RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original documents after microfilm reproductions have been made.

William D. Carter
Signature of Camera Operator

10/14/2003
Date

Certification Rev. 7/98

OVERVIEW

DIV. PUBLIC HEALTH

The New Public Health Lab

1

On Track Towards Healthy Alaskans 2010

Karen Perdue
Commissioner of Health and Social Services
Presentation to House Health, Education and Social Services Committee
January 16, 2001

Why do we plan?

A. So we don't feel hopeless

B. So we can tell if we are making any progress

3

"Even if you're on the right track, you'll get run over if you just sit there."

--Will Rogers

4

5

What Public Health Does

- Prevents Epidemics
- Protects Environment, Food, Water
- Promotes Healthy Behavior
- Mobilizes Communities
- Disaster/Emergency Response
- Assures Medical Quality and Access
- Develops Policies to Promote Health
- Monitors the Health Conditions of the Population

6

It used to be harder to get data and to do everything...

7

8

9

Measuring Health Status – Limitations of Current Data

- "Small number" constraints
- Community data vs. statewide data
- Hospital Data: only for trauma
- Technology: emerging

10

How Have we Done?

Compared with the national average:

Alaska is BETTER for 6 of 19
ABOUT THE SAME for 6 of 19
Alaska is WORSE for 7 of 19

11

Analysis of Alaska Trends

- RIGHT DIRECTION for 12 of 19
- No consistent change for 4 of 19
- WRONG DIRECTION for 3 of 19

12

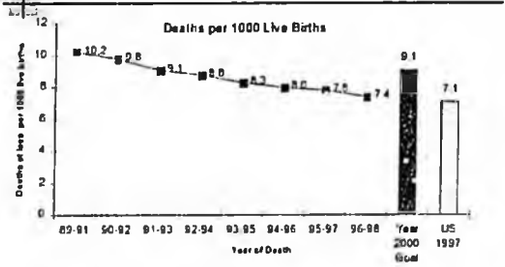
Trends in 19 Alaska Health Status Indicators

Infant Mortality ⇧♥	Children in Poverty ⇧
Overall Mortality ⇧	Lung Cancer ⇔ ♥
Work-related Mortality ⇧♥	
Unintentional Injury ⇧♥	Stroke ⇔ ☹
Motor Vehicle Crash Deaths ⇧♥	Air Quality ⇔☹
Breast Cancer ⇧♥	Suicide Mortality ⇔☹
Coronary Heart Disease ⇧♥	Homicide ⇔☹
AIDS ⇧♥	Tuberculosis ⇩☹
Measles ⇧♥	Prenatal Care ⇩☹
Teen Birth Rate ⇧♥	Low birth weight ⇩☹
♥ Healthy Alaskans 2000 target met	☹ Healthy Alaskans 2000 target not met
AK Trend: ⇧ Better ⇔ Same ⇩ Worse	

Let's look at some of 19 indicators we have been tracking since 1990

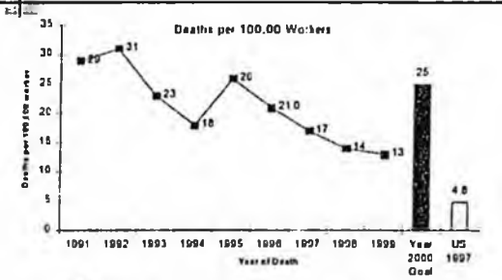
14

Infant Mortality Rate Alaska 1990-98*



15

Work-Related Mortality Rate Alaska 1990-99*

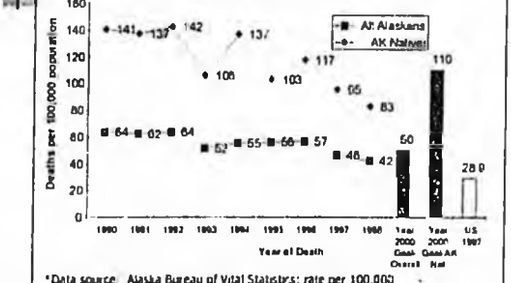


16

Unintentional Injury Mortality Rate Alaska 1990-98

17

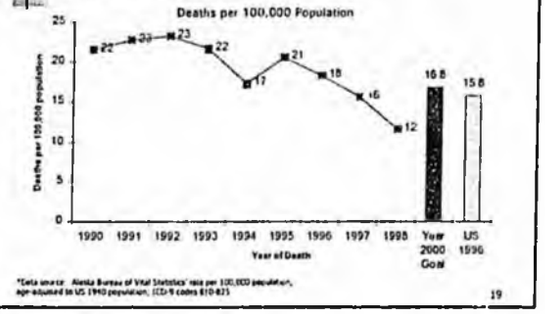
Unintentional Injury Mortality Rate Alaska Native/Non-Native 1990-1998



*Data source: Alaska Bureau of Vital Statistics; rate per 100,000 adjusted to US 1940 population; ICD-9 codes 800-949

18

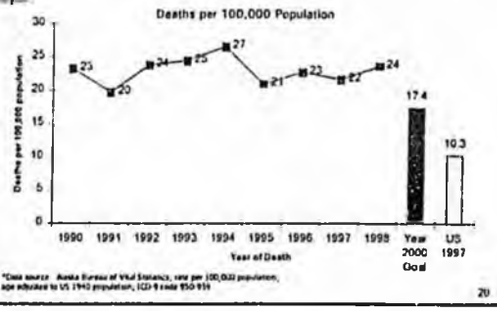
Motor Vehicle Injury Mortality Rate
Alaska 1990-98



*Data source: Alaska Bureau of Vital Statistics' rate per 100,000 population, age-adjusted to US 1940 population; ICD-9 codes 810-825

19

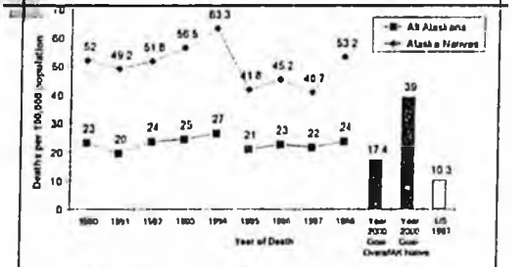
Suicide Mortality Rate
Alaska 1990-98



*Data source: Alaska Bureau of Vital Statistics, rate per 100,000 population, age-adjusted to US 1940 population, ICD-9 code 950-959

20

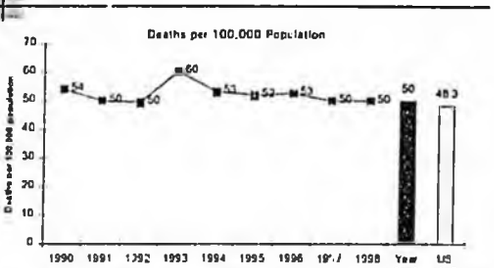
Suicide Mortality Rate
Alaska Native/Non-Native 1990-1998



*Data source: Alaska Bureau of Vital Statistics; rate per 100,000 population; age- adjusted to US 1940 population; ICD -9 code 950-959

21

Lung Cancer Mortality Rate
Alaska 1990-98

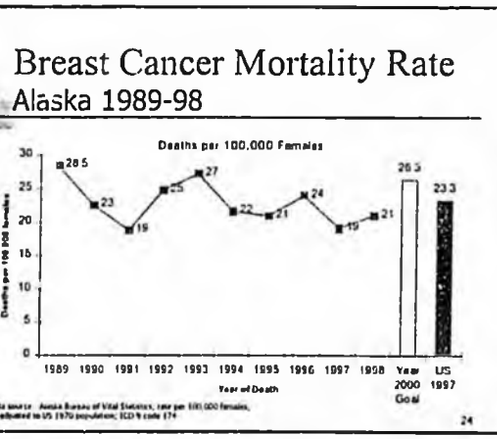


*Data source: Alaska Bureau of Vital Statistics, rate per 100,000 population, age-adjusted to US 1970 population; ICD-9 code 162

22

23

Breast Cancer Mortality Rate
Alaska 1989-98



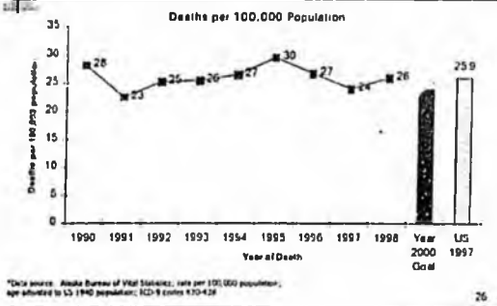
*Data source: Alaska Bureau of Vital Statistics, rate per 100,000 females, age-adjusted to US 1970 population; ICD-9 code 174

24

Coronary Heart Disease Mortality Rate
Alaska 1990-98

25

Stroke Mortality Rate
Alaska 1990-98



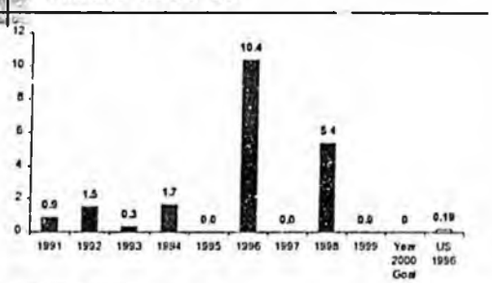
26

AIDS Incidence Rate*
Alaska 1991-99

27

28

Measles Incidence Rate
Alaska 1990-99

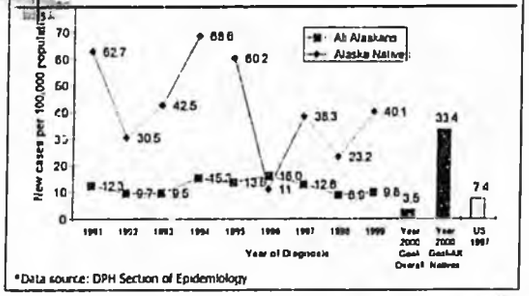


29

Tuberculosis Incidence Rate
Alaska 1991-99

30

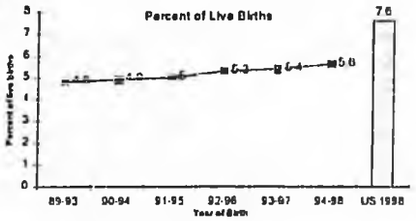
Tuberculosis Incidence Rate
Native/Non-Native Alaska 1991-1999



*Data source: DPH Section of Epidemiology

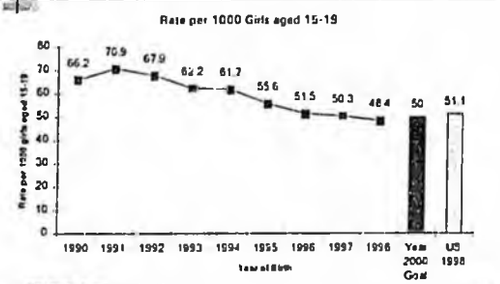
31

Low Birth Weight
Alaska 1993-98



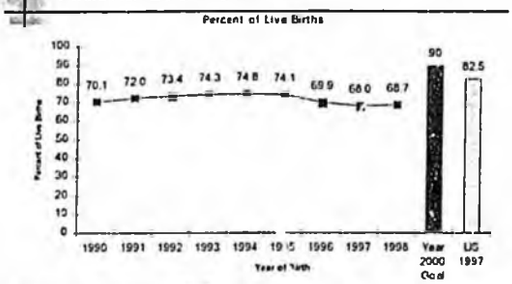
32

Teen Birth Rate: Age 15-19
Alaska 1990-98



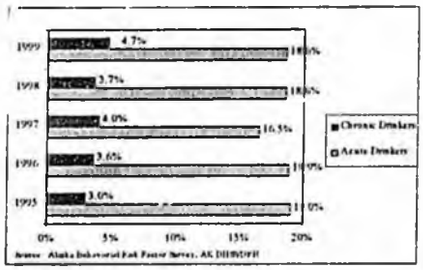
33

Adequate Prenatal Care
Alaska 1990-98



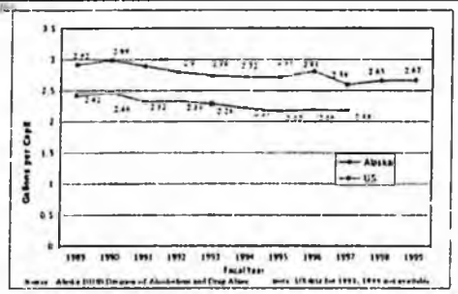
34

Percentage of Alaskans Who Report Acute Binge) and Chronic Drinking, 1995-1999



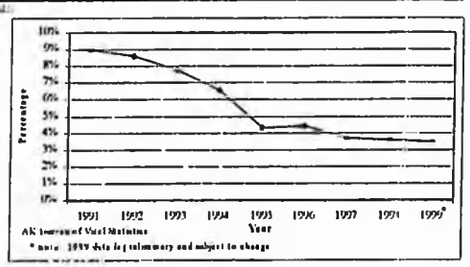
35

Alaska and U.S. Gallons per Capita of Alcohol Consumed, 1989 - 1999



36

Percentage of Women Reporting Alcohol Consumption During Pregnancy



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Healthy Alaskans 2010

What should our targets be?

What actions are needed to hit the targets?

38

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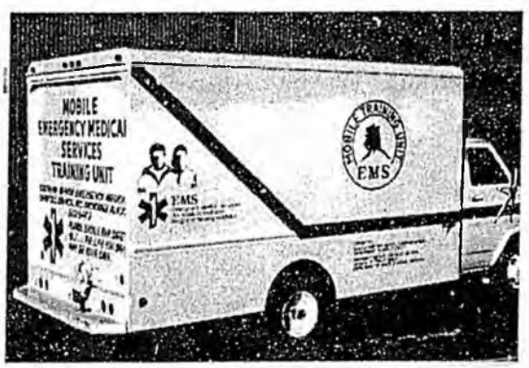
Strengthen our Public Health System

40



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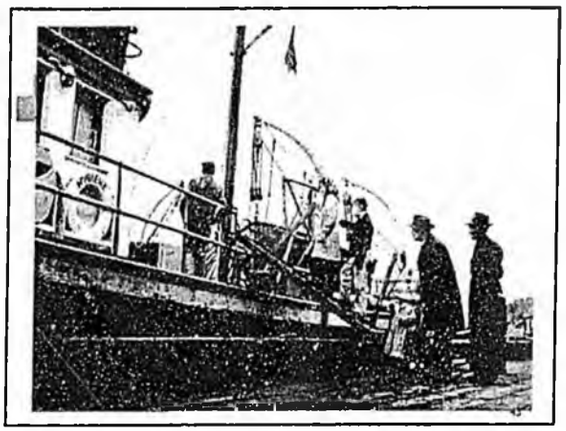
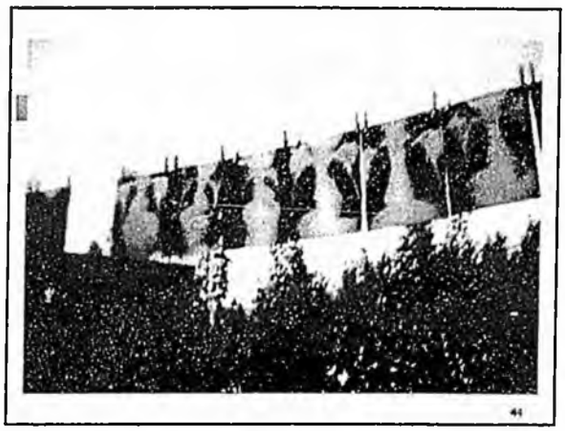
Challenges New and Old

- Tuberculosis
- New Immunization Schedule
- STDs
- Hepatitis C
- Viral and Bacterial Outbreaks
- Environmental Contaminants

42





Governor Knowles is Proposing

Back to Basics

$2.281 million to beef up public health

Back to Basics: A Disease Control Initiative

A **comprehensive, multi-disciplinary** disease control effort

- using nursing, labs and epidemiology expertise
- breaking the cycle of exposure, infection and disease related to TB, Hepatitis, STDs and other communicable diseases in Alaska.

