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ALASKA HEALTH CARE COMMISSION
WEDNESDAY, OCTOBER 1, 2014
1960'S BREAKOUT SESSION
7:40 A.M.
DENA'INA CIVIC & CONVENTION CENTER
600 WEST SEVENTH AVENUE
ANCHORAGE, ALASKA
VOLUME 1 OF 1
PAGES 1 THROUGH 126

1 prepared script. Deb, as those of you that know Deb, always
2 makes you prepared for what you're supposed to do and she has
3 Commissioner Streur welcome, three to five minutes in red,
4 highlighted.

5 MS. ERICKSON: Time's up.

6 COMMISSIONER STREUR: And so I'm going to try to stick to
7 three to five minutes, but you know, these days, we don't take
8 enough time to reflect on our history. So much of what we do
9 today is based on that, and sometimes it's good to go back and
10 take a look. How can we do things better? How did we do
11 things in the past? Where were our successes? Where were our
12 non-successes, and what can we do?

13 Looking back can generate new ideas. It can offer
14 perspective. Well, Bert and I, we've had several
15 conversations, lots of conversations about ways to do things
16 better. He's now with the Pioneer Home. He's knee-deep in it
17 and has been one of my trusted advisors as to how do we bring
18 the Pioneer Homes forward. We're an aging generation. Look
19 around the room, and you know, a lot of us are going to, you
20 know, be looking at, you know, our future forever homes, and
21 so let's dig in. Let's get at it.

22 I appreciate so much the leadership on the '60's, '70's,
23 and '80's. I've worked with so many of you. I look at the
24 young'ns here, and you know, so hopeful of the future that's
25 coming, but you've accomplished a lot and it's been selfless.

1 These are hard jobs that we do, particularly when we're
2 dealing with the healthcare needs of the past and the present.

3 We're privileged and honored to have you here today with
4 us and hope that we capture some great ideas. We'll be
5 capturing your conversations throughout the day. I work very
6 closely with our photographer here and Scott and I have, I
7 think, captured some great stories over the years, but I know
8 some of you very well.

9 So I'm going to encourage you, as you recall the past,
10 not to spin it too much. You know, I don't care if it's not
11 exactly accurate. Yeah (affirmative), Lincoln, I'm looking at
12 you and Ward.

13 All seriousness, from the bottom of my heart, I'm
14 grateful for your experience and I'm grateful for what you
15 bring to the room and have brought to the citizens of Alaska.
16 We're a better place because of what you've done. So we look
17 forward -- I'm sorry I can't be here for the day. I've got a
18 9:00 presentation with the Governor's Council. I'm going to
19 try to get back as the day progresses because this is where I
20 want to be.

21 I learn every day and the wisdom that's in this room
22 probably can't be captured anywhere else. So with that, I
23 think my five minutes are up. Deb's starting to look at me
24 with a frown on her face. So I'm going to turn it over to
25 Deb.

1 MS. ERICKSON: To Craig.

2 COMMISSIONER STREUR: To Craig Holt, my good buddy.

3 MR. HOLT: Good morning, everyone. If any of you have
4 been watching me, I haven't been able to take this smile off
5 of my face and it's not because I'm a little stupid, though, I
6 am. I've been 30 years kind of in the game, very junior to
7 most of you people here.

8 I actually was -- started in state government down in
9 Oregon and was there for 13 years and I've been doing now
10 consulting for about 20 years. That was when I told my bride
11 we're going to maybe try this thing 20 years ago and now here
12 we are doing this, but these kinds of opportunities, to be
13 with folks like you that actually -- I know you've heard this
14 term, but history is an account by someone's recollection
15 that's written down.

16 What we're trying to capture today is the stories and the
17 accounts that actually enabled that record. That's what we're
18 trying to gather from you folks today. I appreciate what the
19 Commissioner shared. This is your perspective, as vivid and
20 lucent as it may be, going back to that time, and you'll
21 notice, we have different decades here represented.

22 So we would expect maybe a finer point on those in the
23 '80's than we might in the '60's, as we go through this, but
24 not necessarily. So we're looking for -- say, this might be -
25 - and maybe most of you have probably been in public meetings

1 throughout your careers, because all of you have been in the
2 spotlight, I don't know if you've ever had a camera following
3 you around like this young gentleman is here.

4 Please, hopefully, you won't be intimidated by that. Also,
5 you'll see, we will actually have a recorder at your table,
6 and again, please don't be intimidated by that, and we have
7 public -- the public sitting and watching you, as well.
8 Please don't be intimidated by that.

9 Obviously, you're not intimidated by much or you wouldn't
10 be here, frankly, because of just your history and have been
11 brought together.

12 So what we'd like to do, just to get started, we're going
13 to start actually here with the '80's, and we're going to end
14 with the marvelous '60's, and we're going to start here with
15 this -- with Sally here, this wonderful young lady that --
16 those of you may or may not -- I just got to know a little
17 about her. We're privileged and honored for her and the
18 sacrifice she's made and the effort that she's taken to be
19 here.

20 So we're actually going to start with Sally, and I'm --
21 so I'm going to say what the assignment and then I'm going to
22 spin for a little bit so that she has a moment to gather her
23 thoughts, and then we're just going to go around the room. We
24 want you just to introduce yourself. You all probably know
25 one another, but just for the record, so we can have that, and

1 the one thing, by the way, this doesn't count for your
2 assignment, so this is a freebie.

3 The one thing maybe you're most proud of that you've been
4 a part of in your career up in Alaska, okay. So it -- by the
5 way, this -- there's no vote for who does the best one and all
6 that kind of stuff, right. This is just so -- I'm -- I'm now
7 spinning for you to gather your thoughts, just kind of the one
8 thing that maybe you're the most proud of that you've been a
9 part of and then we'll actually go into the exercise of doing
10 this assignment.

11 So have I given enough time, and then what we'll do is
12 we'll just go clockwise and then we'll just move around here,
13 and we only have about an hour-and-a-half to do this exercise.

14 No, I'm kidding. This is very quickly, just so everyone
15 -- to kind of get comfortable with one another. So Ms. Smith,
16 if you would, please?

17 MS. SMITH: Thank you. I'm Sally Smith. I reside in
18 Dillingham. I haven't slept in my own bed in 15 months, but
19 that's okay. I am very happy to be here. You cannot
20 understand how excited I am to be here. This is only about my
21 eighth week back out in public. I have been a little sick and
22 the -- when I was a little girl, the reason I'm sitting here
23 is because an airplane landed in the pond outside our bar
24 house and a door opened and there was this woman.

25 She turned out to be the nurse, handed my little sister

1 to my mother and dad and said, "We brought your daughter home
2 so she could die here at home," and mom and dad were crying
3 and I said, "Who are these people that could make my mom and
4 dad cry like this?" I'm most proud of the fact that I'm now
5 here in memory of my little sister, all these years, all these
6 years, to be able to make life change, not only for my mom and
7 dad, to make them happier, but in doing so, I truly believe
8 that I've made change for the better for many other, not only
9 Alaska Natives, but doggone, it's okay if you're non-Native.
10 I think we drug you along to make certain that healthcare,
11 there is no line, Native healthcare, healthcare, when we
12 become sick, we're sick.

13 All we want, and we don't care if it's a red door or a
14 green door, we just want someone to reach out and say, "I can
15 help you and let's journey forward and we'll make you well."
16 Being sick has been the best thing that has ever happened to
17 me. For 42 years, I ran. I served on, you name it, whether
18 it was local, state or national or international speaking, but
19 when I became sick, now I know in the next 20 years I'm going
20 to live or longer, I know what I'm going to do, and I've done
21 well in the past. So that's why I'm here and that's what I'm
22 going to do.

23 MR. HOLT: You can't beat that.

24 MR. SHERRY: Yeah (affirmative), yeah (affirmative), I'm
25 Paul Sherry. I'm glad to see all you guys. I -- my work is

1 basically split into two pieces. I -- this is my 40th year
2 working in health in Alaska and I worked for 20 years for
3 Tanana Chiefs and I worked for 20 years on the statewide basis
4 for the Native Health Board, and then for ANTHC, and I'm still
5 working and enjoying it.

6 I guess I can feel like I'm a junior elder and trying to
7 slide in slow, but I'm most proud of helping the transition
8 for the Native Healthcare System from federal ownership to
9 Native ownership. That's what it's been all about for me.
10 Thank you.

11 MR. HOLT: And if we can just for this (indiscernible -
12 too far from microphone) let's just skip the members right now
13 of the Commission and get the elders real quick, and we'll
14 come back and get them, so.....

15 DR. URATA: My name is Bob Urata. I think I'm most proud
16 of being born in Wrangell, Alaska, and I now practice family
17 medicine in Juneau, Alaska, been there since 1984, and I'm
18 proud to be here to participate and have come back to Alaska.

19 I guess my most proudest moment is being a third -- being
20 a member of the third WAMI class that was held up in Fairbanks
21 and subsequently have come home. My goal was to go back to
22 Wrangell, of course, but I married a Seattle girl and we only
23 got as far as Juneau, so.....

24 MR. BEAN: Good morning, my name is Lincoln Bean. I'm
25 from Kake. I represent the Organized Village of Kake and

1 serve on the SEARHC Board of Directors, as well as ANHB as
2 Chairman, and Sally and I both serve on the ANTHC Board.

3 As I reflect on -- back when I first started, I was a
4 fireman, volunteer fireman, and Nancy, next to me, knew my
5 mother very well, as a health aide, as well as Lotty (sp)
6 Nanuk (sp), in our small community. As a volunteer fireman, I
7 knew, because of my mother being a health aide and living in a
8 small community, that there was a lot of lack of training in
9 the smaller villages.

10 So a bunch of us got together and we went to an EMT class
11 and we became Level One's. With that, we went back to my
12 small community and we reorganized the Health Council and
13 proudly became one of the strongest Health Councils in the
14 state of Alaska, because we're all EMT's, and your mother's a
15 health aide, and Lotty's a health aide.

16 Nancy was there, and we found the biggest and meanest
17 woman and made her President and she sat there and pointed to
18 each one of us, "Lincoln, Danny, EMS. Lincoln, SEARHC." She
19 just pointed at all of us and that's how it -- that's what we
20 did. She had the biggest heart of gold, and the proudest
21 moment I had in getting involved with healthcare was my first
22 meeting to SEARHC, I asked -- I didn't know anyone, just like
23 sitting here, I looked around and I was all knew to the
24 system.

25 I said, "Why don't we take over our own healthcare?"

1 Ethyl Lund, President, Niles Cesar, CEO, said, "What did you
2 say?" I said, "Why don't we take over our own healthcare?" I
3 don't know how much time we have, whether we're just get to
4 cover the one?

5 MR. HOLT: Just the one right now, so.....

6 MR. BEAN: Just the one and why -- why -- okay.

7 MR. HOLT: Yeah (affirmative), you have plenty more
8 later.

9 MR. BEAN: All right, then that's where -- that was the
10 proudest time in my -- without realizing how it would end up
11 and bringing that comment down. Thank you.

12 MS. DAVIS: Good morning, I'm Nancy Davis. I came to
13 Alaska in April. Well, I started as an itinerant public
14 health nurse in April of 1980, and I was the nurse for Kake
15 and Angoon, Pelican, Port Alexander, and four logging camps,
16 and I hesitate to say that I'm proudest, but I'm certainly
17 most grateful for the lessons I learned as a visitor in Kake
18 and Angoon from the most amazing village health aides, they
19 were called then, Lotty and Tilly taught me how to be a good
20 itinerant public health nurse, and so the love and respect I
21 think I learned from them for caring for people that you care
22 about in your own community is priceless.

23 So I took that through the rest of my 25, 26 years as --
24 in public health nursing, all the way to when I became the
25 Chief of Public Health Nursing, because the most important

1 thing was instilling that willingness to open yourself and
2 learn and respect the folks that you're actually there to
3 serve, and so I hope that -- I hope that lesson stayed.

4 I learned that lesson through public health nursing. I
5 hope that lesson stayed in public health nursing, but I feel
6 most grateful for having been taught, so.....

7 DR. MANDSAGER: I'm Dick Mandsager, and it's a hard
8 question to answer. I suspect most people would think that I
9 might answer what am I most proudest, I guess, if you want to
10 describe that would be being a part of the team that got ANMC
11 rebuilt, but I think the thing that will be the most memorable
12 to me at the end of my time on this land, on this earth, will
13 be getting to shepherd the public health law right through the
14 Legislature, all that I learned, getting to talk to people of
15 all political types and libertarians and public health folks
16 and find language that could work for everybody.

17 There were a lot of naysayers who thought it couldn't be
18 done, but it hadn't been done since the territorial days, and
19 I think that's what I'm most proud of.

20 DR. DANN: Good morning, my name's Carl Hild. I was just
21 thinking and reflecting on some of these comments that have
22 been made. I first -- well, actually, not first, but in 1971,
23 I was able to go to the Naval Arctic Research Lab in Barrow,
24 Alaska to study frostbite and hypothermia, and we were
25 studying it because we thought we might have a war with the

1 Soviet Union and we'd fight in the Arctic, and so the idea
2 was, how do we condition our troops to be able to fight a
3 winter war after Korea, and one of the things I learned was
4 that we were studying the wrong area.

5 We were looking at wolves and polar bears, and I said,
6 "Why aren't we looking to the people who live here," and so I
7 shifted gears and started looking at how do people survive
8 well in the Arctic and what are the issues with them?

9 A few years later, I was involved, and this was one of my
10 proudest moments. I had been an EMT, a firefighter with the
11 Barrow Volunteer Fire Department, and young man slipped in the
12 ice and went under the ice. He was underwater for quite some
13 time, about 45 minutes, and I had been studying this. I was
14 aware that he was okay still because the water was so
15 incredibly cold.

16 So I jumped in without any protective gear and pulled him
17 out. We started doing CPR and about an hour-and-a-half later,
18 he was recovered in the hospital, no brain damage as a
19 teenager, which was just rather remarkable.

20 From that, I was invited by Dr. Bill Mills to participate
21 in a meeting to talk about the state needs some protocols near
22 drowning and frostbite and hypothermia, and so those protocols
23 developed out of that process and this discussion that there
24 was new technology and that there were ways that we could
25 improve things, but when I think about my proudest moment, I

1 mean, saving this young man's life was -- is right there, I
2 can't deny that, but the people in Barrow were very concerned
3 about their food and it has made me very happy to see recently
4 in a newspaper, all the articles about the quality of
5 subsistence foods and how important this is against fighting
6 obesity and diabetes.

7 Through a lot of work on contaminants and looking at
8 subsistence foods, I was able to participate in a number of
9 different meetings that ranged everything from local community
10 councils, working with marine mammal hunters, working with the
11 DEC, working with the Governor's Office, working actually with
12 the federal government, and being appointed to be a
13 representative for the Arctic Council, the U.S. delegation,
14 that as Dick just said, shepherding ideas through that
15 ultimately ended up being the Stockholm Convention to
16 eliminate the 12 most egregious, persistent organic pollutants
17 in the world. Thank you.

18 DR. SCHRAER: My name is Cindy Schraer and I started out
19 in Alaska as a medical student going to several villages where
20 pacemaker patients lived and trying to develop a system to
21 check the batteries in their pacemakers by transmitting
22 electrocardiographs over the satellite system and eventually,
23 I left. I eventually returned to Barrow as a general
24 physician for a few years, but I think the -- I guess maybe
25 the highlight and the situation I was most grateful for was to

1 be in the right place and time to recognize that diabetes was
2 an emerging problem among Native people and prior to the mid-
3 1980's, it had been fairly rare, and there was a belief in the
4 medical community that being a northern indigenous person made
5 people somehow immune to diabetes, and this didn't really
6 appear to be true, and so I'm just really grateful that a lot
7 of people were willing to work on the problem, first of all,
8 figuring out that, in fact, this wasn't true.

9 When we went to really find out who all had diabetes,
10 there were over 600 Native people living in Alaska, which was
11 a surprise to the medical community, and we went on from there
12 with numerous tribal partners, IHS, other people to develop a
13 program to try to best address the needs of all of these
14 people.

15 DR. SAYLOR: My name is Brian Saylor. There is -- there
16 is a very important thing and there's the proudest moment and
17 they're different. The important thing, for me, was in 1976,
18 working with the 9th Legislature to put together the --
19 Alaska's response to the then National Health Planning and
20 Resource Development Act, which many of us have been involved
21 in, set up a strong planning apparatus, their certificate of
22 need, and was unfortunately dismantled in the early '80's, but
23 the proudest moment was, I think, a difficult assignment as
24 the Director of API, the Alaska Psychiatric Institute, and
25 watching the psychiatric nurse aides, the PNA's, collapse on a

1 patient who is decompensating.

2 A patient can act out and has lost control of some of
3 their reasoning powers and self-control, and watching these
4 PNAs smother a person, and it was the most touching, loving
5 kind of restraint until the person just sort of ran out of gas
6 and they were able to get the person back to their room and
7 their place, but it was just, to me, being the director of an
8 organization that had that kind of empathy for people with
9 severe persistent mental disorders was just astonishing.

10 MR. DANN: Good morning, my name is Bill Dann, and first
11 of all, thank you for the opportunity. I came to Alaska in
12 '68 to fulfill my military commitment. I was one of the early
13 cohorts of hospital administrators that were recruited by the
14 Indian Health Service.

15 So I was a year in Anchorage, a year in Dillingham, and
16 then I got asked to go to Nome and start the Norton Sound
17 Health Corporation, which I agreed to do for three months and
18 stayed 11 years, and what I'm proudest of is the contribution
19 Norton Sound made to Indian self-determination, and it was
20 because Nome was kind of a historical accident.

21 It was the only part of the state that did not have an
22 Indian Health Service hospital, that had a community hospital
23 that was financially troubled, and the Native population there
24 was underserved. So to some extent, because of that
25 historical accident, we were able to do some firsts.

1 We were the first to ever have a tribal group, to ever
2 have an Indian self-determination act contract. We were the
3 first to hire our own physicians. We were the first, and to
4 my knowledge, the only group that has built its own hospital,
5 meaning we designed it and managed the construction process,
6 and you really know you're old when the building you built has
7 been replaced. It kind of brings that reality into focus.

8 The other thing about that period was we had a physician
9 there who was a very enlightened guy, very difficult to
10 manage, but very bright and very passionate, and he and his
11 team developed the yellow health aide manual that became the
12 statewide manual. So we're very proud of that, and those are
13 the things that I will treasure. Thanks.

14 MR. CLARK: Good morning, my name is Robert Clark. I
15 started way back in '73, just getting out of college. It's a
16 time when many of the minority groups throughout the country
17 were feeling that we needed to do something. OEO was starting
18 and all kinds of things like that when I was in college or --
19 a lot of Indian groups, the American Indian movement and stuff
20 like that, doing a lot of civil disobedience and just trying
21 to do what you wanted to do to have more say, self-
22 determination is I guess what we call it today, but back then,
23 you had to do a lot of crazy things that today, I don't think
24 you quite have to do. Sometimes you might have to, but it was
25 a time of change, so I guess I was in the right place at the

1 right time.

