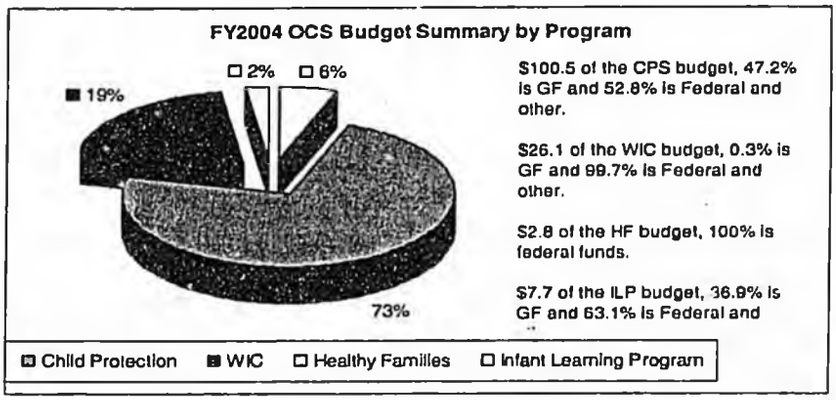
ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
10739 HOUSE HEATH EDUCATION & SOCIAL SERVICES

Budget

The FY2004 OCS operating budget is $137.2 million. Approximately 32% ($52.5) is funded with state General Fund and the remaining 68% ($84.6) is funded with federal and other funding sources.



The FY 2004 OCS budget IS $137.2 million. Approximately 32% (52.5 million) is funded with general funds and the remaining 68% (84.6) is funded with federal funds and other funding sources.

73% ($100.5 million) is for child protection services.

19% ($26.1) is for Women, Infants, and Children (WIC) program.

6% ($7.7) is for Infant Learning Program

2% ($2.8) is for Healthy Family Program

Federal Review of the Child Protection Program

In June of 2002, the Federal government completed the Child and Family Services Review (CFSR) in Alaska. The CFSR consisted of the following activities:

- A Statewide Self-Assessment
- State Data Profile that measured 6 outcomes
- Onsite Review of 50 cases and interviews with stakeholders

Focus of Review was to determine state performance in the areas of

- safety
- permanency
- well-being

There are three major program components in DFYS:

General Administration

Field Operations

Program Administration

General Administration includes the Directors Office, budget and financial management, and statewide data processing support.

Program Improvement Plan(PIP)

Alaska's plan was approved on September 1, 2003, and will be in effect until August 31, 2005. **Alaska** needs to make progress toward improvement or risk losing federal dollars in the future.

Highlights of the PIP:

Safety

- Activities that reduce repeat maltreatment and the maltreatment of children by foster care providers;
- Activities that focus efforts on responding to all reports of harm according to timeframes set in policy;

Field Operations includes screening of reports of harm received in the field offices, investigations of reports of harms, permanency planning of children placed in the custody of DFYS, reunification of children with their families that are placed in DFYS custody, adoption or guardianship, and licensing of foster homes and residential care facilities.

Provide training to new and existing social workers.

Program Improvement Plan (Cont'd)

Permanency

- Activities that address case planning to Increase the number of children reunified within 12 months of removal from home;
- Facilitation of visits between parents and their children;
- Clarify policy on visits between worker & child and worker & parents;
- Activities focused on increasing the number of children who are adopted within 24 months of entry into care;
- Increase the stability of placement for those children in custody;
- Improvement in the assessments of children and families to assure that they receive needed services;

Program Improvement Plan (cont'd)

Well-Being:.

- Support Foster Parents in their efforts to care for children in their care;
- Assure that children in care are receiving all health, mental health, dental, educational services that meet their needs;
- Assure that children we serve in their own homes are receiving appropriate health care.

Systems Improvement:

- The development of ORCA to improve accountability and performance;
- The development of a comprehensive Quality Assurance (QA) program.
- Improve the array of services available to families.

Other Efforts In Progress

The first progress report was submitted on December 30,2003. It reflected Alaska's progress in achieving the benchmarks for improvement.(See Attachment)

Other initiatives directed at improving the system:

- Task Force to address recruitment and retention of staff;
- Repeat Maltreatment Study completed;
- OCS Strategic Planning Process completed;
- Rasmuson Foundation funded the implementation of Family to Family Foster Care Reform Initiative;
- Renewed focus on accountability and measurement of performance;
- Quality Assurance Reviews will include stakeholders;
- Cross training among all OCS programs;
- Focus on helping tribes/tribal organizations with prevention efforts;

AaNA
Alaska
Nurses
Association

Public Health Nursing in Alaska

Public Health Nurses provide frontline disease prevention and health promotion.

We are facing a dramatic increase in infectious diseases for which we have no cures (SARS, Asian Avian Flu, West Nile Virus, Mad Cow disease, AIDs). Our only hope for containing these diseases is quick identification and isolation. This is the job of Public Health Nurses.

Removing frontline disease detection and treatment could have enormous costs for Alaska.

What Public Health Nurses Do – Public Health Nursing in Alaska has a long history of service to our citizens. Public Health Nurses

- Respond to epidemics and work to control communicable diseases.
- Educate and support children and families to enable them to grow and develop.
- Served all age groups, and populations, across the state.

Frontline Prevention and Disease Control Services – Public Health Nurse are devoted to preventing outbreaks and minimizing epidemics utilizing the most current public health practices at the community and village level. Public Health Nurses

- Vaccinate countless children and adults to protect them against diseases such as measles, pertussis, hepatitis A and B, and HIB meningitis.
- Assist communities to prepare for emerging public health problems, like SARS.
- Screen for, treat, and provide follow-up for communicable diseases, such as tuberculosis, hepatitis, HIV and other sexually transmitted diseases, often catching symptoms in people who do not utilize the main health care systems.

Evolving Issues – Public Health Nursing continues to evolve to meet the ever changing needs of our citizens. They focus proactive approaches to emerging health issues such as

- Disaster preparedness
- Chronic disease and cancer screening
- Family violence
- Family planning
- Injury prevention

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Public Health Nursing Methods – Public Health Nurses

- Combine their nursing skills with public health science and social sciences to promote and protect the health of populations.
- Collect information to address real and potential health problems that affect the health status of communities and our state.
- Understand the factors that determine health; behavior, biology, environment, and the health care system.
- Utilize assessment skills to identify needs and strengths of individuals and community.
- Improve health by
  - Providing coordination to access needed health services.
  - Providing clinical services if they are not otherwise available.
- Provide important health data that supports policy development to improve the public's health.

Community Focused – Public Health Nurses work with communities to:

- Provide education on health issues and support for healthier lifestyles and personal responsibility.
- Promote healthier parenting, improved health services, and assist the population to identify and access necessary health and social services.

When They Succeed, So Do We

When Public Health Nurses do a great job at protecting us against diseases and educating us about health, we don't see outbreaks or spread of disease, we see only a healthy community. And most of us never stop to notice, or are not aware of, the continuous frontline protections that Public Health Nurses provide in our state.

Public Health Nursing has drastically reduced Alaska's rate of TB infection, infant mortality, HIB encephalitis, measles, and sexually transmitted diseases. We do not want to see increases in these diseases, which they have worked so hard to contain.

Public Health Nurses represent a state and a community asset that should be supported and sustained.

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The American Nurse

The Official Publication of the American Nurses Association

An 'invisible' workforce

ANA works to support public health nursing and public health infrastructure

By Susan Trossman, RN

Nearly 14 years ago, public health nurse Mary J. Finnin, MSN, RN, began examining the incidence of AIDS and HIV among patients served through the Suffolk County, NY, health centers. At that time, U.S. Center for Disease Control and Prevention (CDC) officials were focusing their attention on developing and promoting HIV/AIDS prevention strategies that targeted the nation's most high-risk group: white, homosexual men. But Finnin's community assessment revealed something different.

She learned that the majority of these patients who were living with AIDs or were HIV-positive were African American or Hispanic, and 40 percent were women. The stats also showed that they contracted HIV and AIDS primarily through IV drug use and heterosexual exposure.

"What we discovered was that our trends were very different from the national trend," said Finnin, RN, president of District 19, New York State Nurses Association (NYSNA). By identifying who was at risk in her community and offering a range of preventive care, screening and early intervention services aimed at them, she and her public health colleagues were able to make real improvements in the health of Suffolk County residents. (The number of cases of HIV transmission from mother to baby alone went from more than 15 cases annually to zero following the implementation of the new strategies.)

"We also persuaded the CDC to change its guidelines to better address the needs of other high-risk populations, including women," Finnin said.

Fast forward to the new millennium — a time in which the public has been forced to think about new and frightening threats to their health, such as anthrax, smallpox, the West Nile virus and SARS. And while the need for public health nurses and a solid public health infrastructure seems to be needed more than ever, nurses and other public health officials continue having to fight to keep their services from the budgetary chopping block.

Montana's nearly 120 public health nurses are definitely "hitting a wall" as they try to juggle more and more responsibilities with fewer resources, said Jo Ann Dotson, MSN, RN, maternal child health director for the Montana Department of Public Health and Human Services. Commissioners in one Montana county, for example, just voted to do away with its public health nursing budget, and a number of the counties fund less than one day a week for public health nursing services, said the Montana Nurses Association member.

"People talk about bioterrorism and our need to be prepared," Finnin said. "Public health nurses are the eyes and ears in the community. They have the expertise to spot trends, do case finding, screen for diseases and make referrals.

"When we decrease the number of public health nurses and the services they provide to the community — that's germ warfare."

Making the 'invisible' visible

In 1999, the CDC released its list of the 10 great public health achievements of the century — many of which could not have occurred were it not for the contributions of public health nurses, according to Kaye Bender, PhD, RN, FAAN, the incoming chair of the American Public Health Association's Public Health Nursing section and a recipient

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Public health

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of ANA's Pearl McIver Public Health Nursing Award. Among the achievements were healthier mothers and babies, the recognition of tobacco use as a health hazard, and a decline in deaths from coronary health disease and stroke.

Yet when it comes to government services, the public generally views only a handful as vital, such as those provided by firefighters or police officers. After all, who wants to take a gamble on a reduced firefighting workforce when one's house could go up in flames? But ensuring a healthy population?

"Public health nurses are concerned with health promotion and disease prevention," said Bender, a Mississippi Nurses Association member. "Many studies have shown that most of the public does not think about public health and public health nursing unless it doesn't work or until they have a problem. So the work of public health nurses in many ways is invisible."

And people often don't get the concept of population-focused nursing practice. Or, they think that government-provided services only benefit the poor.

"Our concern as public health nurses in the District of Columbia is the health and welfare of our entire population," said Sharon Payne, RN, a public health nurse and nurse consultant with the Medical Assistance Administration of the DC Department of Health. "We make sure the population lives in a healthy environment, we build partnerships with other stakeholders to ensure everyone has access to care, we educate and empower the community, and we advocate and provide primary prevention services."

And although public health nurses work with the vulnerable and the underserved, their activities promote health within the entire community, contends Payne, president of the DC Nurses Association. For example, public health nurses are part of a program called the "48-hour Newborn Initiative," which guarantees an RN visit to any family with a newborn — regardless of income.

Alaska Nurses Association member and public health nurse Hisa Fallico, BSN, RN, agreed that the notion of public health touching all is one that is often lost among consumers.

"People don't make the connection that the hand-washing we're teaching in schools and other public facilities — or the immunizations we give — make the rest of the world safe," said Fallico, program manager for the Department of Health and Human Services, Disease Prevention and Control program based in Anchorage.

Fallico pointed to her department's work. During the July to September back-to-school rush, public health nurses immunized more than 3,500 children. They also saw 2,700 clients as part of their tuberculosis oversight program and performed 975 PPDs during the same time frame.

Her department also is working with Environmental Services on a new public health threat — the influx of rats, once a non-issue in the cold climate of Alaska. And her community recently had to deal with the first suspected case of SARS in Alaska, which tested the ability of emergency response and health care providers to prevent a potential outbreak while allaying the fears of the public. (The case was negative.)

Even when the public has direct contact with public health nurses, they often don't realize it.

"We don't wear a uniform, a badge or a white coat," Fallico said. "We don't have a stethoscope dangling from our neck, and we often are out in the community or in a clinic." Fallico said public health nurses within her state and others have often been mistaken for school nurses, Red Cross nurses, hospital nurses or even health aides who are helping out in the community.

But ANA and RNs nationwide hope to bring the work of public health nurses and the importance of public health to the forefront as health care policy is shaped.

At ANA's June House of Delegates meeting, nurse leaders passed a resolution that calls for ANA to advance the crucial nature of the public health nurse's role in promoting and protecting the health of individuals, families and communities.

"I am so pleased that this measure passed," Bender said. She said the resolution comes at a critical time when nurses are in short supply and attempts to substitute registered nurses in public health roles have resurfaced. Like their hospital staff nurse counterparts, public health nurse jobs are often viewed as solely "skills-oriented."

The resolution also calls for ANA to persuade policymakers to invest in information systems technology and training to strengthen the public health infrastructure — particularly in this post-9/11 world. Bender said that the use of technology has been lagging in most public health departments, although the recent infusion of federal dollars to help public health departments prepare for bioterrorist events and other disasters has helped.

The resolution also directs ANA to advocate for federal funds to health departments to attract, retain and continually enhance the role and compensation of public health nurses; for the better enumeration of public health nurses; and for further development and implementation of quality indicators that are sensitive to public health nursing functions.

Other actions

A large part of Dotson's role in Montana has been to educate the public, and particularly county commissioners, about their responsibilities to protect the public's health — such as tracking and reporting communicable diseases. She also routinely explains to lawmakers ways in which public health nurses function within the community. Unfortunately, many of those ways have been subject to tradition and political whim.

"There is very little understanding as to what public health ought to be," Dotson said. "Particularly in the small communities, if a county commissioner's mom or somebody's aunt needs foot care, then the commissioners believe that's what public health nurses ought to be doing."

As government funding dwindles further, Dotson believes public health nursing departments across the nation need to focus more sharply on what the CDC refers to as the three core functions of public health: assessment,

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Public health

(continued from page 2)

policy-making and assurance.

"That means as public health providers, we must do a needs assessment of our community, make sure policymakers have the right information to make good policy and then make sure all residents have access to the services they need to remain healthy," she said.

Public health nurses also are concerned about improving public health education within nursing school programs, particularly because they want to ensure that there are RNs willing and able to follow in their footsteps.

"We need to develop curricula that show how nursing knowledge and skills can be applied to not only individuals, but also to populations," Payne said. And she and other nurses said that nursing students need to be given a broader range of clinical opportunities in public health, as opposed to limiting their experiences to giving shots at a clinic.

Payne also believes her colleagues should work to develop and implement clear public health nursing tracks within their health departments. These tracks would serve as a way to unify public health nurses working in various divisions, such as maternal-child health and communicable diseases, as well as provide a way for nurses to advance their careers without having to leave the profession.

And in New York, Finnin recently worked to get NYSNA delegates to pass a public health nursing resolution similar to the one ANA nurse leaders approved earlier this year. Finnin's resolution, however, included a measure that calls for state and county health departments to have directors of public health nursing in place.

By having qualified professional nurse directors, there is a better chance of ensuring that public health nurses' voices are heard when policies are developed and implemented, according to Finnin. County nurses also testified before Suffolk County lawmakers, urging them to prevent deeper cuts in public health bureau staff, which decreased from 160 in 1990 to 68 currently.

Fallico said that the public health infrastructure and public health nursing currently are in transition.

"Right now, there is a lot of emphasis on bioterrorism and emergency preparedness," Fallico said. "But I believe the pendulum is swinging back toward the middle, and we'll be able to regain focus on prevention and preparedness."

