

**ALASKA STATE LEGISLATURE**  
**HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE**

March 31, 2005

3:07 p.m.

**MEMBERS PRESENT**

Representative Peggy Wilson, Chair  
Representative Paul Seaton, Vice Chair  
Representative Tom Anderson  
Representative Vic Kohring  
Representative Lesil McGuire  
Representative Sharon Cissna

**MEMBERS ABSENT**

Representative Berta Gardner

**COMMITTEE CALENDAR**

HOUSE BILL NO. 225

"An Act relating to medical examiners and medical death examinations."

- MOVED HB 225 OUT OF COMMITTEE

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 53

"An Act relating to child-in-need-of-aid proceedings; amending the construction of statutes pertaining to children in need of aid; relating to a duty and standard of care for services to children and families, to the confidentiality of investigations, court hearings, and public agency records and information in child-in-need-of-aid matters and certain child protection matters, to immunity regarding disclosure of information in child-in-need-of-aid matters and certain child protection matters, to the retention of certain privileges of a parent in a relinquishment and termination of a parent and child relationship proceeding, to eligibility for permanent fund dividends for certain children in the custody of the state, and to juvenile delinquency proceedings and placements; establishing a right to a trial by jury in termination of parental rights proceedings; reestablishing and relating to state citizens' review panels for certain child protection and custody matters; amending the duty to disclose information pertaining to a child in need of aid; authorizing additional family members to consent to disclosure of confidential or privileged information about children and families involved with children's services within

the Department of Health and Social Services to officials for review or use in official capacities; relating to reports of harm and to adoptions and foster care; mandating reporting of the medication of children in state custody; prescribing the rights of grandparents related to child-in-need-of-aid cases and establishing a grandparent priority for adoption in certain child-in-need-of-aid cases; modifying adoption and placement procedures in certain child-in-need-of-aid cases; amending treatment service requirements for parents involved in child-in-need-of-aid proceedings; amending Rules 9 and 13, Alaska Adoption Rules; amending Rules 3, 18, and 22, Alaska Child in Need of Aid Rules of Procedure; and providing for an effective date."

- MOVED CSSSHB 53(HES) OUT OF COMMITTEE

HOUSE BILL NO. 111

"An Act adding birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons."

- MOVED CSHB 111(HES) OUT OF COMMITTEE

HOUSE BILL NO. 220

"An Act relating to mental health patient rights and to a hospital's duty to provide choice of the sex of staff providing intimate care to a mental health patient."

- MOVED CSHB 220(HES) OUT OF COMMITTEE

HOUSE BILL NO. 14

"An Act relating to disclosure of information about a child or a child's family to a legislator or a member of a legislator's staff; and making conforming changes."

- SCHEDULED BUT NOT HEARD

**PREVIOUS COMMITTEE ACTION**

BILL: HB 225

SHORT TITLE: MEDICAL EXAMINERS & AUTOPSIES

SPONSOR(S): REPRESENTATIVE(S) MCGUIRE

03/18/05	(H)	READ THE FIRST TIME - REFERRALS
03/18/05	(H)	HES, FIN
03/31/05	(H)	HES AT 3:00 PM CAPITOL 106

BILL: HB 53

SHORT TITLE: CHILDREN IN NEED OF AID/REVIEW PANELS  
SPONSOR(S): REPRESENTATIVE(S) COGHILL

01/10/05 (H) PREFILE RELEASED 1/7/05  
01/10/05 (H) READ THE FIRST TIME - REFERRALS  
01/10/05 (H) HES, JUD, FIN  
03/02/05 (H) SPONSOR SUBSTITUTE INTRODUCED  
03/02/05 (H) READ THE FIRST TIME - REFERRALS  
03/02/05 (H) HES, JUD, FIN  
03/15/05 (H) HES AT 3:00 PM CAPITOL 106  
03/15/05 (H) Heard & Held  
03/15/05 (H) MINUTE(HES)  
03/22/05 (H) HES AT 3:00 PM CAPITOL 106  
03/22/05 (H) <subcommittee meeting>  
03/31/05 (H) HES AT 3:00 PM CAPITOL 106

BILL: HB 111

SHORT TITLE: MEDICAID COVERAGE FOR BIRTHING CENTERS  
SPONSOR(S): REPRESENTATIVE(S) CRAWFORD

01/26/05 (H) READ THE FIRST TIME - REFERRALS  
01/26/05 (H) HES, FIN  
03/31/05 (H) HES AT 3:00 PM CAPITOL 106

BILL: HB 220

SHORT TITLE: MENTAL HEALTH PATIENT RIGHTS:STAFF GENDER  
SPONSOR(S): REPRESENTATIVE(S) GARA

03/16/05 (H) READ THE FIRST TIME - REFERRALS  
03/16/05 (H) HES, FIN  
03/31/05 (H) HES AT 3:00 PM CAPITOL 106

BILL: HB 14

SHORT TITLE: DISCLOSURES BY FOSTER PARENTS  
SPONSOR(S): REPRESENTATIVE(S) ROKEBERG

01/10/05 (H) PREFILE RELEASED 12/30/04  
01/10/05 (H) READ THE FIRST TIME - REFERRALS  
01/10/05 (H) HES, JUD  
03/31/05 (H) HES AT 3:00 PM CAPITOL 106

**WITNESS REGISTER**

DR. ROGERS

(No address provided)

POSITION STATEMENT: Speaking as a former state medical examiner  
in Juneau,

RYNNIEVA MOSS, Staff  
to Representative John Coghill  
Alaska State Legislature  
Juneau, Alaska

POSITION STATEMENT: Presented HB 53 on behalf of Representative Coghill, sponsor.

REPRESENTATIVE JOHN COGHILL  
Alaska State Legislature  
Juneau, Alaska

POSITION STATEMENT: Answered questions regarding HB 53 as sponsor.

SCOTT TRAFFORD CALDER  
Fairbanks, Alaska

POSITION STATEMENT: Testified in support of HB 53.

REPRESENTATIVE HARRY CRAWFORD  
Alaska State Legislature  
Juneau, Alaska

POSITION STATEMENT: Presented HB 111 as sponsor.

BARBARA NORTON, Certified Nurse Midwife (CNM); Part Owner  
Geneva Woods Birth Center  
Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 111.

MARIBETH GARDNER, Family Nurse Practitioner; Nurse Midwife  
Fairbanks, Alaska

POSITION STATEMENT: During hearing on HB 111, testified in support of Medicaid reimbursing birthing facilities.

JACK NIELSON, Executive Director  
Rate Review  
Office of the Commissioner  
Department of Health and Social Services (DHSS)  
Anchorage, Alaska

POSITION STATEMENT: Provided comments on HB 111.

TORA GERRICK, Part Owner  
Midwives Birth Center  
Anchorage, Alaska

POSITION STATEMENT: During the hearing of HB 111, provided information she has garnered from her own birthing center.

KITTY ERNST

(No address provided)

POSITION STATEMENT: During the hearing of HB 111, opined that birthing centers are safe.

KAYE KANNE, CDM, Executive Director  
Juneau Family Birth Center  
Juneau, Alaska

POSITION STATEMENT: During the hearing of HB 111, expressed the need to support birth centers in Alaska and place them on a level playing field with hospitals, as far as Medicaid reimbursement.

REPRESENTATIVE LES GARA  
Alaska State Legislature  
Juneau, Alaska

POSITION STATEMENT: Presented HB 220 as bill sponsor.

PATRICK HIGGINS  
North Star Behavioral Health System  
Anchorage, Alaska

POSITION STATEMENT: During hearing of HB 220, related that the organization's issues and concerns have been addressed.