2 ANCSA happened. They needed a Native person that had a
3 degree. I didn't know what I was doing, but I grew up on the
4 job and had a lot of help from many of you in here, stumbled
5 along the way, but I'm the longest health director of any of
6 the groups, since '76. I helped start the corporation in '73
7 on the heels of YK and Norton Sound. The old money got spread
8 out eventually to all of us. I think SEARHC might have been
9 the last one there to try to figure out who would host the
10 money and become the health corporation.

11 It seems over the time, that you know, we owe a lot to, I
12 guess, all of our predecessors beyond the '60's, because
13 that's when I was mainly in school, the last part of the '40's
14 child and working in the same hospital I was born in, some 40-
15 something years later, but you know, the state had its part,
16 IHS, BIA, Department of Interior, the Public Health Service
17 Act in '54, lots of different changes, Bill Ward, several
18 people were down in Kanakanak and Bristol Bay that paved the
19 way for us, but we went from advisory to policy, just kind of
20 chasing grants, to now having business plans, strategic plans
21 and kind of picking it on your own terms, except for a little
22 fumble with the state and Xerox, we've been doing pretty well,
23 but we've got a good Commissioner. I really appreciate him
24 and I think we'll weather that storm.

25 I'm real proud about the contributions we've made. I'm

1 happy that the Board thought I could do the job. I've been
2 trying my best to help. My father was one of the health aides
3 and the interpreter and involved with -- I was just one of 11
4 kids, so back then, you had to be pretty self-reliant and make
5 do with what you had.

6 We've seen the days when non-Natives were not very
7 welcome with the public health service facilities. Today, the
8 only thing that's different is the money. Everybody's got
9 green money and everybody has needs and we want to take care
10 of them all and we do. We want to share our wealth. That's
11 one thing we learned as part of our Native custom is share
12 what you have and work with all the groups and we continue
13 that today.

14 So I'm just proud of the system and the state has done
15 quite well. I'm a little disappointed, maybe, in the
16 Affordable Care Act and some of what might happen there, even
17 though there's a number of problems, but I still think maybe
18 we ought to give a go at it.

19 MR. HOLT: Good, thank you.

20 MR. CLARK: That's my little piece for now.

21 MR. HOLT: Thank you, and as we transition to the '60's,
22 just reminding everyone of our -- you can see we're having no
23 problems sharing with our groups, and actually, the assignment
24 was followed pretty well, until we started hitting the '70's,
25 and then it started evolving a bit, and so as we move to the

1 '60's, because it is the '60's, just a reminder of what we're
2 really asking for, which is just kind of introduce yourself
3 and what you're most proud of.

4 This is going to be a fun day. I can tell and it's one
5 of -- isn't it wonderful just to be able to hear and reflect
6 even on just the introduction and wait until we actually get
7 to the meat of it. So let's start with George, but we're
8 going to let you bat clean-up and then we'll go around and
9 make sure we hear from everybody else, please.

10 DR. RHYNEER: My name is George Rhyneer. I came to
11 Alaska in 1967, having spent the previous years as -- learning
12 how to be a cardiologist, which is what I came up here
13 eventually to do, but in 1967, I was actually employed by CDC
14 and assigned to the state Health Department for tuberculosis
15 control and at that time, there were really two prongs of
16 attack to tuberculosis. One was from the side of the state
17 and the public health nurses, that we've heard from already,
18 were a major portion of that and the center of the effort was
19 here in Anchorage at the old McKay building and we had the
20 entire floor, employed a couple of radiology technicians, and
21 I and the technicians and the nurses spent two years traveling
22 throughout the state checking for tuberculosis outbreaks,
23 making sure that people who had tuberculosis were taking their
24 medicines properly, and during that time, I got to be the
25 first physician that many of the villages we visited had seen

1 for a year or two.

2 So before I left, I went to the Alaska Native Medical
3 Center and one of the dentists there compressed four years of
4 dental school into one morning. He gave me forceps, told me
5 how to anaesthetize the jaw and I and my bag of numerous
6 medicines and treatments went out to the bush and took care of
7 tuberculosis, but also was the general physician and held a
8 clinic in most of these places, maybe the first clinic that
9 had been there for months or years.

10 So it was a very interesting time. I find that it was
11 especially interesting, inasmuch as it was before Native land
12 claims. It was before the oil was discovered, and it was a
13 time when there was an amazingly cohesive social order at each
14 one of the villages, which has not seemed to have survived
15 very well, and I'm proud, actually, and grateful to have had
16 the experience in seeing that kind of life and community in
17 the villages I tended.

18 Following that stint though, I became a cardiologist,
19 returned in 1971, and my biggest effort has been to develop
20 most of the cardiovascular services that you see in Alaska
21 today. Thanks.

22 DR. LANIER: I'm Anne Lanier and I came here as a public
23 health -- in Public Health Commission Corps in 1967, and was
24 assigned as a general medical officer at the old Alaska Native
25 Medical Center, and had one year of rotating internship when I

1 took that on and served for two years as the General Medical
2 Officer, including being, I remember OD, which is a different
3 term than now, which is Officer of the Day, in which you
4 literally cover the entire hospital from emergency room to
5 delivering babies to seeing outpatients, just running around
6 like crazy trying to cover all the bases with some very
7 wonderful, valuable specialists who were on-call and would at
8 least talk to you by phone. They usually just said, "Well,
9 you know, you're well-trained, just figure it out, do it
10 yourself," which was not so great when I had to -- thought I
11 had a person with -- a child with an appendicitis way out on
12 the chain. I hardly knew the geography yet and was sure they
13 needed to come in for surgery and I was okay with making that
14 decision. So then I realized I had to actually call the
15 military and get involved with making the decision to, you
16 know, fly somebody all the way in, in this humongous airplane,
17 and so I called ever-famous Dr. Joe Wilson to ask his advice.

18 I was pretty heavy-duty for about the first week on the
19 job to start telling the military what to do, and again, good
20 old Dr. Joe said, "Well, you know, you're the doc. You make
21 the call, go for it." So from there on, it was a little less
22 complicated.

23 What I'm most, probably kind of known for, which isn't
24 the greatest thing in the world, but it is probably some work
25 in cancer and we did get a cancer -- like Cindy Schraer, there

1 was a lot of myth, mythology about what was going on with
2 cancer, particularly in the Alaska Native population, and
3 decided maybe it was time to get some real data and figure out
4 what was going on, and with the help of a person who is very,
5 very famous in the cancer arena, Dr. Joe Fraumeni at NCI,
6 encouraged me to begin to look at the epidemiology of the
7 disease, and with that, we founded an Alaska Native tumor
8 registry in the mid '70's, and have been incorporated into the
9 national system of what they call the SEER Program,
10 Surveillance, Epidemiology, and End Results, which is a
11 nationwide system to capture data on cancer patients.

12 We're the only tribal entity in the, officially in the
13 SEER Program and anyway, we established what was going on in
14 cancer. It was -- they were not immune to cancers like many
15 people have thought. It was a very emerging disease and the
16 registry continues to this day and we now have over 40 years
17 of data, and from that, I hope that there have been many
18 programs and education prevention.

19 I've been less involved in the treatment side of it, but
20 that, too, has grown and that sadly enough, there is an
21 epidemic of cancer among the Native population and hopefully,
22 lots of work is spinning off, having a few facts to work with,
23 and Dr. Ward Hurlburt was very instrumental in that, as well,
24 early on, and I'm most proud of being able to have worked with
25 the tribes and the tribal groups and it's been a privilege and

1 an honor, especially with one lady over there at the first
2 table, Sally Smith.

3 DR. HURLBURT: My name's Ward Hurlburt. My wife, who was
4 about five-and-a-half months pregnant and our one-year-old son
5 and I came up here in 1961, went to Kanakanak. It was the
6 days of the draft and -- and went there. I don't know that I
7 can say that I'm proud, as much as grateful, but to have been
8 associated with so many changes, particularly among the Alaska
9 Native people here.

10 To give one illustration, I was in Koliganek there as a
11 young general medical officer, had a general practice
12 residency, and taking a prenatal history on a woman who was
13 pregnant, asked her when her last menstrual period was and the
14 response was, "When the geese flew," and then I asked her,
15 "How many babies do you have?" We get the gravida and the
16 para, taking this history and her response was, "18, 10 in the
17 ground and eight here." Grand multiparity was so common then.

18 Infant mortality rates were just sky high still in those
19 days, and then as others have said, still lots of opportunity
20 for improvement, but the changes have been remarkable, and to
21 be able to be associated with that and a part of that, almost
22 everybody in this room, I've been a colleague with over the
23 years.

24 We hear so many physicians say, "I wouldn't be a doc
25 again. I wouldn't have my kids become a physician." I

1 absolutely would and I would do the same kinds of things that
2 I've done, because it's been such a privilege, and then just
3 one final thing, starting out there in Dillingham was a pretty
4 good place to start, when you think about it.

5 There are folks, George Wagnon, started out there and
6 spent a career in Southeast Alaska. Ken Fleishman was my
7 predecessor and spent most of his professional career as a
8 pediatrician here. Robert Fortune followed me and was here,
9 and you know, if he were still alive, would be the expert in
10 the room on the history of medicine in Alaska. Mike Howley
11 (sp) followed Robert. Folks who went out there and had a good
12 experience, and I know it won't embarrass Robert, but I've got
13 to say part of it, his dad was a health aide over at Nushagak
14 and was a real leader in the Native community, but if I had to
15 pick say three people who were heroes in my life, one of them
16 would be Robert's dad, Joe.

17 He absolutely wrote the book on what it is to be a
18 servant leader and he had such an impression on me, just
19 helping me as this young kid physician, just out of training,
20 being there, but with his graciousness, his humility, true
21 humility in what he did and compassion, and it's been an honor
22 and a privilege to have been associated with that and to know
23 folks like Bert.

24 MR. HALL: And vice versa. What are the instructions
25 again, sir? Never mind.

1 UNIDENTIFIED SPEAKER: Pretty much whatever you want to
2 do right now.

3 MR. HALL: I came to Alaska in 1956 in the Army. I was a
4 medic, a low-ranking medic, and one of my first experiences
5 relating to public health, there were two while I was there,
6 one was, there was a guy named Commander Holms, who was
7 involved with developing venerable diseases, not developing,
8 but following up on venerable diseases, developing programs
9 and so on.

10 We found out that the GIs on the base wouldn't talk to
11 their supervisors and I was assigned to interview all of the
12 guys on -- to find out how, when, where -- and man, I learned
13 a lot about Anchorage in a very short time, and I learned a
14 lot about people in that process.

15 The other assignment was, a doctor and I from Fort Rich,
16 we were assigned to go to Camp Dexter (sp) in that summer of
17 '56 to support -- the medical support for what the called the
18 Eskimo National Guard, at the time, and that was the eye-
19 opener in my life for what rural Alaska was and could be.

20 Among the things that -- we went out and we -- I had to
21 take a portable X-ray machine from Fort Rich and we flew it in
22 and put it up in the field and X-rayed everybody in the area
23 and then go down to the Maynard MacDougall Hospital and put
24 them -- and develop them and so on.

25 I don't have any idea what it was, but later on, it turns

1 out to be part of the history of public health, and I
2 mentioned to somebody earlier, the ancient history of public
3 health was referred to by a speaker from the east in Alaska,
4 talking about that. It turns out, he was really talking about
5 real (indiscernible - room noise) years earlier, but he
6 described what we were doing out there, but that changed the
7 whole sense of what I was doing.

8 I had a degree in synthetic textiles, you know, which
9 wasn't a real biggie up here in Alaska, but our denomination
10 church-wise was doing -- very active and a long history of
11 churches, homes, children homes, hospitals and so on, and so
12 we ended coming and spending five years doing that, and then
13 got involved in the United Way here in Anchorage and ended up
14 in Juneau at a very young age, at that time, the youngest
15 commissioner that we had in there, and it was an unusual time
16 and it would have been my peak time, if for not some other
17 things.

18 That was the time when we were Health and Welfare, it was
19 called. Everything that's now in environmental conservation,
20 corrections, and everything with health was all in that one
21 department, but it was that time at the very end of the '60's
22 and the early part of the '70's when we had the oil sales, the
23 huge increase, a 43% increase in state support of health and
24 social services. You don't get that much anymore --
25 opportunities to do a lot of organization, a lot of policy

1 kinds of review, reidentification of establishing some bases
2 of things and subsequent to that, I ended up a couple of times
3 as Health Director for Anchorage and Health Director for the
4 North Slope Borough, and through all of those times, a long
5 involvement with the coordinating groups, like the Alaska
6 Public Health Association, and APHA for 16 years, I guess, and
7 when I get back to trying to find out what would be the one
8 thing, if it was only one, I might say it was helping get
9 Brian Saylor to get a Ph.D. so he could come back and do all
10 the wonderful things that he did, but I think the big thing,
11 and it's been touched on a little bit is the 2C study.

12 Who knows what the 2C study is besides Robert? Anybody?
13 Two-C is part of the Land Claim Settlement. It says the
14 Secretary of the Interior, together with the federal agencies
15 shall conduct a study of all federal programs, primarily
16 benefitting Alaska agencies and Natives, and report back to
17 the congress within two years with his recommendations for
18 future management and operation of those programs.

19 That, if you go back and look at that historically, was a
20 major, major thing in beginning to understand the relationship
21 of all of the services for which the state had some
22 responsibility, Indian Health Service, and all the rest, and I
23 think that was a great opening and I was assigned -- I was
24 working for the secretary of HEW at the time for Alaska and
25 assigned to that project and I think that was one of the most

1 important things that we had, as far as opening the eyes of
2 the cross-section of Alaska to the future. Thank you.

3 MR. HOLT: Awesome. Thank you, Bert. Okay, we're going
4 to redeem the time a bit and that means we're going to kind of
5 go pretty quickly through this next piece. We'd like to have
6 three members of the Commission here and then also members of
7 the advisory, an advisory committee, so what we'd like to do -
8 - here's how you can tell the players by the programs here.

9 The green cards, if you're wondering about the names,
10 those are the invited elders to speak. Those that are with
11 the blue cards with an insignia are members of the Commission.
12 You notice there, Ward is like the graduate student that had
13 multiple things on his tassels, as he also is a member of the
14 -- as well as this, and then we also have Jay here, as an
15 advisory committee. So if we could have.....

16 DR. BUTLER: I'll be a member of the 1990's table.

17 MR. HOLT: Okay, yeah (affirmative), that's right, which
18 we'll talk about in another 30 years, by the way. So if we
19 can, though, let's just quickly hear from the, emphasize
20 quickly, from the Commission members, again, who you are and
21 then just one expectation of what you're looking for from the
22 day. So let's start, if we can, with Emily.

23 MS. ENNIS: Thank you. I'm Emily Ennis. I'm on the
24 Commission. I represent the Alaska Mental Health Trust. I'm
25 Executive Director of Fairbanks Resource Agency in Fairbanks,

1 serving over 700 individuals with intellectual and
2 developmental disabilities, as well as seniors with disabling
3 conditions, and certainly, I'm here to hear the history.

4 You know, in the field of development disabilities until
5 the 1960's, the only form of support or therapy or help for a
6 family of a child with a developmental disability came in the
7 form of an airplane ticket and our Alaskans were sent outside
8 to Morningside, to Browns School in Texas, where many of them
9 spent their entire lives.

10 I came into the field in the early '70's when we were
11 seeing the return of those Alaskans and it certainly has been
12 a privilege to be part of helping them have full productive
13 lives in our communities. So I'm here today to hear a little
14 more about the medical care in the '60's, as well as the '70's
15 and '80's, and really appreciate this opportunity. Thank you.

16 MR. HOLT: Thank you.

17 SENATOR COGHILL: I'm Senator Coghill. I represent a
18 portion of the Fairbanks area. I'm one of 20 Senators. So I
19 always tell people, "We are 20. We're all individuals, but we
20 are 20, and we serve one state," so I was born here Alaska.
21 So I've been a consumer of healthcare, sometimes on purpose
22 and sometimes not, you know.

23 We've had some risky behavior down through the years, and
24 you know, we didn't have EMS, for example, in Nenana until, I
25 guess it's '67, when I left home, so probably my goal today is

1 to listen. I'm -- at this point, I'm a policy-maker. So I'll
2 be, obviously, listening for anything I can get solutions --
3 but to you, who have played such an important role, you have
4 my deepest gratitude and the way I'll show my gratitude is
5 I'll be listening, because to me, sometimes when we are doing
6 policy, you have to have the historical context in order to
7 move forward. So I'm going to be listening and hopefully, a
8 little wisdom will drop in somewhere.

9 MR. HOLT: Yeah (affirmative), a lot of wisdom,
10 hopefully. Speaking of wisdom, David Morgan, could you.....

11 MR. MORGAN: I haven't heard that combination of words in
12 my entire life. I'm Dave Morgan. I actually came to Alaska
13 in 1982, but I came a different route than most of the people
14 in the room.

15 I was with the Sisters of Providence and joined and
16 started out as a middle manager in finance at Providence
17 Hospital when -- and then watched it grow over the seven or
18 eight years, and then went into tribal health, working for
19 Eastern Aleutian Tribes in Sand Point and then a long stint
20 with Southcentral and currently, all roads lead to Dillingham,
21 I guess, but I've primarily been in public policy working on
22 the Municipal Health Care Commission and with the state Health
23 Care Commission.

24 I'm the lone, one guy that always says, "Well, how much
25 did it cost?" You know, it gets lonely being the guy in green

1 who says, "How much did it cost?"

2 So I came today, more than anything else, just to hang
3 out with Deb and Ward and possibly listen and enjoy -- I've
4 met or been involved in one way or another with virtually
5 everybody at most of these tables and just being around them
6 is nice and I -- and for once, I'm not on the hook for
7 anything.

8 In fact, I was told I wasn't even supposed to speak,
9 which I was going to really enjoy, so -- because they can't
10 come back, you know, you said 15 years ago, they always come
11 up with all the stuff you were wrong on.

12 That's what I like. So I plan to enjoy and drink some
13 coffee. I've got a couple of diet Cokes, as usual, and I'm
14 just going to enjoy the day and hang out.

15 MR. HOLT: That's awesome. Jay Butler, give me the last
16 word.

17 DR. BUTLER: The 1990's table, I missed my opportunity to
18 come to Alaska in the '80's. I had actually an opportunity to
19 come to Glennallen to the little, what's now the Crossroads
20 Medical Clinic, but actually took a different opportunity and
21 went to Kenya with a mission board that was based there.

