ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672
9114 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

Assessing the equity of a school finance system involves determining the type of equity to be achieved. School finance equity can be described in terms of either taxpayer, horizontal or vertical equity:

School finance equity can be described as taxpayer, horizontal or vertical equity.

- *Taxpayer equity* refers to an acknowledged sensitivity to the level or amount of taxes that are paid by taxpayers in support of public education. Attention is focused on the amount of property or other taxes that taxpayers pay compared with those paid by taxpayers in other communities for public education.

- *Vertical equity* is defined as the unequal treatment of unequals. It implies that there can be rational reasons for providing differing levels of per-pupil funding based on the needs of individual students. The most common illustration of this concept is different treatments required by special needs students, students in poverty and those who are eligible for early intervention programs.

- *Horizontal equity* is defined as equal treatment of equals. The principle states that every student is of equal value and should receive the same amount of programmatic funding and educational services. (In reference to taxpayers, horizontal equity requires identically situated taxpayers to pay identical taxes.)[11]

The task of the policymaker is made difficult because the approaches to equity have competing interests that are very difficult to resolve. To achieve equity, states commonly use what is known as the "foundation formula." A foundation formula is designed to take into account a measure of the local wealth of school districts, ensuring that the taxpayers relative tax burden is considered when the state finance program is created. Many of these formulas incorporate "weightings" to account for the individual needs of students, using the concept of vertical equity. In this way taxpayer equity can be addressed, at least conceptually.

State Strategies

States have used a number of different strategies to address problems that arise from differences in school district spending, and often changes in strategy are prompted by adverse court rulings regarding a state's school funding mechanism. Characteristically, these responses have included appropriation of additional state aid to low-spending districts, capping the amount of money that wealthy districts can spend and capturing "excess" local revenues from wealthy districts for statewide school funding purposes.

Increasing State Spending in Low Wealth Districts

A majority of states have increased the amount of revenues appropriated for low-spending districts. In fact most states have increased spending in virtually all school districts over the last decade.[12] In recent years some states have increased the state share for K-12 education in part, to decrease reliance on the politically unpopular property tax that funds most of the local share of education costs. Others have enacted state lotteries that earmark percentages of revenues for education. (see appendix A).

In 1994, the New Jersey legislature was directed by its supreme court to appropriate additional revenues to 30 "special needs" districts. "The remedy was highly compensatory, setting spending in low-outcome districts equal to wealthy suburban districts, plus an undetermined amount of compensatory aid."[13] This was the third time since 1973 that the New Jersey Supreme Court had deemed the funding system unconstitutional. The court gave the state until the 1997 - 1998 school year to achieve "substantial equivalence, approximating 100 percent," in per-pupil spending by wealthy and poor districts.[14] The 1994 decision came after the state had substantially increased state aid to education. The Center for Educational Policy Analysis (CEPA) determined that state education aid increased nearly $900 million between 1990 and 1991. Aid to the target special needs districts increased $513 million in the same two-year period.

A recently released GAO report, *School Finance, Three States' Experiences with Equity in School Funding*, notes that Tennessee raised new revenue to increase funding in poorer districts by increasing the sales tax 0.5 percent. An earlier plan to implement an income tax for this purpose had been soundly defeated. In addition, the Supreme Court ordered the state to equalize teacher salaries. Forty school systems received increases to address an imbalance between urban and rural teacher salaries. These policy changes were enacted in 1993. This action followed disposition of a school finance lawsuit filed by 66 small school districts, in which a chancery court, the court of appeals and the state supreme court all found that, "neither state nor local school funding is equalized to the point that it satisfies the state constitution's mandate of providing a system of uniform schools."[15]

Tennessee enacted policy changes in 1993 to increase funding in poorer school districts and equalize teacher salaries.

Placing Legislative Spending Caps on Wealthy Districts

Generally, the reason for placing caps on additional revenue is to keep high-wealth districts from disproportionately increasing their revenue above that of low-wealth districts. This approach has been criticized by those who fear that equity will be achieved by making better, or higher-spending, schools worse and is referred to as "leveling down." Some policymakers argue that there should be districts that can serve as models for others and that, without them, well-to-do families will be more likely to leave the school system and send their children to private schools. These model districts are commonly referred to as "lighthouse districts," meaning that their often superior programs, facilities and achievement levels will entice other districts to strive to achieve similar outcomes.

As part of a legislative plan to reduce the reliance on property tax and close the gap between low-and high-spending districts, the Wisconsin General Assembly, in 1995, adopted legislation imposing a limit on the amount of revenue per pupil that each school district could raise through a combination of state general school aid and property taxes. The maximum allowable increase per pupil is a specific dollar amount or the rate of inflation, whichever results in a higher amount for the district. (See the Recapture section which refers to Kansas' local option budget provision that places a cap on the amount of revenues available to high-wealth districts.)

Recapture/Redistribution

Recapture is a feature in state school finance formulas whereby local districts that raise more revenue than they can legally spend must make the excess amount available to the state for redistribution to other school districts.

The recapture feature in state school finance formulas allows the state to redistribute revenues from districts with more money than can be legally spent to other districts.

In a 1993 decision in Wyoming, District Judge Nicholas G. Kalokathis ruled that although the overall system was constitutional, three programs within the school funding formula needed to be replaced. The three programs were established to direct state aid in excess of the base foundation amount to low-wealth districts. One of the three programs was a recapture program that allowed some of these excess local property taxes to remain in wealthy districts. The other two programs were the method the state used to calculating aid for school districts in cities and a provision that allowed for locally levied property taxes. In December 1995, the state supreme court not only agreed with the district court's decision but went further in finding the funding system unconstitutional.

Many states include a combination of these strategies. In 1992, the state of Kansas implemented a pupil-weighted school finance plan that contained a uniform property tax levy designed to reduce expenditure disparities and the influence that school district property tax base variations have on school spending decisions. Excess revenue produced in some school districts by the uniform property tax rate are remitted to the state and are used in helping to fund the state's obligation under the formula. In addition, the legislation allows a local option budget of any amount up to 25 percent of the base amount, subject to approval by the local school board and subject to a protest petition election procedure.

Ultimately the final plan to restructure the Texas financing system resulted in a combination of caps on wealthy districts and a recapture element.[17] The legislature gave districts five choices for reducing their property wealth to a level of $280,000 per weighted pupil:

1. By agreement, a high-wealth district could voluntarily consolidate with a lower-wealth district.

2. By agreement, a school district could detach nonresidential property in order to lower its property value. The detached property would then be permanently annexed to another school district.

3. With the approval of the voters, a high-wealth district could purchase attendance credits from the state as a surrogate method of reducing tax base.

4. High-wealth districts could elect to contract for the education of nonresident students.

5. A high-wealth district could ask the voters of a region to agree to tax base consolidation, similar to county education districts.[18]

A second tier of the Texas school-funding system is a guaranteed yield (GTY) to provide each school district with the opportunity to supplement the basic program at a level of its own choice with access to additional funds for facilities.[19] GTY programs are defined as matching grants. The state matches a percentage of funds raised for education by the school district based on the fiscal capacity of the district. The higher the guaranteed revenue per pupil, the greater the equalization effect and cost to the state.[20] Two states (Indiana and Wisconsin) use this formula approach as the primary mechanism for distributing basic support aid.

Pursuit of Court Directed Remedies

Whereas many states have enacted substantive changes to their education financing systems because of legislative or executive initiatives, others have done so as a result of adverse court rulings. The role that courts play differs across the country. Some have been unwilling to offer specific suggestions to legislatures, not wanting to be seen as intruding on legislative branch discretion since most state constitutions clearly designate authority and oversight of education to the legislature. Other state courts have been more activist and have either given specific strategies in the court opinion or have set deadlines by which the legislative branch is to act. Three examples of court-directed remedies follow.

Texas

Texas Supreme Court, although not telling the legislature specifically what to do, directed the legislature to restructure the system to equalize access to funds among all school districts. The court suggested the following limited options:

1. *Total state funding.* An example of this approach is the state of Hawaii, which is the only state that provides almost 100 percent of the funds for K-12 education. No property tax funds are levied to support education, because state support for the operation of the public schools comes from the state general fund.

2. *Statewide property tax.* Several states use statewide property taxes, which impose a uniform taxation rate across the state. States that use this system include Arizona, Wyoming, Kansas and Washington.

3. *District consolidation.* This approach consolidates or reconfigures school districts in order to balance differences in property wealth.

4. *Limited tax-base consolidation combined with additional state aid.* Very complicated and difficult to implement, this approach allows commercial property from one district to be detached and placed in another district for taxing purposes. If necessary, the state would then provide additional aid to bring the low-wealth district to the statutory threshold for assessed valuation per pupil.

Court roles in state education financing differ across the country.

Kentucky

The Kentucky Supreme Court identified nine "essential" characteristics of an efficient system of common schools as guidance for the Kentucky General Assembly in its attempt to design a constitutional system (see appendix B). The nine characteristics stated that equal educational opportunities must be provided to all children regardless of their place of residence or economic circumstance; that all children have a constitutional right to an adequate education; and that the General Assembly is responsible for providing school funding sufficient to provide each child with an adequate education.[21] Since the enactment of the Kentucky Education Reform Act (KERA) in 1990, the state has allocated roughly $4 billion in new revenues.

Alabama

Borrowing from the Kentucky decision, Alabama Circuit Court Judge Eugene W. Reese's 125-page, 1993 opinion identified nine "essential principles and features of the liberal system of public schools required by the Alabama Constitution" (see appendix B).[22] To date, the remedy order has not yet been implemented, and Governor Fob James filed a motion for appeal of the order to the state supreme court.

Emerging Issues to Consider

Funding to build school facilities, also referred to as school district capital outlay, is almost totally dependent on local property taxes and voter approved levies. Recent litigation in Arizona, Texas and Ohio indicates that states may have to determine how they can participate more in the funding for facilities. The courts have broadened their view of equity to include the condition of school buildings in the determination of equitable finance systems. Additional state support for school facilities could require significant state expenditure, given the backlog of deferred maintenance, and the demands associated with current educational reforms, including educational technology.

Growth in school enrollments has significant implications for classroom space, school infrastructure and personnel needs.

Policymakers will face a difficult challenge resulting from the growth in elementary and secondary enrollments projected by the National Center for Education Statistics (NCES). The center predicts that in one decade, "the nation will need an additional 6,000 schools, 190,000 teachers and $15 billion annually to serve elementary and secondary students. K-12 enrollment will hit 51.7 million in the 1996-1997 school year and is expected to reach 54.6 million by 2006."[23] These numbers have significant implications for classroom space, school infrastructure and personnel needs that states will have to address respectively.

Policy Recommendations

Legislative solutions to inequitable spending patterns need to be sensitive both to taxpayer equity and to concerns for educational equity. The public's support for public education can be maintained only if policymakers and educators make greater effort to take their case to the public and explain how education reform, accountability and adequate revenues are important to the reform strategy.

The stability of the funding system must remain a key consideration at all times. A balanced approach to school funding, where multiple sources of revenues contribute to financing schools, reduces the likelihood that the burden for funding will alienate one segment of the populace. Furthermore, burden sharing builds stability in finance.

- States should include a measure of school district fiscal capacity in their funding approach. In most states, the ability of a school district to fund education at the local level is directly related to its fiscal resources. In most states the only fiscal resource available to school districts is property tax. Therefore, the most commonly used measure of district wealth is a district's equalized assessed property valuation. Because differences in property tax values have tended to be the major contributor to spending disparities, a measure of school district fiscal capacity is a necessity. This will allow states to target aid to the most needy districts while ensuring adherence to broader state educational policy goals. "Basic support aid, also referred to as state aid, is the main component of a state's education finance system, in most cases providing the majority of aid. Basic support aid programs are designed to distribute aid in direct relationship with educational need and inversely to local ability to pay: that is, the greater the perceived educational need of the district, the more aid it will receive compared to districts with less need; and the greater the ability of a district to finance education, the less aid it will receive compared to districts with lower ability."[24]

Legislative solutions to inequitable spending patterns need to be sensitive to both taxpayer and educational equity concerns.

- States need to examine both the positive and negative circumstances associated with the use of earmarked lottery revenues for K-12 funding schemes. Lotteries are regressive and will decline over time, thus states must be careful not to look to them as stable and predictable revenue sources.

- States should be attuned to the principle of program neutrality. The principle proposes that the distribution of state funds not result in an unintentional shift of financial support from one program to another. For example, a pupil-weighting plan understating the actual cost of special education programs could result in the district diverting funds from the regular instructional program to make up the difference.[25]

- States should consider that funding systems in total will likely incorporate the principle of fiscal variability. This means that a state school finance system may have several dimensions–general and categorical aid, equalized and nonequalized aid–thus allowing for a variety of financial aid mechanisms.[26]

- The distribution of state resources should be done in a manner that promotes the most efficient use of those resources at the local level.

A Broader Federal Role in Education Finance?

Reaching a solution to school finance equity may involve a redefinition of the federal role in elementary and secondary education. The average amount of federal aid to K-12 education is about 7 percent.[27] Historically, the federal government has provided categorical aid to help school districts that have large populations of poor students, contain government-owned property (for example military bases) that districts cannot include in their property tax bases and, most recently, to help states finance educational reform efforts under the Goals 2000 legislation.

During the 1996 Republican National Convention, delegates approved a platform that would offer the public an education "warranty," guiding federal policy while handing state and local policymakers most of the power to decide how to use a mix of vouchers, school prayer and immigrant policy. The last two years have seen an unprecedented public debate about what the role and direction of the U.S. Department of Education should be. The debate has been played out in the national media by members of congress, the administration and former secretaries of the department and was a legitimate campaign issue for the 1996 presidential election. (Appendix D contains a complete list of federal funding for elementary and secondary education programs and a discussion of what a broader federal role in education might look like).

Conclusion

Solutions to the problem of fiscal equity in state education programs will be reached gradually.

In addition to school finance, state legislators are dealing with broader implications of educational reform, including charter schools, voucher programs and the implementation of content standards. Nonetheless, public interest in reducing the reliance on property taxes and the pressure of constitutional challenges to the school funding system have ensured that there will be a need for state legislators and governors to continue defending how schools are funded while attempting to bring more equity to finance formulas.

As Jeffrey Katz noted, "legislators are key participants in the process because the states solely determine what constitutes educational equity."[28] Attempts to bring greater equity to all school systems will continue to be a challenging task for state policymakers, both financially and politically. States must craft plans to address equity while being sensitive to concerns in high-spending districts that advancing equity will mean that their state aid will be cut or that local revenues will be capped or recaptured.

