

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

July 26, 2006

8:04 a.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Paul Seaton, Vice Chair
Representative Carl Gatto
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Tom Anderson
Representative Vic Kohring

COMMITTEE CALENDAR

USING HEALTH CARE DOLLARS WISELY: IMPROVING BIRTH OUTCOMES

- HEARD AND HELD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

STEPHANIE BIRCH, Chief
Women's, Children's and Family Health
Division of Public Health
Department of Health and Social Services
Anchorage, Alaska

POSITION STATEMENT: Provided information regarding improving birth outcomes in Alaska.

JERRY FULLER, Project Director
Office of Program Review
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: During discussion of Native health, provided information.

KARLEEN JACKSON, Commissioner
Department of Health and Social Services

Juneau, Alaska

POSITION STATEMENT: Answered questions.

PAT CARR, Health Program Manager
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Provided comments with regard to the results related to the expansion of the community health center program.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at [8:04:35 AM](#). Representatives Wilson, Seaton, and Gardner were present at the call to order. Representatives Cissna and Gatto arrived as the meeting was in progress.

USING HEALTH CARE DOLLARS WISELY: IMPROVING BIRTH OUTCOMES

CHAIR WILSON announced that the only order of business would be a discussion related to using health care dollars wisely to improve birth outcomes. She noted that this meeting and the upcoming meetings will pull together matters that were discussed in a conference in Denver, Colorado, regarding spending health care dollars wisely. The goal is to review programs and determine whether services can continue and increase while saving money in the long run.

[8:08:02 AM](#)

STEPHANIE BIRCH, Chief, Women's, Children's and Family Health, Division of Public Health, Department of Health and Social Services, began by informing the committee of her background as a nurse. Ms. Birch drew the committee's attention to the PowerPoint entitled, "Public Health Protecting and Promoting the Health of all Alaskans." The slides in this PowerPoint review indicators of performance that is measured by her section as well as discussion of solutions. Slide one addresses prenatal care, which is defined as the initiation of care. The current challenge is that the number of visits that women receive during pregnancy don't meet the national standard or the Healthy People (HP) 2010 goals. In fact, data relates that one in five women didn't receive care as early as desired. Furthermore, nearly one in three Alaskan women who delivered an infant received less than adequate prenatal care and nearly one in seven received nearly no care at all. Therefore, quite a large proportion of

women are coming into labor and delivery without having received any prenatal care.

[8:10:28 AM](#)

CHAIR WILSON asked if the lack of care is due to the woman being located far away from where the care is located.

MS. BIRCH answered that often the woman has a lack of the following: knowledge of the pregnancy during the first 12 weeks of pregnancy, funds, insurance, and access in communities. The initiation of the community health centers and the federally qualified health centers will be helpful in regard to a woman determining whether she is pregnant and receiving early prenatal care, she said. However, she noted that the number of providers trained in providing good early prenatal care is limited in terms of access and thus proves to be a challenge.

MS. BIRCH, in further response to Chair Wilson, specified that community health aide providers are located in the village clinics. Those health aide providers are trained in some of the very basic prenatal care and thus pregnant women would periodically visit the regional hubs. In the urban centers, many providers don't want to see a pregnant women until she is in the second trimester of care because of payment. Therefore, a window of opportunity to impact behavioral change, such as with smoking cessation, has been lost. Ms. Birch mentioned that nationally there is a movement with regard to working with women prior to them thinking of becoming pregnant as well as care between pregnancies.

[8:13:09 AM](#)

MS. BIRCH related that coverage for insurance increased up until 2002, and then in 2003 there was a statutory freeze of the Medicaid rate at 175 percent. Furthermore, since there is no ability to modify that statutory freeze for cost of living changes, the eligibility level has steadily decreased over time. Currently, the Medicaid rate in Alaska is about 164 percent of poverty.

