ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5667 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

Additional phases would augment the initial bed capacity plus complete core capacity. Total beds to be provided beyond the initial units will determined during the and facility planning and Certificate of Need processes adjusted for any impact delay in funding for design and construction of future phases.

February 26, 1990

BACKGROUND

HOSPITAL/NURSING HOME CONSTRUCTION

(HB 342 - GO Hospital Construction Bonds)

The 1981 Legislature authorized and funded a study by the Department of Health & Social Services of the plant condition and functional adequacy of 15 rural hospitals and nursing homes.

The result of that study was contained in a report by the Department to the Legislature in March, 1982.

Anchorage and Fairbanks hospitals were not included. Valley Hospital, Palmer and Sitka Community Hospital did not participate as they were currently under construction or reconstruction in 1982.

Overview of Surveyed Facilities

A study team evaluated the adequacy of the physical facilities at each hospital or long term care unit, a number of serious problems and deficiencies were discovered. Such inadequacies tended to fall into common classifications, the most important of which can be grouped as follows:

- Building, fire and life safety code deficiencies and violations;
- Lack of adequate mechanical ventilation to critical areas of the building, and mechanical and electrical inadequacies occasioned by the acquisition and use of high demand diagnostic and therapeutic equipment in laboratory and treatment programs;
- Facility inflexibility in response to changing attitudes, medical technologies and resultant changes in patterns of use; and
- Space shortage occasioned by new patterns of use, increasing complexity in information processing and records storage requirements, and growth in service area populations.

Generally, the deficiencies observed in the health care facilities surveyed are due to the advances and changing techniques in the medical field, coupled with more stringent building, fire and life safety codes which have been adopted over the last few years.

1982 Prioritization of Surveyed Hospitals and Nursing Homes

In conducting the inventory and evaluation study of the fifteen hospitals and long term care facilities in 1982, architectural consultants identified six facilities which were in greater need of immediate attention than others, due to their more severe physical and functional deficiencies. To arrive at a ranking of all surveyed facilities based upon relative need for construction to correct noted deficiencies, the Department assembled a committee to review the report.

(MORE)

This committee consisted of one member of:

The Alaska Medical Facility Authority;
The Alaska State Hospital Association;
Southeast Alaska Health Systems Agency, Inc.;
South Central Health Planning and Development, Inc.;
The Medical Care Advisory Committee, and
The Statewide Health Coordinating Council.

The ranking provided by this committee was based only upon the relative severity of all physical and functional deficiencies found at each facility and did not consider other factors such as facility utilization or population trends: The committee ranking was as follows:

* 1. Cordova Community Hospital and Long Term Care Facility
* 2. Petersburg General Hospital and Long Term Care Facility
3. Seward General Hospital
4. Kodiak Island Hospital and Long Term Care Facility
5. Wesleyan Nursing Home
* 6. Wrangell General Hospital
* 7. South Peninsula General Hospital and Long Term Care Facility
8. Ketchikan General Hospital and Island View Manor
* 9. Central Peninsula General Hospital
*10. Bartlett Memorial Hospital
11. Valdez Community Hospital
12. St. Ann's Nursing Home
*13. Norton Sound Regional Hospital

* completed (Central Peninsula & Bartlett utilized local bonding)

In 1987, the Health Association of Alaska, representing hospitals and nursing homes, recommended that Kodiak, Ketchikan and Seward be ranked as the top priority facilities needing construction grants.

HB 342 by Representatives Davidson, Cato, C. Davis and Taylor

Authorizes issuance of general obligation bonds in the amount of $41,400,000.00. This proposition to be placed on the 1990 general election ballot.

Kodiak Island Borough	$14,500,000.00
City of Seward	9,500,000.00
City of Seward	1,200,000.00
City of Ketchikan	16,200,000.00

# # #

For More Information Contact:

Harlan Knudson
Health Association of Alaska
586-1790

2/26/90

3.0 SUMMARY OF SEWARD FACILITY

Seward General Hospital is a 31-bed acute care center constructed in 1955-56. Currently it serves a population of about 2,800 in Seward and the surrounding area, but the community is now experiencing substantial population growth. The hospital is centrally located in Seward, adjacent to a nursing home, retirement home and a doctors' clinic.

The building's construction must be classified as U.B.C. type V-N (non-fire rated wood), which is unsuitable for hospital use and occupancy. The structure has extensive mechanical and electrical system problems, including numerous violations of applicable codes.

The facility is also seriously short of space to house its present services.

3.1 Recommendations

A. Make immediately-required corrections of existing hosptial's incinerator and propane systems, generator and relocation of laboratory and X-ray units.

B. Conduct a detailed planning study and produce a long-range (10- to 20-year) health facilities master plan based upon anticipated community health care needs. This plan should consider the Wesleyan Nursing Home and Outpatient Clinic which are adjacent to Seward General Hospital and examine the opportunities for joint utilization of some facilities.

C. Construct a replacement facility to house the hospital's acute care functions, and remodel/renovate the existing building for use as a support facility to Seward General, and possibly Wesleyan. Non-direct patient-related services should then be housed there.

Reasons:

1. Seward General Hospital is a non-fire rated structure. It is seriously deficient in meeting building, fire and life safety codes, and has insufficient space to accommodate all hospital services in compliance with D.H.E.W. and AK Adm. codes.

2. Seward General's proximity to Wesleyan's long-term care facilities and to an outpatient clinic make it practical to consider joint-use programming for commonly-needed services such as food preparation, heating, ventilating, incinerator, etc.

3. New construction of acute care facilities for Seward can be accomplished more cheaply than the extensive remodeling which would be necessary to bring the current hospital up to acute care standards, plus construction of a smaller addition.

The City presently owns adjacent property to the present hospital site that appears to be suitable for hospital expansion.

The report on the neighboring Wesleyan Long-Term Care Facility recommends a renovation of the older portion of that building. Therefore, assuming that a new replacement hospital is planned for Seward General, a reasonable sequence of events could be:

1. Construct a new hospital facility adjacent to the existing facility.

2. Provide temporary housing of approximately 23 long-term patients from Wesleyan in the old hospital.

3. Renovate the old portion of Wesleyan.

4. Convert the old hospital into a support facility for Seward General, and possibly Wesleyan, housing non-direct patient-related services there.

The outpatient facility and doctors' offices could possibly be located in the old hospital as long as they maintain a close relationship to the new laboratory and X-ray units.

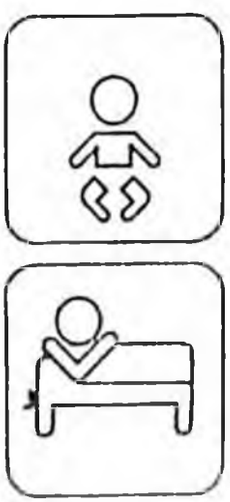
If the existing outpatient clinic could remain in place until new space were available, it would be beneficial. However, the existing clinic building should not be allowed to detrimentally affect the planning of the new hospital.

3.2 Estimated Costs Projected to Mid-1982

A. Immediate correction of incinerator, propane systems, and generator; relocation of lab and X-ray units. Development of long-range master plan:	$ 272,205
B. Option I (Recommended) Construct new acute care addition and remodel existing hospital for use as support facility:	9,636,060
C. Option II (Not recommended) Remodel existing hospital for acute care use and construct addition to house additional space:	13,375,425

GRAND TOTALS:

IMMEDIATE WORK PLUS OPTION I (Recommended)	$ 9,908,265
IMMEDIATE WORK PLUS OPTION II (Not recommended)	$13,647,630



4.0 DESCRIPTION OF SEWARD FACILITY

Seward General Hospital is located at the northwest corner of First Avenue and Jefferson Street in Seward, Alaska. Constructed as an acute care facility in 1955-56 and licensed for 31 beds, the facility is owned by the City of Seward and leased to the Seward General Hospital Association for management and operation. Foss and Olsen of Juneau were the architects for the original building.

Key hospital personnel are:

Keith Campbell, Administrator
Greg Higgins, M.D., Chief Medical Officer
Jane Kesselring, R.N., Head of Nursing
Darrel Hollingsworth, Facility Engineer

Seward's population is approximately 1,800, with an additional 1,000 in outlying areas, which together with the town of Seward make up the hospital's service area. Summers bring an influx of tourists to the area, increasing demands made upon the hospital's emergency unit.

A new $60 million ship repair and service facility, primarily for foreign fishing fleets, is currently being constructed by the City of Seward through public and private investment. Due for completion in May, 1982, it is estimated that this project will create 250 new jobs. The Alaska Skill Center is rapidly expanding here, and South Korea is scheduled to begin exporting coal from the area early in 1982. Each of these developments is expected to cause population increases which will doubtless impact the hospital facility. The hospital's administration believes, however, its facility is large enough to handle both this expected growth and more, with respect to inpatient beds.

The structure is a single story building with a partial basement under the south and east wings. There is a grade level entrance at the basement of the south wing.

The building consists of poured-in-place 8-inch thick concrete exterior walls that run from concrete footings to the roof. The stairwells are poured-in-place concrete. The basement floor and those main level floors which have no basement below, are 4-inch concrete slabs on grade. Structural floors are

concrete over steel joists at the south wing, and structural concrete slabs at the east wing. The roof structure is composed of 2 x 6 wood decking which runs diagonally on steel joists, with joists being supported by steel beams and pipe columns at exterior wall and interior bearing (corridor wall) locations.

A review of the structural drawings indicates that the roof diaphragm is flexible. While it would have been ideal to stiffen this diaphragm with a layer of plywood over the decking when the old roofing and insulation were stripped off the roof (summer of 1981), it is now extremely impractical to consider this step since new roofing has already been installed. Because the hospital is located in a major seismic activity zone (zone 4), stiffening of the diaphragm would have given the building a greater resistance to seismic action. As a whole, however, the building is well constructed and in good condition.

Even though the shell of the building is concrete, the extensive use of wood for partitions and furring, together with the half-inch gypsum wallboard necessitate classifying the building as U.B.C. Type V-N construction. The Uniform Building Code does not allow a Type I-1 occupancy (hospital) to be housed in a Type V-N structure (non-fire rated wood).

The interior non-load bearing partitioning and furring is composed of untreated wood covered with half-inch gypsum wall board. Corridor ceilings have accoustical tile, which has been glued to the gypsum wall board.

A fire sprinkler system was installed in the building (excluding surgery) in 1975, and in 1981 the building had new roof insulation (R-20) and fire-retardant built-up roofing installed. The new roof appears to have good drainage; and windows and doors were weatherstripped and/or caulked in 1981, also. Building drawings indicate, however, that the wall insulation consists of nothing more than 3/4-inch fiberboard on the inside face of the exterior concrete walls. This is very inadequate by today's standards, and contributes to substantial energy losses.

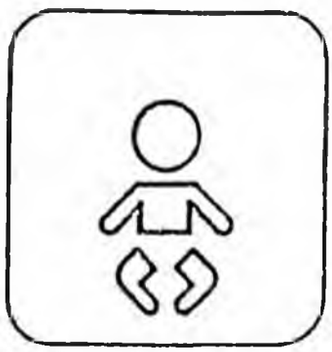
Seward General Hospital is served with City of Seward electric power which originates at diesel-powered generators. There are plans now underway to construct a relatively small hydro-electric project to provide electric power, primarily to the hospital. Seward General is equipped with two standby engine generators.

The city also provides water and sewer service to the hospital. 600 gallons of water can be stored on-site for standby use.

The square footage of the main floor of the building is 15,000. The basement has an additional 5,800 square feet for a total of 20,800 square feet. This includes the addition of a maintenance shop and emergency generator room constructed in 1964; and an emergency entrance/elevator, also constructed in 1964.

Statistics

	Total
No. of beds	31
Square footage	20,800 S.F.



KETCHIKAN GENERAL HOSPITAL

EXPANSION AND REMODELING PROJECT

FACT SHEET

- Hospital Building is owned by the City of Ketchikan. Hospital is operated by the Sisters of Saint Joseph of Peace.

- Ketchikan General Hospital is a regional provider serving Ketchikan, Prince of Wales Island, Metlakatla, Wrangell, and Petersburg.

- Hospital Service Area Population Projections:

1986	1991	1996	2001
23,174	25,364	27,027	28,804

- 21.2% of our admissions come from Prince of Wales, Metlakatla and greater Ketchikan areas, and 4.4% are from Wrangell and Petersburg.

- The need for expansion and remodeling was highlighted in an Inventory and Evaluation of Selected Hospitals and Long Term Care Facilities in the State of Alaska Report from the State Department of Health in 1982. They made some immediate recommendations to make life safety code related changes in our general mechanical and electrical systems, to look at installing automatic fire sprinklers and to upgrade our ventilation systems.

- The report also called for the immediate expansion of the Laboratory, upgrading energy system, and additional parking, as well as recommending the hospital undertake a complete long-range plan including future remodeling of the radiology and administrative support areas.