Not bleak

The public health nurses interviewed for this story agreed that they have and will continue to face challenges — from budget cuts to image problems. But they also clearly enjoy their roles as public health nurses. They enjoy the autonomy of their practice, as well as the camaraderie within their work environment. And while there undoubtedly is a portion of the population who will never understand public health and public health nursing, there are still clients every day who do understand and appreciate the knowledge, skills and caring that public health nurses provide. (For example, the public rallied around nurses when Suffolk County began cutting public health nurse positions and clinics.)

"We also have the ability to impact the health of an entire population when we create and implement good policies," Dotson said.

As a nurse for 50 years, Finnin said that she has been involved in many models of health care. While hospitals seem to focus on medical models — or financial models — public health allows RNs to practice the nursing model of care in the community.

"It's really a professional practice," she said. ■

Susan Trossman is senior reporter of *The American Nurse*.

PUBLIC HEALTH IN AMERICA

Vision:

Healthy People in Healthy Communities

Mission:

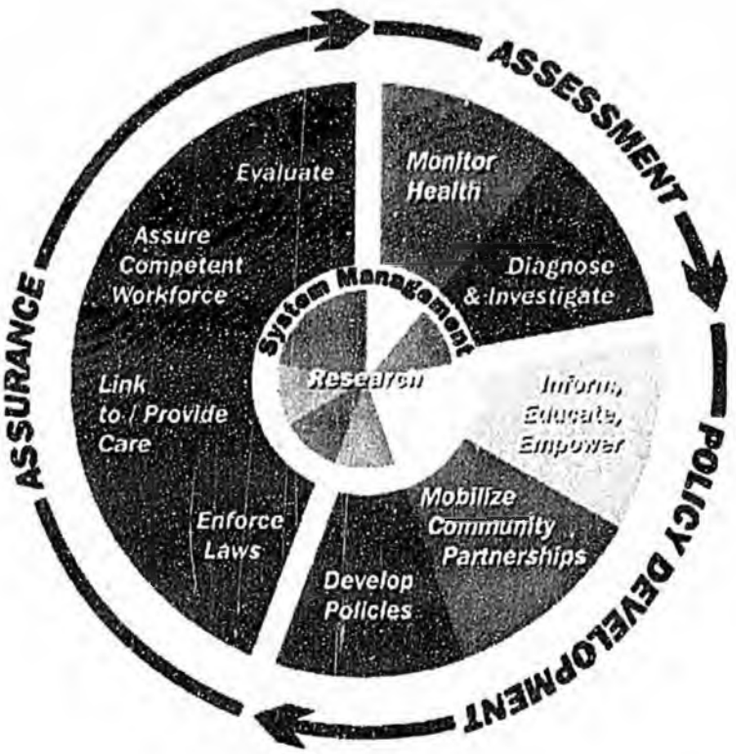
Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems



Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995):
American Public Health Association·Association of Schools of Public Health·Association of State and Territorial Health Officials·Environmental Council of the States·National Association of County and City Health Officials·National Association of State Alcohol and Drug Abuse Directors·National Association of State Mental Health Program Directors·Public Health Foundation·U.S. Public Health Service --*Agency for Health Care Policy and Research·Centers for Disease Control and Prevention·Food and Drug Administration·Health Resources and Services Administration·Indian Health Service·National Institutes of Health·Office of the Assistant Secretary for Health·Substance Abuse and Mental Health Services Administration*

Description	Partners	Structure	Activities	ODPHP

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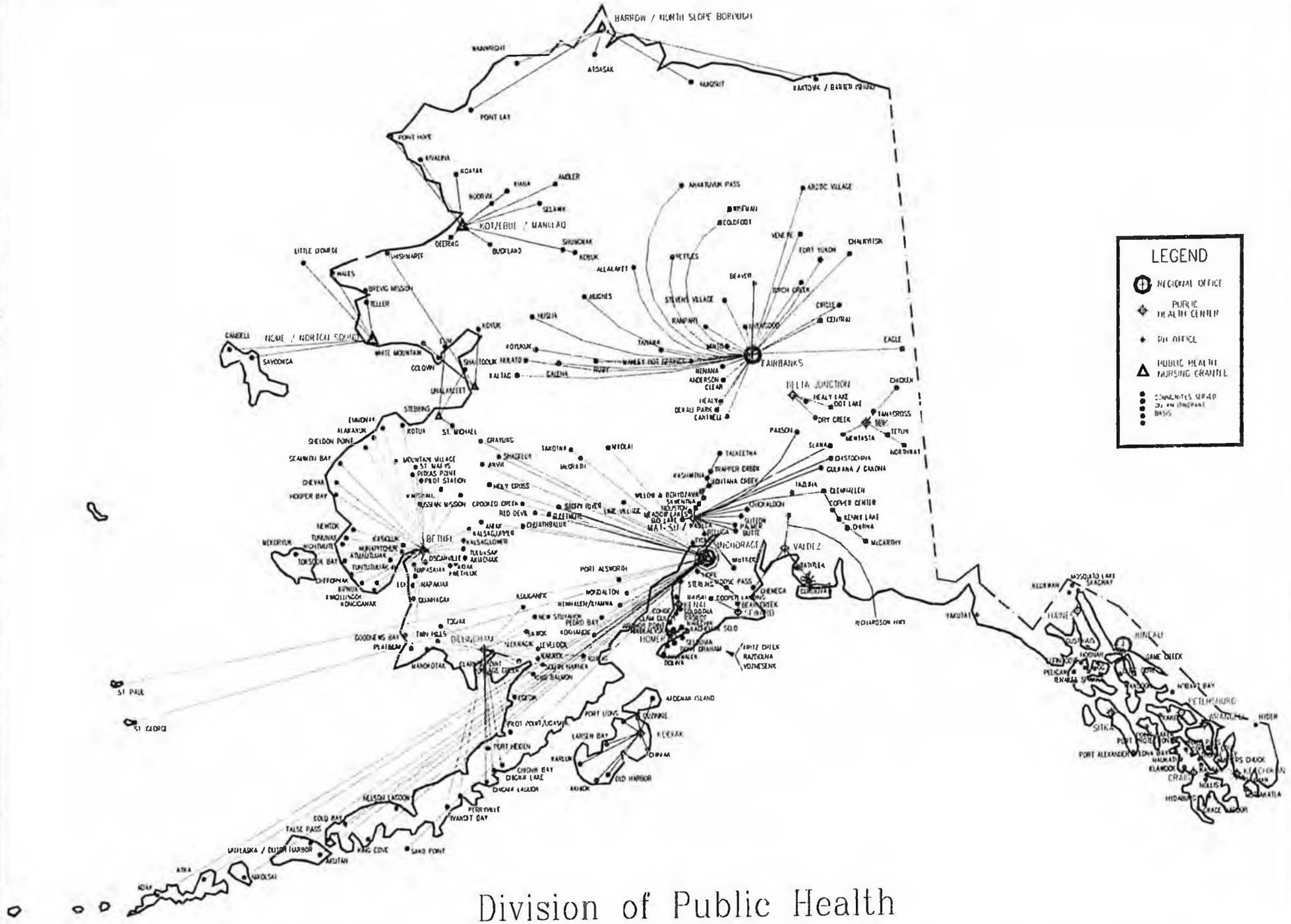

Division of Public Health
PUBLIC HEALTH NURSING

January, 2000

State of Alaska
Department of Health & Social Services

FY03 SERVICE REPORT

The public health nursing client services database does not break out services on an urban/rural designation. Public health nursing services data is tabulated by Public Health Center catchment area. Services provided to small villages and communities that are served on an itinerant basis by public health nurses are routinely tabulated within the statistics of the Public Health Center that serves as the home base of the itinerant public health nurse. We do not have an expedient means of breaking the data down into services provided in each individual community that is served on an itinerant basis. The number of communities served in each Public Health Center catchment area is indicated in parentheses after each health center name in the table below which show services provided in FY 03.

Site	Region	Undup # of Patients	# of Visits	0-19 y.o. Served	# Doses Vaccine	TB Tests	STD Patients	STD Visits	HIV Screens	HIV/AIDS Visits	Fam Plan Patients	Fam Plan Visits	Pap Smears
Fairbanks Health Center (37)	Interior	13,543	32,717	7,090	12,011	2,415	1,457	3,345	633	1,314	2,309	5,717	1,329
Ft. Yukon Health Center (1)	Interior	577	1,305	401	478	331	1	1	0	0	5	5	0
Galena Health Center (1)	Interior	947	1,256	662	623	738	1	1	0	0	1	1	0
Tok Health Center (8)	Interior	885	1,572	512	934	221	2	2	0	0	27	44	27
Glennallen Health Center (1)	Southcentral	575	789	278	477	268	7	9	0	0	9	23	0
Homer Health Center (13)	Southcentral	3,506	7,571	1,748	5,270	390	2	2	0	2	22	32	0
Kenai Health Center (8)	Southcentral	6,025	11,879	3,472	9,842	561	146	318	103	183	397	1,195	246
Cordova Health Center (4)	Southcentral	677	1,052	372	805	248	4	6	1	2	5	7	0
Matsu Health Center (24)	Southcentral	7,718	14,015	3,687	7,803	1,699	434	643	227	310	1,738	5,030	787
Seward Health Center (5)	Southcentral	949	1,668	495	1,168	87	32	48	15	27	165	450	108
Valdez Health Center (2)	Southcentral	2,035	2,932	618	2,585	477	0	0	0	0	2	2	0
Craig Health Center (7)	Southeast	1,834	3,294	940	1,301	1,546	25	40	21	31	94	280	30
Haines Health Center (4)	Southeast	983	1,619	505	938	266	10	26	16	24	90	264	28
Juneau Health Center ((9)	Southeast	4,318	8,991	2,196	3,934	1,612	572	850	470	725	1,221	2,738	671
Ketchikan Health Center (9)	Southeast	4,450	9,162	2,016	3,837	598	254	484	134	233	561	1,573	305
Petersburg Health Center (3)	Southeast	1,390	2,396	704	1,389	301	16	27	8	21	133	284	75
Sitka Health Center (2)	Southeast	1,383	1,988	715	1,726	137	76	137	26	97	57	71	8
Wrangell Health Center (2)	Southeast	1,284	2,118	613	1,297	427	24	33	9	19	105	278	40
Anchorage-based Intinerants (35)	Southwest	1,322	2,215	981	1,179	710	1	1	0	0	2	2	3
Bethel Health Center (40)	Southwest	10,300	14,127	7,698	8,310	6,353	795	1,145	149	311	394	517	503
Dillingham Health Center (22)	Southwest	2,704	3,780	1,895	980	1,875	42	54	4	6	62	97	35
Kodiak Health Center (8)	Southwest	2,697	5,355	1,212	3,822	498	79	130	48	92	416	1,422	189
Sub Totals		70,102	131,801	38,818	70,709	21,758	3,980	7,302	1,864	3,397	7,815	20,032	4,384
Grantees													
Barrow/NorthSlope PHN (6)		3,681	6,937	2,228	5,353	1,707	173	230	19	21	246	518	94
Kotzebue/Maniilaq PHN (12)		3,307	4,189	2,670	2,391	2,556	86	103	6	22	0	0	0
Nome/Norton Sound PHN (17)		6,531	14,420	3,689	7,433	3,896	345	591	14	48	73	109	20
TOTALS		83,621	157,347	47,405	85,886	29,917	4,584	8,226	1,903	3,488	8,134	20,659	4,498

The Municipality of Anchorage uses a different data and reporting system than the rest of the state. Their related data is reported below.

				# Visits	# Doses	(est)TB		STD	HIV			Fam Plan	Pap
		NA	NA	0-19 y.o.	Vaccine	Tests	NA	Visits	Screens	NA	NA	Visits	Smears
Municipality of Anchorage				6,404	9,237	3,656		4,586	2,129			7,686	2,220

Subject: [Fwd: testimony]
Date: Fri, 20 Feb 2004 07:56:56 -0900
From: Peggy Wilson <Representative_Peggy_Wilson@legis.state.ak.us>
Organization: Alaska State Legislature
To: Linda Miller <Linda_Miller@legis.state.ak.us>

Subject: testimony
Date: Fri, 20 Feb 2004 05:12:08 -0800 (PST)
From: laura roberts <finn310@yahoo.com>
To: Rep_Peggy_Wilson@legis.state.ak.us

Dear Rep. Wilson,
I've attached my testimony that I was unable to complete verbally at Tuesday's testimony. Thank you for allowing the submission of my testimony in writing. Sincerely, Laura Roberts

Laura Roberts
119 Austin St. #1202
Ketchikan, AK 99901

ANP Testimony.doc	**Name:** ANP Testimony.doc **Type:** WINWORD File (application/msword) **Encoding:** base64 **Description:** ANP Testimony.doc **Download Status:** Not downloaded with message

My name is Laura Roberts and I am a PHN although I am presently not working in this capacity. Currently, I work as a RN at the Ketchikan General Hospital and live on Prince of Wales Island. I worked on Prince of Wales Island as an Itinerant PHN at the Craig Public Health Center from 2000-2003. I was asked to provide testimony regarding the impacts of losing the State Advanced Nurse Practitioner position in this community. It was unfortunate that I was unable to provide this testimony verbally. But due to the weather and poor phone reception, I am submitting my testimony in writing for which I am most grateful to still be allowed to participate. Losing the ANP that provides some of the Women's Reproductive Health services offered by the state on Prince of Wales would have significant impacts at this point in time. I say "at this point I time" as I do believe Woman's Reproductive Services and Well Child Services could eventually be transitioned to qualified primary care providers (in the state of California only ANPs, Physician Assistants and MDs provide these services to women and children). During this future transition, I do believe some kind of PHN home visiting or case management program will first need to be strengthened in order to continue with the mission of educating, promoting health and providing resources to the high risk groups that PHNs serve. I greatly appreciate this opportunity and I hope I can cover the most pressing points, PHN follow up and case management and access, in my brief testimony.

Prince of Wales Island is currently struggling with the development of a health care system, as is evident by the monthly Health Care Advisory Committee meetings. Much of the discussion and planning surrounds the provision of primary, urgent, and emergent medical care of the population, not the provision of preventive care, such as the Family Planning, particularly to the uninsured, vulnerable population of teens and young women. Besides the Craig Public Health Center, SEARHC is the only other facility on the island that provides service on a sliding scale fee due to the HRSA grant they have been awarded. They also are the only provider of emergent care on the island, which coupled with medical management of illness and urgent care, to my understanding, keeps their primary care providers extremely busy. I do hope you have an opportunity to hear directly from them the nature of their clinic practice. There are two other medical providers, the Craig Clinic and Southeast OB/GYN. These providers, however, are fee for service and cost prohibitive for low income, uninsured women and especially teenagers. Also, Southeast OB/GYN visits monthly for one-two days. The Craig Public Health Center provides Women's Reproductive Health services to just over 90 clients, 39 of which are teenagers and a significant portion of the remaining fifty are young adult women who also demonstrate high risk behaviors. At this point, I think it is fair to say, that SEARCH may not have the time to provide family planning and follow-up of these at risk populations given their already full schedule and current personnel. Consequently, these clients will suffer greatly from losing the state ANP Women's Reproductive services, PHN follow-up and the severe reduction in access to these services.

Lacking PHN follow-up: PHN tracking and case-management in the Women's Reproductive Health program is vital to addressing not only family planning but many different public health issues within this high risk group. This core aspect of a public health focused program will be greatly compromised if the state ANP is lost. After the ANP has provided the initial and yearly woman's health exam, the PHNs follow-up with

these clients periodically to fill prescriptions and handle any problems with the chosen method of birth control. During a routine FP visit, the PHN may also screen for Domestic Violence, pregnancy and STDs, and educate and make referrals for smoking cessation, mental health, alcohol or drug use, nutrition and exercise. The routine FP visit with the PHN also becomes a prime opportunity to educate and promote health and prevent illness in a hard-to-reach, high risk group. In the unfortunate event of possible birth control failure, early access to pregnancy screening facilitates early access to Denali Kid Care and most importantly, early prenatal care. In 2002, the urine screen for Chlamydia and Gonorrhea became available and resulted in a higher number of teens and high risk men and women accepting this STD screening rather than the vaginal or penile swab that was required to obtain such a specimen. The ability to offer this screening will no doubt improve the early detection of these diseases, thus preventing their transmission and the morbidity sequela of PID and sterility. These are just two examples of the eternal justification for investing in public health services: The severity of long term costs of delayed detection or lack of treatment for community members far outweighs the immediate costs of providing screening and prevention for the community.