On the other hand, because of the prohibitive costs it would take to boost all low-spending districts, it will not be possible for most states to pursue a "leveling up" strategy as a lone solution to closing disparities in per-pupil spending and educational resources. For example, when the state of Michigan rewrote its finance system in 1994 it required additional state aid to 41 of 556 school districts to bring them up to a minimum foundation allowance level of $4,200 in school year 1994-1995.[29] When ranked with all school districts, these 41 districts were at the very bottom of spending in 1993-1994.

The problem of determining how to bring fiscal equity to states and districts will be solved incrementally. It is our hope that this publication will give policymakers some insights as to how to accomplish this formidable task.

Appendix A
Nontax Revenues for Education

State lotteries are an important and lucrative source of education funding in a few states. In fiscal year 1993, when NCSL carried out a 50-state survey on the topic, the following states allocated the amounts shown to K-12 education (or related purposes) from lottery proceeds.

State	Amount (millions of dollars)	Purpose	Percent of Total K-12 Coming from Lottery
California	$502	K-12 education	1.8
Florida	831	Dept. of Education	7.4
Idaho	3	K-12 education	0.4
Illinois	588	K-12 education	5.9
Indiana	85	K-12 education	1.7
Massachusetts	533	Local Aid Fund	10.5
Michigan	427	School Aid Fund	4.1
Montana	18	K-12 education	2.6
New Hampshire	37	K-12 education	3.6
New York	961	Local governments for K-12 education	4.2
Ohio	658	K 12 education	6.4
West Virginia	4	K 12 education	0.2
Wisconsin's	200	Property tax relief	3.7
Total	$4,847		

Appendix B
Educational Goals for Kentucky

1. Its establishment, maintenance and funding are the sole responsibility of the Legislature.
2. It is free to all.
3. It is available to all Kentucky children.
4. It is substantially uniform throughout the state.
5. It provides equal educational opportunities to all Kentucky children.
6. It is monitored by the General Assembly to assure there is no waste, no duplication, no mismanagement, and no political influences.
7. Schools are operated under the premises that an adequate education is a constitutional right.
8. Sufficient funding provides each child an adequate education.
9. An "adequate education" is defined as one which develops the following seven capacities:

√ Communication skills necessary to function in a complex, changing civilization.
√ Knowledge to make economic, social, and political choices.
√ Understanding of governmental processes as they affect the community, state, and nation.
√ Sufficient self-knowledge and one's mental and physical wellness.
√ Sufficient grounding in the arts to enable each student to appreciate his or her cultural and historical heritage.
√ Sufficient preparation for students to choose and pursue their life's work intelligently.
√ Skills enabling students to compete successfully with students from other states.

Source: Opinion and Order of the Supreme Court of Kentucky, in *Rose vs. The Council for Better Education Inc.*

Appendix C
Alabama Essential Principles and Features of the "Liberal System of Public Schools" Required by the Alabama Constitution

1. Sufficient oral and written communication skills to function in Alabama, and at the national and international levels, in the communication skills to function in Alabama, and at the national and international levels, in the coming years;

2. Sufficient mathematic and scientific skills to function in Alabama, and at the national and international levels, in the coming years;

3. Sufficient knowledge of economic, social, and political systems generally, and of the history, politics and social structure of Alabama and the United States, specifically, to enable the student to make informed choices;

4. Sufficient understanding of governmental processes and of basic civic institutions to enable the student to understand and contribute to the issues that affect his or her community, state, and nation;

5. Sufficient self-knowledge and knowledge of principles of health and mental hygiene to enable the student to monitor and contribute to his or her own physical and mental well-being.

6. Sufficient understanding of the arts to enable each student to appreciate his or her cultural heritage and the cultural heritages of others;

7. Sufficient training, or preparation for advanced training, in academic or vocational skills, and sufficient guidance, to enable each child to choose and pursue life work intelligently;

8. Sufficient levels of academic or vocational skills to enable public school students to compete favorably with their counterparts in Alabama, in surrounding states, across the nation, and throughout the world, in academics or in the job market; and

9. Sufficient support and guidance so that every student feels a sense of self-worth and ability to achieve, and so that every student is encouraged to live up to his or her full human potential.

Source: Opinion and Order of Alabama Circuit Court Judge Eugene W. Reese, in *Alabama Coalition for Equity, Inc., vs. Guy Hunt*, Circuit Court for Montgomery County, Alabama.

Appendix D
Elementary Secondary Education Program and A Broader Federal Role in Education Finance

Bilingual Education
Title 1 - Compensatory Education
Administration
Basic State Grants
Capital Expenses
Even Start
Handicapped Payments
Migrant Programs
Neglected and Delinquent Children
School Improvement
Dropout Prevention
Special Education
Basic State Grants
Preschool Grants
Infants and Children
Impact Aid
Basic State Grants
Handicapped Payments
Construction
Goals 2000: Educate America Grant
School-to-Work
Title VI: School Improvement Program
Safe and Drug-Free Schools and Communities
Eisenhower Professional Development
Magnet Schools
Indian Education
Immigrant Education
Education for the Homeless Youth

Postsecondary Education
College Work Study
Supplemental Educational Opportunity Grants
Perkins Loans
Pell Grants
State Student Incentive Grants

A Broader Federal Role in Education Finance

Allan Odden, a national school finance expert and University of Wisconsin professor of education administration has done some extensive work in fashioning several strategies that would create a new federal role in K-12 education. He argues that the federal government should try to address the most pronounced interstate disparities, which can be found in most of the poorest states. These states now garner the highest percentage of federal categorical aid, however, their needs for additional monetary assistance remain high. The Goals 2000 program could serve as a vehicle for distributing additional money that is not earmarked for existing categorical programs.

Other ideas include:

- Although costly, a new federal role in general revenue sharing could be targeted to reduce differences in state fiscal capacity. Odden acknowledges that critics will argue that until fiscal capacity is more directly and strongly linked with differences in student achievement, a large and expensive new federal role is unwarranted. The general idea would be for the federal government to ensure a per capita tax yield across the states for similar tax efforts, similar to an intrastate guaranteed tax base program of school financing.

- Another alternative would be for the federal government to bring base education spending up to some minimum level, such as the national average expenditure per pupil or the median expenditure per-pupil level. Odden cautions that if fully funded, it would require a large boost in federal education revenues but would leave intact current differences in state education tax effort. To address this problem he suggests that federal revenue for such a program could be contingent upon a state's exerting a minimum general tax effort, using measures such as an amount of own source tax revenues per capita or a tax rate index at or above 100 on the ACIR (Advisory Commission on Intergovernmental Relations) tax effort index.

- A third, more direct alternative would be for the federal government to implement a nationwide district or school-based foundation per pupil expenditure program. This program would function just like a state foundation program. First, the federal government would set a base spending level, or a foundation per-pupil expenditure level, for all districts or schools. The amount could be adjusted using a state-by-state cost-of-education index. The federal government would make up the difference between this per pupil amount and an amount that would have to be raised by the state. The latter amount could be the yield from a statewide property tax, or it could be the yield from a statewide property tax and an amount of state general fund revenues. Such a program would address both inter-and intrastate spending differences.

Appendix E
Glossary

Assessed Valuation: The value of a taxable property as determined by a government agency or tax assessor. Taxes are paid on the basis of a property's assessed valuation. The assessed valuation of property in most states and localities is usually less than the market value of the property.

Equalization: The process of compensating for differences in order to make equal. Several related concepts are useful. Capacity Equalization is the process of compensating for differences in school districts' ability to support education in order to achieve student equity and taxpayer equity. Service and programmatic equalization is the process of compensating for differences in the level of services or programs in a school or school district in order to achieve student equity.

Foundation Program: A state equalization aid program that typically guarantees a certain foundation level of expenditure for each student, together with a minimum tax rate that each school district must levy for education purposes. The difference between what a local school district raises at the minimum tax rate and the foundation expenditure is made up in state aid.

Fiscal Capacity: The total economic resources available to a government for tax purposes. In school finance, fiscal capacity is generally defined as property valuation per pupil, but several states include income or other measures of wealth with property valuation as a measure of fiscal capacity.

Recapture: A feature in state aid to education formulas where local districts which raise an amount per pupil in excess of the state guaranteed expenditure per pupil would have to pay back the excess to the state for redistribution to poorer school (i.e., those with less valuation per pupil).

Required Local Tax Rate: A term indicating the mandated property tax rate equipped for participation in the state aid system. The required local tax is usually associated with a foundation program and is often expressed in terms of mills. A millage rate is the amount of property tax dollars to be paid for each $1,000 of assessed valuation.

Required Local Effort (RLE): A local tax that must be levied. Local funds raised by the RLE are subtracted from the total foundation funds to determine the amount of state aid the district receives.

Source: John Augenblick, Mary Fulton, and Chris Pipho. *School Finance: A Primer,* April 1991.

Appendix F
Organizational Strategies to Address Equity

The National Education Association, (NEA) and the American Federation of Teachers (AFT) have both recently offered strategies for influencing ongoing educational reform and student achievement. The unions hope these initiatives will positively influence student achievement while also presenting a strong case for advancing educational equity. The NEA strategy involves the development of a "quality index" that can be used by individual schools, districts and the states to "help identify needs and priorities for how schools can gauge whether the programs in place are sufficient to help students meet world class standards." Under a five-year project the union has also released "Keys to Excellence in Your Schools" (KEYS) which provides 35 indicators for identifying strengths, weaknesses and resource needs.[10]

The American Federation of Teachers has released the "Lesson for Life Campaign." The national campaign is based on the public polling work of the Public Agenda Foundation and seeks to establish equity and discipline in the learning environment in order to ensure high academic standards. The initiative seeks to help all students by ensuring that the school environment can focus on learning and achievement as opposed to disruptions within classrooms. It includes the AFT Bill of Rights and Responsibilities for Learning.

A special partnership between the U.S. Chamber of Commerce's Center for Workforce Preparation, the accounting firm Coopers & Lybrand LLP and Fordham University professor Bruce Cooper has produced a resource allocation model for use by local schools and districts. The model seeks to help districts track education spending from the central office into the classroom. Such data could be used by policymakers to examine equity issues within a state and within school districts. The software produces management reports that provide community leaders, administrators and policymakers with information that can contribute to the understanding of how school districts use monetary resources. The model may have implications for addressing equity and other finance-related questions within school districts and states.

Other entities that have done similar expenditure flow analysis include the Washington, D.C. based firm Pelavin & Associates as well as Palo Alto, California, based education researchers Jay Chambers and Tom Parrish. At lease three states–Ohio, Oregon and Florida–have used uniform accounting systems as a means of tracking state expenditures.

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About the Education Partners Project

In early 1994, the National Conference of State Legislatures and the Foundation for State legislatures convened a group of state legislators, legislative staff, business organizations and nonprofit organizations to begin a conversation about the principles and components of a sound state school finance system.

The major purpose of the Education Partners Project is to encourage dialogue and build consensus among these groups because educational goals can be realized only when coupled with a sound funding system.

In addition to a report, three working papers on related education finance topics emerged from the partnership:

- The Relationship Between Educational Expenditure and Student Achievement
- The Search for Equity in School Funding
- Taxation and Revenues for Education

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This document should be attributed to those involved in the project and not to the organizations or legislative bodies to which they belong. The views presented here do not necessarily represent the position of the Foundation for State Legislatures or the National Conference of State Legislatures.

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HB 148 School Funding Formula

Overview

1) Determine the **size adjustment** for the funding community based on the following table. Multiply the ADM by the size factor.

Average Daily Membership (ADM)	Funding Community Size Factor
10-20	2.75
21-40	2.20
41-80	1.90
81-160	1.55
161-400	1.40
401-1,000	1.10
over 1,000	1.00

2) Determine the **area cost factor** assigned to the funding community listed in transition section 25. Multiply the result of step 1 by the area cost factor for that community.

3) Repeat step 1 and 2 for each funding community within a school district.

4) Determine if the funding community is the only one in the district and has an ADM less than 900. If so, determine the **single site adjustment** based on the following table.

Average Daily Membership (ADM)	Factor
1-250	1.12
251-525	1.08
526-900	1.06

5) Add the results of steps 1 through 4.

6) Multiply step 5 by the **special needs adjustment** of 1.20.

7) Determine the **student transportation factor** assigned to the school district listed in transition section 26. Multiply step 6 by the student transportation factor for that district. The result is the school district's **adjusted ADM**. The adjusted ADM is multiplied by the student allotment to determine the base allocation.

8) **Intensive funding** is determined for each funding community by multiplying the number of students receiving intensive services by the area cost factor. Adding the results for each funding community together and multiplying the result by $22,500 determines the districts intensive funding.

9) The base allocation computed in step 7 is added to the intensive funding calculation in step 8 to determine the **district's need**.

