standard for all children in the school or day care setting) would be effective in preventing transmission from children with AIDS to other children in school.

Children with AIDS are highly susceptible to infections, such as chicken pox, from other children. Each child with AIDS should be examined by a doctor before attending school or before returning to school, day care or foster care settings after an illness. No blanket rules can be made for all school boards to cover all possible cases of children with AIDS and each case should be considered separately and individualized to the child and the setting, as would be done with any child with a special problem, such as cerebral palsy or asthma. A good team to make such decisions with the school board would be the child's parents, physician and a public health official.

Casual social contact between children and persons infected with the AIDS virus is not dangerous.



Insects

There are no known cases of AIDS transmission by insects, such as mosquitoes.

Pets

Dogs, cats and domestic animals are not a source of infection from AIDS virus.

Tears and Saliva

Although the AIDS virus has been found in tears and saliva, no instance of transmission from these body fluids has been reported.

AIDS comes from sexual contacts with infected persons and from the sharing of syringes and needles. There is no danger of infection with AIDS virus by casual social contact.

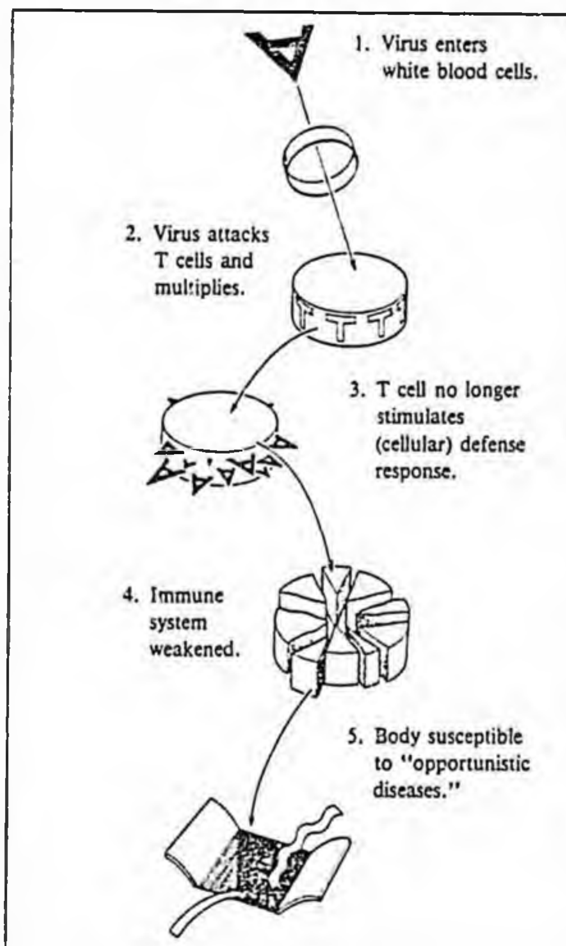
Testing of Military Personnel

You may wonder why the Department of Defense is currently testing its uniformed services personnel for presence of the AIDS virus antibody. The military feel this procedure is necessary because the uniformed services act as their own blood bank in a time of national emergency. They also need to protect new recruits (who unknowingly may be AIDS virus carriers) from receiving live virus vaccines. These vaccines could activate disease and be potentially life-threatening to the recruits.

AIDS: what is currently understood

Although AIDS is still a mysterious disease in many ways, our scientists have learned a great deal about it. In five years we know more about AIDS than many diseases that we have studied for even longer periods. While there is no vaccine or cure, the results from the health and behavioral research community can only add to our knowledge and increase our understanding of the disease and ways to prevent and treat it.

In spite of all that is known about transmission of the AIDS virus, scientists will learn more. One possibility is the potential discovery of factors that may better explain the mechanism of AIDS infection.



Why are the antibodies produced by the body to fight the AIDS virus not able to destroy that virus?

The antibodies detected in the blood of carriers of the AIDS virus are ineffective, at least when classic AIDS is actually triggered. They cannot check the damage caused by the virus, which is by then present in large numbers in the body. Researchers cannot explain this important observation. We still do not know why the AIDS virus is not destroyed by man's immune system.

Summary

AIDS no longer is the concern of any one segment of society; it is the concern of us all. No American's life is in danger if he/she or their sexual partners do not engage in high risk sexual behavior or use shared needles or syringes to inject illicit drugs into the body.

People who engage in high risk sexual behavior or who shoot drugs are risking infection with the AIDS virus and are risking their lives and the lives of others, including their unborn children.

We cannot yet know the full impact of AIDS on our society. From a clinical point of view, there may be new manifestations of AIDS – for example, mental disturbances due to the infection of the brain by the AIDS virus in carriers of the virus. From a social point of view, it may bring to an end the free-wheeling sexual lifestyle which has been called the sexual revolution. Economically, the care of AIDS patients will put a tremendous strain on our already overburdened and costly health care delivery system.

The most certain way to avoid getting the AIDS virus and to control the AIDS epidemic in the United States is for individuals to avoid promiscuous sexual practices, to maintain mutually faithful monogamous sexual relationships and to avoid injecting illicit drugs.

Look to the Future

The Challenge of the Future

An enormous challenge to public health lies ahead of us and we would do well to take a look at the future. We must be prepared to manage those things we can predict, as well as those we cannot.

At the present time there is no vaccine to prevent AIDS. There is no cure. AIDS, which can be transmitted sexually and by sharing needles and syringes among illicit intravenous drug users, is bound to produce profound changes in our society, changes that will affect us all.

Information and Education Only Weapons Against AIDS

It is estimated that in 1991 54,000 people will die from AIDS. At this moment, many of them are not infected with the AIDS virus. With proper information and education, as many as 12,000 to 14,000 people could be saved in 1991 from death by AIDS.

AIDS will Impact All

The changes in our society will be economic and political and will affect our social institutions, our educational practices, and our health care. Although AIDS may never touch you personally,the societal impact certainly will.

Be Educated – Be Prepared

Be prepared. Learn as much about AIDS as you can. Learn to separate scientific information from rumor and myth. The Public Health Service, your local public health officials and your family physician will be able to help you.

Concern About Spread of AIDS

While the concentration of AIDS cases is in the larger urban areas today, it has been found in every state and with the mobility of our society, it is likely that cases of AIDS will appear far and wide.

Special Educational Concerns

There are a number of people, primarily adolescents, that do not yet know they will be homosexual or become drug abusers and will not heed this message; there are others who are illiterate and cannot heed this message. They must be reached and taught the risk behaviors that expose them to infection with the AIDS virus.

High Risk Get Blood Test

The greatest public health problem lies in the large number of individuals with a history of high risk behavior who have been infected with and may be spreading the AIDS virus. Those with high risk behavior must be encouraged to protect others by adopting safe sexual practices and by the use of clean equipment for intravenous drug use. If a blood test for antibodies to the AIDS virus is necessary to get these individuals to use safe sexual practices, they should get a blood test. Call your local health department for information on where to get the test.

Anger and Guilt

Some people afflicted with AIDS will feel a sense of anger and others a sense of guilt. In spite of these understandable reactions, everyone must join the effort to control the epidemic, to provide for the care of those with AIDS, and to do all we can to inform and educate others about AIDS, and how to prevent it.

Confidentiality

Because of the stigma that has been associated with AIDS, many afflicted with the disease or who are infected with the AIDS virus are reluctant to be identified with AIDS. Because there is no vaccine to prevent AIDS and no cure, many feel there is nothing to be gained by revealing sexual contacts that might also be infected with the AIDS virus. When a community or a state requires reporting of those infected with the AIDS virus to public health authorities in order to trace sexual and intravenous drug contacts — as is the practice with other sexually transmitted diseases — those infected with the AIDS virus go underground out of the mainstream of health care and education. For this reason current public health practice is to protect the privacy of the individual infected with the AIDS virus and to maintain the strictest confidentiality concerning his/her health records.

State and Local AIDS Task Forces

Many state and local jurisdictions where AIDS has been seen in the greatest numbers have AIDS task forces with heavy representation from the field of public health joined by others who can speak broadly to issues of access to care, provision of care and the availability of community and psychiatric support services. Such a task force is needed in every community with the power to develop plans and policies, to speak, and to act for the good of the public health at every level.

State and local task forces should plan ahead and work collaboratively with other jurisdictions to reduce transmission of AIDS by far-reaching informational and educational programs. As AIDS impacts more strongly on society, they should be charged with making recommendations to provide for the needs of those afflicted with AIDS. They also will be in the best position to answer the concerns and direct the activities of those who are not infected with the AIDS virus.

The responsibility of State and local task forces should be far reaching and might include the following items:

- Insure enforcement of public health regulation of such practices as ear piercing and tattooing to prevent transmission of the AIDS virus.
- Conduct AIDS education programs for police, firemen, correctional institution workers and emergency medical personnel for dealing with AIDS victims and the public.
- Insure that institutions catering to children or adults who soil themselves or their surroundings with urine, stool, and vomitus have adequate equipment for cleanup and disposal, and have policies to insure the practice of good hygiene.

School

Schools will have special problems in the future. In addition to the guidelines already mentioned in this pamphlet, there are other things that should be considered such as sex education and education of the handicapped.

Sex Education

Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program. The appearance of AIDS could bring together diverse groups of parents and educators with opposing views on inclusion of sex education in the curricula. There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases.

Handicapped and Special Education

Children with AIDS or ARC will be attending school along with others who carry the AIDS virus. Some children will develop brain disease which will produce changes in mental

behavior. Because of the right to special education of the handicapped and the mentally retarded, school boards and higher authorities will have to provide guidelines for the management of such children on a case-by-case basis.

Labor and Management

Labor and management can do much to prepare for AIDS so that misinformation is kept to a minimum. Unions should issue preventive health messages because many employees will listen more carefully to a union message than they will to one from public health authorities.

AIDS Education at the Work Site

Offices, factories, and other work sites should have a plan in operation for education of the work force and accommodation of AIDS or ARC patients *before* the first such case appears at the work site. Employees with AIDS or ARC should be dealt with as are any workers with a chronic illness. In-house video programs provide an excellent source of education and can be individualized to the needs of a specific work group.