Access: In regards to access, the Craig Public Health Center is highly sensitive to the spontaneous visit of the adolescent family planning client. It is very frequent that teens will drop-in after school without an appointment requesting their method of birth control prescription be filled. It is not uncommon for young adult women clients to also request this short notice service. Without much delay, the Craig PHNs are able to either serve these clients on a drop-in basis or schedule appointments within a day or two after school hours. Of course, personal responsibility and planning are an on-going message of Public Health, however, behavior changes are incremental, and it only takes one-time of birth control method delay to result in unwanted and unplanned pregnancy. The SEARHC clinic has many urgent care demands during their drop-in hours and it isn't difficult to predict the access barriers a teen would face in such a busy medical practice. Furthermore, non-native beneficiaries are required to pay for all prescriptions at another local pharmacy, regardless of the HRSA grant thereby presenting another obstacle to low-income teens and young women. Additionally, the SEARHC clinic is in Klawock, seven miles from Craig, presenting another obstacle for many Craig teens and young woman who lack transportation. Access to the ECP would also decline if Family planning services were cut. In the past, SEARHC providers have referred women to the CPHC for this service as they have not provided this service.

Thank you for this opportunity to provide testimony. Sincerely, Laura Roberts

OVERVIEW: FAITH-BASED & COMMUNITY INITIATIVES

HOW TO REGISTER FOR THE CONFERENCE

Please visit the FBCI website at:
http://ltgov.state.ak.us/fbci

The conference is free, but registration is required.

http://ltgov.state.ak.us/fbci

STARS OF GOLD

The Stars of Gold award program celebrates service. It recognizes community individuals and groups who improve the lives of Alaskans.

Service providers help solve social challenges and build stronger families and communities. By actions, they inspire caring for others.

Governor Murkowski and Lieutenant Governor Leman want the Stars of Gold program to elevate service as an important and ongoing responsibility.

For information on the Stars of Gold program. Please visit:

http://ltgov.state.ak.us/fbci

Lieutenant Governor Loren Leman
Contact: Gwen Hall

Faith-Based & Community Initiatives Conference

&

Stars of Gold Award Banquet

Friday, April 30, 2004
Egan Center
Anchorage, Alaska

A GOAL WORTH PURSUING

Alaskans have a long history of helping each other. Now it is important that we fully tap the resources of our faith-based and other community organizations.

The State of Alaska, in partnership with the Faith-Based & Community Initiatives (FBCI) Task Force and the Salvation Army, hope this conference will open up new opportunities for the partnership between government and faith-based and community organizations.

Governor Murkowski and Lieutenant Governor Leman share a sincere interest in fostering successful partnerships among faith-based and other community services and State agencies.

Like President Bush's work on the national level, Alaska's faith-based and community initiative is intended to promote increased ministries and services.

This effort is designed to maintain the integrity of faith-based missions, strengthen private support and reduce bureaucratic barriers. In some cases, this may improve opportunities for service providers to compete for government grants.

http://ltgov.state.ak.us/fbci

A DAY WORTH EXPERIENCING

- Learn more about FBCI
- Make strategic connections with other community leaders and organizations
- Identify additional resources available to your organization
- Learn tips for writing successful grant applications
- Understand keys to successful FBCI-agency partnerships

SCHEDULE OF EVENTS

8:00 - 9:30	Registration
9:00 - 9:20	Remarks from Lt. Governor Leman
9:20 - 9.30	White House Greeting
9:30 - 10:45	Session 1: Resources Available to FBCI
11:00-12:00	Session 2: Do's & Don'ts for FBCI Organizations
12:00 - 1:30	Lunch & Keynote Address
1:45 - 3:15	Session 3: Keys to Successful Partnerships
3:30 - 4:15	Session 4: The ABCs of Grants
4:15 - 4:30	Closing Remarks
4:30 - 5:30	Session 5: Networking
7:00 - 9:30	Stars of Gold Award Banquet

A DAY WORTH EXPERIENCING

President Bush recently recognized Alaska as a leader in expanding the contribution of faith-based and community organizations.

This conference and banquet will take Alaska's participation to the next level. Please consider supporting the FBCI conference and Stars of Gold Award Banquet. You can help by:

- Sponsoring a table at the Stars of Gold Award Banquet.
  - $1000 for a table of 10
  - $500 for a table of 5

  Sponsors will be featured at their tables and in the program.

- Becoming a Conference Sponsor.
  - Gold Sponsor: $5000
  - Blue Sponsor: $2500

  Conference Sponsors will be featured on the conference banner and in the program.

- Making another financial contribution. Make checks payable to The Salvation Army

  Visa, MasterCard and American Express are also accepted

If you have any questions please contact Jenni Ragland by email: jenni_ragland@usw.salvationarmy.org or by phone at (907) 276-2515.

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Faith-Based & Community Initiatives
Conference and Stars of Gold Award Banquet

Friday, April 30, 2004 • Egan Center – Anchorage

An Accomplishment Worth Celebrating

President Bush has recognized Alaska as a leader in expanding the contribution of faith-based and community organizations.

A Goal Worth Pursuing

Governor Murkowski and Lieutenant Governor Leman share a sincere interest in fostering successful partnerships between and among faith-based and other community organizations and State agencies. This initiative is intended to promote and increase ministries and services.

The State of Alaska, in partnership with the Faith-Based & Community Initiatives (FBCI) Task Force and the Salvation Army, hopes this conference will open up new opportunities for the partnership between government and faith-based and community organizations.

A Day Worth Experiencing

- Learn more about FBCI
- Make strategic connections with other community leaders and organizations
- Learn tips for writing successful grant applications
- Understand keys to successful FBCI-agency partnerships

Registration Deadline: *Friday, April 23, 2004*

- The conference is free, but registration is required
  - Registration is on first-come, first-served basis
  - Indicate on the registration form if you would like to attend the Stars of Gold dinner banquet, which is $15 per person

Register online:

http://ltgov.state.ak.us/fbci/registration.php

FBCI
ALASKA

Faith-Based & Community Initiatives Task Force

Legislative Briefing

House Health, Education and Social Services Committee

Juneau, Alaska

April 19, 2004

MISSION STATEMENT

The mission of the Faith-Based and Community Initiative Task Force is:

- To enhance Alaska's health and social service capabilities by expanding the contribution of faith-based and community initiatives.

To accomplish its mission, the Task Force will:

- Develop and help launch innovative ideas for increasing the contribution of faith-based and community initiatives.
- Foster partnerships between and among government agencies and faith-based and community organizations.
- Identify and work to eliminate barriers that hinder faith-based and community initiatives.
- Promote the expansion of volunteerism and highlight outstanding examples of neighbors helping neighbors.

SUMMARY OF ACCOMPLISHMENTS TO DATE

- The FBCI Task Force has been running for five months and has met four times.
- Task Force members have completed more than 60 interviews with organizations that provide services in Alaskan communities.
- Task Force members have educated themselves on the legal issues surrounding faith-based initiatives.
- The Task Force has reviewed FBCI legislation in other states.
- The Task Force has worked to identify the most pressing social needs and gaps in services in Alaskan communities.
- As a result of the Task Force's efforts, the White House has identified Alaska as a FBCI Role Model State.

INTERVIEWS WITH COMMUNITY ORGANIZATIONS

Objectives

One of the FBCI Task Force's primary objectives is to obtain input from a wide range of organizations that are currently providing services to communities throughout Alaska. The extent of our impact depends on the quality of our information; so this "front-line" perspective is critical to success. Consequently, Task Force members will be proactively interviewing numerous entities throughout the coming months. These interviews will accomplish a number of goals:

- Broaden and deepen the Task Force's knowledge base--both individually and collectively.
- Stimulate fresh thinking about potential new ways for faith-based and other community initiatives to expand their positive impact throughout Alaska.
- Clarify how the Task Force can be of maximum service to our state.
- Surface issues and obstacles that need to be addressed.
- Expand the Task Force's visibility and help defuse any community concerns about its role.

Interview Questions

Task Force members will ask the following questions in their interviews:

1. What is your organization's core mission/purpose? What are the primary goals you are trying to accomplish?
2. How are you accomplishing your mission? What programs/services do you offer? Is there a faith component to your organization?
3. How do you measure success?
4. What steps do you take to help your people be successful in their roles? What kinds of training do you provide? Do you use an accreditation process of any kind?
5. What other organizations are critical to your success? Who are your key partners? Do you have connections to any State or Federal agency?
6. From where do you receive your funding and how much comes from each source?
7. What are the three greatest obstacles or barriers you face in accomplishing your mission? Are there any government-related obstacles or barriers?
3. How can the FBCI Task Force help your organization be even more successful?
9. Overall, what should the Task Force try to accomplish?
10. What would you like the Task Force to know?

COMMUNITY ORGANIZATIONS INTERVIEWED

Juneau Youth Services
Catholic Social Services
Covenant House
Crisis Pregnancy Center
Alaska Bible College
SEND International of Alaska
Cordova Family Resource Center
Cross Road Medical Center
Victory Ministry
Alaska Women's Resource Center
Southcentral Foundation
National Association for the Education of Young People
Reach, Inc.
Gastineau Human Services
Nugen's Ranch
Hope Community Resources, Mat-Su Region
Love, Inc.
Narcotic Drug Treatment Center, Inc.
Center for Drug Problems
Interact Ministries
Frontier Community Services
Women's Resource and Crisis Center
Salvation Army Clitheroe Center
Cook Inlet Tribal Council (New Beginning Healthy Family Program)
Community Councils Center
Skate to Greatness, Inc.
Alaska Youth and Family Network
Alaska Youth and Parent Foundation
Alaska Child Abuse Response and Evaluation Services (CARES)
The Christian Business Men's Forum
Alaska Center for Children and Adults
Anchorage Literacy Project
Challenge Alaska
Alaska Children Services
Christian Health Associates
Alaska Center for the Blind and Visually Impaired
National Association for the Mentally Ill
KCAM Radio
Literacy Council
Salvation Army
Upper Tanana Head Start Program
Upper Tanana Aging Program
Whitestone Care Services
Southcentral Counseling Center Day Break
Christmas in May
Alpha Omega Life Care, Inc.
Kodiak Mental Health Center
Kodiak Senior Citizen's Center
Kodiak Women's Resource Center
Tanana Valley Conference of Churches
Careline Crisis Intervention
LOVE Social Services Center, Inc.
Make a Wish Foundation
Catholic Community Services
Christian Homes and Special Kids
Cook Inlet Housing Authority
"Let's Talk" Healthy Relationships Program
Relief Offered by the Congregations of the Kenai Peninsula (ROCK)
Cook Inlet Council on Alcohol and Drug Abuse
Soldotna United Methodist Church
South Peninsula Women's Services INC
Division of Public Assistance
Alaska Police Chaplaincy Program
Family Medical Center
Cook Inlet Housing Authority
Salvation Army: Adult Rehabilitation Program

Alaska Faith Based and Community Initiatives Task Force
Gaps and Needs Survey Report
February 2004

This survey was undertaken to provide the members of Alaska's Faith-Based and Community Initiatives Task Force with a sense of what people saw as the gaps and needs in Alaska's social service system and where and how they thought faith and community organizations might help to fill those gaps and needs. More importantly this survey gave people an opportunity to share their vision and ideas as to how we might ignite a new momentum to rally the spirited volunteer resources of Alaska's faith and community groups to minister to those in need.

Countless reports and studies have been completed to document the gaps and needs in social services, education, services for seniors, health care systems, safe and affordable housing, job opportunities and economic development. This survey is not intended to replace any of these existing assessments, in fact the views and perspectives of those who participated in this survey serves to corroborate the findings of these more scientific and objective snapshots of our human and social condition.

This survey is not an exhaustive inventory of every gap and need in our social systems. The Task Force acknowledges there are challenges facing Alaska that were not identified by those who participated in the discussions that lead to this report. Faith and community groups are strongly encouraged to come together to help solve any need or concern whether it is or is not included in this survey.

The Task Force appreciates the input and involvement of everyone who participated in the gap and needs inquiry conducted by Group 1. It is hoped this survey will be viewed as a primer to what is to come as Alaska moves forward to improve the lives of its citizens through our faith-based and community initiatives.

Background

In 2003 Lieutenant Governor Leman appointed 21 citizens from around Alaska to the Faith-Based and Community Initiatives (FBCI) Task Force. The Task Force was asked to identify how Alaska could maximize its resources of compassion to meet the challenges faced by those in need. At the November 5, 2003 Task Force meeting, Chairman Scott Merriner established working groups to examine key questions to help this task force meet its mission. Group 1 was asked to identify the

major gaps and needs in Alaska's social service system and to identify ways FBCI organizations could become involved to help meet those gaps and needs.

Group 1 solicited written comments from around the State to identify major gaps in social services in Alaska. People were also asked how and in what areas they felt faith and community based groups could assist the State in meeting its social service program objectives. The group hosted public video and audio conferences on November 18 and December 2, 2003 and received verbal and written responses. Forty individuals from faith, community and State agency groups submitted 125 gap/need statements to the working group. These 125 statements were reviewed and assessed and are presented in this report.

Social Services gap and needs

Gaps and needs in social services systems can limit a person's progress toward self-sufficiency and hamper program efforts to effectively support the health and well being of Alaskans in need. Most of those who provided input to the work group generally expressed their concerns with regard to specific client populations including women, children and teens, seniors, those leaving adult or juvenile correctional facilities, single women with children, families, veterans, disabled persons, the homeless, those receiving public assistance and victims of sexual abuse or other crimes. Looking at the 125 statements as a whole, people generally focused their concerns on just a few gaps and need categories or subject areas. Regardless of which specific client group someone spoke to, the concerns raised most often related to one of these three subject areas:

- Housing
- Personalized care and services
- Relational support

- At any given time there are between 3-5,000 families on the Section 8 and Public Housing statewide wait lists and close to 5,300 households in Alaska are receiving housing assistance from AHFC. (Alaska Housing Finance Corporation FY 2003 Annual Public Hosing Agency Plan 07-01-2003)
- In 2002 among the 2,000 plus applicants on the Anchorage Housing Choice Voucher wait list, 20% were on the wait list for more than two years. (Alaska Housing Finance Corporation FY 2003 Annual Public Hosing Agency Plan 07-01-2003)
- Market analysis suggests that upward of 50% of landlords in Fairbanks and Anchorage will not accept voucher assistance. (Alaska Housing Finance Corporation FY 2003 Annual Public Hosing Agency Plan 07-01-2003)
- The number of homeless in Anchorage shelters has grown 8 to 9 percent per year and the increase is projected to continue at the same rate in the near future. (Final Report of the Anchorage Comprehensive Homeless Program Strategy Group, June 2002)

A few statements were submitted relating to gaps and needs in single and unique subject areas like rural subsistence preference or development of international trade. While concerns in these areas are valid, this report will focus on the common concerns over the gaps and needs related to these three main subject areas identified above.

Housing

The concern voiced most often was the need for safe and affordable housing. Those who provided input to the work group identified housing as the greatest challenge and the most significant barrier to a person's progress or success.