Division of Public Health Overview

Presented to Health, Education and Social Services Committee
January 18, 2001

www.hss.state.ak.us/dph/dph_home.htm

Introduction to the Division

Mission

The mission of the Division of Public Health is to preserve and promote the state's public health.

Description of the Division

The Division of Public Health strives to use the best available scientific knowledge to set public health policy and ensure provision of services that guarantee the health of all Alaskans so they can live full lives with optimum well being.

The Division promotes the health and quality of life of all Alaskans by preventing and controlling disease, birth defects, injury, disability and death resulting from interactions between people and their environment. The Division carries out its mission through a range of activities and services centered on the core public health functions of assessment, policy development and assurance.

The Division's activities and services are primarily "population-based" and focus on achieving and preserving the health and well-being of entire communities or populations rather than on the provision of individual medical care. The Division's professional staff monitor and assess the health status of Alaskans through the collection and analysis of vital statistics, risk factor data and data on disease and injury. The Division uses this data and other scientific information and expertise to develop, implement and evaluate strategies, programs and services to inform the public and advise policy makers about health issues. These activities enable citizens and policy makers to make sound policy decisions to prevent and reduce health problems, promote good health and avoid costs.

Populations Served:

The Division of Public Health (DPH) serves the **population of the State of Alaska: 626,932**, according to the April 1, 2000 Census count, living in 320 communities and areas.

In addition, DPH works to protect the health and safety of over **two million visitors** a year to the state, and approximately **70,000 non-resident workers** per year.

The duty to protect the health of the public requires cooperation with other states and nations, because threats to public health like tuberculosis, persistent organic pollutants, and bioterrorism know no borders. DPH serves as both the state and local health agency except for the areas covered by the two areas with "local health departments," Anchorage Municipality and North Slope Borough.

Services:

Public Health provides prevention, health promotion, protection and treatment services directly to individuals, families and communities, and through grantee organizations and contractual arrangements.

DPH also ensures the capacity of systems to protect the public's health: monitor health care and public health workforce availability, training and quality assurance; provide surveillance and monitoring of disease and injury; provide data and educational information so that communities and citizens can make informed choices.

In addition to addressing systems issues and providing many population-based services, DPH has responsibility for serving subgroups of the general population who have special needs, such as Medicaid-enrolled children and other special populations at risk of illness or injury.

Organizational Components:

Structurally the Division is organized into the following Sections, Bureaus or Offices, which design, direct, deliver and evaluate all programs and services within the Division:

- Epidemiology
- Public Health Nursing
- Maternal, Child and Family Health
- Laboratories
- State Medical Examiner
- Vital Statistics
- Emergency Medical Services and Community Health
- Medicaid Services
- Data and Evaluation

The Code Blue Project

Resuscitating Emergency Medical Services in Alaska

Brief History: During the past decade, a crisis has quietly developed in rural Alaskan EMS programs resulting in some services closing their doors and others downgrading the level of emergency medical care they are capable of providing. These EMS agencies are essential components of the rural emergency health care and transportation systems. The Code Blue Project was initiated by the Department of Health and Social Services in 1999 as an attempt to quantify the unmet [illegible] of rural emergency medical services agencies. The development and continuing evolution of the Code Blue project involves a partnership between the department, the Regional and subarea EMS offices, local communities, and others, such as the Alaska Council on Emergency Medical Services. The Code Blue Database includes EMS needs supported by Regional EMS agencies and represents a "snapshot" of documented needs in rural Alaska.

Funding Sources: The need to reinvigorate emergency medical services agencies in Alaska is urgent and worsens with time. Agencies such as the Denali Commission, the United States Department of Agriculture (USDA) and the Rasmuson Foundation have been contacted as potential sources of funds. Governor Knowles is including $533,000 in his proposed capital budget for improving EMS and matching other funding sources. We continue to look diligently for other sources of funding.

Recent Activities: We have spent considerable time working with the Regional EMS Offices to refine our database and reporting systems to be able to more accurately estimate costs and matching funds based on different funding scenarios. Fields related to: USDA funding eligibility and levels; Primary Care Facility priority levels; and "distressed community" designations based on draft Denali Commission and preliminary USDA criteria, have been included. Data have been migrated from a simple spreadsheet to an Access database system. A system for updating and prioritizing equipment needs has been developed. The next update of the database is scheduled for February 2001.

Items Included: Equipment for patient transportation (ambulances and transport vehicles), patient care, training, and communications are contained within the Code Blue list. The Code Blue database does not include the costs of essential EMS related training that also has been identified.

Code Blue Database – 1/2001

Equipment	Cost
Patient Care Equipment	$644,829
Training Equipment	$254,300
Radio Repeaters	$350,000
Communications Equipment	$688,330
Ambulances	$3,450,000
Emergency Vehicles	$1,302,500
Other	$15,000
Total	**$6,729,959**

Estimated Costs: The costs included are the best estimates available at the time of publication.

Local Match: We support the concept of local matching finds and we believe that many communities within the Code Blue Project are capable of generating reasonable amounts of matching funds if given adequate time. Other communities, however, such as those which are significantly economically distressed, based on USDA or Denali Commission Criteria, are not likely to be able to find matching funds, since their available funding is used for mission critical EMS operations (e.g. gasoline, vehicle maintenance, insurance, etc.). The maximum amount of funding from the USDA for a project is 75%.

Revised 1/17/2001

Consequently, the community's share of a $150,000 ambulance would be $37,500. Many small communities simply don't have the financial resources to amass these funds.

Applications for Funding under the Code Blue Project: There are well over a hundred emergency medical services agencies in Alaska ranging from small first responder squads to extremely sophisticated, paramedic staffed, urban EMS systems. The Alaska EMS System is divided into seven regions. The Regional EMS Offices are either 501(c)(3) non-profit organizations, or are within Native Health Corporations or are incorporated into a borough government. The regional EMS offices have been in place for years (some over 20) and are uniquely qualified to apply for and manage funds received under the Code Blue Project.

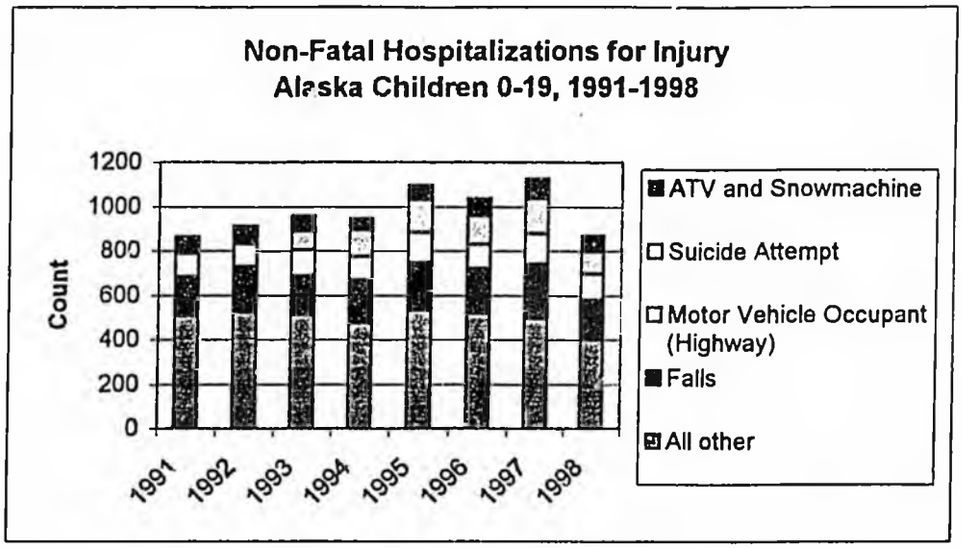
Importance of Funding: It is likely that the problems in rural emergency medical services will increase in frequency and severity if there is not a substantial influx of resources to provide the equipment, training and support necessary for volunteer EMS personnel to do their jobs in a safe and effective manner. Agencies can play an important role in helping improve rural emergency medical care by providing funding to purchase essential equipment and which also can be used as match for other funding sources.

Since many rural EMS squads in Alaska respond to more calls from people from other parts of Alaska or visitors from out-of-state than from local residents, it is in our collective best interests to ensure that we have effective emergency medical services available 24 hours a day, seven days a week, throughout the state.

Division of Public Health Injury Prevention Activities

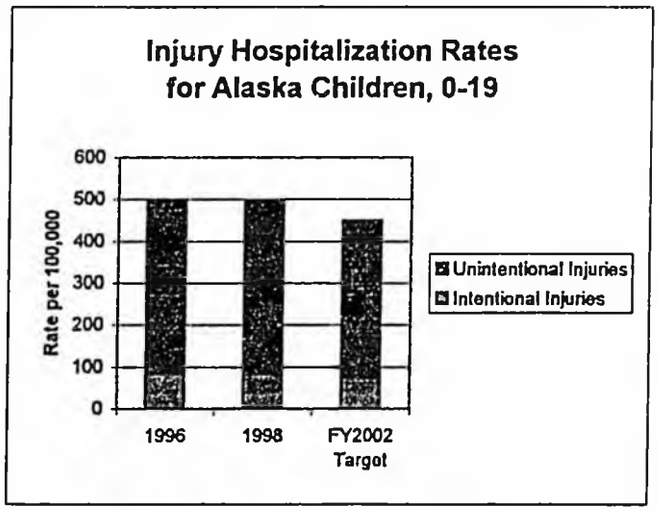
- On going surveillance with the Trauma Registry.
- Developing four injury prevention booklets for children.
- Helmet use PSAs.
- Supporting development of "prevention response teams" at the health corporation level to assist communities, after a significant injury or illness, in developing programs to prevent further occurrences of the same or similar event.
- Injury prevention training at the annual EMS symposium to encourage EMS involvement in local programs.
- Child passenger safety – training car seat inspectors and car seat checks in local communities.
- Kids Don't Float – 235 personal floatation device loaner sites around Alaska.
- Smoke alarm installation project targeting Anchorage and Y-K Delta.
- Support local injury prevention efforts through Safe Kids coalitions in 7 communities.
- Support local injury prevention efforts in Alaska Native Health Corporations.
- Observational study of helmet use for riders on bicycles, ATVs, and snowmachines.
- Co-sponsor bicycle "rodeos" for kids.

Alaska Trauma Registry, non-fatal, hospitalized injuries, AK residents, Age 0-19, 1991-1998
Poisonings were collected beginning July, 1993



Trauma Hospitalizations	1991	1992	1993	1994	1995	1996	1997	1998
All other	507	524	513	474	531	519	496	399
Falls	175	203	172	194	215	199	244	180
Motor Vehicle Occupant	106	106	118	105	138	112	138	118
Suicide Attempt	11	15	87	122	146	128	159	99
ATV and Snowmachine	64	65	69	52	66	77	88	74

Source: Alaska Trauma Registry



Trauma Hc Rates per Thousand Children 0-19 Rates	1996	1998	FY2002 Target
Intentional	82.6	83.3	74
Unintentior	416.8	410.4	375
	499.4	493.7	449

Alaska Trauma Registry, non-fatal, hospitalized injuries, AK residents, Age 0-19, 1991-1998
Poisonings were collected beginning July, 1993

	1991	1992	1993	1994	1995	1996	1997	1998
Motor Vehicle Occupant on Highway	106	106	118	105	138	112	138	118
Snowmachine	15	29	29	20	28	38	34	32
All-Terrain Vehicle	49	36	40	32	38	39	54	42
Pedestrian	23	31	25	21	37	26	24	21
Bicycle	56	55	40	30	47	52	60	43
Water Transport	5	5	5	8	4	7	4	9
Airplane	2	0	4	0	0	0	0	0
Falls	175	203	172	194	215	199	244	180
Fire	15	13	13	25	22	19	16	5
Frostbite/Hypothermia	7	2	4	9	12	4	6	2
Dogbite	23	14	16	12	16	28	16	17
Near Drowning	12	5	6	9	2	3	5	4
Suffocation	7	5	11	4	9	1	12	1
Eyepoke	3	3	2	4	3	3	9	0
Struck by Person/Object (accidently)	40	53	54	39	53	60	31	28
Caught between Objects	10	20	12	3	12	7	9	8
Machinery	3	7	10	9	6	7	10	4
Cut	41	33	31	30	22	26	29	24
Explosion	8	5	9	5	13	6	6	2
Unintentional Firearm	10	26	17	17	16	17	12	13
Burn (hot substance)	27	30	30	19	22	25	15	12
Strain	3	0	5	7	7	7	5	3
Suicide Attempt	11	15	87	122	146	128	159	99
Assault	48	48	47	50	61	43	36	43
Other Animal Injury	4	4	6	4	4	1	6	3
Animal Ride	7	12	2	2	2	2	2	5
Swallowing Foreign Body	21	16	21	18	9	18	20	12
Sledding	33	21	11	17	16	18	17	13
Playground Equipment Fall	41	41	37	24	26	41	31	20
Sports	50	62	55	60	43	56	49	52
Accidental Poisoning	1	0	24	36	48	32	52	30
Other	7	13	16	12	19	10	14	25
Total	863	913	959	947	1096	1035	1125	870

Frontier Health

Problem:

Alaska experiences multiple health and health care delivery challenges that are in many ways unique from the rest of the United States. Alaska has over 300 communities. Approximately 25 percent of all Alaskans, and 46 percent of Native Alaskans, live in communities of less than 1,000 people. Nearly one-quarter of the State's population lives in towns and villages that are reachable only by boat or aircraft. Despite its size, Alaska ranks 47th among the 50 states in road miles and approximately 75 percent of Alaska communities are not connected by road to a community with a hospital. In 1998, Alaska averaged 1.09 persons per square mile compared to 76.36 persons per square mile nationally. The Frontier Health Project will address service delivery and health system issues facing Alaska as a frontier state.

Mission:

The project mission is to assure access to basic quality health care services for all who live and work in rural and remote Alaska, through a collaborative effort geared to strengthening the rural health care service delivery system utilizing HRSA funding and field office support.

This project will support HRSA's goals of assuring 100% access to health care and 0% health disparities. In accordance with HRSA's goals, this project will improve the health of rural Alaskans by assuring equitable access to comprehensive, quality health care. Implementation of state level initiatives under this project will utilize HRSA's strategies of: 1) eliminating barriers to care; 2) assuring quality of care; and, 3) improving public health and health care systems.