Strain on the Health Care Delivery System

The health care system in many places will be overburdened as it is now in urban areas with large numbers of AIDS patients. It is predicted that during 1991 there will be 145,000 patients requiring hospitalization at least once and 54,000 patients who will die of AIDS. Mental disease (dementia) will occur in some patients who have the AIDS virus before they have any other manifestation such as ARC or classic AIDS.

State and local task forces will have to plan for these patients by utilizing conventional and time honored systems but will also have to investigate alternate methods of treatment and alternate sites for care including homecare.

The strain on the health system can be lessened by family, social, and psychological support mechanisms in the community. Programs are needed to train chaplains, clergy, social workers, and volunteers to deal with AIDS. Such support is particularly critical to the minority communities.

Mental Health

Our society will also face an additional burden as we better understand the mental health implications of infection by the AIDS virus. Upon being informed of infection with the AIDS virus, a young, active, vigorous person faces anxiety and depression brought on by fears associated with social isolation, illness, and dying. Dealing with these individual and family concerns will require the best efforts of mental health professionals.

Controversial Issues

A number of controversial AIDS issues have arisen and will continue to be debated largely because of lack of knowledge about AIDS, how it is spread, and how it can be prevented. Among these are the issues of compulsory blood testing, quarantine, and identification of AIDS carriers by some visible sign.

Compulsory Blood Testing

Compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who *test* negatively might actually be positive due to *recent* exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior. The prevention behavior described in this report, if adopted, will protect the American public and contain the AIDS epidemic. Voluntary testing will be available to those who have been involved in high risk behavior.

Quarantine

Quarantine has no role in the management of AIDS because AIDS is not spread by casual contact. The only time that some form of quarantine might be indicated is in a situation where an individual carrying the AIDS virus knowingly and willingly continues to expose others through sexual contact or sharing drug equipment. Such circumstances should be managed on a case-by-case basis by local authorities.

Identification of AIDS Carriers by Some Visible Sign

Those who suggest the marking of carriers of the AIDS virus by some visible sign have not thought the matter through thoroughly. It would require testing of the entire population which is unnecessary, unmanageable and costly. It would miss those recently infected individuals who would test negatively, but be infected. The entire procedure would give a false sense of security. AIDS must and will be treated as a disease that can infect anyone. AIDS should not be used as an excuse to discriminate against any group or individual.

Updating Information

As the Surgeon General, I will continually monitor the most current and accurate health, medical, and scientific information and make it available to you, the American people. Armed with this information you can join in the discussion and resolution of AIDS-related issues that are critical to your health, your children's health, and the health of the nation.

Additional Information

Telephone Hotlines (Toll Free)

PHS AIDS Hotline
800-342-AIDS
800-342-2437

National Sexually Transmitted Diseases Hotline
American Social Health Association
800-227-8922

National Gay Task Force
AIDS Information Hotline
800-221-7044
(212) 807-6016 (NY State)

Information Sources

U.S. Public Health Service
Public Affairs Office
Hubert H. Humphrey Building, Room 725-H
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: (202) 245-6867

Local Red Cross or
American Red Cross
AIDS Education Office
1730 D Street, N.W.
Washington, D.C. 20006
Phone: (202) 737-8300

American Association of Physicians for Human Rights
P.O. Box 14366
San Francisco, CA 94114
Phone: (415) 558-9353

AIDS Action Council
729 Eighth Street, S.E., Suite 200
Washington, D.C. 20003
Phone: (202) 547-3101

Gay Men's Health Crisis
P.O. Box 274
132 West 24th Street
New York, NY 10011
Phone: (212) 807-6655

Hispanic AIDS Forum
c/o APRED
853 Broadway, Suite 2007
New York, NY 10003
Phone: (212) 870-1902 or 870-1864

Los Angeles AIDS Project
1362 Santa Monica Boulevard
Los Angeles, California 90046
(213) 871-AIDS

Minority Task Force on AIDS
c/o New York City Council
of Churches
475 Riverside Drive,
Room 456
New York, NY 10115
Phone: (212) 749-1214

Mothers of AIDS Patients (MAP)
c/o Barbara Peabody
3403 E Street
San Diego, CA 92102
(619) 234-3432

National AIDS Network
729 Eighth Street, S.E.,
Suite 300
Washington D.C. 20003
(202) 546-2424

National Association of People with AIDS
P.O. Box 65472
Washington, D.C. 20035
(202) 483-7979

National Coalition of Gay Sexually Transmitted Disease Services
c/o Mark Behar
P.O. Box 239
Milwaukee, WI 53201
Phone: (414) 277-7671

National Council of Churches AIDS Task Force
475 Riverside Drive,
Room 572
New York, NY 10115
Phone: (212) 870-2421

San Francisco AIDS Foundation
333 Valencia Street,
4th Floor
San Francisco, CA 94103
Phone: (415) 863-2437

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
EPIDEMIOLOGY OFFICE

3601 "C" STREET SUITE 540
PO BOX 240249
ANCHORAGE, ALASKA 99524-0249
(907) 561-4406

AIDS IN ALASKA
CHALLENGES FOR THE FUTURE
March 1, 1987

AIDS -- WHAT HAS CHANGED?

- The number of AIDS cases continues to rise. It is now estimated that in 1991, 270,000 Americans will develop AIDS and 179,000 will have died of AIDS. More than 1.5 million Americans are believed now to be infected with the AIDS virus -- one half may develop AIDS. Epidemiologic studies have shown that heterosexuals increasingly are becoming infected and that heterosexual transmission of the virus occurs more easily than initially suspected.

- Experts believe it unlikely that a vaccine against AIDS will be available or drugs to cure AIDS will be discovered in the next five years--or even longer.

- The National Research Council and Institute of Medicine of the National Academy of Sciences published a major work after reviewing all available information about AIDS-"Confronting AIDS, Directions for Public Health, Health Care, and Research." These experts have called for a major nationwide response to AIDS, recommending federal government expenditures of $1 billion per year for research and $1 billion per year for disease prevention education.

- Surgeon General Koop issued his landmark report on AIDS and stated that "...education concerning AIDS must start at the lowest grade possible...There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases."

AIDS -- WHAT SHOULD ALASKANS DO NEXT?

1) We must continue and strengthen our present program. We must stop considering only the number of AIDS cases and begin to focus on HIV infection. HIV infection is a far more serious problem; for every AIDS case, experts estimate that 50 more are infected with the virus and they are capable of infecting others.

2) We must increase screening for HIV infection and counselling individuals who are infected or are members of high risk groups. This should also help assure the continued screening of rural Alaskans for Hepatitis B which can also be transmitted sexually.

3) We must implement the National Academy of Sciences and Surgeon General's recommendations to provide education concerning AIDS in our schools at the lowest grade possible.

4) We must anticipate the future serious problems that will occur in health care financing and insure that Alaskans who develop AIDS and their families will have access to appropriate medical health and social services.

5) We must insure that confidentiality is protected to assure the voluntary cooperation in the testing of at risk Alaskans for HIV and other communicable diseases.

AIDS FUNDING

FY 83 - FY 88

	State	Federal	Total
FY 83	-0-	-0-	-0-
FY 84	-0-	-0-	-0-
FY 85	-0-	-0-	-0-
FY 86	-0-	$ 39.8	$ 39.8
FY 87	$47.9	200.9	248.8
FY 88 Request	44.0	200.9	244.9
Total	$91.9	$441.6	$533.5

Hepatitis B Funding

FY 82 - FY 88

	State	Federal	Total
FY 82	$ -0-	$ 500.0	$ 500.0
FY 83	-0-	1,000.0	1,000.0
FY 84	250.0	1,000.0	1,250.0
FY 85	250.0	3,600.0	3,850.0
FY 86	658.8	3,100.0	3,758.8
FY 87	187.9	400.0	587.9
FY 88	-0-	350.0	350.0
	$1,346.7	$9,950.0	$11,296.7

It is estimated that there have been approximately 45 deaths in Alaska attributed to hepatitis B infection in the past 30 years.

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
EPIDEMIOLOGY OFFICE

3601 "C" STREET, SUITE 540
PO BOX 240249
ANCHORAGE, ALASKA 99524-0249
(907) 561-4406

AIDS PROGRAM
STATUS REPORT
STATE OF ALASKA

John P. Middaugh, M.D.
State Epidemiologist
Epidemiology Office
Division of Public Health
Chairman, AIDS Task Force
March 1, 1987

EXECUTIVE SUMMARY

- The Division of Public Health has continued its multi-faceted program in response to the pressing public health problems posed by AIDS. Each component of the program is consistent with guidelines established by the national Centers for Disease Control (CDC) and the Association of State and Territorial Health Officers (ASTHO).

- National recommendations continue to evolve based on the results of research and growing experience from the nationwide effort to control AIDS. As research findings become translated into policy recommendations, components of Alaska's AIDS program will need to be modified. As our understanding of AIDS increases, so will our ability to apply sound public health principles and practices to reduce the risk of disease transmission.

BACKGROUND

Acquired Immune Deficiency Syndrome (AIDS) is caused by infection with a virus known as human T-cell lymphotrophic virus (HTLV-III) or Human Immunodeficiency Virus (HIV). There is a wide spectrum of HIV infections, ranging from infection in the absence of signs and symptoms at one end to infection with confirmed AIDS and a high degree of mortality at the other end. Several articles, reprints, and fact sheets are attached in order to provide detailed information about AIDS and about public health policy recommendations.

AIDS CASES IN ALASKA

In order to provide consistent information throughout the United States, a rigorous case definition was developed by national experts and is used to report cases of AIDS in Alaska to the national Centers for Disease Contol.