Gaps and needs related to housing include:

1. Transitional housing for those moving into the community from closed programs;
2. Foster and group homes and half ways houses;
3. Emergency shelters for families, especially single parents with children;
4. Assistance to cover expenses (security deposits, utilities) not included in housing subsidy payments;
5. Drug and alcohol free low income housing;
6. Affordable housing, especially for the elderly;
7. Housing for special populations including the disabled, former offenders, addicts, etc.;

The statements below are indicative of those made with regard to gaps and needs in housing:

- *There is a need for affordable, drug and alcohol free housing for individuals and families. Those who complete treatment or who are waiting to get into treatment have a hard time finding safe, affordable, sober housing.*
- *Many prisoners return right back to the situations that contributed to their incarceration. There is a need for safe housing for felons re-entering society.*
- *The "working poor" can't qualify for housing assistance because they make too much money, but don't earn enough to acquire decent housing.*
- *There is insufficient shelter space for homeless, 2-parent families.*

- *Most federal housing programs don't cover various rent or utility deposit costs set by landlords, the power or water and sewer companies. A person who would otherwise qualify for housing assistance continues to be homeless because they can't come up with the cash to cover these ancillary expenses.*
- *Housing lenders don't provide enough financing for multi-unit housing.*
- *Homeless people trying to get their lives together by getting a job need an address they can list on an application or a message phone number where a prospective employer can contact them for work.*
- *Released inmates, recovering substance abusers, homeless, older teens and low-income families need both transitional and long-term housing.*
- *Convicted felons who need help re-entering society after they are released from jail don't qualify for housing assistance, and all too often they either end up on the street or back in bad living situations like those they were in before they went to jail.*
- *There are not enough foster or group homes to meet the needs of children under the state's care.*

People listed a host of housing problems including lengthy waiting lists for the few shelter beds that are available, no safe and supportive housing alternatives for single fathers with children or for felons who have completed their jail sentences, delays in completing simple inspections to get a home on an approved housing list, and market prices that put 2-bedroom rental units out of the reach of the working poor and those who are underemployed. Many of those who voiced concerns for safe and affordable housing said that without adequate housing, little else mattered.

Examples of how faith and community groups can meet needs and close gaps.

- Promote and recruit foster and adoptive families from the congregation or membership of the organization.
- Develop and operate a group home or transitional housing program for teens, women with children or other client groups.
- Group members can be trained to complete simple home and rental unit surveys to help housing authorities expedite the approval process to qualify a home for a housing subsidy program.
- Groups could offer classes or personal mentoring and transportation support to those in a housing subsidy program.
- Groups could construct and then lease and manage affordable multi-unit apartments for low-income individuals and families.
- Encourage group members to offer rental units to those who may be involved in social service, classes or mentoring programs provided by the church or community group.
- Group members could mentor or befriend people in public housing units to help them continue their progress once they return home after completing substance abuse

Personalized care and services

This broad subject category serves as a heading for the care and service activities provided directly to an individual or family to ameliorate an undesirable condition or circumstance.

Gaps and needs related to personalized care and services to support a person's physical, emotional, behavioral or spiritual well being, include:

1. Mental health and substance abuse treatment, especially in rural areas;
2. Childcare;
3. Housing for seniors, the disabled, former offenders, addicts, etc.;
4. Domestic violence;
5. Transportation;
6. Job Training;
7. Sex offender and victim support;
8. Resources for court referrals in rural areas;
9. In state long term mental health treatment, especially for youth;
10. Resources to fill gaps in state funding;
11. Health care access for working families;
12. Support for a range of senior services;
13. After school study and tutoring programs, especially in rural areas;
14. Fetal alcohol spectrum disorders;
15. Coordination of care by service providers for individual cases;
16. Suicide prevention;
17. Early intervention emphasis;
18. Resources for court referrals in rural areas;
19. Food programs for seniors and the poor;
20. Support and assistance for distance and home schooling programs

The following comments were made with regard to the gaps and needs in the personal care and service category.

- *More mental health and substance abuse treatment services are needed in rural Alaska, for both adults and juveniles. There is a significant difference in the number of direct services available to meet needs of those in urban areas compared to what is available in most rural communities.*
- *There aren't enough services, programs and placements for children, adolescents and adults impacted with Fetal Alcohol Spectrum Disorders.*

- Alaska's FAS rate is 4 times the national average at 1.4 per 1,000 population. The lifetime cost of care for one FAS infant is about $1.5 million. (1999 Annual Report of the Alaska Advisory Board on Alcoholism and Drug Abuse)
- Alaska's rate of alcohol dependence and alcohol abuse is nearly 14 percent, compared to about 7 percent nationally. (State of Alaska, DHSS, *An Integrated Substance Abuse Treatment Needs Assessment for Alaska*, January 2002)
- In fiscal year 2002, DHSS provided at least one episode of mental health care to 5,930 children in Alaska. (Children and Youth Needs Assessment, ACSES Report by UAA, 10-29-02)
- Over 97% of crimes committed by Alaska Natives are committed under the influence of alcohol or drugs. (Alaska Commission on Rural Governance and Employment, Final Report to the Governor, p 106, 1999)

- *Families need help dealing with issues of domestic violence and spousal abuse. Training in conflict resolution would help people find ways to deal with conflict without violence.*
- *People who suffer from undiagnosed mental illness often self medicate with drugs and alcohol. Mental illness, substance abuse and domestic violence play a huge part in child abuse and neglect cases and more services are needed to meet demands in these areas.*
- *Suicide is a big problem for many Alaskan communities. There is a need for screening, diagnosis and professional care to help those who may pose a danger to themselves or others.*
- *There is a need for treatment on demand for substance abusing parents. We need programs that allow parents to have their children with them while they are in treatment.*
- *Teens need after school programs, study and tutoring assistance and the support of positive adult role models. It is difficult for people in rural areas to get help to prepare for and pass GED exams.*

- *Those who make too much money to qualify for Medicaid, do not have health insurance or are not eligible for Native health services need access to doctors, medicines and health care.*
- *Families wanting to home school their children need support to get started and stay on track.*
- *More supervision and treatment services are needed for sex offenders and more counseling and support resources are needed for victims of sexual assault, especially in rural Alaska.*
- *Transportation is a big issue for those moving from welfare into the work place. Public transportation is either not available or is limited in service.*
- *There is a need for service providers to become informed about the state's behavioral health integration efforts. Families can face a set of uncoordinated requirements when they participate in more then one program. Agencies providing direct care to clients need to communicate and coordinate more effectively when serving the same clients.*
- *There aren't enough services, programs and placements for children, adolescents and adults impacted with Fetal Alcohol Spectrum Disorders.*
- *Families entering the workforce need a lot of help with childcare. There is little or no childcare in rural areas and parents don't feel they have safe alternatives for their children as they pursue work or job training.*
- *People and communities need sustainable economies. We need to work together to develop resources, generate jobs, provide job training while protecting our environment and beauty of Alaska.*
- *Disadvantaged persons can suffer from a variety of issues ranging from mental health, poverty, alcoholism,*

Examples of how faith and community groups can meet needs and close gaps.

- Faith groups can offer scriptural based substance abuse intervention programs
- Groups can offer parenting classes and child care services
- Faith and community groups can offer after school programs for teens that would include some recreation and academic skill development opportunities
- Congregations, service clubs and group members can offer rides to seniors, women with children and others who need transportation assistance.
- Groups can host a suicide prevention training event for their congregation and the community at large.
- Groups can encourage their members to offer job or job training opportunities to those wanting to get off welfare or those coming back into the community from a correctional program.
- Groups can conduct special fund raising events to provide money to individuals or families to buy furniture, dentures, car repair, etc.

homelessness, etc. There is a need for coordinated, comprehensive case management. Integrated case management would help maximize the service benefits of individual programs and agencies serving those in need.

- *Before the system is able to help someone, they must reach bottom. We need more services dedicated to earlier interventions so people don't have to get so bad off before they can get help.*
- *There is a need to increase efforts to promote abstinence education.*
- *Services are needed to help families and children deal with a variety of issues when one or both of the parents are incarcerated.*
- *When the court makes a referral for services such as anger management, batterers intervention, etc. there are few if any of these services available in smaller communities.*
- *Alaska doesn't have a long-term mental health treatment program for youth so youth needing this help have to be sent out of state.*
- *Some on public assistance or fixed incomes like SSI only qualify for $10 in food stamps per month. Income qualified seniors need higher food stamp allowances.*

Some individuals commented that their faith organization or faith coalitions provide a variety of mental health, anger management, couples counseling and treatment services for substance abusers but their programs are not approved to receive State funding. Groups have an interest and desire to work with the State to establish a mechanism that would open a governmental funding stream to support these faith centered mental health and substance abuse treatment services.

This subject category also includes gaps and needs for materials, equipment, and special needs funding to meet expenses that are not funded through State and Federal social service programs. This would include dentures or baby cribs as an example.

Relationship support

Individuals who are confronted with difficult challenges in life often times need a friend or helper, someone who can provide encouragement and support to see them through. This category speaks to relationships between individuals that would be more

personal rather than professional. These support relationships would be informal and much less structured than the interactions that typify the relationships between a counselor and client, therapist and patient. People saw a need to support those who were moving into the community after they completed treatment or finished a period of incarceration. In various ways people identified the need of social service client populations to have a companion or friend supporting them as they moved towards greater self-sufficiency and independence. In this category, a volunteer wouldn't necessarily do something <u>for</u> another, but rather would do things <u>with</u> the other person.

The following gaps and needs were identified as barriers to providing more effective and efficient relationship support to individuals in need:

1. Transitional support to aid ex-offenders in making successful transitions into the community;
2. Respite care for families;
3. Support for victims of crime;
4. Advocacy and moral support for those negotiating with landlords or navigating their way through the court or welfare system.
5. Support to strengthen marriages;

These statements illustrate the concerns related to the gaps and needs in the area of relationship support.

- *Youth returning home from a detention or youth facility need relationships with healthy adults willing to help the youth "make it." This would be the same for an adult leaving jail too.*
- *Students need assistance and support to engage in distance education and home school services.*
- *Families and caretakers who care for a disabled person need support and help. There are services for the disabled person, but families and caretakers need support too.*

Examples of how faith and community groups can meet needs and close gaps.

- Groups can "adopt" someone transitioning back into the community from a treatment or correctional program and provide them with companionship, recreational and social activities.
- Group members can volunteer as victim advocates, tutors or playground attendants at the local school during lunch periods.
- Group members could be a "buddy" and be available to others after hours to talk on the phone or help when some challenge comes up after the caseworker is off duty.

- *Women re-entering the community following release from jail are often returning to the same environment they left. These women need help to develop social skills, increase their self worth and transportation to help them re-integrate into the community.*
- *Agencies and families would benefit if volunteer "grandma/grandpa" could watch the children during court hearings or appointments with caseworkers.*
- *Victims of crime need support and advocacy.*
- *Volunteers are needed to supervise visits between children and parents involved in the child protective services system.*
- *Relationships can be strengthened between husbands and wives through involvement in faith group activities and classes.*
- *A person eligible for a housing subsidy sometimes doesn't know how to present or sell themselves to landlords. They may find a suitable apartment to meet their needs, but they don't know quite how to interact with the landlord to complete a rental agreement. Maybe if these people had a "friend" or "buddy" to go with them to look at apartments and to talk with landlords and apartment managers to finalize rental agreements, perhaps more of these people could get off of the street and into homes.*

Success may be easier to find when the person has the support of a friend or mentor as they make their way through a transition processes, learn appropriate social skills or finish school and training programs. Beyond the formalities of our structured social service assistance and treatment programs, people need the help, understanding and encouragement of friends and neighbors long after the social service program case files have been closed. This category is as much about being a good neighbor as it is meeting a program gap in our State social service system.

Areas of need for state agencies and community groups

Agencies were invited to identify areas of need where they thought faith and community groups might render assistance to help them meet their missions. Programs often have a variety of requirements and constraints place on them that limit their organization's ability to meet all of the needs of those they serve.

Some of the gaps and needs identified by State agencies include:

1. Cash grants to cover the ancillary costs of housing and medical care;
2. Vehicle maintenance;
3. Training for staff and volunteers;
4. Volunteer school tutors, mentors and class room aides;
5. Pastoral visits with those in facilities and treatment programs;
6. Meal delivery for shut-ins.

The following is a list of goods and services state agencies and community groups said would help them help those in need.

- *Clients need cash grants to cover rent and utility deposits. Sometimes for the want of $250 cash, a person remains homeless because they can't come up with the funds for rent and utility deposits.*
- *Low-income people need help to keep their vehicles operational. They could use the help of a friend who could help them learn how to change the oil or do minor maintenance of their vehicles. Sometimes they need financial help to get emissions inspection or vehicle registration.*
- *Schools need volunteers to help mentor students in reading, math and science. Volunteers can also help as classroom aides, lunch room and play ground monitors. Volunteers can also help supervise after hours sporting or social events.*
- *Funds have been cut for services and staff training. When someone has a training session, it would be good if the training could be opened to others who otherwise might not be able to afford or have access to that training.*
- *Youth need adult mentors to help them learn good social skills and appropriate behaviors.*
- *State funds usually don't cover the costs of a baby crib, linens, kitchen utensils, personal care items like hairbrushes, deodorant, etc. Women's shelters, foster families or families moving into a new apartment for the first time are some of those who could use help with these things.*

- *Youth and adults in residential, treatment and correctional facilities welcome opportunities to visit with ministers and lay people who are willing to provide moral and spiritual guidance and support.*
- *People in rural communities and those who are disadvantaged need others to advocate for them so policy makers can be made aware of their needs and concerns.*
- *Volunteers are needed to deliver meals to homebound seniors. Volunteers are also needed to help seniors with transportation to appointments or the grocery store. Volunteers might also help with routine cleaning tasks around their homes.*
- *Volunteers are needed to teach home economics (simple cooking, budgeting, cleaning, etc.) to teens with mental health issues.*
- *Due to Senator Stevens' efforts, Alaska has created Community Health Centers (CHC) to offer health care to patients who meet poverty guidelines at a substantially discounted cost. People need to be better informed about the availability of these local health centers.*

Conclusion and Recommendation

There are numerous gaps and unmet needs in our social service system in Alaska. Most of the gaps and needs identified by those who provided input to the work group could be classified under three general subject categories of:

- Housing
- Personalized care and services
- Relationship support

As we in the faith-based and community groups, tribes, local governments, state and federal governments work together we can respond to these gaps in service and answer the unmet needs of Alaska's people. The work group recommends the Faith-Based and Community Initiatives Task Force adopt a policy statement to encourage faith and community groups to marshal their resources to address the challenges of housing, personalized care and services and relationship support for those in need throughout Alaska.

FAITH-BASED AND COMMUNITY INITIATIVE TASK FORCE
Resolution on Social Service Gaps and Needs
Adopted January 28, 2004

WHEREAS, the mission of the Faith-Based And Community Initiative (FBCI) Task Force is to enhance Alaska's social service capabilities by expanding the contribution of faith-based and community initiatives,

WHEREAS, the Task Force has identified a number of gaps and needs in Alaska's social service network,

WHEREAS, the most critical gaps and needs identified can be classified under the three general categories of Housing, Personalized Care and Services, and Relationship Support,

WHEREAS, the spirited volunteers of Alaska's faith and community groups are well positioned to address many of the gaps and needs identified,

IT IS RESOLVED, that the FBCI Task Force calls upon all Alaskan faith and community organizations to marshal their resources to address the following areas of need:

1. Housing
2. Personalized Care and Services
3. Relationship Support

LOOKING AHEAD

- The Task Force is studying 68 carefully selected faith-based and community organizations in order to understand the keys to successful initiatives and partnerships.
- The Task Force will hold a statewide FBCI conference at the Egan Center in Anchorage on April 30.
- The Task Force will develop a prioritized list of specific ideas for new faith-based and community initiatives to address the social service gaps and needs identified.
- The Task Force will be working specifically to understand the unique issues and opportunities present in rural Alaskan communities.
- The Task Force State Department liaisons will report on the FBCI barriers identified by each department and the actions being taken to address them.