- That long-range plan included demographics, population forecast, and the needs of the hospital to the year 2010. Each plan concluded:

  Serious life safety code deficiencies
  Serious space deficiencies (25,000 sq. ft.)
  Asbestos problem
  Lack of parking

- Areas needing renovation/expansion because of growth, technology, and minimum requirements of regulating bodies:

  Emergency Department
  Radiology Department
  Laboratory
  Support Areas
  Conference Rooms
  Private Patient Rooms
  Asbestos Removal

- Significant increases exist in all service areas of the hospital, with the three areas named in the recommendations shown below:

	1966	1979	1987	1989	1990	1992
Radiology -	6,642	6,010	7,773	9,184	11,302	12,224
E.R. Visits -	1,810	5,229	5,625	7,507	10,896	13,184
Laboratory -	20,595	30,549	35,911	43,658	46,625	51,333

- The twenty-four hour Emergency Room Physician staffing begun in May, 1989 will continue.

- Majority of space problems stem from the delivery of new types of care and services in a building outdated based on the delivery of care today.

- Citizens of Ketchikan have had a 1% sales tax since 1962 that has born the cost of construction and remodeling of the facility with the exception of the $1,700,000 jobs bill grant which is being used to construct the parking structure.

- Certificate of need filed with State Department of Health & Social Services for $18,890, [illegible] for the total project.

- The project will require:

  A. Infilling between the Nursing Home and Hospital to expand Emergency, Laboratory, Radiology, Pharmacy Departments and to upgrade the existing building to fire/life safety codes.

  B. Remodel of vacated areas for Surgery, Post Recovery, etc.

  C. Adding a south addition to complete expansion of Radiology.

  D. Expanding Data Processing, Admitting, Patient Accounts, Materials Management, Food Service and adding Conference Rooms.

  E. Replacing existing outdated electrical switch gear, emergency power system, boilers and mechanical equipment.

If you wish further information, please contact:

Edward Mahn, Administrator
Ketchikan General Hospital
3100 Tongass Avenue
Ketchikan, Alaska 99901
225-5171

Reed Stoops
P. O. Box 21211
Juneau, Alaska 99802
463-3223

Harland Knudson, Executive Director
Health Association of Alaska
319 Seward Street
Juneau, Alaska 99801
586-1790

KP/provide copy to Ellis' ofis HB 342

The Greater Fairbanks
Community Hospital Foundation, Inc.

Post Office Box 1396
Fairbanks, Alaska 99707
Phone 457-4291

March 8, 1990

Representative Mark Boyer
P.O. Box V
Juneau, AK 99811

Dear Representative Boyer:

For more than two decades the Greater Fairbanks Community Hospital Foundation has been providing for the healthcare needs of the residents of northern Alaska. We began by developing a hospital facility, but over the years we have attempted to adapt our services and facility to meet the needs of Interior residents.

A key part of our success has been the partnership we formed with the State Legislature. Our conservative operational approach and mission of caring, combined with the legislative assistance of capital monies, has permitted us to build a system which cares for people at some of the lowest rates in the state. We take pride in our accomplishments and appreciate the actions the legislature has taken to support our mission.

In 1983 the Foundation's healthcare mission expanded to include not only Fairbanks Memorial Hospital, but Denali Center as well. It was in November of that year that we purchased Denali Center and added long term care to the services offered by the Foundation.

This commitment has been both rewarding and challenging. While we have felt good about our expanded role and our ability to serve the extended care needs of northern Alaskans, we have felt equally confused and disillusioned by our inability to fulfill our mission: **to provide high quality care in every respect.**

As with the hospital, we want Denali Center to provide quality of care both through appropriate programs and an appropriate environment. In terms of programs we know we still have work to do, but we have made real progress. In terms of providing an appropriate environment, we are

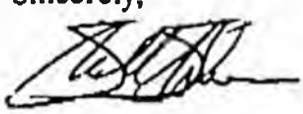
truly stymied. We have a facility which is deteriorating before us, but we have no hope of raising the operational funds needed to significantly impact our problem. This is due in large part to the Medical Assistance Program, which funds the care of over 75% of the residents living at Denali Center. Reimbursement through this program is problematic and does not allow us to recover true operating costs or build a capital base to improve the facility.

As we consider this challenge we cannot help but recall how the legislature helped us to build a strong healthcare system at Fairbanks Memorial Hospital. It is with this same spirit of cooperation that we can make a difference at Denali Center.

In the following pages we lay out our plan to make Denali Center a long term care facility which meets the needs of its' current residents in an efficient manner. We are not asking for money to build a luxurious environment, just an appropriate one. The heart of our request is a ten million dollar-plus capital allocation to replace the existing facility. We feel these changes will give us a solid base from which to address the service needs of Denali Center residents today and twenty years from now.

Mark, I know that you are drafting the legislation to include our request on HB 342. Although we are not sure of the appropriate legislative vehicle to best address our need for capital, we are relying on you and the other members of the Interior Delegation to determine the best method to provide Interior Alaska with an appropriate resident care facility. We hope you will realize the importance of our request and will do your best to help Denali Center, Fairbanks, and all of northern Alaska care for the elderly of today as well as tomorrow.

Sincerely,



Steve Stephens
President

cc. Foundation Board Members
Mark Bertilrud, Administrator, Denali Center
Jim Gingerich, Administrator, F.M.H.

Denali Center
Questions and Answers

1. **What is the dollar amount of the request, and what does it provide?**

Our request is for $10,787,000. These funds will allow us to replace the existing structure with a new facility which will meet current industry environmental standards. The new facility design would address the living space and care needs of Denali Center's residents and allow for more efficient operation. The facility will also be designed to better address the future needs of the Interior's elderly.

The dollar figure listed above does not match the $8.2 million estimate we provided you in December of last year, because we have worked with an estimator in Fairbanks to reflect current building costs.

2. **Why replace the existing facility rather than renovate or add on to the existing structure?**

There are two major reasons why renovation of the current facility would not be a wise choice.

First, the original owner designed the building with little thought for resident care or quality of life issues. As a result, some of its biggest problems, i.e., congested corridors, living space and activity space, would not be adequately remedied by renovation. Second, the current design would make it very difficult to increase the amount of living space to industry standards in any manner which would be cost efficient in terms of construction or operation. Currently, we have approximately 250 square feet of living space per licensed bed, most facilities today provide at least 400 and up to 650 square feet of living space per licensed bed.

If we were to renovate the existing facility, our calculations indicate that the cost to address the current asbestos problem, provide additional living space, and bring

the current facility up to acceptable environmental standards would not represent a significant cost saving.

A rough calculation of our requested amount is as follows:

Cost Factor:	Sq. Feet:	Cost/Sq. Ft.	At a cost of:
Facility	44,000	$200.00	$ 8,800,000
Equip. and Furn.			$ 981,000
A/I/E Fee			$ 778,000
Site Prep.			$ 228,000
			$ 10,787,000

3. **Where will this new facility be located?**

On the current property near the existing building. This location is near Fairbanks Memorial Hospital and many physicians offices and is in a neighborhood of residential dwellings. Proximity to the hospital is very important because many of the Center's residents require advanced ancillary services due to their physical condition. The residential location is important as it further promotes a homelike environment rather than a commercial one.

4. **Why not move Denali Center to the empty space currently available in Fairbanks Memorial Hospital?**

While this might be viewed as a short term solution for Denali Center, it would severely restrict the ability of either facility to meet changing community health needs. While no commitment has been made, the Hospital is currently working with representatives of the Tanana Chiefs Conference to ensure that Chief Andrew Isaac Health Center will remain located within the hospital. Much of the hospital's vacant space would be utilized by the restructured clinic. In addition, there is not enough vacant space to adequately meet the needs of the nursing

5. **What action has the Foundation taken to supp rt the Denali Center?**

The Foundation has subsidized Denali Center through revenues earned at Fairbanks Memorial Hospital. Dollars have been spent to address capital needs and retire long term debt that limited the Foundation's ability to make changes at Denali Center. However, this is not a long term solution as it erodes the hospitals financial base, and places any future needs of that facility in jeopardy.

In addition, the Foundation has received many private contributions of dollars and volunteer time from the public to assist Denali Center in carrying out its mission.

6. **Who will benefit from a new facility in Fairbanks?**

Denali Center has served residents from throughout Alaska for the past seven years. Our primary service area is the Interior region, but currently, as in the past, we serve residents from throughout the state. We commonly serve residents from Fairbanks, Holy Cross, Anaktuvuk Pass, Wiseman, Bethel, Tok, Nenana, Anchorage and the Yukon River Region.

7. **From a reimbursement standpoint, who are the primary consumers of Denali Center services?**

The largest consumer is and will remain the State of Alaska. Approximately 75% of our residents are funded through the Medical Assistance Program. The remainder of our residents bills are paid either privately, by Medicare, Veteran's Administration or Native Health Services.

8. **The current operating lease with the Lutheran Hospitals & Homes Society makes them a 50% owner of the facility in 1993. Why should we provide a grant that will be transferred in part to a company outside of Alaska?**

Any grant monies obtained through this process resulting in improved facilities will be under the sole ownership of the Foundation. Our lease arrangement is currently being restructured to accomplish this task.

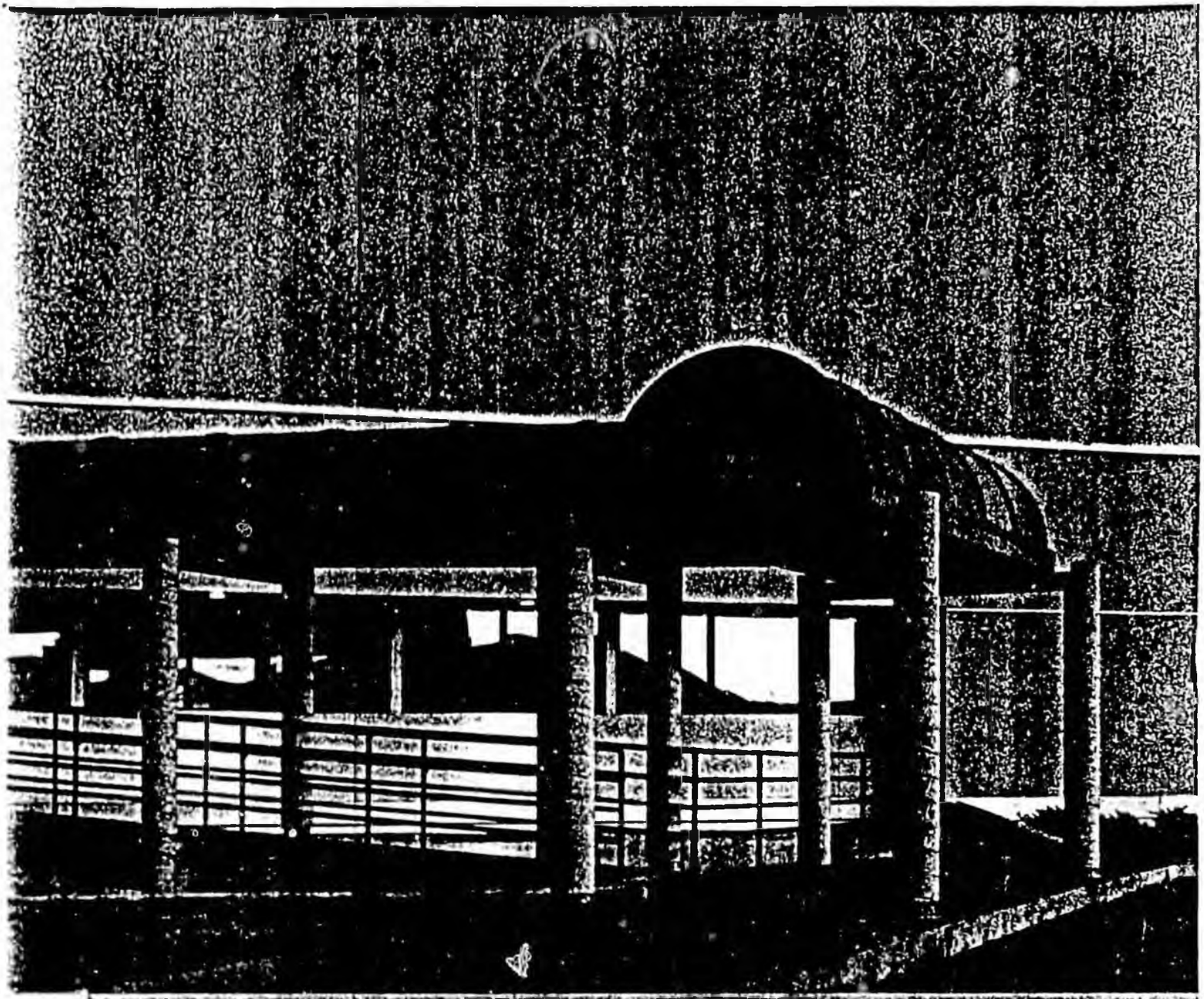
9. **Have there been any other attempts to obtain money to meet the needs of Denali Center?**

No alternative sources of funding have been uncovered. We have evaluated other fund raising projects and we do not believe that it will be possible to raise funds to provide an appropriate resident care facility in Interior Alaska.

