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ALASKA HEALTH CARE COMMISSION

WEDNESDAY, OCTOBER 1, 2014

9:00 A.M.

DENA'INA CIVIC & CONVENTION CENTER

600 WEST SEVENTH AVENUE

ANCHORAGE, ALASKA

BREAKOUT SESSION OF 1970'S

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1 had money for health and he asked them to come up and look at
2 whether or not they'd be willing to fund programs up here, and
3 a guy named Bill Bicknell, who later became the Commissioner
4 of Health in the Commonwealth of Massachusetts and funded an
5 international health program at Boston University, came and
6 looked over the state.

7 It turned out that he had been in Africa with Dr. John
8 Lee, who was the Area Director of the time. They had both
9 been in Africa implementing the Barefoot Doctor Program, which
10 was actually developed by a guy named Rex Fendall from
11 England, and so I'm this young buck and I go to this meeting
12 over at the area office.

13 There are 50 people in the room and Bicknell is asked to
14 speak to all the heads of the various departments of the
15 Alaska Area Indian Health Service about what he was here to
16 do, and he stood up and he said, "Well, we're about empowering
17 poor people and having them have a greater say in their health
18 care," and Dr. Lee -- or he said, "John," he didn't say, "Dr.
19 Lee," which was -- nobody ever called him John, said, "Dr.
20 Lee, you and I were in Africa together. We were peers. We
21 were cohorts," he said, "and you know better."

22 He said, "My considered advice to the Alaska Federation
23 of Natives is that they sue you and the federal government for
24 murder, because your healthcare system, which provides no
25 access to primary care, is creating unnecessary death." You

1 could have heard a pin drop in the room, and at that point,
2 the programs that were funded initially in Bethel and then in
3 Nome a year later, became the enemy of the Indian Health
4 Service because it was stated, "We are your enemy."

5 The moral of that story for me is that real change takes
6 courage, and that was a very courageous step for Bicknell to
7 take.

8 DR. SAYLOR: He was fearless.

9 MR. DANN: Absolutely fearless.

10 DR. SAYLOR: Yeah (affirmative).

11 MR. DANN: Yeah (affirmative). So anyway, it was
12 something I wanted to have, you know, on the record from the
13 '60's, as to how it all got started. He was absolutely
14 outraged by what he saw in Bethel and Nome.

15 DR. HILD: I'd actually like to follow up on that,
16 because I was originally asked to sit at the '60's table, and
17 decided that I was more appropriate for the '70's, but one of
18 the things that I use quite extensively is a document that
19 most people don't know, and I brought a copy to just drop off.

20 This is the Barrow Conference on Native Rights from 1961.
21 So two years after statehood, the Alaska Natives gathered in
22 Barrow and it was a broad group of people and their concern,
23 number one, was food security. This was right after the
24 famous Barrow duck-in, where the agents said, "You cannot
25 shoot these migratory birds because they're out of season, but

1 when they are in season, they're not in Barrow," and so the
2 people did this major duck-in.

3 At the same time, there were plans for making a harbor
4 near Kivalina and Point Hope called Project Chariot, and the
5 people said, "No, we don't think we'll....."

6 UNIDENTIFIED SPEAKER: Point Hope, yeah (affirmative).

7 DR. HILD: Yeah (affirmative), this is not going to
8 happen. So they put together this whole list of aboriginal
9 rights and one of the things they talk about is they needed to
10 have control over subsistence so they can have better foods.
11 The villages needed to be informed about hunting rights and
12 work with the Department of the Interior, that they needed to
13 address Project Chariot and get that stopped, that food be
14 allowed, that people should have more access to subsistence
15 foods, that education -- kids shouldn't be sent out to Mt.
16 Edgecumbe, that there should be local schools, that housing
17 should be made available, better housing and sanitation, that
18 there should be employment, roads, transportation, that there
19 needs to be more hospitals throughout the state, and you know,
20 as you go through this whole list, it's kind of like this is a
21 foundation doc, in that many other things that followed, and
22 one of the people who attended this was a young guy from Point
23 Hope by the name of Howard Rock, who was then given money by
24 this group to start the "Tundra Times."

25 So I mean, this is so incredible because it's this

1 courage to stand up. I mean, the whole civil disobedience of
2 the duck-in, for people to say, "No, we are going to change
3 things and here's a road plan for what we want to see in the
4 future," and so I think you're right, it takes a lot of
5 courage, but I think people were looking for other tools from
6 outside.

7 Civil disobedience was one that was coming up in the
8 early '60's, and you know, how can we get the attention for
9 people to pay attention to what our issues really are.

10 MR. DANN: Just to follow on that, there was a guy --
11 right after I arrived in Nome, I came across this article. I
12 don't remember how I got it, by a guy named Sal Katz (sp). He
13 was still living. He's a professor of -- I think the field is
14 physical anthropology, something like that, at the University
15 of Pennsylvania.

16 Some of you may remember Jim Haun (sp), who was in Nome
17 for a few years. He was one of Sal's students. And the paper
18 was based on observations from research he did in Barrow and
19 his theory was that the reason that the health status of
20 Alaska Natives is in decline, is that they have no control of
21 their lives, and it was inspiring to read. So it's all just
22 part of the same thing, yeah (affirmative).

23 DR. HILD: Right, and the work that Chandler and Milan
24 (sp) have done in Canada have shown that if there are six
25 factors in a community where there's local empowerment, so the

1 people are in charge of their own school and the school
2 district. They're in charge of the policy department.
3 They're in charge of health. They're in charge of the local
4 council assembly. If these six factors are in place in 135
5 First Nation villages, if all six are there, suicide goes to
6 zero, and if five are there, suicide rates go way down, but
7 not quite to zero, and so they put this whole graduate scale,
8 and you know, what a wonderful thing to do in Alaska, to do
9 that same kind of assessment, because in Canada, it was done
10 with First Nations groups, who are more like our Athabascans,
11 but it would very interesting to do it among the Inupiat and
12 the Yup'ik and then in Southeast, as well, to see are there
13 cultural differences to that kind of community empowerment,
14 community control, does that make a difference?

15 MR. DANN: Yeah (affirmative), because if you think of
16 it, there is control now, but it's at a statewide or a
17 regional level, right, I mean, control of their own health
18 system, control our corporations, et cetera, and the people
19 that are involved in those systems, you know, have prospered,
20 but there's not community in it. There's not control in the
21 village. You know, they're not -- they're still not in
22 control of their being able to provide food for themselves, et
23 cetera, you know, be able to have their own court systems, so
24 anyway.

25 DR. HILD: So getting back to our two primary questions,

1 the significant health issue in that case, was that there was
2 so much death in the community and in the hospital. The
3 delivery system wasn't working and that what informed the
4 solution was a Barefoot Doctor Program from out of Africa, and
5 what I was saying was that the events.....

6 MR. DANN: And self-determination, I think, yeah
7 (affirmative).

8 DR. HILD: Exactly, and those things built upon that by
9 looking at those, and I was saying that the idea of the Civil
10 Rights Movement, the passive participation in the duck-in, but
11 taking a real stand on important issues are one way to address
12 significant problems.

13 MR. DANN: The other piece of this, I think, historically
14 is that you've got a number of census here, but every path
15 along the way, the federal government basically resisted the
16 change and so there's a historical precedent here that if
17 you're going to do something meaningful, government is not
18 going to be the solution. Government is the great holder of,
19 you know, the protector of the past, the way it is now.

20 You know, there is -- the bureaucracy, just by its very
21 nature, the culture within the organization is about
22 maintaining the way things are. So it's not going to be an
23 innovator, and I think that's a timeless lesson.

24 MR. CLARK: Yeah (affirmative), anyway, the way I look at
25 a lot of it is kind of like the Department of War over

1 Interior over BIA over IHS, and only until recently, you know,
2 getting into the '70's and really '80's and even '90's, where
3 the Native people have a seat at the table. It was for a
4 while IHS and then the state and then later, they added the
5 ANHB, which is the Native groups inroad, so you pretty much
6 fill the circle, but up to that point, there was like, do it
7 our way, and it was really directed by war and we're the boss.
8 We're the sovereign. You're not. You're subservient to us.
9 So I think -- and even the missionaries, even though they were
10 well-meaning and did a lot of good, the same thing, they
11 suppressed a lot of the local things, whether it's the shaman
12 or any way you did stuff, it was not really good and made you
13 feel inferior and feel like you don't have any real say.