HOLLY GLAESER, Director  
Behavioral Health Unit  
Fairbanks Memorial Hospital  
Fairbanks, Alaska

POSITION STATEMENT: During hearing of HB 220, testified that this issue should be an organizational issue and not a legislation issue.

KARL SANFORD, Chief Nursing Officer  
and Associate Administrator  
Fairbanks Memorial Hospital  
Fairbanks, Alaska

POSITION STATEMENT: Testified in opposition to HB 220.

DORRANCE COLLINS  
Anchorage, Alaska

POSITION STATEMENT: Testified in support of the committee substitute for HB 220.

FAITH MYERS  
Anchorage, Alaska

POSITION STATEMENT: Testified in support of the committee substitute for HB 220.

RON ADLER, CEO  
Alaska Psychiatric Institute (API)  
Division of Behavioral Health  
Department of Health and Social Services  
Juneau, Alaska  
POSITION STATEMENT: Testified in opposition to HB 220.

RICHARD RAINERY, Executive Director  
Alaska Mental Health Board  
Juneau, Alaska  
POSITION STATEMENT: Testified that the Board has requested that the appropriate policies be revised to reflect the intent of HB 220.

ROD BETIT, President  
Alaska State Hospital Nursing Home Association (ASHNHA)  
Juneau, Alaska  
POSITION STATEMENT: Testified in opposition to HB 220.

BILL HOGAN, Director  
Division of Behavioral Health  
Department of Health and Social Services  
Juneau, Alaska  
POSITION STATEMENT: Answered questions from the committee.

#### **ACTION NARRATIVE**

**CHAIR PEGGY WILSON** called the House Health, Education and Social Services Standing Committee meeting to order at [3:07:59 PM](#). Representatives Kohring, Seaton, and McGuire were present at the call to order. Representative Anderson arrived as the meeting was in progress. Representative Cissna was present via teleconference.

#### HB 225-MEDICAL EXAMINERS & AUTOPSIES

[3:09:17 PM](#)

CHAIR WILSON announced that the first order of business would be HOUSE BILL NO. 225, "An Act relating to medical examiners and medical death examinations."

REPRESENTATIVE MCGUIRE, speaking as the sponsor, expressed her belief that the duty of the state medical examiner is of immense responsibility and importance to the citizens of Alaska. She explained that autopsies are performed by the state coroner for various reasons, including suspicious death and possible

communicable disease outbreaks. There is one state medical examiner in Alaska, she related, manages over 1,000 cases, annually. She further explained that Alaska law divides autopsies into two different categories, which include suspicious, unusual or public health related deaths in the first category and leaves other cases to the discretion of the medical examiner.

REPRESENTATIVE MCGUIRE said that HB 225 would require that a deputy medical examiner be appointed to assist the state medical examiner in Alaska. She explained that the state medical examiner has been so overworked in past years, that some deaths have not been properly investigated, due to the lack of resources. She pointed out that the deputy medical examiner would provide respite for the state medical examiner and allow for the development and training of the position. If the state medical examiner became ill, needed to take time off, or decided to leave the position, there would be someone to take over, she related.

REPRESENTATIVE MCGUIRE stated that there is a zero fiscal note attached to HB 225 because the governor's office decided to fund the [deputy commissioner] position. She explained that this position was funded in recognition that this is a critical state responsibility, and a matter of public trust.

[3:14:37 PM](#)

DR. ROGERS said that he was the state medical examiner for 27 years in Alaska. He explained that he resigned and retired when the policy in Juneau shifted requirements to complete only 25 percent of deaths reported to the state medical examiner. He continued:

I couldn't see doing that because we have to sign a death certificate, we have to certify that somebody died of something. And the word certify, I take seriously, ... the word certify is equivalent to being under oath. So, I didn't want to do what they call a walk by autopsy and just make a guess at the cause of death and sign it out .... One of the reasons that the present situation is unsatisfactory is nothing more than death certificate statistics. The Department of Epidemiology ... thought that our autopsy records were the best in the country because we did autopsies on about 98 percent of all the coroner's cases and that includes the unattended

natural deaths, and there are a lot of things to die of besides a coronary, which is what most of them get signed out as now. Our death certificate statistics have become relatively worthless ... for people who die outside of the hospital .... I was at a meeting a while back where a group from Pittsburgh tried an experiment, they would bring a body in, the duty pathologist would decide whether or not to do an autopsy and write down what he would sign it out as; ... if he decided he didn't need to do one, then one of the other pathologists in the group would do an autopsy .... And they found that they were wrong 25 percent of the time and I think that a 25 percent error rate is really not very acceptable.

I think it's a responsibility of the state to know what its citizens die of, and therefore I think this bill will at least provide more people for them to do the work. Right now, one guy just simply can't do it all ... my partner and I, used to do about 1,000 cases a year and it can be done if the time is utilized efficiently .... I really applaud this bill and hope that it will make a difference in the policies that come out of the "department"; I assume that they come from the commissioner .... When they made us change it came through Dr. Nakamura, I think is Dr. Mandsager's predecessor, and it was his view that we should do only an average job compared to the rest of the country. And I wanted to do a better job than the rest of the country, not because we're any better at it, but because there are few enough cases that we could do them all. So, I think we should go back to doing them all, again.

REPRESENTATIVE SEATON moved to report HB 225 out of committee with individual recommendations and the accompanying zero fiscal note. There being no objection, HB 225 was reported from the House Health, Education and Social Services Standing Committee.

#### HB 53-CHILDREN IN NEED OF AID/REVIEW PANELS

CHAIR WILSON announced that the next order of business would be HOUSE BILL NO. 53, "An Act relating to child-in-need-of-aid proceedings; amending the construction of statutes pertaining to children in need of aid; relating to a duty and standard of care for services to children and families; amending court hearing procedures to allow public attendance at child-in-need-of-aid

proceedings; establishing a right to a trial by jury in termination of parental rights proceedings; reestablishing and relating to state and local citizens' review panels for certain child custody matters; amending the duty to disclose information pertaining to a child in need of aid; establishing a distribution age for permanent fund dividends held in trust for a child committed to the custody of the Department of Health and Social Services; mandating reporting of the medication of children in state custody; prescribing the rights of grandparents related to child-in- need-of-aid cases and establishing a grandparent priority for adoption in certain child-in-need-of-aid cases; modifying adoption and placement procedures in certain child-in- need-of-aid cases; amending treatment service requirements for parents involved in child-in-need-of-aid proceedings; amending Rules 3 and 18, Alaska Child in Need of Aid Rules of Procedure; and providing for an effective date."

[3:19:38 PM](#)

REPRESENTATIVE SEATON moved to adopt the proposed committee substitute (CS) for SSHB 53, labeled 24-LS0251\X, Mischel, 3/30/05, as the working document. There being no objection, Version X was before the committee.

[3:20:07 PM](#)

RYNNIEVA MOSS, Staff to Representative John Coghill, Alaska State Legislature, explained the changes made to HB 53 in Version Y. She noted that the amendments recommended by the Department of Law [DOL] had been incorporated with a few exceptions. She explained that Section 1 was split into two sections, and these sections build a bridge between the guardian statutes, the adoption statutes, and the Child in Need of Aid (CINA) statutes as they pertain to an adult family member getting guardianship. She noted that Section 4 originally said that if an adult family member had cared for a child for two years he/she would get preference in an adoption, however this has been changed to 12 consecutive months.

MS. MOSS turned to Section 5 and explained that it mirrors the language [HB 114] dealing with voluntary relinquishment of parental rights. She said, "On behalf of Representative Coghill, I would really like to express our gratitude to [the House State Affairs Standing Committee] and all the work they put into HB 114. That bill is folded into HB 53 in its entirety, with no changes." Section 10, at the request of DOL,

tightens up the provisions for a jury trial, which she remarked would ensure that jury trials were available for termination of parental rights, and "another section of [AS 47.10] which makes the determination of incarceration is grounds enough for termination of parental rights."

