

**MINUTES**  
**SENATE FINANCE COMMITTEE**  
April 3, 2007  
9:02 a.m.

**CALL TO ORDER**

Co-Chair Bert Stedman convened the meeting at approximately [9:02:51 AM](#).

**PRESENT**

Senator Lyman Hoffman, Co-Chair  
Senator Bert Stedman, Co-Chair  
Senator Charlie Huggins, Vice Chair  
Senator Joe Thomas  
Senator Fred Dyson  
Senator Donny Olson  
Senator Kim Elton

**Also Attending:** DOUL LETCH, Staff to Senator Gary Stevens; JAY BUTLER, MD, Director, Division of Public Health, Department of Health and Social Services; GINNY AUSTERMAN, Staff to Senator Olson; JANET CLARKE, Assistant Commissioner, Finance and Management Services, Department of Health and Social Services; ELLIE FITZJARRALD, Director, Division of Public Assistance, Department of Health and Social Services

**Attending via Teleconference:** From Anchorage: PAT LUBY, Advocacy Director, AARP; From an offnet location: SANDRA STARK, Member, Task Force to Assess Public Reporting of Health Care Associated Infections

**SUMMARY INFORMATION**

SB 62-TASK FORCE ON HEALTH CARE INFECTIONS

The Committee heard from the sponsor, the Department of Health and Social Services, and took public testimony. The bill was held in Committee.

SB 4-SENIOR CARE PROGRAM

The Committee heard from the sponsor and the Department of Health and Social Services. The bill reported from Committee.

[9:03:40 AM](#)

#sb62

SENATE BILL NO. 62

"An Act establishing the Advisory Committee on Public Reporting of Health Care Associated Infections; relating to reporting and dissemination of data concerning health care associated infections; and providing for an effective date."

This was the first hearing for this bill in the Senate Finance Committee.

Co-Chair Stedman communicated that the intent today would be to hear an explanation of the bill and then hold it in Committee for further consideration.

[9:04:12 AM](#)

DOUG LETCH, Staff to Senator Gary Stevens, the bill's sponsor, read the sponsor statement as follows.

SB 62 is legislation recommended by the Task Force to Assess Public Reporting of Health Care Associated Infections, which met during the 2006 Legislative Interim to study the unique challenges facing Alaska with regard to tracking and reporting health care acquired infections. This bill creates the Advisory Committee on Public Reporting of Health Care Associated Infections under the Department of Health and Social Services.

Mr. Letch communicated that the Task Force consisted of Senator Gary Stevens, Senator Bettye Davis, Representative Carl Gatto, Representative Peggy Wilson, six health care representatives including Dr. Jay Butler, Director, Division of Public Health in the Department of Health and Social Services who, at the time, was the State Epidemiologist, and two consumer representatives.

Mr. Letch reviewed the make-up of the 11-member Advisory Committee that would be established by this legislation. In

addition to one member being the State official in charge of epidemiology, one member would be a Senator appointed by the Senate President, and another would be a Representative appointed by the Speaker of the House of Representatives. The remaining members would be appointed by the Governor. They would include two physicians with significant experience in the area of infectious diseases and one representative of each of the following: the Alaska Native Tribal Health Consortium; the Alaska Chapter of the Association of Professionals in Infection Control and Epidemiology; the Alaska State Hospital and Nursing Home Association; a health care consumer in urban Alaska; a health care consumer in rural Alaska, and a statistician.

Mr. Letch again read from the sponsor's statement.

In the coming years, the Advisory Committee's role will be to develop recommendations for collecting, analyzing and distributing information related to health care associated infections. By January, 2009, the Advisory Committee will provide recommendations to the Department for establishing a pilot program for public reporting of health care associated infections. By January, 2011, the Advisory Committee will provide to the Legislature a report addressing the unique challenges in the state, as well as recommendations for ongoing reporting.

Some 2 million infections a year are acquired in hospitals and an estimated 90,000 people die as a result of these infections, making it the sixth-leading cause of death in the country. The cost to the consumers is between \$4.5 and \$11 billion a year. Given these alarming statistics, it is vital for consumers to have full knowledge

Mr. Letch stated that, in addition to his Task Force experience, another situation prompted Senator Stevens to further this bill. That being that a close friend of his had nearly died after acquiring a staff infection in a hospital where he had been admitted to for treatment.

Mr. Letch announced that the goal of this legislation was twofold: to promote public awareness of the issue and to encourage those in the health care industry "to take steps to reduce the risk of infections". It was not intended to target any particular hospital or to assign blame.

Mr. Letch noted that Dr. Butler with the Department of Health and Social Services (DHSS) was available to answer technical questions. Dr. Butler's assistance in developing the language in the bill was appreciated.