14 So hearing and seeing things that the blacks did, that
15 Chicanos and others around (indiscernible) John Shively and
16 all those folks were bringing the money home and making things
17 work here is where we started feeling more empowered, and
18 before that, because we were talking about land claims and a
19 little bit of some of the stuff from the early '60's, it's
20 started germinating and then really took more hold of it with
21 ANCSA and then right after because it was by '76 that we
22 finally had all the health corporations and then later, the
23 self-determination law, the healthcare improvement law, the
24 state (indiscernible) stuff, but it's the state, and I think
25 it's '49, they still have not updated their public health law.

1 That's another one that maybe needs to be brought in and
2 looked at.

3 So we're sort of outsiders and advisory only. We didn't
4 have any real power to -- '68 on is when I just started
5 listening and getting the advisory committees, but even
6 through '73 through '76, is I think when we done away with the
7 advisory committee saying, "With all due respect to you guys
8 over there at IHS, and I know you're doing well and you want
9 to do well, we've got to be in control of more of the stuff
10 there," and that's where it started taking a lot more hold,
11 but we -- the state seemed to step back on the money and the
12 services and then we're expected to do it.

13 It seems like today, the health aides are really the
14 public health nurses. The health aides are really carrying
15 the water in behavior health and otherwise, and that's really
16 frustrating. Where I'm at, I get 32 million from IHS and two
17 million from the state, a pittance, and they keep cutting
18 back. Yeah (affirmative), they serve everybody. They serve
19 way more, but I see this health problem, is the health status
20 is still an issue, but the health system, the other side of
21 it, the facilities and infrastructure, no HIE yet, it's coming
22 and all these things that are not quite in place, not buying
23 into the Affordable Care Act for the good and the bad of it
24 and the Medicaid people, 60 -- 40,000 to 60,000 people
25 disenfranchisees, particularly the inebriates and many of

1 those are our own Alaska Natives.

2 They can't get anything. Anything they do is under the
3 table. Maybe I could fish, maybe I can't. I'm not getting
4 wages, you know, nobody's paying my way. Yet, I'm eligible,
5 but they won't trust me. I did my time. Help me. They're
6 not doing it, and this state could do it, but they're not
7 doing it. So there's a lot of lessons learned.

8 MR. DANN: I'm going to follow up on something Robert
9 said, just to (indiscernible) point. When I went to Nome to
10 try to establish the health corporation, they had already had
11 War and Poverty programs around. The Rural Development Agency
12 was there.

13 MR. CLARK: Yeah (affirmative), the Rural Cap and the
14 AFN, the old (indiscernible - speaking simultaneously).....

15 MR. DANN: Rural Cap.

16 MR. CLARK: John Shively bringing the (indiscernible -
17 speaking simultaneously).....

18 MR. DANN: Yeah (affirmative), so I went -- I went around
19 to each community to try to get people on those boards and
20 they said -- to get on the Norton Sound Board, and they said,
21 "We've been on those boards. They're a waste of time. We
22 have no power to do anything. We have no resources to do
23 anything. Yeah (affirmative), it's nice to get a trip to
24 Nome, but no, I'm not -- I'm not going to serve."

25 MR. CLARK: Yeah (affirmative).

1 MR. DANN: Or in some cases, the councils would say,
2 "We're not going to elect anybody," and the only thing that
3 turned it around was saying, "No, you don't understand, we
4 have," what at that time was a lot of money, "\$153,000," and
5 they were like, "Really?" "Yeah (affirmative), and you will
6 program what that money is going to do."

7 So the moral of the story for me is that if you're going
8 to empower people, you have to give them resources. You have
9 to trust them and give them the resources. You -- advisory
10 just doesn't work. So they were already disillusioned in
11 1970.

12 MR. CLARK: Yeah (affirmative).

13 DR. SCHRAER: Yeah (affirmative), I would -- I would echo
14 that with the development of the Diabetes Program, that when
15 we started out, it was -- well, we didn't have any specific
16 funding for it, but Ward Hurlburt had worked in the Lower 48
17 and saw what a problem diabetes had become for a lot of the
18 tribes down there because of all the complications, and we got
19 a little bit of money one year from IHS to do some travel and
20 start doing some training in the villages and we had a lot of
21 people, well, I shouldn't say a lot, there was at least one
22 person in every region who was sort of a missionary spirit who
23 added on extra diabetes care and (indiscernible) Charlie out
24 in your region and others who added onto their routine duties,
25 trying to do activities in prevention and improving the care

1 of the diabetes patients and so on, but it wasn't really until
2 the SDPI, the Special Diabetes Program for Indians, where the
3 funding came in 1998 that enabled lots of positions to be
4 created to actually pay people, you know, give them the time
5 to invent community activities that suited the communities,
6 work on setting up clinics, providing the standard diabetes
7 care and that's really in jeopardy right now with the mood of
8 Congress, because it's a congressional appropriation.

9 MR. CLARK: Yeah (affirmative), year-to-year.

10 DR. SCHRAER: Yeah (affirmative), it's linked to one
11 year-to-year and (indiscernible - speaking simultaneously).

12 MR. CLARK: I'm trying to get five years and try to get
13 150 million to 200 million, but.....

14 DR. SCHRAER: Yeah (affirmative), or even to keep what
15 we've got is the big.....

16 MR. CLARK: Yeah (affirmative), exactly.

17 DR. SCHRAER:big concern.

18 DR. SAYLOR: And the empowerment -- I think the
19 empowerment issues that we're all talking about, extended far
20 beyond the evolution of the Alaska Native healthcare.

21 MR. CLARK: Yeah (affirmative).

22 DR. SAYLOR: You know, under the health planning stuff
23 that we were all involved with,.....

24 MR. CLARK: Yeah (affirmative).

25 DR. SAYLOR:these planning groups that were set up,

1 you know, comp health planning earlier, but then finally, the
2 National Health Planning and Resources Development Act, which
3 established the three regional planning agencies since state
4 apparatus.....

5 MR. CLARK: Yeah (affirmative), right.

6 DR. SAYLOR:were -- probably had more
7 responsibility than almost any previous group, but more than -
8 - I think for approval and disapproval, review and approval,
9 more than review and comment, which it had been before.

10 MR. CLARK: Yeah (affirmative), yeah (affirmative).

11 DR. SAYLOR: But they -- they actually had some juice,
12 and not only that, they were required by law to have a certain
13 kind of geographic distribution, and I mean, you guys were all
14 on it. We were all on it, I think from rural communities.

15 MR. CLARK: Yeah (affirmative).

16 DR. SAYLOR: You were in Nome. I was in Cordova, and you
17 were at home.

18 MR. CLARK: Yeah (affirmative).

19 DR. SAYLOR: And there were -- so there was geographic
20 representation and there was consumer representation, with a
21 certain amount of juice there.

22 MR. CLARK: Yeah (affirmative).

23 DR. SAYLOR: And more, I think that just as important as
24 -- during the evolution that you guys were experiencing, the
25 devolution transfer of management responsibilities, there were

1 opportunities to pull together, as the lines were being
2 blurred between beneficiary care and military care and
3 veterans care and then the private or nonprofit hospital
4 system, the medical care delivery system.

5 There was only one place where all of these issues could
6 be discussed and that was it. That was the only time during
7 this rapid period of change, systems change, that I think,
8 gave rise to a lot of the improvements of health status, if
9 there were any to speak of. That was the only forum that we
10 had and now, now that we really need it, it was discontinued,
11 what, in '80 -- mid-'80's under the Sheffield Administration
12 and now we really need it more than ever.

13 MR. DANN: You know, I've been thinking a lot about this.
14 I mean, I don't know what the ingredients were, but to me,
15 those HSAs were the most creative period where Alaskans of all
16 stripes came together and innovated that I've experienced. I
17 mean they did absolutely some remarkable work. I mean they
18 designed things that had never ever been seen before and what
19 are the lessons, you know, we have -- we still have this
20 divide, the urban/rural divide.

21 There's some lessons there. I'm not -- I'd be interested
22 in your guys' perspective on what it is, but in addition to
23 all the people on the Board liking Robert and his buns, which
24 they talked about quite a bit -- they thought he was very
25 cute. They were, you know, they actually were taken into the

1 field to see the conditions out there.

2 MR. CLARK: Yeah (affirmative).

3 MR. DANN: And it just totally shifted their reality.
4 They had no clue and so what developed was this incredible
5 mutual respect, where the people in the rural areas could take
6 advantage of the expertise and experience of urban folk and
7 the urban folk were just -- got tremendously excited about the
8 challenges out there and designing a system that worked for
9 everybody, and I think it was a real renaissance period and I
10 don't know what you guys -- what the magic sauce was that made
11 that happen, but.....