MS. MOSS turned to Section 15 and noted that that language "interested person" has been changed to "non-party adult family member" in order to make it clear that parties to the CINA case are eligible for public counsel, but non-party adults are not. Section 16 was changed such that the mandatory language for foster parents being mentors was altered to language that would merely encourage it. She explained that in the original HB 53 there was a separate subsection for parental consent for drugs to treat mental health disorders; the new Section 17 folds this in to the original major medical provision that already exists in statute.

MS. MOSS pointed out that DOL recommended that those entities to which confidential information can be disclosed should include a review panel that might be created by a governor or the legislature, which was added to Section 26. She stated that Section 31 provides for a grievance system in statutory language; it allows for the regulatory process to actually design the nuts and bolts of the system. She surmised that this would allow for more public input, public hearings, and public comment. She turned to Section 36 and explained that it would cleanup awkward language dealing with foster homes, foster home licensing, and family homes who become foster homes; she opined that this would make sure that family members who became foster parents would still have a priority for placement.

MS. MOSS said that Section 50 changes the age group for which a transition plan would be prepared; currently it's 16-21 years of age and, at the request of DOL, the bill would change it to cover people ages 16-23 years of age. She continued, "The two areas of contention that will be discussed in [the House Judiciary Standing Committee] ... [are] the jury trial and the construction language. ... I think we're one step closer to the possibility of having at least some jury trials." She remarked, "What we may discuss in [the House Judiciary Standing Committee] is when a judge terminates parental rights on a preponderance of evidence, the parents would have a right to a jury trial."

[3:25:31 PM](#)

REPRESENTATIVE CISSNA stated that she saw a typographical error on one of the handouts she had from a previous meeting, and she asked if that had been remedied in Version X.

MS. MOSS replied that both Legislative Legal and Research Services and DOL had gone over Version X, so she was sure that the typo had been fixed.

CHAIR WILSON pointed out that the typo had indeed been fixed in Version X.

[3:27:26 PM](#)

REPRESENTATIVE JOHN COGHILL, Alaska State Legislature, sponsor, commented that he is willing to pull the jury trial provision out of the bill, and stated that he is open to making changes as the bill progresses. He noted, "There are some things in the bill that I think already give us some comfort level, for example: we have opened up some of the court proceedings, I think, and given some guidelines to that. And we're allowing an oversight board ... that will be formulated under regulations."

CHAIR WILSON stated that one of her concerns is that if everyone got a jury trial it would cost the state a lot of time and expense.

REPRESENTATIVE COGHILL said that it wasn't his expectation that every parental right termination would go to a jury trial.

[3:29:51 PM](#)

MS. MOSS commented that one of the things that has been discussed over a number of years is the disparity between the Indian Child Welfare Act (ICWA) and CINA. She said, "ICWA is clear and convincing evidence to terminate parental rights; CINA is preponderance of the evidence. ... Discussing this trigger point would be one way to bring that level of proof on CINA equal with ICWA."

[3:30:23 PM](#)

REPRESENTATIVE MCGUIRE said that one of the things that has happened as a result of ICWA and that high standard is that more and more Indian and Native Alaskan children are staying within their original family unit, including aunts, uncles, and grandparents. She said:

That was the policy reason behind ICWA and that high standard of clear and convincing evidence, and in point of fact, it's worked. ... You want to get kids out of places where they're not safe, but wherever possible, ... try to keep them placed as close as possible to that family unit that they're connected to in some way.

REPRESENTATIVE COGHILL responded, "That is exactly the point, plus many of the things that we're doing in this bill are creating a more open process, a clearer line of authority, ... but also recognition that the family needs to be more thoroughly involved."

[3:32:32 PM](#)

SCOTT TRAFFORD CALDER commented that he is a parent in Fairbanks and has been interested in these issues for the last 12 years, since his son was "essentially kidnapped and tortured by the Department of Health and Social Services." He continued:

So obviously I'm very interested in this legislation and I think I've established my credibility as a careful reader. And I have to say that there were two other people here earlier who were so upset by the chair's decision not to hear public testimony today that they left, so I think there might be some people expecting 'nasty grams' for that.

I have not previously testified on this bill, so I think that it's appropriate that I be given the opportunity to speak to the committee. And I regret that more public process and more discussion and more involvement with the people who are most interested in this has not taken place. At the same time, I certainly appreciate Representative Coghill and Rynnieva Moss for their diligence in this subject area over most of the years that I have been diligent in this subject area. And so I have a lot of respect and appreciation for them bringing this forward.

MR. CALDER continued:

So I'm for this bill. I have to say though that as a somewhat more than casual observer and a minor expert on this subject, I'm completely baffled by the 20 or so pages of amendments this time, plus the 10 or so

pages of amendments the last time, and a new CS. But I appreciate that the process isn't always simple and easy, so I'm willing to go with that. And I think that it's very appropriate that the committee favorably consider this bill and pass it along with excellent recommendations.

MR. CALDER continued:

At every possible opportunity, I would encourage members of the legislature generally to regard this subject area as a matter of human rights for the people who have been harmed, or who may be harmed in the future, by improper actions by the administration of state government. This is the highest order of responsibility and authority, and potential danger for citizens that can be manifested by government: the interference with parent-child relationships. And so if there is ever any doubt in your mind or confusion about which way to go on any principle, I would ask you to err on the side of human rights and to not shield yourself, or ... negligently avoid the historical facts of this situation. I would encourage you to become more informed about these subjects.

[3:36:22 PM](#)

REPRESENTATIVE ANDERSON commented that oral testimony is no more compelling than a letter, email, or public opinion message. He then defended the chair by saying that she has provided ample time [for public testimony]. He noted that the House Health, Education and Social Services Standing Committee is the first committee of referral for HB 53. He highlighted that the public can track legislation and scheduled hearings through their local newspaper and the legislature's Bill Action and Status Inquiry System (BASIS) on the Internet. He encouraged people not to wait until the last minute to become involved.

CHAIR WILSON closed public testimony.

[3:37:36 PM](#)

REPRESENTATIVE ANDERSON moved to report the proposed committee substitute for SSHB 53, labeled 24-LS0251\X, Mischel, 3/30/05, out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, CSSSHB

53(HES) was reported from the House Health, Education and Social Services Standing Committee.

HB 111-MEDICAID COVERAGE FOR BIRTHING CENTERS

CHAIR WILSON announced that the next order of business would be HOUSE BILL NO. 111, "An Act adding birthing centers to the list of health facilities eligible for payment of medical assistance for needy persons."

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REPRESENTATIVE HARRY CRAWFORD, Alaska State Legislature, as sponsor, explained that HB 111 would give uninsured women the same choice as insured women to have their babies at a birthing center, attended by a midwife. He pointed out that presently Medicaid pays for hospital births and doctors; the bill would allow Medicaid to pay for births at birthing centers as well. He commented that the bill would save Medicaid money because doctors and hospitals cost more than birthing centers.

[3:41:30 PM](#)

CHAIR WILSON asked whether the department estimated any savings from this. She noted that there was a zero fiscal note.

REPRESENTATIVE CRAWFORD replied that the state has no experience to draw on and thus can't estimate any savings. However, a study in California showed a 22 percent savings rate.