Transformational Living Community

Program Update

Provided by
Reverend Mike Ensch, Chaplaincy Coordinator
Division of Institutions
Alaska Department of Corrections

On February 2nd of this year, the Department of Corrections Chaplaincy program launched its first Faith-based residential program in an Alaska correctional facility. Located at the Palmer Correctional Center, this program occupies one complete housing unit of 32 prisoners. Prisoners volunteer to enter the program and may volunteer to exit the program at any time. To date, there have been several hundred prisoners who have expressed interest in the program and the department has a waiting list of qualified applicants.

The program is operated by Alaska Correctional Ministries under the direction of the Department of Corrections Chaplaincy Coordinator. All program operations, including program staff, equipment, and curriculum, are being funded by private sector resources, primarily from the faith community. To date $187,000 has been raised. Major financial partners include Faith Christian Community church, Southcentral Foundation, and the Family Wellness Warriors Initiative. Many other donations have come from churches, individuals, and over $3,000 from the residents themselves.

Called a Transformational Living Community (TLC), this program was designed to provide a new alternative to traditional types of correctional habilitation programs. Specifically, one in which the spiritual dimension of an offender's life becomes the primary gateway to habilitation.

The program is 12 to 18 months in duration and is designed to create a healthy, positive and spiritually-centered community learning environment, conducive to facilitating lasting positive change in the lives of the residents. The residential setting provides the opportunity to limit the negative influences of the general prisoner population and provide an intense focus on personal change.

This program is extremely structured and intense. Their day begins at 5:30 a.m. and does not conclude until 9:00 p.m. Throughout the day they are involved in community group meetings, prayer meetings, work, individual counseling, exercise, and core programs each evening.

The entire program is built on 10 core Biblical values which provide the foundation for the structure, the programs, and all the rules and regulations that govern the community. One of the most important values is accountability and every aspect of the program builds in accountability and personal responsibility. One of the core elements in the program is teaching the residents how to internalize God's truth into their lives. Every aspect of the

program is designed to help the residents internalize truth, and to make the kind of changes that are necessary, so that when they re-enter the community they will be better equipped for return to society.

One of the most exciting parts of the TLC is called MentorNet which occurs each Monday night. Every resident is assigned his own personal mentor from the church community. The Mentors all come to the prison each Monday night as a group. The mentor's role is to provide discipleship, encouragement, accountability and role modeling. The goal is that the relationship that is developed will become a spiritual care net from incarceration back into the community. The relationships and bonds that are created can be very powerful.

Some of the major issues that the program deals with in the lives of the residents have to do with life controlling problems such as sexual addiction, anger, and substance abuse. Focus is also placed on criminal mentality, coping with incarceration, relationships, inner healing issues, moral and character development and preparation for release. All of these issues are dealt with from a biblical perspective through classes and seminars, community group meetings, mentoring, as well as the individual counseling that the men receive.

While the program is very new, early indicators of change include the fact that residents are beginning to take appropriate ownership for their community and pride is being exhibited through the cleanliness of the housing unit and their own personal hygiene. Participating inmates appear to be sincerely seeking change for their lives and, so far, good behavior is providing a management benefit to the correctional staff.

Future outcome measures will be developed as residents complete and graduate from the program and reenter society.

OVERVIEW: GOVERNOR'S COUNCIL ON DISABILITIES & SPECIAL ED.

FRANK H. MURKOWSKI, GOVERNOR
State of Alaska

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

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Mission

To create change that improves the lives of Alaskans with disabilities

Roles

- State Council on Developmental Disabilities
- Special Education Advisory Panel
- Interagency Coordinating Council on Infants and Toddlers with Disabilities
- Alaska Mental Health Trust Authority Beneficiary Board
- Governing Board of the Special Education Service Agency (SESA)

Major Accomplishments towards Securing Alaska's Future

Working collaboratively with the State of Alaska and other stakeholders, the Council helped:

- Reduce high cost institutional services and enable individuals and families to stay in their local communities through the implementation of the Medicaid Home and Community-Based Services (HCBS) Waiver Program
- Contain costs and increase the number of individuals served at the same time through the closure of Harborview Developmental Center and de-certification of Hope Cottages' ICF/MR facilities
- Increase the employment rate of Alaskans with severe disabilities and reduce dependence on State services by leveraging Trust and federal funds and advocating for the passage of the Medicaid Buy-in program for working people with disabilities
- Increase cost-efficiencies and savings to the State of Alaska by conducting an examination of the two waiver programs administered by Developmental Disabilities and convening a workgroup to provide input into the new HCBS waiver regulations.
- Leverage a variety of funds to increase the availability of coordinated, accessible transportation for people with disabilities and low-income individuals to get to work

Current Principal Activities to Secure Alaska's Future

The Council is working with the State of Alaska and a variety of stakeholders to:

- Improve special education services so youth with disabilities leave school with the skills needed to secure jobs in their local communities and reduce their dependence on State government
- Integrate senior and disability services, including the reconfiguring and restructuring of resources
- Implement cost containment within the four HCBS waiver programs without placing undue burden on individuals and families
- Redesign the early intervention/infant learning program to maximize dollars from a variety of sources while increasing the number of children served in a timely manner
- Continue efforts to increase opportunities for Alaskans with disabilities to work and secure transportation to their jobs

Cost Containment Recommendations- Developmental Disabilities Program

- There are 1,430 individuals with developmental disabilities on the waitlist for services. The Council therefore strongly recommends that all cost savings resulting from implementation of these recommendations be used to 1) provide minimal stopgap services (Core Services) to everyone on the waitlist; and 2) reduce the waitlist, including the 25 percent who are not waiver eligible.
- DD Core Services help keep families together while they wait for full services. Currently, 500 families receive $2,550 annually for things like respite care or alarms in case a "runner" tries to leave home; an additional $450 is provided to service providers to administer the funds. Although some mechanism may be needed to ensure funds are spent within specified guidelines (i.e. a small grant to one administering agency), the State would save $225,000 annually if these funds were given directly to families.
- Add an option for ***Individual/Family Support Home and Community-based Waivers***, thereby drawing down federal Medicaid funds to support Core Services for waiver-eligible individuals; currently, Core Services are funded with 100 percent State funds.
- Identify regular State Medicaid plan services that can be modified or utilized more effectively. For example, the Personal Care Assistance program is limited to ***Activities of Daily Living*** (bathing, dressing, transferring from bed to chair, toilet assistance, mobility and eating); if the program were broadened to include ***Instrumental Activities of Daily Living*** (housekeeping, cooking, shopping, medication management, money management and communication), individuals may receive enough support so that more expensive waiver services aren't needed.
- An investment in general fund grant dollars saves the state money; grant-funded services are generally low-cost services, which, if provided at the right time, help keep families together and avert high-cost crisis situations. Although some services were one-time services or did not completely meet people's needs, in FY02 the average cost of grant-funded services was $6,683 compared to the State's share ($28,409) of a waiver.
- Institute a "soft cap" for different services, which includes a process for raising the cap when needed. The Council supports State efforts to reduce costs through the development of a reimbursement system that sets specific rates for waiver services as long as there is a mechanism to increase rates in unusual and rare situations.
- The Council cautiously endorses 638 financing, which offers a previously untapped mechanism to reduce the State budget and take people off the waitlist. However, the Council has some concerns and asks that it be involved in evaluating the impact, outcomes and implications of any pilots.

Other Cost Containment Recommendations

- Create incentives for people with severe disabilities to fully participate in the economy and leave the Adult Public Assistance rolls by allowing participants in the ***Working Disabled Medicaid Buy-In Program*** to save money beyond the current limit of $2,000 ($3,000 for a couple). Research shows that people with disabilities who work are healthier and less likely to use medical care. Research also shows that working and saving money is the best way to escape and remain out of poverty. With access to personal savings, these individuals will be less likely to use cash public assistance and other State-funded services.
- Maximize use of public resources for transportation services and facilitate their further coordination with private resources as a matter of good public policy by issuing an administrative order to establish the Governor's Coordinated Transportation Task Force.

OVERVIEW: MADD

MADD
Activism | Victim Services | Education™

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Like the mythical desert bird that rose from its ashes, Mothers Against Drunk Driving (MADD) is a phoenix that emerged from tragedy. In 1980, MADD started with a loosely assembled group of brokenhearted mothers. Today, it is the largest crime victims' assistance organization in the world with more than 3 million members and supporters.

MADD is about committed spirits and determined volunteers. It is the embodiment of victim support and assistance. MADD is tangible proof that social attitudes can be radically changed.

Since MADD's inception, alcohol-related traffic fatalities have declined 43 percent. Statistics indicate that in 1980, 55 percent (28,100) of the nation's 51,091 traffic fatalities were alcohol-related. In 1999, alcohol-related fatalities represented 38 percent (15,794) of the nation's 41,345 traffic fatalities, according to preliminary statistics. Due in large part to MADD's efforts, more than an estimated 138,000 people are alive today and an untold number have received comfort, support and assistance in dealing with the aftermath of a drunk driving crash.

HOW IT ALL BEGAN

In 1979, five-and-a-half-month-old Laura Lamb became one of the world's youngest quadriplegics when Laura and her mother, Cindi, were hit head-on by a repeat drunk driving offender traveling at 120 mph. As a result of the crash, Cindi and her friends waged a war against drunk driving in their home state of Maryland. Less than a year later, on the other side of the country in California, 13-year-old Cari Lightner was killed at the hands of a drunk driver. Two days prior, the offender was released on bail for a hit-and-run drunk driving crash. He already had two drunk driving convictions with a third plea-bargained to "reckless accident." At the time of Cari's death, the drunk driving offender was carrying a valid California driver's license.

Enraged, Cari's mother, Candace Lightner, and friends gathered at a steak house in Sacramento. They discussed forming a group named "MADD-Mothers Against Drunk Drivers." Thus, MADD was born with a name that would sweep the nation.

A Nation United

Lightner and Lamb joined forces and by the end of 1981, MADD had 11 chapters in four states. MADD began to receive donations from victims and concerned citizens and was awarded a $65,000 grant for chapter development from the National Highway Traffic Safety Administration (NHTSA).

By the fall of 1982, more than 70 MADD chapters were operating, primarily initiated by victims searching for a way to bring some sense to the apparently meaningless deaths and injuries of their loved ones. In March 1983, NBC produced a made-for-television movie about MADD entitled the Candy Lightner Story. By the end of the month, 122 more MADD chapters opened, covering 35 states. At the same time, a poll revealed that an astounding 84 percent of the country had heard about MADD and 55 percent believed MADD was accomplishing its mission.

By its 10th anniversary, MADD had grown to 407 chapters, 53 Community Action Teams (CAT) and 32 state offices with affiliates in Canada, England, New Zealand and Australia. Shortly thereafter, a Gallup survey revealed that Americans cited drunk driving as the No.1 problem on the nation's highways. Three years later, a second Gallup poll showed that the public had become less tolerant of drunk drivers and more supportive of stiffer penalties.

Rounding out 20 years, MADD now has more than 600 chapters and CATs in all 50 states and affiliates in Guam, Canada and Puerto Rico.

MADD's Mission

Originally, MADD's name stood for Mothers Against Drunk Drivers and its mission was "to mobilize victims and their allies to establish the public conviction that impaired driving is unacceptable and criminal in order to promote corresponding public policy, programs and personal accountability." In 1984, MADD changed its name to Mothers Against Drunk Driving to reflect its mission to eliminate a crime and to focus on the act of drunk driving. Following the name change, MADD condensed its mission statement to "stop drunk driving and to support victims of this violent crime."

In 1999 MADD updated its mission statement to reflect its long-running efforts to prevent underage drinking. The new mission, "to stop drunk driving, support victims of this violent crime and prevent underage drinking," reinforces MADD's commitment to reach out to young people.

Public Awareness

MADD vaulted into American homes on October 1, 1980, when three U.S. representatives announced the first strike in a national war on drunk driving-the federal Barnes bill. While the proposed legislation received little attention when introduced the previous year, the addition of two media-savvy mothers and little Laura Lamb seized the heart of America.

The Red Ribbon campaign was initiated at the 1986 Candlelight Vigil of Remembrance and Hope in San Diego. Attendees were asked to take the red ribbons around their vigil candles to their automobiles and "tie them on" as a reminder not to drink and drive. Renamed Tie One On For Safety, this public awareness campaign is MADD's most recognizable and longest-running national program.

In the 1980s, MADD popularized the concept of "designated drivers." Today, it is a household term, and bars and restaurants nationwide ask patrons to "designate a driver"-one of MADD's ongoing awareness and prevention messages.

Victim Assistance

At the heart of MADD's mission is victim assistance. The organization's slogan, "the Voice of the Victim," immediately distinguished it from other highway safety groups. At the organization's first national press conference in 1981, Lamb told the nation that MADD's primary focus was to help victims through the justice process by preparing them for the reality that the defendant has all the rights.

By 1984, a comprehensive victims' assistance program had been developed. Four years later, the first issue of MADDvocate, a magazine for victims and advocates, was published. Today, more than 1,200 victim advocates who have completed MADD's 40-hour advocate education serve thousands of victims through national and state toll-free numbers, e-mail and local advocate services. MADD advocates, volunteers and victims draw from a full catalog of brochures, books and other publications developed by MADD.

The National Institute for Victim Studies was developed in 1996, settling in Huntsville, Texas in 1999, as a partnership between MADD and Sam Houston State University. The new curriculum offers an interdisciplinary bachelor's degree in victim studies, with a master's degree in victim services administration planned for the near future. The Institute also offers volunteer and professional development in victim services administration and victim-related research.

Youth Programs

Since its early days, MADD has conducted a host of programs and activities targeting youth, such as alcohol-free prom parties, speeches in high schools and mock crash events. MADD announced a renewed focus on underage drinking and impaired driving in 1996 with youth programs born out of a Commission on Youth report. Within four years, MADD successfully launched a host of youth programs, including Youth In Action, Take the Lead, MADD Youth Power Camps, Student Activist Training, and the MADD National Youth Summit to Prevent Underage Drinking. A series of public service announcements targeting youth, parents, law enforcement and bar and restaurant servers was introduced. Resource materials such as posters, brochures, billboards, a coloring book and a series of classroom newsletters are also available.

MADD has also formally embraced the prevention of underage drinking as a specific mission goal and has elected the first-ever youth member of its national board.

Public Policy

MADD's grassroots activism has resulted in the passage of thousands of federal and state anti-drunk driving laws. The organization's most well-known legislative accomplishment came in 1984 when a federal law required all states to increase the legal drinking age to 21 or else lose highway funding. In the mid-80s, MADD launched an aggressive anti-impaired driving campaign and also undertook a legislative agenda that focused on administrative license revocation, open container laws, a maximum blood alcohol content (BAC) of .08 percent, Dram Shop laws, Victim Bill of Rights, crime victim compensation and several other measures.

At its 10-year anniversary, MADD introduced the "20 by 2000" plan to reduce drunk driving fatalities another 20 percent by the year 2000. The goal was reached by 1997. Currently, MADD is working in conjunction with the Department of Transportation on the Partners in Progress goal of reducing alcohol-related fatalities to 11,000 or fewer by 2005. MADD's annual National Sobriety Checkpoint campaign, its popular Rating the States program, victim rights and underage drinking prevention remain key components of the organization's legislative initiatives.

While MADD's imprint on the nation is successful by any measure, there is much left to do. For the families and friends of the nearly 16,000 men, women and children who were killed by a drunk driver in 1999 and the nearly one million more who were seriously injured, the progress did not come soon enough. Each statistic represents a face, a soul and a future that were violently interrupted.

MADD will not close its doors until drunk drivers stop taking innocent lives.

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MADD Milestones: 1980-2003

1980 Mothers Against Drunk Drivers is established in California. The first two chapters of MADD are created in California and Maryland.

1982 President Reagan announces a Presidential Task Force on drunk driving and invites MADD to serve on it.

MADD backs a resolution enacted into law by Congress to establish the first National Drunk and Drugged Driving Awareness Week in December 1982.

MADD grows to 100 chapters by year-end.

1983 MADD's national office moves to Hurst, Texas.

NBC produces a made-for-television movie about MADD and its founder resulting in the growth of more chapters and significant media attention.