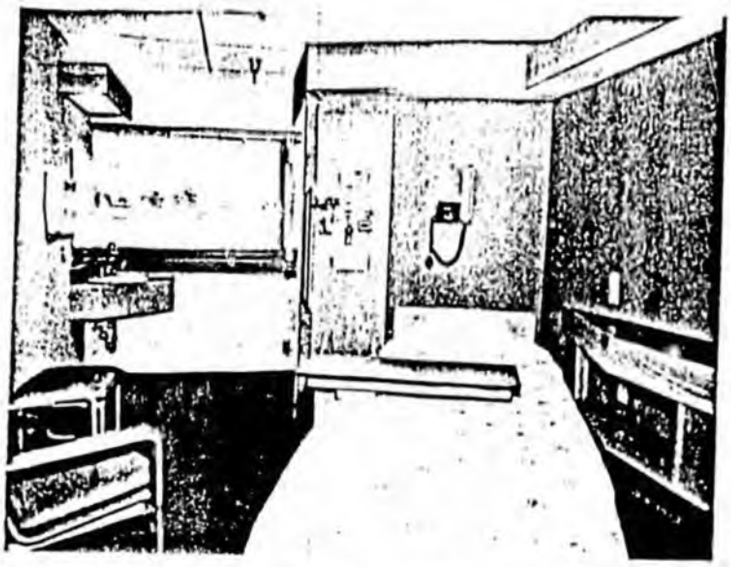
10. **What will this grant do to improve the financial position of Denali Center?**

Under the current rate setting structure, Denali Center would benefit by receiving a rate based on operating costs.

However, it is the plan of the Foundation to use this additional cash only to assist Denali Center's short term needs. Long range use of these funds would provide for ongoing capital replacement requirements.



INNOVATIVE RURAL MEDICAL CENTER

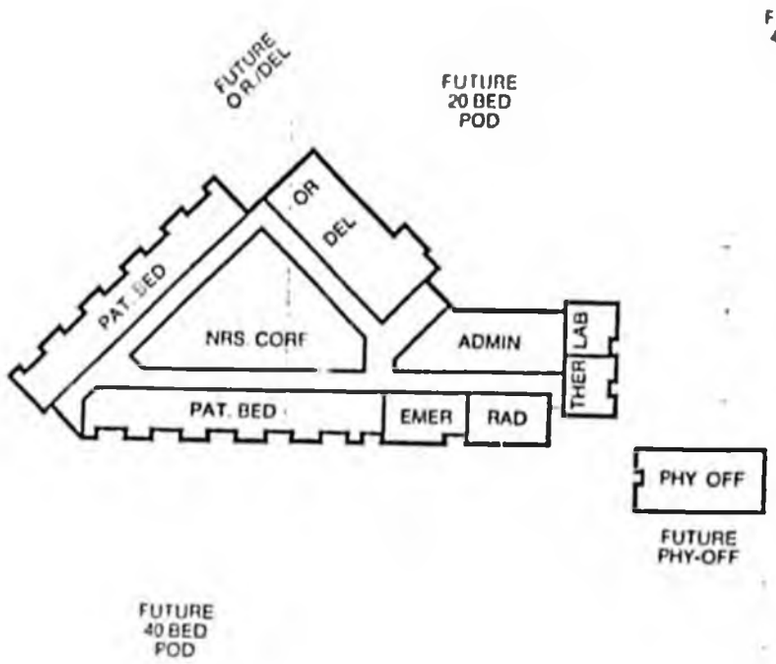


EXPANDABILITY

The "magic" behind the success of Design West's rural medical centers is a master plan which allows a project to start out as an ambulatory care facility and grow incrementally into an acute care facility with a maximum of 120 beds. The master plan facilitates flexibility by allowing independent expansion for every department and a circulation system which is never violated regardless of project scope.

TIME AND COST

The advantage of Design West's factory built rural medical center in today's competitive healthcare market is the ability to place a facility quickly at a below market price. Nine (9) months is a reasonable construction schedule for a twenty (20) bed acute care hospital. Three recently completed facilities in Utah were built for less than $100 per square foot including all site development, construction and design fees. The price also included such first class features as Hill-Rom or Miller casework, nurses stations and laboratory casework.



FACTORY CONSTRUCTION

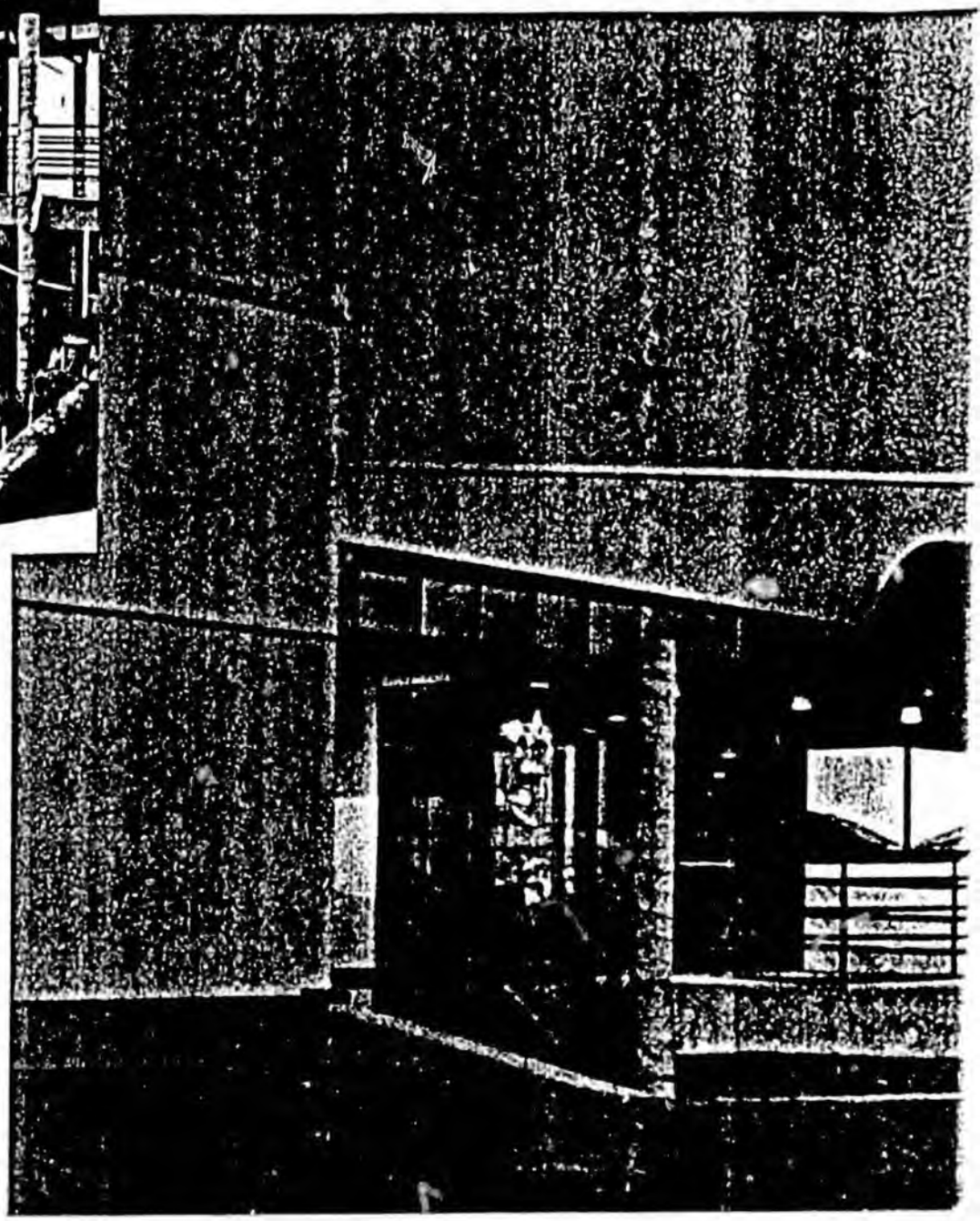
Seventy five percent of construction can be accomplished in a factory (a controlled environment) using production line techniques. For the project shown here thirty-nine (39) modules were built in fifty five (55) days and trucked to the construction site. The finished product shows no evidence of modularity - normally associated with this type of construction.

OPERATIONAL COST

Design West's rural medical center ensures reduced operational cost. Low capital cost, efficient staffing patterns, multiple coverage work stations, low maintenance materials and energy efficient design all contribute to increased operational efficiency and decreased operational cost.

The following is operational cost data for a typical 20 bed rural medical center located in a severe (115° F. swing) climate.

Total Staff Requirements: 26 FTE's for 24 hour/7 day
Electrical Cost (12 months) $22,100 or $1.03/sq. ft./yr.
L.P. Gas Cost (12 months) $1805 or $0.82/sq. ft./yr.



The project illustrated in this brochure is the Sanpete Valley Hospital located in Mt. Pleasant, Utah.

Owner: IHC Hospitals Inc
Admin: Joseph B. May (801) 462-2441
Completion Date: July 12, 1984
Bed Capacity: 20 Acute Care Beds
Area: 20,960 G.S.F.

DESIGN WEST HEALTH FACILITIES INC.
HEALTHCARE DESIGN AND CONSTRUCTION
95 West 100 South Logan Utah 84321 (801) 752-7031
San Jose (415) 962-1199
Salt Lake City (801) 539-8221
Boise (208) 322-5775

CITY OF UNALASKA
P.O. BOX 89
UNALASKA, ALASKA 99685
(907) 581-1251

DATE: JANUARY 16, 1990

MEMO TO: MEMBERS OF THE ALASKA STATE LEGISLATURE

FROM: HERV HENSLEY, CITY MANGER CITY OF UNALASKA

SUBJECT: JUSTIFICATION FOR A NEW HEALTH CLINIC IN UNALASKA

I would like to introduce you to our proposal to develop a comprehensive health care center in Unalaska. The current health care system in Unalaska is undergoing severe stress in proportion to the rapidly expanding fishing industry and support services. Rapid change, accompanying the importance of the community as a seafood processing center, in combination with the fact that Unalaska is the primary population center for the Western Aleutians has created an intense demand for medical services. The highly industrial nature of the work force also causes an unusually high number of injuries, and trauma, in the clinic's patient population. The clinic's physical facility is inadequate and outdated to the point that the provision of healthcare services is often compromised.

The present facility encompasses 3,500 square feet. Incorporated in that space are three exam rooms, two offices which are shared by three medical practitioners, a closet sized room used for a pharmacy, a very small room used as a lab, a small emergency patient area, a business office and a waiting room that is frequently so crowded that patients must often wait outside on the clinic yard, or steps.

The residents of Unalaska are dependent upon the services the clinic can provide. Given the inadequate physical facility there is a real question as to e ability of the health care professional to ensure an adequate and safe level of care. There are no other health care services available in Unalaska. In addition to the permanent resident population who utilize the services of the clinic, the fact that Unalaska is centrally located within the major fishing grounds of the Northern Pacific and Bering Sea means the clinic serves a population that now exceeds 15,000.

The patient load is projected to continue to expand in proportion to the level of fishing, processing and shipping activity in the area. In addition to the large number of patients seen on an annual basis, there were 200 medevacs from the clinic during 1989. It is anticipated that number could grow to 300 during 1990. All medevacs are transported by air, and weather frequently precludes any flights in or out of the community, sometimes for days. Our present small village clinic simply cannot support the numbers of people to be medevaced, and keep them alive while waiting for transportation. Several patients lost last year could be attributed to the facility's capacity of sustaining them.
Presently three major processing plants are either being built, or expanded. One new processing plant is completing a facility that will employ up to 400 new workers. This, along with the 60% growth in population over the last two years, and expected future growth, demand that we provide sufficient medical services.

As with other projects we have asked for, it is not our intention to request the full amount of this project to be funded by the State. However, given the major infrastructure needs of Unalaska, we cannot build the needed clinic on our own. It is our desire to create a project that is supported financially by the City, private industry and the State.

As you can see this is a basic community need, not fluff. For this reason and the fact that Unalaska is working toward accomplishing the stated goal of bringing fishing on shore, and providing jobs and revenue from a renewable resource, I kindly ask that you support funding this project.

PROPOSAL TO DEVELOP A

COMPREHENSIVE HEALTH CARE FACILITY

FOR UNALASKA

PREPARED FOR
ILIULIUK FAMILY & HEALTH SERVICES INC. AND
THE CITY OF UNALASKA

BY

PGS PROFESSIONAL GROWTH SYSTEMS, INC.
327 E. FIREWEED LANE, SUITE 202
ANCHORAGE, AK 99503
276-4414

AND

Kumin Associates, Inc.
3000 "A" STREET, SUITE 202
ANCHORAGE, AK 99503
563-8877

BACKGROUND

The recent growth in Bering Sea fisheries brought about by expanding bottom fish markets and increased use of on shore facilities by foreign fleets has brought explosive changes to the community of Unalaska. As the primary support community for the Bering Sea fishing efforts, some 40,000 persons involved in foreign or domestic fishing ventures look to Unalaska for services including health care.