[3:42:39 PM](#)

BARBARA NORTON, Certified Nurse Midwife (CNM); Part Owner, Geneva Woods Birth Center, clarified that Medicaid pays for midwife services, but does not pay the facility fee. She said:

We really need to encourage the use of midwives in this state. The State of Florida passed a bill several years ago to say that by 2005, they wanted 25 percent of their births attended by midwives because there was significant cost savings. And I believe that they have instituted that. ... Approximately 14-15 percent of births in this state are attended by midwives. And just to compare a Cesarean section rate: ... the Cesarean section rate right now at Providence Hospital is 33 percent and growing because doctors as refusing to do a vaginal birth for someone

who's had a Cesarean section once. So now all of those women are becoming repeat Cesarean sections at twice the cost to Medicaid. Midwives have a Cesarean section rate in this state of between 3-10 percent, and physicians average probably 20-50 percent, depending upon which physician you're talking about. So preventing that first Cesarean section is a huge savings. And using midwives is a very significant way to prevent that first Cesarean section.

MS. NORTON continued, "The other issue is just offering families choice: we're not bringing high risk people to the birthing center; we're only bringing low-risk people to the birthing center."

MARIBETH GARDNER, Family Nurse Practitioner; Nurse Midwife, testified in support of Medicaid reimbursing birthing facilities. She stated that she has attended births at home, at birth centers, and in hospitals. She commented that births attended in nationally certified birth centers or birth centers that meet the National Association of Childbirthing Centers (NACC) are a nice alternative for low-risk women.

JACK NIELSON, Executive Director, Rate Review, Office of the Commissioner, Department of Health and Social Services (DHSS), stated that he works for the DHSS Medicaid program. He said that DHSS is neutral on the bill, but would like to raise a few points. He said:

The bill as it's written now adds birthing centers to the list of facilities whose Medicaid payment rates are required by statute to be established based on reasonable costs incurred by the facility. But ... the way it's written right now doesn't really add birthing centers as a Medicaid service authorized by state law to be offered in the Alaska Medicaid program. The list of authorized services is in AS 47.07.030. Adding the birthing centers to the list of authorized services in [AS 47.07.030] would make legislative intent absolutely clear and possibly assist the department in dealing with getting this type of service approved by the federal government as a Medicaid service so we can get the federal government to share in the cost.

MR. NIELSON continued:

There is a question whether birthing centers are an allowable Medicaid service that the federal government will participate in financially. A few states have obtained federal participation in the past but the federal criteria really aren't clear. And recently it's become more and more difficult to gain federal approval for provider types that are not specifically defined in federal statutes and regulations. The department would, of course, make every effort to gain federal approval. However, if we were not successful, payments to birthing centers would be state general fund only payments rather than payments matched by the federal Medicaid program. ... [In 2006] that match is going to be around 50 percent. The type of federal approval that we're able to gain could also somewhat drive the methodology for calculating payment rates that we would end up using for birthing centers. So, until we have a written approval from the federal agency, we won't know for sure what they would have to say about that.

In 2004 there were close to 10,000 births in Alaska; approximately 50 percent of those were Medicaid. Overall in the state, ... historically about 3 percent of births are in birthing centers. ... In some areas where there are birthing centers, the birthing center rates are much higher. ... Just looking at the statewide statistic though, we'd be looking at maybe 150 or so Medicaid births per year in birthing centers if this provider type were adopted by Medicaid.

MR. NIELSON continued:

Some of the factors to consider in estimating costs and savings on adding this new provider type: on the savings side, we did find a study that was done in California ... where paying for these facility fees for birthing centers instead of hospitals resulted in a 22 percent savings overall in facility fees, and overall to the ... California Medicaid program, it basically resulted in a 7 percent savings, if you include doctor fees versus midwife fees.... So there are studies out there that show some savings along those lines. Certainly the facilities would have a lower cost; the space, the staff, the supplies, would be lower cost. As was mentioned earlier, fewer C-sections would likely happen using the birthing

centers. Probably less epidural anesthesia would be used, and so all of these things are sort of on the savings side of the equation.

MR. NIELSON continued:

On the cost side of the equation we have things like: we would have to change our Medicaid management information system; that costs about \$130,000 to put a new provider type in. We could have some births now that are happening at home that would move to the birthing center; we would have increased costs there. In the case where we have hospital transfers, we may end up paying both the birthing center and the hospital for those situations, and Medicaid would likely have to pay transportation costs between the two.... Hospital costs, of course, are different by different area of the state. There is always the potential of a slight chance of a bad outcome where the patient isn't in the hospital while they're giving birth and so they're not right on site if something bad were to happen. In the hospital study, the birthing centers that were studied were part of a large health network, either owned by an organization that had a hospital and various levels of care within it, or ... the hospital is a member of a network with a firmly established referral process....

This regulation would require the department to set the rates for the birthing centers based on actual birthing center costs. We don't know for sure what those costs are at this point; we would have to find out and set the rates accordingly. But that's sort of an unknown at this point. Presumably it would be less than a hospital cost, but we just don't know how much.  
...

The federal government may have a say in the type of reimbursement system we use. The federal government may not participate, although we would work certainly very hard to try to make sure that happened. ... Alaska Medicaid babies may be more at risk than the California study; you know, we've got a lot of rural communities....

CHAIR WILSON inquired as to the number of birthing centers in the state.

MR. NIELSON replied that there are eight. In further response to Chair Wilson, Mr. Nielson specified that most of the birthing centers are located around population centers. Upon further questioning, Mr. Nielson said that there are at least three states for which birthing centers are covered by Medicaid.

CHAIR WILSON surmised that if there are at least a few other states, the federal government would probably cover Alaska as well.

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REPRESENTATIVE CRAWFORD expressed his willingness to address any problems or concerns with the bill through amendments.

[3:59:32 PM](#)

TORA GERRICK, Part Owner, Midwives Birth Center, commented, "Without this bill we're definitely sending a negative message to our working class and underinsured people in Alaska. I think that we're telling them where they have to have their babies, and frankly, I think it's a subtle form of discrimination, economic discrimination at best." She highlighted that her facility participates in the community in a variety of ways, including the YWCA Early Breast and Cervical Cancer Screening program that offers early cancer screening for low income women in Alaska. She also highlighted that, to the best of her knowledge, all of the birth centers in Alaska are owned by Alaskan women. Therefore, by supporting this bill, the [state] would also be supporting locally owned businesses, and would keep Medicaid monies in the state. In response to an earlier statement by Mr. Neilson, she clarified that women who can't afford the birth center facility fees aren't necessarily choosing home births. In fact, she said she has seen them go to the hospital instead. She also reiterated that the birth centers only offer services to low-risk women, and so high-risk women would already be birthing in hospitals.

[4:02:33 PM](#)

REPRESENTATIVE CISSNA commented that there is no one on Prince of Wales Island to deliver babies, and therefore the women there have to travel to Ketchikan about two weeks prior to their due date to deliver. She asked if those costs wouldn't be cut as well if there were birthing centers in rural areas.

CHAIR WILSON replied that she wasn't sure that Medicaid covered those costs. She noted that no babies are delivered in Wrangell anymore due to insurance costs.

[4:04:27 PM](#)

KITTY ERNST commented that she is not an Alaskan, but is in the state for a meeting being conducted on women's health by the local chapter of the American College of Nurse Midwives. She stated:

[House Bill 111] speaks primarily to a cost savings of only \$40,000 for 100 births in the birth center, which ... it is alleged could easily be offset by one birth center with serious complications. This sort of infers that serious complications don't occur in hospitals, and they do, and they also have added costs when serious complications occur. Cesarean sections ... result from a serious complication. Neonatal intensive care units result from serious complications. Both of these complications, for example, are far less ... in a birthing center, because you're dealing with a low-risk population. But it is significant that in a national birth center study, the Cesarean rate was 4 percent among 17,000 birth center women. I think that represents a significant cost savings. When we look at the fact that the Cesarean section rate in this country in 2003 has climbed to an all-time high of 28 percent and much higher in certain locales. And the prognosticators are telling us it's going to be 50 percent by 2010. And that's attributed to ... elective Cesarean sections, which means it does not have to be a medical indication to have this major surgery, and secondly, the virtual national shutdown of any place to have a VBAC, which is a vaginal birth after Cesarean section. And both ... the American College of Obstetricians and Gynecologists and the American College of Nurse Midwives have strongly stated that the solution to the problem is to reduce the number of primary Caesarian sections. And that is exactly what the birth centers do. ...