1984 Federal "21" minimum drinking age bill is enacted.

MADD goes international when Canada becomes the first country outside of the U.S. to charter a MADD affiliate (MADD Canada: www.madd.ca).

The direct mail campaign is started to educate the public and raise funds for MADD's mission.

MADD changes its name to Mothers Against Drunk Driving.

MADD grows to more than 350 chapters.

1985 England and New Zealand charter MADD affiliates.

1986 MADD establishes Victim Assistance Institutes to train volunteers on how to support victims of drunk driving and how to serve as their advocates in the criminal justice system.

Telemarketing programs spur growth in grassroots support and serve as a major public awareness campaign to educate the general public on drunk driving issues.

Project Red Ribbon is introduced and one million red ribbons are distributed as motorists pledge to drive safe and sober during the Christmas and New Year holidays.

Australia charters MADD affiliate.

1987 National 1-800 hotline is created to provide victim support.

MADD submits an amicus brief to the U.S. Supreme Court opposing an effort by several states to rule the federal Age 21 law ruled unconstitutional. The law was successfully upheld.

1988 Omnibus Anti-Drug Abuse Act is signed. Included in this landmark bill is an amendment extending to all victims of DWI the same compensation rights offered to victims of other crimes. Another amendment creates the Drunk Driving Prevention Act (Section 410) to increase incentives for key state DWI law enactment. Also adopted was the Alcohol Beverage Labeling Act, requiring warnings on alcohol containers.

Impaired Driving Issues Compendium is created and ten companion workshops scheduled to instruct judges, legislators, law enforcement officials and MADD members on how to amend and implement stronger anti-DWI laws.

All 50 states now had passed Age 21 as the minimum legal drinking age.

1989 First MADD National Youth Conference, co-sponsored by the National Association of Broadcasters, is held in Washington, D.C.

MADD forms Victim Impact Panels as a national program and publishes a "How To" booklet and video.

1990 MADD files an amicus brief with the U.S. Supreme Court over the constitutionality of sobriety checkpoints. Following a hearing, the court rules in favor of checkpoints. MADD later establishes the week of July 4th as National Sobriety Checkpoint Week.

MADD introduces its "20 X 2000" plan to reduce the proportion of traffic fatalities that are alcohol-related by 20 percent by the year 2000.

1991 Congress passed the Intermodal Surface Transportation Efficiency Act (ISTEA), which included an updated, more accessible Section 410 program to more effectively encourage states to adopt key anti-DUI legislation; MADD had a key role in shaping the program.

The first national "Rating the States" Survey is released, drawing nationwide attention to the status of state and federal efforts against drunk driving.

MADD sponsored Gallup survey of public attitudes on drunk driving reveals that Americans cite drunk driving as the number one problem on the nation's highways.

The Transportation Employee Testing Safety Act passes, requiring alcohol as well as drug testing of transportation employees in safety-sensitive jobs, including random, pre- employment and post-crash testing. MADD constituents helped turn the tide and secure House action after the Senate had already taken action 11 times.

1992 MADD develops clergy/funeral director seminars, to help educate clergy, funeral directors and allied professionals on the special needs of family members following a tragic death.

MADD testifies on Capitol Hill on issues including funding for the Section 410 incentive grant program and on the Sensible Advertising and Family Education (SAFE) Act, to require extending the current health and safety warnings on alcohol beverage containers to all alcohol advertising.

1993 Fifth state passes a law lowering the legal blood alcohol limit from .10 to .08.

The second national "Rating the States" Survey is released, highlighting progress and remaining challenges in the fight against impaired driving.

1994 MADD releases results from second year-long Gallup survey on drunk driving, which shows the public is becoming increasingly less tolerant of drunk drivers and more supportive of stiffer penalties.

Release of the 1993 Fatal Accident Reporting System statistics reveals that alcohol-related traffic deaths dropped the previous year to a 30-year low; NHTSA credits MADD along with tougher laws.

MADD premieres "Hollywood gets MADD" with Siskel & Ebert on national television.

1995 MADD participates in the Secretary of Transportation's Summit on Highway Safety, announcing a proposed goal of reducing alcohol-related traffic fatalities to 11,000 or fewer by the year 2005.

MADD begins holding public policy institutes to train state public policy liaisons in DUI issues and legislative how-to techniques.

MADD announces national drunk driving fatalities rise for the first time in a decade.

Federal Zero Tolerance Law was passed by the U.S. Congress tying federal highway funds to the passage of a state-level version of the Zero Tolerance Law.

1996 Third national "Rating the States" survey is released announcing drop in nation's grade primarily due to rise in drunk driving fatalities.

MADD announces new focus on underage drinking and impaired driving with youth programs born out of its Commission on Youth report.

MADD pilots first six Youth In Action sites.

MADD launches an online presence at www.madd.org

President Clinton and Senator Dole announce support for crime victims' constitutional amendment

1997 The first MADD National Youth Summit to Prevent Underage Drinking is held. Four-hundred thirty-five teens, representing each U.S. congressional district, attended the historic summit to develop and present their own solutions to America's underage drinking problem.

MADD reached 20 x 2000 goal three years early when the percentage of alcohol-related traffic crashes fell to below 40 percent.

DRIVEN magazine is launched.

MADD hosted the International Candlelight Vigil of Remembrance and Hope at the National Cathedral in Washington, D.C. There were more than 1,000 participants.

1998 MADD hosts the National Diversity Forum and the MADD National Board of Directors adopts recommendations from MADD's Diversity Task Force on program outreach to people of color.

First youth representative elected to MADD's National Board of Directors.

MADD commemorates the tenth anniversary of the Kentucky Bus Crash, the deadliest drunk driving crash in U.S. history killing 27 and injuring 30 others.

U.S. Senate overwhelmingly passes federal .08 bill although House refuses to vote on amendment. Congress adopts a $500 million incentive grant program.

"Zero Tolerance" legislation is passed in all 50 states.

1999 The MADD National Board of Directors unanimously votes to change the organization's mission statement to include the prevention of underage drinking.

MADD establishes a presence in Guam and Puerto Rico. Two chapters are established in North Dakota, giving MADD a presence in all 50 states.

The fourth MADD Rating the States survey is released. The nation receives an average grade of C+ due to the leveling rate of decline in alcohol-related traffic deaths and thwarted passage of key federal legislation.

MADD and Sam Houston State University (SHSU) announce the launch of the National Institute for Victim Studies in Huntsville, Texas.

2000 MADD kicks-off its 20th anniversary year with its *Making a Difference Daily* campaign honoring special MADD volunteers every day of 2000.

MADD holds its 20th anniversary rally outside the U.S. Capitol where 600 activists call upon Congress to enact a national .08 BAC standard.

MADD releases a General Motors-sponsored Gallup survey showing growing support for .08 BAC and other MADD initiatives.

MADD holds its second National Youth Summit to Prevent Underage Drinking in Washington, D.C.

U.S. Congress passes a national .08 BAC measure as part of the Federal Transportation Appropriations Bill. President Clinton signs the bill into law on October 23, 2000.

2001 The *MADD College Commission Report to Address Alcohol's Impact on America's College Campuses* is released along with the announcement of MADD's first college MADD chapter.

MADD develops *Protecting You/Protecting Me* an elementary school curriculum program based on brain research and designed to help children protect themselves and reduce the risks if riding with a driver who has been drinking or other difficult situations.

MADD launches *Fake ID* and *Street Smarts*, multi-media school assembly programs for elementary, junior high and high school students.

The first MADD National Board of Advisors is announced, bringing together experts and celebrities dedicated to MADD's mission.

MADD joins other leading victim service organizations to issue a series of trauma recovery tips following the tragic September 11th attacks on America.

MADD and Mitsubishi Motor Sales of America launch *Pasa Las Llaves (Pass The Keys)*, designed to educate Latino communities about the risks of drunk driving. The campaign is piloted in Los Angeles, Dallas, Miami and Chicago.

MADD is named one of *Worth* magazine's Top 100 Best Charities in America.

DRIVEN magazine is updated to be a more informative and effective magazine in educating and involving the public in MADD's mission.

2002 MADD convenes a National Impaired Driving Summit to identify the most effective countermeasures to significantly cut alcohol-related traffic deaths and injuries and unveils its eight-point action plan to sharply reduce alcohol-impaired driving.

MADD holds national news conferences with support from congressional leaders about the impact of alcohol advertising on youth and opposition to proposed legislation to rollback the federal excise tax on beer.

MADD joins other health and safety groups to release a national public opinion poll showing that 71 percent of Americans would support increasing the national beer tax a few cents per bottle to equal the tax on liquor if the funds were used for substance abuse prevention.

As part of an ongoing commitment to improve traffic safety in diverse communities, MADD launches its Spanish-language Web site found at www.madd.org/spanish.

Protecting You /Protecting Me is officially recognized by the federal government as "a scientifically defensible effective prevention program." MADD's program is one of only 41 programs to receive this distinction.

MADD testifies before Senate and Congressional leaders on the reauthorization of the Transportation Equity Act for the 21st Century (TEA-21), a six-year highway funding bill.

Thirty-four states and the District of Columbia pass the illegal .08 blood alcohol concentration law by 2002.

MADD updates its image with a new logo.

MADD has more than 600 chapters across the U.S. - find out more about connecting with MADD at the grassroots level.

Make a Difference!

Drunk driving and its consequences can be prevented. Tackling it requires the involvement of every concerned citizen. You can take action to make your community a healthier and safer place. Join a growing number of people across the nation who have launched coordinated efforts to prevent drunk driving in their communities.

ADVOCATE FOR CHANGE

MADD activists are working to strengthen existing laws and to enact new ones. Learn how to influence legislation and law enforcement at all levels.

LEND A SHOULDER

Become a trained victim advocate and provide emotional support to victims of drunk driving crashes. Guide victims through the criminal justice system.

HELP A VICTIM BE HEARD

Coordinate a victim impact panel by assigning victim speakers and registering drunk driving offenders.

DROP A LINE

Contact law enforcement agencies and read local newspapers to find out about drunk driving crashes, then send out "We Care" cards to the victims of these tragic events.

UTILIZE OFFICE SKILLS

Answer phones, file, copy, type or perform other office support duties.

TAKE THE LEAD

Lend your leadership skills as a chapter, state or national officer.

VISIT THE COURTS

Ensure that drunk driving offenders are punished to the fullest extent of the law by monitoring court cases and reporting outcomes to the community and media.

ROLL UP YOUR SLEEVES

Join MADD members in hosting public awareness events such as mock-crashes, parades, fairs, safe proms and graduation events.

TIE ONE ON

Distribute MADD red ribbons to encourage people not to drink and drive. Tie a MADD red ribbon on your vehicle to show your commitment to driving safe and sober.

BE A ROLE MODEL

Assist youth in learning about the dangers of underage drinking and lead the way in making positive changes.

SPEAK OUT

Present facts about and solutions for drunk driving and underage drinking by speaking at schools, civic groups, organizations and clubs.

BE A PART OF SOMETHING MUCH LARGER

MADD has over 2 million members and supporters in the United States, Guam and Puerto Rico. Even if there is not a MADD entity located in your area, you could still become part of our family.

MADD ALASKA

The first MADD Alaska Chapter was formed in 1983 after June Garrish lost two young grandsons to drunk driving. Wesley, 11, and Scott, 13, were killed on a bike path in Girdwood in December 1981. The driver had celebrated his 18th birthday by getting drunk with friends. June had no experience with public speaking, had not belonged to social or business organizations and kept close to home. She and her husband had owned a small convenience store, and June had spent as much of her free time as possible with her family. Those boys were her life. When they died a part of June died with them. Like many victims, June wanted to prevent others from going through the pain she was having to endure. June contacted Candy Lightener shortly after the tragedy, and the rest is history. June formed **the Anchorage Chapter** along with assistance from supporters such as Anchorage Police Chief Brian Porter. She traveled to Juneau twice that year, spoke before the Legislature, held press conferences, and worked with Senator Bill Ray, among other legislators, to pass safe laws such as lowering the legal BAC rate to .10 BAC. Today, under the leadership of Marti Greeson, MADD Anchorage is one the most active chapters in the United States.

The MADD Juneau Chapter was established almost 20 years later, in 2001, after a drunk driver, a father of three young girls, relaxed with a few drinks before driving home after a bad day at work. In doing so, he took the lives of Martin Richard and Ladd Macaulay and seriously injured Steve McGee. Cindy Cashen, a daughter of one of the victims, founded the chapter along with a group of diverse people. Because of its location in the capitol, MADD Juneau is the chapter primarily responsible for advocating for MADD Alaska's legislative priorities.

The MADD Mat-Su chapter was started about a year ago when Kevin D. Blake, 15, of Tatitlek and Kenneth Kramer, 11, of Wasilla, were killed by a drunk driver while driving with their grandparents. Kenneth's Aunt, Chrissy Steele, was instrumental in creating the chapter along with other concerned community members for the same reason many of the chapters are created--she didn't want others to have to experience her nightmare.

The MADD Fairbanks Chapter was formalized last winter by a large, vocal group of community members. One of the leaders is a drunk-driving victim, Barbara Dowdy, who lost her seventeen year old daughter in the fall of 2000. The Chapter has been active in public policy and educating youth on the danger of underage drinking.

MADD's membership is comprised of diverse individuals. Some are victims of drunk driving; others have small children. Some are youth; others are senior citizens. Over half of MADD's members are men. Contrary to what some think, MADD members are not prohibitionists. Many of the members are responsible drinkers.

A VICTIM'S STORY

I looked up MADD one night on the computer about three months after Dad's death and was surprised to see Alaska had only one chapter. I left a message with MADD Anchorage and the next day received a telephone call from their victim advocate. She sent me materials, including a book that I read over and over. Additional literature was sent for Mom and my siblings as well as my grandmother. The Anchorage Advocate contacted the MADD chapter closest to my Dad's parents in Washington, as they did not know where to turn for help. Both chapters helped our family by listening to us, sending us information about the court system and helping us know what our rights were as victims.

We learned it was okay to be angry, sad, numb, suicidal, uninterested in food, ravenous, unable to sleep, unable to get out of bed. We learned it was common for family members to deal with their pain in many different ways, at different levels and at different times. My sister and I seemed to spend the first year switching between feeling numb, to aching so badly we would forget to breathe. One of my brothers found himself focused on the crime report, while the youngest one shutdown and would talk to nobody except his wife. We would not leave our mother alone, for fear she might kill herself. We learned the pain and grief we were dealing with was not unusual. And MADD was there to help us when we needed it.

I cannot imagine what it might have been like without MADD, without someone to assist us when we asked for help, to empower us when we wanted to make choices and to listen to us when it seemed nobody else wanted to hear our pain one more time. To give back what was given to me, today I am a trained victim advocate.

Past Alaska MADD Legislation

Throughout the 2000-2001 session, the Anchorage and Juneau Chapters worked with legislators on over twenty-five bills related to MADD issues. A local communication system was created thereby enabling members to testify, write and telephone on alcohol related issues. During that time we observed nine MADD-supported bills become law.

A bill lowering the legal BAC from .10 to .08 and another making underage drinking a misdemeanor has passed. A Therapeutic Drug and Alcohol Court pilot program has been funded to help the chronic drunk driver, the "look-back" into the number of past drunk driving convictions for drunk drivers has increased from five years to 10 years, funding has been provided for vehicle forfeiture and civil action can be taken by bars against minors who attempt to enter them.

Alaska is the only state in our nation which recognizes a day of remembrance, July 3, for drunk driving victims. This particular one was introduced by Representative Rokeberg and Senator Ellis at the request of two young Alaskans who lost their best friend, Jesse Withrow, in 2000 because of drink driving.

There is a Drunk Driving Victims Memorial Wall on display at all Alaska Division of Motor Vehicle. Families and friends may create memorials of loved ones using photos, stories and poems. These displays remind people waiting in the DMV lines to not drink and drive.