12 DR. SAYLOR: I think the magic sauce was the club that
13 the federal government had to make this happen under that
14 federal law that you needed to have agencies that would bless
15 certain programs and some were exempt. Some of the -- some of
16 the programs were.....

17 MR. CLARK: Excluded (indiscernible - speaking
18 simultaneously), yeah (affirmative).

19 DR. SAYLOR:Alaska Native beneficiaries were
20 exempt, but by and large, everything funneled through there.
21 So they may not have had the sort of the whip to ensure
22 coordination, but what it did ensure was dialog, and so if I'm
23 Providence and I wanted to build a new wing or whatever, Bobby
24 Clark had to think that was a good idea.

25 DR. SAYLOR: But that's right.

1 MR. DANN: And the best use of funds, and so it forced
2 that respect for his point of view. That's a good point.

3 DR. SAYLOR: And if a Certificate of Need was not issued
4 and it started at the regional level -- so Bobby, you're there
5 saying, "You know, I'm really concerned about this Providence
6 thing because," I mean, good arguments, if they prevailed on
7 up the line, then all of the revenue that Providence would
8 have gotten from public programs that were directly associated
9 with that expansion would be denied. So it's real money.

10 MR. CLARK: Yeah (affirmative), yeah (affirmative).

11 DR. SAYLOR: It wasn't chump change. It was real money.

12 MR. CLARK: And whether it was then or today, the need is
13 so great with so little resources and you've got to share and
14 not duplicate to the degree that you can, particularly if
15 you've got your hand out to the government for Medicare or
16 Medicaid or whatever it is, it doesn't matter, I mean, you've
17 got to kind of give and take. I mean, yeah (affirmative),
18 you've got to be -- have a good business plan. You've got to
19 have a good return on investment. You've got to stay alive
20 and well in order to provide it, but it's the sharing and
21 you've got to see the health status improving.

22 I mean, if you get something, you've got to show
23 something. It can't be just money that you take, you know, in
24 a brown bag on a stump, and you know, back then, you probably
25 could have gotten away with it and people actually did. I

1 mean, this idea of murder, it is, in fact, true. I mean, the
2 Violet Arrow case where you've got a million-dollar suit, they
3 knew this lady had alcohol problems, just let her sleep it
4 off. It will be all right. Well, she died -- a big suit,
5 malpractice issues, you know, risk, and then people start
6 thinking about, well, we better do something.

7 I mean, whether you call it best practices or risk
8 avoidance or whatever, who cares. You've got to take care of
9 people and try to treat them well and if you've got a facility
10 and people aren't invited there, that's not fair. That's not
11 good. Share, share what you've got. So the tribal
12 organizations serve everybody. It's just, you know, just
13 different payment schemes. I mean, we don't have anybody out
14 there. Nobody can afford to come out, as it is anyway. It's
15 so dog-gone expensive, so make it be all that it can and try
16 to integrate and work with all of the systems, everybody at
17 the table.

18 DR. HILD: I was going to say is what I'm hearing is a
19 great deal of information in regard to having policy-makers
20 become aware of what's going on in the rural areas.

21 MR. CLARK: Yeah (affirmative).

22 DR. HILD: How often is it that the rural people need to
23 go to where those policy decisions -- Washington, D.C., going
24 to Juneau, going to places where people are making big
25 decisions? When I mentioned the Stockholm Convention, one of

1 the key pieces was to get Alaska Natives to the meeting in
2 Johannesburg, South Africa prior to that final document,
3 because.....

4 MR. CLARK: Yeah (affirmative).

5 DR. HILD:the Native people who showed up from
6 Alaska.....

7 MR. CLARK: Yeah (affirmative).

8 DR. HILD:made a serious point that this is in our
9 food now.

10 MR. CLARK: Yeah (affirmative).

11 DR. HILD: It was never here before. These contaminants
12 are now there and that changed a lot of people's opinion to
13 say.....

14 MR. CLARK: It won't happen if you don't go there. I
15 mean, they're good people. I like a lot of the missionary
16 stuff, but I also like -- don't like some parts of it, but
17 they were more -- they were very caring people. Today,
18 they're there for the dollars. They're in and out, in and
19 out, you know. I want to try it, you know, as a -- you know,
20 when people don't go into a job for a life thing, it's just
21 boom, boom, boom, boom.

22 That costs a lot of dog-gone money and we're trying to
23 work our people up, but everything has some value, but if
24 you're not at the table, you can effectuate any real policy
25 change. You can't really tell the story of what's happening

1 in the trenches. They don't always get out. They're better
2 at it, including API sending their people out and having trips
3 and seeing it.

4 You can't really tell them what a honey bucket is until
5 you go out there and you have to go and find one and see it
6 and smell it and.....

7 MR. DANN: Robert, I would want to hear your perspective
8 on this. I think there's a huge difference between you going
9 to the power brokers on their own turf and advocating and
10 getting the power brokers to come to your turf.

11 MR. CLARK: Yeah (affirmative).

12 MR. DANN: The latter is just hugely more effective.

13 UNIDENTIFIED SPEAKER: Absolutely.

14 MR. CLARK: Yeah (affirmative), it is and thanks to
15 Stevens and the people can beat up on him all they want, he
16 brought them up and other people are bringing them up. Those
17 people have to come up and see, and all of those mucky-mucks,
18 they call them, you know, big shots in the D.C. level,
19 commissioners and whoever, assistant secretary or the
20 secretary, if they come, they tend to say, "Yeah
21 (affirmative), you have a need. I'm going to get some bucks
22 for you. I can see it. I know it."

23 DR. HILD: But didn't you just make the reverse point of
24 that, that people need to go to D.C. as well, from the
25 community?

1 MR. CLARK: Yeah (affirmative), both places, yeah
2 (affirmative).

3 MR. DANN: But you may need to go to D.C. to get them to
4 come to your turf.

5 MR. CLARK: Sure.

6 MR. DANN: Okay, I'll share with you my last story about
7 the '60's. What were the healthcare delivery issues? Well,
8 one of them was there was no facility for a health aide to
9 work out in the village.

10 MR. CLARK: Yeah (affirmative), it's out of your home.

11 MR. DANN: None, okay.

12 MR. CLARK: Yeah (affirmative).

13 MR. DANN: So when I went to Dillingham, I mean, the
14 hospital ran itself. They don't need an administrator. The
15 real problems were in the villages. So to address this issue
16 of no facility in the village, I worked with the canneries in
17 the villages and there were two villages that got a loan from
18 a cannery to purchase materials to build their own clinic,
19 okay.

20 Now the issue was, would the Indian Health Service lease
21 them. This is a story of how the village built their own
22 police program (indiscernible). The decisions came down,
23 absolutely not, we will not. Well, at that time, Dr. Emory
24 Johnson, who was the national Director of the Indian Health
25 Service was making a trip to Alaska and everybody wanted to go

1 to Kanakanak. That was kind of the garden spot, we talked
2 about earlier, where everybody wanted to be. There's fishing,
3 you know. There's nice people (indiscernible - speaking
4 simultaneously).

5 UNIDENTIFIED SPEAKER: Food (indiscernible - speaking
6 simultaneously) good women (indiscernible - speaking
7 simultaneously).

8 MR. DANN: So he came out and I.....

9 MR. CLARK: Yeah (affirmative).

10 MR. DANN:basically trapped him.

11 MR. CLARK: Yeah (affirmative).

12 MR. DANN: So I took him up to, I think it was Ekwok. It
13 was one of the two villages that had built their own building.
14 It was about 90% done, no heat. It was in the dead of winter,
15 cold as hell.

16 UNIDENTIFIED SPEAKER: Good going.

17 MR. DANN: Yeah (affirmative), and he goes, and you know,
18 I have pictures of it and there are people, you can see the
19 frost as they're breathing, and he's up to talking to the
20 people in the community and they toured him to the clinic and
21 they said, "We have no money to heat this building," and he
22 initially said, "Well, we have no money to pay you for oil."

23 After an hour-and-a-half of -- because they would listen
24 to him and they would -- they would look at their feet. They
25 wouldn't look at him because they were so disappointed in what

1 he was saying, you know, that he was completely dishonoring
2 this effort they had made to build their own facility,
3 financial risk to get the loan from the cannery and so on, and
4 at the end of the hour-and-a-half, he gave and he said, "All
5 right, we will lease your clinic," and that's how the village-
6 built clinic lease program happened. Had he never been
7 brought to the field, who knows? He.....

8 UNIDENTIFIED SPEAKER: There was (indiscernible -
9 speaking simultaneously).....

10 MR. DANN: But he could not stand and face those men who
11 had built that clinic with their own hands and say, "I won't
12 help you."

