Advisory Board on Alcoholism and Drug Abuse
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Alaska Mental Health Board

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE
431 NORTH FRANKLIN STREET, SUITE 200
JUNEAU, ALASKA 99801
(907) 465-8920

February 15, 2012

Senator Bettye Davis, Chair
Senate Health and Social Services Committee
Alaska State Capitol, Room
Juneau, Alaska 99801

Re: SB 55, Comments to Senate Health & Social Services Committee

Senator Davis,

On behalf of the Alaska Mental Health Board, I would like to thank you and your staff for the years of time, effort, and energy you have put into expanding access to patient grievance procedures for individuals experiencing mental illness. This has been a deliberate and thoughtful process, and we look forward to continuing to work together on this issue.

The Alaska Mental Health Board supports patients' rights and efforts to provide additional protections to mental health consumers and other vulnerable populations. We support the proposed additions to AS 47.30.840(a), though we note that some of these provisions duplicate protections found elsewhere in law (i.e. HIPAA, federal regulation, etc.).

We agree that a patient grievance procedure can be an effective tool for ensuring that quality medical care is provided to people in way that promotes personal dignity. We support the intent of SB 55 and we believe that SB 55 addresses many of the concerns raised by our board and other stakeholders about previous iterations. However, we still have serious concerns with the scope of the bill and potential for complex and duplicative procedures, the minimization of crimes against the mentally ill, and conflict with accepted tenets administrative law.

I. Scope

From the beginning, we noted the differences between involuntary acute care provided at Alaska Psychiatric Institute (API) or another hospital and voluntary outpatient treatment through a community behavioral health center (CBHC). We appreciate the effort taken in SB 55 to define "facility" as a "unit of a hospital in which patients receive mental health evaluation or treatment and for which public funds are provided" (page 7, line 21 *et seq.*). If that is the intended scope of SB 55, we appreciate that distinction. However, because the proposed AS 47.30.847(m)(1) refers to AS 47.30.915 – and AS 47.30.847(a) refers even more broadly to facilities "under AS 47.30.660 – 47.30.915" (page 3, line 7 *et seq.*), we have concerns that SB 55, if enacted, will be interpreted to apply to community behavioral health centers.

We do not support the inclusion of CBHCs in the scope of SB 55's patient grievance procedure. This is not because we think clients of CBHCs should not have the ability to express their

complaints for resolution. It is because the adversarial nature of the grievance procedure laid out in SB 55 will interfere with the patient-centered, collaborative approach to treatment advocates have worked so hard to instill in our system – and because it conflicts with the existing grievance procedure requirements laid out by the Centers for Medicare and Medicaid Services (CMS) and the accreditors of our CBHCs. A matrix showing what is **already mandated** for our CBHCs is enclosed. From that, you can see that SB 55 would impose a complex and conflicting system for CBHC clients seeking to have a complaint resolved. For example, SB 55 mandates a written grievance procedure, while the federal and accrediting organizations require access through oral grievances, telephone, or even third party communications.

There is benefit in establishing a grievance procedure that consolidates these layers in a way that makes it easy for patients to access and navigate the process. SB 55 instead creates a more complex and confusing system and establishes a call center at significant cost to the State of Alaska. To add an additional layer, that is not coordinated with existing procedures, means a more complex grievance process for mental health consumers and a greater burden to providers. We worry that the hospitals providing mental health services, especially DES/DET services, will see this as another obstacle and will choose not to maintain or expand their capacity to serve people in psychiatric emergencies.

II. Jurisdiction and Authority

The administrative process described in SB 55 causes concerns. Except for API and the corrections system, all of our mental health providers are private entities. While the acceptance of Medicaid and Medicare dollars does make them subject to CMS regulations, and the acceptance of state grants requires adherence to DBH's grievance policy, these funds do not convert non-profit providers into administrative agencies. Thus, it is not clear that the Commissioner could legitimately decide a grievance involving a non-profit hospital.