Mr. Letch considered the direction of the bill to be "a good approach to the issue; its does not force anything down anyone's throats" and it provides the industry a chance to assist in addressing "a serious problem".

[9:09:04 AM](#)

Senator Olson asked for clarification as to whether 90,000 people die each year as a result of hospital acquired infections or as a result of infections in general.

Mr. Letch stated that research indicates that 90,000 people die each year from infections acquired in a health care facility including hospitals and clinics.

Co-Chair Stedman asked whether the number of Alaskans who have died from a health care facility acquired infection was known.

Mr. Letch deferred to Dr. Butler who was more familiar with the issue, not only in Alaska but in other states as well.

[9:10:04 AM](#)

Senator Elton deduced that the underlying intent of the bill was to alert consumers to the issue. This would allow them to make choices when considering health care facilities. However, most communities in the State do not have many alternatives.

Senator Elton also concluded that even though many Alaskans travel out of state for medical procedures, the State could not require those hospitals, such as Virginia Mason in Seattle Washington, to reveal what their "incidence of infections are".

[9:11:05 AM](#)

Mr. Letch acknowledged that one of the issues discussed by the Task Force was that many communities "have only one choice of health care" facilities. The determination was to task the Advisory Committee with developing "workable recommendations" to

address this and other public reporting issues including confidentiality.

Senator Elton asked the definition of a health care facility; specifically whether community health clinics and surgical outpatient facilities would be required to report.

[9:13:15 AM](#)

Mr. Letch stated that the definition of a health care facility is addressed in Sec. 3 subsection (3) of Sec. 44.29.599. Definitions. on page 4 line 16 of the bill. That language identifies a health care facility as having "the meaning given in AS 18.15.372". Thus a health care facility would include outpatient clinics and small clinics. Further clarification of the facilities affected by this legislation would be conducted.

[9:14:22 AM](#)

Senator Olson asked whether the reporting requirements that might be enacted could negatively affect certifications held by health care facilities such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certificate.

[9:14:42 AM](#)

JAY BUTLER, MD, Director, Division of Public Health, Department of Health and Social Services, stated that the reporting should not affect facility certifications. That is not the intent of the legislation. One of the issues addressed by the Task Force was "how to achieve the goal of doing good infection control practices and encouraging that within hospitals without being repetitive in terms of the administrative burden it places upon the hospitals ... The goals of any kind of public reporting system would be to be coordinated with" those required by JCAHO, for example.

Senator Olson agreed to the importance of reviewing hospital acquired infections; particularly in consideration of the existence of drug-resistance and aggressive bacteria. He also asked whether such things as the avian influenza, commonly referred to as the bird flu, would be addressed.

[9:15:32 AM](#)

Dr. Butler responded that the legislation could "potentially" address two issues. "One is the overall high rate of hospital or health care associated infections". Recent national Centers for Disease Control and Prevention (CDC) data supports that approximately 1.7 million of these types of infections occur in the nation each year. 98,000 of these infections result in a death.

Dr. Butler noted that even though Alaska does not track this sort of data, national statistics were extrapolated to indicate that 150 to 200 infection related deaths occur annually in Alaska. While not all of these deaths could be prevented by addressing hospital acquired infections, "it does suggest that we can do better to protect patients in the health care environment".

Dr. Butler identified another concern this legislation would address. That being that "health care settings have become the breeding ground for some of our more difficult to treat bacterial infections".

[9:18:07 AM](#)

Dr. Butler contended that drug resistance infections and health care associated infections could be preventable though basic infection control techniques, appropriate use of antibiotics before and after surgery procedures and through simple administrative measures such as facilities making sure that their workers are vaccinated against influenza each year.

[9:18:34 AM](#)

Senator Thomas agreed that the State's statistics would mirror the nationwide experience. He also shared his surprise at learning that health care associated infections ranked so high as a cause of death in the nation. Continuing, he asked about current reporting requirements as he would have thought that standards to address this issue would have been in place by now.

Dr. Butler deemed this a complex question. "The market-based approach or the best practices approach" has not "fully addressed the challenge of health care associated infections". This is partly because infections are difficult to diagnose and it is often difficult to identify where an infection was

acquired. To that point, however, he advised that current epidemiology testing capabilities have improved in this regard.

Dr. Butler cited another factor as being the amount of funding "a hospital is willing to invest in infection control not only in implementing infection control measures but in conducting surveillance to be able to detect the problems that occur".

Dr. Butler communicated that the changing health care environment presents another challenge. For instance, an increasing number of people are being treated outside of a hospital.

Dr. Butler concluded that due to these and other factors, it has been difficult "for the infection control community to get a handle on" the issue.

[9:21:05 AM](#)

Senator Thomas asked whether, in addition to the efforts of the Advisory Committee, the State would make recommendations on this issue since it reimburses and makes payments to medical facilities for services relating to the Medicaid and Medicare programs.