Goals:

1. To enhance and maximize the health care delivery system in Alaska by using existing HRSA resources in a more flexible and expansive manner to leverage additional public and private resources.

2. To provide a vehicle for the receipt of demonstration funding to test options for improving the delivery of primary and other health services in a frontier state.

3. To work collaboratively with the HRSA Region X Field Office and HRSA Administrator's Management Team, in order to enhance HRSA's effectiveness in supporting a frontier state in achieving it's health care objectives.

4. To develop, test and evaluate, in conjunction with HRSA staff, methodologies which will enable federal funding agencies to better support frontier states in delivering health care by expanding criteria to enable them to compete with the more populous states and areas for long-term service delivery grant funds.

5. To increase and enhance the connection between HRSA funded service delivery initiatives and the HCFA funded reimbursement systems in order to maximize access to care for rural Alaskans.

Specific Project Objectives/Activities:

The Alaska Department of Health and Social Services will, in partnership with HRSA, through a cooperative agreement, work to enhance and support the Alaska health care delivery system, in order to improve access to care for rural Alaskans. These activities will be carried out in the following broad categories:

- **Increasing collaborative health service delivery planning and systems development.** Staff supported with funding from this cooperative agreement will work with staff of the various HRSA funded programs and services within and outside the Department and with other local, state, tribal, regional and national level health care providers and funder entities to increase collaborative planning, funding and implementation efforts focused on frontier service delivery.

- **Increasing the ability of frontier states, like Alaska, to access long-term federal funding for building and maintaining the rural health care infrastructure and supporting access to basic health care.** By serving as a pilot state, Alaska has the potential to assist the federal agencies in identifying ways to expand grant programs so that frontier states can access sustainable federal funding for essential work. Current grant programs are frequently unavailable to frontier states, due to small numbers and large geographical areas requiring substantial travel.

- **Identifying, utilizing and documenting the benefits related to having a Field Office team assigned to assist states in HRSA related activities.** The newly developed and assigned field office state technical assistance teams are being asked to relate to and interact with their assigned states in new and more comprehensive ways. The State of Alaska has the potential to assist HRSA in systematically developing and clarifying appropriate roles and responsibilities that will help the teams be effective and in evaluating the impact of the teams in helping states achieve their goals related to maximizing HRSA resources and partnering within the state.

- **Identifying and implementing creative methodologies for increasing the efficiency and effectiveness of the health care infrastructure in rural Alaska using all available public and private resources.** The staff funded by a cooperative agreement would provide technical assistance to community groups, service delivery agencies and funders to increase opportunities for collaboration and to share information which can assist these entities in engaging in more cost effective and innovative activities.

YOUNG CHILDREN ARE VULNERABLE AND A HIGH PRIORITY

Numbers of children born with significant congenital problems:

- Birth defects are a leading cause of neonatal death in Alaska. About 20 infants die each year from a congenital birth defect.
- An average of 1600 children are born each year with *any* type of reportable birth defect.
- Over 400 children are born each year with at least one of the *major* congenital defects.
- The most common birth defects in Alaska are congenital heart defects (about 150 births per year).
- About 25 children are born each year with cleft lip and palate.
- 15 children are born every year with Down Syndrome.
- Seven babies are born each year with a neural tube defect.
- An estimated 30 - 40 children are born each year with significant congenital hearing loss.
- 10 -14 children are born every year with fetal alcohol syndrome.

Children's physical and behavioral health issues:

- At least 250 Alaska Medicaid children are hospitalized for asthma each year
- Only 42% of EPSDT children receive appropriate dental services. Just 19% of Alaska children are estimated to have received at least one dental sealant by the time they reach 3rd grade.
- 17% of Alaska children suffer from anemia - over twice the rate of US children as a whole.
- 7% of Alaska children in infant learning programs have significant behavioral health issues.
- 843 Medicaid recipients under age 21 were on medication for ADHD in 1999.
- 3.4% of children in grades 7-12 dropped out of school in the 1997-98 school year.
- 9% of Alaskan infants are born to mothers who report binge drinking.

Childhood exposures to health risks:

- Children in Alaska are exposed to environmental health hazards at a high rate: In Alaska households where children are living, over one quarter are exposed to cigarette smoke, 18% to binge drinking and 3% to chronic alcohol use.
- As many as one quarter of middle school students and 37% of high school students smoke cigarettes!
- 20% of middle school and 22% of high school students have abused inhalants at some time in their lives.
- Almost half of children in grades 9-12 report using alcohol.

- 1 to 2 % of children under age 18 suffer some form of abuse or neglect each year in Alaska.

MCH Programs that serve young children:

- The following MCFH Programs assess the extent of various problems affecting young children and provide epidemiological data for program planning and evaluation:
  - Maternal Infant Mortality Review
  - Pregnancy Risk Assessment Monitoring System
  - Alaska Birth Defects Registry
  - Alaska Fetal Alcohol Syndrome Surveillance Project

- The following MCFH programs enable or directly provide services to young children:
  - WIC
  - Early Intervention/Infant Learning Program
  - Newborn Hearing Screening
  - Newborn Metabolic Screening
  - Genetics Clinics
  - Specialty Clinics - Cardiac, Neurodevelopmental and Cleft Lip/Palate
  - Health Care Program for Children with Special Needs (HCP-CSN)
  - Healthy Families Home Visitation Program
  - Alaska Family Violence Prevention Program

The Alaska WIC Program Is A Success

- WIC provides free nutritious foods, health screening and referrals, and nutrition education to low income childbearing women, infants and children up to five.
- It is a proven prevention program that saves millions of healthcare dollars.
- The number of people served has doubled in seven years, totaling 43,646 in SFY00.
- During this period, costs have been reduced and service quality and accessibility to services by hard-to-reach populations has significantly improved.
- This was accomplished through innovative changes to federal and state regulations and procedures, and the development of new community partnerships.
- These improvements resulted in the Alaska WIC Program receiving a USDA award for being the outstanding WIC program in the nation in 2000.

At the federal level, Alaska can now convert unused food funds previously returned to the federal government to funding for providing clinic services in bush Alaska. We now substitute salmon for tuna and dried eggs on the WIC food list, exclude COLA for income documentation for military families, and waived the requirement for a street address to establish proof of residency for people in bush areas. Medicaid now provides funds for bus tokens in urban areas to assist families in keeping their WIC appointments.

Because of the high cost of WIC mailed food boxes and complaints about damaged and spoiled food in the boxes, two aggressive efforts were initiated to recruit additional village stores as WIC vendors, and to create a WIC vendor advisory council. As a result, the number of WIC vendors has doubled from 112 in 1994 to 225 in 2000, and today less than 1,000 participants (4%) receive mailed food boxes, down from 25% just six years ago. Small village stores are greatly helped by the increased revenue. The amount of money spent in the private economy of Alaska for WIC foods has tripled from about $5 million to $15 million. By increasing the participant caseload and partnering with vendors, the average cost of participant food packages has been cut almost in half since 1994. Current average costs are $38/month, very close to the $32/month western region state average.

A new computer system was put into operation in 1998. WIC's old cumbersome 5-page application from has been streamlined to a 2-page family or individual application form. A new shortened and more efficient electronic grant process is replacing the cumbersome process that required proposers to develop very lengthy grant applications every two years. Recruitment and retention of WIC nutritionists in Alaska is a chronic problem, but a new distance learning program has been successful in allowing talented WIC

support staff to meet requirements to certify participants. Students use written distance learning modules, take a nutrition course through correspondence or on the Internet, and use Alaska WIC materials and self-grading exams on the Internet. Our first two students graduated in November 2000. In remote clinics that experience high professional staff turnover, these new WIC certifiers will play a significant role in providing continuity to our remote clinics.

Children in Alaska have double the rate of anemia of the rest of the US. Anemic children are often tired and have difficulty in school. It is hard to get children to take iron drops because of the taste. WIC is currently testing the effectiveness of low cost iron fortified chocolate milk in the Y/K area. If it is effective, we will add this to our WIC food list.

In the past six years WIC has opened three new agencies and nine new clinics. A new partnership with the military has resulted in a new clinic site coordinated with military health services in Anchorage, for which WIC and the military share service costs. WIC already has two military clinics on bases in Fairbanks.

The Alaska WIC Farmers' Market Nutrition Program was piloted in Fairbanks in 1998, and expanded to Anchorage, Wasilla/Palmer, Dillingham, Kodiak, Kenai in 2000. WIC participants are given $20 worth of coupons which they exchange for Alaskan grown produce at local Farmers' Markets. This program has significantly increased fruit and vegetable consumption of WIC participants as well as expanded the awareness and sales of Alaskan grown produce. This year we received a grant for a similar Senior Farmers' Market pilot program, for the Anchorage and Mat-Su Valley areas. It will be operated this summer through United Way in cooperation with local senior centers.

WIC is pilot testing a WIC immunization voucher incentive program in Barrow. Public health nurses provide the WIC nutritionist with a list of children who are not up to date on their immunizations. When these children's parents come for their WIC appointment, they are issued only one month's WIC vouchers instead of the usual three months, and referred for immunizations. They can start receiving three-month sets of WIC vouchers once they get their child started on the needed immunizations. This is proving successful in raising immunization rates.

Special Initiatives/Efforts

1. **Breast and Cervical Cancer Treatment Bill**-This is an option recently made available by the federal government to allow states the option of having Medicaid pay the treatment costs for women who have found they have either breast or cervical cancer through the federally funded breast and cervical cancer screening program for low-income women (those below 250% of poverty) and have no insurance to cover such treatment. A bill has been introduced to have Alaska exercise that option. It is a great dis-incentive for women without insurance to be screened, if they know that if cancer is found, they have no source of funding to pay for the needed treatment.

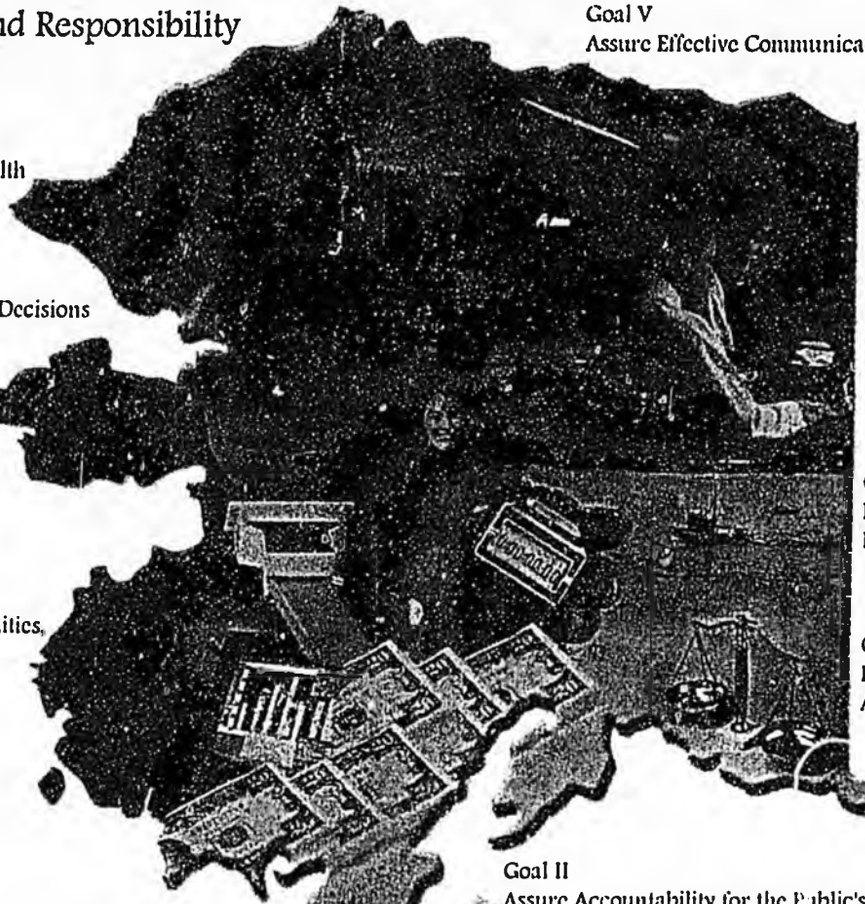
2. **Workforce Development Initiative**-Due to the increasing difficulty in recruiting and retaining a high quality public health workforce, we are partnering with the University of Washington and other states in the Northwest to determine effective strategies to ensure public health workers in Alaska continue to be highly skilled and available to serve the public.

3. **Opening the New Public Health Lab and Medical Examiner Facility**-This month staff are moving into the new, state of the art, public health laboratory and medical examiner facility in Anchorage. Staff of both programs will now be able to do their work in a safer environment, more efficiently, do more complex work and better serve the public in a number of ways. The grand opening is January 26 at 11 am.

4. **Healthy Alaskans 2010**-The Division is managing, on behalf of the Department, a planning effort that will, over the next year, finish defining health goals for the state for the next 10 years. This effort, involving hundreds of Alaskans statewide, will establish a framework for achieving and benchmarks for measuring the success of the state in improving the overall health and well-being of it's citizens.

Public Health: Every Alaskan's Right and Responsibility

The Alaska Public Health Improvement Plan 2000



Goal V
Assure Effective Communication Capabilities in the Public Health System

Goal VIII
Increase Personal Responsibility for Individual Health

Goal X
Improve Interagency Communication, Coordination, and Collaboration between State Public Health, Mental Health, Substance Abuse, and Environmental Health Agencies

Goal VI
Increase Public Input in Statewide Policy Decisions

Goal III
Assure a Well Trained, Competent Public Health Workforce

Goal VII
Engage Communities to Solve Local Health Problems

Goal IX
Assure Access to Public Health Information for Communities, Policy Makers, and the General Public

Goal I
Develop a Strong Legal Framework for Alaska's Public Health System

Goal II
Assure Accountability for the Public's Health

Goal IV
Assure Sufficient, Stable Funding for Public Health Action

Alaska Public Health Improvement Process

Traveling the Road to a New Century in Public Health

COMMITTEE:
HEALTH, EDUCATION & SOCIAL SERVICES

DATE: January 18, 2001

SIGN-IN

Subject of meeting:

Overview of Medical Issues in AK
Presented by Dr Donald Palmisano
Brd of Trustees, AK State Medical Assoc
Continuation of Discussion of the Div of Public Health Issues
Overview: Division of Medical Asst
Public Health & Medical Problems in AK
Solutions the State is Applying

PLEASE PRINT!

NAME	ADDRESS (MAILING / ZIP)	PHONE	REPRESENTING (except for departments, spell out acronyms)	DO YOU WANT TO TESTIFY?
Nancy Davis	P.O. Box 110611 Juneau AK 99801	465-3150	DHSS/DPH	✓
Kim Pearson	"	465-3090	"	✓
Nancy Rodg	"	465-8636	"	✓
Peter Lawrus (Law reason) MD	1919 Lathrop Str. Suite 100 Fairbanks Ak 99701	452-1701 452-0304	Alaska State Med Assoc Exec	✓
Donald J. Palmisano MD	4417 Loring St Suite 200 Metairie LA 70006	504 455-5355	American Medical Association	✓
Jim Jordan	4107 Laurel Creek	561-561-[illegible]	ASMA	✓
Becky Dedura	2626 Lakeview Chicago IL 60614	317 464-4183	AMA - resource/ DOA only	NO
Mark Johnson	DHSS P.O. Box 110616 Juneau - 99811-0616	465-3027	DHSS/DPH	

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I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original documents after microfilm reproductions have been made.