10) **District Need = (ADM X Size Adjustment X Area Cost Factor X Single Site Adjustment X Special Needs Adjustment X Transportation Adjustment) + Intensive Funding**

11) **State Aid = District Need - Local Contributions**

Foundation Funding Calculations (CS SSHB 148)

Determining District Need
Kashunamiut School District

Funding Community	ADM		Size Factor		Area Cost Factor		FC adjusted ADM
Chevak	269.00	x	1.40	x	1.32	=	497.11
		x		x		=	-
		x		x		=	-
		x		x		=	-
		x		x		=	-
					sub total		497.11
					Single Site Adjustment		1.08
					sub total		536.88
					Special Needs Adjustment		1.20
					sub total		644.26
					Student Transportation Adjustment		1.00
					District Adjusted ADM		644.26
					Student Allotment		$3,400

Base Funding $2,190,484

Intensive Service Allocation

Funding Community	Enrolled		Area Cost Factor		FC adjusted Intensive Count
Chevak	3.00	x	1.32	=	3.96
		x		=	-
		x		=	-
		x		=	-
		x		=	-
			Sub Total		3.96
			Intensive Allotment		$22,500

Intensive Funding $89,100

District Need equals **Base** plus **Intensive funding** **District Need** $2,279,584

Determining State Aid

District Need $2,279,584

Local Effort calculations

District Need	2,279,584	x	35%	=	the lesser of 797,854
Full Value Determination	-	x	0.003	=	-

Local Effort $0

State Aid $2,279,584

Hold Harmless FY98 entitlements under existing formulas

Foundation	2,121,185
Pupil Transportation	3,119
Single Site	154,940
Hold Harmless Base	2,279,244
Hold Harmless %	100%

Hold Harmless comparison $2,279,244

Additional state aid due $0

Total State Aid $2,279,584

Change in state aid $340

Foundation Funding Calculations (CS SSHB 148)

Determining District Need
Bristol Bay School District

Funding Community	ADM		Size Factor		Area Cost Factor		FC adjusted ADM
Bristol Bay	303.00	x	1.40	x	1.40	=	593.88
South Naknek	18.00	x	2.75	x	1.40	=	69.30
		x		x		=	-
		x		x		=	-
		x		x		=	-
					sub total		663.18
					Single Site Adjustment		1.00
					sub total		663.18
					Special Needs Adjustment		1.20
					sub total		795.82
					Student Transportation Adjustment		1.07
					District Adjusted ADM		851.53
					Student Allotment		$3,400

Base Funding $2,895,202

Intensive Service Allocation

Funding Community	Enrolled		Area Cost Factor		FC adjusted Intensive Count
Bristol Bay	2.00	x	1.40	=	2.80
South Naknek	-	x	1.40	=	-
		x		=	-
		x		=	-
		x		=	-
			Sub Total		2.80
			Intensive Allotment		$22,500

Intensive Funding $63,000

District Need equals **Base** plus **Intensive funding** **District Need** $2,958,202

Determining State Aid

District Need $2,958,202

Local Effort calculations				the lesser of
District Need	2,958,202	x	35% =	1,035,371
Full Value Determination	187,513,800	x	0.003 =	562,541

Local Effort $562,541

State Aid $2,395,661

Hold Harmless FY98 entitlements under existing formulas

Foundation	1,884,665
Pupil Transportation	217,455
Single Site	-
Hold Harmless Base	2,102,120
Hold Harmless %	100%

Hold Harmless comparison $2,102,120

Additional state aid due $0

Total State Aid $2,395,661

Change in state aid $293,541

Foundation Funding Calculations (CS SSHB 148)

Determining District Need

Yupiit School District

Funding Community	ADM		Size Factor		Area Cost Factor		FC adjusted ADM
Akiachak	172.00	x	1.40	x	1.32	=	317.86
Akiak	122.00	x	1.55	x	1.32	=	249.61
Tuluksak	122.00	x	1.55	x	1.32	=	249.61
		x		x		=	-
		x		x		=	-
					sub total		817.08
					Single Site Adjustment		1.00
					sub total		817.08
					Special Needs Adjustment		1.20
					sub total		980.50
					Student Transportation Adjustment		1.00
					District Adjusted ADM		980.50
					Student Allotment		$3,400

Base Funding $3,333,700

Intensive Service Allocation

Funding Community	Enrolled		Area Cost Factor		FC adjusted Intensive Count
Akiachak	1.00	x	1.32	=	1.32
		x		=	-
		x		=	-
		x		=	-
		x		=	-
			Sub Total		1.32
			Intensive Allotment		$22,500

Intensive Funding $29,700

District Need equals **Base** plus **Intensive funding**. **District Need** $3,363,400

Determining State Aid

District Need $3,363,400

Local Effort calculations

					the lesser of
District Need	3,363,400	x	35%	=	1,177,190
Full Value Determination	-	x	0.003	=	-

Local Effort $0

State Aid $3,363,400

Hold Harmless FY98 entitlements under existing formulas

Foundation	4,279,034
Pupil Transportation	-
Single Site	-
Hold Harmless Base	4,279,034
Hold Harmless %	100%

Hold Harmless comparison $4,279,034

Additional state aid due $915,634

Total State Aid $4,279,034

Change in state aid $0

Fiscal Note Analysis

CONTRACTUAL: The department is requesting a one time appropriation of $498,600 in FY98 to commission an educational cost study. The department believes it will take approximately 18 months to complete the study. Place holder area cost and transportation factors have been placed in transition sections 25 and 26 of this bill. It is the intent of the department to commission the study and adopt the results in regulation. Elements to consider in an educational cost study may included but are not limited to, certified and classified salaries, benefits, geographic location, transportation, fuel, utilities and supplies.

GRANTS: The following table lists the assumptions used to prepare the fiscal note.

Bill Reference	Sec. 29	Sec. 14.17.410(2)	Sec. 27 Transition	
Fiscal Year	Student Allocation	Required Local	Hold Harmless	Enrollment Growth
FY98	$3,400	3.00 mills	100%	FY98 Projections
FY99	$3,925	3.25 mills	80%	1.5%
FY00	$3,970	3.50 mills	60%	1.5%
FY01	$4,010	3.75 mills	40%	1.5%
FY02	$4,045	4.00 mills	20%	1.5%
FY03	$4,045	4.00 mills	0%	1.5%

Sectional Analysis

Section 1 - Defines the purpose of the proposed public school funding program.

Section 2 - Amends Alaska statute 14.17. Listed under Section 2 are sections 14.17.300 through 14.17.990 that outline the proposed Public School Funding Program. Following is a list of the proposed sections and their titles.

Sec. 14.17.300. Public school account.
Sec. 14.17.400. State funding for districts.
Sec. 14.17.410. Equalization funding.
Sec. 14.17.420. Special needs and intensive services funding.
Sec. 14.17.430. State funding for centralized correspondence study.
Sec. 14.17.435. State funding for state boarding school.
Sec. 14.17.440. Local contribution.
Sec. 14.17.450. Funding communities.
Sec. 14.17.460. Funding community size factor.
Sec. 14.17.470. Area cost and transportation factors.
Sec. 14.17.475. Base student allocation.
Sec. 14.17.500. Student count estimate.
Sec. 14.17.505. Fund balance in school operating fund.
Sec. 14.17.510. Determination of full and true value by Department of Community and Regional Affairs.
Sec. 14.17.520. Minimum expenditure for instruction.
Sec. 14.17.600. Student counting periods.
Sec. 14.17.610. Distribution of public school funding.
Sec. 14.17.900. Construction and implementation of chapter.
Sec. 14.17.910. Restrictions governing receipt and expenditure of district money.
Sec. 14.17.920. Regulations.
Sec. 14.17.990. Definitions.

Year 1 1998 - CS SS HB 148
Student allocation $3,400

100% Hold Harmless Req. Local @ 3 mills	FY98 Projected ADM	Wt. ADM	Level I Base	Intensive Allocation	Level I	1996 Assessed Value	Assessed Value @ 3 Mills or 35% of Level I	Level I State Support
ALASKA GATEWAY	568.00	1,353.03	4,600,302	76,950	4,677,252		0	4,677,252
ALEUTIAN REGION	33.00	85.87	291,958		291,958		0	291,958
ALEUTIANS EAST	369.00	1,008.62	3,429,308	89,100	3,518,408	92,545,800	277,637	3,240,771
ANCHORAGE	46,790.50	58,539.67	199,034,878	14,827,500	213,862,378	13,295,065,500	39,885,197	173,977,181
ANNETTE ISLANDS	390.00	742.99	2,526,166		2,526,166		0	2,526,166
BERING STRAIT	1,781.36	4,694.09	15,959,906	129,375	16,089,281		0	16,089,281
BRISTOL BAY	321.00	851.53	2,895,202	63,000	2,958,202	187,513,800	562,541	2,395,661
CHATHAM	332.00	792.35	2,693,990	47,250	2,741,240		0	2,741,240
CHUGACH	160.00	423.78	1,440,852		1,440,852		0	1,440,852
COPPER RIVER	759.50	1,373.77	4,670,818	70,875	4,741,693		0	4,741,693
CORDOVA	530.00	853.85	2,903,090	102,600	3,005,690	166,181,680	498,545	2,507,145
CRAIG	447.00	669.11	2,274,974	70,875	2,345,849	78,670,700	236,012	2,109,837
DELTA/GREELY	839.00	1,418.58	4,823,172	153,900	4,977,072		0	4,977,072
DENALI	395.00	865.89	2,944,026		2,944,026	115,814,500	347,444	2,596,582
DILLINGHAM	580.00	1,114.08	3,787,872	207,900	3,995,772	135,188,600	405,566	3,590,206
FAIRBANKS	16,350.50	20,771.23	70,622,182	4,680,000	75,302,182	3,879,123,580	11,637,371	63,664,811
GALENA	180.00	456.01	1,550,434	89,100	1,639,534	17,707,000	53,121	1,586,413
HAINES	442.00	658.75	2,239,750	70,875	2,310,625	156,454,400	469,363	1,841,262
HOONAH	274.00	527.22	1,792,548	236,250	2,028,798	24,700,900	74,103	1,954,695
HYDABURG	107.50	235.15	799,510	23,625	823,135	5,898,200	17,695	805,440
IDITAROD	436.00	1,336.25	4,543,250	148,500	4,691,750		0	4,691,750
JUNEAU	5,599.17	6,987.70	23,758,384	1,552,500	25,310,884	2,093,307,500	6,279,923	19,030,961
KAKE	190.00	379.13	1,289,042	23,625	1,312,667	17,411,300	52,234	1,260,433
KASHUNAMIUT	269.00	644.26	2,190,484	89,100	2,279,584		0	2,279,584
KENAI	10,579.00	14,856.10	50,510,740	1,440,000	51,950,740	3,714,200,960	11,142,603	40,808,137
KETCHIKAN	2,832.00	3,534.34	12,016,756	270,000	12,286,756	1,090,044,100	3,270,132	9,016,624
KLAWOCK	220.00	434.65	1,477,810	47,250	1,525,060	15,993,700	47,981	1,477,079
KODIAK	2,811.00	4,131.29	14,046,386	261,900	14,308,286	877,746,500	2,633,240	11,675,046
KUSPUK	517.00	1,436.83	4,885,222	29,700	4,914,922		0	4,914,922
LAKE AND PENINSULA	510.00	1,695.66	5,765,244	29,700	5,794,944	68,133,100	204,399	5,590,545
LOWER KUSKOKWIM	3,521.50	7,637.00	25,965,800	712,800	26,678,600		0	26,678,600
LOWER YUKON	1,845.00	4,257.88	14,476,792	29,700	14,506,492		0	14,506,492
MAT-SU	12,605.00	17,278.67	58,747,478	2,542,500	61,289,978	2,339,858,260	7,019,575	54,270,403
NENANA	170.00	382.89	1,301,826	25,650	1,327,476	16,529,900	49,590	1,277,886
NOME	771.00	1,466.71	4,986,814	29,700	5,016,514	153,709,500	461,129	4,555,385
NORTH SLOPE	2,037.00	4,778.39	16,246,526	313,875	16,560,401	12,130,115,480	5,796,140	10,764,261
NORTHWEST ARCTIC	2,044.00	4,870.90	16,561,060	97,875	16,658,935	263,071,000	789,213	15,869,722
PELICAN	40.00	124.19	422,246		422,246	15,566,600	46,700	375,546
PETERSBURG	782.00	1,116.05	3,794,570	90,000	3,884,570	225,246,500	675,740	3,208,830
PRIBILOF	211.00	582.96	1,982,064	63,000	2,045,064		0	2,045,064
SITKA	1,750.00	2,184.00	7,425,600	225,000	7,650,600	583,301,700	1,749,905	5,900,695
SKAGWAY	130.00	284.36	966,824		966,824	126,841,600	338,388	628,436
SOUTHEAST	264.00	737.63	2,507,942	47,250	2,555,192		0	2,555,192
SOUTHWEST	738.00	1,914.26	6,508,484	29,700	6,538,184		0	6,538,184
ST. MARYS	140.00	384.97	1,308,898		1,308,898	4,448,700	13,346	1,295,552
TANANA	100.00	294.57	1,001,538		1,001,538	5,900,100	17,700	983,838
UNALASKA	375.00	925.07	3,145,238	29,700	3,174,938	351,372,100	1,054,116	2,120,822
VALDEZ	900.00	1,375.13	4,675,442	141,750	4,817,192	953,915,450	1,686,017	3,131,175
WRANGELL	525.00	756.62	2,572,508	67,500	2,640,008	133,739,200	401,218	2,238,790
YAKUTAT	174.00	384.42	1,307,028	76,950	1,383,978	32,101,900	96,305	1,287,672
YUKON FLATS	462.00	1,551.53	5,275,202		5,275,202		0	5,275,202
YUKON/KOYUKUK	552.00	1,722.51	5,856,534	151,650	6,008,184		0	6,008,184
YUPIIT	456.00	980.50	3,333,700	29,700	3,363,400		0	3,363,400
ACS	1,669.86	2,003.83	6,813,022	0	6,813,022		0	4,428,464
MEHS	285.00	478.80	1,627,920	0	1,627,920		0	1,627,920
TOTALS	128,119.89	191,345.68	$650,575,312	$29,535,750	$680,111,062	$43,367,419,810	$98,290,190	$579,436,314
	Level I Student Allocation		$3,400					

Year 1 1998 - CS SS HB 148
100% Hold Harmless
Student allocation $3,400
Req. Local @ 3 mills