22 I kind of didn't think about Alaska again for a long
23 time, completed a residency at Vanderbilt and some other
24 clinical training, was settled into kind of a dream job in
25 Atlanta being on faculty at Emory and working at the CDC, and

1 then one day, the Director of the Center for Infectious
2 Diseases called me up and said, "Would you be interested in
3 doing one to two years in Alaska," and I knew that when he
4 called and asked you a question like that, the answer was
5 always yes, and I guess I'll conclude that by saying it's -- I
6 continue to enjoy the best one to two years of my life,
7 so.....

8 MR. HOLT: Wonderful, thank you. Okay, so I'm going to
9 turn it over to Deb here momentarily. The -- again, the
10 intent of that was just kind of to begin the conversation. It
11 was interesting to watch the heads nod of the shared history
12 that's here in the room.

13 So just very quickly about the process that we're going
14 to be using. You're going to be working in your specific
15 decades, but we're also going to be sharing. So they'll be
16 that opportunity as we go forward. So it's obvious none of
17 you are shy, when it comes to either a camera or someone
18 recording your thoughts. So we'll introduce that into the
19 process as we go, but Deb has a few instructions for us, as we
20 get started here.

21 MS. ERICKSON: Well, I mostly just wanted to give you a
22 little bit more background on why we came together today,
23 because some of you, I've had a chance to tell this story to,
24 and others, I haven't, but I was actually sitting with Ward in
25 his office sometime this past spring and briefing somebody on

1 just some real basics about how healthcare delivery works in
2 Alaska and how it's financed, and had brought out the 1984
3 State Health Plan for Alaska, which is the last actual
4 document that's called the State Health Plan, of which I am
5 aware.

6 Paul was one of the leaders of that effort and I think,
7 Brian, you referred to the old Health Systems Agencies, the
8 planning councils that we had at the time were working on
9 developing health plans for the state, and I pulled that
10 document out because I still go back to that periodically to
11 reference how we, at that point, were organizing communities
12 and created the five levels of community, and this was a young
13 person who was trying to -- was struggling with how to
14 categorize how healthcare services are delivered and how to
15 group the communities, and I was just looking at this document
16 published in 1984.

17 I turned to Ward, who knows everything and remembers
18 everything, and said, "Ward, when was the Parran Report
19 published," and he said, "I think it was 1954," and it struck
20 me, what a coincidence it was that it has been exactly 60
21 years this year since the Parran Report was published in 1954,
22 and exactly 30 years, and those are the only two documents,
23 you all will -- you guys are the ones who are going to know.
24 I've been telling people this and nobody has corrected me yet,
25 the only two documents that I'm aware of that produced all in

1 one place, in one document, at a given point in time, kind of
2 an overview, a picture of health status of all Alaskans, of
3 the population, and also a picture of our healthcare delivery
4 system at the time, all in one place.

5 So I thought that is too great of an opportunity to pass
6 up, that it's been exactly 30 years since. We need to pull
7 some sort of initiative together to try to document where
8 we're at today, even though it will be a point in time, and
9 we're kind of moving away from that, and I want to acknowledge
10 one of our members in the audience, Lisa Aquino, is the head
11 of -- on the state side, the Healthy Alaskans 2020 initiative,
12 because the other happy coincidence was recognizing, since
13 this could be potentially a huge initiative and we didn't have
14 the time and didn't plan, or the resources to do it, but the
15 state is in a partnership with the Alaska Native Tribal Health
16 Consortium for the first time ever, the two entities
17 partnering to develop a statewide Healthy Alaskans 2020
18 initiative and the work that they've been doing over the past
19 year-and-a-half or so, they're producing this year a whole
20 series of reports.

21 They just are releasing today the community capacity
22 review, assessing the condition of our state public health
23 system and over the past year, produced reports on the
24 population health status in the state, and the Division of
25 Public Health just sent me last night, the draft report that

1 they've been preparing for us on the healthcare delivery
2 system in the state today, what it looks like today and how
3 it's financed today.

4 The Department of Labor is working on pulling together
5 some current demographic information for us to pull in. So
6 we're going to have a whole bunch of reports and the ones that
7 are available now are already posted on the website and I'd
8 asked Dr. Butler, this is the advisory team that Craig just
9 referred to, Dr. Mandsager and Dr. Hurlburt to serve as kind
10 of a special advisory group to be a very, very small team,
11 because they're the only three people still working, actively
12 engaged in the healthcare system in the state in some form,
13 but who have served at some point or are currently the state
14 health official and responsible for the health of the whole
15 population of the state, and so they're the advisory team
16 keeping me honest, and I'm going to be writing a summary over
17 the next couple of months and we'll circulate it to all of you
18 and for your feedback and just make it available to the
19 general public to offer feedback before we finalize it.

20 So we're pulling all of this information together under
21 this umbrella with just a summary report and some commentary
22 on kind of the historical context and acknowledging some of
23 the successes and also some of the challenges we face right
24 now, and I wanted to just mention, too, I was talking with one
25 of you last night who said, "What are we going to be doing

1 tomorrow? We're not going to be solving any problems," and I
2 had told Craig when we first started working on this, "We're
3 going to have a room full of leaders in here who are going to
4 want to solve problems. They're not going to want to just sit
5 around and tell stories," but stories are so important and
6 it's so -- what we want to hear this morning is what you were
7 doing back when you were working on these things that you were
8 most proud of and we want to understand what you were doing to
9 get at solutions back then.

10 It's so important when you're working through some sort
11 of planning or critical thinking process to step back
12 periodically and reflect on how things have gone, and we're
13 reflecting back over quite an amount of time, but we're
14 working on some pretty huge, daunting and challenging systems
15 issues right now with the Health Care Commission and the state
16 department and in partnership with the Tribal Health System
17 and so taking some time to listen to your stories about what
18 worked well and what didn't, and it's going to be really
19 helpful to us moving forward. So I appreciate so much your
20 time and your wisdom and your knowledge that you'll bring
21 forward today.

22 MR. HOLT: Great, so this is where it gets fun, because
23 I'm going to ask the recorder folks to, if they could, go to
24 their assigned tables as we get ready to get started. I want
25 to reemphasize -- restate something that I said, which is,

1 part of what we're trying to do is we're trying to capture the
2 stories that enabled the history and we're capturing this
3 because there has been a few nights sleep since some of you
4 provided significant changes and some people are now coming
5 behind you and looking maybe to solve critical problems that
6 the benefit of this kind of conversation might just click
7 something for them.

8 So again, if you're wondering why are we doing this,
9 there's a tremendous amount, I mean, I won't say, because I'll
10 respect everyone, but probably many hundreds of years of
11 experience in this room in this state. So with that, let's go
12 ahead and get started. Does everyone have this packet? If
13 you could get this, please, and if you could turn to the
14 second page, and it says, "Preparation," and if you go to the
15 third bullet, it says, "Identify two or three answers to these
16 questions, if you could circle that, please, just circle that.

17 It says, "From your perspective, what were the
18 significant health or healthcare delivery issues of the day,"
19 and then, "What was informing that solution?" We witnessed
20 everyone freelancing a bit with the assignment when we got
21 started initially, and so if you could, that's really what
22 we're going to have you folks do during this next section --
23 session of discussion, is we want you to take turns around
24 your table and we would like you to answer those two
25 questions, and so the way we'd like to do this is quickly, if

1 you'll -- I'm going to give you 30 seconds to do this exercise
2 right now, which is at your table, assign someone to be kind
3 of the leader of your group, so 30 seconds, quickly assign,
4 because I need to say something specific to that person,
5 quickly assign, assign.

6 Twenty seconds, 10 seconds, okay, who are -- let's go
7 ahead, let's just see if the '60's even had a chance to get
8 started on this. The -- who do we have from this table that's
9 the leader?

10 UNIDENTIFIED SPEAKER: Bert's the leader.

11 MR. HOLT: Bert, okay, and who's from this -- leader?
12 Carl, and who's the leader here?

13 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
14 microphone).

15 MR. HOLT: Okay, Nancy. You three -- we'd like
16 everybody, everyone at the table to pay attention to the
17 instructions, but most importantly, you three, because you're
18 going to have to keep everybody kind of following the process,
19 all right?

20 So the three of you, all we'd like to do on this next
21 process is make sure that you give everyone the opportunity to
22 speak. So we'd like them each to just take, on those
23 questions, just share one thing, then go to the next person,
24 and then we'll just -- and then you can keep moving around,
25 okay.

1 You can just keep moving around, but make sure we hear
2 from everyone only one thing, and this is not a comma and an
3 add and a four-paragraph, this is like one thing, and then
4 what informed that decision, then move to the next person, and
5 again, we have people recording, so you don't have to worry
6 about that.

7 The other thing we're going to do, you leaders, is we'll
8 monitor this time, but then we're going to actually have a
9 report out from your group. So you might just be thinking in
10 terms of maybe a couple of the significant highlights from
11 your group, because that's also one of the reasons why we
12 wanted to have these decades here was to be able to also share
13 that experience.

14 Now here's a couple of the rules, and it's just whether
15 you choose to follow them or not. No actually, we would like
16 you -- we would like you, actually, to pay attention to these
17 rules; no arguing. You can seek to understand, but no
18 arguing. This is your perception, all right? So we're not --
19 you're not arguing whether it was correct or not, all right,
20 unless someone really freelances so far off that you need to
21 bring them back, but please, you know, no arguing.

22 Secondly, we will not be voting which one was the best,
23 all right. So you don't have to one-up what the next person
24 said, okay. This is not what was -- we're just trying to
25 capture what was really there, what as -- you're here because

1 of your unique life experience. That unique life experience,
2 we understand will color and shade your perspective. That's
3 okay. What we're trying to do is capture that history, the
4 stories that is informing the history.

5 So with that, are there any questions? No. Good, so
6 let's go ahead. There was, sorry, yeah (affirmative), Nancy,
7 please.

8 MS. DAVIS: In your wording, the second part, you say,
9 "What were the health issues and the delivery issues?"

10 MR. HOLT: Yes.

11 MS. DAVIS: And then the second part is, "What informed
12 the solution," the solution to the health issue or why did I -
13 - why did I pick that?

14 MR. HOLT: The solution to that health issue, and what
15 we're trying to -- thank you, by the way. What we're trying
16 to get at with the second one is what was at your disposal,
17 sometimes a four-hour -- a four-year dental program compressed
18 into one, and then how you used what was available to you to
19 solve that problem.

20 UNIDENTIFIED SPEAKER: At the time?

21 MS. DAVIS: At the time.

22 MR. HOLT: Yes, at the time.

23 UNIDENTIFIED SPEAKER: Not (indiscernible - too far from
24 microphone)?

25 MR. HOLT: No, but at the time, what you were using,

1 because it's really the thinking, the process, the way that
2 you used what was available to you to solve that problem.
3 That's what we're looking for. Great question. Okay, with
4 that, let's go ahead and take out the cameras. We're going to
5 be moving around. Please don't pan for it, don't tell them to
6 go to your left side, it's better, any of that kind of stuff,
7 and I don't -- I'm not powdering my head, so nobody else gets
8 to either, as we go through this, and I'll be just circulating
9 around the tables to maybe -- if we -- if we have a
10 pontificator, to just move it along just a little bit, all
11 right.

12 Please feel free, as we go through this, as you're
13 respecting your fellow members at your table, if you -- a bio
14 break, it's kind of around the corner or some coffee or
15 something, if you want to grab that, but we'd like to just
16 keep the conversation -- and again, there might be members of
17 public moving around. We just ask folks, if you're in that
18 category, please don't interject into the conversation at this
19 juncture. It's a great opportunity for us to witness. So
20 with that, let's go.

21 **1960'S BREAKOUT SESSION**

22 MR. HALL: Let me ask the question as to the division
23 clearly between public health and health delivery, and that
24 question lends itself to two totally different areas, and I
25 wonder if we have to divide that question somehow.

1 If you go back and look at the first question, it's --
2 the way I read it, what were the healthcare delivery -- you
3 can talk about access, you talk about cost, you talk about
4 those kinds of things, but are we talking about state
5 responsibility or prevention, early intervention, those kinds
6 of things, or are we talking about health -- is -- I think
7 their interest is in health, because we're talking about
8 Medicare, Medicaid. We're talking about Obamacare.

9 We're talking -- is that what they're getting at? Is
10 there a distinction between the two from the state's point of
11 view?

12 DR. HURLBURT: I would agree. I think we're talking
13 about health.....

14 MR. HALL: The health, rather than public health.

15 DR. HURLBURT:status, public health impacts on it,
16 healthcare delivery impacts on it, a lot of impacts on it, but
17 totally unrelated to healthcare (indiscernible - room noise)
18 the effects on it. That's how I.....

19 MR. HALL: And most of our prevention programs are based
20 on data that's been collected somewhere that says, "Here's a
21 major problem," and stuff and really we can go back to TV.
22 You can go back to anything and it's a state responsibility.
23 The delivery of healthcare, where -- are we talking about
24 state responsibility for funding, availability for people who
25 do not have access to healthcare? I wonder where they're

1 going with this.

2 DR. RHYNEER: Also, there's a big difference between
3 rural and urban with this at that time. It was even larger
4 than it is now at that -- I mean, the approach and the causes
5 and the treatments, so to speak, are all -- were all so
6 different.

7 MR. HALL: Do we add the complications of the different
8 delivery systems? We have the Indian Health Service in one
9 population, primarily. We have the medical staff of the
10 military is a major component of the delivery of health to
11 people who live in Alaska. There's private enterprise and
12 then there are public functions supported with tax dollars.

13 DR. RHYNEER: And the VA.

14 MR. HALL: And the VA with the government. So that's not
15 an easy -- that opens it up to five or six different ways of
16 dealing with it. Are they looking for -- so they can decide
17 how to spend tax dollars?

18 DR. LANIER: If you're looking at us, we need to ask the
19 question.

20 DR. HURLBURT: No, I think we're.....

21 MS. ERICKSON: Just telling stories from the 1960's about
22 what the health issues are today and -- that were at the time
23 and how you were coming to solutions at the time for those
24 problems.

25 MR. HALL: That's true. That's okay. That changes it a

1 little bit. What were the limits, then, in the '60's.

2 DR. HURLBURT: Well, let me start out. I've got, you
3 know, a whole age related to epidemiology of the times.

4 MR. HOLT: Again, let's just (indiscernible - too far
5 from microphone) kind of get just like, Ward, let's do one,
6 just go right around the -- everyone gets one chance and let's
7 keep circling around to make sure we hear from everybody.

8 DR. HURLBURT: The epidemiology of the time and George
9 alluded to it, talking about TV, and Bert had been involved in
10 the mid '50's in doing that and it was in the mid '50's, the
11 greatest TV epidemic ever in the world, historically, was here
12 among Alaska Natives. Crude mortality rate for Alaska Native
13 people in Kotzebue in the mid '50's was three times -- for a
14 non-age-adjusted, three times what the total mortality is now
15 for a much older population. That was huge.

16 The average census in Kanakanak when I was there was 25,
17 about half of them young kids, bad gastroenteritis. Now they
18 run about four or so for a bigger population. Measles
19 outbreak, you'd get kids with measles pneumonia, measles
20 encephalitis, you could lose kids. Now, no measles because of
21 the (indiscernible - room noise), but a term that sounds
22 pretty socialized, in some ways now, that's used, when you
23 think about it, are social determinants of health and that's
24 why I said what I said a minute ago that a lot of the changes
25 in health status of Alaskans and specifically Alaska Native

1 people is because -- going back to the Parran Report, this
2 health status was much lower, are things that we, as
3 physicians, contributed to, but having jobs, having housing,
4 having sanitation has really contributed more and so today,
5 with the challenges that we have, yes, if we get
6 (indiscernible - room noise), for example, it's probably going
7 to bring in some more STDs. It's going to bring in some more
8 drugs, some more alcohol for a while with the money, but in
9 the long run, it provides jobs.

10 People get better housing. They can get education. They
11 can support their families, and so I think that really was the
12 story when I came back in '61, that yes, we've done a lot in
13 medicine, but we have to recognize that things that enable
14 people to have a living, have some of the good things in life
15 to feel about -- good about it, take care of their families,
16 and so on, really are critical factors, just as much as what
17 we do as docs.

18 MR. HALL: Anne.

19 DR. LANIER: Okay, I did have to step out. I'm very
20 sorry, but so issues of the day, we're talking about the
21 '60's, what were the issues then? Yeah (affirmative), well,
22 when I was the general medical officer in the hospital, most
23 of the time I wasn't thinking very globally, but TB was huge,
24 pediatrics infectious diseases were horrible. You know, the
25 things that we now have vaccines for and there was -- there's

1 always the, you know, the social behavioral components
2 (indiscernible - room noise) alcohol use, huge injury issues,
3 infant mortality, those are the things that come to my mind.

4 MR. HALL: George, can you add to those?

5 DR. RHYNEER: Yeah (affirmative), I think that, you know,
6 the question is what were the healthcare delivery issues and
7 first of all, there was very little easy communication
8 between, speaking predominantly of the rural areas, very
9 little communication ability between villages and the
10 hospitals, health aides, and the physicians. It was all by
11 radio. There were no telephones. Radio transmission was
12 something quite difficult during that time.

13 DR. HURLBURT: Single side band radio was the whole world
14 (indiscernible - speaking simultaneously).....

15 DR. RHYNEER: It was (indiscernible - speaking
16 simultaneously) yeah (affirmative), so which made it even
17 harder to use and so there was -- there was communication,
18 which made it really difficult and made it very hard for the
19 local healthcare givers and local residents in rural villages
20 to find out what the best thing to do for treatment was.

21 You start with that and then you end up with -- move onto
22 transportation was a big deal. Many of the villages at that
23 time didn't have airstrips. You had to land on a lake or the
24 river. In fact -- and then the weather was such that small
25 planes often couldn't fly, so the transportation difficulty,

1 those were huge issues, and there was a marked lack of real
2 sophisticated training the health aides at that time.

3 Health aide training really became a thing in the '80's
4 and '90's. So the health aides had a store of penicillin and
5 that was about the extent of it and the usual treatment for
6 any illness was penicillin, if you listen to the radio
7 transmissions. So the ability to magnify and use
8 telemedicine, which we use all the time now, with the
9 telephone, at least, was absent. So all that made difficult -
10 - made a difficult time of delivering any kind of reasonable
11 medicine to rural Alaska and in Anchorage, it was just a
12 smaller version of that same thing.

13 MR. HALL: How about hepatitis B?

14 DR. RHYNEER: Well, those are the problems that have
15 (indiscernible - room noise) there are many illnesses,
16 hepatitis (indiscernible - room noise) impetigo, scalps just
17 totally pussied out, kids dying of infant diarrhea, respiratory
18 illnesses, injuries, all the things that you see in an area,
19 which doesn't have very good medical care, you saw magnified
20 in villages.

21 MR. HALL: And the suicide?

22 DR. RHYNEER: Less so.

23 MR. HALL: Less so than -- impact of alcohol, you
24 mentioned. What about tobacco?

25 DR. RHYNEER: Well, there again, in the '60's, it was

1 less (indiscernible - speaking simultaneously).