[8:13:49 AM](#)

MS. BIRCH returned to the subject of low birth weight and related that Alaska has had some success in this area. For instance, Alaska's proportion of low birth weights is much better than the national [percentage], but Alaska still doesn't

meet the Healthy People goals. However, Alaska's proportion of preterm births and very low birth weights, which are smaller than they once were, is increasing and these babies are very costly. She related that 75 percent of those babies eventually qualify for Medicaid. Furthermore, often these babies have life-long issues for which Medicaid is often responsible to support.

[8:15:53 AM](#)

MS. BIRCH then turned attention to the birth defects and pointed out that the department has a health data book with 10 years worth of data regarding birth defects in Alaska. She pointed out that Alaska's infant mortality rate due to birth defects looks good as compared nationally, although the state hasn't met the Healthy People goal. However, the incidence of spina bifida and other neural tube defects (NTD) [in Alaska is higher than the national average]. Furthermore, the highest rates of NTD occur in the Interior and Southwest regions. She informed the committee that the best way to prevent such defects is to take an extra dose of folic acid and the knowledge of folic acid by women is increasing. Ms. Birch specified that approximately 5 percent of Alaska's babies are born with at least one major congenital defect, most often cardiovascular. She further specified that 1 in 60 live births have a heart defect and 1 in 150 have congenital urinary defects.

[8:19:04 AM](#)

MS. BIRCH moved on to the slide related to fetal alcohol syndrome (FAS), and confirmed that Alaska continues to lead the nation in the prevalence of children with FAS. Each year approximately 126 children are born with FAS. She informed the committee that FAS is a reportable birth defect, and therefore a chart review is performed on each child reported as such. Ms. Birch expressed concern with a survey in which 36 of OB/GYNs and 18 percent of family practice physicians say that it's acceptable for women to drink alcohol during pregnancy. She questioned where the message has been lost. She then related that once women are screened and found to be drinking during pregnancy, there aren't enough beds or treatment services, particularly for pregnant women with small children.

[8:20:48 AM](#)

MS. BIRCH continued with the slide related to the post neonatal and infant mortality rate. She explained that the neonatal

period is considered the first 30 days of life and thus post neonatal time would refer to the time after the first 30 days to the first year. Unfortunately, Alaska's post neonatal mortality rate is 2.7 times greater than the Healthy People 2010 target and 1.6 times that of the national rate, which can be partially attributed to Alaska's high incidence of sudden infant death syndrome (SIDS). Significant health disparities exist in this area, she emphasized. She related that infants born to mothers less than 20 years of age are significantly more likely to die within the first year of life. Furthermore, infant mortality amongst Alaska Natives is twice that of adults despite the fact that infant mortality has been steadily decreasing. Post neonatal infant mortality of Alaska Natives has steadily increased, and is 3.3 times higher than whites. Although much work has been done in relation to SIDS and the "Back to Sleep" campaign, the aforementioned health disparity persists.

[8:22:32 AM](#)

MS. BIRCH turned to the slide related to the infant sleep position and co-sleeping. She informed the committee that Alaska has an increasing number of women and families who report co-sleeping with their infants. Therefore, the behavioral change doesn't seem to be working. The aforementioned has led to the campaign regarding how to safely sleep with an infant. In the analyzation of Alaska's death records, the association of co-sleeping and infant death was found only in cases when the adult was impaired by alcohol or drugs.

[8:23:59 AM](#)

MS. BIRCH concluded by relating solutions to improve birth outcomes as follows: improved access to preconception and prenatal care; enhanced funding for education of health care providers; enhanced fees for providers who offer care coordination in his/her office. The enhanced fees for providers offering care coordination in the office is utilized in some states.

CHAIR WILSON recalled that the conference in Denver brought out that improving access to [care to] mothers made more difference than anything else. She then inquired as to how much a normal insurance company pays for [preconception and prenatal care].

MS. BIRCH answered that the major provider groups generally pay for a certain number of visits of a regular pregnancy. For a high risk pregnancy, the insurance company requires approval for

additional visits. However, some package insurance plans specify a certain amount of money and thus physicians often want to see the pregnant woman more during the later stages of pregnancy when potential problems exist. In further response to Chair Wilson, Ms. Birch indicated that Medicaid is paid on a per visit basis, but she deferred to others for further detail.