	Proposed Total State/Local	Existing Total State/Local	State/Local Difference Proposed less Existing	AS 14.17 Proposed HB 148 State Aid	AS 14.17 & .09 Existing Formula projected State Aid	Change in State Aid
ALASKA GATEWAY	5,771,740	5,771,740	0	5,711,740	5,711,740	0
ALEUTIAN REGION	773,299	773,299	0	768,249	768,249	0
ALEUTIANS EAST	4,517,068	4,517,068	0	3,801,968	3,801,968	0
ANCHORAGE	279,957,881	279,957,881	0	194,503,463	194,503,463	0
ANNETTE ISLANDS	2,576,166	1,834,264	741,902	2,526,166	1,784,264	741,902
BERING STRAIT	18,231,141	18,231,141	0	17,200,141	17,200,141	0
BRISTOL BAY	3,574,780	3,281,239	293,541	2,395,661	2,102,120	293,541
CHATHAM	2,781,240	2,736,944	44,296	2,741,240	2,696,944	44,296
CHUGACH	1,893,397	1,893,397	0	1,872,397	1,872,397	0
COPPER RIVER	6,627,803	6,627,803	0	6,542,803	6,542,803	0
CORDOVA	3,702,679	3,702,679	0	2,936,382	2,936,382	0
CRAIG	2,938,945	2,938,945	0	2,572,117	2,572,117	0
DELTA/GREELY	5,589,169	5,589,169	0	5,540,169	5,540,169	0
DENALI	4,051,077	4,051,077	0	3,225,984	3,225,984	0
DILLINGHAM	5,093,724	5,093,724	0	4,279,224	4,279,224	0
FAIRBANKS	99,142,561	99,142,561	0	72,062,561	72,062,561	0
GALENA	2,268,955	2,268,955	0	1,930,422	1,930,422	0
HAINES	3,642,562	3,642,562	0	2,354,107	2,354,107	0
HOONAH	2,663,806	2,663,806	0	2,212,423	2,212,423	0
HYDABURG	1,270,222	1,270,222	0	1,078,255	1,078,255	0
IDITAROD	5,454,647	5,454,647	0	5,349,217	5,349,217	0
JUNEAU	36,417,809	36,417,809	0	22,091,809	22,091,809	0
KAKE	1,794,804	1,794,804	0	1,492,694	1,492,694	0
KASHUNAMIUT	2,357,584	2,357,244	340	2,279,584	2,279,244	340
KENAI	75,872,228	75,872,228	0	48,142,151	48,142,151	0
KETCHIKAN	17,665,366	17,665,366	0	10,365,300	10,365,300	0
KLAWOCK	1,820,059	1,820,059	0	1,693,207	1,693,207	0
KODIAK	18,924,918	18,924,918	0	14,014,888	14,014,888	0
KUSPUK	5,820,204	5,820,204	0	5,710,204	5,710,204	0
LAKE AND PENINSULA	8,135,645	8,135,645	0	6,877,145	6,877,145	0
LOWER KUSKOKWIM	40,567,281	40,567,281	0	39,867,281	39,867,281	0
LOWER YUKON	15,352,190	15,352,190	0	14,977,190	14,977,190	0
MAT-SU	84,767,919	84,767,919	0	64,013,187	64,013,187	0
NENANA	1,804,643	1,804,643	0	1,730,519	1,730,519	0
NOME	6,923,968	6,923,968	0	5,450,503	5,450,503	0
NORTH SLOPE	38,854,261	40,382,357	(1,528,096)	10,764,261	12,292,357	(1,528,096)
NORTHWEST ARCTIC	21,134,063	21,134,063	0	18,099,143	18,099,143	0
PELICAN	671,628	671,628	0	614,834	614,834	0
PETERSBURG	5,317,626	5,317,626	0	3,602,176	3,602,176	0
PRIBILOF	2,062,064	2,056,134	5,930	2,045,064	2,039,134	5,930
SITKA	10,770,514	10,770,514	0	6,673,858	6,673,858	0
SKAGWAY	1,470,594	1,470,594	0	851,641	851,641	0
SOUTHEAST	3,498,604	3,498,604	0	3,423,504	3,423,504	0
SOUTHWEST	8,062,092	8,062,092	0	7,536,092	7,536,092	0
ST. MARY'S	1,619,534	1,619,534	0	1,579,534	1,579,534	0
TANANA	1,449,091	1,449,091	0	1,321,091	1,321,091	0
UNALASKA	3,808,251	3,808,251	0	2,173,304	2,173,304	0
VALDEZ	7,722,421	7,722,421	0	3,982,638	3,982,638	0
WRANGELL	3,843,553	3,843,553	0	2,746,823	2,746,823	0
YAKUTAT	1,854,557	1,854,557	0	1,516,557	1,516,557	0
YUKON FLATS	6,814,646	6,814,646	0	6,447,719	6,447,719	0
YUKON/KOYUKUK	6,907,725	6,907,725	0	6,842,725	6,842,725	0
YUPIIT	4,399,921	4,399,921	0	4,279,034	4,279,034	0
ALYESKA CORRES.	4,428,464	4,022,889	405,575	4,428,464	4,022,889	405,575
Mt. EDGECUMBE	1,708,000	1,708,000	0	1,708,000	1,708,000	0
OTHER	27,245,135	27,245,135	0	27,245,135	27,245,135	0
TOTAL	944,390,224	944,426,736	(36,512)	698,191,948	698,228,460	(36,512)

HB

152

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: February 24, 1997 FURTHER REFERRALS: Finance

Date of Committee Action: 3/27/97

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 152

HOUSE BILL NO. 152 REGULATION OF HOSPICE CARE

"An Act regulating hospice care."

recommends it be replaced with the following committee substitute CS HB 152(HES) [X] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

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

[X] fiscal note(s) A+SS [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
			✓	
			✓	
	✓			
			✓	
	✓			

CHAIR'S SIGNATURE _____

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. HB 152

Revision Date:
Title: Regulating Hospice Care
Sponsor: Ryan
Requestor: House HESS

Dept. Affected: Health and Social Services
BRU: Medical Assistance Admin
Component: Certification & Licensing
COMPONENT SERIAL NO. 245
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL	7.5	8.9	10.4	12.0	13.7	1
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	7.5	8.9	10.4	12.0	13.7	1
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	7.5	8.9	10.4	12.0	13.7	15
1005 GF/Program Receipts						
1037 GF Mental Health						
Other (please specify)						
TOTAL	7.5	8.9	10.4	12.0	13.7	15

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: 10.0

ANALYSIS: (Attach a separate page if necessary)

Bill 98 would require licensure of 5 new hospice facilities outside of Anchorage. These travel costs were arrived at by using FY97 calculations for travel for one surveyor to travel for a 3 day survey to each of these agencies. Additionally, it is expected at least one new initial survey would be expected each year at a cost of about $1,000.00 each. Also, anticipating the increased cost of travel, lodging and car rental we added 5% per year.

Prepared by: Shelbert Larsen
Division: Medical Assistance
Phone: (907)561-8081
Date: 02/25/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 3/5/97

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0-LS0649\F
Lauterbach
3/26/97

CS FOR HOUSE BILL NO. 152( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE RYAN

A BILL

FOR AN ACT ENTITLED

"An Act regulating hospice care."

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

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

Chapter 18. Hospice Care Programs.

Article 1. Licensing of Hospice Programs.

Sec. 18.18.005. Policy declaration. It is the policy of the state that regulation of hospice programs should ensure an appropriate standard of care for hospice clients without unduly burdening the programs with requirements that consume staff time and financial resources that are essential for the delivery of services to hospice clients. In furtherance of this policy, this chapter establishes two sets of standards for hospice programs that recognize the more limited staff time and financial resources available to voluntary hospice programs while requiring all programs to comply with basic minimum program standards.

Sec. 18.18.010. License required. A person, including a partnership, association, or corporation, may not represent itself as a hospice program or operate

a hospice program unless the person, partnership, association, or corporation has obtained a license from the department.

Sec. 18.18.020. Issuance and renewal of license. (a) Upon receiving an application and fee, if any, for a license under this chapter, the department shall issue a license if the applicant meets the applicable requirements of this chapter.

(b) If an applicant under (a) of this section does not meet the applicable requirements but makes continued efforts to comply with them and any noncompliance does not directly affect the safety of clients, the department may issue a temporary or provisional license that is valid for a reasonable period of time, as determined by the department.

(c) A license under this chapter shall be issued in the name of the person, agency, or other entity specified in the application and is not transferable or assignable without the written approval of the department.

(d) The department shall, by regulation, establish the application fee, license fee, length of time that a license is valid, and the standards for license renewal. A license is not renewable during the time it has been suspended or revoked under this chapter.

Sec. 18.18.030. Denial, suspension, or revocation of license. (a) The department may deny a license, reduce a license to a provisional license, or revoke a license if the department finds that the applicant or licensee, as appropriate, or the program director or medical director of the applicant or licensee, as applicable, has

(1) endangered the health, safety, or welfare of a client;

(2) a history of deficiencies in quality of care;

(3) had a license to operate a hospice program suspended or revoked in another licensing jurisdiction for a reason other than failure to pay a licensing fee;

(4) been convicted of operating a hospice program without a license in any jurisdiction;

(5) an insufficient number of staff with the training, experience, or judgment to provide adequate hospice care;

(6) committed fraud, deceit, misrepresentation, or an offense involving dishonesty associated with the license application or with the operation of a hospice

program in any jurisdiction; or

(7) violated this chapter or a regulation adopted under this chapter.

(b) The department may, without a hearing, summarily suspend a license of a hospice program if it finds that the actions or deficiencies of the program have caused, or present an immediate threat of causing, serious injury to a hospice program client. A licensee is entitled to a hearing before the department to appeal the summary suspension within seven days after the order of suspension is issued. A licensee may appeal an adverse decision of the department on an appeal of a summary suspension to the superior court. A summary suspension remains in effect until the department finds that the actions or deficiencies are corrected, the license is revoked, or the licensee is successful in appealing the suspension.

(c) The department may, without a hearing, reduce a hospice license to a provisional license for a period of time established by the department if the department finds that the licensee is temporarily unable to comply with this chapter or is in the process of becoming decertified under the Medicare program but is taking appropriate steps to bring the program into compliance with this chapter or Medicare certification requirements. A licensee is entitled to a hearing before the department to appeal a reduction to a provisional license under this subsection within seven days after the order to reduce the license is issued. A licensee may appeal an adverse decision of the department on an appeal of the order reducing the license to a provisional license to the superior court. A program with a provisional license under this subsection may not accept new clients. If the program fails to correct its deficiencies and does not successfully appeal the order reducing the license to provisional status within the period stipulated in the provisional license, the department shall revoke the license.

Sec. 18.18.040. Right of entry and inspection. A duly designated employee of the department may enter the premises of a hospice program that has applied for a license or who is licensed under this chapter. These employees may inspect documents of the hospice program to determine whether the program is in compliance with this chapter and regulations adopted under this chapter. The right of entry and inspection extends to premises and documents of persons whom the department has reason to believe are operating a hospice program without a license.

Sec. 18.18.100. Requirements for licensure. (a) Except as provided in AS 18.18.200 for volunteer hospice programs, a hospice program shall meet the requirements of this section. If a hospice program meets the requirements of this section and AS 18.18.010 - 18.18.040, the department shall issue a license for the program.

(b) A hospice program shall have a clear mission statement that is consistent with hospice philosophy.

(c) A hospice program shall have at least the following features:

(1) a governing body;

(2) an established set of admission criteria for determining appropriate clients;

(3) a program director;

(4) an interdisciplinary team;

(5) volunteers; and

(6) a medical director.

(d) A hospice program may only provide services to a person if the person

(1) consents to receive those services; and

(2) fits the admissions criteria of the hospice program.

(e) Hospice services shall be delivered in accordance with a care plan approved by the interdisciplinary team regardless of whether the hospice services are provided by hospice program staff or by contractors. The care plan must be reviewed periodically by the interdisciplinary team and revised as needed. The client, and the client's family if the client desires, must be given the opportunity to participate in the development of the care plan and must be informed of the opportunity to attend interdisciplinary team meetings. The interdisciplinary team must consider the need for at least the following services when developing the care plan:

(1) social services;

(2) nursing care;

(3) counseling;

(4) pastoral care;

(5) volunteer visits to provide comfort, companionship, and respite;

(6) bereavement services for at least one year after the death of the person who is terminally ill; and

(7) medical services.

(f) Nursing services provided by a hospice program shall be provided in accordance with a care plan and must be under the direction and supervision of a nurse supervisor. The nurse supervisor shall

(1) develop nursing objectives, policies, and procedures consistent with hospice philosophy;

(2) develop job descriptions for nursing personnel consistent with hospice philosophy;

(3) establish staffing and on-call schedules for nursing staff to ensure the availability of nursing services 24-hours a day, seven days a week; and

(4) develop and implement orientation and training programs for nursing staff.

(g) Before providing a hospice service in a hospice program, a direct service provider shall receive an orientation of at least four hours specific to hospice service. The policy and procedures of the hospice program define the agenda of the hospice orientation program. The hospice program shall document in personnel files that staff members have completed the four-hour orientation. Indirect service volunteers shall be oriented according to program policies. The hospice orientation program must include the following subjects:

(1) hospice philosophy;

(2) personal death awareness;

(3) communication skills;

(4) personnel issues;

(5) identification of hospice resource people;

(6) stress management;

(7) ethics;

(8) stages of dying; and

(9) funeral arrangements.

(h) A hospice program shall provide an educational program that offers a

comprehensive overview of hospice philosophy and hospice care. A minimum of 18 hours of education, received within a one-year period, including four hours of orientation, is required for all direct service providers delivering hospice care. Documentation of completion of this program is transferable from one hospice program to another. The educational program must include the following subjects:

(1) hospice philosophy;

(2) family dynamics;

(3) pain and symptom management;

(4) grief, loss, and transition;

(5) psychological perspectives on death and dying;

(6) spirituality;

(7) communication skills;

(8) volunteer roles; and

(9) multidisciplinary management.

(i) Direct service providers in a hospice program shall complete a minimum of eight hours of continuing education or in-service training each year after the first year, based on date of hire.

(j) A hospice program shall maintain, at a minimum, the following records:

(1) a record for each client that includes copies of the client's care plan, progress notes, assessments, and a description of services provided to the client and the client's family;

(2) minutes of governing body meetings;

(3) all receipts and expenditures; and

(4) training provided to paid staff and volunteers.

(k) A hospice program shall have and follow written policies and procedures governing its operation, including policies relating to confidentiality, training, and admissions.

(l) A person who enters a hospice program shall be given information regarding living wills and durable health care powers of attorney.

(m) The hospice program shall have a functional quality assurance or improvement plan in place that

(1) continually monitors and evaluates the care provided;

(2) identifies issues and potential issues;

(3) proposes and implements improvements; and

(4) reevaluates the care provided to determine if further improvement is possible or needed.

Article 2. Licensing of Volunteer Hospice Programs.

Sec. 18.18.200. Licensing requirements. (a) The department shall issue a license to a volunteer hospice program that complies with this section and with AS 18.18.010 - 18.18.040 and 18.18.100(a), (b), (c) (1) - (3) and (5), (d), (g), and (j) - (l).

(b) A direct service volunteer must

(1) submit a written application;

(2) undergo a screening interview and an interview after training;

(3) attend an 18-hour standard training program;

(4) submit a confidentiality statement in which the volunteer agrees to follow the program's policy regarding confidentiality required by AS 18.18.100(k) and (a) of this section; and

(5) if the volunteer will transport individuals, have proof of auto insurance and a valid driver's license.

(c) Volunteer hospice programs shall develop and maintain policies and procedures that address the following with respect to volunteers in the program:

(1) recruitment, retention, and dismissal;

(2) screening;

(3) orientation;

(4) scope of function;

(5) supervision;

(6) ongoing training and support;

(7) team conferencing;

(8) records of volunteer activities; and

(9) bereavement services.

(d) Volunteer services in a volunteer hospice program must be directed by a

coordinator of volunteer services who shall

(1) implement a direct service volunteer program;

(2) coordinate the orientation, education, support, and supervision of direct service volunteers; and

(3) coordinate the use of direct service volunteers with other hospice staff and community resources.

Article 3. General Provisions.

Sec. 18.18.300. Individual licenses. A program license received under this chapter does not relieve an individual who is an employee, volunteer, or contractor with the licensed hospice program from requirements outside this chapter pertaining to licensure of the individual.

Sec. 18.18.310 Sanctions. A person who violates this chapter commits a civil violation for which a fine not to exceed $100 a day of violation may be assessed by a court.

Sec. 18.18.320. Administrative Procedure Act. Regulations and contested cases under this chapter are governed by AS 44.62 (Administrative Procedure Act).

Sec. 18.18.330. Regulations. The department may adopt regulations to implement this chapter that are consistent with the policy expressed in AS 18.18.005.