2 DR. HURLBURT: When I came, a (indiscernible - room
3 noise) Native population was (indiscernible - speaking
4 simultaneously).....

5 UNIDENTIFIED SPEAKER: (Indiscernible - speaking
6 simultaneously).....

7 DR. HURLBURT:until proven otherwise, yeah
8 (affirmative), and among the Caucasian population of the
9 country, it was long since a carcinoma, until proven
10 otherwise.

11 DR. RHYNEER: Right. So the solutions were sort of self-
12 evident, that they were dependent upon technology, really, and
13 improvement in the (indiscernible - room noise) of healthcare
14 delivery and those just gradually came on. I don't think
15 there was any big watershed period of time.

16 MR. HALL: Up until statehood, virtually all hospitals
17 were, non-governmental hospitals were operated by churches
18 with mission staff. The (indiscernible - room noise) hospital
19 that we had (indiscernible - room noise) the first thing we
20 did, we raised the rates from \$35 to \$40 a day.....

21 MR. HOLT: From a process standpoint, we should have at
22 least two (indiscernible - too far from microphone) at this
23 juncture.

24 MR. HALL:back in the '60's. Is that a question?
25 Who -- where were the private hospitals? Where were the -- is

1 that a good -- whether -- we had Providence Sisters. Alaska
2 Regional had just started as a Presbyterian hospital. The
3 hospital in Palmer was a Presbyterian Pennies for Palmer.

4 SENATOR COGHILL: St. Joseph's was Catholic.

5 UNIDENTIFIED SPEAKER: Yeah (affirmative), in Fairbanks.

6 MR. HALL: Is that part of the system of hospitals
7 available in urban areas and transportation then, to access
8 institutional places of care? I'm just feeding ideas to see
9 how you're going to report this. The '60's were.....

10 DR. HURLBURT: Hospitals are so high tech now, but there
11 were, historically, a hospital and Aniak, the Yukon, Unalaska,
12 and so on, and Unalaska, until the Japanese bombed it and then
13 there was none there, but lots of places around the state had
14 hospitals, either church or government, at one point in time.

15 DR. RHYNEER: Yeah (affirmative), technology has driven
16 that out, basically, because physicians and medical trainees
17 now are trained in areas where you have a full complement of
18 technology behind them and don't really want to practice in an
19 area that doesn't have that technology. Technologies are
20 important. So it's very difficult for hospitals like Seward
21 or Valdez or Homer or South Peninsula, whatever, to have all
22 of the technology that physicians in (indiscernible - room
23 noise) and other people like to use. So it's sort of a self-
24 defeating kind of a problem. I mean, the more physicians are
25 trained, the more unlikely they are to be able to go into the

1 rural areas.

2 MR. HALL: So how do we answer the question when you have
3 to report back for us? It says, "What are the two or three?"
4 Do we have to identify the most serious or it seems to me that
5 whole list is what you need to look at. I don't know how you
6 can identify, you know, TB as one or STDs as another, only,
7 and forget the others. How do we answer these questions if we
8 have to report back? The question is confusing.

9 UNIDENTIFIED SPEAKER: Yes, it is.

10 DR. HURLBURT: Well, I, you know, I think you have to
11 look at infectious disease and obviously, you have to look at
12 TB. It was, on a global concept, it's a huge, huge problem
13 here.

14 MR. HALL: Conclusion then is the policy has got to move
15 toward public health and prevention and treatment, of course,
16 with that, with these health issues?

17 DR. HURLBURT: Well, I think you've got to -- what are
18 the health issues? It's infectious disease. TB is a big one.
19 We have an INH PAS (indiscernible - room noise) at that time
20 and then we have way better drugs. They're -- when Joe Wilson
21 came to the ANMC in 1961, there was a one-year waiting list
22 for resective pulmonary surgery for TB.

23 MR. HALL: Really?

24 DR. HURLBURT: Yeah (affirmative), and now, you don't do
25 surgery for TB. You have drugs. You don't see so much TB.

1 It was -- it was huge, and then the usual childhood diseases
2 that we used to talk about, were really big and now, we have a
3 reporter talking to Joe McGloughlin saying, "What is mumps,"
4 or we have a mom refusing a polio vaccine for her child,
5 saying, "What is polio," when in 1953, there were 93 cases of
6 polio in Ketchikan, 83 of which were (indiscernible - room
7 noise) people with iron lungs.

8 So you know, I think the infectious diseases, we've told
9 ourselves we're getting beyond the age of infectious disease,
10 UB, D68, ebola, whatever, and we're not, but some of the
11 changes have been dramatic.

12 Then the accidents and injuries, still the biggest
13 killer, unintentional injuries for age one to age 44, in this
14 state, but the rates are much, much less than they used to be
15 back then.

16 SENATOR COGHILL: (Indiscernible - room noise) to think
17 about, Ward, and then I don't want to mess with (indiscernible
18 - room noise).....

19 DR. HURLBURT: It's okay.

20 SENATOR COGHILL: The safety culture today is so
21 different than back then.

22 DR. HURLBURT: Yes.

23 SENATOR COGHILL: We had people working on steam issues.
24 We didn't have -- in Nenana, we still had mostly outhouses.
25 We worked on old trucks. People had engines fall on them and

1 crush their chest. They just had to deal with it.

2 DR. HURLBURT: Yeah (affirmative).

3 SENATOR COGHILL: The mechanics were making slings for
4 the health aide. I can remember, I got my hand caught in a
5 ring washer and I had a Native lady who just bandaged it up
6 and then every week, it would be dressed up. So it was just -
7 - the healthcare delivery was, you did what you could do
8 because quite often, resetting a bone had -- somebody had to
9 pull it while somebody wrapped it. There wasn't even a good
10 health aide there to do that. So I can remember people being
11 deformed because they just couldn't get some place to get
12 their leg set.

13 DR. HURLBURT: Yeah (affirmative), I think that's right,
14 and I would -- I was say maternal and childhood issues, the
15 third one is the infant mortality rates and even some maternal
16 mortalities and so I -- you know, I think (indiscernible -
17 room noise) we'd want to look at health issues, but the
18 epidemiology of cancer has changed so much that -- no lung
19 cancer. We thought we were basically going to do away with
20 invasive cervical cancer, but you could go to a village and
21 get out a hard wooden table and say, "Okay, every woman in the
22 village come and get your pap smear," and they did, you know.
23 Today, the things are barbaric, but we got better coverage
24 than we do today and we saw our cancers of cervical cancers
25 (indiscernible - room noise), yes, we (indiscernible - room

1 noise) esophageal cancer, for some reason, more like
2 (indiscernible - room noise) and that went down, but others
3 have (indiscernible - room noise) lung cancer.

4 MR. HALL: The '60's was also an era of mental health, as
5 one of the people spoke to earlier. Those were the days when
6 we didn't -- we'd sent people to (indiscernible - room noise)
7 down in Portland and the decision was made in 1969 and
8 implemented in '70, that we would remove all kids from there
9 and bring them back to Alaska and take them to Valdez, and I
10 remember signing the same letter to people promising that
11 their kid would be the last one removed. People did not --
12 some people did not want to ever see their kids again and I
13 actually sent that letter to three different people, because
14 they said -- I thought (indiscernible - room noise), but yours
15 will be the last to come and we did. We moved them to Valdez
16 and that was at the very end of the '60's, a major change of
17 policy of the way we used to do things when it was mental
18 health, to Morningside. We'd take people from jail, put them
19 in jail for 30 days, wait until they're out, put them on a
20 plane. That's where Jay (indiscernible - room noise) was
21 practicing psychiatry there before he came here as one of the
22 most outspoken people of the '60's (indiscernible - speaking
23 simultaneously).....

24 DR. HURLBURT: (Indiscernible - speaking simultaneously)
25 practice?

1 MR. HALL: No, I'm talking about being just the most
2 outspoken person in the state, in public health. Remember, we
3 had the big debates on the beginning of the federal
4 intervention, where Alaska and Arizona were the last two
5 states in the late '60's to be involved? In fact, they didn't
6 come in until the '70's, when they were mandated and Fred
7 McGinnis rolled over, but those were major issues at that time
8 in the '60's. Would that be an issue?

9 DR. RHYNEER: You mean with the adoption of Medicaid,
10 basically, isn't that (indiscernible - speaking
11 simultaneously).....

12 MR. HALL: A whole change in philosophy of how we were
13 going to handle.

14 DR. RYHNEER: That was, you know, about 1968 when
15 Medicaid come on the (indiscernible - speaking
16 simultaneously).....

17 MR. HALL: Well, it wasn't there when I left in '71.
18 Fred McGinnis followed me as Commissioner, and when he died a
19 little over a year ago, in his obituary, it says his -- one of
20 his various claims is successfully implementing Title 18 and
21 19 in the state. Now, I think my obituary is going to say I
22 was the last Commissioner that kept it out. The reasons then
23 were different than they are now. We had no idea it was a
24 swath of money. We'd been getting funds from the feds for
25 three things in the '60's, for aid to families with dependent

1 children, old age assistance, general relief, you know,
2 (indiscernible - room noise) and these were just general
3 funds. Those were the only federal funds that came.

4 UNIDENTIFIED SPEAKER: You got not Medicare, no Medicaid?

5 MR. HALL: No, no, until I left and Fred came, but it was
6 mandated anyway, a year or two later, so it didn't make any
7 difference, but they had a formula that said, like 31, 37, in
8 the first 37, \$75 were going, that's how you got your money,
9 and they teased you by saying, we will give you 75%, was the
10 deal, and Fred, his idea was we can get a lot more money to
11 spread and of course, it did work for a while and then
12 eventually, it changed over, but that was a major policy in
13 the '60's, and it gets into this question and a lot of policy
14 changes in the '60's with oil and new money, and the ability
15 of the state to do a lot of things that they couldn't do
16 before, especially before statehood.

17 DR. HURLBURT: So the things we're talking about,
18 largely, have dramatically improved, but then there's some
19 other things that have gotten way worse, like I never saw a
20 diabetic patient in my first two years here and it wasn't
21 here. There were seven in Kodiak among the Native people.
22 There were seven Southeast people who had longer contacts with
23 Western diets, but the Eskimo race, the state in the largely
24 Athabascan areas, there really wasn't.

25 MR. HALL: Diet.

1 DR. HURLBURT: Yeah (affirmative).

2 MR. HALL: Diet.

3 DR. HURLBURT: Yeah (affirmative), the diet has changed.
4 The level of physical activity changed. The -- I never saw a
5 patient with MI, with a heart attack in my first two years,
6 because they really didn't start -- Native people didn't start
7 smoking cigarettes until the war and if you were in the
8 service, you got free cigarettes and you brought it home and
9 the spouses smoked and they've accumulated enough pack years
10 to support people, like a cardiologist.

11 When -- have you noticed -- have you noticed in your own
12 practice, have you -- you started as a cardiologist in '67,
13 was it, George?

14 DR. RHYNEER: Seventy-one.

15 DR. HURLBURT: Seventy-one, okay, so well, among the
16 Native people that you saw, because you were the only
17 cardiologist, right?

18 DR. RHYNEER: You know, you couldn't see enough of a
19 cross-section and the sampling size wasn't large enough to
20 really draw any types of conclusions about that, but you know,
21 atherosclerosis, which is the condition of the arteries that
22 leads up to heart attacks, actually has been present even
23 prehistorically.

24 You know, there was that family that was crushed in
25 Barrow 7,000 years ago (indiscernible - room noise). The

1 woman had atherosclerosis in her coronary arteries and
2 obviously, they were -- didn't have any of the modern
3 (indiscernible - room noise) the exception to risk factors,
4 I'd say. So it's been around for a long time, but the risk
5 factors that you mentioned are very problematic and have
6 probably, although I don't know for a fact, have increased the
7 incidence of (indiscernible - room noise) disease in the
8 arteries and the legs, and the arteries in the neck, and the
9 arteries of the heart, and that's just been exposure to the
10 things that we know are harmful, unfortunately.

11 I think that your talking about infectious disease,
12 injuries, and -- and injuries are really sort of the two main
13 health issues of the '60's, you know, when you consider all
14 the different infectious diseases, tuberculosis and
15 (indiscernible - room noise) and otitis and bacterial, you
16 know, parasitic, and that, really, the solution actually was
17 developed elsewhere and that was (indiscernible - room noise)
18 tuberculosis really never got under control until the three
19 triple (indiscernible - room noise) medicines for
20 tuberculosis.

21 The same with the diarrhea diseases, IVs and antibiotics,
22 and the same thing with otitis, and you know, immunizations
23 for hepatitis and polio. The solutions were technologic and
24 then I remember (indiscernible - room noise) Johnson, if you
25 remember, he was a TB physician and head of medicine at the

1 old ANMC hospital. He always was amazed by the fact that
2 there was a remarkable decline in incidents and mortality from
3 tuberculosis after the saturation of antibiotics or anti-
4 tuberculosis drugs, which was not paralleled by an improvement
5 in housing conditions, which was thought to have been the
6 major contributing factor for the development of these
7 illnesses, because everyone lived in very small building,
8 breathed the same air day in and day out, and once one person
9 got tuberculosis, everybody got tuberculosis, and that housing
10 circumstance didn't change really substantially at all when
11 the incidences of tuberculosis was.....

12 DR. HURLBURT: Going down.

13 DR. RHYNEER: Right, yeah (affirmative), so the public
14 health outcome there was not driven by sanitation, which is
15 always important. It wasn't driven by better housing, wasn't
16 driven by -- or household income. It was just driven by the
17 fact that some guys, you know, in the eastern part of the
18 country had developed (indiscernible - room noise).....

19 DR. HURLBURT: The patient case finding and drugs.

20 DR. RHYNEER: That helped, right, yeah (affirmative). So
21 it's.....

22 DR. HURLBURT: And one of the interesting things on that,
23 that's kind of unique on a case finding was the tool that we
24 used, the tuberculosis skin test converters, because
25 worldwide, the BCG vaccine was used and that obviates a need

1 and like George (indiscernible - room noise) from John Hopkins
2 remembers -- came up here, it's been a long time, and was a
3 supporter of not using the DCG, but it was really an important
4 tool in the case finding.

5 DR. RHYNEER: Right.

6 DR. HURLBURT: And finding little kids in school and
7 figure out, well, let's grab (indiscernible - room noise)
8 sitting at home has got a cavity in their chest and coughing
9 up.

10 DR. RHYNEER: Yeah (affirmative). When I was in public
11 health service, I made a movie about that and actually, I
12 don't know if you've seen it. It's called "The Hot Spot
13 Team."

14 DR. HURLBURT: No.

15 DR. RHYNEER: Yeah (affirmative), it was shown in the
16 schools around the state for quite a while and then it sort of
17 disappeared and I thought it was lost, but my daughter found
18 it at the University of Alaska in Fairbanks, and so I have a
19 CD of it. I've been giving it to all my.....

20 MR. HALL: Did you have hair then?

21 DR. RHYNEER: What?

22 MR. HALL: Did you have hair then?

23 DR. RHYNEER: No, it's -- it's on DVD, but at any rate,
24 it was basically about use of tuberculin skin testing to find
25 out who was spreading tuberculosis and Ward mentioned BCG, and

1 for those not familiar with that, that's a type of modified
2 tuberculosis bacteria that is -- that you are infected with,
3 pretty much like the small pox vaccination, and so you get
4 infected with this tuberculosis-like organism and that, in
5 some people, makes you relatively resistant to getting the
6 standard (indiscernible - room noise) producing tuberculosis,
7 but at the same time, it also made your tuberculin skin test
8 become positive.

9 So once you've had that BCG vaccination, your tuberculin
10 skin test was always positive and even though you got live,
11 regular bad tuberculosis, you couldn't tell, because your skin
12 test was already positive and you could be infecting other
13 people and it ruined the epidemiology of the use of the skin
14 test, which was used extremely effectively up here for finding
15 active tuberculosis in patients.

16 MR. HALL: I know they told us we can't use documents and
17 so on, but I'd have a hard time getting away from data that's
18 already recorded and most of it -- this was in 1968/'69,
19 before the Anchorage Health Department (indiscernible - room
20 noise) and it goes right through (indiscernible - room noise)
21 big, huge things have developed and Helen Burn was involved in
22 all that, tuberculosis, it talks about the 5,853 TB tests that
23 you just described written in here. It gives them results of
24 all of the things and the whole -- why, you know, are we going
25 from things from memory here, but there are things we're

1 talking about that really (indiscernible - speaking
2 simultaneously).....

3 DR. HURLBURT: (Indiscernible - speaking
4 simultaneously).....

5 MR. HALL: I gave her a bunch of reports that I had that
6 -- I didn't give her this one. These are just all kinds
7 of.....

8 DR. HURLBURT: To Deb?

9 MR. HALL: Yeah (affirmative), but I gave -- these are
10 all historical documents. They go through how health
11 departments were formed and stuff. We put them all together
12 in a form and gave them out and then.....

13 DR. HURLBURT: I'm sure she would (indiscernible -
14 speaking simultaneously).....

15 MR. HALL: I've given here.....

16 DR. HURLBURT: You better copy this.

17 MR. HALL: I did. I gave her.....

18 DR. BUTLER: I think her advisory team should
19 (indiscernible - speaking simultaneously).....

20 MR. HALL: I had given -- I've given her several reports
21 of things that -- one of the most important is one that Dr.
22 Saylor worked on. This is the history of health and Ted Mala
23 was Commissioner. He put this in. The only thing he did
24 wrong in it is he put -- he put me in the back page without a
25 beard. That's the only time in my life I didn't have a beard,

1 is when I was in Juneau, but it's very accurate, with a lot of
2 the things that historically went through that period and I
3 just get worried a little bit about our contradicting, you
4 know, data that's been verified in the path with impressions.

5 I know I've made mistakes, get things wrong already and
6 things that I had thought happened 35 or 50 years ago that
7 didn't. They're not backed up in the data. I'm just
8 challenging a little bit of this process, but that's neither
9 here nor there.

10 DR. LANIER: Well, it was pointed out so many of those
11 things that were serious issues have been actually and greatly
12 improved and I think Ward explained that with (indiscernible -
13 room noise) things that wasn't meant to say that local -- it
14 was major global happenings, but that's just, you know,
15 antibiotics, telecommunication, transportation, I mean, all
16 these things that have changed and (indiscernible - room
17 noise) one thing that it's still -- it was a huge thing was
18 adaptation on housing and again, that's all been a massive
19 effort (indiscernible - room noise) in the rural areas to
20 improve that and it has improved, and I do believe there are
21 some studies now that will prove that good sanitation makes a
22 difference in infectious diseases in small communities,
23 correct, and I know you do some of that.

24 So if we're trying to learn why did things change, how to
25 improve -- I'm not sure any of us sitting here really, you

1 know, people will use the things that were available. So when
2 more and more vaccines came in, treatments for (indiscernible
3 - room noise) that leads to serendipity.