Dr. Butler clarified that the State would "not be directly involved in" this regard as the federal Center for Medicaid and Medicare Services has regulations in place regarding infection control practices in health care facilities receiving Medicaid and reimbursements and payments. The State's involvement would relate to processing the data provided by hospitals and producing that information "in a form that's interpretable to the public".

Dr. Butler advised that even though there is no scientific evidence that the reporting of health care associated infections would reduce the rate of hospital acquired infections, the consumer group driving this nationwide reporting effort believes that consumers have the right to know what the risk of infection is when they go into a health care environment.

[9:22:36 AM](#)

Dr. Butler informed the Committee that 14 states have passed 14 "very different" forms of public disclosure legislation in terms

of the information that must be disclosed. Of those, two states require confidential reporting to state public health officials.

Dr. Butler noted that the Task Force also considered CDC recommendations; specifically the one supporting traditional public health reporting techniques such as having the hospital provide information to a state's public health agency as opposed to allowing a hospital to independently publicize "whatever data they collect and would like to disclose..." The traditional public health reporting would assist in providing "a level playing level amongst hospitals..."

[9:23:32 AM](#)

Senator Elton observed that the bill would require a health care facility to report. He asked whether audits would be conducted or whether a penalty would be imposed for non-reporting or inaccurate reporting.

Dr. Butler responded that this is a challenge in any public health reporting situation as there are "no public health police". A trust relationship between the State and the hospital must be developed.

Senator Elton pointed out that if the effort is "to induce better behavior" by having informed consumers, inducements should be provided to encourage accurate reporting, however, the negative aspect of that is the possible loss of patients to another health care facility.

Dr. Butler agreed. The accuracy of the reporting would be based "on a trust relationship and the good will" of a hospital to the welfare of its patients.

Dr. Butler avowed that the Task Force had considered the downside of public disclosure. Hospitals with good surveillance in place and who "identified and reported infections could potentially appear to have a higher rate of infections. That is certainly not the intent of this effort".

Senator Thomas asked for information regarding the timelines for action as specified in Sec. 5 page 4 line 23 through page 5 line 3. To that point, he observed that Members' packets included an article [copy on file] published in the Boston [Massachusetts] Herald newspaper on February 21, 2007 which stated that the

president of the "Beth Israel Deaconess Medical Center, created a big stir recently when he posted the hospital's infection rates on his blog and encouraged other hospitals to follow suit without a complicated state mandate".

Continuing, Senator Thomas opined that allowing the health care industry to independently report might be preferred to enacting legislation.

[9:27:09 AM](#)

Dr. Butler stated that this had been discussed by the Task Force. The issue is that hospitals have no uniform standard for collecting data. This would be detrimental to the effort to provide "useful" information to both the hospitals and the public.

Dr. Butler also noted that Alaska has "some peculiar challenges"; one of those being the limited number of health care facilities in the State and the fact that only six hospitals have more than 50 beds.

[9:28:10 AM](#)

PAT LUBY, Advocacy Director, AARP Alaska, testified via teleconference from Anchorage in support of the bill. While the reporting requirements might not be as useful to the citizens of Alaska as they might be in an area with more hospital choices, they would assist in promoting "error reductions". Studies conducted by The Institute of Medicine indicate that, by "admitting to each other what problems" have been experienced hospitals and health professionals can reduce errors.

Mr. Luby declared that this was not "a gotcha bill" in the sense of "trying to catch hospitals ... or health professionals who may have made an error". Instead the intent of the reporting would be to address an error, "find out how it happened and let's find out how we can prevent any further errors from happening. Our health professionals are very good about tracking problems, but they need to know the number and the scope of those problems."

Mr. Luby considered this legislation to be "a good first step toward reducing" medical errors.

[9:29:32 AM](#)

SANDRA STARK, Member, Task Force to Assess Public Reporting of Health Care Associated Infections, testified via teleconference from an offnet location in support of the bill. Requiring individual hospitals to report infections would encourage them to improve their procedures and thereby reduce health care related infections.

Ms. Stark communicated that the effort to control infections is compounded by many things. People do not stay in hospitals as long as they used to and people are more transient. Thus, in addition to improving hospitals' approach to containing infections, an effort must be made to improve health care throughout the State. The size of a facility should not be a consideration.

Ms. Stark relayed that because some infections have a long incubation period, symptoms might not present until long after a person concluded their hospital stay. Thus knowledge of the problem is often not immediately known. It is also possible that the institution might never be informed. Even though hospitals and their staff have improved their approach to infection control, "the lack of information exchange" between entities is an obstacle. This bill would address that situation.

Ms. Stark applauded the dialogue that has occurred. It has improved the bill to a point where it would be in "the best interest and not a threat to health care facilities".