Sec. 18.18.390. Definitions. In this chapter,

(1) "bereavement services" means emotional support services related to the death of a family member, which may include counseling, provision of written material, social reorientation, and group support for up to one year following the death of the client who was terminally ill;

(2) "care plan" means a written service delivery plan that the interdisciplinary team, in conjunction with the client, shall develop to reflect the changing care needs of the client;

(3) "client" means the person who is receiving the hospice services;

(4) "department" means the Department of Health and Social Services;

(5) "direct service provider" means employees or volunteers who provide hospice services directly to a client under a hospice program;

(6) "family" means a spouse, primary caregiver, biological relatives,

and individuals with close personal ties to the client;

(7) "governing body" means the entity that establishes policy and is legally responsible for the overall operation of a hospice program;

(8) "hospice philosophy" means a philosophy that is life affirming, recognizes dying as a normal process of living, focuses on maintaining the quality of remaining life, neither hastens nor postpones death, strengthens the client's role in making informed decisions about care, and stresses the delivery of services in the least restrictive setting possible and with the least amount of technology necessary by volunteers and professionals who are trained to help clients with the physical, social, psychological, spiritual, and emotional issues related to terminal illness so that the clients can feel better prepared for the death that is to come;

(9) "hospice program" means a program that provides hospice services;

(10) "hospice services" means a range of interdisciplinary palliative and supportive services provided in a home or at an inpatient facility to persons who are terminally ill and those persons' families in order to meet their physical, psychological, social, emotional, and spiritual needs;

(11) "interdisciplinary team," for a hospice program providing comprehensive services, means a group comprised of at least a primary health care provider, a licensed registered nurse, a social worker, a pastoral or other counselor, and a volunteer coordinator or representative;

(12) "medical director" means a licensed physician who oversees the medical components of hospice services and the interdisciplinary team;

(13) "nurse supervisor" means a licensed registered nurse with education, experience, and training in hospice nursing care who is designated by the program director to oversee nursing services for the hospice program;

(14) "primary health care provider" means the physician or advanced nurse practitioner identified by the client or by the person authorized to make decisions for the client under a durable health care power of attorney;

(15) "program director" means the person designated by the governing body of a hospice program as responsible for the day-to-day operations of the program;

(16) "terminally ill" means that a person has a life expectancy of less

than one year, in the opinion of the person's primary physician or the medical director, and is no longer receiving curative treatment;

(17) "volunteer" means a trained individual who works for a hospice program without compensation;

(18) "volunteer hospice program" means a hospice program that provides all direct patient care at no charge.

WRITTEN Testimony.

Ketchikan Hospice
Po Box 7973
Ketchikan AK 99901
(907) 225-6711
Dara Fruchtnicht, RN

Ketchikan Hospice agrees with the philosophy and intent of Bill # 152.

We believe this bill must adhere to the National Hospice Organization Standards. We believe the bill must take into account Small Communities and their Resources. We need to provide Hospice Service at the "grass Roots" level.

We need to be able to be innovative, flexible and creative in maximizing available Resources and Personnel. We do this in Ketchikan by forming a joint partnership with our Certified/Licensed Home Health Department. We want to be able to continue to provide this unique combination of Services to meet the needs of all our families and provide Service to Hospice families at no charge. We follow NHO guidelines and are in Support of this bill as long as we can continue to meet the needs of our families. We do NO charge for Hospice Services. We are committed to this. We do not want Licensing to increase Administrative Costs. We Run on a Shoe String budget all of it is

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To Ray Brandt	From Dara Fruchtnicht
Co CAL HESS	Co
Dept. Telephone #	Fax #

March 21, 1997

Chairman Bunde and Committee Members,

Due to the very brief time allowed for testimony concerning HB 152, I wish to share my complete comments here My name is Paula McCarron I have been employed with Hospice of Anchorage since 1982

First, I wish to address the concerns expressed by some that this bill would hinder or dissolve the volunteer hospices in our state In fact, it is my belief that the bill provides legitimization of these programs that could lead to increased opportunities for funding More importantly, I believe the bill provides assurance that consumers seeking the help and services of a hospice program in Alaska can be assured of quality and consistency in care.

Like most hospice programs in Alaska and across the country, Hospice of Anchorage grew from the volunteer efforts of concerned community members and health care workers who wanted to create an alternative in caring for terminally ill persons The majority of hospice care then and now is provided to terminally ill persons who wish to remain in their own homes

Since that time, significant change has occurred in the health care system The average length of stay for hospitalized patients currently is 3 - 4 days Hospitals once provided what was known as a "social admission" to alleviate the distress of family members in caring for a dying loved - this is now rarely an option Nursing homes or assisted living homes are not an option as coverage is limited and "out of the reach" of most Alaskans at $3000 a month

Combined with these changes in health care, an aging population and increasing numbers of people living alone translates into a growing need for hospice services HB 152 is primarily a consumer protection act as it ensures a consistent level of standards and quality assurance measures for receiptants of hospice services

Personally, I do not see this bill so much as a regulatory issue but a compassionate and humane response to meeting the needs of terminally ill persons in our state In my work, I often hear patients and families say, "It is not death that I fear It's the journey." I believe HB 152 would help ensure that terminally ill Alaskans and their families would find care and support for that journey

Submitted by

Paula S McCarron

Paula S McCarron
205 E Dimond Blvd #167
Anchorage, Alaska 99515

561 - 5322 w
248 - 6317 h

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To Rep Bunde	From [illegible]
Co HLHES	Co
Dept.	Phone #
Fax # 465-3871	Fax # 353-1261

re: HB 152

HOSPICE & HOME CARE of Juneau

3200 Hospital Dr. Suite 100 ♥ Juneau, Alaska 99801
(907) 463-3113 ♥ FAX 463-3835

March 21, 1997

Hon. Con Bunde, Chair
House HESS
Room #104
State Capitol, Juneau, AK 99801-1182

Dear Representative Bunde:

While I was grateful to have the opportunity to testify in support of House Bill 152, my comments were incomplete because of the lateness of the hour. The following is a brief elaboration of the reasons why I believe it is important for the bill to pass, and remain intact.

The intent of the bill is to prevent just anyone from hanging out a shingle and claiming to provide hospice services. The terminally ill and their families are a vulnerable populatic ı, bearing the emotional and physical burden of facing death. While these people are frequently overwhelmed with their situation, it is an unfortunate reality that there is potential opportunity for companies to make money, and provide less than acceptable services. This bill will help to maintain the integrity and the quality of services provided by hospices through the licensing process.

The bill is well written, and adequately differentiates between voluntary hospices and certified hospices. As the administrator of a voluntary hospice, I do not believe that the bill is too restrictive, or puts too much administrative or financial burden on voluntary hospices. I believe that these are *minimum* standards which every agency calling themselves a hospice is ethically obligated to meet to ensure quality of care for its clients.

I encourage you to pass the bill, as it is written, in order for all terminally ill persons in Alaska to be guaranteed high quality hospice care.

Sincerely,

Ritchie Sonner
Executive Director

Alaska State Legislature

House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR & COMMERCE
MILITARY & VETERANS AFFAIRS
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Representative Joe Ryan

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MEMORANDUM

TO: Rep. Con Bunde, Chairman
House Hess Committee

FROM: Rep. Joe Ryan JR

DATE: March 20, 1997

IN RE: revised sectional analysis of CS For HB 152 (work draft)

A revised summary by section of CS For HB 152 follows. This bill adds a new chapter, entitled Hospice Care Programs, to Title 18 of Alaska Statutes.

Please note that a sectional analysis is not generally considered to be the most authoritative interpretation of a bill; the bill itself is the best statement of its purposes and effects.

Section 1 remains CS For HB 152 only section. It adds Chapter 18 to Title 18 of Alaska Statutes. Chapter 18 contains three articles, the first of which sets out standards for certified, professional hospice programs. Article II establishes a shorter set of standards for volunteer hospice programs. Article III clarifies individual licensing requirements and defines a number of terms germane to the regulation of hospice care. An analysis of each of these three articles follows.

1. *Article 1* sets out parameters for licensing certified hospice programs and mandates that all hospice programs must be licensed to operate in Alaska. It enables the Department of Health & Social Services (DH&SS) to issue licenses, temporary licenses, and provisional licenses, and to deny, suspend, and revoke such licenses.

Article 1 specifies procedures for license applications, hearings, and modifications of license status, and gives DH&SS the right to enter hospice facilities, to inspect documents and premises.

Article 1 continues by requiring specific regulations a hospice program must meet in order to be licensed, including a mission statement, a governing body, admission criteria, a program director, an interdisciplinary team, volunteers, and a medical director. It requires a hospice program to follow admission criteria for potential clients. It mandates that services be provided in accordance with a care plan, and lists services for the interdisciplinary team to consider when crafting a care plan. It states that nursing services must be provided only under a nurse supervisor.

Article 1 ensures that direct service providers will go through orientation before providing hospice services, that they will complete an educational overview of hospice philosophy and care, and that they will then receive continuing education or in-service training over time. It further requires a minimum level of record-keeping and written policies and procedures.

Article 1 necessitates provision of information about 'living wills' and 'durable health care powers of attorney' to hospice clients. It also provides for quality assurance and improvement planning for certified hospice programs.

2. *Article 2* establishes standards for volunteer hospice programs, citing the specific elements of Article 1 that constitute the licensing framework for volunteer operations. These include the first four (4) sections of Article 1 that govern licensing and the licensing process, and specified parts of AS 18.18.100. It requires volunteer hospice programs to have a minimum structure that includes a mission statement, admission criteria, a director, and volunteers.

Article 2 applies the same standards regarding client consent and use of admission criteria to volunteer hospice programs as to certified ones. It calls for volunteer direct service providers to get four (4) hours of hospice service orientation. It mandates minimum record-keeping and written policies and procedures for volunteer hospice organizations, specifically volunteer policies and procedures. It necessitates provision of information about living wills and durable health care powers of attorney to volunteer hospice clients. Finally, it standardizes the co-ordination of volunteers.

3. *Article 3* specifies that certified or volunteer hospice program licensing does not remove or mitigate individual licensing requirements from any employee, volunteer, or contractor working with a hospice program. It allows for civil penalties for violations of Chapter 18. It makes the licensing process and regulations subject to the Administrative Procedures Act. Finally, *Article 3* defines numerous terms used throughout the bill.

0-LS0649\B
Lauterbach
3/12/97

CS FOR HOUSE BILL NO. 152( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE RYAN

A BILL

FOR AN ACT ENTITLED

"An Act regulating hospice care."

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

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

Chapter 18. Hospice Care Programs.

Article 1. Licensing of Hospice Programs.

Sec. 18.18.010. License required. A person, including a partnership, association, or corporation, may not represent itself as a hospice program or operate a hospice program unless the person, partnership, association, or corporation has obtained a license from the department.

Sec. 18.18.020. Issuance and renewal of license. (a) Upon receiving an application and fee, if any, for a license under this chapter, the department shall issue a license if the applicant meets the applicable requirements of this chapter.

(b) If an applicant under (a) of this section does not meet the applicable requirements but makes continued efforts to comply with them and any noncompliance does not directly affect the safety of clients, the department may issue a temporary or

provisional license that is valid for a reasonable period of time, as determined by the department.

(c) A license under this chapter shall be issued in the name of the person, agency, or other entity specified in the application and is not transferable or assignable without the written approval of the department.

(d) The department shall, by regulation, establish the application fee, license fee, length of time that a license is valid, and the standards for license renewal. A license is not renewable during the time it has been suspended or revoked under this chapter.

Sec. 18.18.030. Denial, suspension, or revocation of license. (a) The department may deny a license, reduce a license to a provisional license, or revoke a license if the department finds that the applicant or licensee, as appropriate, or the program director or medical director of the applicant or licensee, as applicable, has

(1) endangered the health, safety, or welfare of a client;

(2) a history of deficiencies in quality of care;

(3) had a license to operate a hospice program suspended or revoked in another licensing jurisdiction for a reason other than failure to pay a licensing fee;

(4) been convicted of operating a hospice program without a license in any jurisdiction;

(5) an insufficient number of staff with the training, experience, or judgment to provide adequate hospice care;

(6) committed fraud, deceit, misrepresentation, or an offense involving dishonesty associated with the license application or with the operation of a hospice program in any jurisdiction; or

(7) violated this chapter or a regulation adopted under this chapter.

(b) The department may, without a hearing, summarily suspend a license of a hospice program if it finds that the actions or deficiencies of the program have caused, or present an immediate threat of causing, serious injury to the public health, safety, or welfare. A licensee is entitled to a hearing before the department to appeal the summary suspension within seven days after the order of suspension is issued. A licensee may appeal an adverse decision of the department on an appeal of a summary

suspension to the superior court. A summary suspension remains in effect until the department finds that the actions or deficiencies are corrected, the license is revoked, or the licensee is successful in appealing the suspension.

(c) The department may, without a hearing, reduce a hospice license to a provisional license for a period of time established by the department if the department finds that the licensee is temporarily unable to comply with this chapter or is in the process of becoming decertified under the Medicare program but is taking appropriate steps to bring the program into compliance with this chapter or Medicare certification requirements. A licensee is entitled to a hearing before the department to appeal a reduction to a provisional license under this subsection within seven days after the order to reduce the license is issued. A licensee may appeal an adverse decision of the department on an appeal of the order reducing the license to a provisional license to the superior court. A program with a provisional license under this subsection may not accept new clients. If the program fails to correct its deficiencies and does not successfully appeal the order reducing the license to provisional status within the period stipulated in the provisional license, the department shall revoke the license.

Sec. 18.18.040. Right of entry and inspection. A duly designated employee of the department may enter the premises of a hospice program that has applied for a license or who is licensed under this chapter. These employees may inspect documents of the hospice program to determine whether the program is in compliance with this chapter and regulations adopted under this chapter. The right of entry and inspection extends to premises and documents of persons whom the department has reason to believe are operating a hospice program without a license.

Sec. 18.18.100. Requirements for licensure. (a) The department shall adopt regulations that specify the requirements for licensure under this chapter. The regulations must include the requirements of this section for hospice programs that are not volunteer hospice programs.

(b) A hospice program shall have a clear mission statement that is consistent with hospice philosophy.

(c) A hospice program shall have at least the following features:

(1) a governing body;

(2) an established set of admission criteria for determining appropriate clients;

(3) a program director;

(4) an interdisciplinary team;

(5) volunteers; and

(6) a medical director.

(d) A hospice program may only provide services to a person if the person

(1) consents to receive those services; and

(2) fits the admissions criteria of the hospice program.