Through March 1, 1987, 33 Alaskans have been confirmed to have AIDS, meeting the case definition of AIDS used by CDC. All AIDS patients have been members of identified high risk groups. Of the 33 cases, 27 were Caucasian, 3 were Native, 2 were Hispanic, and 1 was black. Cases have occurred in the following locations:

Location	Cases
Anchorage	19
Juneau	6
Fairbanks	1
Kenai	2
Dillingham	2
Other Alaskan communities	3

Age group	Cases
<20	1
20-29	8
30-39	12
40-49	9
50+	3

Of the AIDS cases, 31 were male; two were female. Patient groups have included:

- Homosexual or bisexual men - 26
- Heterosexual with contact with a person with AIDS or at-risk for AIDS - 2
- Transfusion with blood/blood products - 3
- Hemophilia - 1
- IV Drug Abuse - 1

INFECTION WITH HIV - SCREENING PROGRAM RESULTS

Since 1985, the Division of Public Health has established eight sites in order to make accessible to Alaskans blood testing to detect infection with HIV. In 1986, through January 1, 1987, 132 of 2448 (5.4%) individuals tested were positive for HIV infection. HIV test results by risk category include:

RISK CATEGORY	HIV RESULTS #positive/#tested (%)
Homosexual or Bisexual	112/623 (18.0)
IV Drug User	6/210 (2.9)
Hemophilia/Coagulation Disorder	2/2 (100.0)
Heterosexual Contact with person with AIDS or at risk for AIDS	2/228 (0.9)
Transfusion with blood/blood products	1/41 (2.4)
All others	9/1344 (0.7)

Between October 1985 and September 1986, no positives were found among 1871 military recruit applicants screened in Alaska.

RISK ESTIMATE DATA

HIV transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HIV has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions. Epidemiologic evidence has implicated only blood and semen in transmission.

Studies of non- :ual household contact of AIDS patients indicate that casual contact with · _iva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers.

The kind of non-sexual person-to-person contact that generally occurs among workers and clients or consumers in the work place does not pose a risk for transmission of HIV.

None of the identified cases of HIV infection in the United States are known to have been transmitted in the school, daycare, or foster care setting, or through casual person-to-person contact. All medical evidence to date finds that there is no risk of transmission of AIDS virus in the kinds of contacts school children and personnel have under normal circumstances.

DESCRIPTION OF AIDS PROGRAM IN ALASKA

Reporting and Surveillance - The Division of Public Health in cooperation with the Arctic Investigations Laboratory, Centers for Disease Control, Anchorage, cooperatively established a voluntary reporting and surveillance system for AIDS in January 1982. In January 1985, the Division of Public Health included AIDS as a disease required by regulation to be reported to the Division of Public Health by all physicians and other health care providers in the State of Alaska.

All cases of AIDS or suspect AIDS are reported to the Epidemiology Office, Division of Public Health. A case investigation is then conducted to establish the validity of suspected diagnosis. Cases that are verified to be AIDS are then, in turn, reported to the national Centers for Disease Control, Atlanta, Georgia. All patient identifying information is strictly confidential and is protected from disclosure by Alaska statute.

Blood Bank - Screening
In May 1985, a laboratory test became available to screen for the presence of infection with HIV virus. Screening activities began in blood banks in Anchorage and Fairbanks for all prospective donors. All individuals found positive on screening are excluded from donating blood. Through January 1987, of approximately 16,468 donors screened, only one individual was positive - a bisexual man who said he wished to donate blood in order to have his blood screened for the presence of HIV virus.

At the same time, the Northern Regional Laboratory, Section of Laboratories, Division of Public Health, began providing HIV testing through the alternate testing sites and for communities that depend on walk-in donors. Through January 1987, 2 of 780 prospective blood donors were found to be positive. Further investigation revealed that the two individuals positive for HIV were members of high-risk groups who were not able to be tested at an alternate site.

Screening for HIV Infection - When HIV blood tests were developed, their primary purpose was to screen out potentially infected individuals to protect the nation's blood supply. Because early experience with the test raised questions as to its validity (sensitivity, specificity, and predictive value), the use of the test was recommended to be restricted solely for the purpose of screening blood donors.

However, it was recognized that many individuals in high risk groups would wish to be tested to see if they were infected with HIV. Concern was raised that members of high risk groups and other members of the general public might descend upon blood banks, not to donate blood, but to obtain the blood test. In order to protect the blood banks, alternate testing sites were recommended to be established so that concerned individuals could be tested.

Alternate test sites were established in Alaska in May 1985 according to CDC recommendations. These recommendations mandated pre-test and post-test counseling of all persons who requested blood testing for HIV. Counseling is done by STD clinic personnel who have received specialized training.

The purpose of counseling is to discuss with individuals the complex information about HIV infection, AIDS, the limitations and strengths of the laboratory test, and the interpretation and implications of laboratory results. Individuals who test positive are counseled about the need to refer close contacts who may be at increased risk of infection, and in risk reduction behaviors that can reduce transmission of HIV.

All identifying information is held strictly confidential by the individual who draws the blood and provides counseling. Testing is conducted in the State Laboratory using specimen identification numbers only. No information that would enable laboratory personnel to identify individuals is available to the laboratory.

AIDS Task Force - In October 1985, Commissioner Pugh, Department of Health and Social Services, appointed an AIDS Task Force. The purpose of the Task Force is to provide expert medical opinion regarding AIDS and HIV infection to the Division of Public Health and to the Department of Health and Social Services, and to aid in establishing policies regarding AIDS for the State of Alaska.

The Task Force recommends policies to the Division of Public Health for its consideration. The Task Force also has been charged with identifying AIDS program components in need of increased attention in order optimally to deal with problems related to AIDS and HIV infection in Alaska.

POLICY DEVELOPMENT - The Department of Health and Social Services has coordinated AIDS program activities closely with numerous individuals, agencies, and organizations, including the private medical community; Indian Health Service; Arctic Investigations Laboratory, Centers for Disease Control, Anchorage; and other Departments of the State of Alaska. Based on recommendations from the Task Force, the Department of Health and Social Services developed official policies regarding AIDS pertaining to schools, daycare and foster care; corrections; and providers of pre-hospital emergency care.

The Task Force has identified several areas in need of policy development. The Department of Health and Social Services should take an active role in assuring that AIDS patients have access to the full range of psychiatric, medical, and dental services. A working group should be established to explore health care financing options for the provision of comprehensive medical care to AIDS victims including outpatient care, psychological counseling, hospitalization, nursing home care, and hospice care.

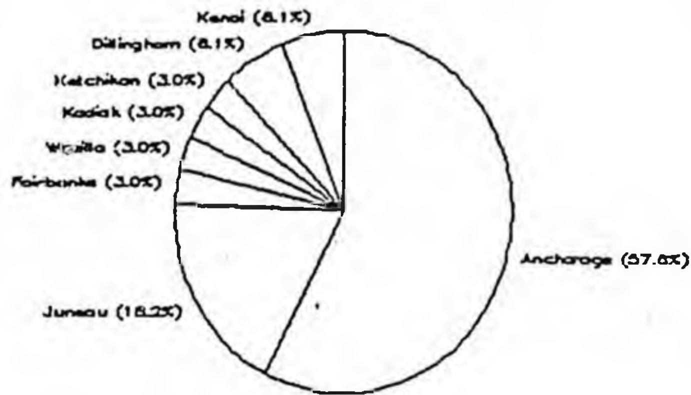
Network - The Division of Public Health is developing a network of AIDS knowledgeable physicians and other health care providers as a resource for communities throughout the State of Alaska.

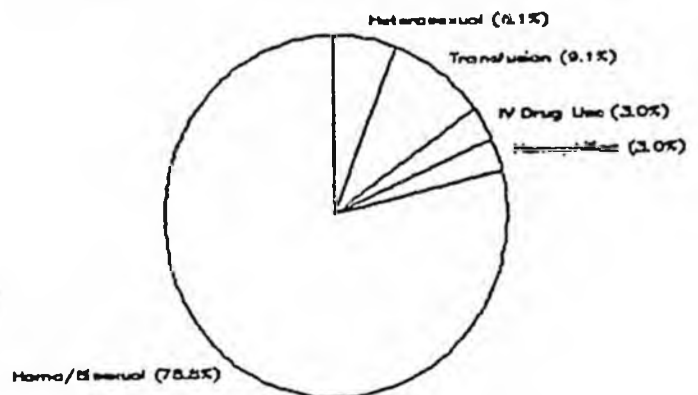
Confidentiality - In many public health activities, issues of confidentiality play an extraordinarily important role. Numerous diseases are required by regulation to be reported routinely to the Division of Public Health. The track record of the Division of Public Health in preserving confidentiality while working to protect the public's health is admirable.

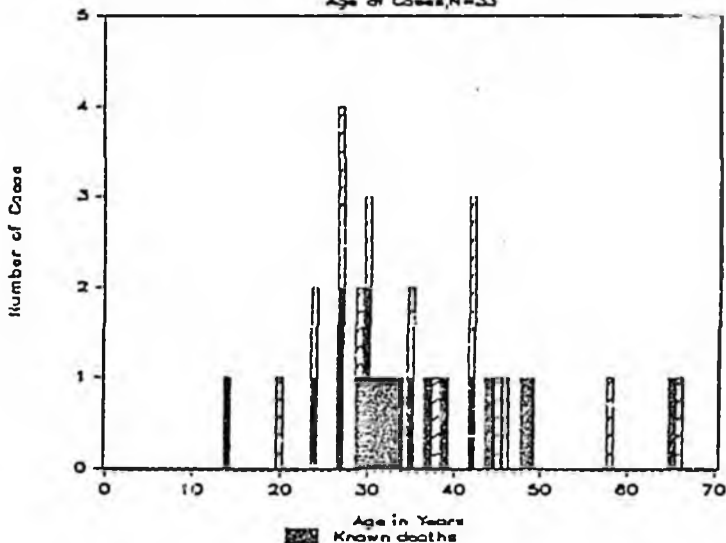
Confidentiality issues related to AIDS are extremely important. Through January 1986, AIDS program activities in Alaska have effectively balanced protection of individual rights and confidentiality and have effectively balanced those rights against requirements to protect the public. As medical research and national public policy guidelines continue to evolve, issues of confidentiality will continue to play a major role in program decisions.