Over the last three years the resident population of Unalaska has grown by 41%.

TABLE I
POPULATION CITY OF UNALASKA/DUTCH HARBOR
1987-89

YEAR	POPULATION EST.
1987	1,354
1988	1,908
1989	2,265

Source: City of Unalaska, PGS Inc.

The need for health care services has outstripped the ability of the present clinic facility to provide those services. The situation at the clinic has become a true crisis. Owned and operated by Iliuliuk Family and Health Services, Inc., the facility is managed by a community governing board and serves the entire resident population as well as the transient fishing fleets.

At the request of the corporation and City, the State conducted a site review in August. The group; headed by Commissioner of Health & Social Services, Myra Munson; offered the following finding:

- "Although well maintained, the facility is dated and a few improvements have been made since its construction. It is too small to handle the number of visits, hold adequate supplies, or to appropriately accommodate visiting specialists and limits the potential advantages for co-locating related community services."

The explosion of health care demand has prompted the Corporation and City to seek a new facility on an emergent basis . The City has agreed to donate a parcel of land for the new facility. Major processors in the area have agreed in concept to participate in the capital construction cost of the facility. The goal set by the City is a $500,000 local share of the capital construction burden.

THE CURRENT SITUATION

During the past three years, especially this past year, clinic utilization has risen even more sharply than the population. Both after-hours emergencies and medical evacuations to Anchorage have risen more sharply still. Table II details these developments.

TABLE II
ILIULIUK CLINIC UTILIZATION
1987-1989

Year	Clinic Visits	After Hrs. Emergencies	Medical Evacuations
1987	6,491	491	44
1988	6,651	818	154
1989*	14,085	1,700	200

* 1989 Estimate based on actual figures and extrapolation to year-end

Source: Iliuliuk Clinic and PGS Inc.

The community sees the current crisis arising from off shore fleet growth. The unforeseen explosion to some 40,000 has placed an undue burden upon the community infrastructure, most notably health services.

The present clinic facility is beset with the following physical and operational problems:

- Only three exam rooms are available to the two physician assistants practicing in the clinic. These rooms must also accommodate the visiting physicians which travel twice a month for a one week period each. No less than five exam rooms are needed to meet present demand.

- The emergency room can accommodate only two patients. Recent experience bears out that on any given day, there is an 80% chance of a multiple casualty situation resulting in treatment of some in hallways or on the floor.

- There is capacity to hold two patients while awaiting medical evacuation to Anchorage. Given the number of multiple casualties seen by the clinic this meets about half the need. The present holding area is at the opposite end of the clinic from the emergency room making spill over into the emergency room facility or visa versa an unworkable solution.

- There is no facility for health personnel to sleep in the facility while on call. Emergencies now number better than five per night on a seven-day-a-week basis.

- The waiting area will accommodate only ten patients (or family members) at a time. The clinic is averaging 45 patients per day currently and waiting area is inadequate.

- Medical supplies are now being stored in the attic, crawl spaces under the building and a donated trailer unit.

- Virtually all the medical equipment is inadequate. There is only a portable x-ray machine when more than one is needed. The patient delays for x-rays is considerable.

- There is no emergency electrical generation. Power surges in the community utility system have damaged almost all of the equipment. Further, due to power outages the staff has had to deal with emergencies without power. Over the last three months, minor surgery using flashlights has been performed on several occasions.

- Space for administrative staff to carry out patient appointments, billing etc. is inadequate

- The present roof is in need of major repairs or replacement to deal with recurring leaks

- Medical supplies and pharmaceuticals are located at opposite ends of the building

- Visiting dentists are currently holding clinic outside the facility due to lack of space

- The clinic has no audiometric or spirometric testing capacity to deal with environmental and occupational hazards arising from the fishing industry. Such facilities are a requirement of employers to meet Federal OSHA standards.

- Present staffing of medical providers as well as laboratory and x-ray technicians is inadequate. However, with present facilities, additional staffing could not be accommodated.

THE FUTURE

Three major expansions of processing plants on the Island are already under construction or have been committed too. One processor in completing a facility that will need 200-400 workers to Operate. Another is 40% complete on a project that will need an additional 200 workers upon completion. A third processor awaits construction permits on a plant of similar size.

A preliminary estimate of population growth is that increases of 15% and 10% are foreseen for the next two years and 7% each for the next three years. By the end of 1994, the population of the Island will have nearly doubled to 4,293. These estimates will be refined and substantiated in future planning efforts by the City.

In summary, the present situation has reached a true crisis . The clinic cannot accommodate present demand. Meeting growth already planned for the next two years will not be possible. The City and Clinic is

faced with an explosive on shore development and off shore expansion it cannot control but must accommodate.

PROPOSAL

To accommodate the increases in numbers of visits, the high rate of emergencies, needed holding capacity for medical evacuations, as well as integrate other health providers into a central facility the following changes in the physical plant are recommended:

EXPANSION NEEDED TO ACCOMMODATE PRESENT SCOPE OF SERVICES

1. Exam Room - Increase from 3 to 8 exam rooms plus a triage room

2. Emergency Room - Expand from 2 to 4 treatment stations

3. Holding Beds - Increase capacity from 2 to 3 beds plus a room that could also be used for isolation or psychiatric patients

4. Radiology - Expand from an existing portable machine to two permanent diagnostic rooms/machines as well as a new portable

5. Laboratory - Expand capacity to over 700 net square feet and assume separate staffing of lab and x-ray

6. Physical Therapy - Provide space for this much needed service to include whirlpool. The space would also be used for casting of bone breaks

7. Pharmacy - Assume operation of a full-time dispensing facility versus the present closet with dispensing by nursing personnel

8. Support - Significant expansion of administrative areas and storage

9. Provision of emergency electrical generation

ADDITIONAL SERVICES

To accommodate present and future needs, the following additional spaces and services are needed:

1. Audiometry and spirometry room

2. Dental operatory

3. Apartment for visiting physicians as well as on-call practitioner

4. Development of an optometry service

5. Relocation of State Public Health Nursing to the clinic under a lease arrangement with the State

6. Relocation of the Community Health Aide to the clinic under a lease with the Aleutian Pribilof Islands Association (A/PIA)

7. Lease of office space to the A/PIA mental health and alcohol counselors, social worker, WIC program, patient educator

Over the next 2-3 months, these findings and recommendations will be further refined through an extensive feasibility study, functional plan and as well as cost estimate. Further, the feasibility of relocating State and other agencies to leased space within the new clinic will be determined.

UNALASKA CLINIC

Project Cost Summary

I	Site development costs (Estimate prepared by Department of Public Works, City of Unalaska)	$ 60,000.
II	Construction of clinic (Estimate prepared by HMS, Inc., based on Kumin Associates' space summary and description of systems)	$ 3,026,000.
III	Medical Equipment (Estimate prepared by Bill Dann of PGS, Inc.)	$ 420,000.
IV	Non medical furnishings & equipment (Estimate prepared by Kumin Associates, Inc.)	$ 45,000.
V	Overhead Costs @ 20% of above includes soils investigation, survey, design, construction administration and inspections, insurance, legal and other administrative expenses.	$ 792,000.
VI	Project Contingency - @ 5% of above	$ 220,000.
	Total Estimated Project Cost	$ 4,563,000.

UNALASKA CLINIC

Summary of Spaces

1.	Clinic - 2500 S.F. + 300 S.F. interior circulation includes 8 exam rooms, triage, PHS house, reception, etc.	2800 S.F.
2.	Emergency Area - 1225 S.F. + 200 S.F. interior circulation includes treatment stations, waiting etc.	1425 S.F.
3.	Miscellaneous support spaces - 4000 S.F. + 700 S.F. interior circulation holding beds, psych. room, patient bath, kitchen, laundry, lab areas, pharmacy	4700 S.F.
4.	Offices - 2000 S.F. + 300 S.F. interior circulation, physicians, counselor, administration, conference records storage	2300 S.F.
5.	Physicians apartment - 750 S.F.	750 S.F.
	Subtotal	11,975. S.F.
6.	Non-program spaces	
	Vertical circulation	500 S.F.
	Circulation, between units & entry vestibules	1198 S.F.
	Mechanical room, electrical room, & emergency generator	600 S.F.
	General storage	400 S.F.
	GROSS FLOOR AREA	14, 673. S.F.

STATE OF ALASKA
HOUSE OF REPRESENTATIVES
Box V, Juneau, Alaska 99811
(907) 465-2487 • 465-2498

REPRESENTATIVE CLIFF DAVIDSON • DISTRICT 27 • Box 746, Kodiak, Alaska 99615 • (907) 486-8250

TO: Representative Johnny Ellis, Chairman
House Health, Education & Social Services Committee

FROM: Representative Cliff Davidson

DATE: March 1, 1990

SUBJECT: House Bill 342 - Issuance of GO Bonds for Hospital Construction, Reconstruction and Repair

Economic diversification and wise use of our State's abundant resources depend on a healthy population with access to health care facilities which address local health care needs. Physical plants in a number of Alaska's hospitals and nursing homes have been allowed to deteriorate while other State priorities have been addressed. It is time to correct this imbalance with passage of HB 342.

No two Alaskan communities are alike. Seasonal population growth from tourism, fishing or logging seriously taxes health care facilities in many communities. Facilities now find that, without renovation or replacement, the State's own standards for health and safety are violated. This is counter to our public policy goals which seek to ensure access to high-quality health care services for all Alaskans.

The rising cost of health care is on everyone's mind. In Alaska, as elsewhere, recruitment and retention of skilled health care professionals is very costly, as is delivery of products and services necessary for responsible diagnosis and treatment. Nevertheless, from the report of the Governor's Interim Commission on Health Care, health care still accounts for only about 4 percent of all state and local government spending in Alaska, compared to the average for all states of close to 12 percent. We need to re-examine our priorities.

In many Alaskan communities access to adequate health care services will continue only if skilled health care professionals can be retained or recruited. Physicians, nurses and ancillary service professionals don't want to practice in facilities that lack compliance with basic health and safety codes.

Sound planning can only be based on the assurance that adequate funding will be available to bring facilities into code compliance to fund renovation and remodeling which can emphasize more cost-effective outpatient services, and to create facilities which can accommodate radical seasonal population shifts without heavy reliance on extremely expensive medical evacuation by air for all but the most basic treatment services.

The process used to identify priority needs has been a long and thorough one. It goes back to a study authorized and funded by the 1981 Legislature. Fifteen rural hospitals and nursing homes were assessed for plant condition and functional adequacy. Anchorage and Fairbanks facilities were not included, nor were Sitka Community Hospital and Valley Hospital in Palmer. The latter two facilities were under construction or reconstruction at the time.

Ranking was based on the severity of all physical and functional deficiencies found at each facility, and did not consider other factors such as facility utilization or populations trends. In 1990, we find that seven of the 15 facilities have completed major renovation or reconstruction projects. Five are co-located facilities in Cordova, Petersburg, Wrangell, Nome and Homer, where both acute care services and long-term care services are combined in one facility. Other acute care facilities in Juneau and Soldotna have completed all or a major portion of required renovation. In some cases, local communities provided their own funding when the Legislature cut allocations in these areas.

Ten years is a long time to wait to address identified deficiencies which can only be corrected by major renovation. House Bill 342 would move us toward a more adequate statewide network of health care facilities. Here's what House Bill 342 would accomplish:

- In Kodiak, Kodiak Island Hospital would receive $14 million toward the $14.5 million replacement cost of a facility which includes both acute and longer term care services.
- In Ketchikan, Ketchikan General Hospital and its long-term care facility would receive $16.0 million toward a total facility replacement cost of $19 million.
- In Seward, Seward General Hospital would receive $10.7 million to replace its aging and inadequate facility.

To provide appropriate health care to our Alaskan citizens, we must have adequate facilities. We need to be secure in the knowledge that emergency services for trauma victims and primary care services for the ill or injured are available in Alaska's communities. Our senior citizens and the disabled, as well as their loved ones, deserve to know that long-term care is available close to home.

In smaller Alaskan communities, health care facilities are a major source of year-round employment and an innovative health education resource for all citizens. These facilities, with payrolls of at least $1 million, reinvest those dollars in the local community. Payroll dollars are estimated to turn over at least three times before they become part of the state of national economy. Sometimes we're so busy looking for "quick fix" solutions to health care costs, we forget the contributions these facilities make to a community's continued economic health.

Rather than generalizing about the need to control the cost of health care in Alaska, we must learn to differentiate between those costs we can control and those we cannot. When communities are providing services in substandard facilities, it is time for these projects to go back to the priority list where they were in 1982.

People continue to be Alaska's most important natural resource. There is nothing more worthy of our attention and our dollars. Alaska's economic health and social health depend on our ability to nurture a healthy and productive population. I urge your support for House Bill 422.

February 26, 1990

BACKGROUND

HOSPITAL/NURSING HOME CONSTRUCTION

(HB 342 - GO Hospital Construction Bonds)

The 1981 Legislature authorized and funded a study by the Department of Health & Social Services of the plant condition and functional adequacy of 15 rural hospitals and nursing homes.