(e) Hospice services shall be delivered in accordance with a care plan approved by the interdisciplinary team regardless of whether the hospice services are provided by hospice program staff or by contractors. The care plan must be reviewed periodically by the interdisciplinary team and revised as needed. The client, and the client's family if the client desires, must be given the opportunity to participate in the development of the care plan and must be informed of the opportunity to attend interdisciplinary team meetings. The interdisciplinary team must consider the need for at least the following services when developing the care plan:

(1) social services;

(2) nursing care;

(3) counseling;

(4) pastoral care;

(5) volunteer visits to provide comfort, companionship, and respite;

(6) bereavement services for at least one year after the death of the person who is terminally ill; and

(7) medical services.

(f) Nursing services provided by a hospice program shall be provided in accordance with a care plan and must be under the direction and supervision of a nurse supervisor. The nurse supervisor shall

(1) develop nursing objectives, policies, and procedures consistent with hospice philosophy;

(2) develop job descriptions for nursing personnel consistent with

hospice philosophy;

(3) establish staffing and on-call schedules for nursing staff to ensure the availability of nursing services 24-hours a day, seven days a week; and

(4) develop and implement orientation and training programs for nursing staff.

(g) Before providing a hospice service in a hospice program, a direct service provider shall receive an orientation of at least four hours specific to hospice service. The policy and procedures of the hospice program define the agenda of the hospice orientation program. The hospice program shall document in personnel files that staff members have completed the four-hour orientation. Indirect service volunteers shall be oriented according to program policies. The hospice orientation program must include the following subjects:

(1) hospice philosophy;

(2) personal death awareness;

(3) communication skills;

(4) personnel issues;

(5) identification of hospice resource people;

(6) stress management;

(7) ethics;

(8) stages of dying; and

(9) funeral arrangements.

(h) A hospice program shall provide an educational program that offers a comprehensive overview of hospice philosophy and hospice care. A minimum of 18 hours of education, received within a one-year period, including four hours of orientation, is required for all direct service providers delivering hospice care. Documentation of completion of this program is transferable from one hospice program to another. The educational program must include the following subjects:

(1) hospice philosophy;

(2) family dynamics;

(3) pain and symptom management;

(4) grief, loss, and transition;

(5) psychological perspectives on death and dying;

(6) spirituality;

(7) communication skills;

(8) volunteer roles; and

(9) multidisciplinary management.

(i) Direct service providers in a hospice program shall complete a minimum of eight hours of continuing education or in-service training each year after the first year, based on date of hire.

(j) A hospice program shall maintain, at a minimum, the following records:

(1) a record for each client that includes copies of the client's care plan, progress notes, assessments, and a description of services provided to the client and the client's family;

(2) minutes of governing body meetings;

(3) all receipts and expenditures; and

(4) training provided to paid staff and volunteers.

(k) A hospice program shall have and follow written policies and procedures governing its operation, including policies relating to confidentiality, training, and admissions.

(l) A person who enters a hospice program shall be given information regarding living wills and durable health care powers of attorney.

(m) The hospice program shall have a functional quality assurance or improvement plan in place that

(1) continually monitors and evaluates the care provided;

(2) identifies issues and potential issues;

(3) proposes and implements improvements; and

(4) reevaluates the care provided to determine if further improvement is possible or needed.

Article 2. Licensing of Volunteer Hospice Programs.

Sec. 18.18.200. Licensing requirements. (a) A volunteer hospice program must comply with this section and with AS 18.18.010 - 18.18.040 and 18.18.100(a), (b), (c) (1) - (3) and (5), (d), (g), and (j) - (l).

(b) At a minimum, a direct service volunteer must

(1) submit a written application;

(2) undergo a screening interview and an interview after training;

(3) attend an 18-hour standard training program;

(4) submit a confidentiality statement in which the volunteer agrees to follow the program's policy regarding confidentiality required by AS 18.18.100(k) and (a) of this section; and

(5) if the volunteer will transport individuals, have proof of auto insurance and a valid driver's license.

(c) Volunteer hospice programs shall develop and maintain policies and procedures that address the following with respect to volunteers in the program:

(1) recruitment, retention, and dismissal;

(2) screening;

(3) orientation;

(4) scope of function;

(5) supervision;

(6) ongoing training and support;

(7) team conferencing;

(8) records of volunteer activities; and

(9) bereavement services.

(d) Volunteer services in a volunteer hospice program must be directed by a coordinator of volunteer services who shall

(1) implement a direct service volunteer program;

(2) coordinate the orientation, education, support, and supervision of direct service volunteers; and

(3) coordinate the use of direct service volunteers with other hospice staff and community resources.

Article 3. General Provisions.

Sec. 18.18.300. Individual licenses. A program license received under this chapter does not relieve an individual who is an employee, volunteer, or contractor with the licensed hospice program from requirements outside this chapter pertaining

to licensure of the individual.

Sec. 18.18.310 Sanctions. A person who violates this chapter commits a civil violation for which a fine not to exceed $100 a day of violation may be assessed by a court.

Sec. 18.18.320. Administrative Procedure Act. Regulations and contested cases under this chapter are governed by AS 44.62 (Administrative Procedure Act).

Sec. 18.18.390. Definitions. In this chapter,

(1) "bereavement services" means emotional support services related to the death of a family member, including counseling, provision of written material, social reorientation, and group support for up to one year following the death of the client who was terminally ill;

(2) "care plan" means a written service delivery plan that the interdisciplinary team, in conjunction with the client, shall develop to reflect the changing care needs of the client;

(3) "client" means the person who is receiving the hospice services;

(4) "department" means the Department of Health and Social Services;

(5) "direct service provider" means employees or volunteers who provide hospice services directly to a client under a hospice program;

(6) "family" means a spouse, primary caregiver, biological relatives, and individuals with close personal ties to the client;

(7) "governing body" means the entity that establishes policy and is legally responsible for the overall operation of a hospice program;

(8) "hospice philosophy" means a philosophy that is life affirming, recognizes dying as a normal process of living, focuses on maintaining the quality of remaining life, neither hastens nor postpones death, strengthens the client's role in making informed decisions about care, and stresses the delivery of services in the least restrictive setting possible and with the least amount of technology necessary by volunteers and professionals who are trained to help clients with the physical, social, psychological, spiritual, and emotional issues related to terminal illness so that the clients can feel better prepared for the death that is to come;

(9) "hospice program" means a program that provides hospice services;

(10) "hospice services" means a range of interdisciplinary palliative and supportive services provided in a home or at an inpatient facility on a 24-hours-a-day, seven-days-a-week basis to persons who are terminally ill and those persons' families in order to meet their physical, psychological, social, emotional, and spiritual needs;

(11) "interdisciplinary team," for a hospice program providing comprehensive services, means a group comprised of at least a primary health care provider, a licensed registered nurse, a social worker, a pastoral or other counselor, and a volunteer coordinator or representative;

(12) "medical director" means a licensed physician who oversees the medical components of hospice services and the interdisciplinary team;

(13) "nurse supervisor" means a licensed registered nurse with education, experience, and training in hospice nursing care who is designated by the program director to oversee nursing services for the hospice program;

(14) "primary health care provider" means the physician or advanced nurse practitioner identified by the client or by the person authorized to make decisions for the client under a durable health care power of attorney;

(15) "program director" means the person designated by the governing body of a hospice program as responsible for the day-to-day operations of the program;

(16) "terminally ill" means that a person has a life expectancy of less than one year, in the opinion of the person's primary physician or the medical director, and is no longer receiving curative treatment;

(17) "volunteer" means a trained individual who works for a hospice program without compensation;

(18) "volunteer hospice program" means a hospice program that provides all direct patient care at no charge.

Alaska State Legislature

House of Representatives

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Representative Joe Ryan

1-800-922-3875 http://www.akrepublicans.org

CS FOR House Bill NO. 152 (Work Draft)
SPONSOR STATEMENT

CS For House Bill 152 will provide for licensing of hospice care programs in Alaska, ensuring that terminally ill persons receive comfort, support, and care consistent with hospice philosophy and concepts through a uniform level of services. There is no federal regulation or licensing requirements for either certified or volunteer hospice programs. As of the January 1997, forty (40) states are licensing or regulating hospice programs. Of the ten (10) states without hospice licensing, five (5) have laws or regulations pending. The licensing and appropriate regulation of volunteer and certified hospice programs in Alaska will assure consumers of consistent standards in the delivery of hospice services.

Hospice is a unique component of the health care delivery system, one that has evolved over the past 20 years in the United States. Hospice provides care and support for people with terminal illness. The goal of hospice care is to enable patients to live an alert, pain-free life and to manage symptoms so the last weeks and months of life may be spent in dignity and peace. One out of every three people who die of cancer or AIDS in this country are served by a hospice program.

Annual growth in hospice programs averaged about eight per cent (8%) in the early '90s. In the last five (5) years growth has averaged seventeen per cent (17%). Hospice services are provided through a variety of means, including independent community-based organizations, divisions of hospitals or home-health services, and government agencies. Rapid growth of hospice programs is due to increased demand for home care services, the desire of terminally ill persons to keep control over the remainder of their lives, and a trend towards reimbursement for home-care services. ***Consumers need to be aware of specific characteristics that differentiate hospice from other health care providers. Hospice offers comfort and care, not curative treatment.*** Hospice addresses emotional, spiritual, and social needs in addition to physical needs. Hospice considers the patient and loved ones as the unit of care. ***Hospice affirms life and regards dying as a normal process, seeking neither to hasten nor postpone death.*** Hospice care extends beyond a patient's death to include bereavement care for grieving family members.

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Fear of painful suffering, of abandonment, and of losing control are primary concerns of people experiencing terminal illness. Hospice care is designed to address these concerns by providing support, care, and needed services to help the terminally ill live their lives in maximal comfort and control.

Passage of House Bill 152 will standardize hospice care guarantee the Alaskan public the opportunity to access quality hospice care.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

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Passage of CS For House Bill 152 will standardize hospice care and guarantee the Alaskan public the opportunity to access quality hospice care from both volunteer and certified hospice programs.

(revised March 19, 1997)

Alaska State Legislature

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MEMORANDUM

TO: Rep. Con Bunde, Chairman
House HESS Committee

FROM: Rep. Joe Ryan

DATE: March 18, 1997

RE: sectional analysis of HB 152

A summary, by section, of House Bill 152 follows. This bill adds a new chapter, entitled Hospice Care Programs, to Title 18 of Alaska Statutes. Please note that a sectional analysis is not generally considered to be the most authoritative interpretation of a bill; the bill itself is the best statement of its purposes and effects.

Section 1 is HB 152's only section. It adds Chapter 8 to Title 18 of Alaska Statutes. Chapter 18 contains three articles, each of which pertains to a different aspect of regulating hospice care. An analysis of each of the three articles follows.

1. *Article 1* sets out parameters for licensing of hospice programs. It mandates that any and all hospice programs must be licensed to operate in Alaska. It sets out that the Department of Health & Social Services (DH&SS) can issue licenses and conditional licenses, and can revoke or suspend licenses so issued. It specifies that Medicare-certified hospice programs automatically meet this bill's criteria, and are eligible to receive a state hospice facilities and access their records, although a warrant must obtained if the facility refuses permission to DH&SS.

Article 1 continues by outlining specific requirements a hospice must meet in order to get a license, including a mission statement, a governing body, admission criteria, a program director, an interdisciplinary team, volunteers, and a medical director. It requires a hospice program to adopt admission criteria for potential clients. It mandates that services be provided in accordance with a care plan, and lists services that the interdisciplinary team must consider when crafting a care plan. It sets out that nursing services be provided only under the auspices of a nurse supervisor.

Article 1 provides that direct service providers go through orientation before providing hospice services, requires direct service providers to complete an educational overview of hospice philosophy and care, and mandates continuing education or in-service training over time. It further requires a minimal level of record-keeping and written policies and procedures. *Article 1* necessitates provision of information about living wills and durable health care powers of attorney to hospice clients. Finally, the first article in Chapter 18 of Title 18 mandates quality assurance and improvement planning, and requires Medicare certification of a facility used for an inpatient hospice program as a condition of state licensing.

2. *Article 2* sets out standards for volunteer hospice programs, primarily the things direct service volunteers must do in order to prepare to provide hospice services. It mandates policies and procedures dealing with direct service volunteers, including coordination of such volunteer efforts. *Article 2* also requires volunteer programs to meet the "relevant" requirements of *Article 1*.

3. *Article 3* specifies that program licensing under Chapter 18 of Title 18 does not remove or mitigate individual licensing requirements from any employee, volunteer, or contractor working with a hospice program. It allows for civil penalties for violations of Chapter 18. Finally, *Article 3* defines numerous terms used throughout the bill.

Our Philosophy

Hospice is a philosophy of care for those experiencing the dying and/or bereavement process. Our goal is to allow the patient to die in peace and with dignity, and enable the family to surmount the experience and go forward. The mission of Hospice of the Tanana Valley is: to provide support for people who are dying, their families and loved ones; to provide individual, group, and community support for those who have experienced a loss through death.

Our History and Funding

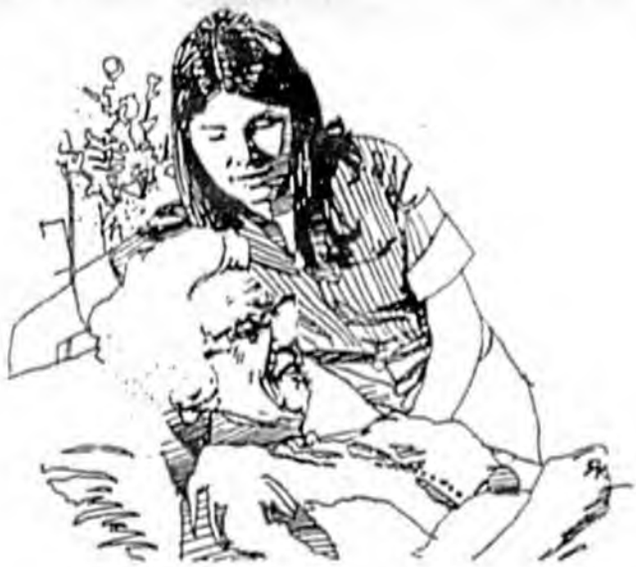
Hospice of the Tanana Valley was incorporated in October, 1986 as a tax-exempt, non-profit corporation. We have been a member of the National Hospice Organization since 1988 and a United Way Member Agency since 1995. We are supported by annual membership dues, lifetime memberships, annual business sponsorships, donations, fund raisers, grants and volunteer time.

Our Services

Hospice of the Tanana Valley coordinates care with other health care agencies and with the patient's physician. Our staff and volunteers care for the terminally ill patients and their families, providing services which may include:

- Short-term respite care
- Emotional support
- Funeral Planning
- Transportation
- Errands and shopping
- Chaplain Referral
- Bereavement counseling

Our staff and volunteers are carefully selected and trained. Arrangements for services, whether in the home or institutional setting, are made on an individual basis depending on the family's needs and the availability of volunteers. Expenses for all our services are paid for by memberships and donations.