Alaska's alcohol excise tax has been increased from 3 cents to a dime per drink. Small brewers are exempt from the increase. *Alaska is still among the lowest in the nation for total taxation amount of alcoholic beverages.

It is now both a civil Liability and a class C felony to knowingly provide alcoholic beverages to unrelated minors if it results in a serious injury or fatality.

MADD Alaska Priorities for 23rd Legislative Session:

HB27 (Rep. Lynn) Enhanced penalties for drunk driving offenders with passengers who are under 9 years of age or pregnant. MADD supports penalties for the reckless endangerment of minors 18 year of age and younger.

HB65 (Rep. Lynn) Forfeiture of motor vehicles, airplanes and vessels for illegal transportation of alcohol.

HB143 (Rep. Heinz) Offender ineligible for PFD for 4 years after a DUI or for refusal to submit to BAC test.

HB175 (Rep. Rokeberg) Wellness Court clients (DUI offenders) allowed a drivers permit to and from work.

HB213 (Rep. Weyhrauch) Graduated Drivers License.

HB217 (Rep. Weyhrauch) Enhanced penalties for repeat DUI offenders.

HB234 (Rep. McGuire) Alcohol Beverage Control Board policy changes.

HB261 (Judiciary, Gov. reqst) Minor Consuming law revision: Increased community work service, license revocation period consecutive, not concurrent, with other DMV violations, probation begins on second offense, youth courts allowed as alternative courts.

HB274 (Rep. Dahlstrom) Uniform bar closure hours across the state.

HB342 (Rep. Gatto) Enhanced penalties for high-risk offenders (those with high BAC levels).

SB53 (Sen. Ogan) partner bill to Rep. Dahlstrom's HB274.

SB58/59 (Sen. Cowdery) DUI offender ineligible for PFD for one year for first offense, 5 years for repeat offenders. Enhanced penalties for of lack of motor vehicle insurance.

SB249 (Sen. Wilken) partner bill to Rep. Weyhrauch's HB213 GDL bill.

Keg Registration.

Mandatory alcohol/other drug education in schools.

Sober servers in drinking establishments.

*Bills in bold were requested by MADD

Mother's roadside memorial destroyed

Letter to the editor

Monday, January 12, 2004

On Dec. 8, 2002, I lost my son, Gary Smith, when a drunk driver struck and killed him. Gary was walking along a Hoonah roadside when the tragedy occurred and ever since my life has not been the same. I have "moved on" as best I can, but there are times when the loss of my son makes me feel so sad. This past holiday marked the first anniversary of Gary's death. It was a difficult time for me, Gary's aunts, uncles, daughter, grandchildren, many relatives and friends who knew Gary.

While I was in Hoonah last month I had a cross made with MADD red ribbons had it placed in the spot I thought Gary was struck and killed. The cross lasted seven days, as someone not only took the memorial sign, they broke it into pieces and threw it in the ditch.

It really broke my heart all over again over this violent act. It is hard for me to have to deal with the unnecessary cruelness. Building and placing the cross on that site made me hopeful others might see it and remember not to drink and drive. It was also an act of love from a mother to her son.

I would ask the person who destroyed the cross: why? I would ask the people who know of this act of destruction: I would ask those who knew and cared for my son to prevent this from happening again this by speaking in support of sober driving and against acts of violence. If not for Gary, then for yourselves and loved ones.

Diane Carrier
Juneau

HB

7

Alaska State Legislature

House of Representatives

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Representative Harry Crawford
District 21

Memorandum

JAN 2 2 2002

TO: Representative Peggy Wilson
Chair House Health, Education and Social Services Committee

FROM: Representative Harry T. Crawford

DATE: January, 22nd 2003

RE: House Bill 7

I respectfully request that House Bill 7 be scheduled for hearing in the House Judiciary Committee at your earliest possible convenience.

E-mail: Representative_Harry_Crawford@legis.state.ak.us

Alaska State Legislature

House of Representatives

JAN 22 2003

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Representative Harry Crawford
District 21

SPONSOR STATEMENT: HOUSE BILL 7

HB 7 allows for an employer and her/his employee to agree to an hourly wage up to $2.00 less than the minimum wage if she/he uses that amount of money to provide for "adequate health care, as defined by the commissioner." Many part-time and minimum-wage workers in Alaska are working without benefits. This bill provides an incentive for employers to provide Alaskans with health care.

E-mail: Representative_Harry_Crawford@legis.state.ak.us

Comparing benefit costs for full- and part-time workers

Health insurance appears to be the only benefit representing a true "quasi-fixed cost" to employers, meaning that the cost per hour worked is greater for part-time employees than it is for full-time employees

Michael K. Lettau and Thomas C. Buchmueller

Employers' costs for total benefits grew roughly 50 percent faster than employee wages over the 1980–96 period, according to the Bureau of Labor Statistics Employment Cost Index (ECI). By March 1996, nonwage compensation represented 28 percent of total compensation for U.S. private workers. Given these figures, it is not surprising that there is great interest among economists and other analysts in the role that benefits play in labor markets.

Simple labor market theory suggests that employers mainly are concerned about the level of *total* worker compensation (wages, salaries, and benefits), and that, apart from tax considerations, they consider the division between cash wages and other compensation of little economic consequence. However, this simple approach ignores potentially important differences between wages and benefits. It is commonly asserted that benefits represent quasi-fixed costs, meaning that they vary with the number of workers rather than with the number of hours worked.[1] To the extent that this is true, the structure of employee compensation packages may influence employers' demand for full- and part-time workers, as well as their decisions on the use of overtime.

The assumption that benefits represent quasi-fixed costs is common in studies of the effect of benefits on decisions of employers and employees.[2] The basis for this assumption, however, is somewhat tenuous. For many benefits—such as defined contribution pension plans and certain types of paid leave—costs are a direct function of cash earnings and thus are proportional to the number of hours worked. And while this generally is not the case for benefits such as health insurance, employers can at least use employee contributions to vary the costs of such benefits by employee hours.

By comparing the costs to employers of providing various benefits to full- and part-time workers, this article directly tests the hypothesis that benefits represent quasi-fixed costs. It also examines the extent to which these costs vary across different types of benefits. The results suggest that, because it is the only benefit for which the average per-hour cost is greater for part-time workers than for full-time workers, health insurance is the only benefit representing a true quasi-fixed cost to employers.

The data

This article analyzes data from two establishment surveys conducted by the Bureau of Labor Statistics—the Employee Benefits Survey (EBS) and the Employment Cost Index (ECI) survey. These data provide rich detail on the costs and provisions of various benefit plans offered by employers. Also, the data usually are collected for mul-

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tiple jobs from each establishment surveyed. Thus, although benefit plans in part-time jobs are relatively rare, where they do exist, they nearly always can be compared with a benefit plan offered to full-time workers from the same establishment.

The ECI survey, conducted quarterly by BLS, collects data on total compensation per hour for a sample of jobs. The microdata from the ECI report the average cost per hour among workers who hold the sampled job. The EBS, on the other hand, is an annual study of the incidence and detailed characteristics of employer-provided benefit plans; the EBS also provides information on employee participation in such plans. The EBS covers medium- and large-size establishments in odd-numbered years, and small establishments in even-numbered years.[3]

The ECI data used here are from March 1994. For the EBS, data from the 1993 and 1994 surveys were combined in order to obtain a representative sample of small-, medium-, and large-size establishments. Both the ECI and EBS samples are restricted to private establishments. Also, for both surveys, the data usually are collected for four, six, or eight jobs for each establishment in the sample.

Following the practice of the ECI and EBS, jobs are defined in this study as full or part time based on how the establishment classifies the job. The ECI also provides information on each job's scheduled annual hours. In general, the establishments' designation of full time and part time coincides with a definition based on scheduled hours. For example, the median scheduled annual hours among jobs designated as full time is 2,080, while the comparable median for part-time jobs is 1,040. Moreover, 90 percent of the jobs designated as full time report scheduled annual hours of at least 1,820 (35 hours per week times 52 weeks per year), while 95 percent of those designated as part time have scheduled annual hours of not more than 1,820. Among part-time jobs, those with benefit plans tend to have a longer work schedule. For example, among part-time jobs with a health insurance plan, the median for scheduled annual hours is 1,342.

Comparing benefit costs

Based on microdata from the ECI, table 1 presents summary statistics on benefit plan coverage and costs for full- and part-time jobs. The top portion of the table shows the proportion of jobs that have a positive cost for the benefit. For all benefits except those that are legally required, full-time jobs are substantially more likely to be covered by benefit plans than are part-time jobs. In addition, the difference in coverage rates between full- and part-time jobs varies considerably, ranging from about 19 percentage points for savings plans to 63 percentage points for health insurance benefits.

The lower portion of the table shows statistics for the cost of benefit plans among jobs that offer such plans, excluding jobs for which the costs of benefits are imputed. A comparison of average costs for full- and part-time jobs provides information on the degree to which the different benefits are effectively prorated by employee hours. For benefits that represent quasi-fixed costs, the hourly cost will be higher for part-time jobs. Costs are "purely quasi-fixed" when the annual cost is the same for both full- and part-time jobs. Prorating benefits by the number of hours worked will lower the relative cost of providing benefits to part-time employees. If benefits are "perfectly prorated" by hours—meaning that the benefit accrues at the same rate per hour worked for full- and part-time workers—the cost per hour will be the same for both groups of workers.

The figures in table 1 provide little evidence to suggest that benefits represent quasi-fixed costs. Indeed, all benefits appear to be more than perfectly prorated, in the sense that their costs accrue more slowly with hours worked for part-timers than for full-timers among covered workers. One po-

Table 1. Benefit provision and costs for full- and part-time workers, March 1994

Characteristic	Vacation	Holiday	Sick leave	Health insurance	Pension	Savings	Legally required
Percent of jobs covered							
Part time	44.9	43.3	25.7	23.5	26.0	16.3	100.0
Full time	89.1	89.3	63.0	86.4	52.4	34.9	100.0
Average cost per hour							
Part time	$0.26	$0.24	$0.18	$1.56	$0.47	$0.11	$1.02
Full time	.73	.51	.29	1.61	1.09	.44	1.77
Average annual cost							
Part time	$300	$261	$215	$1,844	$547	$139	$1,016
Full time	1,377	968	522	3,078	2,079	821	3,404
Number of covered jobs							
Part time	937	939	457	469	560	251	1,792
Full time	11,908	13,024	7,609	11,619	6,915	4,819	12,252

Source: Microdata from the March 1994 Employment Cost Index.

tential difficulty with interpreting these statistics is that they may result from differences between full- and part-time jobs and the firms that employ them that are unrelated to the issue of prorating. For example, the mean comparisons do not control for wages, which is important because the cost of some benefits are defined as a technical function of cash earnings, and it is well established that part-time jobs tend to have lower cash wages than do full-time jobs.[4]

In addition, the mean comparisons may be confounded by differences in the types of establishments that employ full- and part-time workers. To mitigate these problems, the difference in annual costs and cost per hour worked between full- and part-time jobs is estimated in a regression framework.[5] The regressions include as controls the natural logarithm of the job's wage rate and zero-one indicator variables for whether the job is unionized, the occupation of the job, and an indicator variable for each job's establishment.[6]

With the exception of health care benefits and legally required benefits, the regression analysis yeilds qualitatively similar results to the mean tabulations shown in table 1—they suggest that most benefits are more than perfectly prorated by employee hours and hence are not quasi-fixed costs. For health insurance, the regression estimates suggest that the cost per hour worked is 18 percent higher for part-time jobs than for full-time jobs, while the annual cost is 31 percent *lower* for part-time jobs. These results suggest that health insurance costs are only partially prorated. For legally required benefits, the cost per hour worked is slightly higher for part-time jobs, at about 2 percent.

Prorating health insurance costs

The extent to which employers prorate health insurance costs by employee hours and the means by which prorating is achieved are explored next. The focus is on health insurance for three reasons. First, health insurance is arguably the most important benefit, as indicated by its share of total compensation and the importance of employer-provided health insurance in the U.S. health care system. Second, both prior expectations and the results above suggest that health insurance is unique among employee benefits in terms of the relationship between employer costs and employee hours. Third, this relationship has potentially important policy implications. In recent years, for example, numerous legislative and other policy proposals would have mandated that employers provide health insurance to certain employees. The cost and impact of such mandates will depend on the extent to which they allow for prorating, as well as the ability of employers to achieve prorating.

To investigate how employers prorate the cost of health insurance benefits, a sample of 253 establishments in which there is at least one part-time job and one full-time job—both with health insurance—was examined. Such firms contribute 424 part-time and 787 full-time jobs to the ECI sample. Table 2 presents three cost measures for which the unit of observation is the establishment: (a) the average cost of health benefits provided to part-time jobs; (b) the average cost of health benefits provided to full-time jobs; and (c) the within-establishment difference between (a) and (b). In addition to the mean of each variable, we also report the 25th, 50th, and 75th percentiles.

Table 2. Differences in annual health insurance costs between full- and part-time jobs, March 1994

Characteristic	Part time	Full time	Difference
Number of jobs	424	787	—
Number of establishments	253	253	—
Mean	$2,052	$2,715	$664
Standard deviation	1,275	1,395	1,279
25th percentile	1,115	1,834	0
Median	1,834	2,393	0
75th percentile	2,715	3,408	1,209

SOURCE: Microdata from the March 1994 Employment Cost Index. Sample restricted to establishments reporting data for both full- and part-time jobs.

The difference in the mean annual costs for health insurance plans between full- and part-time jobs is about 24 percent, which, as expected, is quite close to the differential implied by the regression results discussed earlier. The difference in median costs is of roughly the same magnitude, at 23 percent. Again, this suggests that employers who offer health insurance to part-time workers structure employee cost sharing, benefits, or other plan provisions in such a way as to partially prorate the cost by employee hours.

But a closer examination of the distribution of cost differentials within the same establishment reveals a more complex story. Both the 25th percentile and the median of intrafirm difference are zero. In contrast, the 75th percentile difference is quite large at $1,209. In other words, for a substantial proportion of the establishments, the cost of health insurance does represent a purely quasi-fixed cost. The difference in mean costs is driven by large cost differentials within a minority of establishments.

Comparing health insurance plans

In this section, several possible explanations for the differences in annual costs for providing benefits to full- and part-time workers are examined. First, they may arise indirectly from the fact that part-time employees are less likely to participate in available benefit plans—either because they are less likely to meet tenure-related eligibility requirements, or because they are more likely to decline coverage.[7] Also, prorating may result from specific employer policies—for example,

employers may require higher premium contributions from part-time employees. Finally, in the extreme, employers may offer their part-time employees different plans than those offered to their full-time employees; such plans may be less costly to employers and provide fewer overall benefits to employees.

The first explanation explored is whether the lower average cost for part-time jobs arises from lower participation rates among part-time workers. Tabulations from the full sample of combined EBS data from the 1993 and 1994 surveys reveal significant differences in health plan participation rates between full- and part-time employees among jobs in which at least one employee participates in a health plan. When only medical plans are considered, the average participation rate for part-time jobs is 76 percent, compared with 92 percent for full-time jobs. When dental and vision plans also are considered, the full- and part-time average participation rates are about 94 percent and 79 percent, respectively.[8]

Thus, the average participation rate among part-time jobs is 84 percent of the average participation rate among full-time jobs. If full- and part-time plans otherwise were the same, the average annual cost for health insurance would be 16 percent lower in part-time jobs than in full-time jobs. The results in table 1 suggest that the average annual cost for health insurance in part-time jobs is 40 percent lower than in full-time jobs. Therefore, participation rates appear to provide only a partial explanation for the lower average cost for part-time jobs.

As noted above, the difference in the average annual cost for health insurance between full- and part-time jobs is smaller when jobs from the same establishment are compared, either using the regression framework or as reported in table 2. However, when the same regression framework is used to compare participation rates among jobs from the same establishment, the resulting average participation rate in part-time jobs is about 11 percentage points lower than in full-time jobs. Thus, lower participation rates in part-time jobs again appear to provide only part of the explanation.