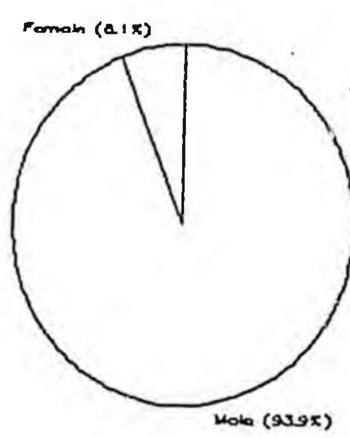
Education

The Division of Public Health has recently begun to implement a CDC Community Health Education and Risk Reduction grant. We have hired a health education coordinator, conducted a survey of knowledge and attitudes about AIDS among the general public, and initiated efforts to increase AIDS prevention education in Alaska schools.

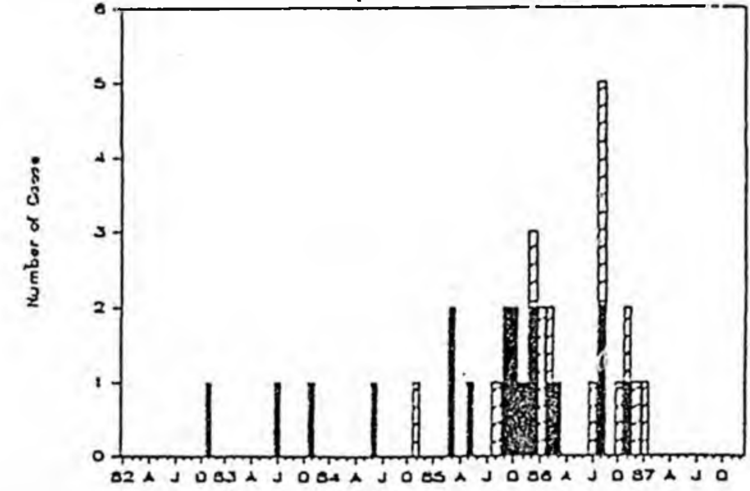








Epidemiology Office
Division of Public Health
Department of Health and Social Services



STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

P.O. BOX H-01
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030

January 30, 1987

Dear Administrator:

As you know, acquired immune deficiency syndrome (AIDS) has become a serious public health problem. It constitutes a most frightening disease by any measure. It devastates those who catch it; it is currently incurable and fatal. Furthermore, it is spreading at a menacing pace.

Fears and misconceptions about AIDS, however, have spread even faster than the disease itself. We hear, for instance, that AIDS is spread by mosquitoes or by sharing drinking glasses, statements not supported by scientific evidence. AIDS is deadly, but fortunately, it is difficult to catch.

The United States Public Health Service stresses that the disease is not transmitted through any casual contact. AIDS is spread only by intimate sexual contact, through transfusion of infected blood or blood products, and from an infected mother to her fetus or newborn child.

Obviously, the behaviors that are most risky for catching AIDS involve sex with multiple partners, intravenous drug use, and sexual contact with an I.V. drug user. Still, many people remain unconvinced.

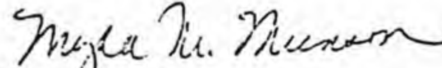
The U.S. Public Health Service has developed a comprehensive plan to inform the American public about AIDS in order to create general awareness and understanding of the syndrome, the ways in which the virus is transmitted, and the relative threat it poses to various population groups and to the public health. The ultimate goal of the public information program is to help prevent and control AIDS.

The nature and effects of AIDS make it desirable to target selected information to several audiences. The public needs to know that AIDS is an infectious, sexually transmitted, blood-borne disease. The fact that both homosexual and heterosexual people may be at risk for AIDS because of sexual contact is an important message for everyone. So, too, is the r posed by drug injection.

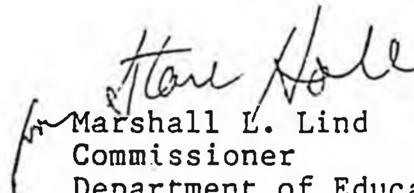
I am sending you materials developed by the Public Health Service and the American Red Cross. I am enclosing, also, a copy of the report on AIDS to the nation by the Surgeon General of the United States.

The PHS/Red Cross brochures on AIDS and Children are aimed at school administrators and teachers and at parents of children in school. I hope you will make these available to your staff and to parents who may ask questions about AIDS. For any additional information or materials related to AIDS, please do not hesitate to write or call me.

Sincerely,



Myra M. Munson
Commissioner
Department of Health &
Social Services



Marshall L. Lind
Commissioner
Department of Education

Hepatitis B Funding

FY 82 - FY 88

	State	Federal	Total
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AIDS FUNDING

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FY 87	$47.9	200.9	248.8
FY 88 Request	44.0	200.9	244.9
Total	$91.9	$441.6	$533.5

SB

212

HOUSE COMMITTEE REPORT

(7)

Date referred: 5/15/87

FURTHER REFERRALS:

DATE: May 16, 1987

The Health, Education and Social Services Committee has considered CSSB 212(HESS)

"An Act extending the termination date of the Special Education Service Agency; and providing for an effective date."

RECOMMENDS:

[ ] replace with ______________ [ ] the same title

[ ] attached amendment(s) [ ] a new title

[ ] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ______________ Committee

ADOPTS: [ ] __________ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[ ] fiscal impact

[ ] zero fiscal note

[ ] zero with analysis

[ ] same as previous fiscal note published ______________

[ ] same as previous zero fiscal note published ______________

SIGNING DO PASS:

[signatures]

SIGNING OTHER RECOMMENDATIONS:

[signature]

Chairman's signature

STATE OF ALASKA 1987 LEGISLATIVE SESSION

FISCAL NOTE

Bill Version : CSSB-212/dZ55

Publish Date :

REQUEST:

Revision Date:

Title : ...extending the termination date of the Special Education Service Agency..

Sponsor : Senator Zharoff

Requestor : Senate HESS

Agency Affected : Education

BRU : K-12 Support

Components : Schools for the Handicapped

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		Ø	Ø	Ø	Ø	Ø
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
GENERAL FUND		Ø	Ø	Ø	Ø	Ø
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Funds for the operation of the Special Education Service Agency are presently included in the department's operating budget.

Prepared by : Steve Hole

Phone : 465-2800

Division : Commissioner's Office

Date : April 30, 1987

Approved by Commissioner : William G. Demmert

Date : April 30, 1987

Agency : Education

Distribution (by preparer):

Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)
Senate Secretary

page ___ of ___

A PERFORMANCE REPORT ON THE DEPARTMENT OF EDUCATION SPECIAL EDUCATION SERVICES AGENCY

March 25, 1987

Audit Control Number

05-1298-87-R

Commissioner, Department of Education	Marshall L. Lind

Special Education Services Agency
B ard of Directors

President	Robert A Franken
Vice President	Terry L. Coon
Secretary	Todd R. Risley
Treasurer	Richard Kronberg
Member	Shirley Craft
Member	Duane M. French
Member	Mary Rubadeau
Member	Noreen Thompson
Ex-officio Member, Department of Education	Steve Hole
Ex-officio Member, Department of Health & Social Services	Blanche Brunk

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W
JUNEAU, ALASKA 99811-3300

March 25, 1987

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

A PERFORMANCE REPORT ON THE
DEPARTMENT OF EDUCATION
SPECIAL EDUCATION SERVICES AGENCY

March 25, 1987

Audit Control Number

05-1298-87-R

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

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PURPOSE AND SCOPE OF THE REPORT

Purpose

In accordance with the provisions of AS 24.20. 271(1) and AS 44.66.050, a review of the Special Education Services Agency (SESA) was conducted to determine whether there is a demonstrated need to continue delivery of educational programs for low-incidence handicapped students in the form it is presently provided. To determine that need, we reviewed the historical development of educational programs for low incidence handicapped students, alternative modes of delivery, current national trends and the economy, efficiency, and effectiveness of this agency.

Alaska Statute 44.66.010(a)(13) specifies that SESA will terminate on June 30, 1987 with one year allotted for concluding its affairs. This report shall be considered during the legislative oversight function in determining whether SESA should be reestablished and, if so, in what form.

The policy and audit approach utilized by the Division of Legislative Audit for performance reports can best be described as "audit by exception." This methodology focuses audit effort on areas of an auditee's operation that have been identified by a preliminary survey as having a high degree of probability for needing improvements.

Therefore, by design, finite audit resources are used to identify where and how improvement can be made and little time is devoted to reviewing well-run operations or programs. Consequently, this report highlights those areas needing improvement and does not emphasize those operations and programs that are properly functioning.

Scope

The functions reviewed included board activity, administrative, and program delivery. Because SESA had only been in existence for seven months at the time of our review, data available for our review was limited, and our scope, therefore, limited. Our review consisted of analyzing and evaluating the following:

1. Applicable statutes and regulations.
2. Interviews with staff members.
3. Agency policies and procedures.
4. Quarterly statistical reports.
5. Interviews with related service providers.
6. Interviews with Department of Education personnel.
7. Revenue and expenditure reports.

ORGANIZATION AND FUNCTION

The Special Education Services Agency (SESA) was created by ch. 112, SLA 1986 and formed as a private, not-for-profit corporation in August 1986. It is governed by a board of directors comprised of five to seven members of the Governor's Council for the Handicapped and Gifted and three members appointed by Alaska Association of Administrators of Special Education, National Education Association, Alaska, and the Alaska Association of School Administrators.

The purpose of SESA's creation was threefold: to assist districts and REAAs to make more special education and related services available to exceptional children; encourage cooperation between districts and education agencies in making special education programs and services available; and ensure that qualified specialists are available to assist districts in provision of services to exceptional children.

SESA is providing these services through the following programs:

° Low-Incidence Handicapped Outreach Project. SESA's primary target group has been students, ages 3-21 years, with low incidence handicaps; i.e., mentally retarded, hard of hearing, deaf, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf/blind, and multihandicapped. SESA aids rural school districts in providing special education needs through itinerant education specialists.