MS. ERNST continued:

I really urge you not to take a short sighted look in your decision on whether or not to reimburse birth

centers because my 30 year experience in working to establish and demonstrate and evaluate this innovation in the delivery of health care ... is that we need a lot more evidence before we shut these places down. And if you don't pay a facility for its services, it's going to shut down. ... All the other things are also important, such as giving choice to Medicaid mothers. ... We have the experience ... that the time and education and intensive care given by midwives in birthing centers empower these women to take control of their lives.

MS. ERNST shared a few anecdotes regarding empowerment of women at birth centers. She concluded by saying that birth centers are safe and there is a 97 percent satisfaction rate among the women who use birth centers.

[4:13:22 PM](#)

KAYE KANNE, CDM, Executive Director, Juneau Family Birth Center, pointed out that she recently calculated that on average a hospital facility fee is about \$2,500 more than a birth center facility fee, not counting any additional services. She also noted that in 2004, an estimated 186 women on Denali KidCare have had babies at Alaskan birth centers. She said that an additional 85 women were not able to pay the facility fee. She calculated that the state paid over \$200,000 additional for those 85 women to go to the hospital instead of the birth center. Noting that the hospital in Juneau has a Cesarean section rate of 40 percent while the local birth center has an eight percent rate, she commented that many of those 85 women probably ended up having Cesarean section, which cost the state tens of thousands of additional dollars.

MS. KANNE stated that even if the federal government did not support this, the cost to the state of paying 100 percent of the birth center facility fees is still less than paying 50 percent of the hospital facility fees. In response to Representative Cissna's earlier question, she replied that many women from rural areas come to Juneau to deliver their babies, and if they have Denali KidCare coverage, this will pay for the travel and lodging expenses, whether the women have their babies at the birth center or at the hospital. However, if there is a hospital in the rural area, Denali KidCare will cover the mother at that hospital, but not cover her to travel to Juneau to deliver her baby.

MS. KANNE replied to an earlier remark by Mr. Nielson:

I have never seen anybody have a home birth and then go to a birth center birth; once they've had a home birth, they're always going to have a home birth. What I do see is women who choose to have a hospital birth because they can't afford the facility fee. One thing we do at a nonprofit birth center is we donate that facility fee if people cannot afford to pay, or we offer them a sliding scale. And it does make it hard for our ... nonprofit birth center to pay the bills. And I think it is really important to support our birth centers and to keep our doors open; we do need to be on an even playing field with the hospitals as far as getting reimbursement from Medicaid.

CHAIR WILSON remarked that she assumes that midwives' charges are less than the doctors' charges.

MS. KANNE replied, "Midwives charges are less than a physicians', and Medicaid pays midwives at a lower rate than they pay physicians. ... We do get paid by Medicaid, but probably we get ... 60 percent of what physicians get."

[4:19:44 PM](#)

CHAIR WILSON closed public testimony.

[4:19:52 PM](#)

REPRESENTATIVE SEATON moved to adopt Conceptual Amendment 1, which would make the provisions of Section 1 contingent upon approval of matching funding from the federal Medicaid. There being no objection, Conceptual Amendment 1 was adopted.

[4:20:22 PM](#)

REPRESENTATIVE KOHRING commented that he thinks it is good to encourage people to attend birthing centers, however, he stated, "From a philosophical standpoint, I just am concerned about the fact that we're encouraging use of Medicaid monies for what you had described as not a sickness...." He questioned the wisdom of using Medicaid dollars when "if they're young, capable of producing children and they're healthy, they ought to figure out a way to pay their own bills." He said, "I think that perhaps we ought to go the other direction and not encourage Medicaid payments either in these kind of facilities or in hospital

situations, and perhaps that will be an incentive for women to go to these kind of facilities." He continued, "My point is that maybe we ought to discourage the use of Medicaid monies and not encourage the use of Medicaid monies."

[4:22:47 PM](#)

REPRESENTATIVE CRAWFORD clarified that this bill is not to encourage more people to use Medicaid, but to allow those people who are already on Medicaid to use a lower cost facility.

[4:23:21 PM](#)

REPRESENTATIVE SEATON moved to report HB 111, as amended, out of committee with individual recommendations and the accompanying fiscal notes. There being no objection, CSHB 111(HES) was reported from the House Health, Education and Social Services Standing Committee.

HB 220-MENTAL HEALTH PATIENT RIGHTS:STAFF GENDER

CHAIR WILSON announced that the next order of business would be HOUSE BILL NO. 220, "An Act relating to mental health patient rights and to a hospital's duty to provide choice of the sex of staff providing intimate care to a mental health patient."

[4:24:30 PM](#)

REPRESENTATIVE SEATON moved to adopt the proposed committee substitute (CS) for HB 220, labeled 24-LS0667\Y, Mischel, 3/31/05, as the working draft. There being no objection, Version Y was before the committee.

[4:25:11 PM](#)

REPRESENTATIVE LES GARA, Alaska State Legislature, sponsor, said, "House Bill 220 is about the basic rights of our most vulnerable patients to be treated with dignity." He explained that the bill would require that mental health patients have the opportunity to choose the gender of the person who bathes, dresses, or otherwise cares for them in an intimate way. He presented examples of particular instances in which female patients have expressed discomfort in being cared for by a male staff member. He pointed out that there are news articles regarding this issue in the committee packets.

REPRESENTATIVE GARA said that a number of mental health advocacy groups have read the bill. In fact, the National Association for the Mentally Ill has said, "The right to choose a same-sex care provider while in a vulnerable mental state should be a state mandated right." He continued:

The Mental Health Consumer Web supports the bill. The Law Project for Psychiatric Rights [and] the Disability Law Center support the bill. And the bill essentially parallels a policy that has been adopted at a facility in Maine, the Bangor Mental Health Facility; they have a provision like this. A number of concerns have been raised by some of the facilities in the state. We've satisfied I believe about 98 percent of the concerns. [Alaska Psychiatric Institute (API)] still has some concerns about the bill that, frankly, you'll either support the bill or you'll support API's position that we shouldn't have a bill like this, and we can't get past API's concerns.

We've tried to make the bill flexible so it doesn't require that any facility hire any additional staff. If a ... female patient asks for a female provider and no female provider is available, that just has to be documented on the chart. We've tried to put as little burden as possible on professional staff so if a female patient ... wants a female staff member to bathe that person, the female staff member doesn't have to be of a particular license or particular profession; it's up to the facility.

REPRESENTATIVE GARA continued:

If [the facility] can't provide a provider of the appropriate gender, then all they have to do is get a licensed staff member of the other gender to do the bathing; just so you have a licensed staff member there in that case. But then even ... if there's no staff member that's available to satisfy the concerns of the patient, ... then all you have to do is say in the chart, "We had no female staff members available that day." ... So you don't have to hire anybody additionally; you just have to put it in the chart as to why you couldn't comply.

One of the mental health facilities raised the concern that sometimes you have a mental health patient who

would inappropriately ask for a particular gender of provider, maybe somebody with a sexually aggressive condition or something like that, and so we've put in the bill that if it would be inappropriate for the patient's treatment to let them choose what gender person treats them then that's fine too; then you don't have to comply with the provisions of the bill.