8:27:21 AM

REPRESENTATIVE GARDNER highlighted that many Alaskans have access to health care through Indian Health Care Services. She then inquired as to whether Indian Health Care Services cover prenatal or pre prenatal care.

MS. BIRCH confirmed that Indian Health Care Services do offer prenatal care. In fact, for the last three years Indian Health Care Services have had a high risk maternal fetal physician who cares for the highest risk families. However, the challenge is tracking Native families who come in and out of population centers and the village. In reviewing data, it is apparent that much could be done to work with rural health providers to educate them regarding new trends and information, such as the high risk factors of hypertension and diabetes.

8:29:23 AM

REPRESENTATIVE CISSNA asked if there has been any study with regard to the ties between Alaska's increase in obesity and low birth weights.

MS. BIRCH said that she didn't know of any studies reviewing the rate of obesity associated with low birth weight. She related that some of the most obese patients have some of the smallest babies because much of an obese woman's blood supply is already diverted to her own weight. Therefore, sometimes there isn't enough nutrient value and blood supply to feed the baby. Another interesting fact is that most very obese women aren't able to deliver vaginally and thus have a higher rate of cesarean deliveries. Furthermore, very obese women are also at greater risk of having pregnancy-induced hypertension and diabetes, which results in babies that are delivered early. Therefore, these are often smaller babies with small lungs who are in the intensive care unit for a long period. This all supports the need to focus on [health care during] preconception and the time in between pregnancies.

REPRESENTATIVE CISSNA highlighted the expense, monetarily and socially, of infants who are hospitalized after birth when they should be bonding with the mother and others. She suggested the need to focus on decreasing hospitalization in order to address [later] social, mental, and physical problems.

MS. BIRCH noted her agreement. She informed the committee that the newborn intensive care units have dramatically changed, such that now it's common to have single-room care so that parents can help care for their infants. The ICU has made many accommodations to allow parental involvement. Ms. Birch related that children born with long-term problems are at more than twice the risk for child abuse and neglect. She highlighted the stress involved in a situation in which a baby is 1,500 miles or more away receiving care.

8:34:49 AM

REPRESENTATIVE GARDNER returned attention to the slide regarding low birth weight and preterm birth, which specifies that Alaska is doing better than the national average.

MS. BIRCH pointed out that the data regarding the aforementioned is from 2003. More recent data shows that Alaska's [incidence of low birth weight and preterm birth] have steadily increased. One of the reasons Alaska's low birth weight has decreased is the advent of the newborn intensive care unit in the 1980s. However, the numbers of smaller and sicker babies are increasing.

8:36:49 AM

MS. BIRCH, returning to solutions, emphasized the need to review smoking cessation because data indicates that it's one of the most important interventions. She attributed the aforementioned to the fact that no matter a mother's social situation, she wants to have a healthy baby. Therefore, mothers tend to be very motivated to change their behavior. She explained that mothers benefit the most from smoking cessation educators trained to work with pregnant women. However, there aren't enough cross-trained individuals to support smoking cessation of pregnant women. Ms. Birch then reiterated the need to place greater emphasis on the use of folic acid; support the alcohol abstinence programs; support the "Back to Sleep Program"; and provide co-sleeping education. She then informed the committee that eliminating maternal smoking may lead to a 10 percent reduction in all infant deaths and a 12 percent reduction from

perinatal conditions such as low birth weight, respiratory disease, and SIDS.

8:39:40 AM

MS. BIRCH related other solutions including the need for greater access to intra-conception care such that the use of regular birth control is encouraged as is birth spacing of two or more years. She informed the committee that women who qualify for the Denali KidCare Program for pregnancy receive up to eight weeks of postpartum care. Therefore, unless such women have a permanent solution for birth control, they have no birth control after 60 days. Although public health and community health centers dispense birth control pills for free or a reduced rate, that reduced rate is still fairly expensive. She then related that [data shows] that young women will take birth control pills correctly the first three months, after which they take them incorrectly. Therefore, much support and education regarding the various forms of contraception is necessary.