° Blind/Visually Impaired Infant Learning Program. An early intervention and training program for children throughout the State, ages birth to three years, who have visual impairments.

° Model Demonstration Project. Through a three-year In-service Training Grant from the U.S. Department of Education, SESA is providing technical training workshops for teachers working with severely handicapped and/or deaf/blind students. Validated model classrooms have been established in Juneau and Kenai where teachers receive intensive training for five days.

° Services to the Deaf/Blind. SESA has obtained Federal funds to provide special services to deaf/blind (vision and hearing impaired) children and youth ages 0-21. Services include assistance in obtaining qualified evaluators, coordination of service providers, counselling families and teachers, and individual and group inservice training for staff and family members.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02–576(2/77)

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° Statewide Systems Change Project (SSCP). A U.S. Department of Education funded project to improve delivery systems for severely handicapped children and youth ages birth to 21. The purposes of the SSCP are to identify services available to the target population, analyze weaknesses in those services, and improve upon the transition of these individuals through the service delivery system.

Although SESA has only been in existence since September 1986, some of the programs described above were provided prior to that time. Provision of services began in 1971 when Federal funding was received by the Easter Seal Society of Alaska for the Alaska State Deaf/Blind program. In 1972 that program helped develop classrooms for Alaska's deaf/blind and severely handicapped students within the Anchorage School District and an outreach model for deaf/blind students in rural communities. The Anchorage School District program has continued to date providing classroom services as the Alaska State School for the Deaf and providing outreach services until 1986.

A blind/visually impaired program was established within the South Central Regional Resource Center (SCRRC) in 1977. The next year the Alaska State Deaf/Blind program was transferred to SCRRC and its name changed to Alaska Resources for the Moderately/Severely Impaired (ARMSI). Services were expanded to include multihandicapped students statewide. SCRRC closed in 1980 and ARMSI was transferred to the Employment and Training Center of Alaska (ETCA). In 1982 ARMSI received a three-year grant from the Alaska Department of Education to operate an outreach program for all low-incidence handicapped students thus adding severely emotionally disturbed, orthopedically impaired and other health impaired to those students previously served. ARMSI became SESA in September 1986.

Staffing at SESA was maintained at the same level as ARMSI until Governor Sheffield's ten percent budget reduction. As a result of that action two professional employees were shifted to Federal programs, two vacant positions left unfilled and one support position eliminated. SESA is currently staffed by 25 employees, including an executive director, program supervisor, 18 education specialists, and 4 support positions. In FY 87 SESA is eligible to receive $1,060,574 in State funding after the Governor's budget reduction. Other State and Federal grant funds total $557,354 for a total FY 87 budget of $1,617,929.

REPORT CONCLUSION

Policy Issues

This review contains policy issues raised as a result of our evaluation of various SESA practices. The final policy decisions affecting those practices are not within the scope of this review but require legislative consideration. In debating these decisions the legislative oversight committees should take into consideration the findings and recommendations presented in this report, so that the potential impact of the policy changes can be evaluated.

Report Conclusion

In our opinion, the Special Education Services Agency should continue to provide itinerant resources services for low-incidence handicapped students in Alaska. The public need which prompted the enactment of ch. 112, SLA 1986, the creation of the Special Education Services Agency, remains unchanged. Alaska has approximately 200 low-incidence handicapped students in rural school districts who are entitled to comprehensive special education services by both Federal (P.L. 94-142) and State (AS 47.80.100) mandates. Alaska Statute 47.80.100 requires that those services must be state-operated or purchased, dispersed geographically, designed to minimize institutionalization, and provided in the least restrictive setting, enabling a person to live as normally as possible within the limitations of the handicap.

There is, therefore, a necessity to provide services within the school district the student is enrolled. It has been demonstrated that it is more cost effective to provide those services on an itinerant basis rather than in-house for rural school districts for the following reasons. Because of the very small numbers of students suffering from severe disabilities in any given district, the cost of providing specialized personnel to serve each type of disability would be extremely high on a per student basis. Additionally, because of the high degree of specialization required, recruitment, even for the urban districts, has traditionally been difficult. Thirdly, specialized educational instruction for this population is not available in the private sector; therefore, even if districts wished to contract independently, services would not be readily available. This third reason could also result in placement of the student out of district or out of state contrary to policy enumerated in AS 47.80.100.

Having determined that the itinerant delivery concept is sound we reviewed alternatives to SESA's delivery mode. The three alternatives considered were: (1) services provided by a private, nonprofit corporation through a competitive

grant award as was done prior to the establishment of SESA; (2) services provided by the Southeast Regional Resource Center (SERRC) through State funding; and (3) services provided by a limited number of school districts on an itinerant basis to other districts in that geographical region.

We found the SESA mode to be preferable at this point in time to these alternatives for the following reasons. The creation of a permanent agency to provide these services has provided a stabilizing effect on SESA's ability to secure and retain professional staff, which in turn provides improved continuity of services to students. Also the naming of the Governor's Council on the Handicapped and Gifted as the governing entity has provided a statewide rather than regional perspective on service needs, and improved coordination and cooperation with other agencies providing related services. The SERRC model is very similar to the SESA model with the exceptions that SERRC is governed by a regional board and is housed in Juneau thus increasing travel expenses to provide services to the majority of recipients.

Providing services through direct funding of school districts is not viable at this time as there is no mechanism for assuring that additional revenue generated by these students would result in increased services for them (see Recommendation No. 1). Additionally, districts would still face the problems of limited service providers in the private sector with whom to contract.

Although effectiveness of SESA services was reviewed, we were unable to draw any conclusions on it for the following reasons. There are no program standards defining acceptable minimum program services (see Recommendation No. 1). Secondly, SESA had only been in existence for seven months at the time of our review. Although services are substantially the same as those provided by ARMSI, SESA has broader discretion in how services are provided which has resulted in a shift from providing services strictly for students to providing training and services for special education instructors working with the target population in addition to working with students.

Program statistics compiled by SESA (Appendixes B-C) demonstrate that SESA is attempting to provide services to all students referred to the agency in accordance with the two year plan of service provided to the Department of Education (DOE) as required by statute. Program benefit has also been reflected in the ratings SESA has been given by district personnel receiving services (Appendix D).

The funding mechanism for determining the level of special education funds SESA is eligible for from DOE was reviewed in conjunction with the proposed changes to foundation program funding under HB 126. This proposed legislation will dramatically increase the revenue available to districts based on the number of students receiving intensive or hospital/homebound special education services.

We recommend that if HB 126 becomes law and program standards are promulgated and monitored, a statutory amendment be sought to require mandatory contributions to SESA's funding from districts utilizing its services (see Recommendation No. 2). This action would recognize that revised foundation funding formula attempts to fund services based on what those services cost, and therefore, should not require additional funding. It also would enable the districts to accurately determine the cut-off point when it would be more cost effective to provide services in district rather than itinerantly.

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FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Department of Education (DOE) should promulgate regulations delineating special education program standards, and once enacted, monitor school districts for compliance with those standards.

DOE is required by AS 14.07.020(4) to prescribe by regulation a minimum course of study for the public schools. The Department requires that each district administer a program offering special education and related services so as to provide an appropriate educational program for exceptional children ages 3-21 who reside within the district (4AAC 52.020). That educational program is established by a written, individualized education program (IEP) for each child eligible for services. However, there are no minimum standards nor definition of "appropriate educational program" these IEPs must conform to. The Department does perform periodic technical compliance audits of the IEPs, but does not evaluate them as to adequacy of services proposed.

The result of this deficiency is that program services provided for special education students vary among Alaska's fifty-five school districts. Standards are established by individual district policy and commitment regarding special education, availability of resources, degree of pressure from parental and organizational advocacy groups, and the result of legal challenges to the district's adequacy of service. Although DOE would not be able to develop standardized programs for students because of differing needs, minimum acceptable levels of service should be determined. Once promulgated the Department should implement a program to periodically and routinely monitor compliance with established standards.

Recommendation No. 2

Alaska Statute 14.30.650 should be amended to require school districts utilizing SESA services to contribute to SESA funding.

Alaska Statute 14.30.650 currently requires that each year DOE allocate to SESA not less than $85 for each special education student in the State in average daily membership, or the equivalent of two percent of the funds appropriated for special education, whichever is greater. These funds are separate from the funds made available to school districts for special education services through the foundation funding formula.

Current foundation funding for special education does not differentiate among types of special education students nor attempt to fund services based on the cost of providing those services. It is reasonable, therefore, that the services for low-incidence handicapped students which are the most costly for districts on a per student basis, be funded over and above foundation funding. However, this mechanism is not equitable in that the SESA funding formula is based on the number of all special education students statewide, yet SESA does not provide services to the largest districts containing the majority of special education students.

Currently under legislative consideration is House Bill No. 126 which proposes a revised foundation program. This bill changes the formula under which special education instructional units are generated to vary with the level of services needed. Intensive or hospital/homebound students would generate .333 instructional units thus producing sufficient revenue to cover the cost of services for these students. Once program standards are promulgated (see Recommendation No. 1) setting out minimum services which need to be provided, districts should choose whether they wish to provide those services in district or have SESA provide them. If SESA is chosen a portion of the increased foundation revenue should then be allocated to SESA to cover the cost of providing itinerant services to the district.

This recommendation would provide two substantial benefits: (1) it would eliminate the current inequity in funding distribution in that only those districts receiving SESA services would be generating SESA funding, and (2) it would provide the districts with accurate data on the cost of the itinerant services and, therefore, a basis to determine the point at which it becomes more cost effective to provide the services in-district.