13 MR. CLARK: But from those days to today, we're suing the
14 government because they are only paying half of what it costs
15 to operate the clinic and we get a penny none from the State
16 of Alaska, yet we allowed a public health person, everybody to
17 use the clinic. It's just not fair. So the communities that
18 put in whatever they can, they're destitute, too. They can't
19 really put it in and today, the clinic is joint-commission
20 accredited, which means it has to be kept up and the dollars
21 are less than half. So thanks to (indiscernible) and the four
22 of us, we're suing them and we won in court, but that doesn't
23 mean we really got the money, or you know, we won one hurdle,
24 but we've got more to go, on behalf of all the villages. It's
25 taken that long. We're still held to something from the '60's

1 and '70's, those days, the same old rules that don't even
2 apply. They're so antiquated and yet, through ANTHC and HB
3 and everybody else and the state, we've come up with the
4 modern clinic and Denali helped build, in my case, 16 of 27
5 and they're state of the art, but no money, and we have to put
6 our own money in to keep it up, because if they fail, we fail.
7 They're the outpatient part of the hospital at the village
8 level. They're your neighborhood clinic, whatever you want to
9 call it, and some things have really come and some things are
10 still -- we're fighting, fighting, fighting for.

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

13 DR. SCHRAER: Well, another problem, I think, with the
14 funding deal, which it comes up at ANMC, is that nowadays, the
15 reimbursement for procedures, surgical procedures,.....

16 UNIDENTIFIED SPEAKER: Yeah (affirmative).

17 DR. SCHRAER:is better. So that -- I mean, it's
18 better than providing preventative care, general outpatient
19 care, et cetera, and so there's a lot of pressure to do
20 reimbursable technologic procedure sort of stuff and one arena
21 in this that may be impacting us is amputations in people that
22 have diabetes.

23 UNIDENTIFIED SPEAKER: Yeah (affirmative).

24 DR. SCHRAER: You know, I don't know the details of the
25 finances,.....

1 UNIDENTIFIED SPEAKER: Yeah (affirmative).

2 DR. SCHRAER: But basically, performing an amputation is
3 a procedure. Performing a lot of detailed foot care doesn't
4 get you the reimbursement that procedures do and I think.....

5 MR. CLARK: But that's where that -- those grants, like
6 the diabetes grant help a lot to do, population health
7 and.....

8 DR. SCHRAER: Yeah (affirmative).

9 MR. CLARK:the 20/20 plan and all those. Those are
10 still alive and well, but you're right, it's hard to.....

11 DR. SCHRAER: But they're really in jeopardy and.....

12 MR. CLARK: Yeah (affirmative).

13 DR. SCHRAER: And I think -- I don't know what the
14 solution to this is, because it's a deeply rooted problem
15 through the entire U.S. medical care system, but preventive
16 care, patient education, general public education.....

17 MR. CLARK: Yeah (affirmative).

18 DR. SCHRAER:really takes a back seat to
19 intervention with technologic means, which is really the end,
20 what you have to do many times as the end result of all the
21 rest and that's happening.

22 MR. CLARK: Well, if we get rid of the four-wheelers, we
23 get rid of the pop, we get rid of the junk food in stores and
24 go back to the old way, maybe we could get there, but we are
25 where we are, so.....

1 DR. SCHRAER: Yeah (affirmative).

2 MR. CLARK:trying to educate and reintegrate and
3 change and say, you know, exercise for fun versus exercise to
4 survive, certainly, you know, is.....

5 DR. SCHRAER: Yeah (affirmative), yeah (affirmative).

6 DR. HILD: Think about it like this, I think.....

7 MR. HOLT: If I can real quick, we have about 15 minutes.
8 Can I have your attention? When I've been in all these
9 exercises, they can tend sometimes to drift between decades.
10 So just as you're -- as you're -- kind of -- we've got 15, 20
11 minutes or so, kind of in this part. Remember, the '80s are
12 focusing on the '80s, the '70s on the '70s, and the '60s on
13 the '60s.

14 I don't know if that's how the conversation has been, but
15 there's just some natural drift that tends to happen. So just
16 as you continue on your conversations, remember the '60s are
17 with the '60s, and the '80s for the '80s, and we all know what
18 happened in the '70s. So with that, let's go ahead and
19 continue.

20 MR. CLARK: We went from doing everything in
21 (indiscernible - speaking simultaneously).....

22 DR. SCHRAER: We went to the '90's and.....

23 MR. CLARK:very little of anything and the state
24 didn't have much money. The feds didn't have much money. The
25 Native people didn't have much money, but in the '70's with

1 ANCSA, we started getting roads and we started getting
2 airports. We started getting all kinds of stuff and again, it
3 is what it is and whether they're good, bad or whatever today,
4 like we had good water systems. Today, they are old and
5 falling apart, in spite of the best of care because at the
6 time, the technology wasn't what it was. There were
7 (indiscernible - speaking simultaneously).....

8 DR. HILD: So let me ask you -- do you -- let me just go
9 back to one other point here in regard to the diabetes and
10 trying to change public attitude.

11 MR. CLARK: Yeah (affirmative).

12 DR. HILD: Think about the '70's, think about smoking.

13 MR. CLARK: Yeah (affirmative).

14 DR. HILD: I remember going to the Alaska Public Health
15 Association meetings in the '70's and (indiscernible -
16 speaking simultaneously).....

17 MR. CLARK: And in the meeting hall, we smoked.

18 DR. HILD: And picking up the ashtrays prior to the
19 meeting and hiding them in the corner.

20 MR. CLARK: Yeah (affirmative), yeah (affirmative).

21 DR. HILD: So that people wouldn't smoke during the APHA
22 meetings, APHA meetings.

23 MR. CLARK: Yeah (affirmative), it's still that, but it's
24 so much better.

25 DR. HILD: But -- but what happened? What happened in

1 the '70's was people started to become aware of issues
2 and.....

3 MR. CLARK: Yeah (affirmative).

4 DR. HILD:it's taken decades for that to change.

5 MR. CLARK: Yeah (affirmative), yeah (affirmative).

6 UNIDENTIFIED SPEAKER: Yeah (affirmative).

7 DR. HILD: Diabetes, I think, is going to fall in the
8 same line.

9 MR. CLARK: Yeah (affirmative).

10 DR. HILD: Only now do we have the data, just like Anne
11 was talking about on cancer and the rates of diabetes and
12 obesity.

13 MR. CLARK: Yeah (affirmative), yeah (affirmative).

14 DR. HILD: It's kind of like, okay, we now have the data.
15 How do we change the system? It takes time.

16 MR. CLARK: Yeah (affirmative), it's a (indiscernible -
17 speaking simultaneously).....

18 DR. SAYLOR: Well, I think that there may be a way of
19 knitting some of that together using what we know worked
20 during the '70's with the HSAs, the forums and stuff that we
21 had, and not a complete devolution, because it was a regional
22 review in (indiscernible - room noise) system.

23 UNIDENTIFIED SPEAKER: Yeah (affirmative).

24 DR. SAYLOR: But you can push it down farther by using
25 existing state law that gives units of local government health

1 powers and there are only -- there are still only two units of
2 government that have health powers in the state, full health
3 powers, Anchorage and North Slope Borough, but there's this
4 opportunity to bring -- I mean, I think you're right. You
5 said, "The government will tend to do what it does and it
6 doesn't have that much response."

7 Now, I know that there's a lot of to-ing and fro-ing of
8 the discussion of block grants, but imagine that Bristol Bay
9 had health powers and you could, Bobby, have a system that was
10 constructed by a board of directors that served everybody and
11 emphasized preventive things, which we know would be.....

12 MR. DANN: Or whatever they wanted to.

13 DR. SAYLOR: Whatever they wanted to and it pushes the
14 decision-making to the local level so that it's geographically
15 responsive, culturally responsive, empowering.....

16 MR. DANN: Purdue wanted to do that. I don't know what
17 happened.

18 DR. SAYLOR: Who?

19 MR. DANN: I remember talking to Karen Purdue when she
20 was Commissioner.

21 DR. SAYLOR: Well, that whole thing of believing in the
22 power of families and communities.

23 MR. DANN: Yeah (affirmative).

24 DR. SAYLOR: We thought it was a great model.

25 MR. DANN: I did too.

1 DR. SAYLOR: I wish we would have kept it up, but we sort
2 of forgot it.

3 MR. DANN: Well, I don't know what the road block was,
4 but she wanted to do just that. Instead of each program
5 having its little funding to an entity in each area, she
6 wanted to pull it all together in the form of a -- like a
7 block grant to an authority in the region or in the community.