REPRESENTATIVE GARA continued:

[In Version Y] we made about six changes to address the concerns that came in. ... We don't want this bill to apply to small facilities because small facilities don't have enough staff, frankly, to let people choose the gender of who treat them. So it only applies to facilities where you have 10 or more staff members on duty providing mental health care, and still they have an out even then if they don't have enough women or enough men available on a particular day.

REPRESENTATIVE GARA said that the original intention of the bill was to require that the provider be the same gender as the patient, but it was changed to allow the patient to decide. However, he noted that if the committee preferred, he would be willing to allow a conceptual amendment to return the bill to its original state, requiring the provider to be the same gender as the patient. He commented, "I think we've satisfied the concerns of every mental health facility that's contacted us except for API."

[4:32:35 PM](#)

REPRESENTATIVE MCGUIRE remarked that she thinks this is a great bill and she applauds the efforts involved. She said that she prefers to leave the bill as is. She inquired as to why the bill only applies to patients 18 years of age or older.

REPRESENTATIVE GARA noted that Alaska law says that parents get to make medical care choices for people under 18 years of age. He said that the original version applied to all patients, and provided that the parent would have the right to make the request for anyone under 18. He commented:

One of the facilities in Anchorage made an interesting point; they stated that there is sometimes a link between a child who has mental health problems and

parents who have mental health problems. And [the facility] saw a problem with allowing a parent with a mental health problem to make a choice like that for a child with a mental health problem. I don't know what to think about that concern. The majority of mental health patients are adults, and I suppose it's a policy call for the committee. We were somewhat sympathetic to the concerns of the folks at [North Star Behavioral Health System] in Anchorage about the difficulty of dealing with the concerns from a parent for a child who's in a facility. We could go either way; I suppose we prefer the CS the way it is right now.

CHAIR WILSON pointed out that a spokesperson from North Star Behavioral Health System was on the teleconference.

4:36:06 PM

PATRICK HIGGINS, North Star Behavioral Health System, began by relating that the current version of HB 220 does address the organization's issues. He explained that his agency serves children ages 3-17, and many of them have disorders involving sexual contact issues. He said that the agency attempts to take a great deal of care with these issues and thus have policies dealing with the same-gender issue.

REPRESENTATIVE MCGUIRE commented:

What we're dealing with here then is probably a drafting issue and a legal issue, because ... [it] sounds like there aren't any problems accommodating the basic policy that's contained in the bill, but rather because of an issue of capacity, not having achieved the age of majority that then you would have to provide for that parent to have that choice, and that's where the problem comes about.

REPRESENTATIVE MCGUIRE suggested that perhaps intent language could be included in the bill.

4:38:47 PM

CHAIR WILSON stated that sometimes [the gender of the care provider] is part of the treatment plan. She said that there are instances of children who "like to act out in front of somebody of the opposite sex."

REPRESENTATIVE SEATON noted that many times children are in the custody of the state, and he questioned how the state would deal with these issues.

4:40:24 PM

REPRESENTATIVE ANDERSON commented, "I give great deference and credence to the opinions of like associations.... I also give great deference to Providence Hospital because of its size and probably impact in the bill affecting it more than any other facility. ... Have they talked to [Representative Gara]?"

REPRESENTATIVE GARA replied that he had been in contact with a number of facilities and "we were able to satisfy ... what we considered to be the valid concerns of many of the facilities." He offered his belief that every member [excluding API] of the Nursing Home Association either has no concerns, hasn't stated concerns, or thinks the bill is okay. He noted, "The bill doesn't require that you ask the patient what gender of a provider they would like. It would only be if they bring it up; they have the right to request it." He said that if the patient is a child in the custody of the state, the original bill would have allowed the state to decide. He further commented:

Sometimes people are being treated for sexually inappropriate conduct, and so the bill provides that if it would not be in the best interests of the patient's treatment ... to allow the patient to make that choice, ... then the bill just doesn't apply; we're not going to give people the right to undermine their own treatment.

REPRESENTATIVE ANDERSON remarked that he would be interested in any studies suggesting that male to male or female to female staff care would reduce abuse, "unless your intent here is just for the comfort of the patient." He then stated that the bill concerns him as a possible "haven for lawsuits." Lastly, he commented, "[It is intriguing], if you're looking at mental capacity, and in this case very diminished, I'm intrigued at how they can have the capacity to choose gender."

REPRESENTATIVE GARA replied that if a patient is so incapacitated that he/she needs to have a guardian, then the guardian would make the request. But, he noted, "If you're not so incapacitated, you just have mental health problems, but you don't have a guardian, then you have the right to make the

request." Regarding Representative Anderson's question about possible studies, Representative Gara answered that he doesn't think there are any such studies. He reiterated that this bill is dealing with "a comfort issue, a privacy issue, it's a dignity issue." Regarding liabilities, Representative Gara responded that the bill doesn't provide for penalties or any specific cause of action or damages. He again explained that if a facility is unable to provide the requested gender of the care provider, the facility only needs to document this.

[4:46:35 PM](#)

CHAIR WILSON commented that nurses and care providers are very aware of the importance of documentation.

[4:47:05 PM](#)

REPRESENTATIVE CISSNA commented that some children have become inappropriately sexualized by manipulative adults, and therefore it's best to leave the power in the hands of the parent and the therapist to develop the best plan for a child under 18 years of age. Having worked as a mental health therapist, she stated that when the state has custody of a child, the state usually listens to the advice of the professionals.

[4:49:39 PM](#)

REPRESENTATIVE SEATON pointed out that subsection (c) is putting a new duty on the facilities, and he asked if the sponsor had spoken with the facilities about the bill's requirement that a notice be posted in the patient rooms. He commented that if a notice was posted in every room it would probably cause more casual requests rather than requests in order to remedy genuine problems.

REPRESENTATIVE GARA said that no one has raised a question about posting the notice. He said:

This is almost a catch-22; if you don't post the notice you'll have some patients who are too timid to request to be treated appropriately, and the notice would ... let them know they have a right to be treated appropriately. On the other hand, if you do post the notice, you might have more people request them than is necessary.

[4:52:48 PM](#)

REPRESENTATIVE ANDERSON asked if Mr. Higgins supported the bill.

MR. HIGGINS said that North Star's issues and concerns have been addressed by the sponsor.

HOLLY GLAESER, Director, Behavioral Health Unit, Fairbanks Memorial Hospital, testified that this issue should be an organizational issue and not a legislation issue.

KARL SANFORD, Chief Nursing Officer and Associate Administrator, Fairbanks Memorial Hospital, testified in opposition to HB 220. He stated his belief that this is an unnecessary bill. He said:

Currently all hospitals of any size in the state, I believe, are accredited by the Joint Commission for Hospitals nationally. Accrediting bodies such as the [Joint Commission for Hospitals], the state itself, as well as the mental health board, are oversight bodies which really are intended to prevent issues that Representative Gara, I believe, has introduced this bill to address. Those bodies frequently and on a regular basis ensure that facilities abide by patient rights, policies within the facilities. ... I have an overall concern about legislating response to patient complaints; I think it's a bad policy to follow. ...

This bill overrides my nursing judgment as a professional nurse. I'm offended by this because it is my job as a nurse to make an appropriate assessment of the patient upon admission into a facility and to make sure that that patient's issues are dealt with appropriately. I believe I have the capability, as do every other registered nurse in the state that takes care of mental health patients.

CHAIR WILSON asked Mr. Sanford if the bill would prevent him from conducting any services that he now gives.

MR. SANFORD replied that it would not.