8:41:15 AM

REPRESENTATIVE CISSNA recalled that last year when she visited public health offices in rural areas, she was informed that they were having difficulty obtaining birth control pills. Therefore, she questioned whether access to birth control is a problem.

MS. BIRCH responded that some types of birth control is more difficult to obtain than others. Therefore, another project is attempting to work on the access to birth control. She pointed out that sometimes the high cost of birth control is caused by the prices of the pharmaceutical companies. Ms. Birch then related that for every \$1 spent in family planning \$3 in Medicaid for prenatal and newborn care is saved. Therefore, access to family planning could be very helpful.

8:42:45 AM

REPRESENTATIVE GATTO inquired as to whether high birth weight infants are increasing.

MS. BIRCH related that women with diabetes are monitored heavily. The challenge is that as babies are larger in a diabetic mother, they aren't necessarily healthier. Therefore, these babies are often delivered earlier through cesarean and have many problems. She reminded the committee that babies born

to women who are obese are often smaller because the blood supply from the mother is diverted to supporting the mother's weight. All of the aforementioned carries a cost and often carries long-term effects.

REPRESENTATIVE GATTO commented that folic acid is really cheap. He then inquired as to whether it would be valuable to take folic acid prior to conception. He also inquired as to whether there is any impact on males who take folic acid prior to conception.

MS. BIRCH agreed that folic acid is inexpensive. She explained that the department has encouraged even young women to take multi-vitamins with 400 micrograms of folic acid. However, she noted that access to and cost of multi-vitamins can be difficult in rural areas. With regard to men taking folic acid, there are studies related to the importance of folic acid in the prevention of heart disease and some cancers. She mentioned that folic acid has been added to cereals and bread.

[8:46:28 AM](#)

REPRESENTATIVE SEATON recalled an advertisement regarding a new long-term implant for birth control, and asked if it's in use in Alaska.

MS. BIRCH informed the committee that this new long-term implant was just FDA approved, and therefore has limited availability. She surmised that the department will have to review it in terms of cost as well as access to mid-level nurse practitioners who would be required to insert this new implant. Through an agreement with the Division of Public Health, funds were provided to help purchase contraceptives other than birth control pills, including two long-term IUDs and a vaginal ring.

REPRESENTATIVE SEATON requested that Ms. Birch provide the committee with the information regarding the cost effectiveness of the implant, as well as the cost of the failure of taking the pill incorrectly.

[8:49:10 AM](#)

MS. BIRCH, in response to Chair Wilson, said this new implant has just been approved and hasn't had much usage. She offered to provide any data that comes forward in relation to this new implant. She then related the downside of other birth control methods that came to light after usage.

8:51:35 AM

REPRESENTATIVE GATTO returned to the issue of co-sleeping, which would seem to be natural, and asked if there is any research regarding the benefits of co-sleeping.

MS. BIRCH answered that there is much research with regard to the benefits of co-sleeping, especially with regard to breast feeding. In fact, there is a study that specifies that SIDS may be reduced by co-sleeping. In Alaska the approach is to educate folks with regard to how to safely co-sleep with an infant.

8:54:35 AM

MS. BIRCH then reminded the committee that Alaska has a Maternal Infant Morbidity and Mortality Review Committee. In reviewing 10 years worth of data, it was found that alcohol was a contributing factor in 28 percent of the deaths of mothers occurring at the time of delivery up to a year later. The data also found that 23 percent of those deaths were related to socioeconomic factors while 10 percent of those deaths were attributed to inappropriate medical care. The data ultimately showed that 60-77 percent of those deaths for women were preventable by better patient education, more aggressive tertiary referrals, and improvements in medical management.

8:56:03 AM

REPRESENTATIVE GARDNER inquired as to whether the medical factors leading to mothers' death were related to the postpartum condition.

MS. BIRCH answered that some of [the deaths] were related to the lack of recognition of high blood pressure. She explained that typically mothers who delivered vaginally are seen six weeks postpartum while those who delivered via cesarean are seen eight weeks postpartum. Sometimes, she related, a woman with high blood pressure will see a climb in that blood pressure after delivery and that's not recognized. The aforementioned was the case for some of the deaths. A high contributing factor to the deaths of the mothers was drug use. Therefore, [the medical factors leading to mothers' death] are related to the chronic conditions of the mother that weren't well controlled after delivery.