<u>Recommendation No. 3</u>

<u>The Special Education Services Agency Board of Directors should adopt a policy stating the maximum number of students of any one disability they will serve in a school district.</u>

The primary purpose of the Special Education Services Agency is to serve low-incidence handicapped students, meaning students with specific disabilities which occur infrequently in a school district. The rationale in creating the agency was to provide itinerant services for those students for whom it is not cost effective for the district to provide services in house. However, there is a cut-off point once the district has certified enough students of a given disability that it would be less costly to the State for the district to provide the services directly than for SESA to continue providing services. SESA has operated under an informal

policy that once a district has certified eight children in any one disability they encourage the district to provide services. We recommend the Board formally adopt a policy to avoid any potential conflict with districts over who should provide services, and to avoid unnecessary strain on SESA resources thus limiting services required of other qualified students.

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ANALYSIS OF PUBLIC NEED

Limited Analysis

The following analyses of SESA activities indicate both positive and negative factors as they relate to the public need factors defined in AS 44.66.050. These analyses were not intended to be all-inclusive, but address those areas we were able to cover within the scope of our review.

I. The extent to which the board, commission, or program has operated in the public interest.

SESA has attempted to meet the needs of low-incidence handicapped students through an outreach program staffed by educational specialists. It is assisting rural school districts in complying with Federal and State mandates governing students with disabilities. We were unable to evaluate the agency's effectiveness because there are no program standards defining acceptable minimum programs services (see Recommendation No. 1), and also due to SESA only being in existence for seven months at the time of our review.

II. The extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices which it has adopted, and any other matter, including budgetary, resource, and personnel matters.

Our review did not find SESA legislation, which has been in existence for only seven months, restrictive or overly broad. SESA has been able to provide basic educational services to all eligible students referred to them by rural school districts However, SESA has not formally adopted a policy stating the maximum number of students in a district with one disability that SESA will serve which may strain SESA resources in the future (see Recommendation No. 3).

III. The extent to which the board, commission or agency has recommended statutory changes which are generally of benefit to the public interest.

No statutory changes have been recommended regarding SESA, but agency personnel have been actively involved and supportive in the effort to enact legislation revising foundation funding.

IV. The extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service which it has provided.

Services are provided to districts based on student service plans and staff/parent service plans formulated with SESA and district personnel as well as parents which generate a technical assistance agreement (TAA) between SESA and the district. District personnel are annually asked to rate SESA services provided under the TAAs. The results of the most recent survey are included as Appendix D to this report.

V. The extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.

No regulations have been promulgated by SESA. All meetings of the board of directors are noticed and open to the public.

VI. The efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, to the department to which a board or commission is administratively assigned, or with the Office of the Ombudsman have been processed and resolved.

There is no record of any complaints being filed with SESA or the Department of Education. SESA is not within the jurisdiction of the Office of the Ombudsman, therefore complaints would be referred to DOE.

VII. The extent to which a board or commission which regulates entry into an occupation or profession has presented qualified applicants to serve the public.

This point of analysis is not applicable to SESA as it does not regulate entry into an occupation or profession.

VIII. The extent to which State personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.

SESA employees are not in the State service and are not subject to the State Personnel Act. Hiring, termination and grievance procedures are enumerated in the SESA procedures manual and are in compliance with EEO guidelines.

IX. The extent to which statutory, regulatory, budgeting or other changes are necessary to enable the agency board or commission to better serve the interests of the public and to comply with the factors.

Please refer to the previous section, Findings and Recommendations.

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APPENDIXES

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APPENDIX A

DEPARTMENT OF EDUCATION
SPECIAL EDUCATION SERVICES AGENCY
SCHEDULE OF REVENUES AND EXPENDITURES
For the Period September 1, 1986 through February 28, 1987
(UNAUDITED)
(Note 1)

Revenues (Note 2)	
State Grants (received to date)	$618,746
Federal Grants	131,287
Total Revenues as of 2/28/87	$750,033

Expenditures (Note 2)	
Administrative Staff	$ 69,295
Certified Staff	343,818
Classified Staff	43,331
Payroll Taxes	40,949
Teacher's Retirement System	32,386
Public Employee's Retirement System	3,361
Professional/Technical Services	6,760
Travel	134,912
Communications	18,246
Facility Rental	32,374
Education Maintenance	1,980
Office Supplies/Equipment	10,297
Professional Materials	1,496
Equipment Maintenance	2,485
Accounting/Audit	1,960
Insurance	4,729
Printing	1,309
Other	1,072
Total Expenditures as of 2/28/87	$750,760

Note 1: The information included in this schedule was obtained from SESA records. This information has not been audited by us and accordingly, we express no opinion on it.

Note 2: SESA has been authorized to receive and expend $1,617,929 in Federal and State grants as of February 28, 1987.

Note 3: This schedule does not include monies received or expended by SESA's predecessor (ARMSI) prior to the organization of SESA.

APPENDIX B

Special Education Services Agency
Districts and Sites Visited and Students Served
July 1, 1986 - December 31, 1986
(Note 1)

Visits	District	Site	Students
3	Alaska Gateway	Eagle	2
		Mentasta	1
		Northway	4
		Tetlin	2
		Tok	2
9	Bering Strait	Diomede	1
		Elim	1
		Gambell	1
		Koyuk	1
		Shishmaref	2
		Teller	1
		Unalakleet	2
		Wales	1
1	Bristol Bay	King Salmon	1
2	Chatham	Gustavus	1
1	Copper River	Glenallen	1
		Kenny Lake	2
2	Craig	Craig	2
5	Delta Greely	Delta Schools	5
		Ft. Greely	1
2	Dillingham	Dillingham School	2
2	Fairbanks	Barnette Elementary	1
		Birch	1
		Ft. Wainwright	1
3	Haines	Haines Elementary	2
		Mosquito Lake	1
1	Hydaburg	Hydaburg Schools	1
2	Juneau	Floyd Dryden	1
		Juneau Douglas H.S.	1
		Marie Drake M.S.	1
		Mendenhall Glen	1
		St. Jude	2
1	Kashunamuit	Chevak	1
1	Kenai	Kalifonsky Beach	2
		Kenai Elementary	2

Note 1: All information obtained from SESA "Department of Education State Contract for Low Incidence Handicapped Outreach Service Quarterly Report" for the period October - December 1986 and FY 87 year to date.

APPENDIX B

Special Education Services Agency
Districts and Sites Visited and Students Served
July 1, 1986 - December 31, 1986

Visits	District	Site	Students
7	Ketchikan	Houghtaling	1
		Ketchikan City	1
		Ketchikan H.S.	2
		Pt. Higgens	1
		Schoenbar Jr. H.S.	1
		Valley Park Elementary	4
		White Cliff Elementary	1
1	King Cove	King Cove Elementary	1
4	Klawock	Klawock Schools	2
4	Kodiak	Chiniak	1
		East Elementary	1
3	Lake & Penn.	Newhalen	2
		Perryville	1
13	Lower Kuskokwim	Bethel M.E.	4
		Eek	1
		Kasigluk	1
		Kipnuk	1
		Kongiginak	2
		Kwethluk	3
		Nunapitchuk	1
		Toksook Bay	1
		Tonunak	1
3	Lower Yukon	Marshall	1
		Mt. Village	1
		Pilot Station	1
4	Mat-Su	Swanson Elementary	1
		Wasilla H.S.	1
2	Nenana	Nenana Schools	1
5	Nome	Nome Elementary	5
3	North Slope	Barrow Elementary	4
		Barrow High School	2
		Pt. Lay	1
5	NW Arctic	Buckland	1
		Kotzebue M.S.	2
		Kotzebue H.S.	1
1	Pelican	Pelican Schools	1
2	Petersburg	Petersburg M.S.	2
2	Railbelt	Anderson	2
		Cantwell	1
4	Sitka	Baranof Elementary	1
		Blatchley Jr. H.S.	1
		Mt. Edgecumbe	2
		Sitka High School	2

APPENDIX B

Special Education Services Agency
Districts and Sites Visited and Students Served
July 1, 1986 - December 31, 1986

Visits	District	Site	Students
3	Skagway	Skagway City	2
1	S.E. Island	Hollis	1
5	S.W. Region	Levelock	1
		New Stuyahok	1
		Togiak	1
4	Wrangell	Wrangell Elementary	5
2	Yukon Flats	Ft. Yukon	1
		Venetie	2
4	Yukon-Koyukuk	Bettles Field	1
		Huslia	1
		Kaltag	1
		Koyukuk	1
1	Yupiit	Tuluksak	1
118	37 Districts	91 Sites	141

APPENDIX C

Special Education Services Agency
Type and Number of District Persons Assisted
July 1, 1986 - December 31, 1986
(Note 1)

District	No. of Teach.	No. of Aides	No. of Admin.	No. of Cert.	No. of Non Cert.	No. of Parents	Total
Alaska Gateway	6	0	4	0	2	2	14
Bering St.	22	1	9	2	1	6	41
Bristol Bay	1	0	1	1	0	1	4
Chatham	1	1	1	0	0	0	3
Copper Riv.	2	1	2	0	1	0	6
Craig	1	0	2	0	3	0	6
Delta/Gre.	8	1	3	1	1	3	17
Dillingham	3	1	1	1	2	2	10
Fairbanks	5	2	2	3	0	3	15
Haines	5	1	2	1	2	3	14
Hydaburg	1	0	1	0	0	0	2
Juneau	12	4	5	4	3	4	32
Kashunamuit	2	0	1	0	0	0	3
Kenai	4	0	1	1	0	2	8
Ketchikan	12	0	7	4	9	1	33
King Cove	2	0	1	0	0	1	4
Klawock	4	1	3	1	1	1	11
Kodiak	4	0	3	1	2	2	12
Lake & Penn.	5	1	3	1	3	2	15
Low. Kusk.	20	8	9	6	6	11	60
Low. Yukon	3	0	4	0	3	2	12
Mat-Su	3	4	3	0	2	1	13
Nenana	5	0	1	0	1	1	8
Nome	6	2	2	1	4	0	15
North Slope	10	4	5	0	0	5	24
NW Arctic	16	0	5	0	4	1	26
Pelican	1	1	1	0	0	2	5
Petersburg	6	0	2	1	3	2	14
Railbelt	2	1	2	0	3	0	8
SE Island	1	1	0	1	0	1	4
Sitka	12	3	6	5	5	9	40
Skagway	1	0	1	0	0	2	4
SW Region	7	1	2	3	0	2	15
Wrangell	3	3	1	1	5	3	16
Yukon Flats	3	2	3	3	3	1	15
Yukon-Koy.	7	2	2	1	3	1	16
Yupiit	1	0	2	0	0	0	3
Total	207	46	103	43	72	77	548

Note 1: Data from SESA DOE State Contract for Low Incidence Handicapped Outreach Service Quarterly Report for the period 10/1/86-12/31/86 and FY 87 year to date.