The result of that study was contained in a report by the Department to the Legislature in March, 1982.

Anchorage and Fairbanks hospitals were not included. Valley Hospital, Palmer and Sitka Community Hospital did not participate as they were currently under construction or reconstruction in 1982.

Overview of Surveyed Facilities

A study team evaluated the adequacy of the physical facilities at each hospital or long term care unit, a number of serious problems and deficiencies were discovered. Such inadequacies tended to fall into common classifications, the most important of which can be grouped as follows:

- Building, fire and life safety code deficiencies and violations;

- Lack of adequate mechanical ventilation to critical areas of the building, and mechanical and electrical inadequacies occasioned by the acquisition and use of high demand diagnostic and therapeutic equipment in laboratory and treatment programs;

- Facility inflexibility in response to changing attitudes, medical technologies and resultant changes in patterns of use; and

- Space shortages occasioned by new patterns of use, increasing complexity in information processing and records storage requirements, and growth in service area populations.

Generally, the deficiencies observed in the health care facilities surveyed are due to the advances and changing techniques in the medical field, coupled with more stringent building, fire and life safety codes which have been adopted over the last few years.

1982 Prioritization of Surveyed Hospitals and Nursing Homes

In conducting the inventory and evaluation study of the fifteen hospitals and long term care facilities in 1982, architectural consultants identified six facilities which were in greater need of immediate attention than others, due to their more severe physical and functional deficiencies. To arrive at a ranking of all surveyed facilities based upon relative need for construction to correct noted deficiencies, the Department assembled a committee to review the report.

(MORE)

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

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

H. HESS 3-2-90

H. HESS 3-15-90

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

February 26, 1990

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(MORE)

This committee consisted of one member of:

The Alaska Medical Facility Authority;
The Alaska State Hospital Association;
Southeast Alaska Health Systems Agency, Inc.;
South Central Health Planning and Development, Inc.;
The Medical Care Advisory Committee, and
The Statewide Health Coordinating Council.

The ranking provided by this committee was based only upon the relative severity of all physical and functional deficiencies found at each facility and did not consider other factors such as facility utilization or population trends: The committee ranking was as follows:

* 1. Cordova Community Hospital and Long Term Care Facility
* 2. Petersburg General Hospital and Long Term Care Facility
3. Seward General Hospital
4. Kodiak Island Hospital and Long Term Care Facility
5. Wesleyan Nursing Home
* 6. Wrangell General Hospital
* 7. South Peninsula General Hospital and Long Term Care Facility
8. Ketchikan General Hospital and Island View Manor
* 9. Central Peninsula General Hospital
*10. Bartlett Memorial Hospital
11. Valdez Community Hospital
12. St. Ann's Nursing Home
*13. Norton Sound Regional Hospital

* completed (Central Peninsula & Bartlett utilized local bonding)

In 1987, the Health Association of Alaska, representing hospitals and nursing homes, recommended that Kodiak, Ketchikan and Seward be ranked as the top priority facilities needing construction grants.

HB 342 by Representatives Davidson, Cato, C. Davis and Taylor

Authorizes issuance of general obligation bonds in the amount of $41,400,000.00. This proposition to be placed on the 1990 general election ballot.

Kodiak Island Borough	$14,500,000.00
City of Seward	9,500,000.00
City of Seward	1,200,000.00
City of Ketchikan	16,200,000.00

# # #

For More Information Contact:

Harlan Knudson
Health Association of Alaska
586-1790

2/26/90

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

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Mary Van Nimwegen

H. HESS 3-2-90

H. HESS 3-15-90

HB

364

HOUSE COMMITTEE REPORT

(7)
Date Referred: January 8, 1990 FURTHER REFERRALS: FINANCE

Date of Committee Action: 1-31-90

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 364

HOUSE BILL NO. 364 ALCOHOL INFORMATION WITH MARRIAGE LICENSE

"An Act requiring marriage licensing officers to distribute information related to the health effects of alcohol consumption."

RECOMMENDATIONS:
[X] be replaced with CSHB 364 (HESS) [ ] the same title [X] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[X] fiscal impact DHSS
[ ] zero fiscal note
[ ] zero with analysis

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
[ ] zero fiscal note(s) _____
[ ] zero fn/analysis _____

SIGNING DO PASS:

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
		✓	
		✓	

Chairman's Signature

A M E N D M E N T

OFFERED IN THE HOUSE

TO: HB 364

Page 1, line 7, after "the":

Insert "fetal"

Page 1, line 8, after "consumption":

Insert ", drug abuse, and domestic violence"

Page 1, line 13, after "alcohol":

Insert ", abuses drugs, or is a victim of domestic violence"

Page 1, line 15:

Delete "and"

Insert ","

After "effects"

Insert ", and the effects of drug abuse and domestic violence"

Violence against pregnant women also hurts unborn

LOS ANGELES (AP) — About one of every 12 pregnant women in a study of prenatal clinics was beaten by her male partner, making it more likely the babies died or suffered birth defects, the March of Dimes foundation said Friday.

"Battered women are four times more likely to deliver low-birthweight babies, and twice as likely to miscarry," compared to other mothers, said Betsy Berkhemer-Credaire of the group's Southern California chapter.

"Low-birthweight babies are more likely to be born with birth defects and more than 40 times more likely to die during the first month of life," she added.

Nurses, a prosecutor, the operator of a battered women's shelter and a woman who tearfully told how she was brutalized while pregnant joined Berkhemer-Credaire at a news conference.

They urged doctors and nurses to watch for signs of battering in their pregnant patients and to help document injuries so the assailants can be prosecuted. Battered women also should seek help and emergency shelter and leave their persecutors, they said.

Abuse against expectant mothers happens in all racial and socioeconomic groups and ranges from "slaps, punches, fractured jaws and punctured eardrums all the way to being pushed down the stairs," said Anne Stewart Helton, a community health nurse consultant at Texas Women's University.

Helton conducted a foundation-financed study of 290 pregnant women randomly selected from public and private prenatal clinics in Houston.

When drug babies reach school age

Their aptitudes vary widely, their behavior is unpredictable

Los Angeles Times

LOS ANGELES — The 4-year-old girl in teacher Vicky Ferrera's preschool class had made remarkable progress, the high point of her year being when she learned to tie her shoes. Mastering that task, which her pals asked her to help them with, made the little girl proud.

Then, in one week, her class took a field trip, went to an assembly and entertained a visitor. To most 4-year-olds, the disruptions would have been easy to handle, even fun.

But the deviation from routine so crushed the 4-year-old's self-confidence that she suddenly forgot how to tie her shoes. She reestablished the skill only after Ferrera taught her how to do it again.

Though the incident may seem trivial, it is not in Ferrera's classroom, where such small matters are part of a bigger concern for the Los Angeles Unified School District, public educators and health experts nationwide. They all are beginning to deal with the emergence of a generation of children, like Ferrera's student, who are known simply as "drug babies."

These youngsters have been the focus of intense media scrutiny, which has etched into the public consciousness images of infants wailing in hospital cribs as they suffer the effects of their mothers' abuse of alcohol, cocaine, phencyclidine (PCP) and other substances.

But what has been less publicized is that as the drug babies have grown — many now are reaching school age — their presence is prompting questions and concerns about their future in society.

In Los Angeles, the school district has taken the unusual — and, in some quarters, controversial — step of housing some drug babies, now ages 4 and 5, in three special classrooms in two inner city schools.

There, teachers like Ferrera are trying to identify instructional techniques to help get the drug babies back into regular classrooms as soon as possible.

Ferrera said it is too early in the school year to predict whether youngsters in the district program, who will be old enough, will be ready for first grade next fall.

Los Angeles is not alone in facing a daunting challenge of educating drug children. New York, Miami, Detroit and Philadelphia also can expect large numbers of drug babies to enroll in their schools, said Coryl Jones, a research psychologist at the National Institute on Drug Abuse.

Based on their studies, experts now believe this about the developing drug babies:

• They seem to display a wider range of academic ability than first was anticipated. Dr. Ira Chasnoff, a prominent drug baby researcher at Northwestern University in Chicago, said he believes that their mothers' drug use will have widely varying effects on children's intellectual and educational development; many will qualify for gifted classes, many will be in normal programs and some will be permanently impaired.

• They are not supplying answers to a crucial, long-term question about their physical and mental health, as well as their educational achievement: Which is more damaging to the child — the physiologic damage from drug exposure or the harm of being raised in the social environment of drug abuse?

There is good evidence that environment plays the more significant role, say some experts, including Chasnoff and Dr. Rachelle Tyler, a University of California, Los Angeles pediatrician, Los Angeles school district physician and researcher.

Chasnoff said the arrival of drug babies in school systems has developed into enough of a trend nationally that school districts should start examining ways to deal with such children if they are not already doing so.

"Drug babies are everywhere," Tyler said. "They're going to be in private schools and in middle class areas. Cocaine, for instance, is a drug that everybody aspired to and has been widely used."

Both Tyler and Chasnoff are involved in long-term studies of dozens of drug babies. UCLA is following 40 youngsters born to poor women using PCP; they are being compared from birth to age 2 with 25 youngsters born at the same hospital to drug-free women.

The more ambitious Northwestern study is tracking 200 youngsters, now age 3, who were identified before birth as potential drug babies. Chasnoff said researchers in Chicago hope to follow the children as they enter schools.

"We're following some kids who were exposed to drugs but were adopted and are now being raised in middle-class, stable, drug-free homes," he said, noting it will be "interesting" to see if the children have similar behavioral disorders as those raised in their original homes.

Chasnoff and other experts emphasize that drug babies are far from a cohesive group. Their strengths and shortcomings can be expected to vary widely depending on what drugs, the amounts and when their mothers took the substances during pregnancy; alcohol, methadone, heroin, marijuana, PCP and cocaine have widely varying effects on the fetus.

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

House Bill No. 364

"An Act requiring marriage licensing officers to distribute information related to the health effects of alcohol consumption."

BACKGROUND

HB 364 requires the distribution of information regarding the dangers of the use of alcohol during pregnancy.

Fetal Alcohol Syndrome (FAS) is the term given to those infants who have been severely affected by the alcohol consumed by the mother during pregnancy. It is estimated that FAS may be the most common birth defect in the nation, although it has only been recently recognized. People must be given the information that drinking while pregnant is dangerous to the unborn child. HB 364 is an efficient and cost effective way to distribute information on this topic.

FAS information is currently being distributed by the court system using a brochure produced by the March of Dimes. Central supply at the court estimates that a maximum of 10,000 brochures are required for distribution each year. This allows one brochure to be given at the time of application for a marriage license and is sufficient for rural communities to include in a public information pamphlet rack.

POSITION:

The Department of Health and Social Services supports this legislation as a way to assure that information regarding the dangers of substance abuse during pregnancy are distributed throughout the State. Educating Alaskans is a critical first step in protecting babies from the harmful effects of FAS.

Recommended by: Jay Livey for
Sally Mead, Coordinator
Office of Prevention

Date: 1-23-90

Approved by: Myra M. Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 1-23-90

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: HB 504
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to requiring Marriage Licensing Officers to distribute . . .
Sponsor: Representative Ulmer
Requestor: _____

Agency Affected: Health & Social Services
BRU: Administrative Services
Components: Office of Prevention

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	6.0					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	6.0	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	6.0	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL	6.0	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) FY90 Fiscal Impact is "0". Based on the cost of a similar project, the Office of Prevention estimates that $6,000 would be needed to prepare and print an Alaska specific brochure for distribution. Ongoing distribution costs will be absorbed within the Department of Health and Social Service current budget.

Prepared by: Sally Mead, Coordinator for
Phone: 561-4211
Division: Office of Prevention
Date: _____

Approved by Commissioner: Myra M. Munson
Myra M. Munson
Date: 1-23-90
Agency: Department of Health & Social Services

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Alaska State Legislature

HOUSE OF REPRESENTATIVES

REPRESENTATIVE FRAN ULMER

MEMORANDUM

January 22, 1990

TO: Rep. Johnny Ellis, Chair
House HESS Committee

FROM: Rep. Fran Ulmer

TO: HB 364, relating to alcohol information with marriage licenses

---

HB 364 requires the state to distribute information regarding Fetal Alcohol Syndrome (FAS) with each marriage license that is issued. Children born with FAS suffer from a combination of irreversible physical and mental birth defects caused when alcohol crosses the placenta and damages the fetus. These defects include:

(1) Pre and/or post natal growth retardation (weight, length, and/or head circumference below the tenth percentile);

(2) Central nervous system problems (intellectual impairment, developmental delay, and neurological abnormality);

(3) Characteristic facial features (including crossed eyes, small eyes, short nose, or abnormalities of the mouth such as cleft palate).

Alaska has the highest estimated incidence of FAS births in the nation. Certain portions of the state record the highest FAS rate among any population in the world (e.g., nationally: 1.7 per 1,000 births; Copper River, Alaska: 250 per 1,000 births). FAS ranks as the number one cause of congenital mental retardation in Alaska. It is the only cause of mental retardation which is totally preventable.