8:57:08 AM

MS. BIRCH continued to relate that these deaths were preventable with alcohol and drug abuse treatment, mental health counseling, [recognition of and treatment for] postpartum depression, and greater availability of shelters and safety management plans for women experiencing domestic violence. She noted that a number of these women "died by their partners."

[8:57:47 AM](#)

CHAIR WILSON pointed out that domestic violence increases during pregnancy, and inquired as to whether domestic violence continues after the pregnancy.

MS. BIRCH replied yes. In fact, domestic violence tends to escalate after the pregnancy because the baby becomes the focus of attention rather than the batterer.

[8:58:57 AM](#)

CHAIR WILSON referred to the [health data] book, which related that almost double the children with disabilities are located in northern and southwestern Alaska where most Natives are located. Therefore, she suggested that it's an area on which the committee should focus, although those populations receive their health care for free. She mentioned that education could be helpful. Chair Wilson encouraged the committee members to review ways in which to save funds in the area of health care in Alaska.

[9:01:04 AM](#)

JERRY FULLER, Project Director, Office of Program Review, Department of Health and Social Services, said that although it's technically correct that Alaska Natives receive health care free, the Indian Health Service (IHS) grant to the Alaska Tribal Health Corporation isn't all that encompassing. In fact, nationally it's estimated that it funds about 57 percent of the need. The aforementioned funds aren't nearly sufficient to provide all the services that are available to those with a private insurance plan. He opined that Alaska Natives have very inadequate systems for meeting the needs of the membership. Therefore, [Alaska Natives] look to Medicaid as the first payer for some services. Mr. Fuller stated that the care system isn't funded adequately to meet all of the needs.

[9:02:50 AM](#)

REPRESENTATIVE SEATON returned to the issue of prenatal care, and asked if IHS provides adequate funding for prenatal services.

MR. FULLER said it's hard to say. However, he opined that tribal corporations do spend their federal funds to support prenatal care and birthing services, although the ability to do so may vary with the corporation. He indicated that there may be deficiencies due to other factors beyond funding, such as inability to obtain certain health professionals.

CHAIR WILSON recalled her time working in the clinic in Tok that also housed a physician's assistant who was in charge of the five health clinics for the nearby villages. She suggested that perhaps training for the villages would be appropriate. She then inquired as to the cost to the state for prenatal and postnatal care costs.

MR. FULLER offered to provide that information to the committee.

[9:06:07 AM](#)

KARLEEN JACKSON, Commissioner, Department of Health and Social Services, related that per prenatal visit Medicaid will pay \$77.61, for delivery Medicaid will pay \$1,207, and per delivery post care Medicaid will pay \$2,428. Therefore, although there may be Medicaid funding such that a woman doesn't have to pay for prenatal care, there are still issues with regard to reimbursement related to Medicaid. The aforementioned requires review, she said.

[9:07:13 AM](#)

COMMISSIONER JACKSON, in response to Chair Wilson, offered to obtain budget information for the committee.

CHAIR WILSON expressed the need to review the budgets as changes are made in order to determine whether those have cut costs and address any new problems.

REPRESENTATIVE GARDNER commented that the challenge is in demonstrating the savings.

[9:08:27 AM](#)

PAT CARR, Health Program Manager, Department of Health and Social Services, related that over the past 6 years the number of federally funded community health centers has increased in number from 2 to over 23 such organizations that receive federal health center funding. These grants are usually at least \$650,000 per year, although many of the health centers receive more funding than that. She noted that this program includes a definition of a more comprehensive range of care. About half of the community health centers are tribally managed, which has resulted in a partnership between tribal delivered services and traditional nontribal services. Alaska, she related, was one of the first states to have such a partnership across systems. She suggested that perhaps the committee may want to review the results of this partnership. Although there are 24 funded organizations, the funding is disseminated between 75-100 of Alaska's health centers. With the increase in federal funding for health centers, only a few new health centers have surfaced. Ms. Carr said that she couldn't specify how many of these community health centers provided prenatal care or how many are able to increase the level of prenatal care with the increased funds.