[4:56:01 PM](#)

DORRANCE COLLINS stated:

I support the passing of the committee substitute for HB 220. I also ask that the committee read the seven

support letters submitted. House Bill 220 is based on a Bangor, Maine policy which uses words like "must" and "will." It's a strong policy and very clear. House Bill 220 is also very strong. In a perfect world we could just send everybody involved an e-mail or a letter and tell them to handle it. ... It is not a perfect world; everyone has an axe to grind. Laws, regulations, and guidelines are necessary on this issue.

House Bill 220 is fair to the psychiatric patients, many of which have been sexually abused, not always by the opposite gender, which is why gender choice for intimate care is very important. House Bill 220 is fair to the institutions; it gives them an out. On page 2 of the bill it says the institutions only have to make a good faith effort, then document in the patient's records why gender choice was not provided. That is a huge loophole for any contingency for the institutions.

Defeating this bill is only a matter of convenience to the mental institutions. What the last hundred years has taught us is the institutions will fight for convenience. It is much more to the patient; it is about not being degraded or humiliated, and maintaining some control over your life and your body. It is important and it is doable. We ask that HB 220 be passed.

[4:58:21 PM](#)

FAITH MYERS testified in support of the committee substitute for HB 220. She stated that she is a former psychiatric patient. She said:

Over the last four years I have testified on the issue of psychiatric patients not having the right to gender-choice for hands-on intimate care. I have traveled to Fairbanks, Juneau, and in Anchorage. I have testified in front of all relevant boards and committees. House Bill 220 is a patients' rights bill; it is necessary. A high percentage of the psychiatric patients in Alaska's mental hospitals have been sexually abused as children or adults; it is difficult to know which gender abused them, which is why it is important to let the patient choose the

gender of the staff they feel most safe and comfortable with. This is why gender choice of staff is more preferable than same-sex of staff in legislative wording of the bill.

There is an out for the institutions: on page 2, line 2, of HB 220 it states the institutions must only make a reasonable and good faith effort. On line 4 it simply says that the institution document in the patient's record the reason why they couldn't provide the requested gender. That gives the institution an out for any contingency. Some of the seven support letters submitted in favor of a bill have been written by people who either had the experience of being in an Alaskan psychiatric institution or have had family members in an Alaskan psychiatric institution. House Bill 220 is based on a Bangor, Maine policy and has proven that it is doable. I support CSHB 220 and ask that it be passed.

[5:00:32 PM](#)

RON ADLER, CEO, Alaska Psychiatric Institute (API), Division of Behavioral Health, Department of Health and Social Services, testified in opposition to HB 220. He said:

We believe this is a policy issue and want the opportunity to address these issues in policy rather than legislation, especially since there's only one situation that we're aware of that raises a concern over this issue in the entire system of care. We have no reports of this whatsoever....

MR. ADLER continued:

I'm seeing this bill as the API bill, not a patients' rights bill. ... Some of the negotiations that have already occurred really exempt every other hospital in the State of Alaska but API, so it really is the API bill. Let me tell you why I think that's inappropriate. ... On [July 1, 2003], API requested from the [Assistant Commissioner of the Division of Finance and Management Service, Department of Health and Social Services] Janet Clarke [to find] funding to create a consumer and family specialist position with a specified program. This was granted and with this new program at API, on a daily basis we have a

consumer and family specialist that surveys all of our guests at the hospital to assure that appropriate and quality treatment services happen. Results of these daily surveys are tabulated each month and reviewed by the API governing board. On [July 1, 2003] there was no incentive for us to do this; we did it because it was the right thing to do.

On [October 1, 2004], API established a gender-sensitivity policy which already provides a person receiving services at the hospital everything that's being requested. We have gone to the point of training all of our staff on this competency that's all recorded in personnel documents. On [October 1, 2004] there was no legislative incentive or mandate for us to do this; we did it because we listened to input and feedback at our various meetings in the community and we did it because it was the right thing to do. ...

This issue came before the Alaska Mental Health Board's legislative committee who refused to support legislative intent on this issue. Rather, the board decided to assert its influence by making recommendations to [Bill Hogan, Director, Division of Behavioral Health], and specifically requests [Bartlett Hospital] and Fairbanks Memorial Hospital to comport to the same standards as API. The department supports this position: allowing the division to make reasonable changes to advance health care in policy rather than legislation. ...

MR. ADLER continued:

This legislation is framed within the context of patients' rights. API provides an office for the Disability Law Center in the hospital; what other hospital in Alaska makes such a provision to ensure excellence in patients' rights? One of the other changes that happened here is, ... if there is no unlicensed individual on staff, you're allowing the hospital or institution to redirect a licensed person from another unit - this is a problem with [registered nurses (RN)]; we have a recruitment and retention issue with RNs not only at API but statewide. We know from an operating perspective when you ask an RN to step outside their prescribed duties and tasks for the

evening and go do another task, medication error rates go up. And actually that is one of the number one issues ... all hospitals face in our regularly scheduled joint commission site reviews. We've looked every month at our medication error rates; we're keeping them very low at API, but we know the more extraneous demands we make on RNs, the more difficulty we have in managing this. ...

The Mental Health Board has asked us to make some language changes in our existing policy so that it will exactly mirror the policy of Bangor Mental Institute. We agreed to do that. So our basic position is that this is unnecessary at this time.

CHAIR WILSON asked Mr. Adler if this bill would prevent API from conducting the services that it now gives.

MR. ADLER replied that it would not.

[5:06:34 PM](#)

REPRESENTATIVE ANDERSON said that he had some concerns and they coincided with Dr. Adler's. He remarked that the witnesses' comments that patients are being degraded and humiliated "rubbed me wrong because it suggests that when it's a male to male or female to female there's degrading and humiliation." He asked Mr. Adler to respond to this, and commented, "I assume the current system is working fine other than the, again, comfort level of some mentally disabled folks."

MR. ADLER replied:

This brings up a very sensitive point. I just really dislike talking about acute psychiatric and behavioral disorders in public because it's just a terrible disorder that people have. And what is degrading and erodes dignity and respect for the person receiving services is when they have to do something that they are forced to do on an involuntary basis. Yet that is the reality that we're faced with. People frequently are admitted to API not of choice, but on a legal basis and frequently we have to do things to stabilize people. And while we make every attempt in the world to do that in a respectful and dignified way, there are times we have to prevent people from hurting

themselves or others and that requires us to make certain accommodations in terms of these issues.

REPRESENTATIVE ANDERSON said that some say the theme of this bill is about "comfort level." He asked if most of the patients in API are there because they have been sexually abused.

MR. ADLER answered that this is an emerging concern on a nationwide level. He said:

We believe in this field that we are finding evidence of trauma more and more often, and we believe that we have to do a reasonable trauma screen and evaluation to make sure we don't help people relive past traumas. ... Whether that's a child watching a violent family interaction, which is a traumatic experience, or somebody being sexually abused, or somebody being witness to a friend's suicide, we know that this has an impact, and we know that if we don't deal with this in an appropriate way, especially in an acute in-patient setting that ... we're not doing what's best for the individual.

REPRESENTATIVE MCGUIRE commented that if it is already the policy at API to do all that is necessary for the patients' comfort, then she fails to understand why Mr. Adler opposes the bill. She said, "All the bill does is put into place statutorily the policy that ... you have in place at API."

[5:11:36 PM](#)

MR. ADLER said that API makes that accommodation currently, while the bill exempts all the other hospitals within Alaska. He said, "Why legislate something that's happening?"

CHAIR WILSON asked if Mr. Adler was saying that no other hospitals have a staff of over 10 people.

MR. ADLER replied, "On any given shift, if you were to take a survey of the other hospitals today, that's correct."