4 MR. HOLT: Well, no, I think -- I just wanted to
5 interject for (indiscernible - speaking simultaneously).....

6 DR. LANIER: That's so -- I -- I mean I -- can we apply
7 those to the (indiscernible - room noise) today to move on?
8 You know, I'm not sure.

9 MR. HOLT: Well, but that -- this isn't -- this isn't
10 being necessarily captured for you folks. It's for the people
11 that are looking forward and (indiscernible - room noise) we
12 don't know an oral history of what's been captured and one of
13 the things, remember about the '60's, is the Internet wasn't
14 there, and the research was based on whoever wrote it.

15 So you're going to be -- I mean, there's maybe a little
16 concern about if this was written and said something
17 different, but I mean, the reality was is there was a lot of
18 single-sourced then than it is now, and part of what we're
19 trying to do is -- that's why we want to just really try and
20 do is capture from your folks, besides the stuff that's
21 written what else, what other stuff. So I think this kind of
22 continues to be free-flow with that and don't think in terms
23 of how would this be if (indiscernible - room noise) out
24 there, just get it out there. Yeah (affirmative), just get it
25 out there.

1 DR. HURLBURT: Well, one of the things that was really
2 common was streptococcal laryngitis and because of that, you
3 saw patients with mitral stenosis, with (indiscernible - room
4 noise) and this was probably in the part of the early
5 (indiscernible - room noise) work in the early days of cardiac
6 surgery, am I right, kind of the first major procedure was the
7 mitral commissurotomy, whether it was to fix a fracture or put
8 the (indiscernible - room noise) or whatever, but the rest of
9 the country had gotten beyond that when they didn't have the
10 epidemiology with as much streptococcal infection and none of
11 those disease processes that cover it. So we had it up here.

12 For a young, aspiring physicians and young aspiring
13 cardiac surgeons, these (indiscernible - speaking
14 simultaneously) were worth their weight in gold. So they
15 would not (indiscernible - speaking simultaneously).....

16 MR. HOLT: If I can real quick, we have about 15
17 (indiscernible - speaking simultaneously) I think to tend
18 sometime to drift between decades. So just as you're
19 (indiscernible - room noise) we've got 15, 20 minutes or so,
20 kind of in this part. Remember, the '80's are focusing on the
21 '80's, the '70's on the '70's, and the '60's on the '60's.

22 I don't know if that's how the conversation has been, but
23 there's just some natural drift that tends to happen. So just
24 as you continue on your conversations, remember the '60's are
25 with the '60's, and the '80's for the '80's, and we all know

1 what happened in the '70's. So with that, let's go ahead and
2 continue.

3 DR. HURLBURT: But that's gone now, but the other thing
4 that we had that you'll remember too, because the approach to
5 it was, well, we've got all of this stuff, streptococcal
6 infection and it's uniformly sensitive to penicillin. So we
7 had bicillin (indiscernible - room noise) and you lined up the
8 kids in school and every child in the school got a shot of
9 bicillin, trying to reduce the incidence of streptococcal
10 infection, and we did a lot of things you could get sued for
11 now, but it was recommendations from the experts of the day.

12 MR. HALL: I'd like to start on the question, if we -- we
13 talked, I think 98% of the stuff is more public health than
14 other health. I mean, accidents, response, and (indiscernible
15 - room noise) you know, we kind of think broken arms. Have we
16 talked at all about what it was like in the '60's for other
17 healthcare, routine healthcare, other than things that we kind
18 of pushed toward public health as preventative kinds of deals
19 and epidemics and all those kinds of things?

20 DR. HURLBURT: Well, you know, another -- because of the
21 high incidence of purulent otitis media.....

22 MR. HALL: Right.

23 DR. HURLBURT: The Public Health Service, the Indian
24 Health Service contracted with some of the best academic
25 pediatric otorhinolaryngologists in the country and NIH was

1 involved and they basically said, "Well, the anatomy of the
2 Native people is different, and we could a T&A on these little
3 kids, if safely, we could put them to sleep." So there were
4 T&A clinics and you'd go to a community and get in a log cabin
5 in a cot and have a nurse anaesthetist and an
6 otorhinolaryngologist and they'd line up all these little --
7 even kids one year old and so, and do a T&A, which you
8 (indiscernible - room noise) for surgeons an easy procedure to
9 do, but you don't do anything that there isn't a risk for.
10 That was the best science. That was expert recommendations.

11 On the purulent otitis media, what I was advised to do is
12 witchcraft. You suck it out with an aspirator, pack the
13 external (indiscernible - room noise) and then packed it in
14 and again, we'd be sued for doing that, but we thought that
15 was the best thing to do and that's what the experts were
16 telling us.

17 It reminds me, I think I had the same kind of dental
18 training that you did. Close your ears, Brad. You know, we
19 learned how to do a block and then you'd go out and pull teeth
20 that, you know, a dentist could have salvaged, and then the
21 other thing, Joe Shelton, I remember the ophthalmologist, just
22 generation after generation (indiscernible - room noise) would
23 take you for three days and teach you how to do a refraction,
24 when you have a tough confrontation type refraction and you'd
25 go with your big box of lenses, and you know, now, you go to

1 the optometrist and do so much better job than we did trying
2 to do that. It -- I don't think (indiscernible - room noise).

3 DR. LANIER: You didn't mention dental or the -- an
4 issue.

5 DR. HURLBURT: Mention what?

6 DR. LANIER: Dental as an issue.

7 DR. HURLBURT: Yeah (affirmative).

8 UNIDENTIFIED SPEAKER: They don't count.

9 DR. LANIER: That was terrible, you know, (indiscernible
10 - speaking simultaneously).....

11 UNIDENTIFIED SPEAKER: (Indiscernible - speaking
12 simultaneously).....

13 DR. HURLBURT: Yeah (affirmative), and for all of it,
14 there was no money to travel people. Now, we could send
15 somebody from Kanakanak (indiscernible - room noise) to try to
16 (indiscernible - room noise) that, but to get from Stuyahok or
17 Togiak or somewhere that could (indiscernible - room noise),
18 we'd all go on our own nickel and no money for the drugs in
19 the village (indiscernible - room noise) expensive penicillin.
20 They'd have video games. They'd have movies and charge a
21 dollar and (indiscernible - room noise) the drugs if you could
22 prescribe on (indiscernible - room noise).

23 MR. HALL: In the private practice sides of things, too,
24 we always seem to be always back to what government is doing.

25 DR. HURLBURT: Yeah (affirmative).

1 MR. HALL: I'm thinking of what -- especially in rural
2 places like Cordova in the '60's, we had three dentists who
3 came to town periodically and have clinics there, and you
4 know, you didn't have -- people had (indiscernible - room
5 noise) it doesn't matter, if you have to come to Anchorage,
6 you have a 22-bed hospital with -- at one time, we had four
7 physicians and one time, we had one, during the '60's, and all
8 the staff in the hospital, except two, were missionary low-
9 paid kinds of deals.

10 DR. HURLBURT: Yeah (affirmative).

11 MR. HALL: It wasn't the medicine cost utilization in the
12 '60's in communities that are off the highway system, you
13 know. How do they access -- did access to healthcare in the
14 '60's for routine healthcare an item that we ought to be
15 telling them about?

16 DR. LANIER: Well, one thing, there were a lot of births
17 at home in (indiscernible - room noise), right?

18 DR. HURLBURT: Well, actually.....

19 DR. LANIER: And then it improved?

20 DR. HURLBURT: The two years I was in Kanaknak, we got
21 96% hospital deliveries and we didn't pay for the
22 transportation, but it's almost better than they're doing
23 today with the popularity of home deliveries (indiscernible -
24 room noise).

25 It's -- you know, people were very accepting of

1 healthcare and it wasn't a sophisticated time. It's much
2 better now, because healthcare is a collaboration between the
3 physician and the patient. The physician is partly an
4 educator of the risks and benefits, and they make a joint
5 decision. In those days, it was whatever the doc said, went.
6 So if you can be our spokesperson?

7 MR. HALL: I'm not. I decline. No, it's got to be one
8 of your two, yeah (affirmative), one of you. I think you
9 should do it.

10 DR. LANIER: (Indiscernible - room noise).

11 MR. HALL: Don't you think that one of you guys should
12 report this, rather than me?

13 DR. RHYNEER: Well, I'd like to, you know, Ward would do
14 a fine job. Ward will.

15 MR. HALL: Okay.

16 DR. HURLBURT: Yeah (affirmative), I think, yeah
17 (affirmative), we kind of -- then maybe using the broad
18 categories of issues.

19 MS. ENNIS: May I ask a question? You know, I'm the one
20 that talked about sending folks outside for behavioral and
21 intellectual developmental disabilities (indiscernible - room
22 noise) institutions. When you were in the rural areas, did
23 you see patients who clearly had mental retardation or other
24 forms of developmental or intellectual disabilities, and you
25 know, or -- and what advice or what were families asking for?

1 DR. HURLBURT: I think we were probably not as cognizant
2 and not as aware of it at that time. When ANMC was first
3 built, it was before I was here, there were a very small
4 number of mental health beds that (indiscernible - room noise)
5 when I was here, they -- the Indian Health Service was very
6 adamant, this was the state's responsibility and that we did
7 not provide mental healthcare there and then the state did
8 that.

9 It was interesting because they were, the Indian Health
10 Service was paying for public health nursing services.
11 They've operated them in the rest of the country in the
12 states. They paid about 20% of the cost of public health
13 nursing service, and I remember it was when (indiscernible -
14 room noise) was with the state and when things started getting
15 good and building the pipeline and with his Indian Health
16 Service background, he said, "We don't need that money
17 anymore. You guys need it more than we do," and so we stopped
18 paying it, but there was a real separation.

19 On the alcoholism, the behavioral health things, I don't
20 think that was as bad when I first came and then it got worse,
21 and then -- and then we're getting out of the '60's, but the
22 movement starting like the alcohol -- I like the story in
23 British Columbia. It seemed to me there was a better sense of
24 ownership of alcohol-related problems, specifically at the --
25 if it was specifically alcohol among the Native community.

1 In any AFN meetings for a number of years were almost
2 like a revival meeting, where people would say, "I was an
3 alcoholic and (indiscernible - room noise) me and my family
4 and I've been sober for two years," or whatever. So there's
5 been kind of a change in that, but it was a problem and we
6 didn't have the five levels of dryness, but you know, people
7 would buy the real vanilla that was made with an alcohol base,
8 lots of bottles. They could buy it in Dillingham and take it
9 to (indiscernible - room noise) or somewhere else and then
10 drink that, but it wasn't as big a problem as drinking later,
11 but I think it was, you know, it was still closer to a
12 subsistence economy, you know, and then we had -- you didn't
13 have television. You didn't have radio in the village and
14 people became aware of that. There were other social
15 pressures, but we weren't -- probably weren't real -- like I
16 think we're not as aware, at least, of the issues then.

17 MS. ENNIS: If a child was born with down syndrome or
18 cerebral palsy, you know, or a significant -- those children
19 were.....

20 DR. HURLBURT: But it -- yeah (affirmative), in
21 (indiscernible - speaking simultaneously), they'd be taken
22 care of by the family.

23 MR. HALL: Yeah (affirmative), were you here when I
24 talked about closing our state (indiscernible - room noise)?

25 MS. ENNIS: (Indiscernible - room noise).

1 MR. HALL: Yeah (affirmative), that all evolved right in
2 that timeframe. The other part relating to (indiscernible -
3 room noise), when the new money came at the end of the '60's
4 and at the first part of the '70's, when we had huge money, we
5 had more money available to do an alcohol (indiscernible -
6 room noise) and we created behavioral health as a concept and
7 one of the things that we set as a policy, and it carried on
8 for several years, like people thought it was law, is no less
9 than 10% of the money that we had available would be going
10 into prevention, no less than -- if you -- the idea of
11 prevention, early intervention and treatment, you could put
12 all your money to treatment and you've got nothing left.

13 Early intervention became, you know, a major function and
14 we said that for years and people thought that was the
15 official -- we just declared it at a meeting in Juneau one and
16 said, "We're making this as the policy," and it was not
17 supported by the Legislature. We just did it, and it carried
18 on for several years, and in Anchorage at the end of the '60's
19 and the early '70's, too, because we handled all of the state,
20 federal, and local monies.

21 We used federal monies first, state money second, local
22 money third, one end to the other, but that's what the -- it
23 all developed in that end. The whole change of philosophy of
24 things like we can take care of these kids that are outside
25 now. We can do them in Alaska and so Valdez is where we put

1 them, and eventually, that wound down.

2 I was thinking about one of the great public health
3 leaders, Arnie Hess, she had her kids down in Valdez and they
4 said it had never been -- one of her sons turned out to be the
5 model of a kid that could come out of there and come into
6 society and be a part and it was around Anchorage and
7 (indiscernible - room noise) in Nevada one day on a trip he
8 made, but there were some great stories that came out of that
9 and that was the late '60's and the very end.

10 DR. LANIER: Delivery of care (indiscernible - room
11 noise) public health nurses (indiscernible - room noise) that
12 (indiscernible - speaking simultaneously).....

13 DR. HURLBURT: Well, they.....

14 DR. LANIER: They actually focused on the Native
15 (indiscernible - room noise) and the docs were doing the field
16 trips.

17 DR. HURLBURT: Almost every clinic I went on
18 (indiscernible - room noise) we had one in Dillingham and one
19 in King Salmon, and so if I'd go up to Nushugak or down on the
20 Alaska peninsula, I always went with a public health nurse.

21 DR. LANIER: And you were making the rounds and you were
22 assigned those (indiscernible - room noise).

23 DR. HURLBURT: It was -- it was hit or miss, like the
24 ones up in Nushugak, I would go five times a year and the ones
25 down in the peninsula, I'd go twice a year.

1 MR. HALL: (Indiscernible - room noise) I hope.

2 DR. LANIER: I don't know when, but at some point,
3 there's a regular public health nurse.

4 DR. HURLBURT: But now, we can't get a public health
5 nurse to live there. So they're in larger places like Fort
6 Yukon, Galena, McGrath, where they used to be public health
7 nurses (indiscernible - room noise).

8 UNIDENTIFIED SPEAKER: (Indiscernible - room noise).

9 DR. HURLBURT: I gave some (indiscernible - room noise)
10 hope they're somewhere else.

11 DR. LANIER: Somehow the (indiscernible - speaking
12 simultaneously).....

13 DR. HURLBURT: One of them I gave (indiscernible -
14 speaking simultaneously).....

15 DR. LANIER:being totally responsible for the
16 community and then the public health nurse (indiscernible -
17 speaking simultaneously).....

18 DR. HURLBURT: (Indiscernible - speaking
19 simultaneously).....

20 DR. LANIER:at that time.

21 DR. RHYNEER: That hasn't been done (indiscernible - room
22 noise).

23 DR. LANIER: (Indiscernible - speaking simultaneously) to
24 a couple of communities in the region (indiscernible -
25 speaking simultaneously).....

1 UNIDENTIFIED SPEAKER: (Indiscernible - speaking
2 simultaneously).

3 DR. LANIER:janitorial closet and I just prayed
4 that I was holding the right one. I do better with the
5 (indiscernible - speaking simultaneously) I was worried I was
6 taking the wrong ones out, but if was, you know, you've got
7 some responsibility for the community is what I'm saying, I
8 think that's been not quite the same (indiscernible - speaking
9 simultaneously).....

10 UNIDENTIFIED SPEAKER: (Indiscernible - speaking
11 simultaneously).

12 DR. RHYNEER: I don't know. I've got the idea that it
13 still is.

14 DR. LANIER: Okay, all right.

15 DR. RHYNEER: Yeah (affirmative), (indiscernible -
16 speaking simultaneously).

17 DR. LANIER: Well, (indiscernible - speaking
18 simultaneously).

19 DR. RHYNEER:working with ANMC.

20 DR. LANIER: Yeah (affirmative), right.

21 DR. RHYNEER: And they all try to, at least, you know,
22 get to know the people, see the same people each time.

23 DR. LANIER: Well, the specialists are going to the hub
24 and (indiscernible - speaking simultaneously).

25 DR. RHYNEER: Right, but even some of them still go out

1 to Dillingham, and you know, the (indiscernible - speaking
2 simultaneously).....

3 DR. LANIER: No, no, I meant the small -- I'm talking
4 about the small (indiscernible - speaking simultaneously).....

5 DR. RHYNEER: Right, right, I know.

6 DR. LANIER: I think the system has (indiscernible -
7 speaking simultaneously).....

8 DR. RHYNEER: Right.

9 DR. LANIER: You get specialty service through the hub
10 (indiscernible - room noise), you know, and (indiscernible -
11 room noise) and everything and probably can see everybody in
12 the community.

13 DR. HURLBURT: So because we've been around for a while
14 at this table, we've seen a lot of change, but in 30 years
15 from now, they'll say the same thing. When you were, whatever
16 it was, CEO of APS, I remember I met with you and your board
17 four or five years ago and you recommended Winberg's (sp) book
18 that you had read and I think most of the members of the board
19 had read and I really encouraged the Health Care Commission
20 members to read, but you know, when you think of those kinds
21 of observations, I think they're very related to quality of
22 health and appropriateness of healthcare, being more evidence-
23 based, but as we learn that kind of stuff, and (indiscernible
24 - room noise) it's going to have an impact, hopefully, on what
25 we do.

1 DR. RHYNEER: I think the big move in medicine is we have
2 a reason, scientific reason for everything that the doctor
3 always does. It sounds laudable, doesn't it? That's called
4 evidence-based medicine. That's the lingo (indiscernible -
5 room noise).

6 SENATOR COGHILL: I've been hearing a little bit about
7 it.

8 DR. RHYNEER: And if they have a wonderful notion, but it
9 can (indiscernible - room noise) actually, because the
10 evidence is based upon looking at large groups of individuals
11 treated one way versus another way, and then you find out
12 which way works the best and then you treat everybody that
13 way. The problem is, it's a large group, that we're all
14 individuals.

15 SENATOR COGHILL: So different.

16 DR. RHYNEER: So we're always trying to not fall into
17 that trap, but pay more attention to each individual and use
18 that other group information as sort of a background basis for
19 making a more thought out and person-specific with them.

20 DR. HURLBURT: It informs your clinical decision, but
21 when the rubber meets the road, when you're there with the
22 patient, you have to make the best informed recommendation you
23 can.

24 SENATOR COGHILL: You know what else is interesting from
25 growing up in the '60's to now that I've seen is hospitals and

1 doctors were kind of the center of the world. Once you got
2 into their care (indiscernible - speaking simultaneously).....

3 MR. HOLT: (Indiscernible - speaking simultaneously) get
4 to the next five to seven minutes so (indiscernible - speaking
5 simultaneously), go ahead and we'll (indiscernible - speaking
6 simultaneously).