[9:11:19 AM](#)

REPRESENTATIVE GARDNER opined that it seems obvious to partner with tribally managed organizations. However, she asked whether there are any disadvantages to doing so.

MS. CARR informed the committee that one of the requirements of the community health center program is that there has to be a community board. However, the tribal organizations aren't required to do so. She noted that there have been some situations in which there has been perceived competition within the communities. Ms. Carr opined that through this [community health center] program, more care has been provided in the local communities.

[9:12:58 AM](#)

REPRESENTATIVE CISSNA related that one of the huge concerns is that the state may make changes or mandate changes in a community for which the state doesn't come through with its end of the bargain. She also highlighted the concern that villages may experience with regard to having decisions made from those outside of the area.

CHAIR WILSON recalled 1993-1997 when it was difficult to find a health aide willing to be responsible and available at all hours.

[9:15:58 AM](#)

COMMISSIONER JACKSON related that the department has had to work on developing a trusting relationship with the tribal organizations in order to develop the aforementioned partnership. Then it takes time to establish the bureaucratic pieces. Therefore, these partnerships aren't easy to establish.

[9:16:37 AM](#)

MS. BIRCH returned to the issue of prenatal care and related that an avenue for delivery of prenatal care locally using the community health centers and the federally qualified health centers is a terrific area upon which to focus attention. She related that she has found providers to be very interested in providing care. She indicated that [some of the difficulty with providing prenatal care in the aforementioned centers] is that most of the providers are generalists and face a wide population to serve. In fact, heavy users in villages are those with chronic illness, which is what many of the village providers have to focus. Ms. Birch suggested that her section may need to develop a needs assessment in order to determine what would be helpful for providers in providing for early prenatal care and in between pregnancy care.

[9:18:05 AM](#)

CHAIR WILSON suggested that perhaps schools could have good health day curriculum.

[9:19:22 AM](#)

MS. BIRCH related that most school districts require health education at both the elementary, middle school, and high school levels. However, the information provided is dependent upon the level of comfort of the instructor.

[9:20:24 AM](#)

REPRESENTATIVE GATTO mentioned that the Mat-Su School District does have school nurses in each school. Although the school nurses are an important part of the curriculum, the school is doing so many other things that it may be difficult to fit into

the school day. He suggested that school nurses are becoming adjunct parents to a great many kids.

[9:23:22 AM](#)

REPRESENTATIVE CISSNA opined that the state could develop curriculum modules for health education through various subjects.

[9:24:53 AM](#)

CHAIR WILSON pointed out that each district has its own curriculum and thus such an endeavor would require including the school board.

[9:25:31 AM](#)

COMMISSIONER JACKSON reminded the committee that Northwest and Interior Alaska have higher instances of substance abuse, mental health issues, and suicide. Therefore, perhaps specific school districts could be targeted to promote health around multiple issues.

REPRESENTATIVE CISSNA discussed getting involved with local school districts.

CHAIR WILSON expressed her desire that by the end of this process, the committee would be able to determine what areas of the state need the most help and what help can be provided. She reviewed ideas for addressing issues that arise, such as using public service announcements and faith-based initiatives.

[9:29:09 AM](#)

REPRESENTATIVE SEATON recalled testimony that Denali KidCare is really 164 percent of poverty rather than 175 percent, which has been attributed to inflation. However, he said he understood that the poverty rate is inflation indexed. If that's the case, he questioned why the percentage hasn't remained 175 percent.

COMMISSIONER JACKSON related that the legislation specified the dollar amount of what was 175 percent of poverty at 2003. Therefore, the dollar amount doesn't change.

MR. FULLER agreed, adding that the legislation eliminated the inflation factor and froze the income level at a certain dollar amount in statute.