8
9 DR. HILD: Brian, when did Anchorage receive those health
10 authorities?

11 DR. SAYLOR: When Anchorage was first founded, so this
12 predates statehood, they had a health board that, I think
13 formally, it morphed into health powers when there was a state
14 to delegate health powers.

15 DR. HILD: Because the North Slope Borough, when it
16 incorporated in '71, structured itself that way.

17 DR. SAYLOR: Yeah (affirmative).

18 DR. HILD: And this has been one of the questions, is we
19 have the model boroughs, but they're not in existence, you
20 know.

21 DR. SAYLOR: Well, there are a lot of people right now --
22 if a unit of local government does not adopt health powers,
23 then the state constitution,.....

24 DR. HILD: Right.

25 DR. SAYLOR:which says that the state will provide

1 for the federal health and welfare and the rural education
2 attendance areas, you know.

3 UNIDENTIFIED SPEAKER: Yeah (affirmative), yeah
4 (affirmative).

5 DR. SAYLOR: There are rural school where we've changed
6 that, but we haven't done the equivalent for health. So if
7 somebody elects not to have health powers, which obligates
8 them, you know, to raise revenues and tax and stuff like that.

9 UNIDENTIFIED SPEAKER: Yeah (affirmative).

10 DR. SAYLOR: Then the state -- the state has to do it.
11 So in many instances, the state continues to do it and it
12 creates the problems that you're talking about where you can't
13 get any money for (indiscernible - speaking simultaneously) or
14 whatever.

15 UNIDENTIFIED SPEAKER: Well, it disempowers the local
16 communities.

17 UNIDENTIFIED SPEAKER: Absolutely, yeah (affirmative).

18 MR. CLARK: There may be -- I keep thinking of 1949, that
19 it may have been tinkered with, the public health powers and
20 stuff, but not everybody is an organized borough and not
21 everybody's a first class city, though. Just about every
22 place will have a regional health organization for the most
23 part intact because of Stevens, otherwise, it would have been
24 all disassembled and not as efficient, but you've kind of got
25 a large part of the stuff there.

1 DR. SAYLOR: And so if the unit of government ends up
2 being the regional corporation, which I know gets into all
3 sorts of legal issues and (indiscernible - speaking
4 simultaneously).....

5 MR. CLARK: Yeah (affirmative), yeah (affirmative), yeah
6 (affirmative).

7 UNIDENTIFIED SPEAKER: That's an issue in itself, too.

8 DR. SAYLOR: But the infrastructure, the basic building
9 blocks of the regional health system.....

10 MR. CLARK: Right, is sort of there, yeah (affirmative).

11 DR. SAYLOR:with the governance and all that stuff
12 is already there.

13 MR. DANN: So we've got a couple of themes. One is, I
14 think, what the history is showing us is that policy-makers
15 need to understand the lay of the land locally, A.....

16 MR. CLARK: Yeah (affirmative).

17 MR. DANN: And B) I think the history teaches us that the
18 optimal solutions are locally devised and managed, and I think
19 that's really what the rise of the health corporations have
20 demonstrated. One little story I wanted to share because it's
21 a cute story; in the '70's, I'm sticking to the appropriate
22 decade here, in the '70's, it's (indiscernible - speaking
23 simultaneously).....

24 UNIDENTIFIED SPEAKER: You made (indiscernible - speaking
25 simultaneously) then you get a free gift.

1 MR. DANN: We were training the health aides.

2 MR. CLARK: Yeah (affirmative).

3 MR. DANN: But the policy was that the health aides were
4 not allowed to have narcotics, which was part of this whole
5 theme about, you know, if we go back to the TB days, we don't
6 trust them to take their meds. We don't trust the health
7 aides to not turn everybody into drug addicts or become drug
8 dealers, et cetera. So they're not going to be allowed to
9 have narcotics.

10 It was a gentleman who was the hospital administrator at
11 the IHS hospital in Kotzebue and he was out on a hunting trip
12 and he fired his rifle and the recoil came back and the scope
13 blew a hole in his head around his socket and he was bleeding
14 profusely, and they took him into the clinic and the clinic
15 was staffed by one of the icons of the old CHA. She'd been
16 doing it for 20 years and as Lincoln said, just a tough --
17 that everybody obeyed and she sat there and sewed him up with
18 no pain killer, and she said, "You know, if we had narcotics,
19 it'd be a lot easier for you," and he went back to the
20 hospital and he issued an order that allowed them to be issued
21 out of the pharmacy and that's how -- that's the story of how
22 they eventually got into our (indiscernible - speaking
23 simultaneously).

24 UNIDENTIFIED SPEAKER: That's how it gets done.

25 MR. CLARK: Yeah (affirmative).

1 DR. HILD: But a similar story, again from the '70's, so
2 keeping it in order, the Northern Region EMS Council rotated
3 between Fairbanks, Kotzebue, and Barrow, and.....

4 MR. CLARK: Yeah (affirmative).

5 DR. HILD:everybody in the north was saying, "We
6 need more training, because sometimes we have to hold onto
7 patients for a while and," you know, dah, dah, dah.

8 MR. CLARK: Yeah (affirmative).

9 DR. HILD: So we had a meeting in Barrow and we invited
10 physicians up so that they could hear all the arguments on why
11 the EMTs needed more training and support, because we often
12 staff the hospital because the hospital just didn't have
13 enough man power and so they came up for their meeting and
14 everything was (indiscernible) they went to get on their plane
15 at 4:00 in the afternoon and they heard the jet and the fog
16 came in and the jet went away, and they said, "What happened,"
17 and kind of like, "Well, the plane will be back tomorrow."
18 "Well, what do you mean, it will (indiscernible)?" They said,
19 "You know, it's fogged out. We can't do it. This is
20 September." They said, "You've got to be kidding." I said,
21 "This is why we wanted to have this additional training," and
22 they said, "No, no, no, we can't afford this. You just ship
23 your patients out."

24 Fine. So the next day, everybody's up at the airport
25 really anxious to go, and the plane, you hear it, and it goes

1 by, four days in a row. These physicians were going crazy.
2 They were calling Fairbanks, you know, having to reschedule
3 appointments and surgeries and all kinds of stuff, and then
4 they decided, we should give them more training. So the same
5 type of story. It was kind of like you had to get the people
6 in the community to realize it.

7 UNIDENTIFIED SPEAKER: Yeah (affirmative), yeah
8 (affirmative), that's right.

9 UNIDENTIFIED SPEAKER: Yeah (affirmative).

10 DR. HILD: You can't always get out, even on a jet. You
11 cannot get out.

12 MR. CLARK: They just don't understand Alaska and the
13 people in Anchorage often don't go out, and Juneau, people and
14 all that, and the D.C. people, but you've got to go out and
15 see it to believe it and understand it. I mean, that's the
16 only way it's going to really change. I mean, airport to
17 airport is island to island. There's no roads.

18 Call it an island. Call it what it is; isolation from
19 isolation, and they only fly when the weather's good. Thank
20 god for teleded, but the beam-me-up-Scotty part's not there,
21 so you know, trained people and the drug's got to be there and
22 the right facility has got to be there and if you don't have
23 the infrastructure in place and you can't afford it at .80
24 cents a kilowatt hour, you know, it's like, hey, you know, a
25 dollar here is like five dollars over here. It's the same.

1 Why worry about you got more and I've got less. I mean,
2 we did the same thing in, you know, '73 to '76 arguing about
3 what should the money be that was left over from the Norton
4 Sound YK OEO money and we looked at small, medium, and large,
5 equitable.

6 You've got to try to make it fit and that's the only way
7 you can do it. That's why you have small, medium, and large
8 clinics. A lot of the principles of HSAs and all of these
9 things, they work in some way. They're just upgraded. I
10 mean, you know.....

11 MR. DANN: You know there's another -- I'm trying to
12 think of what would be helpful with Debra and the state in
13 terms of policy, and there's another little piece here in the
14 history, which is what you're describing and what Robert's
15 describing, which is the resistance of the professions to
16 change.

17 MR. CLARK: There is.

18 MR. DANN: And you know, initially there was a lot of
19 opposition, you know, if we talk about not giving the health
20 aides pain meds. When I was in Nome and we looked at what
21 should a health aide actually be paid, there was tremendous
22 resistance from the nurses because they didn't feel like they
23 should be paid that because they hadn't gone to nursing
24 school.