7 SENATOR COGHILL:people going home (indiscernible -
8 speaking simultaneously) when I was a kid, you know, if we
9 had, for example, if we had TB, we were taken out of town, go
10 to the hospital, and then the hospital would send us back home
11 when they were satisfied or if I had hepatitis, which you
12 know, the water along the river banks, hepatitis or yellow
13 jaundice was common.

14 DR. HURLBURT: Right.

15 SENATOR COGHILL: And they would give you a series of
16 shots (indiscernible - speaking simultaneously) shot and when
17 you came home, you were under the doctor's care until they
18 were done with what they were going to do, and the homecare
19 was, you know, okay, go back to work, you know, and now, with
20 the outpatient world, the after care quite often is left up to
21 either an agency that is (indiscernible - room noise) or a
22 family who (indiscernible - room noise) very different.

23 DR. RHYNEER: Yeah (affirmative), the organization of
24 medicine has not (indiscernible - room noise) so that the work
25 that's done in hospitals, it's not readily continued in a

1 seamless fashion or capacity (indiscernible - room noise) and
2 part of the problem is there are different people in different
3 organizations with different bosses and different goals. So
4 it's a big -- there's a big chasm there that we haven't
5 solved.

6 SENATOR COGHILL: Good point (indiscernible - speaking
7 simultaneously).

8 DR. RHYNEER: It could be solved and it is solved in some
9 places where it's the same organization, you know,
10 (indiscernible - room noise), but in the private area, that
11 has not been worked out satisfactorily and it's partly --
12 well, it's due to budget, but partly due to how people are
13 paid. Usually, they.....

14 UNIDENTIFIED SPEAKER: Follow the money.

15 DR. RHYNEER: Yeah (affirmative).

16 UNIDENTIFIED SPEAKER: So I figured it was 10:00, so I
17 could say something, but I promised I was just (indiscernible
18 - speaking simultaneously).

19 UNIDENTIFIED SPEAKER: Yeah (affirmative), go ahead, go
20 ahead.

21 MR. HOLT: Can I get everybody's attention real quick?
22 There was a question that was just, I think, raised that --
23 let's do this at each table, which is based -- it's kind of --
24 we're rapidly rolling to our break, which is based on kind of
25 your discussion you had here, what would be, young man, do you

1 remember the statement that you said (indiscernible - room
2 noise)?

3 MR. DANN: I said that (indiscernible - room noise).

4 MR. HOLT: Everyone listen to this and if we could use to
5 get kind of answer this question (indiscernible - speaking
6 simultaneously).

7 MR. DANN: So when we shared, what's evident is that this
8 history is one of a lot of innovation and the question I asked
9 is, what is it that has enabled that innovation to take place?
10 What has created fertile soil for innovation that we want to
11 preserve going forward, so that we don't get stuck the way
12 (indiscernible - room noise) did.

13 MR. HOLT: Perfect, and so if you could think about it in
14 terms of the nugget for the '60's, the '70's, and the '80's,
15 what would those -- what would be those things you'd want, now
16 from your discussion, people to remember from that time
17 period, okay. So take about five to seven minutes, just free-
18 form your conversation and then you'll be on break.

19 DR. RHYNEER: You know there's a good example in the past
20 of one way not to do that, you know, not to get from A to B
21 very easily, and that was the Health Systems Agencies that
22 were in place in the '70's. You're familiar with those, and
23 the Health Systems Agencies were funded by the federal
24 government and these groups were located in communities and
25 they were charged with reviewing block grants and also doing

1 certificate of need applications, and they were the principal
2 determinant of who got a certificate of need for a hospital,
3 whatever -- whatever have you, and it seemed like such a
4 wonderful idea. However, I can remember one time the doctor
5 from Glennallen.....

6 DR. HURLBURT: Pineo (sp), Jim Pineo.

7 DR. RHYNEER: Pineo, yeah (affirmative), Pineo comes down
8 to the Health Systems Agency. There are (indiscernible - room
9 noise) sitting on the board listening to him request a
10 certificate of need to increase his clinic by two beds and it
11 was going to cost like \$250,000 or something to do this.
12 However, it cost him and the clinic hundreds of thousands of
13 dollars to develop a certificate of need application.

14 DR. HURLBURT: And this was the little mission clinic
15 running on a shoestring.

16 DR. RHYNEER: Right and (indiscernible - room noise) yeah
17 (affirmative), and I'm sure, because he'd just gotten back
18 from a year's furlough, that most of that money he'd raised by
19 giving slide shows in basements to church folks and these
20 people were throwing in quarters and nickels and dimes and
21 whatnot.

22 That money that he had to spend developing his
23 certificate of need application so he could increase his beds
24 in that little missionary clinic and hospital, and I thought,
25 "Boy, there's something horribly wrong with this system that

1 wastes money in such a fashion," and then at that time, there
2 was a big mandate to not allow more than one CAT scanner in
3 any community and there are huge fights.

4 Why not, and everybody (indiscernible - room noise) CAT
5 scan and we would never go back to the days before you could
6 have a CAT scan to see what's inside of me, rather than doing
7 exploratory laparotomy, of course it was a common surgical
8 procedure when I came to town. If something (indiscernible -
9 room noise), they would (indiscernible - room noise) to take a
10 look. Now, we can look under the CAT scan, MRI (indiscernible
11 - room noise) and stuff. All those things had to get
12 certificate of needs, including when I bought an
13 echocardiogram machine for my office. I had to get a
14 certificate of need and go through all that.

15 So it was one of those things which seemed like such a
16 good idea, but it had huge negative unintended consequences
17 and I just, you know, always preach that, that we need to be
18 very careful by regulating things in a way which may turn out
19 to -- can be very detrimental, and as far as I'm concerned,
20 the certificate of need did at least (indiscernible - room
21 noise) and it probably still does. We still have the
22 certificate of need in this state.

23 DR. HURLBURT: Yeah (affirmative), I don't disagree with
24 that statement, but the other side of the issue is that
25 medical care is so unique that basically, if you build it,

1 they will come. You know, if you build (indiscernible - room
2 noise) more interventional cardiologists, you're going to have
3 more stints put in, including a lot of people with chronic
4 stable angina and so we need free market approaches, because
5 that's the American way. That's the way we do things in our
6 country, but healthcare is unique and I'm not disagreeing with
7 -- that there are real down sides to the CON process, but the
8 other side is that healthcare is so unique and then you can
9 understand why (indiscernible - room noise).

10 DR. RHYNEER: Yeah (affirmative), I would agree at a --
11 it's the economic standpoint that allows our (indiscernible -
12 room noise) thing to happen because people are not responsible
13 for the economics of their own healthcare anymore.

14 DR. HURLBURT: Yeah (affirmative).

15 DR. RHYNEER: If you had to pay for an angiogram, one of
16 my patients that are (indiscernible- speaking
17 simultaneously).....

18 MR. HOLT: About three more minutes and then you break
19 again and you can have a working break, if you want, or you
20 can take a break, but at 10:30, we'll start back up again
21 formally.

22 DR. HURLBURT: You interrupted us.

23 DR. RHYNEER: He was in the hospital for 24 hours. His
24 bill was a dollar a second, \$72,000. Now if, you know, which,
25 you know, is a better part of a house, right? If he had been

1 personally responsible for that or his family had been, it's
2 hard to know what the outcome of that would have been.

3 Now, when a person comes in with a heart attack and you
4 do an angioplasty as an emergency, that prevents a long
5 hospitalization and allows the person to go back to work in a
6 couple of days. Whereas (indiscernible - room noise) when I
7 came to town, you'd be at the hospital for a couple of weeks.
8 They were home for a couple of months and they were off work
9 for three months and that was the standard of treatment for a
10 heart attack and they were left with a permanently damaged
11 heart.

12 Nowadays, technology has allowed us to reverse that,
13 abort it, and allow the person to go back to work in a short
14 period of time with a totally undamaged heart, and no one
15 would go back to the former way, but I think the question is,
16 well, how do we decide how our really very vast resources
17 ought to be allocated?

18 DR. HALL: Can I make a comment? I'm glad I left the
19 room, because I don't know what you said (indiscernible - room
20 noise) I can add one last point that ties into that. I was
21 going to mention it earlier. It has to do with the late '60's
22 and how we handled the hospital construction.

23 Remember we shared how we handled the (indiscernible -
24 room noise) how we handled all those -- all those funds were
25 put together and they were put out to bids and there were

1 competing bids and so on, and they went through processes and
2 they ended up in '69, this is the biggest (indiscernible -
3 room noise) of money was (indiscernible - room noise)
4 competing from the Alaska region, which was then
5 (indiscernible - room noise) and Providence, and the way it
6 worked out, it ended up all going in one place in that fund,
7 and I had to make a decision, but the review processes that we
8 did were so naive in those days.

9 We didn't have good measurements. We didn't have that
10 kind of stuff. Some of us were hoping that we wouldn't build
11 an empire. We'd be able to have too strong a hospital
12 (indiscernible - room noise) proposal and I had to sign off
13 and agree that they had the better proposal, and that brought
14 up a whole major theme in '69 and '70, about how we were going
15 to handle state funds, which gets to the big issue that we
16 touched off of the very end, state health policy. How do we
17 establish state health policy? Is it all political? There
18 was (indiscernible - room noise) took place in that period of
19 time, remember the -- I shouldn't probably say too much about
20 this, but the Legislature went through an entire session
21 without a single capital funds thing for an activity in
22 (indiscernible - room noise) nothing had ever heard. It never
23 came before the Anchorage reviews and everything before
24 finding -- it never came before the city, anything, but it
25 appeared after the two legislative bodies went into joint

1 conference, it appeared, \$354,000 for our new blood bank in
2 Anchorage.

3 That's right, and it was to be appropriated to the Health
4 Department in Anchorage for us to build. We had never heard
5 about it, not one single thing, and we used that as an example
6 of good politics/bad policy, and it's an illustration and this
7 began in the '60's when the new money came. Policy was more
8 political in most areas and in a lot of places, if you were
9 doing a lot of fisheries, it was based on escapement and
10 scientific evidence. If you were doing, you know, and -- but
11 not in a lot of the health social services, it was who had big
12 clout, and that was evident when the new money popped in the
13 '60's, and it was who has a lot of the clout.

14 I say that in front of the powerful legislator here, but
15 I think that needs to -- that's something that is a major
16 change in the '60's, from when things were done by planning
17 and by operation, and then fell apart, and the Commission
18 still considers me a trusted advisor.

19 UNIDENTIFIED SPEAKER: Don't write that down.

20 UNIDENTIFIED SPEAKER: Did you have another thought? You
21 said it (indiscernible - room noise).

22 SENATOR COGHILL: This is the most disciplined I've been
23 for a long time, sitting here listening without (indiscernible
24 - room noise), but my seat has been (indiscernible - room
25 noise). No, I appreciate -- you know, I guess I got to grow

1 up in the '60's. I was born in 1950, so I became aware of
2 what was going on and I had the mumps. I had the measles. We
3 had to deal with impetigo. We had (indiscernible - room
4 noise) continually broken on people's knees. We had -- the
5 way we took care of it, we didn't have EMTs.

6 We had a Native health nurse and my aunt was a nurse that
7 came up there to work for the mission and we didn't have a
8 hospital. If you did, you had to either fly, if it was an
9 emergency, without an EMT, or you had to take a train, which
10 it only ran three times a week. So you just had to deal with
11 it.

12 A lot of bones were set, like I say, because I'm a
13 mechanic and I know how to do a splint. A lot of hands were
14 crushed. People were having deformed (indiscernible - room
15 noise). It was common. We still had people limping from
16 polio. A lot of kids my age had polio. So we were probably a
17 little more careful because we had -- I mean, like if you went
18 on a trap line, like I say, there's nobody covering your back,
19 so take what you need with you.

20 Today, we're a lot more risky in that regard. We expect
21 a helicopter to come get us if we're (indiscernible - room
22 noise). So it's just very different, but if I was on a trap
23 line and nobody heard from me for two days, somebody went
24 (indiscernible - room noise) because I told them where I was
25 going, but the risk you take when now you can get a snow

1 machine and be 100 miles from nowhere in 25 minutes.

2 It's (indiscernible - room noise) that we don't know if
3 we can get there and so I've been working on the
4 (indiscernible - room noise) because you told people where you
5 were going and somebody knew where you were at. So that was
6 our health (indiscernible - room noise), but if you got
7 whooping cough, you were quarantined for -- told, "Go in that
8 room and you don't come out until either a health nurse comes
9 by and that way we can ship you to Fairbanks, but we're not
10 going to put you on a train. We have to put you on a plane,"
11 because you're not going (indiscernible - room noise).

12 DR. HURLBURT: But a plane was taking out a few seats and
13 arranging some room.

14 SENATOR COGHILL: Yeah (affirmative), that's exactly what
15 it was.

16 DR. HURLBURT: It wasn't an air ambulance.

17 SENATOR COGHILL: Yeah (affirmative), I -- I mean, I
18 probably -- my first grade class was probably 15 and by the
19 time I graduated from high school, it was probably
20 (indiscernible - room noise) we had from just those diseases,
21 but lice, impetigo, were common, commonplace. You just had to
22 deal with them. I can remember having my hair combed out
23 many, many times.

24 MR. HALL: Hair?

25 SENATOR COGHILL: That's probably what happened, the lice

1 got them, but the innovation, you know, it's driven by
2 necessity. I think it's -- I can still remember health nurses
3 coming around to the school and rounding everybody up and we
4 got our immunizations and some people reacted badly, but they
5 were already gone, you know.

6 DR. HURLBURT: Yeah (affirmative).

7 SENATOR COGHILL: And if you reacted badly, too bad for
8 you, but for the most part, my mom was not a big fan of
9 immunization because she had a bad experience as a kid in
10 Fairbanks and that was -- and then we had doctors that came up
11 here, some were really good and some were not, but you didn't
12 always get the choice.

13 DR. HURLBURT: Yeah (affirmative).

14 SENATOR COGHILL: I can remember a few of them. I had
15 rheumatic fever when I was a kid and I was (indiscernible -
16 room noise) hospitals and places (indiscernible - room noise)
17 nobody, no doctor wanted to deal with it. So I stayed in the
18 hospital the whole time.

19 DR. HURLBURT: Yeah (affirmative), it was -- Bill Dann
20 was telling a story about Nome, and I can remember as a
21 surgeon, you know, getting calls from Nome. The only thing I
22 could depend on when the patient got to the ER at ANMC was it
23 was not the way the patient was presented because the quality
24 of care was purely awful, and when Dave (indiscernible - room
25 noise) I remember was out there for a clinic and it was in the

1 (indiscernible - room noise), and he said (indiscernible -
2 room noise) no, we have the number nine surgeon in the whole
3 world, you know, we were so lucky. That guy was
4 (indiscernible - room noise), but then when they started
5 getting residency trained docs, like David (indiscernible -
6 room noise) dad (indiscernible - room noise), the quality of
7 care just dramatically improved. I went from thinking, you
8 know, no, we're the armpit of the Arctic, as far as the
9 quality of medical care, that there wasn't a town in the
10 country that had better quality care and people (indiscernible
11 - room noise).

12 UNIDENTIFIED SPEAKER: And you've seen this first-hand.

13 **END 1960'S BREAKOUT SESSION**

14 **NO 1970'S BREAKOUT SESSION AUDIO**

15 **NO 1980'S BREAKOUT SESSION AUDIO**

16 10:21:39

17 MR. HOLT: Okay, let's go ahead, and if you could get
18 your break refreshments and get back into your groups and
19 we'll go ahead and do this next part of the process. Thank
20 you, all, by the way, for just free-wheeling with that. It
21 was really interesting observation-wise, just watching these.
22 I was alive through all of these decades in the Lower 48.

23 I've actually worked in 40 different states and I've
24 shared with -- I've actually been coming up here, started
25 working with the Legislature, with a gentleman, at then time,

1 Senator Parnell, on some stuff. So it's been 20 years I've
2 actually been coming up here.

3 I do believe of all the places that I've personally been
4 a part of working, facilitating inside of government and
5 outside, from my short 30-year career, this is still one place
6 where if you want to effect change of significance, it can
7 still happen. I truly do believe that up here, and so it's
8 wonderful to see the mix of folks that are up here and the
9 discussions, and so it was interesting, you know, the '60's,
10 the folks were reflecting on just, you know, basically how a
11 necessity, mother of invention and you just -- you couldn't
12 wait for the Internet to boot up. You had to solve things.
13 That was one of them from the '60's.

14 The '70's, they were just laughing and having a good
15 time, the whole time they were doing stuff, and the '80's were
16 solving world problems. I mean, it was just interesting just
17 to watch the three different groups, but in all seriousness,
18 there were some wonderful things that popped up. I mean, me
19 just interloping and some themes, actually, that started to
20 emerge that for someone that might be looking forward, are
21 going to be really good thought pieces about the causality of
22 maybe what made things better or worse and how applicable are
23 those today and going forward.

24 So I just want to commend you folks for, at least the --
25 what I was being able to witness and it's infectious. I'll

1 just share with you, and I won't say which one, but one of the
2 stenographers was jazzed up, listening to the discussion. By
3 the way, they weren't supposed to be doing it, but that's a
4 bonus. I mean, they were supposed to just be kind of -- but
5 just listening to it, and it's now wanting -- what is the
6 history of the group and what's going to go forward.

7 So again, I commend you folks for being engaged and being
8 present and putting aside any politics or persuasions you had
9 and just engaging in the dialog. We want to continue that now
10 and we're going to actually start with the '80's and move back
11 to the '60's. We've asked the leaders of the different groups
12 to just kind of bring up, you know, a couple of kind of, if
13 you will, kind of key themes or key points of discussion that
14 came from that group, and then we're going to pause and we're
15 just going to see if there was a group from another decade
16 that if there was something you wanted to throw into the
17 record.

18 Again, we're -- this -- if you can remember that it was
19 the '80's and then the '70's and the '60's. So the '80's is
20 done. You all don't -- you don't get to pile on anymore.
21 Okay, so when we go through the -- yes, please.

22 UNIDENTIFIED SPEAKER: I would just throw out that it
23 might be really good if time allows.....

24 UNIDENTIFIED SPEAKER: Use your microphone.

25 UNIDENTIFIED SPEAKER: I would just throw out, if time

1 allows toward the end, it would really be good to have 10 or
2 15 minutes to give -- get some perspectives on the health
3 system of today from people in the group. I don't know if
4 time allows, but I think it would add some interest or value
5 and so people might think about that. I don't know how you're
6 time schedule is, just throw that out.

7 MR. HOLT: Okay, so if time allows, let's take that into
8 consideration as we go forward. So again, let's just start
9 with the '80's. Nancy's going to just share a couple of --
10 not -- but a couple of points, and if it just -- if it brings
11 up something that you thought, you know, boy, did you all
12 think about this, this would be the time to do that, and we're
13 going -- and we'll do that as we go to the different decades,
14 but '80's folks, you had your chance. So it's not any more
15 piling on. All right, so with that, Nancy.