[5:13:13 PM](#)

REPRESENTATIVE SEATON said:

That doesn't mean that if you don't have 10 [staff members on duty] you shouldn't do it." He stated that

he is a little concerned that page 1, subsection (b), and said, "If somebody's incapacitated, then we put in an immediate burden that it has to be the same-sex ... nurse, and I'm wondering why we're doing that. ... We don't have a request, but all of the sudden we're putting this blanket duty on if somebody's incapacitated; now we're presuming that there is this request that it's going to be the same-sex person and it seems to me that possibly even if you have 10 staff members on duty, that could be a burden.

[5:14:32 PM](#)

REPRESENTATIVE GARA said that according to the bill, if a person is incapacitated and there isn't same-gender staff available, then the exceptions would apply; it just has to be written in the chart. He agreed that the bill would be creating a presumption in the cases where a person is incapacitated.

[5:16:17 PM](#)

RICHARD RAINERY, Executive Director, Alaska Mental Health Board, said that the board supports the intent of the legislation however, "we felt the most direct approach was to ask the Division of Behavioral Health and [API] to institute policy changes that reflect these concerns." He noted that there are some differences between the board's policy and the policy followed in Bangor, Maine; the board would ask that the hospital honor the patient choice of gender.

The committee took an at-ease from 5:18:12 PM to 5:18:25 PM.

[5:18:37 PM](#)

REPRESENTATIVE SEATON asked Mr. Rainery if removal of subsection (b) from the bill would influence the board one way or another.

MR. RAINERY replied, "I don't believe so, no." He pointed out that the majority of the members of the Mental Health Board are consumers of mental health services or their families.

[5:20:00 PM](#)

CHAIR WILSON said, "So basically what you're telling us is that because this has come up, the Mental Health Board itself has decided to put a policy in place that would take care of this concern."

MR. RAINERY responded, "We have formerly requested of the Division of Behavior Health and [API] that they revise the appropriate policies to reflect the intent of what this bill asks for, yes. And we intend to work with them to make sure that those revisions do that."

[5:20:50 PM](#)

ROD BETIT, President, Alaska State Hospital Nursing Home Association (ASHNHA), testified in opposition to HB 220. He said:

We don't support the bill, and not because of what the sponsors are attempting to do, but because of the scope of what the bill would set in motion and a solution for a problem that really has only been one incident, to our knowledge, and that it would go beyond what's necessary to address the concerns. We think that the professional practice expectations of the medical staff that are working with these patients, each facility's commitment to meet those kinds of intimate care expectations when someone requests them and policies that they have in place to do that have been affective. To their knowledge there's been no surveys or reviews by licensing organizations to indicate there's any failure in those policies. And that would be the best place for us to put our trust in terms of what needs to happen next to fix the one incident that occurred. And so, we would agree with the Mental Health Board on that.

MR. BETIT applauded Representative Gara's efforts and said that at this point this bill would not impact all five members of the ASHNHA with mental health units, but would primarily affect API and occasionally Providence Hospital as well.

[5:22:52 PM](#)

CHAIR WILSON asked that the director of the Division of Behavioral Health come forward, and she asked him how he felt about the bill.

BILL HOGAN, Director, Division of Behavioral Health, Department of Health and Social Services, commended the bill's sponsors because "we think what is being considered in the bill is very important to the people that we serve." However, he continued:

We feel as though we can accommodate the concerns that are being raised through policy changes at [API]. In fact, we have ... over the last year and a half or more, tried to change policy based on consumer concerns to ensure that clients or patients do have ... gender choice when there's intimate care involved. We also recognize the concerns expressed by the Mental Health Board.... We have every intention of working with the Mental Health Board with the [API] governing body to implement those policy changes as well. ... Our feeling is that we can make the changes that need to occur through policy and through practice standards, and not through legislation.

CHAIR WILSON said, "If you're going to do that, ... what is the objection of having it in statute?"

MR. HOGAN responded, "Perhaps it's philosophical. We feel as though we can do what needs to be done without statutory change, and if there was a need for statutory change, I believe I would be up here supporting [it]."

[5:25:16 PM](#)

REPRESENTATIVE MCGUIRE responded to Mr. Hogan:

I might trust you now and the people who are in the position of policymaking right now, and five years from now I may not. And I think that's one of the most important things about considering statutory changes versus allowing your policies to govern. If the issue is important enough, we put it in the law books, and that way it's there for all time to come. And if a future legislature decides for policy reasons to remove that, then the debate will occur in a public setting; the public will be aware of it, and there will be an opportunity for folks to testify. The concern about making these really important decisions on a policy level is, oftentimes, many people don't even know that they're taking place; they don't know the policy is in place, they don't know the policy is being changed. So there isn't that opportunity for people to weigh in on it. And so, with all due respect, I think that's why it is appropriately placed in Alaska state law.

REPRESENTATIVE SEATON said that he is uncomfortable with parts of the bill. He moved to adopt Conceptual Amendment 1, as follows:

Page 1, lines 11-14  
Delete subsection (b)

REPRESENTATIVE SEATON stated that the requirement in subsection (b) could be quite burdensome [to the treatment center].

REPRESENTATIVE ANDERSON objected for discussion purposes. He asked if Representative Seaton would object to the addition of a friendly amendment to the conceptual amendment, or if perhaps he should make his own amendment to change line 10 on page 1 to read, "is the opposite sex."

CHAIR WILSON recommended that Representative Anderson make a separate amendment to address this concern.

REPRESENTATIVE ANDERSON removed his objection.

REPRESENTATIVE MCGUIRE asked for clarification of the definition of "incapacitated," and wondered what percentage of the population in a mental hospital would be considered incapacitated. She commented that her only concern is that [the deletion of the word "incapacitated"] would gut the bill.

REPRESENTATIVE SEATON replied that he didn't think it would gut the bill. He explained:

If you're saying that anybody in a mental institution is incapacitated, what we're really saying is there's an automatic no-request; everybody in the institution must be treated as if they did make a request. ... What I'm trying to do is get it so if anybody makes a request, or their guardian or whoever [makes a request], then that request would be honored through [subsection (a)], but that we would get rid of the automaticity of ... if somebody's incapacitated.

REPRESENTATIVE MCGUIRE responded, "So then it would speak to nothing on incapacity; there would be no policy."

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REPRESENTATIVE GARA said:

I think that's right. ... By taking out [subsection (b)] you now make the law say, "If you're 18 or older, you get to make the choice." And I think it's implied that if you're 18 or older and can't make the choice and you have a personal representative, then the personal representative can make the request. You might want to make clear that [the bill is referring to] a person 18 or older or their personal representative, just to make that clear, but I think that would be implied. So I think you could take out [subsection (b)] and you would still protect people or their personal representatives who want to make the request.

[There being no objection, Conceptual Amendment 1 was adopted.]

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REPRESENTATIVE SEATON moved to adopt Conceptual Amendment 2, as follows:

Page 2, line 3, after "place"  
Delete "in patient rooms"

REPRESENTATIVE ANDERSON objected for discussion purposes.

REPRESENTATIVE SEATON explained, "This is a lot of signage going up around; all we need is notification in the hospital."

REPRESENTATIVE ANDERSON removed his objection.

[There being no objection, Conceptual Amendment 2 was adopted.]

REPRESENTATIVE MCGUIRE moved to report the committee substitute for HB 220, labeled 24-LS0667\Y, Mischel, 3/31/05, as amended, out of committee with individual recommendations and the accompanying fiscal notes.

REPRESENTATIVE ANDERSON objected for discussion purposes. He recounted that many of the treatment centers that testified are opposed to the bill, which is of concern for him. He removed his objection.

CHAIR WILSON stated her concern [that the treatment centers are opposed to the bill].

There being no objection, CSHB 220(HES) was reported from the House Health, Education and Social Services Standing Committee.

**ADJOURNMENT**

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at [5:34:02 PM](#).