25 MR. CLARK: Yeah (affirmative).

1 MR. DANN: One of the big problems we had out there in
2 those days is that nobody could get eye glasses, right. You
3 could get eye glasses twice a year and so we developed a
4 program with an enlightened former IHS ophthalmologist, whose
5 name I can't recall right now, but he was willing to train a
6 young gal from King Island to dispense glasses, a lot of
7 opposition to him doing that, you know, that became.....

8 UNIDENTIFIED SPEAKER: Just like the dentists.

9 UNIDENTIFIED SPEAKER: Well, but the dentist
10 (indiscernible - speaking simultaneously).....

11 UNIDENTIFIED SPEAKER: Yeah (affirmative), (indiscernible
12 - speaking simultaneously).....

13 MR. DANN: I'm trying to stick to the decade.

14 UNIDENTIFIED SPEAKER: (Indiscernible - speaking
15 simultaneously).....

16 UNIDENTIFIED SPEAKER: (Indiscernible - speaking
17 simultaneously).....

18 MR. DANN: But I mean, that's something the state has got
19 to look at.....

20 MR. CLARK: Yeah (affirmative).

21 MR. DANN:if we're going to progress. I mean, we
22 have to have -- if we're really going to serve everybody, this
23 is not just a state problem, it's a national problem, you
24 know, with the cost of our system, we've got to have everybody
25 operating at the top of their licensing. We've got to be very

1 creative about what we license them to do and the professions
2 are going to have to give ground. That's my (indiscernible -
3 speaking simultaneously).....

4 MR. CLARK: Yeah (affirmative), yeah (affirmative), the
5 certificated people often are better than the licensed people
6 because that's all they do and they're so good at it. They
7 could teach these other guys something, but they're limited
8 and that's fine, as a certified health aide, and that's they
9 way they can get Medicaid and VA money, but people are -- my
10 god, standing orders, my license is on the line. They can't
11 do that there.

12 UNIDENTIFIED SPEAKER: But yet, if you look at the
13 history.....

14 MR. CLARK: But look at the curriculum, look what they
15 do, I mean (indiscernible - speaking simultaneously).....

16 DR. SAYLOR: Yeah (affirmative), the behavioral health
17 aides are (indiscernible - speaking simultaneously).....

18 MR. CLARK: They prove it. It doesn't matter if it's an
19 open book test or not. If you've got it, you've got it.
20 You've got the skills, and they go from babies to old folks to
21 the grave. They know it all. I mean, that's the way it is.

22 UNIDENTIFIED SPEAKER: You know, how many examples of
23 malpractice or whatever you want to call it do we have of
24 health aides over the 40 or 50 years?

25 MR. CLARK: Yeah (affirmative).

1 UNIDENTIFIED SPEAKER: It's nothing.

2 DR. SAYLOR: I remember just, I guess, in the past year,
3 we were on a long ferry ride with Rob Burgess and.....

4 DR. SCHRAER: That must have been a gas.

5 DR. SAYLOR: It was wonderful, and I said, "Rob, you
6 know, the number that we still throw around is that a
7 community health aide can do 85% of what a physician can do
8 prior to medivac," and he said, "You're wrong." I said,
9 "Well, wasn't this in one of those clinical audits that you
10 guys did?" He said, "Yes it is, but that's what it's based
11 on. You're wrong." I said, "No, I've been using that
12 number." He said, "No, it's like 87%."

13 DR. SCHRAER: He said, "It's closer to 97."

14 UNIDENTIFIED SPEAKER: Well, it's.....

15 DR. SAYLOR: But going back to something that Denny said,
16 a good -- well, we all know Denny.

17 UNIDENTIFIED SPEAKER: Yeah (affirmative), yeah
18 (affirmative).

19 DR. SAYLOR: And one of the things he said early on when
20 he was the Director of the Alaska Native Health Board is that
21 during the transition of power, we need to make sure that
22 people are allowed to fail.

23 UNIDENTIFIED SPEAKER: Yeah (affirmative).

24 DR. SAYLOR: There's no rescuing here. They're going to
25 do what they do and that's part of it.

1 UNIDENTIFIED SPEAKER: Yeah (affirmative).

2 DR. SAYLOR: And if we begin to think about regions
3 becoming essentially the recipients of health powers and the
4 governance for all of that, which includes the distribution of
5 resources, that we have to think of avoiding what happened
6 years ago up in Maniilaq where they adopted health powers,
7 took all the money for public health and put it into senior
8 care, you know, because their assisted living facility or
9 something was going belly-up, and the state came in, in fact,
10 it was Nancy Davis and I that went up there and tried to sort
11 of straighten it out, the state ended up saving them because
12 it's the state's residual responsibility for doing that.

13 So there's something about accepting the responsibility
14 and authority to do it and accepting the responsibility for
15 failure and making good on it, but that's something we're not
16 quite as good about. We always go back to the state and
17 (indiscernible - speaking simultaneously).....

18 UNIDENTIFIED SPEAKER: You and I had a conversation at
19 the time and I recall that, yeah (affirmative), yeah
20 (affirmative).

21 MR. CLARK: But you look at -- you look at then and the
22 seven major hospitals out there that are still there today,
23 yeah (affirmative), ups and downs, but we're still alive and
24 well.

25 DR. SAYLOR: Still alive.

1 MR. CLARK: And just the other day, I read 27 hospitals
2 closed in the Lower 48, a lot of the critical access
3 hospitals, but also some inner-city big places, a lot of
4 layoffs. You don't quite see that up here.

5 DR. SAYLOR: That's right.

6 MR. CLARK: For whatever reason, we're learning and you
7 do a business plan and you only spend what you've got. It
8 wasn't always that way and not everybody started off doing
9 audits and we got burned a little bit, but they learned and
10 we've learned since then and so the regional corporations and
11 everybody that you've got to follow the rules and yeah
12 (affirmative), maybe you chase a few grants and dollars, but
13 normally, this is our problem and this is what we need to take
14 care of them, rather than taking something you don't really
15 need, living beyond your means.

16 So incrementally, there's a lot of credit that we don't
17 always give ourselves. I mean, take that smoking, I mean,
18 many places are smoke-free. You don't smoke in the house.
19 You smoke outside. Yes, they're doing it, but it's
20 incrementally less. The problem is the new kids come up and
21 try it, too, and it's hard to get a total stop, but it gets
22 better.

23 MR. DANN: You know, Robert, you raise an interesting
24 thing. I was just last -- I guess it was last week, I was in
25 Montana doing a presentation to 15 critical access hospitals

1 that are struggling. They don't know how to innovate.

2 MR. CLARK: Yeah (affirmative), you've got to.

3 MR. DANN: And they go into a victim mentality, you know,
4 and trying to protect themselves from the punishing federal
5 policies. Our system up here doesn't do that.

6 MR. CLARK: A lot of your stuff, and thank you for
7 sharing at (indiscernible) even, the latest was strategic
8 planning and all those lessons learned and various things, but
9 the thing is, you know, what we're doing, we do it every year
10 and you look at, you have to say, "Okay, a futurist,
11 economist, healthcare expert, our own input," you know, keep
12 looking ahead, best practices, will it work, will it not work,
13 you know, Blue Ocean, I mean, things that you'll say, "I don't
14 know, it may be too far out," but if you don't try it, you
15 ain't going to go somewhere. You'll be a darn dinosaur and we
16 can't be a dinosaur. We have to change. The only thing that
17 is dynamic is the stuff in the museum and while we like to
18 retain our culture, it's on our terms, not behind a glass
19 thing somebody looks at.

20 MR. HOLT: (Indiscernible - speaking simultaneously) in
21 the next five to seven minutes to a good stopping point, just
22 go ahead and we'll (indiscernible - speaking
23 simultaneously).....

24 MR. CLARK: It is something different than before, but
25 you keep learning and growing and changing and modifying, and

1 the '70's started a lot of that. We can do it. It gave us
2 the.....

3 DR. SAYLOR: Maybe the diabetes stuff, if I can just see
4 if I can trace through the shifting of resources. You had
5 said that because of the reimbursement, differential
6 reimbursement for surgeries, there is more financial incentive
7 to allow someone to undergo an amputation than.....

8 DR. SCHRAER: Well, I'm not -- yeah (affirmative), I
9 don't want to be misrepresenting, you know.....

10 MR. CLARK: Yeah (affirmative).

11 DR. SCHRAER: It isn't like anybody sits down and says,
12 "Gee, if I let this foot ulcer fester, it will lead to
13 amputation and that's (indiscernible - speaking
14 simultaneously)....."