William D. Carter
Signature of Camera Operator

10/14/2003
Date

Certification Rev. 7/98

OVERVIEW

GOV.'S COUNCIL DISABIL. SPEC. ED

TONY KNOWLES, GOVERNOR
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

P.O. Box 240249 • Anchorage, Alaska 99524-0249 • Phone: 907-269-8990 • Fax: 907-269-8995

GCDSE presentation to the House HESS Committee

Honorable Committee Member:

The Governor's Council on Disabilities and Special Education respectfully asks that, as a member of the House Health, Education & Social Services Committee, you take into account the following when considering any change to the State Medicaid Program.

- Persons with disabilities often require ongoing services simply to maintain the functional ability necessary to live independently, but health care delivery often focuses on a cure rather than long-term supports.

- Medicaid is often the only health insurance available to a child or adult with severe disabilities since private insurance is unavailable to many individuals with disabilities.

- The cost of providing services in a person's home has been shown to cost less than building centralized facilities.

- The cost of providing proactive, preventive health care is usually much less than the cost of providing emergency services.

Attached you will find a brief white paper on how individuals with disabilities require access to Medicaid for health coverage which backs up the statements made above. Our fellow Alaskans must be supported in maintaining good health and having their health needs addressed. The Council recognizes that the cost of health care for everyone is increasing and that Alaska faces some difficult choices now and in the future. Please consider carefully the potential future costs both financially and in human suffering of any reduction in health care to Alaskans with disabilities.

The need for health care will remain even if access to supports is reduced.

Respectfully yours,

Nikki Kinne
Chair of the Governor's Council on
Disabilities and Special Education

Individuals with disabilities use health care differently than individuals without disabilities. "The 'medical model', around which the U. S. health care system is structured, focuses on curing and improving health status and fails to consider the long-term service needs associated with many disabilities. Persons with disabilities often require ongoing services simply to maintain the functional ability necessary to pursue independence. In addition, the onset of both initial and secondary disabilities could be deterred or avoided if preventive services were promoted and available on a regular basis." (National Council on Disability, 1993, pg 9). It is essential to recognize that an individual is more than a disability and deserves access to the health services generally available to the non-disabled population. People with disabilities need providers and interventions that focus on their overall health, taking disability and environmental factors into consideration. Improving the primary condition and preventing secondary conditions are at the root of providing health supports for individuals with disabilities. Proactive medical supports are absolutely necessary to avoid medical emergencies that often cost far more than it costs for preventive medical supports.

Although over 60 percent of persons with a disability have private health insurance, this coverage remains unobtainable for many in the disability community.(National Council on Disability, 1993. pg 17) In fact, private health insurance is even becoming a luxury for the healthy as insurers find ways to exclude persons who show any risk of incurring medical expenses. Preexisting-condition exclusions have important, and often detrimental, consequences for persons with disabilities. Preexisting-condition exclusions are used to reduce an insurer's expected first-year medical claims expense. While health insurance may be offered to an individual with a disability, it may not cover a condition that existed prior to the time the individual sought coverage. For example, a person with multiple sclerosis may be able to obtain private health insurance, but services related to multiple sclerosis may be uncovered for a year. Because the individual cannot remain uncovered for services related to the disability for an entire year, the person may need to stay on publicly funded insurance.

The most common preexisting-condition limitations are exclusions for certain services and waiting periods. Although these provisions are legal and are considered by insurers to constitute sound business practice, they essentially discriminate against persons with disabilities. Even when insurance companies don't exclude pre-existing conditions, insurance policies often limit or restrict many services needed for independence by people with disabilities, "...assistive devices and personal assistance, are rarely covered by insurance; if these services are covered, the coverage is often restricted in amount, duration, and scope. In addition, the preventive care necessary to avoid the onset of secondary disability is often excluded from coverage." (National Council on Disability, 1993, pg 10). The end result is that the person may have to utilize Medicaid for health coverage, instead of being able to use private insurance.

The number of people living in Alaska with a disability is growing and the need for supports and services will also continue to grow. Medicaid Home and Community Based Care services are serving a growing number of people. These services on average are less expensive to provide than institutional care. In FY01 approximately $110 million

was used for waiver expenditures and nursing home expenditures combined. Nursing homes would have cost approximately $190 million without the waivers.(Division of Medical Assistance, 2001. pg 6 This means that the Medicaid program has been able to provide long term care services to far more people for the money available than if nursing home usage had kept growing.

Some ideas for addressing issues involving health and wellness of people with disabilities in a fiscally responsible way are:

1) Expanding the availability and capacity of private health insurance providers to meet the needs of individuals with disabilities.
2) Examining systems issues that prohibit health and wellness opportunities particularly related to environmental accessibility and accommodation, including issues of discrimination, and financial affordability.
3) Creating consumer-based materials that educate persons with disabilities on how to practice health promoting activities and behaviors, how to find and utilize community health and wellness resources, and how to advocate for access to health and wellness promotion opportunities.
4) Increasing the capacities of health and wellness providers to respond to the health and wellness needs of persons with disabilities, including education related to the need for and benefits of health and wellness promotion practices and for specific information about "best practices" in this area. (Health and Wellness Among Persons with Disability, Rehabilitation research and Training Center Health and Wellness Consortium, pg 6)

References

National Council on Disability, (1993). Sharing the risk and ensuring independence: A disability perspective on access to health insurance and health related services. A report to the President and the Congress of the United States.

Rehabilitation Research and Training Center. Health and Wellness Among Persons with Disability

State of Alaska, Division of Medical Assistance, (2001). Annual Report

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Date

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OVERVIEW

LONG-TERM CARE

4/18/02

MEMORANDUM

April 10, 2002

To: Commissioner Jay Livey, Health and Social Services
CC: Deputy Commissioner Elmer Lindstrom, HSS
Director Sever Ashman, DOA, Division of Senior Services

From: Fred Dyson
State Representative

RE: Long Term Care Task Force and Assisted Living Reports

We are scheduling a House HESS Committee meeting at 3:00 on April 18 hoping to learn more about long term care and assisted living in Alaska.

First we would like to hear a summary of what was accomplished by the Long Term Care Task Force effort. What is in existence now that would not have been... what was left undone... what unintended consequences... We would also welcome a department written statement on what you would like to see if the Legislature authorizes future task forces.

Secondly, we would like a comprehensive picture of assisted living options in Alaska. I have attached a possible grid that could be filled out to paint this picture. The idea is to define the columns as all possible assisted living options and add whatever rows are necessary to distinguish easily between the options in the columns. Feel free of course to design the "picture" as you see fit, but please answer the questions this grid implies. Incidently, we have LCD projection on which we can show Excel files.

	Group # 1	Group # 2	Group # 4	group # 3	Group #4	Group # 5
Type of Housing	Studio Apartment	One BR Apartment	two or more BR	Pioneer home	Senior's Private Home?	Private Group Home?
Facility owner	private business	hud		State of AK	client	
Number of Beds						
Services Provided	none other than subsidized housing.				Housekeeping 2-3 Meals per day Laundry Transportation Intermittent Nursing Services	
Type of Client	elderly	dd		?		
Caregivers per facility	n/a					
Revenue source/s:						
State Subsidy		$				
Medicaid Subsidy		$				
Co-pay		$				
HUD		$				
Other						
Accountability:						
Case Managers						
Regular Audit						
Licensing Authority						
Inspections						
Billing Procedure						
Note: Please expand this and fill in the blanks...						

Jason,

Please Schedule a HESS meeting on "Long Term Care". We want two departments to tell us 1) What actions have been taken, 2) What actions will be taken, 3) How actions have changed services for the recipients 4) What is still "broken? Note: These are just draft leading questions... Please get refinement from Sheila Peterson in Wilken's office and perhaps Halcro--- and of course we will pump Fred ...

Fyi: The "requests" resulted from a long term care task force (LTCTF) that tried to resolve some of the snarls that exist partly because there are two Dept's involved. I do not remember who was on the LTCTF other than Senator Wilken. Probably Halcro was on it also or he would not have asked. Sheila will know and we could find it in HESS minutes in 1998. They produced a really nice report and proposed three or four pieces of legislation several of which passed. So, the goal of this meeting is to preserve the work that was done and keep the issued defined for us and those that might follow.

After this rush of bills we are collecting in HESS there will be a lull. Because HESS is often the first committee of referral, we are the first to feel the slack. Put this request in your queue file and watch for an opportunity to schedule it promptly after the rush. Just before scheduling it (not more than a day or two), contact DOA and HSS and put them on notice that we want a response to the questions.

Early April

Sheila (Wilken)
3709

9:36

ALASKA STATE LEGISLATURE

CHAIR
TRANSPORTATION

VICE-CHAIR
LABOR AND COMMERCE

MEMBER
COMMUNITY AND REGIONAL AFFAIRS

SPECIAL COMMITTEE
ECONOMIC DEVELOPMENT AND TOURISM

REPRESENTATIVE ANDREW HALCRO
District 12

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MEMORANDUM

TO: Representative Fred Dyson, Chair
House HESS Committee

FM: Representative Andrew Halcro AH

DATE: January 25, 2002

RE: Long-Term Care Task Force recommendations

After our conversation, I reviewed the fifteen recommendations made in the 1999 Report by Long-Term Care Task Force. Four of the fifteen required specific legislation, of which, three became law while the fourth failed due to an $800.0 fiscal note.

The remaining recommendations were directives for the administration to follow. I am interested in checking the progress of the nine recommendations not requiring legislative action. I have attached the LTCTF recommendations for your review. At your convenience, we can discuss this further.

WES
WHAT DO YOU THINK ABOUT HAVING THE ADMINISTRATION TELL A HESS HEARING WHAT THEY HAVE DONE to follow THE RECOMMENDATIONS of THE LONG-term CARE TASK FORCE?
Yes - but maybe ^we need to wait & combine something similar (maybe Assisted Living)
2/15/02 - I called Sheila Peterson & bounced idea off of her - she really likes the idea. I asked Jason to put it on schedule.

E-Mail: Representative_Andrew_Halcro@legis.state.ak.us

Long-Term Care Task Force
Time Table for Specific Requests

Request	Who	What	To Whom	When	Comment
No. 3 *		Introduce legislation relating to the disclosure of licensing reports and licensing of home health agencies.			
No. 6	Department of Administration	Consider the formal recommendations outlined in *The Alaska Guardianship Report* and recommend necessary statutory changes.	Senate President and House Speaker	March 31, 1999	
No. 7 *		Introduce legislation relating to the protection of a vulnerable adult from a guardian, attorney-in fact or surrogate decision-maker who may harm the vulnerable adult.			
No. 8	Alaska State Hospital and Nursing Home Association	Prepare a full report on the actions required to be taken as a result of the conclusion reached at the statewide *Work Force Development Summit* to be held April 9-10 , 1999	Senate President and House Speaker	No Date Specified	
No. 10	Alaska Commission on Aging	Implement a plan to increase the awareness of Alaskans to advance directives and prepare a report on the Commission's efforts to do so.	Senate and House HESS Committees	Beginning of the Second Session of the 21st Legislature	
No. 12	Department of Health and Social Services	Aggressively pursue the rebuttal of the federal Health Care Financing Administration's interpretation of the Social Security Act as it relates to the Indian Health Service.	Legislature	Semi-annually	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 13 *		Introduce legislation relating to the establishment of a home and community-based services program for certain adults with long-term care needs.			
No. 14	Departments of Administration and Health and Social Services.	Review all options available to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and prepare a preliminary report outlining findings and recommendations	Senate President and House Speaker	April 30, 1999	
No. 18	Alaska Commission on Aging	Coordinate efforts to inform and educate all Alaskans on the various long-term care services available and provide updates on its efforts.	Senate and House HESS Committees	Semi-annually	
No. 19	Department of Administration	Establish a uniform and comprehensive screening and assessment tool and develop a pilot to assess its validity and reliability.	Not Specified	July 1, 2000	
No. 21 *		Introduce legislation relating to the adoption of the nursing home certificate of need recommendations developed by the *Legislative Working Group on Long-Term Care.*			
No. 24	Department of Health and Social Services	Identify necessary changes to assure the Medicare program funds health care services provided to dual eligible patients. Prepare a report on its efforts and make recommended changes.	Senate President and House Speaker	March 31, 1999	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 29	Department of Commerce	Compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public.	All Alaskans	January 1, 2000	
No. 31 *	Senate and House HESS Committees, in consultation with legislative leadership	Consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.			
Letter to Commissioner Bob Poe	Department of Administration	Prepare a summary of a public hearing regarding the administrative practices of the Anchorage Pioneers' Home and corrective actions either taken or proposed to be taken, by the department.	Senate and House HESS Committees	February 28, 1999	

* Requires legislation

LTC TASK FORCE
Long-Term Care Task Force

FINAL REPORT
January 1999

Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman

State Capitol Building
Juneau, Alaska 99801-1182

Long-Term Care Task Force Members

Representative Con Bunde - Co-chairman
Senator Gary Wilken - Co-chairman

Representative Al Kookesh
Representative Joe Ryan
Senator Lyman Hoffman
Senator Bert Sharp
Ms. Joyanna Geisler
Mr. John Hanchett
Mr. Dennis Murray

Ms. Alison Elgee
Ms. Karen Perdue
Ms. Deborah Sedwick

The Long-Term Care Task Force recorded its meetings. The tape recordings may be obtained from the Alaska Legislative Reference Library, Goldstein Building, Room 400, Juneau, AK 99801.

LTC TASK FORCE
Long-Term Care Task Force

FINAL REPORT
January 1999

Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman

State Capitol Building
Juneau, Alaska 99801-1182

Alaska State Legislature

Official Business

State Capitol
Juneau, Alaska 99801-1182

Long-Term Care Task Force

January, 1999

To the reader;

The report you are now holding could not have been possible without the dedication and hard work of many people, in government and the private sector, who overcame significant limitations in time and resources to produce valuable recommendations on how Alaska can best provide long-term care for its citizens.

While we helped guide this process as co-chairs of the Long-Term Care Task Force, the credit for its achievement lies with them. We would therefore like to acknowledge our appreciation:

To the members of the Long-Term Care Task Force themselves, who absorbed vast amounts of data and produced creative approaches to one of our state's most pressing human concerns;

To the staffers at various state agencies, who generously shared their experience and expertise so that our recommended actions would have the best possible foundation in real-world experience;

And to the members of the public, who honored us with their time and attention, and whose personal testimony ever reminded us that all Alaskans have a personal stake in ensuring quality long-term care in the Last Frontier.

Thank you one and all.