CHAIR WILSON recalled that at the time it was a way of controlling costs when cuts were necessary. If the price of oil wasn't at its current level, the state would still be facing the need to make cuts. Therefore, as was stated at the Denver conference, whatever the state does needs to be sustainable over the long-term. Chair Wilson opined that the [specified dollar amount in statute] shouldn't be changed.

[9:32:41 AM](#)

COMMISSIONER JACKSON reminded the committee that the Federal Medical Assistance Percentage (FMAP) rate is only held harmless through 2008, after which the state will face a large [increase] in the amount of the percent of Medicaid that the state has to provide from general funds.

CHAIR WILSON commented that the more that can be done with regard to prevention provides savings "at the other end."

[9:33:55 AM](#)

MR. FULLER highlighted that certain [health care] investments early can also impact savings in the juvenile and education budgets.

CHAIR WILSON announced that tomorrow the Blue Ribbon Committee on Early Childhood Development study and its recommendations will be released.

[9:35:14 AM](#)

REPRESENTATIVE GARDNER noted her agreement with Mr. Fuller and recalled two years ago the committee agreeing to look at everything with the alcohol filter. She suggested that if the state can get a handle on alcohol abuse, then maternal child health can be discussed and savings can be seen across a wide range of areas.

CHAIR WILSON indicated that perhaps the general public may not realize the aforementioned connections.

REPRESENTATIVE GARDNER interjected that everyone knows it.

CHAIR WILSON expressed the need to have the research and information ready for next year to be prepared for the budget

deliberations on these matters. She highlighted that it will take some time to realize any savings.

COMMISSIONER JACKSON, in response to Chair Wilson, announced that the topic of the next committee meeting is behavioral health, which should address alcohol, substance abuse, and mental health issues as well as faith-based and community issues.

[9:38:20 AM](#)

REPRESENTATIVE SEATON provided the committee with an e-mail dated June 1, 2006, from a former Alaska Psychiatric Institute (API) nurse who resigned because she believed that working at API jeopardized her license. He suggested the need for the committee to review this situation at a future meeting, perhaps next week.

[9:42:36 AM](#)

CHAIR WILSON recalled that this past session the budget included raises for state employed nurses. However, the funds only covered the raises for nine months. She mentioned that API doesn't pay as much as the private sector, which she indicated as one of the problems with API.

COMMISSIONER JACKSON informed the committee that the Department of Administration is performing a wage study for the family of nurse job categories, which should be complete around the end of July. The state's nurses receiving a salary increase will be retroactive to July 1st. Commissioner Jackson said that she may not have all the pertinent information next week for a meeting, but she offered to have a preliminary discussion.

CHAIR WILSON emphasized that this is an important issue to address because if API loses enough nurses, it will have to shut down beds due to the lack of staff to cover the beds. Therefore, she said she didn't have a problem calling a meeting next week.

[9:44:49 AM](#)

REPRESENTATIVE CISSNA commented that throughout discussions regarding the shortage of nurses there has been a lack of focus on retention issues. Recent studies, she related, specify that a nurse's wage isn't as important as the conditions of employment. She pointed out that the e-mail refers to some of

the conditions at a state institute and if the state can't set a high bar with regard to the environment, one can't expect private sector to do so either. Without establishing better working environments, nurses will be lost to other states and countries.

[9:46:17 AM](#)

COMMISSIONER JACKSON suggested that perhaps she could contact the involved parties in order to schedule this meeting.

[9:47:05 AM](#)

REPRESENTATIVE SEATON clarified that he doesn't want the meeting to be merely a wage discussion. The e-mail discusses lower standards of care that need to be reviewed and perhaps addressed with rapid adjustments.

[9:48:49 AM](#)

COMMISSIONER JACKSON expressed the desire to address the issues brought forth in the e-mail.

[9:49:12 AM](#)

REPRESENTATIVE GATTO, drawing from discussions with his daughter who works in the State of Washington treating troubled children, related his suspicion that underfunded and understaffed [mental health facilities] is a nationwide problem.

[9:49:58 AM](#)

REPRESENTATIVE CISSNA opined that ultimately cutting costs in the short-term means large costs later.

[9:50:11 AM](#)

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at [9:50:13 AM](#).