Who We Serve

Our care is available to everyone, regardless of age or diagnosis, who:

- Has a terminal illness
- Accepts the principles of hospice care

When To Refer

Referrals are accepted from the patient, the family and loved ones, as well as from physicians, nurses, and other care providers. Hospice can be of great service when there is sufficient time to assess, plan, coordinate, and most importantly establish a relationship of trust with the patient, family, and loved ones. A call to Hospice as early as possible will enable staff to most effectively meet the patient and family needs.

For More Information

If you are in need of our services or if you would like to help through a donation or by becoming a volunteer, call or write:

Hospice of the Tanana Valley
P.O. Box 82770
Fairbanks, AK 99708
Tel: (907) 474-0311
Fax: (907) 452-7643

Caring Thoughts

THE SPIRIT OF HOSPICE

by Diane H. Jones, ACSW

Hospice and home care: two concepts that are as similar as they are different. In fact, when hospice was just getting started, home care providers were apt to say, "What is it that you can do that we haven't already been doing for 100 years—caring for the dying people in their own homes? What makes you think you can do it any different or any better?"

And hospices would reply, "You are the experts in short-term, restorative nursing; your goals are to care for the patient and to return a functioning individual back to the community. We are the experts in terminal care, our goals are to care for the patient and family and to return a functioning family back to the community after the patient has died."

Hospice is a special kind of home care that cares for terminally ill patients and their families in their own homes, in nursing homes, or other inpatient facilities, even on a park bench if that is where the patient happens to be. Hospice services are comprehensive, inclusive, specialized, and compassionate. Nurses, physicians, social workers, home care aides, counselors, chaplains, volunteers, and therapists all form the hospice interdisciplinary team, meeting the patient and family where they are, and caring for them. The interdisciplinary team meets regularly to discuss and update the plan of care for each patient and family. The plan of care includes assessing for nursing, social work, and home care aide visits, spiritual counseling needs, volunteer support, bereavement plans, and medications, supplies, and equipment.

Hospice patients do not have to be homebound, in fact, early admissions give hospice staff and patients and families time to get to know one another. Hospice patients are encouraged to live as fully as possible for as long as they are with the hospice. Stories abound about how hospices are able to help patients fulfill their final wishes by living long enough to celebrate a family wedding, a baby's birth, an anniversary, a last trip, or even just a visit to the community park.

Hospices treat the patient and family as the unit of care, which means the family unit is included in the plan of care. An admission to a hospice program often precipitates a crisis in the family because family members must face the reality that the patient is terminally ill with a limited life expectancy. Denial, grief, anger, bargaining, and acceptance may all be present at different times and with different members of the family. The hospice interdisciplinary team assesses the situation and plans interventions that will support, comfort, and enable them to do the very hard work that lies ahead.

Hospice staff follow patients across all settings of care, providing a comprehensive continuum of care. Patients are usually in their own homes, but there are times when hospital or respite care in an inpatient facility is needed to treat the patient's symptoms or the family's fatigue. If a patient is hospitalized, the hospice team visits the patient and works closely with the hospital staff to get him or her home as quickly as possible. The hospice nurse communicates frequently with the patient's physician to ensure that the patient's wishes are honored in terms of treatments and procedures. Respite care gives family members a break—time to renew themselves for a short period before resuming their roles as primary caregivers.

The specialness and spirit of hospice is exemplified through trained volunteers who devote their time and talents in many ways. Volunteers, often referred to as the backbone of hospice, find innovative and creative ways to fulfill a patient's last wishes, whether it is as adventuresome as taking the patient on one last sailing trip or as quiet as sitting by the bedside of a patient who doesn't want to die alone.

Hospice families continue to be cared for by the hospice even after the patient has died. For up to a year after the death, family members receive support through the mail, by phone, and in person. Hospice staff and volunteers make sure that special occasions, holidays, birthdays, and anniversaries are not forgotten. Hospices know that these are the times when the pain of loss can seem unbearable, when the world stops going around, when comfort and caring of familiar voices and faces provide a way through the pain.

So yes, hospice and home care have much in common. They both provide compassionate care in times of need, they keep families together when they might otherwise be torn apart, and they are an integral and important fabric of the community. They are the same, and they are different.

About the Author: Diane H. Jones, ACSW, is Assistant Director of the Hospice Association of America.

THE CHANGING FACE OF

INTERVIEW WITH IRA BYOCK, MD

Ira Byock has been involved in hospice care for more than 15 years. He currently is hospice medical director of Partners in Home Care, as well as director of The Palliative Care Service, both located in Missoula, Montana. A founding member of the Academy of Hospice Physicians (AHP), Byock serves on the academy's board of directors and is chair of the AHP Ethics Committee.

Byock was the featured speaker at the Hospice Association of America's annual meeting in San Francisco this past October, where he spoke on maintaining ethical responsibility in a managed care environment.

CARING is honored to have had the chance to speak with him earlier this fall. His thoughts, presented in this interview, cap this issue on hospice care and set the industry on the path for future thought and care.

Q What do you see as the ethical issues for hospice in a managed care delivery system?

A Our health care system is changing rapidly in a number of ways, changing in different ways and at different paces as the country experiments with a variety of regional delivery systems. Several trends are strongly indicated: one is integration of systems, the other is managed care.

In a sense hospice has more experience with managed care than perhaps any other segment of the health care system. For years hospice has dealt with prospective payment through the Medicare hospice benefit and similar payer systems; gradually hospice has emerged as a specialized managed care system. So we have considerable experience with providing care in a cost-effective manner, and with looking at outcome measures. It's not quite clear what the impact on hospice or palliative care will be by the adoption of a managed care model in the larger health care system. There is both opportunity and considerable danger.

The dangers first. Proprietary managed care companies at present have the sense that hospice is something toward which modern consumers of care are favorably disposed; this, in turn, gives companies a positive predisposition toward hospice care. But at present there is little real understanding by leadership in managed care organizations of what hospice is. Currently, hospice is reimbursed as a full. Managed care leadership does understand that a financial advantage of hospice is in keeping people out of the hospital. The real danger of hospice being incorporated into the larger managed care model is that it may be unbundled into component parts, with almost exclusive emphasis on the skilled nursing visit.

Hospice is by definition an interdisciplinary team approach to care for persons and their families who are encountering life-threatening illness. It is cost effective. A recent Lewin-VHI study confirmed that hospice saves $1.52 for every Medicare dollar spent on hospital

services for every last year in a cancer patient's life. (Lewin-VHI, Inc. 1995) It is important that we have an entire team to provide services such as patient and family education and comprehensive management. And not to stop there, hospice follows through with bereavement counseling.

All that is an essential part of hospice service. The concern is that managed care companies will use the label "hospice" and provide skilled nursing visits just to reduce hospitalizations. That is short-sighted, and will prove fiscally self-defeating as well as damaging to the goals and fundamental principles that give hospice its identity and real value. When Medicare and Medicaid certification waivers are given to enable managed care organizations to explore innovative delivery models under capitated payment arrangements and cradle-to-grave coverage, those organizations—not existing certification standards—will determine what is paid for and what personnel and resources are available. They may not have the same standards that hospice currently embodies.

So there is reason both theoretically and on a concrete level to be concerned. Hospice does face a number of challenges in a managed care environment. First, from bureaucracy, which has a legitimate need to have outcome measures that are reliable, reproducible, and that measure something meaningful. Second, hospice faces challenges from others within the health care system that are profit motivated and that would like to claim the label of hospice without preserving its essence. The third challenge comes from within the clinical practice of hospice care. In addition to the real, ongoing challenge of improving our ability to control symptoms, hospice currently lacks sufficient clinical specificity in the psychosocial realm. This inhibits our ability to relieve suffering that is not strictly physical but is primarily psychological, emotional, or spiritual.

When hospice providers talk about the management of pain, we are very specific, detailing the various pathophysiological causes and pharmacological means of intervention. But when someone is suffering in the psychosocial realm, too often the care plan includes "psychosocial support," meaning we send in a pastor or social worker. They function to provide support on an intuitive level. Too often I hear, "The patient still has work to do." We can sense intuitively what that means, but it is unacceptable to managed care organizations or to the health care financing bureaucracy for hospice to be that nonspecific. Unless we can effectively communicate what it is we're doing, they won't let us do it for very much longer.

Bureaucracy has a legitimate need for outcome measures in the health care system. If we are to be as clinically effective in the psychosocial realm as we are in the symptomatic realm, we need to define and be more specific about what we do. For instance, the written goals of hospice often include treatment of symptoms and provision of adequate psychosocial support and attention to preserving quality of life. I would submit that even the phrase "quality of life" is woefully nonspecific and insufficient. Auditors of the future—who may not have the same "hospice spirit" and who have had little hands-on hospice experience—may look at our records and consider retroactively allowing counseling services of a social worker or hospice chaplain. Similarly, managed care systems may assert, "Of course we do hospice, we control symptoms." Hospice as a discipline must be able to develop meaningful and measurable outcomes and must choose a therapeutic model and language to talk about what it is that we do that is beyond symptom management. This model and language can provide a basis for meaningful research in the psychosocial realm. All these areas are things that have been as yet inadequately attended to. They are areas of much-needed development within the clinical discipline and the emerging "industry" of hospice.

GROWING TOGETHER: Managed care companies need to be educated to understand that hospice is more than symptom management and pain control. Hospice offers the chance for individuals and families to learn and grow together.

Photo by Wendy Ashton

Q Are managed care organizations saying that symptom management is hospice?

A Too often hospice care is equated with symptom management. I see the terms "comfort care" and "hospice-like care" used all the time. Hospice goes beyond symptom management; that's what separates it from the best of traditional health care for the terminally ill. I have come to believe that what distinguishes hospice from the most comprehensive symptom management is that hospice inherently recognizes a role in preserving the opportunity for the person and family to grow even at the end of life.

So often in clinical practice we have the privilege of witnessing people paradoxically expressing

a sense of wellness, even as they are dying. Anecdotal personal experience and collective clinical experience confirm that if symptoms are managed and there is adequate basic support for the patient and family, opportunity is preserved, allowing people to grow—inwardly and together—even as life wanes.

We were all taught in our college psychology classes and our early childhood development classes and in the behavioral medicine component of pediatrics or family practice that human development can be a lifelong process. We in hospice have simply confirmed that even as they die people can indeed change in ways that prove deeply meaningful and important to them.

However, having said all this, I also recognize that "hospice" is just a word. As ardent a proponent as I am for hospice care, it will matter little to me if the word goes away, as long as the health care system embodies a real commitment to preserve and even gently nurture the opportunities for the person and family that lie within the process of dying. That's a tall order, but if a managed care system can embrace those values, then the future of end-of-life care is very positive.

We're at a critical time right now. Hospice has a small window of opportunity, I would guess no more than a few years, in which to articulate very clearly, through a model that is secular and that does not rely on religious or overly spiritual terms, that dying is a profound personal experience for individuals and families. As care providers we must approach care as more than a set of medical problems to be solved, although it includes this. If we can incorporate specific language within our national professional standards and within each of our programs' mission statements and guiding principles that refers to preservation of opportunity for patients and families, there is a hope of bringing these values forward as the health care system is transformed.

However, if we are simply worried about continued existence of our own individual organizations in our own communities we will make compromises of quality and sacrifice the essence of hospice care for the continuation of something that carries a sham hospice label.

Q How can we address the national conscience so that its essence is brought forward?

A The Hospice Association of America and the National Hospice Organization have to be specific in writing professional standards that define hospice as more than symptom management. We must emphasize the potential for subjective value and importance in this time of life called dying, and acknowledge openly that hospice care seeks to preserve opportunity within the dying experience.

Nowadays health care trend writers often note that baby boomers are beginning to confront their own limited life expectancy. We "boomers" are the generation that rejected the notion that health as the absence of illness. This generation talks about health in terms of living fully and in peak performance. I think it is no longer comical or antithetical to speak of wellness in dying. If the most emotionally robust people among us will eventually die, there must be some meaning to the idea of dying well. In dying well a person has a chance to change in ways that are valuable to them: things like completing one's most important relationships, or achieving an increased sense of meaning about one's life or about life in general. For some, dying well includes coming to some peace about lifelong expectations and frustrations and having the opportunity to explore life's deepest questions.

Q Is it the health care bureaucracy or the public that doesn't yet look at dying this way?

A The culture in general does not think of dying this way. The words dying and death are often used interchangeably. They are not synonymous. Life does not actually end upon receiving a terminal diagnosis. In reality death is the opposite of life; yet dying is part of living.

I have stopped using the phrase "good death." For one thing, I have yet to meet anyone who knows anything about death. And for another, the idea of a "good death" sounds too formulaic, as if one could carefully follow strict instructions and ensure a preconceived, positive outcome. Today the notion of a good death is usually described in terms of what people don't want to have happen: people don't want to die in pain, don't want to be a burden emotionally, physically, or financially to their families. This is like a photographic negative: it only conveys what we want to avoid. We in hospice have a responsibility to contribute color, tone, and texture to that image of dying well. It's a very real experience. It's not fun and need not be easy but so many of the most important and valuable experiences of life are neither.

The idea of personal growth is helpful here. If you look at what stimulates growth in any person's life—times of crisis, of profound change—these times are rarely easy or pretty. People emerge from those periods feeling enlarged, feeling a sense of wellness. That is what I've repeatedly observed in people who are helped through this time of life.

Only now is the health care system starting to be able to accept this idea.

Q Is the US having a harder time than other cultures?

Photo by Mario Piperni

WINDOW OF OPPORTUNITY: The hospice community has the chance now to educate managed care about the holistic benefits of hospice; it also has a chance to develop into the continuum of care, beginning with palliative care.

A Not inherently. Baby boomers are leading the way; they show a real openness to concepts of wellness that are different from their parents' generation.

However, in the area of financing care for persons at the end of life, the US is certainly in a particular state of crisis. Many people worry about and suffer from financial burdens directly related to health care. It is an artificial source of suffering, people fearing that they are going through their savings and leaving their families with debt. Currently Americans tend to think that financial devastation is a universal problem for the dying. They're surprised when I point out that health care systems the world over do not routinely add money woes to the worries of the terminally ill. People in the UK, for instance, do not have medically caused financial worries complicating their end of life experience. So we have some education to do. I would hope that the new health care system—whatever emerges—will address this in a way that the current system has not.

Q You have noted that hospice will have to be creative with how it provides care. In what aspect—clinical care, reimbursement, how hospices are organized? What are some examples?