The EBS data do not provide information on the exact reason for this difference in participation. Figures presented below indicate that it is at least partly due to the tendency of some employers to impose longer length-of-service requirements on part-time workers. The result is that, among workers with low job tenure, part-time workers will have lower rates of benefit eligibility. Higher rates of job turnover among part-time workers will magnify the effect of differences in length-of-service requirements. In addition, even when they are eligible, part-timers may be less likely to participate in certain benefits plans, such as health insurance, often obtaining such benefits through the plans of their spouses or other family members.[9]

Next, the extent to which employers vary the terms and conditions of health insurance coverage between full- and part-time employees is explored, and whether these differences effectively prorate the cost of health insurance by employee hours. For each establishment in its sample, the EBS provides data on plan provisions and employee participation for all plans in which at least one worker participates. If any plan provisions—such as covered benefits, eligibility periods, or contribution requirements—differ across sampled jobs, workers in different jobs are considered to be in separate plans.

The EBS also provides information on the rate at which workers in each sampled job participate in each available plan. Therefore, in establishments in which health insurance represents a purely quasi-fixed cost, workers in full- and part-time jobs will be observed with similar participation rates in a common set of plans. Such establishments are defined as *integrated*. In contrast, where employers have modified plan provisions in order to reduce the hourly cost of health benefits provided to part-time workers, full-time workers participate in one set of plans, while their part-time counterparts participate in a distinctly different set of plans. These establishments are defined as *segregated*.[10] Differences in plan provisions within segregated establishments provide some insight into how employer policies affect the cost of health benefits provided to full- and part-time employees.

Table 3 shows average plan provisions by whether the establishments are classified as integrated or segregated. Plans with imputed provisions are excluded. Of the 264 establishments with at least one full-time job with a health insurance plan and one part-time job with a health insurance plan, 192 are classified as integrated and 72 are classified as segregated. Applying the EBS sample weights, the 72 segregated establishments represent more than one-fourth (28 percent) of the 264 establishments.

The estimates in table 3 suggest that there are three ways in which segregated establishments lower the cost of providing health benefits to part-time workers. The first is to require greater monthly premium contributions for part-time workers. In 73 percent of the plans offered by segregated establishments to full-time employees, the entire monthly premium for single coverage is paid by the establishment; by contrast, employers pay the entire premium in only 48 percent of the plans offered to part-time employees.

When limited to plans requiring workers to make some contribution, however, the differences between full- and part-time employees are small. For single coverage, the average contribution required of full-time employees is $40.19, compared with an average of $45.86 for part-time workers. For family coverage, the difference is even smaller and is not statistically significant.

A second way that plans offered to part-time workers differ from those offered to their full-time counterparts is that the former are more likely to have a restriction on preexisting con-

Table 3. Proportion of full- and part-time jobs covered by various medical plan provisions by type of establishment (integrated or segregated), 1993–94

(In percent, except where noted)

Characteristic	Integrated establishments		Segregated establishments	
	Part-time jobs	Full-time jobs	Part-time jobs	Full-time jobs
Fee arrangement:				
Fee-for-service	54.6	54.5	59.5	32.8
PPO	18.2	18.4	26.9	53.2
HMO	27.2	27.1	13.6	14.0
Other	0.1	0.1	0.0	0.0
Self-insured	42.9	45.4	31.0	17.2
Employee contribution for single coverage:				
None	46.1	44.5	48.1	72.8
Flat amount	31.0	26.1	44.7	16.6
Average monthly contribution (in dollars)	$48.33	$48.58	$45.86	$40.19
Other	22.8	29.3	7.2	10.6
No information	0.1	0.1	0.0	0.0
Employee contribution for family coverage:				
None	8.9	8.9	41.5	44.6
Flat amount	31.4	30.9	28.2	25.0
Average monthly contribution (in dollars)	$156.00	$148.99	$185.96	$186.59
Other	59.2	59.8	30.3	30.4
No information	0.4	0.4	0.0	0.0
Preexisting restriction	63.9	64.5	68.0	43.7
Eligibility requirement:				
Yes	18.3	19.7	29.6	60.1
Number of months:				
1	19.4	19.3	36.7	25.3
2	4.1	4.1	2.5	16.4
3	50.1	51.6	16.3	55.9
4	4.5	4.6	0.0	1.9
5	0.4	5.3	0.0	0.0
6	14.2	9.5	41.2	0.6
7	0.0	0.0	0.0	0.0
8	0.0	0.0	0.0	0.0
12	1.0	1.0	3.3	0.0
14	0.0	0.0	0.0	0.0
36	6.3	4.6	0.0	0.0
No	40.4	39.5	2.5	3.7
No information	41.2	40.8	67.9	36.2
Number of plans	480	1,007	226	429
Number of establishments	192	192	72	72

NOTE: Sample restricted to establishments reporting data for both full- and part-time jobs

SOURCE: Microdata from 1993 and 1994 Employee Benefits Survey.

ditions. The explanation for this difference probably has more to do with insurer concerns about adverse selection—the situation in which individuals take insurance coverage because they anticipate large medical expenses—than the desire of employers to prorate costs. Nonetheless, the differential treatment of preexisting conditions may partially explain why the cost of health benefits is lower for part-time employees in some establishments.[11]

The third important way that the plans available to part-time employees differ from those offered to full-timers is the length-of-service eligibility requirement. Among part-time plans that have such a probationary period, 45 percent have periods of 6 months or longer. In contrast, in 98 percent of the plans in which full-time employees are required to complete a probationary period, that period is 3 months or less. An important caveat concerning these figures is that, for a large fraction of plans—particularly those offered to part-time employees—no information is available on the existence or length of a probationary period.

Nonetheless, when this information is available, the data suggest that the difference in probationary periods may partly explain the differences in plan participation. Moreover, participation rates in segregated versus integrated establishments provide supportive evidence. As noted above, the within-establishment regressions suggest that the average participation rate is about 11 percentage points lower in part-time jobs than in full-time jobs. When similar regressions are estimated separately for integrated and segregated establishments, the average rate is lower by about 19 percentage points for segregated establishments, compared with about 10 percentage points for integrated establishments.

THIS ARTICLE PRESENTS EVIDENCE on the cost to employers of providing benefits to full- and part-time workers. The evidence corroborates the well-documented difference in benefit coverage between these two groups of workers. Additionally, however, this analysis finds significant differences in the *value* of benefits received by full- and part-time workers.

Previous studies have suggested that the low rate of benefit coverage among part-time workers may be explained by the fact that nonwage compensation is a quasi-fixed cost, making it more costly, on a per-hour basis, to provide benefits to part-time workers. However, the results presented in this article challenge that argument, showing that most voluntary benefits—such as pensions and paid leave—are not quasi-fixed costs. The cost of employer-provided health insurance, on the other hand, does have an important quasi-fixed component.

Mean regressions suggest that health benefit costs often are partially prorated, although a closer examination reveals that in a substantial number of establishments in which part-time workers are eligible for health insurance, the costs associated with these benefits are not prorated by hours at all. The mean results appear to be driven by a minority of establishments in which there are large differences between the cost of health benefits provided to full- and part-time employees.

The data show that, when it does occur, prorating is accomplished by several means. Part of the cost differential arises from lower plan participation rates for part-time employees. This difference probably is due in part to employers setting different eligibility requirements for full- and part-time workers. Also, part-time workers are somewhat more likely to decline certain benefits (particularly health insurance), often obtaining them through their spouses or other family members. Finally, a relatively small proportion of employers require that part-time workers make greater premium contributions to their plans, some offer less generous coverage to part-time workers, and some employ both of these methods.

Footnotes

[1] See, for example, Ronald G. Ehrenberg and Robert S. Smith, *Modern Labor Economics* (New York, HarperCollins, 1994), pp. 132–136.

[2] Selected examples include Ronald G. Ehrenberg, *Fringe Benefits and Overtime Behavior* (Lexington, MA, Lexington Books, 1971); Mark Montgomery and James Cosgrove, "The Effect of Employee Benefits on the Demand for Part-Time Workers," *Industrial and Labor Relations Review*, October 1993, pp. 87–98; and David M. Cutler and Brigitte C. Madrian, "Labor Market Responses to Rising Health Insurance Costs: Evidence on Hours Worked," *RAND Journal of Economics* [illegible]umn 1998, pp. 509–30.

[3] For more information on the ECI, EBS, and other BLS compensation measures, see *BLS Handbook of Methods*, Bulletin 2490 (Bureau of Labor Statistics, April 1997), pp. 57–66.

[4] See, for example, Michael K. Lettau, "Compensation in Part-Time Jobs versus Full-Time Jobs: What if the Job is the Same?" *Economics Letters*, September 1997, pp. 101–06.

[5] The actual regression estimates may be obtained from the authors upon request. E-mail: Lettau_M@BLS.GOV

[6] The regression equations are of the form

$$(1) \quad \ln B_{ji} = a^{A}_{j} PT_i + b^{A}_{j} \ln W_i + g^{A}_{j} \phi X_i + u_{ji}$$

$$(2) \quad \ln b_{ji} = a^{H}_{j} PT_i + b^{H}_{j} \ln W_i + g^{H}_{j} \phi X_i + v_{ji},$$

where B_{ji} (b_{ji}) represents the annual (hourly) cost of providing benefit j to job i. The independent variable of primary interest is PT, an indicator variable that equals one for part-time jobs and zero for full-time jobs.

[7] The average cost among workers in the job for the ECI includes both nonparticipants and participants in the benefit plan.

[8] The sample generating these figures includes some observations for which plan participation is imputed. Regardless of how imputations are treated, however, the average participation rate for full-time workers is roughly 15 percentage points higher than that for part-time workers. Also note that the median participation rate equals one for both full- and part-time jobs. The lower average rate for part-time jobs is due entirely to a lower rates in the bottom third of the distribution.

[9] Data from the Current Population Survey suggest that part-time and low-wage workers are less likely than their full-time or high-wage counterparts to participate in health insurance plans offered by their employers. See Stephen H. Long and M. Susan Marquis, "Gaps in Employment-Based Health Insurance: Lack of Supply Or Lack of Demand?" *Health Benefits and The Workforce* (U.S. Department of Labor, 1992), pp. 37–42; and Henry S. Farber and Helen Levy, "Recent Trends in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?" NBER Working Paper No. 6709, 1998.

[10] The classification of integrated versus segregated establishments is based on a segregation summary statistic calculated by comparing participation rates among full- and part-time jobs for each health plan in the establishment. The segregation statistic ranges from zero to one. At the extremes, it equals one if full- and part-time workers never participate in the same plan, and it equals zero if full- and part-time workers participate in the same plans at the same rates. An arbitrary threshold of 0.5 is used to designate whether the establishment is integrated or segregated. Only participants in health plans are considered, so nonparticipants do not affect the classification.

[11] The Health Insurance Portability and Accountability Act of 1996 limits the use of preexisting conditions exclusions. Under the new law, coverage for preexisting conditions can be denied for no more than 12 months. New employees who were insured prior to joining a group plan can apply the period of their prior coverage to the exclusionary period.

HB

32

ALASKA STATE HOUSE OF REPRESENTATIVES

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Room 204

REPRESENTATIVE JOHN COGHILL

Memorandum

Date: Thursday, May 08, 2003

To: Representative Peggy Wilson, Chair
House Health, Education and Social Services

From: Representative John Coghill JBC

Re: Hearing Request for HB 32

Please Schedule HB 32, "An Act relating to use of a uniform prescription drug information card and forms, standards, and procedures in processing health insurance claims; and providing for an effective date." for a committee hearing at your earliest convenience. I have attached the committee packet.

Thank you for your consideration.

Representative_John_Coghill@LEGIS.state.ak.us

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REPRESENTATIVE JOHN COGHILL
MAJORITY LEADER

Sponsor Statement
HB 32 – Uniform Prescription Information Card

The intent of HB32 is to have a uniform prescription card implemented to expedite the amount of time a pharmacy technician spends gathering necessary information from the insurance company in order to process the insurance claim. Pharmacists are spending a disproportionate amount of time trying to address reimbursement issues rather than serving the health care needs of their customers. HB 32 would allow for more face-to-face care between pharmacists and patients. It would also minimize confusion, eliminate unnecessary paperwork, decrease administrative burdens, and streamline the dispension of prescription products paid for by third party payors.

Representative_John_Coghill@LEGIS.state.ak.us

LETTER OF INTENT

OFFERED IN THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES
BY REP. COGHILL

TO: CS for HB 32

It is the intent of the Alaska State Legislature that any entity that provides coverage for prescription drugs and issues an insurance card shall provide on the insurance card uniform information necessary for claims submission and adjudication.

The uniform prescription card should consist of items that are required for the adjudication of claims. The card may include but is not limited to: the health care insurer's name, address, business identification number, the covered individual's identification number, telephone number of the pharmacy benefit manager (if different from the health care insurer), processor control number, group number, person code. If an insurance company issues medical cards that have the necessary pharmacy information on them, there will be no need to reissue new, separate pharmacy cards.

It is also the Alaska State Legislature's intent that the Division of Insurance confer with covered individuals, pharmacies or their representatives, and insurance companies or their representatives in developing regulations to implement the act.

23-LS0203\D
Ford
3/5/03

CS FOR HOUSE BILL NO. 32( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Gruenberg, Whitaker

A BILL

FOR AN ACT ENTITLED

"An Act relating to use of a uniform prescription drug information card and forms, standards, and procedures in processing health insurance claims; and providing for an effective date."

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

* **Section 1.** AS 21.06.085(a) is amended to read:

Sec. 21.06.085. Uniform data and procedures for health claims. (a) The director shall adopt by regulation uniform claims forms, **uniform prescription drug information cards,** uniform standards, and uniform procedures for the processing of data relating to billing for and payment of health care services provided to state residents. A health care insurer shall use the uniform claims forms and comply with the uniform standards and procedures established under this section.

* **Sec. 2.** AS 21.06.085(b)(2) is amended to read:

(2) "health care services" has the meaning given in AS 21.86.900 **and includes prescription drugs**.

* Sec. 3. This Act takes effect immediately under AS 01.10.070(c).

NACDS
NATIONAL ASSOCIATION OF
CHAIN DRUG STORES

May 8, 2003

The Honorable John Coghill
Alaska State House of Representatives
State Capitol, Room 204
Juneau, AK 99801-1182

Dear Representative Coghill,

Thank you so much for your testimony yesterday afternoon before the House Labor and Commerce Committee. On behalf of the Alaska members of the National Association of Chain Drug Stores, I want to thank you for presenting this important issue to your colleagues in such a clear and succinct manner.

After listening to the hearing, I felt remiss in perhaps not having provided you with important information you needed in responding to some of the questions from your colleagues.

I am proud to announce that 26 states have passed legislation adopting uniform prescription drug cards ... both Washington and Oregon are among those states.

To clarify for Representative Gatto, it is not the intent, nor desire of the pharmacy community to require insurers to issue yet another card, but to put the necessary information on the cards that are currently issued.

In some states we've made arrangements for stickers with the information to be placed on the cards until new cards are normally issued if it would be a time/money saver in the short-term.

Unfortunately as Ms. Campbell stated there is little we can do to combine all the cards into one. That would have to be something worked out among and between the insurance companies.

I am attaching for your information the rules that were adopted by the Washington State Office of the Insurance Commissioner to implement the uniform drug card statute that was passed here in 2001.

Like Alaska, we have a number of insurance companies in Washington, both large and small. In dealing with this issue in Alaska, the two companies most involved in the discussions have been Aetna and Blue Cross. Both companies operate in Washington State and beginning July 1, 2003 will have to comply with the rules as adopted here.

Once they have made the formatting changes for Washington, adopting similar requirements in Alaska would eliminate any additional charges.

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