APPENDIX D

Special Education Services Agency
Technical Assistance Satisfaction Ratings
July 1, 1986 - December 31, 1986
(Note 1)

	First Quarter		Second Quarter	
	Cum. No.	Rating (Note 2)	Cum. No.	Rating (Note 2)
A. Was the purpose of this trip achieved?	4	6.50	43	6.40
B. The assistance provided was beneficial to me.	4	6.00	43	6.49
C. I will utilize the assistance/information provided during the school year.	4	7.00	43	6.58
D. Overall, the assistance provided met my needs to better serve the students.	4	6.75	43	6.60

Note 1: Data was obtained from SESA "Department of Education State Contract for Low Incidence Handicapped Outreach Service Quarterly Report" for the period October - December 1986 and FY 87 year to date.

Note 2: School district personnel were asked to rate SESA services on a 7.0 point scale, with 7.0 being the highest rating.

SPECIAL EDUCATION SERVICE AGENCY

2211-B ARCA DRIVE / ANCHORAGE, ALASKA 99508 / PHONE (907) 279-9675

April 21, 1987

RECEIVED
APR 22 1987
LEGISLATIVE AUDIT

Mr. Gerald Wilkerson
Legislative Auditor
Division of Legislative Audit
Pouch W
Juneau, Alaska 99811-3300

Dear Mr. Wilkerson:

This letter is in response to your report, "A Performance Report on the Department of Education, Special Education Service Agency, March 25, 1987."

In this report, you made three recommendations. We will respond to each.

Recommendation No. 1

The Department of Education (DOE) should promulgate regulations delineating special education program standards, and once enacted, monitor school districts for compliance with those standards.

We concur with this recommendation and have and will continue to assist the Department in this endeavor. Recently, we and others in the state have suggested that the Department of Education go to public hearing with Program Standards developed through the Program Standards Task Force.

Recommendation No. 2

Alaska Statute 14.30.650 should be amended to require school districts utilizing SESA services to contribute to SESA funding.

The funding of education services in this state has needed major revision for a number of years. The current formula for SESA was derived because of the need to provide stability to the agency and to provide a funding mechanism which provides enough revenue to provide an appropriate amount of service to school districts. We feel that SESA's funding needs to be considered with the state's funding formula for education and changes made as experience with these formulas reveal discrepancies or problems. We would support a funding mechanism which provides stability to the agency and provides enough dollars to perform the job.

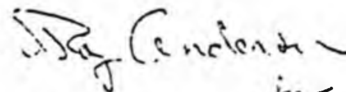
Recommendation No. 3

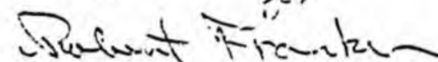
The Special Education Service Agency Board of Directors should adopt a policy stating the maximum number of students of any one disability they will serve in a school district.

We concur with this recommendation and plan to adopt such a policy at our May 30, 1987, Board meeting.

Thank you for the opportunity to respond to your report. In all, we found the report quite well done and complete.

Yours sincerely,





Robert A. Franken, President
SESA Board of Directors

RBA:jar

STEVE COWPER, GOVERNOR

DEPARTMENT OF EDUCATION

OFFICE OF THE COMMISSIONER

GOLDBELT PLACE
801 WEST 10th STREET
POUCH F
JUNEAU, ALASKA 99811

April 22, 1987

APR 27 1987

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit
Pouch W
Juneau, Alaska 99811

Dear Mr. Wilkerson:

This is in response to the Performance Report on the Special Education Services Agency dated March 25, 1987. Your recommendations and our responses are as follows:

Recommendation No. 1

The Department of Education should promulgate regulations delineating special education program standards and once enacted, monitor school districts for compliance with those standards.

Response: On April 28, 1987, the Department will present to the Alaska State Board of Education proposed regulations for program standards for promulgation.
It is anticipated that these regulations will be in place prior to the beginning of the 1987-88 school year.

Recommendation No. 2

Alaska Statute 14.30.650 should be amended to require school districts utilizing SESA services to contribute to SESA funding.

Response: The Department of Education concurs with this recommendation as a philosophy, but the mechanics of establishing a system of payment by the districts would be extremely difficult to implement and enforce. A survey conducted by the Office of Special Services on this issue indicated that half of the responding districts would not use SESA services if they were required to pay for the services. It would be very difficult for SESA to build a budget and hire staff not knowing how many districts would purchase these services. Further, it would probably result in many students who are eligible for and in need of services not receiving those services.

Recommendation No. 3

The Special Education Services Agency Board of Directors should adopt a policy stating the maximum number of students of any one disability they will serve in a school district.

Response: The Department of Education does not concur that an agency board should prescribe a policy of this nature. A random number may hinder services in one district and not another, depending upon the geographical conditions of the district. Eight students may be appropriate in a rural district while three may be appropriate in an urban district.

Sincerely,

William G. Demmert
Commissioner

SB

228

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

House Hess:

April 24, 1987
April 27, 1987

SSHB 228 An Act relating to regulation of the practice of dentistry; and providing for an effective date.

FILE CONTENTS

1) Copy of HB 228

2) Copy of SSHB 228

3) Amendment (3 pages) Utermohle

4) Special Report on the Department of Commerce and Economic Development Board of Dental Examiners, Audit dated August 27, 1986

5) Letter - Kirk Johnson to Legislators, 4/1/87

6) Fiscal Note, Commerce and Economic Development, with position paper

7) Committee Substitute for SSHB 228 (HESS)

8) House HESS minutes, 4/24/87

9) House HESS minutes, 4/27/87

HOUSE COMMITTEE REPORT

(7)

Date referred: 4/8/87 FURTHER REFERRALS: Finance

DATE: 4-27-87

The Health, Education and Social Services Committee has considered SSHB 228

"An Act relating to regulation of the practice of dentistry; and providing for an effective date."

RECOMMENDS:

[ ] replace with CSSSHB 228 (HESS) [✓] the same title
[ ] attached amendment(s) [ ] a new title

[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the ________ Committee

ADOPTS: [ ] ________ letter of intent

ATTACHES NEW FISCAL NOTE(s):

[✓] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis
[ ] same as previous fiscal note published ________
[ ] same as previous zero fiscal note published ________

SIGNING DO PASS:

[signatures]

SIGNING OTHER RECOMMENDATIONS:

[signature]
Co-Chairman's signature

5-0914L
Utermohle
4/23/87

Original sponsors: Menard, Gruenberg and Boucher

1 IN THE HOUSE — BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

2 CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 228 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to regulation of the practice of
7 dentistry; and providing for an effective date."

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

9 * Section 1. AS 08.36.010 is amended to read:

10 Sec. 08.36.010. CREATION AND MEMBERSHIP OF BOARD. There is
11 created the Board of Dental Examiners consisting of nine [SEVEN]
12 members. Six [FOUR] members shall be licensed dentists who have been
13 engaged in the practice of dentistry in the state for five years
14 immediately preceding appointment, one member shall be a dental hy-
15 gienist licensed under AS 08.32 who has been engaged in the practice
16 of dental hygiene in the state for five years immediately preceding
17 appointment, and two members shall be public members.

18 * Sec. 2. AS 08.36.070(a) is amended to read:

19 (a) The board shall [:]

20 (1) provide for the examination of [EXAMINE] applicants and
21 issue licenses to those applicants it finds qualified;

22 (2) register licensed dentists and licensed dental hygien-
23 ists who are in good standing;

24 (3) report annually to the governor and the department on
25 the board's proceedings during the year, findings concerning the
26 standards and availability of dental services in the state including
27 the number of licensees, examination and licensing activities, other
28 matters related to dental practice, and board receipts and expendi-
29 tures;

1 (4) affiliate with the American Association of Dental
2 Examiners, and pay annual dues to the association;
3 (5) hold hearings, and order the disciplinary sanction of a
4 person who violates this chapter, AS 08.32, or a regulation of the
5 board;
6 (6) supply forms for applications, licenses, permits,
7 certificates, and other papers and records;
8 (7) enforce the provisions of this chapter and AS 08.32 and
9 adopt or amend the regulations necessary to make the provisions of
10 this chapter and AS 08.32 effective;
11 (8) adopt regulations ensuring that renewal of registration
12 is contingent upon proof of continued professional competence by a
13 licensed dentist or licensed dental hygienist;
14 (9) provide the department with the requirements for proof
15 of continued professional competence and request the department to
16 make these requirements available to each licensed dentist and li-
17 censed dental hygienist at least one year before the date on which the
18 dentist or dental hygienist must renew registration;
19 (10) at least annually cause to be published in a newspaper
20 of general circulation in each major city in the state, a summary of
21 disciplinary actions the board has taken during the preceding calendar
22 year;
23 (11) issue permits or certificates to licensed dentists,
24 licensed dental hygienists, and dental assistants who meet standards
25 determined by the board for specific procedures that require specific
26 education and training;
27 (12) regulate the reentry into practice of inactive dentists
28 and dental hygienists.
29 * Sec. 3. AS 08.36.110 is repealed and reenacted to read:

