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The Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse oppose the expansion of ombudsman jurisdiction to include private, non-governmental health care providers.

SB 72, proposed at the request of the Alaska Ombudsman, seeks to extend ombudsman authority and jurisdiction to patient complaints from certain private, non-governmental health care providers. The Alaska Mental Health Board (AMHB) and the Advisory Board on Alcoholism and Drug Abuse (ABADA) believe this to be contrary to good public policy, possibly impairing the ability of patients to have complaints and grievances addressed in a timely and effective manner.

The U.S. Ombudsman Association defines the jurisdiction of governmental ombudsmen as being over "complaints about government actions."[1] Under SB 72, the Alaska Ombudsman seeks to broaden jurisdiction to include non-governmental actions – by "a person under a contract . . . with a state agency to provide a juvenile detention facility, treatment facility, or residential treatment program accepting placement of juveniles committed to the custody of the Department of Health and Social Services." (SB 72 at page 5). Not only is authority over private non-profit organizations and businesses outside of the recommended scope of practice for governmental ombudsmen, it is based on a misconception of the services rendered by residential health care providers and how they are regulated.

Given that there are well-utilized ways for patients and their parents/guardians to have complaints addressed, and the lack of evidence that the Alaska Ombudsman is better-suited to resolve these issues, AMHB and ABADA recommend that this entire clause (lines 11-14 at page 5) be removed.

Residential Treatment Facilities Provide Health Care Services

Based on both the supporting documents provided with these bills and meetings with Alaska Ombudsman staff, we believe there is **a fundamental misconception** about the nature of services provided by residential behavioral health care providers. The Alaska Ombudsman characterizes these facilities as being similar to detention or penal institutions and the services as being involuntary. Neither characterization is accurate.

Residential psychiatric and behavioral health services are not punishment – they are health care. The providers of these health care services are private businesses and non-profit organizations. They provide health care services reimbursed by Medicaid (and other insurance), services which

[1] U.S. Ombudsman Association Governmental Ombudsman Standards, Preamble at page 1.

the ombudsman expressly exempted from the intent of the bill in the analysis provided with the bill.

The health care organizations that serve youth in the custody of the Office of Children's Services (OCS) or Division of Juvenile Justice (DJJ) provide a wide array of health care services to support the psychiatric and/or substance use disorder treatment and recovery process. These health care services include psychiatric services, clinical therapy services for individuals and families, medication, diet, wellness services, and other services to promote healing and recovery. In addition to psychiatrists and clinical therapists, these health care organizations often have neurologists, general practitioners, nurses, and dieticians on staff.

These health care services are provided in a residential setting – not a detention facility. None of these health care organizations are locked facilities from which youth cannot leave. (Of course, should a young person leave, providers and OCS/DJJ work quickly to find the youth and return him or her to a safe setting.) Youth are admitted to treatment with parent or guardian consent. State regulation and the standards of care require that the youth be engaged, with their parents and other guardians, in the treatment planning and evaluation process.

Existing Oversight and Procedures for Patient Complaints

When a youth is in the custody of OCS or DJJ, there is a court which has ordered such custody and is monitoring that custody. The youth is represented by a *guardian ad litem*, a court appointed special advocate, or a lawyer (and sometimes a combination of these). The parents are represented by lawyers, as well. This means that the parents and youth have the ability to file a motion for hearing at any time during the cause of action.

When a youth is admitted to residential treatment, it is pursuant to a court order, after which the courts hold status hearings at least every 90 days. The parents and youth, through their representatives, can request more frequent regular hearings or *ad hoc* hearings whenever there is a need to review or change a treatment decision. Medication decisions are also reviewed by the court.

All of Alaska's behavioral health providers are subject to three layers of oversight, all of which require formal grievance and complaint procedures (see attached chart). The Department of Health and Social Services (DHSS) exercises oversight – and has the authority to enforce recommendations when made – through the licensing process as well as through the funding process. All of the residential health care providers targeted by the bill are Medicaid service providers and therefore subject to oversight from the Centers for Medicare and Medicaid Services (CMS). Like DHSS, CMS – as a federal agency – has the power to enforce recommendations for improvements to standards of care and policies and procedures. All of these health care providers are required to be accredited by a nationally recognized health care organization, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities. These accrediting organizations also have authority to enforce recommendations for improvements to care.