15 MR. CLARK: Yeah (affirmative), yeah (affirmative).

16 DR. SCHRAER: You know, the hospital will get more money.
17 It isn't that kind of thing. It's more that the pressure is
18 not to make time for the healthcare providers to provide
19 education to work at preventive stuff. The pressure is to do
20 reimbursable technologic procedures.

21 MR. CLARK: Yeah (affirmative), it's easy to say, "I did
22 all these surgeries." It's hard and it takes years to prove
23 what you were doing today is paying off over here.

24 DR. SCHRAER: Right.

25 UNIDENTIFIED SPEAKER: Avoiding (indiscernible - speaking

1 simultaneously).....

2 DR. SCHRAER: Yeah (affirmative).

3 MR. CLARK: And the people don't want to necessarily put
4 the money into it to the degree that they need to.

5 DR. SCHRAER: Yeah (affirmative).

6 MR. CLARK: But population health, public health is a
7 critical part that most of our tribal organizations are
8 holding onto, but people need to have dollars to make it work,
9 too, at the same time.

10 DR. SCHRAER: Yeah (affirmative).

11 MR. CLARK: And if it's only one year and then you don't
12 have it and people are dependent on it, what are you going to
13 gut, rob Peter to pay Paul to make it work?

14 DR. SCHRAER: Yeah (affirmative).

15 MR. CLARK: So if we could just teach people to do it on
16 your own and we'll help you and provide advice, it's better.
17 It becomes a lifestyle commitment and change and everything.

18 DR. SCHRAER: Yeah (affirmative).

19 MR. DANN: So what is the.....

20 MR. CLARK: And it's going back in some ways, because
21 we're so entrenched in all this junk food and everything else
22 that they got, that they get hooked on it. I mean, I'm
23 drinking a bunch of sugar here. I know that, but the coffee,
24 at least I put milk in it to help my bones, because as I get
25 older, maybe I won't be so hunched over.

1 DR. SCHRAER: Yeah (affirmative).

2 UNIDENTIFIED SPEAKER: Good for you.

3 MR. CLARK: Right, you know, running with the devil.

4 MR. DANN: So my question is, what is it that if we look
5 at this history, it's been one of a lot of innovation.

6 MR. CLARK: Yeah (affirmative).

7 MR. DANN: So what is it that has enabled that innovation
8 to take place that we want to preserve? What is it that
9 creates fertile soil for that? Is it the daunting challenges?
10 Is it that we just happen to have innovative people? What's -
11 - how does that history instruct us about how to continue to
12 be innovative?

13 MR. CLARK: Well, you can't be afraid of change.

14 DR. HILD: (Indiscernible - speaking simultaneously)
15 Barefoot Doctors, yeah (affirmative).

16 MR. HOLT: Can I get everybody's attention real quick?
17 There was a question that was just, I think, raised that is --
18 let's do this at each table, which is based -- it's kind of --
19 we're rapidly rolling to our break, which is based on kind of
20 your discussion you had here, what would be, young man, do you
21 remember exactly the statement that you said? I'm going to
22 (indiscernible - too far from microphone). You just said it.

23 MR. DANN: I said that as we've traced this history.....

24 UNIDENTIFIED SPEAKER: Use your mic, Bill.

25 MR. DANN: Yeah (affirmative).

1 MR. HOLT: Everyone listen to this and if we could use
2 you to get kind of an answer to this question (indiscernible -
3 speaking simultaneously).

4 MR. DANN: So as we've shared, what's evident is that
5 this history is one of a lot of innovation, and the question I
6 asked is: What is it that has enabled that innovation to take
7 place? What has created fertile soil for innovation that we
8 want to preserve going forward, so that we don't get stuck the
9 way many large systems do.

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

16 DR. HILD: And I was going to follow up, you brought --
17 and started by talking about the Barefoot Doctors.

18 UNIDENTIFIED SPEAKER: Right.

19 DR. HILD: So best practices, you mentioned that, kind of
20 what is going on elsewhere in the world that we might be able
21 to do?

22 UNIDENTIFIED SPEAKER: Instructs us, yeah (affirmative).

23 DR. HILD: And you know, we might start looking at some
24 of the environmental issues. It's kind of like, yeah
25 (affirmative), what was the empowerment that was going on?

1 What really triggered people? Stopping Project Chariot took
2 place in large part because of what happened in Bikini and the
3 people in Bikini were talking to the people in Point Hope
4 because of short wave radio, and they were saying firsthand,
5 "You don't want an atomic bomb in your backyard."

6 UNIDENTIFIED SPEAKER: Yeah (affirmative).

7 DR. HILD: And so that kind of global communication was
8 able to share and get people motivated to do something.

9 MR. DANN: I think the second thing, I mean, I've kind of
10 -- my career's morphed and I'm now kind of an organizational
11 junkie, and you know, what all the literature and all of my
12 experience tells me, there's a concept of organizational
13 change called the Wild Ducks, and the theory is that if you
14 want change, then you bring into the room people that don't
15 look like you, don't talk like you, have very different
16 experiences and have no power. The real innovation comes from
17 the fringes, and I think what this history has taught us is
18 that's where the innovation is coming from.

19 It's coming from the field. So I think that's the lesson
20 going forward is that there needs to be a continued
21 empowerment and dialog with the fringes, because I think
22 that's where the innovation is going to happen.

23 DR. HILD: Cindy, do you think that would help with
24 diabetes?

25 DR. SCHRAER: Yeah (affirmative), I think so. I think

1 having local -- local leaders, local control over preventive
2 activities. For example, in the -- unfortunately, this gets
3 back to funding, that when our program first started, we had
4 some carry -- well, it's sort of a long story, but we ended up
5 with some extra money that we didn't spend one year. So we
6 apportioned that out essentially in a grant program to
7 villages that came up with ideas for how they could increase
8 the exercise level and so on in their villages, and I think a
9 lot of those were successful.

10 It ranged all the way from preventing gestational
11 diabetes through nutrition education to building a walking
12 trail in another village, which was funny. We -- they applied
13 for money and we said, "Well, gee, we notice you have budgeted
14 something like one supervisor for every two or three workers.
15 Can you justify this," and they said, "Yeah (affirmative), the
16 workers are junior high kids with chainsaws."

17 UNIDENTIFIED SPEAKER: Enough said.

18 DR. SCHRAER: The supervisors are the guys that are going
19 to make sure that things don't go wrong, you know, we said,
20 "Okay," you know.

21 MR. DANN: Where I see this not working right now is in
22 mental health. I have a couple of tribal clients, you know,
23 this is at the fringes on the ground floor. They're very
24 concerned about, you know, the mental and emotional health of
25 their population. They're totally constrained from being

1 innovative by the state regulations.

2 MR. CLARK: Yeah (affirmative), I would agree, yeah
3 (affirmative).

4 MR. DANN: They can't integrate with the general health
5 system. There's all this bugaboo about sharing records, and
6 you know, only certain people with certain licenses can do
7 certain things and to me, the existing system that is holding
8 onto the ways things are, has not come up with a solution. So
9 they don't hold the high ground, in my view, for this is how
10 you do it, and they ought to be allowing this innovation to
11 take place.

12 DR. HILD: How did that happen in the '70's? I mean, we
13 were able to break things loose.

14 MR. DANN: We had our own money.

15 MR. CLARK: And you know, we didn't have very many
16 attorneys around telling us we couldn't do it, too, and you
17 know, no malpractice. We weren't used to that.

18 MR. DANN: Yeah (affirmative).

19 DR. SCHRAER: Yeah (affirmative).

20 MR. CLARK: There's a whole bunch of things today like,
21 my god, every time you turn around, I'm breaking a reg, got to
22 talk to the attorney, got to talk to the accountant.

23 DR. SCHRAER: Yeah (affirmative).

24 MR. CLARK: HIPAA, you know, on and on and on, I mean,
25 it's.....

1 DR. SCHRAER: Yeah (affirmative), that HIPAA rule really
2 is (indiscernible - speaking simultaneously).....

3 MR. CLARK:so constraining that people just simply
4 wanted to make it better. Most people weren't thinking of
5 their back pocket or nepotism or doing something else or
6 trying to get at -- they wanted to help. It doesn't matter
7 who they were, Native or non-Native, and people wanted to
8 share. Today, it's I, me, mine, you know, we're changing this
9 whole, what do you call it, telemed or whatever, this whole,
10 you know, these fancy phones and all this stuff here, in a
11 heartbeat, looks what happens around the world, Russia, any
12 place, that Isis, holy criminy, I mean, before, you probably
13 never would have heard about it for five years and by then, it
14 would have been done and over with, but there's just so much
15 so fast.