16 MS. DAVIS: Okay, I have like three themes. One was the
17 -- in the '80's, there were a lot of infrastructure
18 improvements that really improved the health system. The
19 whole tribal development and ownership of Tribal Health
20 Services made a really big difference in the health system.

21 Learning to listen to communities and people about what
22 they need seemed to be a theme in the '80's of asking what was
23 needed and it went beyond the traditional health definition to
24 listening. The communities needed a laundromat or they needed
25 water improvement. So it was health in the big sense.

1 The other part of that infrastructure improvement was
2 changes that occurred in the community health aide
3 practitioner training and supervision and changes in the Nurse
4 Practice Act that created advanced nurse practitioners in the
5 state made a big difference in how we transitioned to primary
6 care, especially at the village level.

7 There was a willingness to work together in the '80's,
8 resolving a lot of jurisdictional issues because of the
9 requirement that if you wanted to actually accomplish
10 something, you had to partner with everybody. The large
11 medical centers began to help small rural hospitals. There
12 were state, tribal, and federal, both formal and informal
13 opportunities for working together to address immediate kinds
14 of health issues, and everybody seemed willing to work toward
15 access to care. That was a theme in the '80's.

16 The third thing was a number of developments in clinical
17 care and solutions, not just limited to CT scans and
18 technology, but also treatment options like clot busters that
19 nobody ever thought would even show up in small towns in
20 Alaska, but began to be a possibility.

21 We also had a number of opportunities to address
22 infectious disease problems that -- to reduce disease through
23 the Hepatitis B immunization effort, the Hib vaccination
24 effort, Hep A. There were a number of dramatic shifts in some
25 infectious disease areas and we began to identify and talk

1 about previously -- subjects that were previously silent in
2 healthcare like domestic violence and sexual assault and the
3 advent of more shelters and community level supports, but also
4 health providers willing to talk about and face those new
5 threats, and we all identified that substance abuse was one of
6 those things that we faced at every level, village, large
7 town, every size community, all kinds of families, and it was
8 -- it created impacts that the health system could not ignore.

9 MR. HOLT: Yeah (affirmative), well stated. Okay, other
10 -- anyone, do they -- would be -- feel completely incomplete
11 if they didn't share something right now about the '80's? All
12 right, thank you. Thank you. Good job for the '80's.

13 Okay, moving back in time for the '70's.

14 UNIDENTIFIED SPEAKER: The '70's show, yes, okay.
15 Reflective of what the '80's has just reported, our group
16 started, I think, by saying one of the things that was
17 happening in the '70's, that we were looking for best
18 practices from anywhere in the world, that the Barefoot Doctor
19 Program that had been developed in Africa was seen as
20 something that could be brought to Alaska.

21 The civil rights movement that was going on was something
22 that people were saying, "Wow, we can get this involved here
23 in the state," and actually, I brought a copy of a Point
24 Barrow conference on Native rights that outlined a number of
25 things that the Native community was saying that we need to

1 have in order to move forward.

2 At this particular point in time, there was a feeling of
3 departmental wars, that the Department of Interior, Department
4 of Health, Department of Economic Development, whether it's
5 federal or state, were fighting with each other, and that
6 communities were really getting caught either in the crossfire
7 or just not being there at all, and so trying to figure out
8 what mechanisms might come into play that would allow people
9 to really have a good, solid dialog, and toward the end of our
10 discussion, we got into this idea of cultural dialogs, and
11 this wasn't just Alaska Native/non-Native, but rural Alaska,
12 urban Alaska, young generation, older generation. What are
13 all the various cultural components that make up our community
14 and how can those be brought together to improve services?

15 When we looked at it a little bit more, it was an issue
16 of following the money. Where was the money coming from and
17 what restrictions were on it, and that was hobbling some of
18 the capacity for the communities to really want to do
19 something.

20 So there was a discussion about how to better take those
21 funds and bring them into more of a comprehensive type program
22 and some of the early discussions about either geographic or
23 consumer representation. One item that was brought up was the
24 local health powers and Brian had mentioned that the
25 Municipality of Anchorage identified very early on that it had

1 certain health powers, and I brought up the fact that in '71,
2 when the North Slope Borough was organized, it was organized
3 as a home rule borough with all the possible health powers
4 that it could have, that those structures then allow a tax
5 base for certain things to take place, and you know, watching
6 how those two boroughs dealt with the '70's was very different
7 than looking at some of the other areas that really weren't
8 quite positioned with the same infrastructure.

9 The increase of dialog, Bobby mentioned that the -- one
10 of the best things to do to get people to understand a
11 situation is to bring them to a rural area and have them
12 experience the site, the smell, and use of a honey bucket.
13 You know, it's a powerful image. It really is, and you know,
14 so this was needed.

15 I mentioned about a group of physicians that came to
16 Barrow and the EMS assistant was saying, "We need more
17 training, because we can't always get people out," and those
18 physicians were in Barrow for four days because the planes
19 couldn't land and suddenly, they realized, you do have a
20 serious problem

21 There was -- Bill mentioned about someone coming up and
22 going to a clinic in the middle of winter and there was no
23 fuel for the clinic. So they had a meeting in a very, very
24 cold building. Those types of stark realizations were
25 happening in the '70's. It was, you know, civil disobedience,

1 maybe in our own way, the fact that we were bringing decision-
2 makers to the streets to see the real situation.

3 In regards to -- Cindy mentioned about diabetes, this was
4 a concern that people's times were being allocated to do
5 certain things and part of this was by what was being
6 reimbursed at the time, and unfortunately, prevention and
7 education are not reimbursed as well as all the definitive
8 practices, and so a concern about where and at what point will
9 local communities be able to make particular recommendations
10 for action?

11 So the local communities need to provide the lay of the
12 land locally and let the policy-makers know what that
13 situation is, but the policy-makers must then trust the local
14 decision-makers to come up with solutions and manage them, and
15 that discussion was happening in the '70's, and it hadn't
16 happened quite yet, and so here, the '80's talk about, "This
17 is beginning to collaborate. It was great." You know, that
18 was.....

19 MR. HOLT: It's the onset, yeah (affirmative).

20 UNIDENTIFIED SPEAKER: That was our frustration in the
21 '70's of seeing this on the verge, but it wasn't really quite
22 coming to play yet.

23 MR. HOLT: Yeah (affirmative), interesting.

24 UNIDENTIFIED SPEAKER: Denny DeGross was mentioned, about
25 the transfer of authority and that people need to be allowed

1 to fail. I've often used the reference of Alaska's a teenager
2 or the Native corporations have gone through a teenage time
3 period, where they were given money, but they really hadn't
4 been given all the responsibility for how to deal with that
5 and now that they've learned and they've gotten some
6 experience and are now doing audits and they understand how,
7 suddenly, wow, they can do this, and it -- yeah (affirmative),
8 they could have always done this, but they hadn't had the
9 parenting to get them to that point right off the bat, and now
10 that's happening. So it's a factor over time.

11 The bottom line, innovation, people in communities have
12 their own ideas of what will work and they've got to be
13 allowed to try those things. It may be very different. It
14 may be totally off the wall, but when people have the
15 opportunity and are given the responsibility to make something
16 happen, that works.

17 So again, the best practices, trying to bring them in
18 from a global perspective. Bill Dann used the phrase wild
19 ducks. It's good to bring the outliers, the people in the
20 bell-shaped curve, at the edges of the bell-shaped curve,
21 bring them into discussion. You don't want to always be
22 talking to the people in the middle of the bell-shaped curve.
23 You want to look at those extremes because those people will
24 help give you insight in the center of discussion, and then
25 local empowerment with money to take action.

1 MR. HOLT: Very good.

2 UNIDENTIFIED SPEAKER: Seventies, yes, go.

3 MR. HOLT: Any other thoughts for the '70's? It was
4 interesting because you had mentioned -- because it came up in
5 the '80's, which is you had mentioned kind of groups coming
6 together and collaborating together and helping one another
7 and it metastasized itself to where in the '80's -- I mean,
8 how many -- there were -- I interloped on one, how many
9 signatures were required? You were -- Dick, you had mentioned
10 that it had gone to like the extreme, like 17 or.....

11 UNIDENTIFIED SPEAKER: Nineteen.

12 MR. HOLT: Nineteen, that's taking involvement to an
13 unconscionable level and it was reinvented down to five,
14 right. So it's interesting to know, it just started in the
15 '70's. It metastasized itself into the '80's, and had to kind
16 of pull itself back. So as we move to the '60's -- I'm sorry,
17 go, please.

18 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
19 microphone).....

20 UNIDENTIFIED SPEAKER: Use your mic.

21 MR. HOLT: Mic, use your mic, please, yeah (affirmative).

22 UNIDENTIFIED SPEAKER: He mentioned the North Slope
23 Borough having health powers and at that time in the '70's,
24 there were only two jurisdictions that had those, the
25 Anchorage Borough and that. The City of Galena one time voted

1 it and another group down in Southeast did vote, but then they
2 never went through with it. So it does raise the question of
3 the fact local.....

4 MR. HOLT: That's a good point.

5 UNIDENTIFIED SPEAKER:two local areas around the
6 state take on the responsibility, their share of it, anyway,
7 for the provision of the traditional services, health services
8 in the community, but nobody else in the whole state, since
9 the '70's, has ever chosen to do that, just an observation.

10 MR. HOLT: That's a great observation, great observation.
11 Thank you, and as we transition to the '60's, remember this is
12 -- this is, what, the end of -- this is just what -- as you
13 look at the '60's, one year past statehood, just to keep it in
14 perspective.

15 Again, that was -- then the '60's, the end of it, was 11
16 years, but it was, remember '59, I remember that. I was born
17 then. I remember your, you know, I don't remember actually
18 when you became -- statehood, obviously, because that was when
19 I was just brought into this world, but that's how I mark the
20 time, your statehood.

21 So remember, that was this time. It's just the beginning
22 of the '60's was just, you know, on one hand how many years
23 you'd been statehood, and some of you may be sitting here
24 thinking, "Seriously, it was only that far back," but that was
25 it and so you're enabling legislation, the departments that

1 were being born.

2 I mean, Bert had mentioned his -- it was a unique
3 department that then -- and money that flowed in. So again,
4 it's a fascinating time and when you think about it -- so not
5 to give Dr. Hurlburt too big of a build up, but with that,
6 from the '60's, kind of share some of the thoughts, if you
7 will, Ward, from your table.

8 DR. HURLBURT: Speaking of right after statehood, here's
9 my voter ID card for Alaska, number 220, that.....

10 MR. HOLT: Wow.

11 DR. HURLBURT:I got in Dillingham.

12 MR. HOLT: Yeah (affirmative).

13 DR. HURLBURT: But things were being implemented and it
14 was a time of change.

15 MR. HOLT: Wow.

16 DR. HURLBURT: We identified a couple of main areas, but
17 I would say one difference, and we didn't specifically -- we
18 talked around this, compared with the '70's and the '80's, is
19 that you were on your own more. There were not as many
20 resources available. Transportation resources weren't there
21 and so that was a difference. It was harder to get from
22 Togiak to Dillingham, harder to get from Dillingham to
23 Anchorage, harder to get from Anchorage to Seattle, or Mayo or
24 whatever, but we identified two large health areas that are
25 with us today, but have changed and for the most part,

1 improved.

2 We identified some other health areas that I won't
3 mention, but that things have gotten worse compared with the
4 '60's. The one large area was infectious disease and that we
5 have seen dramatic improvement in a number of areas, for
6 example, the TB epidemic, where the crude mortality rate in
7 Kotzebue in the mid '50's was three to four times the total
8 crude, mean non-age-adjusted, mortality rate from all causes
9 now. It was a huge epidemic here and now, it's still a major
10 problem for Alaska.

11 We still have people with complexes in their lungs that
12 breakdown and we still need to remain on top of that, but that
13 improved for a number of reasons. A lot of credit is given,
14 as Dr. Rhyneer pointed out, often times to improvements in
15 housing and sanitation. That was important, but really, the
16 epidemic curve on that was going down before we saw much of
17 that improvement for that specific issue, and so there were
18 the technological changes there.

19 We had the drugs coming along that became more effective.
20 We had case finding. We had intensive efforts. Both George
21 and Bert had a history of going -- working with the state and
22 with CDC of going to the field doing some of the case finding
23 efforts. So that's gone down.

24 What we used to call usual childhood diseases, measles
25 and so on, that were so common there, we don't see, because we

1 now have vaccines. When I arrived in Kanakanak, we were
2 structured with 36 beds. We averaged about 25 and when I left
3 two years later, we had reached about 18, but several times
4 what we have now for a smaller population, largely infectious
5 disease driven, a lot of gastroenteritis in kids, picking up
6 salmonella or shigella infections and coming in, typhoid,
7 even.

8 So we naively have thought, at various times, that we're
9 kind of getting beyond the age of infectious disease, until
10 you turn on the TV now and you hear about EV-D68 and ebola and
11 so on, but the picture has changed and it's been pretty
12 dramatic and it was due to technical innovations and medical
13 care, along with the so-called social determinants of health,
14 living conditions and so on.

15 The second area that again remains -- continues to be a
16 problem, but would be unintentional injury, that we call now
17 accidents and injuries, as we used to term them, and today,
18 for age one through age 44, still the biggest killer of
19 Alaskans, those ages, with unintentional injury, but the rates
20 of death from them have gone down by a factor of more than 50%
21 and that has been the development of trauma systems.

22 There was no such thing as an EMT in those days or a
23 paramedic. You -- if you were wanting to medivac a patient,
24 you took whatever you could get. You took some seats out of a
25 Cessna and got somebody in to move them there, but we now have

1 trauma systems. We have the incredible lessons of trauma care
2 that have been learned through the various wars that we've had
3 as a country and now you get the advantage of that, if you
4 were in Bethel or Nome or Anchorage or wherever, and there
5 have also been the changes where injuries from automobile
6 accidents with road engineering, with more aggressive
7 enforcement against DUI situations and so on.

8 So those were major areas that impacted us then in a
9 milieu where you were more on your own in those days and where
10 we have seen solutions.

11 MR. HOLT: I'm back on. Okay, thank you, Ward, and from
12 the '60's. So what we were just -- we're going to do a --
13 call an audible -- go ahead, Lincoln.

14 MR. BEAN: I think I (indiscernible - too far from
15 microphone).

16 UNIDENTIFIED SPEAKER: We need you on a mic here.

17 MR. BEAN: I'm sure my voice will carry. I really
18 appreciate Dr. Hurlburt's report on tuberculosis. When we
19 took over the hospital, we always knew that there was a bunker
20 out there that had bodies in there from the TB epidemic time
21 and I don't know if any of you have ever seen that, but it
22 would break your heart because into a rock pit was an ammo
23 bunker with cement walls and the people who died at the
24 hospital from TB, they didn't have money to send them home.

25 So what they did was they had layers of concrete coffins

1 and they filled those coffins and then started another layer.
2 To this day, I've never seen anything like it. The reason I'm
3 telling you this story is because as Chairman of the Alaska
4 Native Health Board, I went to them and I said, "I see your
5 names on this list of the people that are in this cave and
6 it's stacked high. You need to bring them home because
7 they're going to blow this place up and make an airport out of
8 it."

9 I share that history with you because a lot of people
10 don't know and we wouldn't allow cameras to come in to video
11 this. The people, family members, came around and surrounded
12 the door that was welded shut with one wreath of flowers for
13 all those people that were in there.

14 One oriental guy, he came in sick on a boat and passed
15 away and the boat had left, he was in there, and three people
16 from Japan came over and as they opened the door, the three
17 people laid on the ground holding their incense all the way to
18 the entrance in honor of that one man.

19 You will never see this in a book or on camera because
20 we, as Native leaders, said, "We want to tell this in a
21 traditional way, so they don't forget. So that you'll always
22 remember the story came from a Tribal leader that this never
23 happens again."

24 Most of them were sent home. It was the saddest time of
25 you life to stand at the entrance as family members from all

1 over the state came to take the remains home, but there's one
2 story I'll never forget about that. Not all of them were
3 returned and the tribe met in Sitka to see what they would do
4 with these people that weren't -- no one claimed, and like
5 this room, some of the elders stood up and said, "We'll put
6 them in Potter's Field, and we'll take care of their graves
7 and put flowers on them every Memorial Day."

8 It was quiet, and they said, "There's one unknown young
9 lady that doesn't have a name. What do we do with her?"
10 Again, it was quiet like now. An elder woman stood up. She
11 said, "I'm going to adopt her. She'll have my name. Put her
12 in my plots." So now you've heard the story about the TB
13 epidemic with SEARHC before and what had happened.

14 They built their airport. It wasn't without controversy.
15 They didn't video it. My son was the youngest one at the time
16 and even today, he remembers that story. So it never ever
17 gets forgotten, and we'll never forget, and it will never
18 repeat itself. Thank you very much.

19 MR. HOLT: That was powerful, Lincoln. Thank you. Let's
20 just pause for a moment and reflect. It's why we do things
21 like this and the power of the oral history and what you
22 shared with us. I mean, I -- again, thank you so much. That
23 was powerful, and the importance of sharing it in a personal
24 way as opposed to a history book, the power of that, which is
25 what we're capturing today, maybe not to that degree of

1 emotion, but who can know that what you all have shared, what
2 will happen with that to inform future generations of what
3 happened. So again, Lincoln, thank you for that.

4 Here's what we'd like to do, anybody here ever watched a
5 football game?

6 UNIDENTIFIED SPEAKER: Yeah (affirmative).

7 MR. HOLT: Yeah (affirmative), okay. Anyone here ever
8 watched a guy named John Elway.....

9 UNIDENTIFIED SPEAKER: Denver Brocos.

10 MR. HOLT: Yeah (affirmative), right, for the Denver
11 Broncos, Indianapolis Colts, right, I mean, if you're a
12 Seahawk fan, you watched him with glee this last Super Bowl.
13 He's infamous for doing something when he walks us -- and so
14 for those of you that don't play football, the quarter back is
15 the one that walks up and takes the ball and makes the play,
16 but he's infamous for calling what's called an audible, when
17 he comes up to the line and he assesses the situation and he
18 just changes the play right on the spot. We're doing that
19 right now. We're calling an audible.

20 Here's what we'd like to have you do with just -- and
21 we've got probably about 15 minutes to do this. There was
22 some wonderful, as we were kind of interloping, some wonderful
23 discussions that came up about some of the issues and the
24 topics. What we'd like to see and tease out very specifically
25 -- so team leaders, if I can get -- if you're watching me

1 right now, because we're going to kind of, as much as we can
2 hold any of you accountable for anything, you're kind of doing
3 whatever you want, and it's working out, by the way. It's
4 okay.