Sincerely,

Representative Con Bunde
Co-Chair

Senator Gary Wilken
Co-Chair

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INTRODUCTION TO LONG-TERM CARE

Once thought of as a nation of young people, the United States quickly is becoming elderly. Declining fertility rates, longer life spans, better health care, improved technology and an aging baby boomer generation are contributing factors. Because of the advancements in technology and health care, elderly people and people with disabilities are living longer. Soon people 65 years old and older in this country will outnumber the young.

"Soon people 65 years old . . . will outnumber the young."

In 1900, there were 3.1 million people age 65 or older in the United States. By 2020, this population is expected to reach 54 million, representing about one out of every six Americans. In addition, a large portion will be over the age of 85 – a group that is most likely to need assistance with everyday activities.[1]

Alaska, too, is experiencing a rapid growth in our senior and disabled populations. Senator Bert Sharp, Fairbanks, and Senator Jim Duncan, Juneau, introduced Senate Concurrent Resolution 11 (SCR 11) in 1997 to address this critical issue and plan for the future. In his sponsor statement, Senator Sharp made the following comments regarding this resolution:

> As Alaska's senior community grows, it is necessary that we plan for the long-term care needs of these citizens. While it is the desirable goal of most families to provide home care for their elderly parents, the reality is that most will live in a long-term care facility. Either way, the costs of providing long-term care is becoming insurmountable to the state and to our private citizens.
>
> SCR 11 will create a long-term care task force. Their mission is to review the findings of the legislative working group and develop an equitable plan for providing actuarially sound and affordable long-term care options for all of the Alaska's senior citizens.[2]

"The Long-Term Care Task Force is created."

This resolution was adopted in 1998 and the 12-member Long-Term Care Task Force, composed of legislators, state officials and private citizens, was created.

The Task Force held meetings in Anchorage and many concerned Alaskans from around the state talked to the panel about the long-term care needs of seniors and adults with disabilities. Rural residents raised concerns about sparse services in rural Alaska. Many pointed to a shortage of workers to provide in-home personal care, the kind of help that can keep older people in their own homes. The exploding price tag associated with the cost of providing long-term care was frequently mentioned.

The task before this group was daunting, but all members of the task force were willing to devote their time and expertise to grapple with the challenge of accommodating and providing for adequate long-term care services for more and more Alaskans. The first step for the Task Force was to review the various reports and studies conducted over the past several years. These studies were invaluable in their work.

"Between the years of 1990-96, Alaska had a 42 percent increase in people age 65 years and older."

The *Legislative Working Group on Long-Term Care*, created in 1996, analyzed the state's population trends and noted that the number of Alaskans age 65 years and older is growing dramatically. The senior community is growing about 5 percent annually while the rest of the population is growing annually about 2 percent.

Alaska is second in the nation in the proportional growth of our senior population – with a 42 percent increase in people age 65 years and older in only six years (1990-96). Only Nevada had a greater rate (45 percent) in the same period of time.

Equally impressive is the anticipated long-term growth of Alaska's senior population. In 1980, there were 11,547 people over the age of 65 years. Using moderate growth projections, population experts agree this number may reach 80,927 by the year 2015. This is a 600 percent increase in only 35 years.[3]

The increased number of Alaskan seniors is the result of many factors, the three most mentioned being: 1) the state's more stable economy which makes it feasible for seniors to retire in Alaska; 2) successful public health care services; and 3) the many community-based programs which assist seniors to receive long-term care at home in their communities.

"Who should pay for long-term care?"

However, an increase in the number of elderly and adults with disabilities in Alaska means a dramatic increase in the number of people needing long-term care services. The *Legislative Working Group on Long-Term Care* noted that in FY96 the annual cost to provide long-term care services was $73 million, while in FY15 those same services would cost $372 million (assuming moderate population growth

and inflation). "The growth of the long-term care programs ... will be significant over time if costs or population grow at even a moderate rate."[4]

The question of who should pay for long-term care – the federal government, the state government, or private individuals themselves – was the focus of much discussion. Since Medicare and most private health insurance policies generally do not pay for long-term care, many people look to public financing to fund their nursing home or home health care needs.[5] In Alaska, Medicaid pays for the care of 80 percent of all nursing home residents. (The state pays 40 percent of all Medicaid costs.)

"The public is in denial about long-term care needs."

"The public is in denial about long-term care and routinely ignores the risk. Less than ten percent of seniors have purchased long-term care insurance and virtually none of the baby boomers have done so," stated Mr. Stephen Moses, Long-Term Care Center President, before a National Press Club Forum on November 19, 1998 in Washington, D.C. One out of three of us will need long-term care at some point in our lives. However, fewer than one in 20 Americans have purchased insurance to pay for it, forcing Medicaid to pick up the tab instead.[6]

Both at the state and federal level, policymakers are wrestling with this issue. *The Wall Street Journal* reported on December 7, 1998 that the Clinton administration was working on a proposal to provide tax credits to defray the cost of long-term care for the elderly and people with physical disabilities. Others are urging reform through the Social Security Act.

"The recommendations proposed by the Task Force will slow the growth of state expenditures."

The Task Force only scratched the surface in its discussion on how to adequately fund the increasing demand for long-term care for seniors and persons with disabilities living in Alaska. More in-depth and extensive research and analysis is necessary before a single funding plan, or a group of funding alternatives, can be structured. In the meantime, the recommendations proposed by the Task Force will slow the growth of state expenditures and begin the shift from public spending to private payers. ❖

QUALITY LONG-TERM CARE

As society has changed, so has the long-term care community. Long-term care now includes a broad spectrum of care including subacute medical care, ongoing skilled nursing care, care of the developmentally disabled and special populations, to adult day care, residential care, assisted living, and home and community-based care.[7]

A big change in home care for seniors and adults with disabilities was the development of the Medicaid waiver CHOICES program in December 1993. Indeed, a number of low-income seniors and adults with physical disabilities, who otherwise would need nursing home care, may now elect to receive long-term care services in their home or community. The plan of care is designed to meet the needs and preferences of each individual.

"The CHOICES alternataive is a popular option; the number of clients more than doubled between 1996 and 1998."

The CHOICES alternative is a popular option for qualifying Alaskans; the number of clients more than doubled between 1996 and 1998. Unfortunately not all seniors have this choice. The vast land area of our state, low population density, and our population distribution combine to create difficult hurdles to clear. But these unique problems can be solved, one step at a time.

The Task Force recognizes that long-term care is reinventing itself as providers strive to meet the diverse needs of Alaska's seniors and adults with physical disabilities. With each step, the quality of long-term care continues to improve. ❖

PERSONAL CARE ATTENDANT

RECOMMENDATION 1

The Task Force acknowledges and supports the effort of the Personal Care Attendant Design Team to redesign the personal care services delivery system and establish professional standards for personal care attendants.

Personal Care Attendant (PCA) services enable adults with physical and mental disabilities and elderly Alaskans to live in their own homes or communities. PCA services are typically provided in a consumer's home by trained health care para-

professionals and include assistance with activities of daily living such as eating, bathing, dressing, personal hygiene and medication needs. Ideally, these services are part of a continuous and coordinated system of social and medical support.[8]

In order to facilitate their integration with other home and community-based services, PCA services are administered through the Division of Senior Services, Department of Administration. Two models of personal care services are available in Alaska: the *independent model* and the *agency-based model.*

"Two models of personal care services are available in Alaska: the independent model and the agency-based model."

In the *independent model*, the consumer hires and manages the personal care attendant as an employee. In FY97, independent personal care attendants provided services to approximately 65 individuals. Independent care attendants who serve Medicaid clients contract directly with the Division of Medical Assistance for $12 per hour.

In the *agency-based model*, specific non-profit agencies provide personal care attendant services. In FY97, almost 950 individuals received personal care services through agency personal. The reimbursement rate for agencies to provide personal care services to Medicaid clients is $21 per hour. The attendant directly providing the services receives an average of $9-12 per hour, with or without benefits.

Personal care attendants are the cornerstone of home and community-based programs that allow Alaskans to receive health care support services in their home communities.

"Personal care attendants are the cornerstone of the waiver programs."

On November 14, 1998 a "Personal Care Attendant Services Summit" was held in Anchorage to develop clear objectives for improving Alaska's delivery of PCA services. The summit was directed by a steering committee composed of the key individuals and organizations, both public and private, actively involved in providing or directing long-term care services in the state.

Approximately 85 participants attended the statewide "Personal Care Attendant Services Summit." This conference was an instrumental step toward refining the way thousands of Alaskans with disabilities and seniors will receive long-term care in their homes and communities and continue to live independently in the future. To accomplish their goal, summit attendees 1) adopted guiding principles for a delivery system that provides service for all levels of care; 2) began the design of a PCA service program that fits Alaska; and 3) identified potential bar-

riers that must be addressed before a smooth transition to the new delivery system can occur.[9] (Please see Appendix G, page 79, for further detail.)

The Task Force recognizes that this summit represents a first step in a long, involved process that may include regulatory and statutory changes, as well as some possible change in funding sources. The Task Force applauds and encourages that beginning. As the Division of Senior Services and others continue and complete their work, the Task Force encourages the general public to get involved.

In addition to reviewing the options for a new delivery system for personal care attendant services, the Task Force recommends that the Division of Senior Services and others review the possibility of establishing professional standards for personal care attendants. The adoption of standards developed through a public process will provide a reasonable framework to assure quality care. ❖

"The Task Force recommends that the Division of Senior Services review the possibility of establishing professional standards for PCAs."

DELEGATION OF NURSING ACTIVITIES

The Task Force recognizes the efforts of the Alaska Board of Nursing to address the issue of "delegation of nursing activities" and challenges all interested parties to actively participate in the Alaska Board of Nursing public hearing process when this issue is addressed.

On September 21-23, 1998, approximately 100 community, agency and senior advocacy leaders from across Alaska met to identify and address opportunities and challenges affecting the growing number of older Alaskans. The focus of the conference, entitled *Alaskan Seniors: Finding the Common Ground*, was to unite the participants' efforts to better meet the needs and address the concerns of Alaskan seniors. (Please see Appendix H, page 81 for further detail.)

"Alaska is proud of its caregivers."

At this conference the participants stressed that the foundation of any long-term care service is the quality of the actual service provided through the public and private sector. A person who is elderly or experiences a disability must have assurance that the care provided is appropriate, provided in a timely manner, and performed by qualified personnel.

Likewise it is recognized that many long-term care recipients may wish to maximize their personal independence. To achieve this independence, they are willing to assume some personal risk.

The caregivers in Alaska are dedicated and well respected. "The degree of commitment to clients of those working in the Alaska long-term care systems seems higher than most states."[10] Alaska is proud of its caregivers.

"Delegation of some nursing activities is appropriate."

With the growth of Alaska's senior community and the expansion of the home and community-based programs and assisted living homes, the care of Alaskan seniors and people with disabilities may be provided by unlicensed assistive personnel. Unlicensed assistive personnel are individuals who are not authorized to perform nursing acts or tasks that are regulated by the Board of Nursing except pursuant to legal delegation by a nurse.[11]

Changes in the levels of health care provided in traditional and non-traditional settings have altered the scope of practice of nursing and its relationship to unlicensed assistive personnel. The unlicensed home care provider may now be involved in procedures such as assisting with medication, intermittent bladder catheterizations and gastrostomy feedings.[12]

Delegation of some nursing activities is appropriate and, in fact, a legally accepted part of the practice of nursing. However, at times, it can be difficult to define what is appropriate to delegate and in what circumstance. The Board of Nursing has the authority to regulate nursing practices, including the delegation of nursing tasks. In 1993 and 1995 the Board of Nursing wrote two position statements on how the practice of using unlicensed assistive personnel relates to the nursing practice.

"The Task Force applauds the continued effort of the Alaska Board of Nursing to establish guidelines."

Alaska is not alone in wrestling with this issue. At the national level, the issue of appropriate, safe nurse delegation is an ongoing topic among state boards of nursing and health care providers.

The question of delegation of responsibilities extends beyond the nursing staff. Other professionals such as pharmacists, social workers, physical therapists and occupational therapists provide input and directives regarding the care of clients. Unlicensed assistive personnel often carry out their directives.

The Task Force applauds the continued effort of the Alaska Board of Nursing to clarify the guidelines regarding the delegation of nursing tasks by nurses. In addition, the Task Force recognizes the importance of approaching this task with cre-

ativity and the active engagement of all interested individuals, agencies, long-term care providers and other professional boards. The Task Force challenges everyone to participate in the decision-making process. ❖

HOME HEALTH AGENCIES/LICENSING REPORTS

The Task Force recommends that legislation be drafted and introduced relating to the disclosure of licensing reports and licensing of home health agencies.

The Task Force was presented draft legislation that covered two specific areas of concern. The first subject dealt with the disclosure of licensing reports. Under current law, AS 18.20.090, the Department of Health and Social Services cannot make available to the public the annual inspection and investigation reports of the hospitals or nursing homes licensed by the department. As noted in testimony before the Task Force, full public disclosure of licensing reports would benefit the public and help individuals make appropriate decisions regarding their health care needs.

"Full public disclosure of licensing reports would benefit the public."

The proposed legislation under consideration will make the department's licensing reports available to the public within 14 calendar days after the information is made available to the health care facility being reviewed. Any information that identifies patients or clients remains confidential.

The second area of discussion centered on the actual licensing process for home health agencies. A home health agency, either public or private, is an entity that provides primarily skilled nursing care and therapeutic services to people in their own homes, an assisted living home, or another residential setting.

"A home health agency is an entity that provides primarily skilled nursing care."

The Department of Health and Social Services has, since the early 1980s, licensed home health agencies. Regulations (7AAC 12.500-12.590) were adopted under the department's broad regulatory authority. Only recently did the Department of Law question that authority. The draft legislation presented to the Task Force provides the Department of Health and Social Services with the necessary and specific statutory authority to license and regulate the quality of care provided by

these agencies. The continued oversight of home health agencies will assure the public that the quality of care being provided to clients meets minimum standards.

The Task Force acknowledges the importance of the concepts included in the proposed legislation and recommends the legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.)

SMALL BUSINESS TRAINING

The Task Force supports an increased effort to train Assisted Living Home administrators in proven small business practices and urges collaboration between the Department of Administration and the University of Alaska to provide this education.

On January 14, 1994 Governor Wally Hickel introduced legislation that developed a system of long-term care "by encouraging the establishment of assisted living homes that provide a homelike environment for elderly persons and persons with a mental or physical disability who need assistance with the activities of daily living." (Chapter 130, SLA 1994) Assisted living homes promote and sustain the independence of Alaskans through a social model of community-based long-term care.[13]

"Eighty-five assisted living homes have been licensed by the Department of Administration."

Assisted living homes provide a home-like setting as well as certain health-related services or assistance with certain personal activities. Such services allow the elderly to age in place, rather than having to be transferred to a more institutionalized nursing-home setting, and allow adults with a physical or mental disability to become integrated into their community.[14] Eighty-five assisted living homes have been licensed by the Department of Administration to serve the elderly. In addition, the Department of Health and Social Services has licensed 134 assisted living homes to provide care primarily to individuals with a mental or developmental disability.