1 Sec. 08.36.110. QUALIFICATIONS FOR LICENSE. An applicant for a
2 license to practice dentistry shall
3 (1) be a graduate of a dental school that at the time of
4 graduation is accredited by the Commission on Accreditation of the
5 American Dental Association;
6 (2) hold a certificate from the American Dental Association
7 Joint Committee on National Dental Examinations that the applicant has
8 successfully passed the written examinations given by the commission;
9 (3) submit proof satisfactory to the board that the appli-
10 cant
11 (A) has not had a license to practice dentistry re-
12 voked or suspended in this state or another state; and
13 (B) is not the subject of an unresolved complaint,
14 review procedure, or disciplinary proceeding in another state;
15 (4) pass, to the satisfaction of the board, written, clin-
16 ical, and other examinations administered or approved by the board;
17 and
18 (5) meet the other qualifications for a license established
19 by the board by regulation.
20 * Sec. 4. AS 08.36.130 is amended to read:
21 Sec. 08.36.130. EXAMINATION. An examination shall be given at
22 least once a year and at other times and at places determined by the
23 board to be convenient and economical for the applicants and the
24 state. At least once each year the board shall appoint an examination
25 committee of at least three licensed dentists who have been engaged in
26 the practice of dentistry in the state for five years immediately
27 preceding appointment to conduct <u>or to supervise</u> the examination
28 <u>process</u> for applicants for licenses to practice dentistry. The board
29 shall also appoint an examination committee of at least two licensed

1 dentists who have been engaged in the practice of dentistry in the
2 state for five years immediately preceding appointment and one person
3 licensed to practice dental hygiene in the state to conduct the ex-
4 amination for applicants for licenses to practice dental hygiene. The
5 examination committees shall report the results to the board for
6 official action.
7 * Sec. 5. AS 08.36.160(a) is amended to read:
8 (a) The examination conducted or approved by the board shall be
9 designed to test the qualifications of the applicant to practice
10 dentistry and shall consist of a written and a clinical examination.
11 * Sec. 6. AS 08.36.180 is amended to read:
12 Sec. 08.36.180. REEXAMINATION [RE-EXAMINATION]. An applicant
13 shall pass [EACH SUBJECT OF EACH SECTION OF] the examination conducted
14 or approved by the board with a score equal to or exceeding the mini-
15 mal acceptable score set by the board by regulation [OF AT LEAST 75
16 PERCENT]. If an applicant fails the examination [IN ONE SUBJECT IN
17 EACH SECTION], the applicant may be reexamined [RE-EXAMINED IN THAT
18 SUBJECT. IF AN APPLICANT FAILS IN MORE THAN ONE SUBJECT IN ANY SEC-
19 TION, THE APPLICANT SHALL BE RE-EXAMINED IN THE WHOLE SECTION]. If an
20 applicant fails the examination [OR ANY SECTION OF IT] on two separate
21 occasions, the board shall refuse to examine the applicant further
22 until the applicant produces evidence satisfactory to the board that
23 the applicant has pursued further study in preparation for the exami-
24 nation.
25 * Sec. 7. INITIAL APPOINTMENT. The governor shall appoint one quali-
26 fied person to an initial term of four years and another qualified person
27 to an initial term of two years to fill the new positions created on the
28 Board of Dental Examiners by sec. 1 of this Act.
29 * Sec. 8. Sections 2 - 5 of this Act are retroactive to January 1,

1987.

* Sec. 9. This Act takes effect immediately under AS 01.10.070(c).

5-0914ba
Utermohle

A M E N D M E N T

Offered in the HOUSE

By Menard

TO: SSHB 228

Page 1, line 7, following "dentistry;":

Insert "extending the termination date of the Board of Dental Examiners;"

Page 1, following line 8:

Insert a new bill section to read:

"* Section 1. AS 08.03.010(c)(6) is amended to read:

(6) Board of Dental Examiners (AS 08.36.010) -- June 30, 1991 [1988]."

Page 1, line 9:

Delete "* Section 1."

Insert "* Sec. 2."

Renumber following bill sections accordingly.

A M E N D M E N T

Offered in the HOUSE   By Menard

TO: SSHB 228

Page 4, lines 12 - 24:

Delete all material and insert:

"Sec. 08.36.180. REEXAMINATION [RE-EXAMINATION]. An applicant shall pass [EACH SUBJECT OF EACH SECTION OF] the examination conducted or approved by the board with a score equal to or exceeding the minimal acceptable score set by the board by regulation [OF AT LEAST 75 PERCENT]. If an applicant fails the examination [IN ONE SUBJECT IN EACH SECTION], the applicant may be reexamined [RE-EXAMINED IN THAT SUBJECT. IF AN APPLICANT FAILS IN MORE THAN ONE SUBJECT IN ANY SECTION, THE APPLICANT SHALL BE RE-EXAMINED IN THE WHOLE SECTION]. If an applicant fails the examination [OR ANY SECTION OF IT] on two separate occasions, the board shall refuse to examine the applicant further until the applicant produces evidence satisfactory to the board that the applicant has pursued further study in preparation for the examination."

A M E N D M E N T

Offered in the HOUSE

By Menard

TO: SSHB 228

Page 1, line 7, following "dentistry;":

Insert "providing for retrospective effect of examining powers of the Board of Dental Examiners and qualifi ations for license;"

Page 4, following line 28:

Insert a new bill section to read:

"* Sec. 8. Sections 2 - 5 of this Act are retroactive to January 1, 1987."

Renumber the following bill section accordingly.

A SPECIAL REPORT ON THE DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT BOARD OF DENTAL EXAMINERS

August 27, 1986

Audit Control Number

08-4271-87-S

Commissioner, Department of Commerce and Economic Development	Loren H. Lounsbury
Deputy Commissioners, Department of Commerce and Economic Development	Greg Baker Terry Elder

Members of the
Board of Dental Examiners

President	Robert E. Warren, D.D.S.
Secretary	Christine A. Baxter
Member	Paul S. Buxton, D.D.S.
Member	Jerry F. Zemlicka, D.D.S.
Member	Timothy J. Woller, D.D.S.
Member	Patrick J. Gullufsen, Esq.
Member	Hubert J. Gellert

STATE OF ALASKA

AUDIT DIVISION
POUCH W
JUNEAU, ALASKA 99811-3300

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

August 27, 1986

Members of the Legislative Budget
and Audit Committee:

In accordance with a Legislative Budget and Audit Committee special request and the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

A SPECIAL REPORT ON THE
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
BOARD OF DENTAL EXAMINERS

August 27, 1986

Audit Control Number

08-4271-87-S

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

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PURPOSE OF THE REPORT

In accordance with a Legislative Budget and Audit Committee request and the provisions of Title 24 of the Alaska Statutes, this special report has been prepared to evaluate the Alaska Board of Dental Examiners' licensing and examination practices.

We were requested to review the Board's examination practices to determine whether they are setting standards which are artificially high in order to limit competition. In addition, we performed a follow-up review of actions taken by the Board in response to House and Senate Letters of Intent adopted in conjunction with the passage of CSHB 614(HESS) (title am), an act extending the termination date of the Board of Dental Examiners, during the second session of the 14th Alaska State Legislature.

ORGANIZATION AND FUNCTION

The Alaska Board of Dental Examiners was created in 1955. The Board consists of seven members; four licensed dentists, one dental hygienist, and two public members which are appointed by the Governor subject to confirmation of the Legislature. Board members serve terms of four years.

The Board is organized under the Department of Commerce and Economic Development, Division of Occupational Licensing. Administrative functions of the Board are provided by Occupational Licensing, such as processing applications, maintaining licensing files, answering inquiries, and providing investigative support.

The primary function of the Board is to ensure a minimum quality of dental care to Alaskans by licensing qualified applicants and establishing regulations necessary to enforce statutes. The Board regulates dentists, dental specialists, and dental hygienists who perform services in the State. Special permits are issued by the Board to Federal agencies that supply dentistry to residents of isolated areas remote from major population centers.

The responsibility and authority for evaluating the competence of candidates for dental licensure are vested in the Board. A clinical and written examination has been developed by the Board to assess a candidate's competency. The clinical examination is a two day practical examination, requiring candidates to complete an amalgam and a gold inlay restoration procedure. Dental hygienists are also required to take a clinical and written examination. Although dental specialists are not required to take an examination, they must be licensed dentists in Alaska and may be required to have completed additional years of education in their specialty area.

REPORT CONCLUSIONS

AUDITOR COMMENTS/CONCLUSIONS

The Alaska Board of Dental Examiners has historically been the subject of much criticism. Criticism has been prompted by high failure rates experienced on past dental examinations and by the Board's decision not to provide a means for dental licensure by credentials as allowed by Alaska law. Though it is an inherent nature of all licensing boards to restrict entry into regulated professions to only those applicants possessing satisfactory qualifications, it has been suggested that the Alaska Board of Dental Examiners may be overly restricting entry into the dental profession in Alaska through adherence to licensing standards which are artificially high in order to limit competition. In our review of the Board's examination and licensing practices and procedures we did not find evidence which supports this contention. We did find, however, that entry into the dental profession in Alaska has been effectively limited due, in part, to the Board's failure to provide a means for dental licensure by credentials and, in part, to the commonness of high failure rates on past dental examinations.

We have included recommendations in this report which, if implemented, would serve to minimize the natural tendency to restrict entry into the dental profession in Alaska by allowing easier access to dental licensure in the State, while at the same time continuing to ensure adequate protection to the public by only allowing licensure to those dentists who are qualified and competent to practice dentistry. Our recommendations are included in the findings and recommendations section of this audit report.

REGULATION OF THE DENTAL PROFESSION

All fifty states plus Puerto Rico, the Virgin Islands, and the District of Columbia, regulate dentists through licensure. Regulation through licensure of qualified dentists is necessary to protect the public's health, safety, and welfare. Though specific requirements for licensure vary between jurisdictions, two common elements involve the need to ensure that all candidates for initial licensure possess satisfactory theoretical knowledge and can demonstrate satisfactory clinical skills. Theoretical knowledge is measured by the use of written examinations while clinical skills are assessed through the use of practical, or clinical, examinations requiring procedures to be performed on patients. Successful completion of both written and clinical examinations, in some form, is required prior to initial licensure in all jurisdictions. (See Appendix B and Appendix C.)