It is important to note that the Courts, the Department of Health and Social Services, the Centers for Medicare and Medicaid Services, and the accrediting organizations all have authority to investigate complaints, recommend resolutions and improvements to policy and standards of care, and enforce those recommendations. The Alaska Ombudsman lacks the authority to enforce recommendations. This means that, while an additional layer of government oversight is created through this bill, there is no real value to youth and their families, health care providers, or the behavioral health system as a whole.

Lack of Capacity, Expertise

The Alaska Ombudsman currently has jurisdiction over the Division of Juvenile Justice and the Office of Children's Services. This results in jurisdiction over complaints relating to placement, contact with division staff and customer service, decisions related to supports and services provided to youth and families, etc. The ombudsman seeks jurisdiction over health care and treatment decisions, which are already subject to judicial oversight. Even if these decisions were not subject to judicial oversight, the Alaska Ombudsman lacks the capacity and clinical expertise to resolve complaints related to medication, treatment modality, treatment milieu, and treatment goals.

The Alaska Ombudsman has provided a zero fiscal note and indicated that additional staff would not be necessary to address complaints from the identified youth and families. This reflects a lack of understanding of the possible number of youth and families making complaints and the complexity of those complaints. In FY12, 81 youth in state custody received Medicaid-reimbursed residential psychiatric treatment services, 364 youth in state custody received Medicaid-reimbursed short term residential treatment services, and 91 youth in state custody received Medicaid-reimbursed inpatient psychiatric hospital services. Hundreds of youth and families are served by these health care providers. There are hundreds more children and youth in therapeutic foster care (discussed below).To carefully evaluate and investigate these complaints – of which there would be many – will require dedicated staff. It would be a disservice to the Office of the Ombudsman and the potential complainants to expect these to be absorbed into existing staff caseloads. Additional staffing should be considered in the fiscal implications of this bill.

Given that the Alaska Ombudsman already has jurisdiction over all the aspects of placement and monitoring of youth in state custody through its existing authority over DHSS, all that remains outside of that scope are complaints about clinical services provided by the health care organizations. Complaints about psychiatric medication, treatment modalities, and clinical outcomes all fall outside the current capacity and expertise of the Alaska Ombudsman and her staff. To adequately evaluate and investigate these complaints will require not only additional investigative staff, but also access to experts in child psychiatry, suicide, neuropsychology, addiction, brain injury, fetal alcohol spectrum disorder, developmental disability, and adolescent health **at a minimum.** These expert consultations are expensive and often not available except from the health care organizations the Alaska Ombudsman seeks to investigate (and so an outside – possibly out-of-state – expert would be required). The cost of these expert consultations should be included in the fiscal implications of this bill.

AMHB and ABADA also have concerns that the avenue of an ombudsman investigation will actually delay resolution of patient/client complaints. The Alaska Ombudsman has stated that the intention is to investigate complaints absent notice to the executive agency involved. A thorough ombudsman investigation can take days or weeks (or longer). In some cases, where the youth is receiving inpatient hospital services, the hospital stay is less than a week. Thus, the youth is discharged before the complaint is resolved. Even when recommendations are made, the health care provider can choose whether or not to accept the Alaska Ombudsman's recommendations. DHSS would not have notice of the complaint, and so would not have taken action to resolve the problem. So, the youth or family member has pursued resolution of the problem down the one avenue that results in a lack of enforcement, and has spent time that could have been used seeking resolution from one of the avenues that could result in a reasonably quick decision – the Court System or DHSS.

Unintended Consequences

As drafted, SB 72 would provide ombudsman jurisdiction over complaints about therapeutic foster parents. These foster parents provide highly skilled care and supervision, based on and coordinated with the foster child's behavioral health treatment plan. These foster parents are clearly "a person under a contract with a state agency . . . to provide a . . . residential treatment program accepting placement of juveniles committed to the custody of the Department of Health and Social Services." Foster parents are already subject to oversight by DHSS, through licensing and child protection services, and by the courts through the Child in Need of Aid proceedings. Complaints related to placement, services, and level of care are already within the Alaska Ombudsman's purview through jurisdiction over DHSS. Complaints about therapeutic services and daily living issues are subject to judicial review. To add another layer of oversight of foster parents, especially one that cannot guarantee a result due to lack of enforcement powers, adds little value to the system.

It is for all of these reasons that AMHB and ABADA recommend that the entire clause related to ombudsman jurisdiction over health care providers (section 12) be removed from the bill.