Assisted living homes have become a reality in many, but not all, areas of Alaska.[15] In some instances, it is difficult to establish an assisted living home and provide the necessary care. Interested care providers must first have an adequate, safe facility and then must obtain the required licensure, insurance coverage, and per-

sonnel before they can open their doors to clients. The start-up costs can be substantial and the risks great.

As was noted in the draft *Alaska Rate Study Report*, November 1998, many assisted living home owners/operators are not financially prepared or sufficiently trained in business operations to meet the needs of Alaska's aging population. The Division of Senior Services recognizes that more in-depth business education is necessary, and plans to expand its training options available to interested long-term care providers.

"The University ...is exploring the possibility of offering a three-credit college course in business practices for assisted living home administrators."

Currently assisted living home administrators and executive personnel are offered a one-day orientation seminar in which necessary fiscal practices are reviewed. The covered topics include general accounting practices, the state and federal reimbursement systems, availability of bank financing and various insurance requirements. In addition, the Division conducts a weeklong workshop and similar topics are reviewed in greater depth. At the completion of this course, the participants are recognized as "certified assisted living home administrators."

The Division of Senior Services and the University of Alaska are exploring the possibility of offering a three-credit college course in business practices for assisted living home administrators. The Task Force applauds this effort and encourages continued business training for owners and operators of assisted living homes. ❖

ASSISTED LIVING STANDARDS

The Task Force requests the Department of Administration review the current regulations governing assisted living homes and, through a public process, establish statewide standards for long-term care services provided in an assisted living home.

Recently the *Assisted Living Quality Coalition*, a coalition of six assisted living consumer and industry associations, issued a report that provides a framework for quality initiatives in assisted living facilities, as well as guidelines to help state policymakers set minimum quality standards.

The *Assisted Living Quality Coalition* consists of the American Health Care Association, the Alzheimer's Association, the American Association of Homes and Services for the Aging, the American Association of Retired Persons, the American Seniors Housing Association, and the Assisted Living Federation of America.[16]

"The guidelines will provide an excellent frame of reference to begin a discussion on statewide standards."

The issues addressed by this coalition are the same concerns regarding long-term care expressed by the Alaska Chapter Alzheimer's Association. It was noted in a letter to the Task Force that standardization of care in all facilities across the state is of utmost importance.[17] The quality initiative and the consensus guidelines as proposed by the *Assisted Living Quality Coalition* will provide an excellent frame of reference to begin a discussion on statewide standards for quality care in assisted living homes.

The Task Force requests the Department of Administration review the current regulations governing assisted living homes and, through a public process, establish statewide standards for long-term care services provided in an assisted living home. The standards may include a standard of care that takes into account each individual resident's needs and preferences, as well as whether the living arrangement is appropriate for a particular level of care.

In addition, the Task Force requests the Department of Administration determine if the current assisted living regulations are appropriate for any size facility. In certain instances, regulations that are appropriate for a small assisted living home may not be appropriate for a larger home. The Department is requested to promulgate the necessary changes, if needed. ❖

ALASKA GUARDIANSHIP SYSTEM

The Task Force urges the Department of Administration and the Division of Senior Services give serious consideration to the formal recommendations outlined in the report, *The Alaska Guardianship System*, and notify the Legislature of any statutory changes necessary.

Three guardianship systems exist in Alaska, each providing a different mix of services; public guardians, private professional guardians; and private unpaid (usually family) guardians. Under each system, the guardian is legally in charge of the affairs of a minor or incapacitated person.

In September 1998 the McDowell Group, Inc. reviewed and assessed the guardianship system in Alaska and issued a report entitled, *The Alaska Guardianship System.* This review was funded by the Mental Health Trust Authority and is the result of the Trustees' desire to look proactively at the future of guardianship services in Alaska. Most clients served within Alaska's guardianship system are Trust beneficiaries.

"The Alaska Guardianship System is reviewed."

The final product met two major objectives: 1) To describe and quantify the entire complex guardianship system; and 2) To identify and analyze major issues and provide clear recommendations for improving the quality of guardianship in Alaska.

This study included 70 in-depth interviews, a facilitated group discussion with the public guardian staff, and a sample telephone survey of 17 private guardians in Anchorage and Fairbanks. In addition, court data on open guardianship cases was analyzed and secondary research was conducted on other state's practices and standards.

The Alaska guardianship system was found to be complex, sophisticated, fragmented and confusing. Guardianship is a wide-ranging issue interconnecting Alaska courts, state agencies, the legislative branch, the legal profession, non-profit sector, many local, state and federal social service agencies, and private households.[18]

"The McDowell Group estimated that individuals suffering from Alzheimer's Disease account for approximately half of all guardianship cases."

As estimated by the McDowell Group, individuals suffering from Alzheimer's Disease and related dementia accounted for approximately half of all the guardianship cases and individuals experiencing developmental disabilities accounted for a quarter of all the cases. In other words, almost seventy-five percent of all clients receiving guidance and support from a guardian may also be receiving long-term care service.

The Task Force applauds the foresight of the Mental Health Trust Planning Board in initiating this review and urges serious consideration and discussion of the formal recommendations outlined in the report. In addition, the Task Force recommends that the President of the Senate and the Speaker of the House be notified by March 31, 1999 of any statutory changes necessary to implement the report's recommendations. ❖

LEGISLATION TO PROTECT VULNERABLE ADULTS

The Task Force recommends that legislation be drafted and introduced to protect a vulnerable adult from a guardian, attorney-in-fact or surrogate decision-maker who may harm the vulnerable adult.

AS 47.24.900 (16) defines a vulnerable adult as a person 18 years of age or older who, because of physical or mental impairment, is unable to meet his or her own needs or to seek help without assistance.

Under current law, if a person has reason to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect or self-neglect, the concerned individual must contact the Department of Administration which, in most instances, initiates an investigation. After the department conducts an investigation, a written report is prepared of the department's findings, recommendations, and determination of whether supportive or protective services are necessary.

"After the department conducts an investigation, a written report is prepared."

The department must immediately terminate an investigation upon the request of the vulnerable adult who is the subject of the report. Unfortunately, in some instances, the adult's guardian, attorney-in-fact, or surrogate decision-maker, who is the alleged perpetrator of the abuse and the subject under investigation, may make the request. Currently AS 47.24.015 (c) does not allow the Department of Administration any option in such a case but to terminate the investigation. A change to this statute is necessary to adequately protect the vulnerable adult.

The investigation findings and the reports of the abandonment, exploitation, abuse, neglect or self-neglect of a vulnerable adult filed with the department are considered confidential. However, the reports are disclosed if the vulnerable adult who is the subject of the report consents in writing. A problem arises when the vulnerable adult's guardian, attorney-in-fact or surrogate decision-maker is suspected of abuse and is under investigation. The disclosure of the complaint, in this case, would severely restrict the department's ability to effectively continue with its inquiry.

"A problem arises when the vulnerable adult's guardian is under investigation."

The Task Force recognizes that a situation may arise where a guardian, attorney-in-fact or surrogate decision-maker will abuse or harm a vulnerable adult and the statutes should reflect this possibility. The proposed legislation addresses this like-

lihood and gives the Department of Administration the needed leeway to conduct a thorough investigation in order to protect the vulnerable adult. (Appendix B)

Federal and state law provides for long-term care ombudsman services for vulnerable adults who are 60 years and older and reside in a nursing home or an assisted living facility. The Task Force recognizes that vulnerable persons under the age of 60 who reside in nursing homes or assisted living facilities also have a need for protective services. The Disability Law Center, the State Independent Living Council and its regional centers, the Division of Senior Services, and the Division of Mental Health and Developmental Disabilities offer protective and advocacy services to these individuals. Greater access and collaboration between these organizations will help strengthen their ability to meet the needs of these vulnerable persons under the age of 60 who are living in an institutional setting.

"The Task Force recognizes that vulnerable persons under the age of 60 who reside in nursing homes or assisted living facilities also have a need for protective services."

The Task Force recommends that these entities coordinate efforts: 1) to increase residents' awareness of the protection and advocacy services available within the state; 2) to facilitate the system's response to complaints and requests for assistance. ❖

WORK FORCE DEVELOPMENT SUMMIT

The Task Force endorses the efforts of the Alaska State Hospital and Nursing Home Association, in conjunction with the other training councils, to hold a statewide Work Force Development Summit.

On September 17, 1998 the Alaska Human Resource Investment Council (AHRIC) and the University of Alaska Statewide Vocational/Technical Education Advisory Council (UASVTEAC) held a joint meeting in Seward to discuss issues surrounding the demand and capacity of Alaska's health care industry.

"Low pay, lack of adequate training and frequent job turnover (are) problems."

The concerns expressed at this joint meeting parallel the testimony received by the Long-Term Care Task Force. Many long-term health caregivers testified in great detail about how fragile the job situation is for people who provide day-to-day health care for seniors and adults with disabilities. Low pay, lack of adequate training and frequent job turnover were some of the reoccurring problems mentioned.

"Alaska faces a crisis in meeting the demand for qualified workers within the health care industry."

Alaska faces a crisis in meeting the demand for qualified workers within the health care industry. The quality, affordability and availability of health care impacts every community and citizen in Alaska. The inability to meet the workforce demand translates into higher customer costs, limited service in the community, lower quality of service and added stress on the existing limited health care workers.[19]

The Alaska State Hospital and Nursing Home Association (ASHNHA) plans to hold a statewide conference, in cooperation with AHRIC and UASVTEAC, on April 9 - 10, 1999 to address the five major areas of concern identified on September 17, 1998. The goal of the conference is to find ways to: 1) increase training opportunities for health-related occupations: 2) create career ladders for personal care attendants, certified nurse aides, licensed practical nurses, and individuals with an associate's degree in nursing; 3) design worker retention strategies for employers and existing workers; 4) recommend new workplace policies; and 5) increase the number of Alaska residents acquiring new jobs in the industry.[20]

The Task Force further recommends that a full report on the actions required to be taken as a result of the statewide summit be submitted to the President of the Senate and Speaker of the House for additional review and action. ❖

CAREER LADDER FOR HEALTH CARE PROVIDERS

The Task Force encourages the University of Alaska to explore further the development and expansion of its curriculum to facilitate a career ladder for health care providers.

On September 17, 1998 more than 70 people attended a statewide conference sponsored by the Alaska Human Resource Investment Council and the University of Alaska Statewide Vocational/Technical Education Advisory Council, focusing on *Alaska's Health Care Industry: Workforce Demand and Capacity*. The Department of Labor outlined the workforce demand and occupational forecasts for the health-care industry. In addition, several industry representatives offered a unique view of the current workforce demand in health care and the corresponding training capacity.

During the facilitated roundtable discussions, the group was challenged to envision a more responsive workforce development system that produces a quality, skilled Alaska health care workforce. A common theme throughout the discussion was the lack of a formal, education career ladder that encourages an individual health caregiver to advance and grow within the health care field. As it was envisioned, a person could enter the health care profession at the entry level (personal care attendant) and through training and college education advance in the field. Through training, education and experience the caregiver could obtain certification at each level of expertise. This career ladder would enhance the training, education opportunities, and earnings for health care providers.

"It is projected that more than 1,500 new jobs in the health care profession will be created over the next five years."

As noted at the conference, it is projected that more than 1,500 new jobs in the health care profession will be created over the next five years. One half of these new jobs will require two-year associate's degrees, four-year baccalaureate degrees or master's degrees. An integrated training program that includes both vocational and college education will be necessary to meet this new job demand.

The Task Force is excited about the new job possibilities and expansion of the health care industry, but also recognizes the challenge before the University of Alaska and other training institutions. A well-qualified, trained workforce must be available. The Task Force applauds the University of Alaska's active involvement in addressing the needs of the health care industry and encourages the University to explore further the development and expansion of its curriculum to facilitate a career ladder for health care providers. ❖

ADVANCE DIRECTIVES

RECOMMENDATION 10

The Task Force encourages the Alaska Health Fair, Alaska Commission on Aging, AARP, and other related organizations to provide educational information on the importance of advance directives and encourage the use of advance directives in the provision of health care.

"Advance directives help all individuals maintain control over their health care decisions."

Advance directives are legal documents, prepared in advance of any incapacitating condition, stating the author's preference for health care. Advance directives help all individuals maintain control over their health care decisions even after the loss of decision-making capability. The Task Force heard testimony in support of

the concept of planning medical decisionmaking through the use of living wills and durable powers of attorney for health care.

In a *living will*, the applicant describes a specific preference for medical treatment if terminally ill or near death. With this document, even if the patient cannot communicate, he/she ensures that his/her desires have been conveyed to the doctors and family members. Alaska's living will has a checklist that helps describe the type of care desired.

"A person does not give up any control with an advance directive."

A *durable power of attorney* for health care is a legal document that expresses an individual's wishes about health care treatment and appoints someone to speak for the patient if the person becomes seriously ill or injured and cannot speak. Once signed and witnessed, this document becomes part of the individual's medical record.

A person does not give up any control with an advance directive. As long as the individual is able to make decisions, he/she is the decisionmaker. An advance directive only applies when one cannot speak or otherwise provide instruction to caregivers. The document can be changed or revoked at any time, as many times as wished.[21]

"AARP has established an education network to inform its membership on many issues facing us as we age."

The Alaska Health Fair plans and stages over 120 health fairs annually throughout Alaska, reaching approximately 40,000 people in both urban and rural settings. This outreach venue provides an excellent opportunity to inform many citizens on the various advance directives honored in Alaska.

In addition, the American Association of Retired Persons has established an education network to inform its membership on many issues. The Alaska Commission on Aging also regularly circulates information on resources available to all Alaskans as we age. Together their added voices will increase the education effort on the advance directives available.

The Task Force encourages the Alaska Health Fair, Alaska Commission on Aging, AARP, and other related organizations to provide educational and informational forums, as appropriate, on the importance of advance directives and encourage the use of advance directives in the provision of health care. In addition, the task force requests the Alaska Commission on Aging to coordinate these efforts, develop an implementation plan by December 31, 1999, and report to the Senate and House HESS Committees at the beginning of the Second Session of the 21st Legislature regarding the Commission's activities. ❖

ACCESS TO LONG-TERM CARE

One way, and possibly the best way, to ensure that Alaskan seniors and adults with disabilities remain as independent as possible for as long as possible is through a continuum of care. Under a continuum of care, individuals have available to them a broad spectrum of services that range from home and community-based services and preventive services at one end to 24-hour skilled nursing home care, notes the Alaska State Hospital and Nursing Home Association.

The Alaska long-term care system has many services available. However, it is not always the case that seniors are able to have a choice as to the type of service or the location of these services. This is especially true for services in the rural communities, as many Native elders need to leave their home communities and travel great distances to obtain services in unfamiliar urban settings.

"It is not always the case that seniors are able to have a choice."

The *Legislative Working Group on Long-Term Care* noted, "Access to the present long-term care system of direct services, payments for service, and grants to non-profits is very uneven across Alaska. In general, the range and quantity of available long-term care services increases with community size. Seniors in communities such as Kwethluk and Usibelli have no long-term services in their communities, while seniors in Fairbanks or Anchorage have limited access to a full range of services."