DISTRICT 33 — JUNEAU
PO BOX V • JUNEAU, ALASKA 99811-3300 • (907) 465-4947

Approximately 29 babies are born each year with FAS in Alaska; 26 of these survive the first year. Ten years ago, almost all of these infants died at birth. Today, the developments of medical technology keep them alive. However, the costs associated with FAS and FAE children are staggering and few, if any, families can afford to pay them. FAS babies typically need intensive hospital care at birth, at an average cost of $2,400 per day. Hospital costs per FAS birth average $99,740; physician fees average $11,065 per birth, for a total of $110,805 per child. It is common for FAS babies to be rehospitalized during the first year, at an average cost of $40,410 per hospital stay.

In addition, 10 times as many babies are born with a lesser set of symptoms known as Fetal Alcohol Effects (FAE). These children, while less severely damaged, may actually have a greater financial impact on state and community services. For example, the IQ of the average FAS baby is below 70; FAE babies' IQ ranges between 70 and 100. It is these children who typically require added counseling, legal and corrections services.

The attached chart itemizes the costs associated with each FAS and FAE patient. The lifetime cost per FAS birth is approximately $1.4 million. This figure reflects only the most basic medical and therapeutic services necessary. It does not include the additional financial and social costs of welfare payments, child abuse, sexual abuse, learning disabilities and incarceration.

Education, through efforts like the FAS brochure proposed in HB 364, is the surest route to prevention of this tragic and costly condition. Oregon, Wisconsin, New Hampshire, Rhode Island and Illinois currently distribute information regarding FAS through offices issuing marriage licenses. Last year, in response to a request from Senator Johne Binkley, the Alaska court system began distributing a pamphlet on FAS which was supplied by the March of Dimes. The purpose of this bill is to ensure that this practice becomes a permanent, on-going effort of the state in order to reduce the incidence of FAS births in Alaska.

attachments

TABLE 1

LIFETIME COST ESTIMATES OF SPECIFIC BIRTH DEFECTS IN FAS BIRTHS -- ALASKA

	Birth Defect	Annual Cost per Patient	Number of Times or Years	Lifetime Cost per Patient	Prevalence	Number Per Yr (% x 26)	Lifetime Cost: All Born 1988
	ANNUAL FAS BIRTHS (29 BIRTHS; 26 SURVIVORS)						
1	Neonatal Unit/Providence	99,740	1	99,740			
2	Neonatal Physician	11,065	1	11,065		11	1,097,140
3	First Year Rehospitalization	13,470	1	13,470		11	121,715
4	Initial Audio Screening	100	1	100	52%	3	40,410
5	Audio Check-up	100	4	400	100%	15	1,500
6	Otitis Media Surgery	1,224	1	1,224	56%	26	10,400
7	Hearing Aid	1,260	14	17,640	33%	15	18,360
8	Hearing Aid Mold	50	65	3,250	33%	9	158,760
9	Heart Surgery	75,000	1	75,000	5%	9	29,250
10	Cleft Palate Surgery	65,000	1	65,000	12%	1	75,000
11	Infant Learning Program (HSS)	2,513	3	7,539	100%	3	195,000
12	H/C Child: phys defect (HSS)	8,700	18	156,600		26	196,014
	H/C Child: devel delay (HSS)	8,700	3	26,100	58%	7	1,096,200
13	Minimal Special Eductn (DOE)	4,000	15	60,000	42%	15	391,500
14	Child Mental Retardation (DOE)	20,000	15	300,000	58%	11	660,000
15	DD Child (HSS)	25,000	18	450,000	58%	15	4,500,000
16	Alaska Youth Initiative (HSS)	90,000	12	1,080,000		15	6,750,000
17	DD Adult Initial Training(HSS)	45,000	3	135,000	58%	1/2	540,000
18	DD Adult Supervised Work (HSS)	22,500	44	990,000	58%	15	2,025,000
19	Institution	109,000	65	7,085,000	3%	15	14,850,000
						1	7,085,000
	Lifetime Costs for FAS Births: 1988						
	Lifetime Costs per FAS Birth			1,373,836			39,841,249
20	ANNUAL FAE BIRTHS AT TWICE FAS RATE (58)						
21	Infant Learning Program (HSS)	2,513	3	7,539	58%	34	256,326
22	DD Child (HSS)	25,000	18	450,000	58%	34	15,300,000
23	Child Mental Retardation (DOE)	20,000	15	300,000	58%	34	10,200,000
24	DD Adult Initial Training(HSS)	45,000	3	135,000	58%	34	4,590,000
25	DD Adult Supervised Work (HSS)	22,500	44	990,000	58%	34	33,660,000
	Lifetime Costs for FAE Births: 1988						64,006,326
	Total FAS/FAE Births						103,847,575

NOTES TO FAS COST TABLE

Numbers refer to line numbers on the table.

1. Neonatal Unit. Charges per FAS patient in the Providence Hospital Neonatal Intensive Care Unit were $68,910 in 1987 and $130,570 in 1988, for an average of $99,740. Average length of stay of FAS infants in the Neonatal Intensive Care Unit more than doubled between 1987 and 1988. It was 27 days in 1987 and 65 days in 1988 (v. 19.7 and 23.7 days for all low birthweight babies in the unit). Statistics provided by Lisa Wolf of Providence Hospital.

2. Neonatal Physician. Physician costs per FAS child were $6,130 in 1987 and $16,000 in 1988, for an average of $11,065. Estimates by Sharon Lee of Alaska Neonatal-Perinatal Associates.

3. First-year rehospitalization. Cost estimate is based on 1988 Providence Hospital pediatric charges of $900/day. The number of infants and average length of stay (12.5 days for moderately low birthweight infants and 16.2 days for very low birthweight babies) are from the National Institute of Medicine and are for all low birthweight infants. Applied to FAS births, these may be underestimates. Streissguth reports it is "usual" for FAS babies to be rehospitalized in the first few months of life.

4. Initial Audio Screening. The state audiologist, Communicative Disorders Program, Anchorage, reports all FAS children need a workup. This report estimates that 11 infants receive a workup in intensive care; the 15 remaining surviving infants are counted in this entry.

5. Audio Check-up. FAS children need three to four follow up checks. The $100 charge is from the Alaska Treatment Center in Anchorage; the check-up estimate is from the state audiologist.

6. Otitis Media Surgery. Estimate .s from the Geneva Woods Ear Nose and Throat Associates. Source of 56% prevalence is Harwood and Napolitano. These costs do not include less severe ear problems common to 93 percent of FAS patients (Alaska Treatment Center). Twenty-nine percent of FAS patients have permanent hearing loss.

7. Hearing Aid. A hearing aid for a baby costs $1,260; it is replaced once every five years for life at this cost. Cost estimate from Alaska Treatment Center.

8. Hearing Aid Mold. A $50 ear mold must be replaced annually. Estimate from Alaska Treatment Center.

9. Heart Surgery. Up to 70 percent of FAS patients have heart problems (Streissguth reports the portion at 30-40 percent; Hild reports 70 percent). Harwood and Napolitano report 10 percent require heart surgery, but reduce the estimate to 5 percent to reflect cases actually having surgery. Cost estimates from Vicki Hild, Alaska Native Health Board FAS coordinator.

10. Cleft Palate. Costs include an average of four surgeries, dental and orthodontics work. They do not include long term speech therapy at $96/session twice or three times a week. Estimates from Vicki Hild. The 12% estimate is average of Abel and Sokol (11.5%) and Harwood and Napolitano (12.3%).

11. Infant Learning Program. Mary Diven of the state division of Maternal and Child Health reports these figures are "deceptively low", under estimating the true cost of rural service. Infant Learning Program costs as much as $6,000/year in some rural areas.

12. Handicapped Children's Program. Cost estimates include averages for children with heart problems, cleft palate and developmental delay. Children with physical problems can be on the program for 21 years; children with developmental delays may be on the program for as few as three years. Cost estimates by Kathy Robinson, Maternal and Child Health, Alaska Department of Education. This report estimates that one child per year has heart problems (a low estimate in view of the 30 to 70 percent with heart problems); three have cleft palates; and three more have other physical problems such as spina bifida, progressive scoliosis, or severe visual and hearing loss.

13. Minimal Special Education. Costs cover only $4,000/year for additional special education for learning disabled children, above normal operating and capital education costs (Tom Buckner, Department of Education). Christine Hagmeier of the Department of Health and Social Services cautions that patients with IQ's above 70 and below 100 "may well be more expensive than those with lower IQ's" because they an become involved in counselling, corrections and the law. These costs are not reflected in this report. The 42 percent prevalence estimate is from Streissguth

14. Child Mental Retardation. Cost of special education for severely retarded children is $20,000 - $23,000/year, in addition to normal operating and capital education costs. Estimates from Tom Buckner, Department of Education.

15. Developmentally Disabled Child (HSS). Cost estimate by Christine Hagmeier of the Department of Health and Social Services. Costs can include foster care, in-home care, shared care, respite care, in-home training, advocacy and family support. Hagmeier reports that severely disabled children can cost between $35,000 and $85,000 with average cost of $55,000.

16. Alaska Youth Initiative. Cost estimate from John Van Den Berg, Department of Health and Social Services. This is a program for 52 severely troubled youths. The average age is 15.8 years; the average number of failed housing placements is 16. Currently five FAS youths are in the program. This report estimates children remain on the program an average of 12 years (based on Van Den Berg's report that "absolute minimum lifetime costs per child are $1 million".) It further assumes that one FAS child would enter this program every two years. Streissguth reports that aggressive behavior may be a problem for about 40% of the boys. Those from a less structured and protected environment may be "quick to anger when crossed and quick to strike out impulsively".

17. Developmentally Disabled Adult Initial Training. Costs include $25,000 residential care (example: foster care and independent living) plus initial vocational rehabilitation costs of $20,000, for a total of $45,000. Initial vocational rehabilitation costs average between two and five years. Estimate by Christine Hagmeier.

18. Developmentally Disabled Adult Supervised Work. After initial rehabilitation costs (see #17 above), costs can "fade" to between $10,000 and $25,000 for lifetime residential care plus $5,000 lifetime vocational rehabilitation care (Hagmeier). The average of this $15,000 to $30,000 range is $22,500.

19. Institution. Estimate by Ellen Ganley, Governor's Council for the Handicapped and Gifted.

20. FAE Births. Annual FAE births are calculated in this report at twice that of FAS births. This is a conservative estimate. Hild believes the actual number of FAE births annually is ten times the FAS births (or 290 FAE births and 168 developmentally disabled FAE persons.) In this report, cost estimates for FAE births are limited to mental retardation. They do not include costs associated with mild learning disabilities, physical anomalies, child abuse, sexual abuse or the justice system.

21. See #11.
22. See #15.
23. See # 14.
24. See # 17.
25. See # 18.

MEMORANDUM State of Alaska

TO: Jay Livey
Special Assistant
Office of the Commissioner

DATE: November 2, 1989

FILE NO:

Thru: Matt Felix
Coordinator

TELEPHONE NO: 561-4213

FROM: Suzanne Perry
FAS Coordinator
Office Alcoholism/Drug Abuse

SUBJECT: FAS info with marriage licenses

The bill sponsored by Rep. Fran Ulmer would require information regarding the dangers of drinking while pregnant to be distributed at the time a marriage license is issued. This is currently being done in other states, and has been well received.

There are a variety of materials that could be used for this purpose. I believe the March of Dimes pamphlet has been used elsewhere with positive results (copy attached). My preference, of course, would be to develop an Alaskan pamphlet for this purpose, because I believe people are more apt to read something that appears very relevant to their situation rather than something that is obviousl generic.

My understanding is that marriage licenses are issued by persons employed by the court system. The court system has a central supply to which such material should be sent for further distribution.

I am not aware of the number of marriage licenses that are issued each year, but will try to obtain this information if that would be helpful.

As FAS is a newly identified problem, education of everyone is necessary. Even though some couples will not have children, giving them the information will only help to increase the level of awareness overall. As we still have a very young population, I believe it is very important to disseminate the information at every opportunity.

I will follow up on the numbers of marriage licenses issued and will forward that information to you. If there is anything else I can do on this subject, please let me know.

Will My Drinking Hurt My Baby?

March of Dimes
Preventing Birth Defects

March of Dimes
Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains NY 10605

For more information on drinking and pregnancy, ask your doctor or your local March of Dimes chapter.

This pamphlet is made possible through contributions to the March of Dimes.

For additional copies contact your local March of Dimes chapter.

10/86

09-165.00

March of Dimes
Birth Defects Foundation

Would You Give Your Newborn Baby A Drink of Liquor or Wine or Beer?

Of course you wouldn't. You know that a baby doesn't need or want alcohol in any form. You wouldn't think of putting an alcoholic drink in your baby's bottle because you know it's not good for him or her.

Well, exactly the same is true *before* your baby is born. When you are pregnant, every time you take a drink, your baby takes one too. The drink he gets is just as strong as the one you get, and because he is so much smaller than you are, it hits him a lot harder.