The shifting of the burden of proof to the mental health provider is also unfair, and contrary to accepted tenets of law. The burden of proof – of persuasion and production – is, according to accepted principles of evidence, placed upon the person seeking relief:

> The burdens of pleading and proof with regard to most facts have been and should be assigned to the person who generally seeks to change the present state of affairs and who therefore naturally should be expected to bear the risk of failure of proof or persuasion. (2 J. Strong, McCormick on Evidence § 337, 412 (5th ed. 1999)).

There are some situations in which the burden of proof is shifted, but usually only in situations such as the pleading of an affirmative defense or exception by the respondent. The federal Administrative Procedure Act incorporates this common law rule imposing the burden of proof on the person seeking relief, and so does the Alaska Administrative Procedures Act:

> AS 44.62.460(e) Unless a different standard of proof is stated in applicable law, the (1) petitioner has the burden of proof by a preponderance of the evidence if an accusation has been filed under AS 44.62.360 or if the renewal of a right,

authority, license, or privilege has been denied; (2) respondent has the burden of proof by a preponderance of the evidence if a right, authority, license, or privilege has been initially denied or not issued.

To ask the mental health provider to prove that the act or behavior complained of did not happen creates a situation in which a grievance cannot be resolved in a manner acceptable to both the mental health consumer and the treatment provider. This will erode the partnership between the two, impairing the treatment process by creating an adversarial relationship.

III. Stigma and Minimization of Serious Offenses

SB 55 provides an "urgent level of review" for grievances involving sexual or physical abuse, denial of "lifesaving" medical care, or denial of "basic care of human rights." Were these acts to be committed against a mental health consumer by a mental health provider, they would be criminal acts. As such, they should not be minimized or reduced to "grievances." Both the current grievance procedure at API and the requirements of the Joint Commission, which accredits our hospitals and some of our CBHCs, require the immediate involvement of proper investigator authorities when abuse or unlawful conduct are reported.

Assault, abuse, and denial of emergency care should be considered crimes and reported to law enforcement immediately for investigation and prosecution if appropriate. Unfortunately, crimes against persons with disabilities often go unaddressed. Either the victim is blamed or they are undervalued to the point where crimes committed against them no longer matter. To codify this attitude in statute seems to be a step back after so many years of advocacy.

IV. Suggestions

1. Clarify the language in the proposed AS 47.30.847(a) so that it more clearly aligns with the express definition of facility in AS 47.30.847(m)(1), and remove references that could lead to the interpretation that SB 55 applies to community behavioral health centers.

2. Provide greater flexibility in the form of grievance possible. Current federal regulations and state policies allow for the making of a grievance in person, by telephone, by email, or through a family member or designated representative/advocate. SB 55 would not permit those sorts of grievances.

3. Delete AS 47.30.847(g) in its entirety, so that the burden of proof for this procedure is governed by existing legal standards.

4. Amend AS 47.30.847(c)(7) to allow an emergency grievance for complaints regarding use of restraints, seclusion, or an immediate threat to safety or welfare, removing references to crimes such as assault and abuse. This reinforces the protection afforded in SB 55's additions to AS 47.30.840(a).

5. Delete AS 47.30.847(b) and all references to a call center following.

6. Amend AS 47.30.847(c)(4)(C) so that the hospital's governing body or designated grievance committee is the arbiter for the third level of review. This would resolve the conflict between the federal regulations requiring this level of review and SB 55's proposal that the Commissioner review appeals.

7. Change the reference in proposed AS 47.30.855(d) to AS 47.30.915(4), since AS 47.30.847 does not define a mental health "facility."

In closing, the Alaska Mental Health Board is grateful for your tireless advocacy on behalf of Alaska's most vulnerable citizens. We appreciate the effort you and your staff have made to include stakeholders and consumers in the dialogue about how to improve our mental health patient grievance procedures.

Sincerely,

J. Kate Burkhart
Executive Director

Encl.

cc: Daniel Meddleton, Chairman AMHB