The Task Force recognizes that in some areas of the state access to appropriate health care services is a problem and recommends several changes to improve the availability of long-term care. ❖

AFN RESOLUTION

The Task Force recognizes and supports Resolution 98-59, *In Support of Elder Care Facilities in Rural Alaska*, as adopted at the Alaska Federation of Natives 1998 Annual Convention.

"The resolution supports elder care facilities."

At the recent Alaska Federation of Natives 1998 Annual Convention, Resolution No. 98-59, *In Support of Elder Care Facilities in Rural Alaska*, was submitted by the St. Mary's Native Corporation and formally approved by the whole convention. This resolution recognizes Alaskan elders as a respected group of people within the family unit and acknowledges the lack of proper facilities in rural areas that provide care for elders.

The resolution resolves that "(T)he Alaska Federation of Natives politically supports the efforts of rural organizations in seeking, acquiring, and administering the required funding, facilities, personnel, and technical and professional support for elder care facilities." The Task Force supports this effort to expand long-term care services in rural Alaska.

In FY99, the Division of Senior Services received funding to implement a rural long-term care development proposal that will focus on increasing home and community-based services in the rural regions of Alaska. The Alaska Mental Health Trust Authority is funding this two-year effort.

"By the end of FY00, more assisted living homes will be available in these five communities."

Five interested communities will receive assistance on ways to expand an existing home and community-based program or means to implement a new program. Local government, tribal authorities and federal and state agencies will be included in the planning and implementation process.

By the end of FY00, more assisted living homes will be available in these five communities. An appropriate workforce will also be created to meet the long-term care needs in those settings. ❖

INDIAN HEALTH SERVICE

RECOMMENDATION 12

The Task Force supports the Indian Health Service's role in providing long-term care services and encourages the Department of Health and Social Services to aggressively pursue its rebuttal of the Health Care Financing Administration's interpretation of the Social Security Act.

The Indian Health Service plays a pivotal role in the delivery of health care in rural areas of Alaska. "Designing a health care delivery system in rural Alaska, mostly populated by Alaskan Natives residing in communities of a few dozen to a couple thousand people, has been totally dependent upon the system developed by the Indian Health Service."[25]

"The Indian Health Service plays a pivotal role in the delivery of health care in rural areas of Alaska."

The Indian Self-determination and Education Assistance Act (PL 93-638) enabled Alaska Native people to become more actively involved in determining their destinies in health and educational affairs by allowing tribes to take over the operation of Indian Health Service programs and facilities. The Alaska Area Native Health Service encompasses nine service units distinguished by their cultural similarities and transportation patterns. Each service unit's field hospital or clinic serves as that service unit's headquarters and hub from which services radiate. In addition, personnel work at 22 health centers, and 167 village-built clinics.[26]

It has required ingenuity and determination to deliver community-based care to the dozens of villages scattered over thousands of square miles that each tribe serves without benefit of a road system.[27] The principal provider of health services at the village level is the community health aide, chosen by the village council. Planning for long-term care involves determining the level of patient care needed and providing home health services when possible. To date, with the exception of a nursing home wing in Nome, there are no nursing facilities in Alaskan villages and only two developing home health agencies. The establishment of home and community-based long-term care services has been difficult and has achieved limited success.

"The principal provider of health services at the village level is the community health aide."

New federal policy released during FY97 expanded 100 percent federal funding for Medicaid services to Alaska Natives to include tribal facilities and contract health services. Unfortunately the Health Care Financing Administration (HCFA) has determined that the actual health care must be provided "in" an Indian Health Service or tribal owned or leased facility in order to qualify for the 100 percent

federal funding. This ruling effectively eliminates any home and community-based care services from receiving the full federal reimbursement.

"The DHSS took exception to this ruling."

The Department of Health and Social Services took exception to this ruling and on June 9, 1997 wrote a position paper in support of an expansion of HCFA's interpretation to include community-based care. This letter states, "(It) is clear that the intent in adopting the 100 percent Medicaid Reimbursement Formula was to remedy the problem of access to Medicare and Medicaid supported services, and assure that states did not receive an unfair and inequitable burden of costs that normally would have been born by the Indian Health Service."[28]

The paper continued, "Home care services are under the control of the Indian Health Service or tribal health program, authorized under the Indian Health Care Determination Act, and covered as State Plan services under Medicaid, and should not be restricted from enhanced federal funding."[29]

The Indian Health Service is the prime provider of long-term care health service in rural Alaska. If the Health Care Financing Administration were to alter its opinion and recognize community-based services as being eligible for 100 percent federal reimbursement, the potential additional funding would have a definite beneficial impact on the level of services provided in rural Alaska.

"The Task Force recognizes and supports the Indian Health Service's role in providing long-term care."

The Task Force recognizes and supports the Indian Health Service's role in providing long-term care services. In addition, the Task Force encourages the Department of Health and Social Services to aggressively pursue its rebuttal of the Health Care Financing Administration's interpretation of 1905 (b) of the Social Security Act and provide the Legislature with semi-annual updates on the process of the Department's inquiry. ❖

HOME AND COMMUNITY-BASED LEGISLATION

RECOMMENDATION 13

The Task Force recommends that legislation be drafted and introduced to establish a home and community-based services program for certain adults with long-term care needs.

In 1995 Governor Knowles appointed a Long-Term Care Steering Committee, chaired by Department of Administration Commissioner Mark Boyer and Department of Health and Social Services Commissioner Karen Perdue, to develop and implement an interdepartmental Long-Term Care Strategic Plan. The Steering Committee developed legislation to create a comprehensive home and community-based services program that would not be limited to just Medicaid-eligible persons.

"Many seniors and adults with disabilities cannot fully pay for all the long-term care services they need."

Many seniors and adults with disabilities cannot fully pay for all the long-term care services they need, but still cannot qualify to receive Medicaid benefits. When these moderate income seniors or adults with disabilities do not receive the necessary health care services, they can ultimately require more intensive services than would have been needed had they received earlier support to stabilize their situation.

The legislation proposed by the Steering Committee authorizes the Department of Administration to establish and administer a program of home and community-based support services for adults with long-term care needs. Under this proposed legislation, adults receiving services are expected to contribute through co-payments for services on a sliding scale and are required to apply for payment from other sources if available.

"The Task Force acknowledges the value of home and community-based long-term care services."

The long-term care home and community-based program offered under Medicaid is meeting great acceptance. When given an option, people often elect to receive the long-term health care they need in their home and community rather than an institution. Almost twice as many Alaskans elected this Medicaid waiver in FY97 as in FY96.

Passage of the proposed legislation will allow all Alaskans with demonstrated needs the opportunity to request services through the Department of Administration's home and community-based care program, not just those eli-

gible for Medicaid. The Task Force acknowledges the value of home and community-based long-term care services and recommends this legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.) ❖

MEDICAID COVERAGE FOR ALZHEIMER'S PATIENTS

The Task Force requests the Departments of Administration and Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders.

Alzheimer's Disease and Related Disorders (ADRD) refers to cognitive impairments that are progressive and degenerative in nature. As a result of these impairments, effected adults require supervision and cueing from other individuals in order to adequately and routinely perform activities of daily living and instrumental activities of daily living.[30] People whose sole diagnosis is Alzheimer's Disease and Related Disorders do not typically require daily supervision by medical professionals.

"To be eligible for Alaska's Medicaid long-term care waiver programs, applicants must require skilled nursing services."

To be eligible for nursing home care and home and community-based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursing or intermediate care. Persons whose sole diagnosis is ADRD typically do not meet the criteria for skilled nursing or intermediate care and consequently, the Alaska Medicaid program will not pay for nursing home placement or home and community-based services.

Alaska is only one of two states whose Medicaid eligibility standards for nursing home and home and community-based services require that the patient needs "professional-level medical supervision."[31] This requirement, as determined by the Department of Health and Social Services, effectively eliminates eligible Medicaid ADRD-only patients from the state's major long-term care services.

Persons with ADRD may have great difficulty living without assistance.[32] Currently for many people who suffer from ADRD, respite service for their families is the only long-term care service available.[33] The Task Force recognizes the desire for additional assistance for this particular group of Alaskans and understands that

the temporary relief provided to the family caregivers is not enough to adequately address the pressing long-term care needs of an ADRD individual.

However, modifying the Medicaid eligibility requirement for ADRD-only patients may have budget implications for the state.[34] Approximately 40 percent of the cost for qualified Medicaid patients is paid from the state's General Fund. Some states have reduced the budget impacts by requiring that all long-term care patients receive universal care plan counseling. (Please see recommendation 20) The effect of this requirement has been to place residents in the least restrictive long-term care setting, which often is also the lowest-cost setting. The effect has been to prolong the time that residents can pay for their own care, and therefore, reduce the potential cost to the Medicaid program.[35]

"Persons with ADRD may have great difficulty living without assistance."

In addition to the budget concerns, the Division of Senior Services may not have the capacity to serve the additional clientele who may apply for home and community-based waiver services if ADRD is included as an eligible diagnosis.

Even though changing the Medicaid eligibility requirement to include ADRD-only patients raises serious concerns, 48 other states offer Medicaid programs to patients suffering from only Alzheimer's Disease. Alaska should too.

The Task Force requests the Department of Administration and the Department of Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders. Also, the Task Force requests that a preliminary report outlining the departments' findings be submitted to the President of the Senate and Speaker of the House by April 30, 1999. ❖

INCREASE MEDICARE ACCESS

RECOMMENDATION 15

The Task Force requests the Department of Health and Social Services conduct a review of Medicare patients' access to medical services within the state and, if warranted, explore options to increase their access to health care.

The Task Force heard testimony regarding individuals covered by Medicare who were having difficulty accessing health care services. General concerns were ex-

pressed that some medical providers may refuse to accept new clients covered by Medicare, may drop patients as they approach age 65, or may elect not to become Medicare certified.

"Lack of access to adequate care under Medicare may have adverse consequences for the health of elderly Alaskans."

Lack of access to adequate care under Medicare may have adverse consequences for the health of elderly Alaskans and, as such, impact the long-term care needs of that population. If our seniors cannot get adequate primary care, their health may deteriorate. Because Medicare does not pay for most long-term care services, the lack of access to primary care has the effect of shifting the cost of care from Medicare to Medicaid, out-of-pocket expenses, and other local resources.

The Task Force is concerned about the possible limited access to Medicare services. The Task Force requests the Department of Health and Social Services conduct a review of Medicare-eligible Alaskans' access to medical services within the state and, if warranted, explore options to increase their access to health care. The Task Force recommends that a comparison be made of allowable Medicare rate reimbursements to the actual cost of providing the service and a summary of the findings be included in the review. ❖

INCREASE RATE FOR GENERAL RELIEF PATIENT CARE

The Task Force supports an increase in the rate paid to assisted living home providers under the general relief assistance program and requests the recommendations of the *Alaska Rate Study Report* be considered in determining the new rate structure.

The Department of Administration has the responsibility to provide a vulnerable adult with protective services when necessary. (AS 47.24.017) Often, the needed protective service includes placement of the vulnerable adult in an assisted living home at the state's expense.

"The rate...for the typical general relief client was established in 1983 at $34.50 per day."

The general relief payment made by the state is the amount needed to make up the difference between what the clients can pay, and the predetermined cost of provided services. The rate of payment for assisted living services for the typical general relief client in Alaska was established in 1983 at approximately $34.50 per day. The Division of Senior Services noted on a 1998 fiscal note accompanying legislation under consideration, "(T)he current base rate is not adequate to meet rising costs of providing assisted living care. A rate increase is overdue."[36]

It was also noted in a recent study that over 95 percent of the residents living in smaller assisted living homes (15 beds or less) are being provided help with activities of daily living. While the vast majority of these residents are private pay, the general relief residents were being provided most of these services as part of the base rate. "It should be noted that these services are much more difficult to provide in the smaller homes without the appropriate staff-to-resident ratio."[37] Without adequate reimbursement for general relief clients, it is difficult to maintain the appropriate staff-to-resident ratio.

"The lack of cost-of-care adjustments to the Assisted Living Home fee structure jeopardizes the future of Assisted Living Homes," wrote the Division of Mental Health and Developmental Disabilities, February 25, 1998.[38] Subsequently, the Assisted Living Training Institute, LLC, was hired as a consultant by the Department of Administration to review the current rate structure for general relief clients, and recommend a new rate plan that fairly represents the cost to provide the needed long-term care services.

"The lack of adjustments to the fee structure jeopardizes the future of Assisted Living Homes."

The Institute stated, "(M)inimal support of Activities of Daily Living (ADL) should and must be provided within any rate agreed upon. All facilities surveyed indicated that ADL services are now being provided without compensation."[39]

The Task Force recognizes that the current daily rate for general relief patients is unacceptable and supports an increase to the basic rate. The *Alaska Rate Study Report* should be considered in determining the final rate structure increase. ❖

SENIOR HOUSING OFFICE

RECOMMENDATION 17

The Task Force urges continued support for Alaska Housing Finance Corporation's Senior Housing Office and its state planning grant program.

In 1990 the Legislature established the Senior Housing Office (SHO) to " . . . promote a comprehensive response to the needs of senior citizens for adequate, accessible, secure, and affordable housing in the state." (AS 18.56.700) Initially the Senior Housing Office was operated within the Department of Community and Regional Affairs. On July 1, 1992 the SHO, other DCRA housing activities

and the Alaska State Housing Authority were merged with the Alaska Housing Finance Corporation.

Before the creation of the Senior Housing Office, senior housing development was almost nonexistent. Since its inception, AHFC programs have helped to create 25 new senior housing facilities with total development costs approaching $85 million. According to testimony presented to the Task Force, all senior housing has been designed with the "aging in place" concept, which helps facilitate both the current and future needs of older Alaskans.

"AHFC programs have helped to create 25 new senior housing facilities with total develoopments costs approaching $85 million."

Recently the Senior Housing Office has been expanding its efforts to encourage the construction of assisted living facilities. Within the past couple of years, the SHO has helped in the development of approximately 135 new units of assisted living, thereby providing increased capacity to seniors who need long-term care services.

In addition to the loan program available under AHFC, the Senior Citizen's Housing Development Fund (AS 18.56.800) provides grants to qualified recipients to develop and plan various types of senior housing facilities. Funds from this program cover professional expertise (preliminary architectural drawings, construction and operating estimates, legal fees, and other services) necessary to develop and plan a senior housing unit. Testimony indicated that this program is vital to the future growth of senior housing in Alaska.

The Task Force recognizes the past efforts of AHFC's Senior Housing Office and applauds its success in assisting in the construction of 25 senior housing facilities. The Task Force urges continued support of the Senior Housing Office and its vital state planning grant program. ❖

LONG-TERM CARE DELIVERY SYSTEM

The *Legislative Working Group on Long-Term Care* stated its goal was to "advocate for long-term care that is responsive to the individual circumstances of Alaska's senior citizens and those with physical disabilities."[40] The *Working Group* recommended making the fullest use of the state's long-term care funding through expanding health care choices that are cost-effective and provide the long-term care as close to home as feasible.

"The Working Group recommended making fullest use of the state's long-term care funding through expanding health care choices."