What is worse, his hangover could last a lifetime.

What Is Fetal Alcohol Syndrome?

Fetal alcohol syndrome (FAS) is a pattern of physical and mental birth defects that are the direct result of the mother's drinking alcohol while pregnant.

FAS babies are abnormally small at birth, especially in head size. Unlike many newborns who are too small, few of these children catch up to normal growth. Most of them have small brains and show some amount of mental retardation. Many are jittery and poorly coordinated. They have short attention spans and behavioral problems. Their mental problems may not improve with age.

FAS babies usually have narrow eyes and short upturned noses. Some have heart defects, which may require surgery.

I Don't Drink That Much. Could It Happen To My Baby?

We don't know how much alcohol is "safe." The best decision is not to have any while you are pregnant--or when you might be.

About *one out of every 750 babies born has FAS!* * That's a lot of damaged babies. We don't realize how common FAS is because we don't hear about it as much as other birth defects. We haven't known about FAS for very long.

What Can I Do About It?

Everything. Unlike many other birth defects, FAS is *completely preventable*. By you. Nobody else can do it for you—not your doctor or your mother or the baby's father.

FAS is forever. There is no cure. But it doesn't have to happen at all. All you have to do is say "no" to the next drink, and keep on saying it until after your baby is born.

Other Than The Tragedy Of FAS, Are There Any Other Reasons Not To Drink While I'm Pregnant?

Alcohol is a drug that adds calories, but no food value, to the diet -- your diet and your developing baby's. Having an alcoholic drink instead of milk or fruit juice deprives your baby of the nourishment it needs to grow and develop normally.

Women who drink heavily during pregnancy have more miscarriages and more stillbirths (babies born dead) than other women. Even moderate drinking is suspected of causing those problems. It is also suspected of causing learning disabilities and minor physical problems. There is much we still have to learn, but pregnancy is no time for guessing how much is too much.

When Should I Stop?

It's never too soon.

From the moment of conception, your baby's organs start forming. Alcohol can damage them. For example, brain, heart and blood vessels start to develop in the third week of pregnancy. The heart begins to beat by the fourth week, even though the embryo is less than ¼ of an inch long.

Since most women do not know that they are pregnant until a month or more has passed, they may have been drinking all along. So the best time to stop drinking is *before* you become pregnant. If you are pregnant and are still drinking, the time to stop is *now*. If you need help, ask your doctor.

THE ONLY SAFE ADVICE IS: IF YOU DRINK HEAVILY, DON'T GET PREGNANT; IF YOU'RE PREGNANT, DON'T DRINK.

YOUR BABY CAN'T SAY NO.
SAY IT FOR YOUR BABY.

* Centers for Disease Control, U.S. Dept. of Health and Human Services/Public Health Service: *Morbidity and Mortality Weekly Report*, January 13, 1984.

6-1636E
Lauterbach
1/30/90

Original sponsor(s): REP. ULMER, Ellis

IN THE HOUSE BY THE HESS COMMITTEE

CS FOR HOUSE BILL NO. 364 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to distribution of information about fetal health effects of alcohol consumption, chemical abuse, and battering during pregnancy."

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

* Section 1. AS 18.05 is amended by adding a new section to read:

Sec. 18.05.037. FETAL HEALTH EFFECTS. The department shall prepare distributable information on fetal alcohol effects and the fetal health effects of chemical abuse and battering during pregnancy. The department shall make this information available to public hospitals, clinics, and other health facilities in the state for distribution to their patients.

* Sec. 2. AS 25.05.111 is amended by adding a new subsection to read:

(b) With a license issued under (a) of this section, the licensing officer shall also give to the parties written information about fetal alcohol effects and the fetal health effects of chemical abuse and battering during pregnancy. The Department of Health and Social Services shall prepare this information and submit it in distributable form to each licensing officer in the state.

HB

365

HOUSE COMMITTEE REPORT

(7)
Date Referred: January 8, 1990 FURTHER REFERRALS: STATE AFFAIRS FINANCE

Date of Committee Action: 2/6/90

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 365

HOUSE BILL NO. 365 PFD CHECKOFF FOR ALC/DRUG ABUSE GRANTS

"An Act relating to the alcohol and drug abuse grant fund and contributions to the fund; and providing for an effective date."

RECOMMENDATIONS:

[X] be replaced with CS HB 365 (HESS) [X] the same title [ ] a new title

[ ] have attached amendment(s)

[ ] do pass

[ ] do not pass

[X] no recommendation

[ ] individual recommendations

[ ] additional referral to the ________ Committee

ADOPTS: ________ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[X] fiscal impact DOR

[ ] zero fiscal note ________

[ ] zero with analysis ________

APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal note(s) ________

[ ] zero fiscal note(s) ________

[ ] zero fn/analysis ________

SIGNING DO PASS:

[signature]

Mark Boyer

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
Peter Goll		X	
Cheri Davis		X	
[signature]		X	
[signature]		—	

[signature]
Chairman's Signature

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 365

"An Act relating to the alcohol and drug abuse grant fund and contributions to the fund; and providing for an effective date."

Analysis

Section 1. of the Bill would have the Department of Revenue change the permanent fund dividend application form to allow an applicant to have $10.00 subtracted from their dividend and contributed to the alcohol and drug abuse grant fund. Contributions, less an administrative fee, would be deposited in a special dividend contribution account.

Section 2. would establish a grant fund within the Department of Health and Social Service that would be administered by the Office of Alcoholism and Drug Abuse. In awarding grants the Office should place priority on programs aimed at youth. By regulation the Department is to develop eligibility requirements and application procedures.

Section 3. establishes the effective date of this legislation as January 1, 1991.

Discussion

The need for additional financial resources for alcohol and drug abuse prevention and treatment services is well documented. In FY 90 grant application requests from community based organizations exceeded the amount of available funding by more than $6,000,000. Several geographical areas of the state are unable to offer residents as comprehensive array of services as they feel are necessary due to lack of funding. Salaries in the alcohol and drug abuse grant-in-aid program are quite low according to a House Research Agency study that was conducted last year. With various budget cuts in recent years due to declining oil prices, many grant-in-aid programs are operating with less state funding now than they had available in FY 83. Of course this has resulted in fewer services being provided.

Sufficient resources for alcohol and drug abuse services are a problem in other states as well, and they too have sought new and innovative methods of raising the funding level. Florida, for example, recently instituted a .50 cent a day special charge on all automobile rentals to raise money for their

alcohol and drug programs. California is currently considering a .05 cents a drink tax on alcoholic beverages for the same purpose.

Position

The Department of Health and Social Services recognizes that abuse of alcohol and drugs is one of the most serious problems facing Alaska and that adddressing problems associated with this abuse will require additional State resources. HB 365 offers a way to generate these funds. However, the Department defers to other agencies regarding the cost of implementing a permanent fund checkoff for this purpose.

Matthew C. Felix
Coordinator

Myra Munson
Commissioner

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: HB 365
PUBLISH DATE:

FISCAL NOTE

REQUEST

Revision Date:
Title: Alcohol and drug abuse grant fund and contributions to the fund
Sponsor: ULMER, Boyer, Ellis, et al
Requestor: House HESS

Agency Affected: Revenue
BRU: Permanent Fund Dividend Division
Components: Permanent Fund Dividend Division

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
OPERATING						
PERSONAL SERVICES	24.1	11.9	11.9	11.9	11.9	11.9
TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
CONTRACTUAL	5.0	5.0	5.0	5.0	5.0	5.0
SUPPLIES	0.2	0.2	0.2	0.2	0.2	0.2
EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
LANDS & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	29.3	17.1	17.1	17.1	17.1	17.1
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	29.3	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	17.1	17.1	17.1	17.1	17.1
TOTAL	29.3	17.1	17.1	17.1	17.1	17.1

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	3	2	2	2	2	2
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: See attached.

Prepared By: Ervin Jones
Division: Permanent Fund Dividend Division
Phone: 465-2323
Date: January 24, 1990

Approved by Commissioner:
Agency: Revenue
Date:

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Department of Revenue
Permanent Fund Dividend Division
Fiscal Note Analysis
HB 365
January 24, 1990

Assumptions:

1. The bill will take effect for the 1991 permanent fund dividend year and application. It is too late to amend the 1990 dividend application.

2. There are other bills which if signed into law, would result in some form of "check-off" on the 1991 dividend application. The Department of Revenue has no insight as to which, and how many, of these bills will become law. This fiscal note is prepared on the assumption that the subject bill is the only bill of this nature which will become law. The passage of multiple bills with varying formulas will inevitably have a compounding effect. Whereas there may be savings in some areas, there will be increased costs in others.

3) Income from the account will not be available until FY92, and a general fund appropriation will be required in FY91. The costs of administering this law will be borne by the trust fund in FY92 and subsequent years.

4) The incremental cost of computer resources will result in a chargeback by the Department of Administration.

5) The Olympic check-off will be repealed effective December 31, 1989 by passage of SB 102.

6) Whereas the cost of programming changes will be a one-time cost, the cost of document review, data capture, and data processing chargeback will be continuing.

7) Contributions will only be honored to the extent of available funds. Garnishments and assignments will take precedence in the order established by statute. Contributions and elections will then be honored in the order listed on the form schedule, which will be in the order they become law.

8) The check-off will apply to both adult and child applications.

Program Summary:

The provision of a new contribution decision on the dividend application will cause additional administrative cost in several areas:

a) The computer system will need to be changed to [illegible] change in the program, to establish new accounts [illegible] to provide for the transfer of funds to the alcohol and drug abuse grant fund (see Attachment A).

b) Each of approximately 525,000 PFD applications will need to be visually reviewed and coded as to decision on the contribution decision. Each application will be data captured with additional attention and keystrokes expended on each positive decision.

Department of Revenue
Permanent Fund Dividend Division
Fiscal Note Analysis
HB 365
January 24, 1990

		FY 90	FY 91
1.	Positions		
	1 PPT Analyst/Programmer V, R21 @ $6,110.86/Mo including salary and benefits for 2 months =	$12.2	
	PCN 04-1125 would be funded for an additional two months, in accordance with Attachment A. Ongoing maintenance of new programs would be accomplished by existing staff.		
	1 PPT Document Processor I, R7 @ $2,340.37/Mo, including salary and benefits for 3 months =	$7.0	$7.0
	This position would assist in the manual review and coding of 525,000 applications for the new contribution decision. This position represents the equivalent of the additional time and effort.		
	1 PPT Data Processing Clerk I, R8, @ $2,446.08/Mo, including salary and benefits for 2 months =	$4.9	$4.9
	This position would assist in the data capture of the additional contribution decision. The position represents the equivalent value of the additional time and effort.		
	TOTAL Personal Services	$24.1	$11.9
2.	Other Expenditures:		
a)	Travel:	$0.0	$0.0
b)	Contractual:		
	Data Processing Chargeback	$5.0	$5.0
c)	Supplies:	[illegible]	[illegible]
d)	Equipment: Use existing equipment		
	TOTAL COST	[illegible]	[illegible]

Department of Revenue
Permanent Fund Dividend Division
Fiscal Note Analysis
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January 24, 1990

3. Funding: General Fund in FY91, thereafter from the special dividend contribution account.

4. Section Cost Analysis: N/A.

Computations: N/A.

Economic Impact: N/A.

Impact on Local Government: N/A.

Suggested Amendments:

1a. Section 1, line 13 could be amended to read, ". . . applicant or the sponsor of a child applicant to elect to have $10 subtracted from the dividend check and . . ."

1b. Alternatively, a sentence could be added to Section 1 to read, "This contribution shall not be allowed on children's applications."

Discussion: There have been concerns raised in the last few months as to the legislature's intent regarding parents contributing $10 of their children's permanent fund dividends towards any purpose. This intent could be clarified by a choice of one of the above amendments.

Attachments: Attachment A: "Summary of DP Needs"

Department of Revenue
Permanent Fund Dividend Division
Fiscal Note Analysis
HB 365
Summary of Data Processing Requirements
January 24, 1990

Wang data entry processing	75.0 hours
Includes: Data entry Batch lists Corrections Wang to IBM transfer	
IBM Update jobs	30.0 hours
Includes: Edits Batch listings Log sheets	
DMS Online programs for lookup and changes	37.5 hours
Nightly Update of Changes	22.5 hours
Warrant Jobs	90.0 hours
Includes: Printing warrants with different amounts. Include check stub messages. Modify warrant registers as needed for balancing. Create new program(s) for transferring accumulated decisions to the alcohol and drug abuse grant fund, and to account for the reserve necessary due to returned and cancelled PFD warrants.	
Miscellaneous 45.0 hours	
Includes: Setting up test files on IBM Systems testing Administrative functions, i.e. paper work required by Admin. DP to add files and programs to tables.	
TOTAL HOURS	300.0 hours

Alaska State Legislature

HOUSE OF REPRESENTATIVES

REPRESENTATIVE FRAN ULMER

M E M O R A N D U M

January 24, 1990

TO: Rep. Johnny Ellis, Chair
House HESS Committee

FROM: Rep. Fran Ulmer

RE: HB 365, relating to voluntary contributions to the alcohol and drug abuse grant fund

---

HB 365 authorizes a Permanent Fund Dividend checkoff for substance abuse programs in Alaska. Specifically, it allows a dividend applicant the option of authorizing $10 to be subtracted from the dividend check and deposited to a special alcoholism and drug abuse fund which will be administered by the State Office of Alcoholism and Drug Abuse.