A Hospice will have to be very creative. In the future it will be less important to think of hospice as a single delivery model. We should look at it in several ways. The British, for example, are now talking about a three-tiered approach to palliative care. At the apex of the system are regional academic research and training centers of palliative care. Secondly, within most communities are hospice programs that serve as local centers of expertise and can provide consultation to patients' physicians as well as providing direct patient care when necessary.

A third tier focus of palliative care lies within general health care education where an increasingly strong component of palliative medicine is required because end-of-life care is a component of basic health care and should, therefore, pervade the health care system.

This may prove a good model for this side of the Atlantic as well. We should incorporate the fundamentals of effective symptom management as well as acknowledging the poignant, personal nature of dying throughout professional health education and practice. Neither the health care setting, nor what the program of care is called, is as important as the quality of the experience for each person and family.

Q You sounded almost pessimistic in talking about the future of hospice. Is that an accurate reading? Why is that? Should others be pessimistic? What do you suggest industry members do to re-inject optimism into the idea/heart of hospice?

A We're in a time of real danger, but also a time of enormous opportunity. Remember that hospice has been demonstrated to be cost effective; thus, win-win opportunities abound! I think we have a window of opportunity to educate the health care leadership as well as the general public in the core values of hospice, in the essence of what enlightened care at the end of life is, and what lies beyond symptom management. Hospice needs not only to tout the cost benefits of its care, but also to demystify the notion of dying well and clearly acknowledge that this time of life encompasses more than merely waiting for death to come. If we incorporate this appreciation into written program and practice standards and into the mission statements of various community health care organizations, we have a real chance of doing something extremely important and lasting for this country and the American culture.

The discipline of hospice care faces crucial challenge in the new health care environment. I am reminded of something Carl Jung wrote years ago: "...the greatest and most important problems of life are fundamentally insoluble... They can never be solved, but only outgrown."

Like a person who faces perilous challenges in life, I am hopeful that hospice will find a way to grow through this new set of challenges. □

Further Reading

Jung, C., Introduction to *The Secret of the Golden Flower*

An Analysis of the Cost Savings of the Medicare Hospice Benefit. Prepared by Lewin-VHI, Inc. for The National Hospice Organization, May 2, 1995

NEWSPAPER ARTICLE

Hospice to bring comfort to scene of death

By SARANA SCHELL
Fairbanks Daily News-Miner

FAIRBANKS — As a funeral director, Mike Hawkins was often the last to leave the scene of a death.

Years ago, as he was about to leave the home of a man whose wife had just committed suicide, he looked back. He knew it would be several hours before the man's family would arrive.

"I saw that elderly man standing on his porch in a bloodied robe, and I couldn't leave him. I just couldn't," Hawkins said. He went back and called a minister friend to come wait with the man.

Hawkins has called other ministers over the years to comfort people left alone by death. The ministers would come, but they had no training in crisis intervention. He was sure the service could be provided in a less haphazard way.

Then, last summer, a call to Hospice of the Tanana Valley became the catalyst for a team of first responders — the Emergency Grief and Bereavement Response Team — who will comfort people who have suddenly lost a loved one.

"A tour company called us to say that a couple had been touring in Denali Park, when the man died of a heart attack," said Sally Fenno of Hospice.

Hospice found someone to stay with the woman, who was from the Lower 48, until she could take a plane home, said Fenno, the bereavement services coordinator for Hospice.

At first, Hospice thought the emergency response volunteers for visitors could be an offshoot of longer-term bereavement counseling. But Hawkins, a member of the Hospice board of directors, helped broaden the effort to include regular members of the community.

It became clear there was a need for a separate program.

"Fairbanks has an awful lot of people who have families somewhere else, and a lot of visitors come through," Fenno said. "Many visitors are older."

Hospice is now training volunteers to be part of the Emergency Grief and Bereavement Response Team, on call 24 hours a day. A volunteer can quickly be at a grieving person's side, help them with practical matters such as making phone calls, and wait there until family or close friends show up.

"They may ask, do you have your address book with you? Is there anyone you want me to call?" Fenno said, or even, "Do you want me to dial the number?"

Visitors especially may need help setting up arrangements.

Please see Page B-2, FAIRBANKS

FAIRBANKS: Hospice aims to fill need

Continued from Page B-1

They may not know, for example, what to do with the body before it can be shipped out.

Once the training of volunteers is complete, Hospice will send letters to area hotels, park agencies, fire and police departments and other groups, announcing the service. Hospice will give them a pager number to call, Fenno said.

Sgt. Mike Corkill of the Alaska State Troopers said he looked forward to hearing from Hospice about the program.

"It's our most difficult job to tell people they've lost a loved one," Corkill said. "Although my folks have got some training in dealing with this, and are sensitive to people, Hospice works with this on a regular basis. I can see a lot of good coming from this."

Ingrid Hinde came close to being alone when her husband, Fairbanks newsman Chuck Hinde, died of a heart attack in the middle of a June night in 1995.

"Luckily I had a friend of my husband's in town," Hinde said, "but otherwise I would've been totally stranded."

Now Hinde, a Hospice volunteer, is training to be an emergency bereavement volunteer. The goal is to make a traumatic experience a little less traumatic, she said.

"It's way out on the cutting edge," she said. "There isn't any other program out there like it."

The group is preparing for the coming tourist season, Hinde said, by composing a list of people who speak different languages or who can provide grieving visitors with a short-term place to stay.

HB

153

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: March 17, 1997 FURTHER REFERRALS: Finance

Date of Committee Action: 4/10/97

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 153

HOUSE BILL NO. 153 ALIENS AND ASSISTANCE PROGRAMS

"An Act relating to the eligibility of aliens for state public assistance and medical assistance programs affected by federal welfare reform legislation; and providing for an effective date."

recommends it be replaced [ ] the same title
with the following committee substitute _____ [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

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

[ ] fiscal note(s) _____ [X] fiscal note(s) (3) DH+SS 2/24/97

[ ] zero fiscal note(s) _____ [X] zero fiscal note(s) (2) DH+SS 2/24/97

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
			✓	
			✓	
	✓			
	✓			
	✓			
			✓	

CHAIR'S SIGNATURE Can Bondo

HOUSE COMMITTEE REPORT

3/17/97

(7)
Date Referred to Committee: February 24, 1997

FURTHER REFERRALS: HESS, Finance

Date of Committee Action: 3/15/97

The STATE AFFAIRS Committee considered: HB 153

HOUSE BILL NO. 153 ALIENS AND ASSISTANCE PROGRAMS

"An Act relating to the eligibility of aliens for state public assistance and medical assistance programs affected by federal welfare reform legislation; and providing for an effective date."

recommends it be replaced with the following committee substitute _____ [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

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

[ ] fiscal note(s) _____ (3) [✓] fiscal note(s) (3) DHSS 2/24/97

[ ] zero fiscal note(s) _____ (2) [✓] zero fiscal note(s) (2) DHSS 2/24/97

SIGNING WITH RECOMMENDATIONS		DP	DNP	NR	AM
Jeannette James	James	✓			
K. P. SO	Elton	✓			
Gail Berkowitz	Berkowitz	✓			
Mark Hodgins	Hodgins			✓	
Fred Dyson	Dyson	✓			
Al Vezey	Vezey			✓	
		(4)		(2)	

CHAIR'S SIGNATURE Jeannette James

James

STATE OF ALASKA
1997 LEGISLATIVE SESSION

Bill Version: HB 153
(H) Publish Date: 2/24/97

Revision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to the eligibility of aliens for state public assistance and medical assistance programs
BRU: Public Assistance
Component: PFD Hold Harmless
Sponsor: Rules Committee
COMPONENT SERIAL NO. 225
Requestor: Governor
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(37.3)	(69.2)	(96.2)	(119.0)	(138.4)	(138.4)
MISCELLANEOUS						
TOTAL OPERATING	(37.3)	(69.2)	(96.2)	(119.0)	(138.4)	(138.4)
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1050 PFD Funds	(37.3)	(69.2)	(96.2)	(119.0)	(138.4)	(138.4)
TOTAL	(37.3)	(69.2)	(96.2)	(119.0)	(138.4)	(138.4)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

PFD Hold Harmless payments replace ATAP benefits when receiving the dividend causes individuals to lose eligibility or have benefits reduced. The savings to the ATAP program provided for in this bill reduce costs in the ATAP component of the Public Assistance BRU. PFD Hold Harmless costs for ATAP benefits will decrease in direct proportion to the decreases produced by reductions in ATAP expenditures for each fiscal year.

Prepared by: Jim Nordlund, Director
Phone: 465-2680
Division: Public Assistance
Date: 02/03/97

Approved by Commissioner: Karen Perdue, Commissioner
Date: 2/5/97
Agency: Department of Health & Social Services

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H&SS - PFD HOLD HARMLESS- FISCAL NOTE

ANALYSIS (cont.):

Assumptions:

Legislation implemented July 1, 1997

PFD Hold Harmless costs for ATAP benefits will decrease in direct proportion to the decreases produced by this legislation.

Calculations:

FY 97	$0.0
FY 98	($37.3)
FY99	($69.2)
FY00	($96.2)
FY01	($119.0)
FY02	($138.4)
FY03	($138.4)

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

Bill Version: HB 153
(H) Publish Date: 2/24/97

Revision Date:
Title: An Act relating to the eligibility of aliens for state public assistance and medical assistance programs
Sponsor: Rules Committee
Requestor: Governor

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: Adult Public Assistance
COMPONENT SERIAL NO. 222
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(156.0)	(304.2)	(444.6)	(577.2)	(705.9)	(705.9)
MISCELLANEOUS						
TOTAL OPERATING	(156.0)	(304.2)	(444.6)	(577.2)	(705.9)	(705.9)
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(156.0)	(304.2)	(444.6)	(577.2)	(705.9)	(705.9)
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1007 I/A Receipts						
TOTAL	(156.0)	(304.2)	(444.6)	(577.2)	(705.9)	(705.9)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

This legislation provides that most legal immigrants who arrived in the U.S. before August 22, 1996 will remain eligible for Adult Public Asssitance (APA) benefits. This legislation prohibits APA benefits to most legal immigrants who arrive on or after August 22, 1996 for five years from their date of arrival into the U.S. The program savings generated by this legislation represent caseload decreases due to attrition. These caseload decreases are not offset by newly eligible immigrants because most new immigrants are barred from program participation for five years after their date of entry.

Prepared by: Jim Nordlund, Director — Phone: 465-2680
Division: Public Assistance — Date: 02/03/97
Approved by Commissioner: Karen Perdue, Commissioner — Date: 2/5/97
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

Assumptions:

Legislation implemented July 1, 1997

Caseload will decrease each year from FY98 to FY02 by 5 percent due to normal attrition.

Caseload remains constant after FY02 due to new immigrants becoming eligible after the five year bar.

Calculations:

Fiscal Year	# Persons Affected	Annual Savings
FY97	0	$0.0
FY98	40	($156.0)
FY99	78	($304.2)
FY00	114	($444.6)
FY01	148	($577.2)
FY02	181	($705.9)
FY03	181	($705.9)

FISCAL NOTE

Bill Version: HB 153
(H) Publish Date: 2/24/97

STATE OF ALASKA
1997 LEGISLATIVE SESSION

Revision Date:
Title: An Act relating to eligibility of aliens for state public assistance and medical assistance programs
Sponsor: Rules Committee
Requestor: Governor

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: ATAP
COMPONENT SERIAL NO. 220
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(405.9)	(752.4)	(1,046.1)	(1,293.6)	(1,504.8)	(1,504.8)
MISCELLANEOUS						
TOTAL OPERATING	(405.9)	(752.4)	(1,046.1)	(1,293.6)	(1,504.8)	(1,504.8)
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(368.6)	(683.2)	(949.9)	(1,174.6)	(1,366.4)	(1,366.4)
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1007 I/A Receipts	(37.3)	(69.2)	(96.2)	(119.0)	(138.4)	(138.4)
TOTAL	(405.9)	(752.4)	(1,046.1)	(1,293.6)	(1,504.8)	(1,504.8)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

This legislation provides that most legal immigrants who arrived in the U.S. before August 22, 1996 will remain eligible for Alaska Temporary Assistance (ATAP) benefits. This legislation prohibits ATAP benefits to most legal immigrants who arrive on or after August 22, 1996 for five years from their date of arrival into the U.S. The program savings generated by this legislation represent caseload decreases due to attrition. These caseload decreases are not offset by newly eligible immigrants because most new immigrants are barred from program participation for five years after their date of entry.

Prepared by: Jim Nordlund, Director
Division: Public Assistance
Phone: 465-2680
Date: 02/03/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/5/97

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ANALYSIS (cont.):

Assumptions:

Legislation implemented July 1, 1997

Caseload will decrease each year from FY98 to FY02 by 15 percent due to normal attrition.

Caseload remains constant after FY02 due to new immigrants becoming eligible after the five-year bar.

Calculations:

Fiscal Year	# Persons Affected	Annual Savings
FY97	0	$0.0
FY98	123	($405.9)
FY99	228	($752.4)
FY00	317	($1,046.1)
FY01	392	($1,293.6)
FY02	456	($1,504.8)
FY03	456	($1,504.8)

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

Bill Version: HB 153
(H) Publish Date: 2/24/97

Revision Date:
Dept. Affected: Health and Social Services
Title: An Act relating to the eligibility of aliens for state public assistance and medical assistance programs affected by federal welfare ...
BRU: Medical Assistance
Component: Medicaid Non-Facility
Sponsor: Rules Committee
COMPONENT SERIAL NO. 229
Requestor: Governor
See also (SN#): 230

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES	( )					

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Progrs eipts						
1037 GF/Mental h						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

Historically, Medicaid covered legal resident aliens who met all other Medicaid eligibility criteria. As a result of federal welfare reform, Alaska Medicaid cannot continue to cover most aliens without this legislation. Even with legislation, most aliens who arrive in the country after August 22, 1996 are ineligible for Medicaid for their first five years in the U.S. This bill provides the Alaska program with the authority to continue Medicaid coverage for qualified legal aliens who are not subject to the five-year bar. Funding for the coverage of these aliens is already included in the Medicaid budget. Therefore, there is no new cost to continuing this coverage.

Failure to extend Medicaid coverage for aliens would result in a loss of Medicaid eligibility for some aliens. However, aliens who do not qualify for full Medicaid coverage are eligible for Medicaid coverage of emergency medical treatment. In addition, aliens needing non-emergency hospitalization, nursing home services, or prescription drugs for certain chronic conditions may be eligible for the General Relief Medical program. See the following page for additional information about the impacts of not passing this legislation.

Prepared by: Jon Sherwood
Division: Division of Medical Assistance
Phone: 465-3355
Date: 02/03/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/5/97

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H&SS - MEDICAID NON-FACILITY ZERO FISCAL NOTE