The system of delivering long-term care has changed over the past few years. The current and projected population growth have encouraged new and creative long-term care programs. Alaskans are now able to receive the care they need in their homes or as close to their homes as is possible.

As the delivery system continues to evolve, issues that are of mutual interest to long-term care consumers and their families and private and public long-term care providers will be identified and resolved. It is a never-ending evolution of ideas and solutions. ❖

LONG-TERM CARE SERVICES AVAILABLE

RECOMMENDATION 18

The Task Force requests the Alaska Commission on Aging coordinate and strengthen efforts to inform and educate all Alaskans on long-term care services available in Alaska.

Alaska's home and community-based long-term care services enable a limited number of Alaskans to receive long-term care in their homes and communities, rather than in institutions. Under this program, Alaska offers a wide variety of services to seniors and adults with physical disabilities.

Home and community-based care services are partially funded through Alaska Commission on Aging grants to non-profit corporations across Alaska. In most instances, the state grants cover from 45 percent to 60 percent of the actual cost of services. The non-profit corporations generate a mix of local funding to cover the actual costs of services. Clients pay for services on a sliding scale according to their income. The services provided are as follows:

"The care coordinator identifies appropriate services based on (an) assessment."

- *Care Coordination* is a service through which a trained professional assesses a frail consumer's needs. The care coordinator identifies and arranges appropriate services based on this assessment and in consultation with the consumer's family. Care coordination incorporates outreach, intake screening, initial assessment, care planning, service arrangement, ongoing monitoring and formalized assessment.

- *Adult Day Centers* provide supervised group care and therapeutic activity in a social setting for seniors needing assistance with daily living tasks. Care is provided at a central site during the weekdays. Recently some centers have begun providing limited weekend care as well.

- *Respite Care* is provided by trained caregivers who provide periodic care in a senior's home. This means family caregivers can take a break from their work as full-time caregivers. While this care is usually provided in the elder's own home, respite care can also be provided in facilities such as assisting living homes, nursing homes, and adult day centers.

- *Hot nutritious meals* are prepared and served in group settings to seniors at central locations or delivered to homebound seniors.

"Medicaid provides funds for two long-term care home and community-based waiver programs, through the CHOICES program."

- *Escorted transportation services* are available in many communities and allow consumers access to community services.

Medicaid provides funds for two long-term care home and community-based waiver programs, through the CHOICES program. These programs, administered by the Division of Senior Services, Department of Administration, cover the costs of care necessary for individuals to continue living within their home or community. The cost of these waiver services must not exceed the cost of nursing home services the person would otherwise receive.

In addition to care coordination, adult day services, and respite care, the CHOICES program may cover the following, as necessary:

- *At-Home Skilled Nursing Care* provides skilled nursing care by licensed professionals.

- *Assisted Living Care* services, other than room and board, are provided for seniors or adults with physical disabilities who need assistance with activities of daily living.

- *Personal Care* provides in-home assistance with activities of daily living such as bathing, dressing, toileting, eating and moving from one place to another. These services can enable a person with non-technical medical care needs to remain at home rather than live in an acute or long-term care facility. (A person does not need to elect a waiver program to receive personal care services.)

"Over the last several years, home and community-based alternatives have increased dramatically."

Over the last several years, home and community-based alternatives to institutional long-term care in Alaska have increased dramatically, in part because of the expansion of Medicaid coverage of these services.[41] However, it still is difficult for the consumer to negotiate the confusing array of long-term care service alternatives.[42] Concise, relevant information on services available to seniors and individuals with disabilities must be readily and easily accessible to all.

The Task Force requests the Alaska Commission on Aging coordinate and strengthen efforts to inform and educate all Alaskans on the various long-term care services available. In addition, the Task Force requests the Alaska Commission on Aging to provide semi-annual updates on its efforts to the members of the Senate and House Health, Education and Social Services Committee. ❖

SCREENING AND ASSESSMENT TOOL

The Task Force requests the Department of Administration establish a uniform and comprehensive screening and assessment tool to be used by all program administrators when an individual enters a nursing home or selects a Medicaid waiver program.

In April 1996 the United States General Accounting Office examined the assessment instruments utilized in long-term care planning for all 50 states. Their findings indicated that very few states use a comprehensive assessment tool. Questions were raised as to whether sufficient information was being collected in the

less comprehensive assessments to develop an appropriate plan of care across settings.

Alaska is no exception. Alaska does not utilize an assessment process that supports a smooth transition between places of care.[43] At this time, several divisions within the Department of Health and Social Services and the Department of Administration administer programs for seniors and adults with disabilities. These agencies not only bring different perspectives to long-term care assessment, but also use different assessment tools for a variety of different purposes. This fragmented assessment process makes it difficult for a patient to move along the long-term care continuum of services.

"An accurate assessment is a valuable cornerstone to any program that provides for the long-term needs of Alaskans."

An accurate assessment is a valuable cornerstone to any program that provides for the long-term needs of Alaskans. Such assessment is especially relevant in Alaska, where there are multi-service long-term care programs offered. A uniform screening and assessment tool will assist patients to receive the right level of care, at the right time, and in the most cost-effective manner possible.

A comprehensive assessment tool will assist extended care providers in Alaska in planning for a person's health care needs at the first point of service along the continuum of care. This information will 1) ensure that the patient receives the right level of care, at the right time, and in the most cost-effective manner; 2) provide a centralized data base for the efficient and effective planning for extended care services in Alaska; and 3) contribute to developing a seamless planning process as the patient moves between settings along the continuum of care.[44]

"The use of consistent definitions...will provide health caregivers a common understanding of long-term needs in Alaska."

The Task Force recognizes that a genuine effort has been made to reach the goal of having a uniform, comprehensive screening and assessment tool, but unfortunately this goal has not yet been met. The Division of Senior Services is poised to tackle this challenge and plans to involve all the key health care industry stakeholders to help design the assessment tool, as well as determine the necessary health care definitions. The use of consistent definitions that are recognized and understood statewide will provide health caregivers a common understanding of long-term care needs in Alaska.

The Task Force requests the Department of Administration establish a uniform and comprehensive screening and assessment tool to be used when an individual enters a nursing home or selects a Medicaid waiver program and develop a pilot program to assess its validity and reliability by July 1, 2000. ❖

UNIVERSAL CARE PLAN COUNSELING

The Task Force requests the Department of Administration evaluate a phased-in universal care plan counseling requirement for all Alaskans entering the long-term care system, regardless of their ability to pay.

The purpose of universal long-term care plan counseling (or pre-admission assessment) is to educate consumers about their long-term care options. Long-term care counseling helps individuals find an appropriate long-term setting of their choice. Currently long-term care counseling is not available to all Alaskans entering the long-term care system.

"The purpose of universal long-term care plan counseling is to educate consumers about their long-term options."

Medicaid eligible patients are now more likely to receive information about their long-term options than are non-Medicaid eligible individuals. "(N)on-Medicaid eligible Alaskans who are being discharged from hospitals are not receiving adequate and consistent information, and as a result, some have been placed in nursing homes without understanding their choices. Others are not necessarily receiving the services of their choice, or in the location of their choice."[45]

Under a pilot project in Anchorage, long-term care planning is available in hospitals and long-term care facilities. Professional staff from the Division of Senior Services, Department of Administration, work directly with long-term care providers to identify Medicaid-eligible Alaskans for whom the waiver program might be appropriate. A care coordinator is assigned to the patient and the patient's needs are screened and assessed. The seniors and the adults with physical disabilities are active participants in the planning process and determine the best health care plan for them. Based on the information provided to them, many adults opted for the waiver services.

"Medicaid eligible patients are now more likely to receive information about their long-term options than are non-Medicaid eligible individuals."

Both Medicaid-eligible and non-Medicaid-eligible individuals will benefit from long-term care planning. The Task Force recognizes how important appropriate and timely long-term care planning and care coordination is for the long-term health of both seniors and adults with disabilities. Therefore, the Task Force requests the Department of Administration evaluate a phased-in universal care plan counseling requirement for all Alaskans entering the long-term care system, regardless of their ability to pay. ❖

CERTIFICATE OF NEED

RECOMMENDATION 21

The Task Force recommends that legislation be drafted and introduced to adopt the nursing home certificate of need recommendations developed by the *Legislative Working Group on Long-Term Care* (1997).

Under AS 18.07, the Department of Health and Social Services administers the Certificate of Need Program. This program was created as a tool to control health care costs and prevent unnecessary or duplicative facilities or services. A certificate of need is required of any health facility planning to spend one million or more for construction, expansion or remodeling.

"The certificate of need review process is required of any health facility planning to spend a million dollars or more for construction."

The certificate of need review is initiated when a health care facility submits a letter of intent to the Department of Health and Social Services. This letter of intent provides the project description, estimated cost, and starting and completion dates for the project. Based on the letter of intent, the department determines whether a detailed certificate of need application is needed. Once the application is received and declared complete, department staff analyzes the request and makes a recommendation to the Commissioner of Health and Social Services, who decides to approve or deny the application. The decision to grant or deny a certificate of need may be appealed.

In June 1996, HB 528 was signed into law (Chapter 84, SLA 96). This placed a two-year moratorium on the issuance of certificates of need or licenses for any new nursing home beds in Alaska effectively preventing any nursing home beds from being added until the moratorium expired. This two-year moratorium expired May 1, 1998. The law was passed due to concerns over the potential rapid growth of nursing home beds that became imminent as the result of the planned addition of 147 new nursing beds costing $11 million annually. The moratorium allowed time to develop alternatives to nursing home beds and assess what could be done to promote cost containment.[46]

The six-member working group established under HB 528 thoroughly analyzed the current procedure to grant certificates of need to long-term care health facilities and determined several weakness in existing law. As currently written, AS 18.07.041 requires the Department of Health and Social Services to grant a certificate of need if "the availability and quality of existing health care resources or the

accessibility to those resources is less than the current or projected requirement for health services to maintain the good health of citizens of this state." In other words, the Department must grant a certificate of need for new construction, expansion or remodeling of a nursing home facility if the service is not available or sufficiently accessible, and the applicant can demonstrate that the proposed service will be provided in a quality manner.

"The Legislative Working Group states that the certificate of need program requires more explicit statutory definition."

In its report the *Legislative Working Group* stated the following:

> While availability, accessibility and quality are important, they are insufficient for assessing a current or projected requirement for health services. Meeting a current requirement does not mean that there is a long-term need for the service or facility or there will be the resources necessary to sustain the service or facility throughout its life cycle. Similarly, meeting a current or projected need does not mean that it is the most cost-effective method for doing so; nor does it mean that the State, facing declining resources, should encourage and support a low priority service in the face of more pressing priorities. The certificate of need program requires more explicit statutory and regulatory definition in these areas to better control costs and better target the health care priorities of Alaskans.[47]

Currently there is a potential in Alaska for many new nursing beds to be built and, if built, these beds will cost the state a great deal. Using a medium growth projection, it is estimated that the senior population in Alaska will grow from 31,398 in 1997 to 80,927 by 2015.[48] In FY97, the Alaska Medicaid program spent $43.8 million for 720 licensed nursing home beds. If the need for beds remains constant in the future, the number of beds could grow to 1,861 by 2015, a 250 percent growth at the annual cost to Medicaid of an additional $109.5 million. "Proposed projects need to be compared against feasible alternatives to determine if the proposal is the most cost effective way of achieving comparable results."[49]

"Under the legislation, new nursing home projects will need to demonstrate cost effectiveness."

Under the legislation proposed by the *Legislative Working Group on Long-Term Care*, new nursing home projects will need to demonstrate the cost-effectiveness of each request. Proposed projects will be compared against feasible alternatives to determine if the proposal is the most effective way to achieve comparable results. The Task Force recognizes that this issue needs more discussion and recommends that legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail. ❖

CONSOLIDATION OF SERVICES

The Task Force requests the Departments of Health and Social Services and Administration monitor the success of long-term care programs offered by states which have consolidated their efforts and determine if consolidation would benefit the people of Alaska in the future.

In 1995, the Division of Senior Services, Department of Administration, contracted with Ladd & Associates to review the long-term care system in Alaska, compare it with other state systems, and evaluate its effectiveness.

In its analysis of Alaska's long-term care system, Ladd & Associates said, "The state organizational structure that administers long-term care is one of the most fragmented in the nation. Each of these units of state government has different missions and different methods of conducting business. Many of these agencies serve other populations besides those requiring long-term care, and they also administer other health and social programs. It is difficult to make long-term care a priority in this current state structure."[50]

"It makes little sense, from a management point of view, to have this program separated from the other components of long-term care."

Based on its findings, Ladd & Associates recommended that the Division of Senior Services, Department of Administration, be transferred intact to the Department of Health and Social Services. "It makes little sense, from a management point of view, to have this program separated from the other components of long-term care, and the other supportive health and social services that seniors require."[51]

The Alaska State Hospital and Nursing Home Association (ASHNHA) also echoed ideas expressed by Ladd & Associates. In August 1996 ASHNHA hired Health Dimensions, a consulting firm specializing in health care issues, to identify common themes regarding long-term care services in Alaska and propose solutions to the identified problem areas. As the result of this review, ASHNHA recommended the reorganization of the Pioneer Homes under the authority of the Department of Health and Social Services. "The Pioneer Homes and the community nursing homes are under separate administrative offices yet they are a significant financial component to providing long-term care services to seniors."[52]

"Keeping these homes under separate funding sources supports the continuation of a fragmented continuum of care."[53] Under their proposal, the Department of

Health and Social Services would become a central point for identifying and monitoring statewide efforts to provide increased services to the increasing senior population with limited state dollars.[54]

"Other states in general have found that through consolidation, they reduce the time and energy spent managing these programs and concentrate their resources on the people that the programs serve."[55]

"A major organizational restructure occurred with the creation of the Division of Senior Services."

The Task Force wrestled with these recommendations from two respected, yet distinctly different, consultants. The Task Force noted the fact that both long-term care advisors arrived at the same conclusion. However, it also recognized that in 1993, a major organizational restructure occurred with the creation of the Division of Senior Services within the Department of Administration. As noted in Administrative Order No. 139, the purpose of the reogranization was to provide better access to services and promote dignity and independence for seniors. In addition to this major reorganization, in 1996 and 1997, several other programs were transferred from the Department of Health and Social Services to the Department of Administration.

The Task Force recognizes that the various programs responsible for the delivery of long-term care services have undergone significant management restructuring over the past few years and, possibly, the time is not right to consider yet another move: a move towards consolidating all long-term care programs within one department.

"At some point, the time may be right for Alaska to consider the value of consolidation of services."

However, at some point the time may be right for Alaska to consider the value of consolidation of services. The Task Force recommends the Department of Health and Social Services, Department of Administration, and the Legislature monitor the success of the various long-term care programs offered by states that have consolidated their efforts into one agency and determine if consolidation would benefit the people of Alaska in the future.

In addition, the Task Force received testimony that the Office of the Long-Term Care Ombudsman may be more effective if placed in a department or agency that is independent of the administrative functions that administer long-term care services, funding or licensing. The Task Force requests the Department of Administration survey other states to determine whether the Office of the Long-Term Care Ombudsman is located in a neutral agency and recommend any necessary changes.