The checkoff is entirely voluntary. Those who do not wish to participate will see no effect on their dividend check.

Over the course of the four years the Olympic checkoff appeared on the PFD application, the Olympic Committee realized an average of $750,000 per year. The total amount contributed to the Olympics through the PFD checkoff, from 10/1/86 to 1/17/90 is $2.817 million. I believe the high level of concern expressed by Alaskans regarding the incidence of drug and alcohol abuse we experience in our communities will result in a considerably higher contribution rate than the Olympic checkoff received. An additional million dollars would go a long way towards increasing local efforts to treat and prevent substance abuse.

The bill has been drafted to give first priority to programs for youth. The greatest financial and social returns clearly result from those strategies which alleviate drug and alcohol problems before they becomes severe.

Administrative costs associated with the checkoff will be borne by the new program.

District 413 — Juneau

PO Box V • Juneau, Alaska 99811-3100 • (907) 465-4947

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL NO. 365

"An Act relating to the alcohol and drug abuse grant fund and contributions to the fund; and providing for an effective date."

Analysis

Section 1. of the Bill would have the Department of Revenue change the permanent fund dividend application form to allow an applicant to have $10.00 subtracted from their dividend and contributed to the alcohol and drug abuse grant fund. Contributions, less an administrative fee, would be deposited in a special dividend contribution account.

Section 2. would establish a grant fund within the Department of Health and Social Service that would be administered by the Office of Alcoholism and Drug Abuse. In awarding grants the Office should place priority on programs aimed at youth. By regulation the Department is to develop eligibility requirements and application procedures.

Section 3. establishes the effective date of this legislation as January 1, 1991.

Discussion

The need for additional financial resources for alcohol and drug abuse prevention and treatment services is well documented. In FY 90 grant application requests from community based organizations exceeded the amount of available funding by more than $6,000,000. Several geographical areas of the state are unable to offer residents as comprehensive array of services as they feel are necessary due to lack of funding. Salaries in the alcohol and drug abuse grant-in-aid program are quite low according to a House Research Agency study that was conducted last year. With various budget cuts in recent years due to declining oil prices, many grant-in-aid programs are operating with less state funding now than they had available in FY 83. Of course this has resulted in fewer services being provided.

Sufficient resources for alcohol and drug abuse services are a problem in other states as well, and they too have sought new and innovative methods of raising the funding level. Florida, for example, recently instituted a .50 cent a day special charge on all automobile rentals to raise money for their

alcohol and drug programs. California is currently considering a .05 cents a drink tax on alcoholic beverages for the same purpose.

Position

The Department of Health and Social Services recognizes that abuse of alcohol and drugs is one of the most serious problems facing Alaska and that adddressing problems associated with this abuse will require additional State resources. HB 365 offers a way to generate these funds. However, the Department defers to other agencies regarding the cost of implementing a permanent fund checkoff for this purpose.

Matthew C. Felix
Coordinator

Myra Munson
Commissioner

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

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

H. HESS 1-25-90

H. HESS 2-2-90

H. HESS 2-6-90

Mr. Donald Dapcevich
P.O. Box 021571
Juneau, Ak 99802

January 31, 1990

The Honorable Fran Ulmer
House of Representatives
State of Alaska
P.O. Box V
Juneau, Ak 99811

Dear Representative Ulmer:

First I would like to commend you and your staff for your willingness to tackle alcohol and other drug abuse among Alaskans. House Bill 365 offers real hope for large numbers of Alaskan youth who are suffering from the devastating effects of chemical dependence.

I congratulate your insight in dedicating the funds from this revenue source to the treatment of adolescents suffering from chemical dependence. Currently hundreds of thousands of dollars from both federal and state resources are dedicated to prevention and education programs for youth. In the current legislature I understand that the democratic majority is introducing legislation that will dedicate more prevention/education monies, and without a doubt more is needed.

The problems with securing funds for adolescent treatment is a very complex one. At the core of resistance to dedicating funds for adolescent treatment is an unwillingness to accept chemical dependence as an adolescent problem. Many adults have real problems accepting the possibility of a 16 year old being an alcoholic or an addict. Most people feel that alcoholics are people over fifty who stand on our street corners drinking cheap wine. Those of us in the profession who have embraced the disease concept, understand that the age of the user of drugs and alcohol is only one of many factors of the disease and lately we are seeing more and more full-blown addicts among 14-18 year olds.

We have also learned that prevention/education programs, while helpful, should not have all of our attention any more than should prevention without adequate treatment programs for diabetes or heart disease patients.

Please do not succumb to the pressure to change this bill from treatment oriented to prevention/education oriented measure.

Sincerely,

Don Dapcevich

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: HB 365
PUBLISH DATE: 1/8/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: "An Act relating to the alcohol and drug abuse grant fund."
Sponsor: Ulmer
Requestor:

Agency Affected: Health & Social Services
BRU: Alcohol & Drug Abuse Services
Components: Grants

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: (Attach a separate page if necessary)

The FY 90 fiscal impact is zero.

Prepared by: Matthew C. Felix
Division: Alcoholism & Drug Abuse
Phone: 586-6201
Date: 1/23/90

Approved by Commissioner: Mike McMenamin
Agency: Health & Social Services
Date: 1/24/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

6-1652H
Cook
2/1/90

Original Sponsor(s): REP. ULMER, Boyer, Ellis, Brown, Menard, Finkelstein, Gruenberg, Koponen

IN THE HOUSE

CS FOR HOUSE BILL NO. 365 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the alcohol and drug abuse grant fund and contributions to the fund; and providing for an effective date."

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

* Section 1. AS 43.23 is amended by adding a new section to read:

Sec. 43.23.016. CONTRIBUTIONS FROM DIVIDENDS. The department shall prepare the permanent fund dividend application to allow an applicant to elect to have $10 subtracted from the dividend check and contributed to the alcohol and drug abuse grant fund (AS 47.37.055). Contributions shall be deposited in a special dividend contribution account and allocated by the department to the alcohol and drug abuse grant fund, except that the department shall use money in the account to pay administrative costs incurred by the department under this section.

* Sec. 2. AS 47.37 is amended by adding a new section to read:

Sec. 47.37.055. ALCOHOL AND DRUG ABUSE GRANT FUND. (a) There is established in the department the alcohol and drug abuse grant fund, which shall be administered by the office. The fund consists of money appropriated to it and donations, gifts, and grants received by it. The fund may be used by the office only to make grants for alcohol and drug abuse education, prevention, or treatment programs and for costs of administering the grant fund. Priority in the award of grants shall be given to programs aimed at youth.

(b) The department shall by regulation establish grant

eligibility requirements and grant application procedures.

* Sec. 3. This Act takes effect January 1, 1991.

Dear Representative Ulmer,

The students at Harborview School have read House Bill 365, examined the drug and alcohol problems in our middle schools, and have come to the following conclusions:

We support the drug and alcohol abuse program, but we also think that the legislature should match the money that we send in so that we would have enough money to pay for more programs.

Zaedryn Ensor-Estes
Tiara Hauf
Morgan Bergstrom
Brian Silverman

We support the checkoff and we think that the money we give should be matched by collected taxes from alcohol and cigarette sales.

(O Nadene Lambie
Hilary Partlow
Nathan Haight

We agree and support the $10checkoff but we think the government should match the money the program makes from the checkoff. We would alwo like to see some of the sales tax from alcohol and cigarette go to the program.

Rose Foley
Amelia Rivera
Jared Hendricks
Scott Mansuy
Kiana Putman

I support the $10 checkoff, but I think that the government should pay the administrative costs. The administrative costs are not part of the intention of the program. All the money should go to the program.

Chris Berry

I disagree with the checkoff. The more money people get the more they spend and the more they spend the more taxes they have to pay, so you eventually get the money anyway!

Sincerely,
Nathan Lutchansky

Thanks for providing us the opportunity to give you our ideas about the bill. We believe there is a real need for drug and alcohol programs for youth.

Sincerely,
Bob Deitrick and the
Extended Learning Students
Harborview School, Juneau
Userid: JURJD or JYHV

+▮▮▮▮ar
To: JURJD
RE: Funds for youth programs
.Thank you so much for your comments
.on the check off proposal and on the
.drug and alcohol programs. The bill
.will be heard again in House Health
.Education and Social Services Co.
.tomorrow morning, and I will take
.your comments with me to share with
.the committee. I will let you
.know what they say and do. Fran
.*EXIT*
Sent to JURJD - Keeping in touch with kids!

6-1652J
Cook
2/5/90

Original Sponsor(s): REP. ULMER, Boyd, Ellis, Brown, Menard, Finkelstein, Gruenberg, Koponen

IN THE HOUSE BY THE HESS COMMITTEE

CS FOR HOUSE BILL NO. 365 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the alcohol and drug abuse grant fund and contributions to the fund; and providing for an effective date."

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

* Section 1. AS 43.23 is amended by adding a new section to read:

Sec. 43.23.016. CONTRIBUTIONS FROM DIVIDENDS. The department shall prepare the permanent fund dividend application to allow an applicant or person applying on behalf of a minor or incompetent individual to elect to have $10 subtracted from the dividend check and contributed to the alcohol and drug abuse grant fund (AS 47.37.055). Contributions shall be deposited in a special dividend contribution account and allocated by the department to the alcohol and drug abuse grant fund, except that the department shall use money in the account to pay administrative costs incurred by the department under this section.

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Sec. 47.37.055. ALCOHOL AND DRUG ABUSE GRANT FUND. (a) There is established in the department the alcohol and drug abuse grant fund, which shall be administered by the office. The fund consists of money appropriated to it and donations, gifts, and grants received by it. The fund may be used by the office only to make grants for alcohol and drug abuse prevention or treatment programs approved by the office and for costs of administering the grant fund. Priority in the award of grants shall be given to programs aimed at youth.

(b) The department shall by regulation establish grant eligibility requirements and grant application procedures.

* Sec. 3. This Act takes effect January 1, 1991.

HB

369

HOUSE COMMITTEE REPORT

(7)
Date Referred: January 8, 1990 FURTHER REFERRALS: FINANCE

Date of Committee Action: 2/28/90

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 369

HOUSE BILL NO. 369 SUBSTANCE ABUSE GRANT FUND

"An Act creating the community action against substance abuse grant fund."

RECOMMENDATIONS:
[X] be replaced with C.S.H.B. 369 (HESS) [X] the same title
[ ] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal impact _____ [ ] fiscal note(s) _____
[X] zero fiscal note DHSS [ ] zero fiscal note(s) _____
[ ] zero with analysis _____ [ ] zero fn/analysis _____

SIGNING DO PASS:

J. Ellis
Mark Greenberg
Mark Bergsoll

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
Pete Jarvis		X	
Cheri Davis		X	

J. Ellis
Chairman's Signature

ANCHORAGE POLICE DEPARTMENT

4501 SOUTH BRAGAW STREET • ANCHORAGE, ALASKA 99507-1599
TELEPHONE (907) 786-8500

TOM FINK
MAYOR

February 12, 1990

Jim

Representative Johnny Ellis
Chairman, HESS Committee
Alaska Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Representative Ellis:

Thank you for the opportunity extended to members of my staff to testify before the HESS Committee at the teleconference on January 25, 1990. We are extremely pleased at the initiative taken by members of the HESS Committee to address the lack of funding for local proactive programs targeting the epidemic spread of substance abuse.

The Anchorage Police Department has also taken the initiative in the development and implementation of a highly successful and nationally recognized chemical abuse crime prevention program based on a pro-active educational model - the Police-In-School Liaison Program (PSL). This PSL Program has been in operation in a partnership role with the Anchorage School District since 1984. However, with municipal funding at its current level we are unable to expand the program to the required seven officers that are needed - one for each junior high and feeder elementary system. The Anchorage Police Department has always paid the entire cost of this program without financial assistance from the Anchorage School District or benefit of state grants. Our department has written federal, state and local grants for this PSL program in the past.

My staff has compiled a report for your committee based on the questions you asked at the teleconference.

Attachment #1 is a listing of every school district throughout the state, indicating which communities have both a junior high/ middle school and a local police department. It further indicates how many of these communities have a PSL program in place (modeled after Anchorage) and how many communities would like to start a PSL program.

ATTACHMENT 1

POLICE-IN-SCHOOL LIAISON PROGRAM
SUMMARY SHEET
LOCAL POLICE DEPARTMENTS

35 Junior Highs in Alaska w/co located police departments

21 Surveyed police departments

17 Interested police departments in PSL
3 No Response (Haines, Valeez, North Pole)
1 No police administrator (Bethel)
(21)

9 Departments with PSL on staff of schools

11 PSL officers statewide