5 What we'd like to do, is if you could just take like 15
6 minutes right now at your table and really focus on this
7 question, what were the techniques, the strategies, the tools
8 that were informing your decision-making during this time
9 period? So the '80's, the '70's, and the '60's, what were the
10 tools, the techniques, the strategies that were informing you
11 folks during those specific times?

12 So just that, not any more about what -- but really what
13 was informing you in your decisions. Okay, does that make
14 sense? All right, good, you've got 15 minutes, okay, jump
15 into it, jump into it.

16 (Off record)

17 (On record)

18 MR. HOLT: Okay, if you could just take a couple of
19 minutes and kind of wrap up your thoughts and then what we're
20 going to have you do is each one of the team leads from their
21 table that are all talking right now, actually. I'm sorry.
22 Yeah (affirmative), go out the door, you stupid facilitator.
23 Yeah (affirmative), I know. Now that I have very rudely
24 interrupted, because what we would like to do in about two
25 minutes is -- because we didn't actually record this at your

1 specific -- what we'd like to do is get a report out, kind of
2 like, what were kind of the things that were informing your
3 decisions, if you can, and again, we're going to follow --
4 we're going to follow the historical roll-back process we've
5 been using, starting with the '80's to the '70's and then to
6 the '60's, so about two minutes and then we're going to go
7 ahead and start with Nancy.

8 (Off record)

9 (On record)

10 MR. HOLT: Okay, again, the question, not that it really
11 matters much, but the question that we asked you folks kind of
12 to engage on was what were the tools, the techniques,
13 strategies that were actually informing your decision-making,
14 and I know -- I'll have to say this, I sat with the '60's.
15 They actually started answering that question and I left.
16 They were still on the assignment, so I'm very curious to see
17 what Ward reports out after I left, but let's go ahead. Let's
18 start, Nancy, if you could, and then I'll just -- all I'm
19 going to say about this report out is it's what standing
20 between you and lunch, not that matters, but I'm just letting
21 you know that. So with that, Nancy, please.

22 MS. DAVIS: Okay, the 1980's group, we looked at how --
23 how we came to know things and we used experts and specialists
24 to learn new technologies and to inform us about moving
25 forward.

1 The boards, we had, especially among the Native Health
2 Board, Sally commented they learned to trust the staff to keep
3 the board well-informed so that they could make the right
4 governance decisions. Everybody agreed that we all came to
5 know that health is way more than medical and clinical care.
6 It's a huge big picture, including economics and safety and
7 all kinds of things.

8 We all agreed that listening to patients, and I would
9 extend that to families and communities, is the secret to
10 learning and knowing and informing your decisions. One point
11 was that with a consumer, a board of consumers, who are the
12 governance structure, you have direct feedback all the time
13 because you are close to the users.

14 One point was that there was a challenge, but this is one
15 way we got better was finding that communication point between
16 the experts and the communities and Paul mentioned that one of
17 the good parts about the HSA planning process is it kind of
18 forced people into the same room and with several disciplines
19 and they just kind of had to learn to listen to each other and
20 learn from each other.

21 One comment was -- I commented that in the '80s, there
22 were no personal computers in any of the health centers. We
23 had IBM Selectric typewriters, which we thought was great, but
24 that data collection was by the pencil and paper method, and
25 it would dawn on you after you collected enough hashmarks of a

1 particular kind that you might be now recognizing a problem
2 through data.

3 One other thing was that we learned by earning trust and
4 being willing to know things through many different ways, not
5 just data and not just our own personal experience, but
6 learning to know in different ways. We did arrive at kind of
7 an aha moment and we said one of the things that would be
8 helpful would be having a broad convening forum like the
9 Alaska Native Health Board has a system for hearing from
10 everybody and we all commented, "Isn't it funny, we have a
11 Board of Education. We have a Board of Fish. We have a Board
12 of Moose, Game. We have boards that govern almost everything,
13 but we've never seen a requirement to have a Board of Health
14 that had authority." The Health Care Commission is probably
15 the closest that we've come, and we decided we either are
16 doing so okay that there's no compelling push to have a Board
17 of Health or that just no one wants a group with that
18 authority.

19 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
20 microphone) okay. We did try to keep to the assignment,
21 actually, the techniques, tools, and strategies, but what I'll
22 do is I'll put all the techniques that we talked about and
23 then the tools and the strategies.

24 So the techniques that we looked at were the fact that in
25 the '70's, people were being asked to review and approve or

1 disapprove particular ideas and so that was a technique that
2 engaged the community in some ways. Also, the idea that one
3 man/one vote/voice, trying to get consensus within communities
4 was much more of a traditional practice, but we're getting a
5 shift into, well, we'll now have more of a debate and a vote
6 and if there's 51%, we move forward. So it's not quite the
7 solid type of background, but the idea that local decision-
8 makers still do have a say, and that was beginning to happen
9 in the '70's.

10 Another technique was the fact that, as was just
11 mentioned by Nancy, getting health data, and in the '70's, we
12 didn't have Selectric typewriters, so it was even more
13 primitive, and trying to get to that record is really
14 difficult and trying to start compiling it, again because of
15 small numbers and this has always been a challenge in Alaska
16 with any regional group, you're talking small numbers and the
17 statisticians say, "We can't do anything with that. There's
18 not enough numbers." So you know, those were some of the
19 techniques that we were frustrated with.

20 The tools were the fact that we did have the Health
21 Systems Agencies and corporate boards that were beginning to
22 form that did want to participate and engage in these types of
23 discussions. Other tools were the fact that Bobby mentioned
24 that, you know, we went from the stone age to the space age in
25 just a few years.

1 You figure in '69, man landed on the moon, right, and so
2 in the '70's, we were suddenly -- and suddenly, we had
3 telecommunications. We had a satellite and I remember working
4 on the North Slope where the health aides called in on the one
5 phone from the village, that was shortly after they got off
6 the CB radios, telling everybody what the health issues were.

7 So you know, being able to step through this process of
8 telecommunications and that whole improvement, that people got
9 to talk to each other more, versus waiting for mail and other
10 paper to arrive, people were encouraged, let's actually meet
11 face-to-face and have discussions, and that the world was
12 beginning to open up with people coming in with known best
13 practices, you know, what was going on elsewhere in the world
14 that did seem to work in similar situations and could we start
15 beginning to put these together?

16 So one of the strategies was can we apply those tools?
17 Can we see a best practice, see what the community wants and
18 make those merge to get some kind of enthusiasm? Also, the
19 idea of breaking down the isolation, that rural communities
20 were feeling very isolated. They didn't know what anybody
21 else was doing. They wanted to address some particular
22 issues, but how best to do that?

23 So there was an attempt to meld the disparate messages
24 and missions from the various departments into something that
25 made sense for the community and it was a very difficult

1 compaction process, and then the whole issue of empowerment,
2 so trying to build on the civil rights movements that, you
3 know, local communities could have certain says, and to move
4 this forward in a way that was not a cookie cutter, because
5 what everybody was realizing, every area of the state is a
6 little bit different and so the phrase that Brian came up with
7 was community decision support systems.

8 So what was trying to form in the '70's was a mechanism
9 for communities to make those decisions with the support of
10 other structures outside and all of this was fostering
11 resilience.

12 DR. HURLBURT: I think ours was probably a little more
13 generic and it was -- that thought was fostered partly by the
14 difference between -- in the earlier report, where in the
15 '60's, folks were more on their own, but one of the strengths
16 that we've had here, and as Dr. Rhyneer pointed out, driven by
17 a relatively small population, but growing now, is that folks
18 have tended to work together across disciplines, across
19 employee entities, across government and private sector,
20 across the wide range of geography and that has served us
21 well, and as we have more and more Alaskans and have broached
22 3/4 of a million, it's going to be important to ensure that we
23 preserve that, because we feel it really does happen here more
24 than other places and that has been one of the keys to the
25 improvements that we've seen.

1 Related to that, it was also pointed out and both by the
2 examples, such as we heard earlier of how do you block the
3 nerve going to the teeth in your mandible when you don't know
4 anything about it and you're going to pull teeth like several
5 of us, it had happened when we came up here or whatever we
6 did, that we all benefitted by mentoring from people who were
7 knowledgeable here, had been stable here, and knew what they
8 did, and so for those of us in all that -- all of the tables
9 in the room here, it's important for us to accept that as a
10 responsibility, to be cognizant of that for the elders in
11 training, like the 1990's group, that -- to pick up that
12 baton, which Jay does already, of course, but that mentoring
13 has been important.

14 You can go to any state and all states say, "We're
15 unique," but we know we really are here, but there really are
16 unique challenges here. As a surgeon, I used to go to IHS
17 headquarters and talk to people in Washington, D.C. It's like
18 if you had appendicitis in Madison, Wisconsin and had to go to
19 Washington, D.C. with a couple of stops in between, that's I
20 deal with. If you get appendicitis in Wainwright and have to
21 go to Barrow and go to Anchorage and so on, and so that's
22 different. It's unique. Those challenges are unique.

23 So that we thought that working together has been
24 important. It doesn't mean it's always perfect. It doesn't
25 mean we always agree on everything, but people work together.

1 They're committed to doing that and the mentoring has been
2 important and it ought to be preserved.

3 MR. HOLT: Again, thank you. Thank you, folks, for those
4 perspectives. I just want to echo something I heard in the
5 '60's, which was this, the mentoring construct. I've worked
6 in a lot of states. I've worked in other smaller states. It
7 is not the same. There's a unique culture up here that I do
8 think you need to leverage forward and that's the whole idea
9 of understanding that there are those that went before you
10 that can offer you something.

11 That -- the culture here, and why this is called Health
12 Elders, is that what we're calling this?

13 UNIDENTIFIED SPEAKER: (Indiscernible - too far from
14 microphone).

15 MR. HOLT: I do, yeah (affirmative). It's evolving with
16 the -- we can thank the '70's for that. The -- yeah
17 (affirmative), but I think there's some things that are unique
18 to your state that I just encourage you, as the outsider
19 facilitator, who's not supposed to give any counsel, that you
20 continue to honor that forward, and this whole construct of
21 mentoring and people that you can learn from that have walked
22 the path, I think still is accepted in the culture up here and
23 valued, and I would strongly counsel you to run with that as
24 far and hard as you can, because just even as you listen here,
25 there's nothing that replaces the human interaction, nothing.

1 There's no Google site yet that can have the same kind of
2 impact on a life that a conversation can with someone else.
3 So with that, let me turn it over to Deb for -- I want to
4 personally, just thank you all. You actually stayed to the
5 script pretty good and for a bunch of leaders and problem
6 solvers, thank you for actually staying within the guidelines,
7 to quote the "Pirates of the Carribean," that we kind of set
8 up for you folks today, so thank you, folks. Let me turn it
9 over to Deb for kind of the next steps and closing remarks.

10 MS. ERICKSON: Yeah (affirmative), and again, thank you
11 all so much for taking time out of your busy lives to be here
12 today. The -- I think the main reason, and when I first got
13 the idea to bring you all together was following on Ward's
14 point, recognizing the importance of mentoring, and many of
15 you, if not most of you, have been real important teachers and
16 mentors for me.

17 I remember, I had not been thinking about this, but had a
18 flashback first thing this morning to Paul putting me on a
19 very small airplane and sending me out to a village, I think
20 in the mid '80's, when I showed up in Fairbanks and he was
21 running the Tanana Chiefs Conference and just looked at me,
22 he's like, "Go learn something from the community health aides
23 about how this really works here," and Brian had to step out
24 of the room, but I learned so much from him when he was Deputy
25 Commissioner and the years following the work of the Health

1 Systems Agencies and state health planning, reflecting on how
2 important stories are, and I first learned, I asked Lincoln
3 earlier this morning if he thought it would be okay if tell a
4 story -- a story about Della Chini (sp), who's from Kake.

5 I was working on public health improvement at one point
6 in the late '90's, and Della was from, at that point, the
7 community of Sitka and working a statewide public health
8 improvement process and I was -- would facilitate group
9 discussions and at one point Della looked at me and she said,
10 "You're not listening to me," and I was very taken aback,
11 because I thought I was such a good listener and at least
12 adequate facilitator and trying to explain that we were, you
13 know, working through a process and we needed to -- and we had
14 an agenda to stick to, and she just kept saying, "You're not
15 listening to me," and so I started.

16 I started listening to Della and I continued to get
17 frustrated because we would be talking about systems and she
18 would start -- and she would tell the story of her father
19 taking her into the forest and turning over logs and how they
20 would look at the ecology of what was going on with the
21 different types of insects under the logs, and I would look at
22 her and say, "We're talking about systems. Why are you
23 talking to me about bugs," and then we were talking about the
24 importance of systems and partnerships and she would start
25 telling stories about migrating geese and how they supported

1 each other and the lifts that their wings would give each
2 other, and I would look at her and say, "Della, we're talking
3 about partnerships and collaboratives, why are you talking
4 about geese," and another point, when we were talking about
5 infrastructure and Della was a weaver, probably still is a
6 weaver, and would explain the roles that the warps and the
7 wefts would play in weaving and I would look at her and say,
8 "Della, we're talking about infrastructure support. Why are
9 you talking to us about weaving?" I eventually got it. I
10 have a really thick head, but I did, I started listening to
11 Della and I started getting it, and those stories are so
12 important. We have witnessed so much success in healthcare
13 and in public health in this state over the decades.

14 One of the things that is just so amazing to me, just as
15 one example, the fact that we went maybe 10, 12 years ago,
16 Ward, from being 49th in the country for infant mortality,
17 neonatal mortality, and we're now number one, and that was for
18 having the best in the country, and it was work that folks did
19 at the community level, partnerships between the medical
20 community and the public health community and others, working
21 deliberately on the process to make that sort of improvement.

22 We have real serious challenges right now and -- but you
23 all were dealing with serious challenges at the time, too.
24 Things were -- we were focused on access and quality. Right
25 now, we're struggling with questions of sustainability. We

1 have, it seems to me, so many more layers of rules. It feels
2 like we're so much more money-driven and we need to figure out
3 how to get back to where -- to how we were informing ourselves
4 back then.

5 So the Commission's at a point right now -- so this isn't
6 just about this project we're working on. The Commission's at
7 a point right now where we've spent the past three years
8 really more in kind of a study and advisory role.

9 We've been very focused, and probably will continue to be
10 very focused on acute medical care, because there is no other
11 group working on that, where there are groups working on other
12 areas, but we're looking at how -- evolving and taking on a
13 new role and this is something we'll be talking about over the
14 next couple of days because we are just advisory and I would
15 not anticipate being handed any more responsibility beyond
16 that at any point in the near or distant future, but we do
17 have this body, where we haven't had one for quite a while, a
18 statewide group responsible for looking at these issues and
19 providing a forum for it and we're going to be talking,
20 particularly tomorrow morning, but over the next couple of
21 days in that meeting, about taking on more of an action role
22 and seeing what we could do to start serving as more of a
23 convenor and a facilitator.

24 So hearing these stories and being informed about the
25 issues you all were dealing with 40, 30 years ago, 50 years

1 ago, some, has been really helpful. I'm glad we've been able
2 to capture it here. As I mentioned earlier, it will in part,
3 inform this Health and Health Care in Alaska 2014 project.
4 We'll have the video posted on that website and we're getting
5 ideas from some of the folks around the room about sharing it
6 with medical students, new public health students and we will
7 be bringing -- we've had Commission members at the tables as
8 elders, but also sitting and listening, as well, and we'll try
9 to bring some of the ideas about innovation and collaboration
10 that you all have talked about forward, as we kind of enter
11 this new phase.

12 So with that, I think lunch is going to be ready in just
13 a few minutes. Should we invite some closing comments? Yes.

14 UNIDENTIFIED SPEAKER: I'd like to just, you know, since
15 this is a public record, that the quarterback for the Denver
16 Broncos was Peyton Manning, not John Elway. John Elway was
17 older and he currently is the general manager.

18 UNIDENTIFIED SPEAKER: Thank you for that (indiscernible
19 - too far from microphone).

20 MS. DAVIS: At one point, you asked us, I think, to talk
21 a few minutes about after our first session, kind of, you
22 know, what things would we bring forward to the now, and one
23 of the things that our table talked about was, you know,
24 obviously partnerships and collaborative and coordination
25 between the system is important, but one of the comments was

1 that urgency toward a particular issue was important to get
2 people to act, and we commented that the real pressing thing
3 coming to healthcare is really chronic disease and the aging
4 demographic, the silver tsunami.

5 One of the things that was commented was it's harder to
6 get urgency about chronic disease issues and that may be one
7 of our huge challenges to translate the urgency of Hepatitis B
8 and TB and the things that we faced during the '60's, '70's,
9 and '80's, how do we bring that sense of urgency to act when
10 our maybe biggest problem is going to be chronic disease and
11 the aging, the impact of an aging demographic. So as the
12 group leader, I forgot to say that a long time ago, but I
13 think that is -- that's kind of a closing comment.

14 MS. ERICKSON: (Indiscernible - too far from microphone)
15 or questions? Yeah (affirmative), well, I -- Dr. Saylor.

16 DR. SAYLOR: There are a lot of us who have great hopes
17 for the Commission and some of it, at least for me, is
18 revisiting this -- this attempt at systems planning that had a
19 brief life, but wonderful promise and a lot of us that were
20 involved in that era saw something that I think would be
21 invaluable as our current healthcare delivery system changes
22 so rapidly.

23 The thing that Nancy was talking about, how do we, as a
24 state, respond to that in a coherent way, all the way from
25 training, all the way to deployment and changes of scope and

1 practice and reimbursement mechanisms and managed care and
2 intensive case management for people with chronic conditions,
3 those are not decisions that are typically made in silos, that
4 are either funding streams or facilities.

5 They're made collectively at the lowest level possible.
6 So at least the structure that is emerging through the
7 Commission to begin to bring back this planning process and,
8 at the very least, a forum, a broad forum where the public
9 discussion of these issues, I think is invaluable. Don't lose
10 the opportunity.

11 MS. ERICKSON: I think that was probably a great closing
12 comment. So what I would suggest for those of you, and I'm
13 sorry, Paul, we ran out of time, but we have lunch now. If we
14 -- if anybody wants to talk about either what the Commission
15 is doing now and will be doing next, if you want to talk about
16 some of the issues that are challenging or frustrating you
17 today, we have -- they'll probably going to be want to be
18 setting up for tomorrow's meeting at some point, but we have
19 this room for the afternoon.

20 We have lunch now and all the members of the public who
21 sat in, too, are welcome to join us for lunch. It's just
22 outside the door. You can bring it back it, but I would be
23 happy to stick around and have a conversation with anybody
24 who's interested in kind of talking about where we're at today
25 and where we're going next, but in the meantime, thank you,

1 all, so much for coming in and sharing your experience and
2 your reflections and your wisdom and some stories from some of
3 the olden days. We really appreciate it. Thank you.

4 11:37:34

5 (Off record)

6 **SESSION RECESSED**

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