16 DR. SAYLOR: Let me just add another ingredient to this.
17 If there are.....

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

22 DR. SAYLOR:empowered regional health authorities
23 that -- that -- I'm thinking up in Nana (indiscernible -
24 speaking simultaneously) in order to allow the local entities
25 to continue to function in scarce resources, there are two

1 ways to do it. One is you can bug some other unit of
2 government that has taxation powers or a tax base to do
3 something. The other is that you tax at a regional level,
4 hire, or develop new industries.

5 Now I know that right now, there's a certain, you know,
6 we're great at producing carved birch bowls and fish, but then
7 you're pretty much out. You know, there's not a whole lot of
8 economic development and manufacturing going on, but there
9 would be an incentive to create industries that can be -- can
10 provide a tax base that would allow a region or a unit of
11 local government to generate the funds needed to take care of
12 the people.

13 So it doesn't always have to go back to the federal
14 government. If you devolve the system to the regional
15 government, it sort of plays into the economic development
16 scenarios, which I think is a good thing, but it puts
17 additional pressure on local governments to develop and
18 attract industry.

19 It also creates jobs and opportunity for a desire for a
20 healthy workforce. You know, of the things that happened up
21 in Kotzebue with Red Dog, I think, you know, you listen to
22 John over time and a lot of people worked up there. I mean,
23 that was a real shot in the arm.

24 UNIDENTIFIED SPEAKER: It still is.

25 DR. SAYLOR: And it created a tax base. So there are a

1 lot of other consequences, maybe anticipated/not anticipated
2 by having a regionally administered and controlled health
3 system.

4 DR. HILD: So this gets back to the question I raised
5 earlier about the model boroughs. You know, is this something
6 that people should be pursuing to develop those types of tax
7 bases?

8 DR. SAYLOR: Well, if you look at the two places that
9 have health powers, they're places that can tax.

10 DR. HILD: That's right, exactly.

11 DR. SAYLOR: And tax pretty heavily, Anchorage,
12 Municipality of Anchorage and the North Slope Borough.

13 DR. HILD: North Slope.

14 MR. CLARK: If you don't have a good revenue sharing and
15 everybody feels a part of it, it's, you know, that the feeling
16 that the central government or that community gets it all and
17 everybody gets little or nothing. The Naknek Borough seems to
18 be that way. Across the river at south Naknek gets very
19 little, if anything, like the disenfranchised orphan. Naknek
20 gets it all. King Salmon gets some because there's a road
21 between the two. The lake (indiscernible) I hear a similar
22 story of the fishermen versus the few people up the lake
23 getting not a whole lot.

24 Dillingham and that whole area is nothing, but right now,
25 Dillingham is trying to annex the whole Nushagak River and not

1 have any sharing plan and all the villages are fighting it.
2 My region's fighting it. The health corporation and the
3 school district and everything, they're saying, "You've got a
4 defacto borough." I mean, make the whole damn thing a borough
5 and everybody share. That's the only real way, but the
6 problem is we've got two already and they don't want to give
7 up to have one, and why have three? I mean, there's too much
8 duplication. You know, so you can't quite get them together,
9 the good ideas, but not everybody embracing it, so -- yeah
10 (affirmative).

11 UNIDENTIFIED SPEAKER: Which era was the consortium in?

12 MR. CLARK: Ninety-five, '97, around there, yeah

13 (affirmative).

14 UNIDENTIFIED SPEAKER: Okay, so it's out of our.....

15 MR. CLARK: Yeah (affirmative), yeah (affirmative).

16 UNIDENTIFIED SPEAKER: Out of our charge.

17 MR. CLARK: Out of our -- yeah (affirmative).

18 DR. SCHRAER: Yeah (affirmative), '97, I think is when

19 (indiscernible - speaking simultaneously).

20 MR. CLARK: But the '70's, we got at least the state and
21 IHS to do a little more formalized work together and ANHB was
22 on the fringe and then it was later that we got in on a seat
23 at the table, but we were nipping at the edges on getting some
24 of that going.

25 DR. SCHRAER: Well, I think the '70's and '80's, the

1 other thing that I remember that I liked about it was that
2 there was a sense that you could do something to benefit
3 people all over this state.

4 MR. CLARK: Yeah (affirmative).

5 DR. SCHRAER: And there wasn't so much regional rivalry.

6 MR. CLARK: Yeah (affirmative).

7 DR. SCHRAER: And I remember, for example, some -- during
8 the early days of the compacting negotiations, some lawyer
9 saying that we were going to have to start keeping track of
10 every phone call that (indiscernible) clinical workers took
11 from the field because we were going to have to start
12 apportioning the money out to, you know, by how much of our
13 time got spent.

14 MR. CLARK: Yeah (affirmative).

15 DR. SCHRAER: It was just totally impractical, ignoring
16 things, like some region had a high amputation rate. They
17 needed help getting special shoes. Another region had a
18 different problem. They had a higher kidney failure rate.
19 They needed help getting blood pressure under control.

20 MR. CLARK: Yeah (affirmative).

21 DR. SCHRAER: And we did have the ability to look at the
22 whole picture and see where the individual problems were and
23 try to help all those different situations without a lot of
24 rivalry, like what you're talking about one outfit trying to
25 get all the goodies.

1 MR. CLARK: Yeah (affirmative).

2 DR. SCHRAER: The downside was there's less local
3 control, obviously, so.....

4 MR. CLARK: Yeah (affirmative), and you know, and it's
5 the good with the bad, the outsiders coming in have a
6 different perspective. The locals have a different
7 perspective, but generally, if you go into somebody's home, if
8 you want to stay in their home, you try to live with the
9 customs of that home, rather than changing it too
10 dramatically.

11 DR. SCHRAER: Yeah (affirmative).

12 MR. CLARK: In the storytelling, sitting around the
13 table, after a while, you've got some good ideas and I could
14 do some of this and that and the other, but if you go in there
15 and you start telling them what to do or you don't like
16 it,.....

17 UNIDENTIFIED SPEAKER: Yeah (affirmative).

18 MR. CLARK:you're out.

19 UNIDENTIFIED SPEAKER: Well, that's what the
20 (indiscernible) did, unfortunately.

21 MR. CLARK: You've got to work your way into it.

22 DR. SCHRAER: Yeah (affirmative).

23 MR. CLARK: And explain it in a culturally appropriate
24 way. It doesn't matter if it's in Anchorage or Fairbanks or
25 Juneau or Dillingham, it don't matter. You just got to work

1 into it and not push your way into it. Just because you've
2 got lots of knowledge doesn't mean you've got any common
3 sense.

4 I mean, Jesus, I mean, how many people are, "I've got a
5 PhD, I'm a doctor, I'm a lawyer." Yeah (affirmative), but
6 you're a dummy, you know, and like a lot of us that went away
7 to school, too, the more you went to school, the less you knew
8 about subsistence and the day-to-day stuff, but on the
9 weekends and time off, you could learn that.

10 Are they going to do the reciprocating on the other side,
11 and give both, you know, the crab thing, pulling down, why not
12 put them up, instead of pulling them down? We've got few as
13 it is, you know, import, and import is good if they want to
14 stay and do it, but they come and go, come and go, come and
15 go, and we can't afford that, maybe better off just working
16 somebody on their way up and having that health aide work to
17 become a doctor in time.

18 We've got a doctor come and go and he doesn't fit and he
19 does everything haywire, then that's not good. It makes a bad
20 name for them, the whole profession is one, and the
21 organization is like, "What the heck are you guys doing? You
22 know, are you representing us or not?"

23 DR. HILD: But it is nice to hear more and more young
24 people saying that they.....

25 MR. CLARK: Yeah (affirmative).

1 DR. HILD:started as an EMT. They got to be a
2 community health aide. They've now gone into nursing.
3 They're now looking at medical school.

4 MR. CLARK: It's starting to germinate and help, yeah
5 (affirmative).

6 DR. HILD: It's kind of like, "Yes, that's working."

7 MR. CLARK: Yeah (affirmative), they get out and be
8 doctors, PhDs and other folks that we have in the Native
9 sector that have been helping the whole state, I mean, the
10 Arctic Slope being number one. They do what they can.
11 Bristol Bay does what they can. Nana and everybody, it keeps
12 the money in Alaska and everybody benefits. We don't have to
13 be jealous. It would be nice to maybe work for some of them,
14 but if you apply, you have a good shot, you know.

15 UNIDENTIFIED SPEAKER: Should we take five?

16 DR. HILD: Take five, thank you very much.

17 9:56:13

18 (Off record)

19 End Requested Portion

20

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