[9:32:42 AM](#)

Co-Chair Stedman questioned the expense of supporting the Advisory Committee, as depicted in the DHSS fiscal note #1. In addition to the effort to control the State's operating budget, the Legislature is attempting to control the expenses of the "litany" of State supported boards and commissions.

Mr. Letch deferred the fiscal note question to the DHSS.

[9:33:27 AM](#)

Dr. Butler explained that the fiscal note would provide for travel and other Advisory Committee expenses. It would also provide for Department staff support for the Advisory Committee and funding to the Department for managing the data that would

be collected. Even though managing the data would be a complicated process, an effort was taken to develop an efficient fiscal note.

Dr. Butler disclosed that historically, the Division of Public Health "has not interacted in the health care world much". This is unfortunate as the health care world has experienced dramatic changes, and the "clear cut line between the community and the health care environment" has dissipated. Therefore this would expand the type of work the Division had previously conducted. Absorbing this additional work should not be done at the detriment of existing Division responsibilities.

[9:35:01 AM](#)

Co-Chair Stedman followed up on Senator Thomas' earlier question by asking whether the Department had considered developing an internal data collection method which would allow them "to organize it, consolidate it, and then maybe make recommendations without creation of another board".

Dr. Butler expressed that even though "it would be desirable to use that approach", the Task Force concluded, as it conducted its proceedings, that it would be unable to "tackle" the entirety of complicated and technical issues involved in this effort in its allotted time-span.

[9:36:03 AM](#)

Senator Olson asked to the type of interaction that occurs between the CDC and the State's epidemiologic section in this regard. Furthermore, he inquired whether establishing this program might negatively affect the funding of the epidemiologic section.

Dr. Butler informed that currently no federal funds are provided to support State health care related issues; however 75 percent of the funding received by the State's epidemiologic section is federal funds. The balance is State general funding. In addition, no federal funds have been identified to support this issue. To date, the CDC has acted as a technical consultant and adviser in addition to ensuring that the State's data and information is shared with other states.

[9:37:32 AM](#)

Senator Elton observed that the Department's fiscal note #1 indicates that program costs would be incurred through FY 2013, even though the Advisory Committee would terminate in FY 2012.

[9:38:01 AM](#)

Dr. Butler communicated that, due to the numerous unknowns, the decision was to specify a termination date for the Advisory Committee. That decision could be revisited if, once in operation, the Advisory Committee advised otherwise. The bill's sponsor might be able to provide specific information to the dates specified in the fiscal note.

Co-Chair Stedman, noting that the bill would be held in Committee, stated that the discussion on the fiscal note would continue during the next hearing on the bill. Other fiscal note concerns include whether the overhead costs specified for the program include the entirety of board operating costs and whether there has been consideration that health care facilities, rather than the State, might absorb the program expenses.

[9:39:37 AM](#)

Senator Elton, noting this would be a voluntary reporting program, asked whether the State might "accept liability ... if a hospital doesn't report correctly" and a consumer made a health care choice based on information provided by the Department.

Dr. Butler stated that this issue would be researched.

Co-Chair Stedman ordered the bill HELD in Committee.

[9:40:35 AM](#)

#sb4

SENATE BILL NO. 4

"An Act extending the cash assistance benefit program for seniors under the senior care program and increasing the benefit amount; and providing for an effective date."

This was the second hearing for this bill in the Senate Finance Committee.

Co-Chair Stedman communicated that the intent today would be to move this bill from Committee. A new fiscal note, dated April 3, 2007, relative to the Version 25-LS0056\C committee substitute adopted during the bill's first hearing, had been distributed.

[9:41:17 AM](#)

Senator Olson, the bill's sponsor, informed the Committee he had worked with both the House of Representatives and the Department of Health and Social Services to perfect the language in this bill. SB 4 would extend the Senior Care cash assistance program to 2011. In addition, it would eliminate the under-utilized prescription drug benefit component of the current program.

Senator Olson explained that the bill would provide monthly cash assistance payments to eligible individuals as follows: \$175 to those whose household income did not exceed 100 percent of the federal poverty guidelines for Alaska; \$150 to those whose household income did not exceed 135 percent but was above 100 percent of the federal poverty guidelines for Alaska; or \$100 if the household income did not exceed 150 percent of the federal poverty guidelines for Alaska.

Senator Olson specified that the bill would not require individuals meeting the household income test to provide information on their asset holdings.

Senator Olson noted that provisions in the bill would prohibit an individual from being eligible for both this program and the Longevity Bonus Program were it re-authorized.

Senator Olson communicated that the new fiscal note estimated FY 2008 expenses to be \$17.4 million. That amount was based on the Department's estimation that 7,800 seniors would qualify for the program.

[9:43:11 AM](#)

GINNY AUSTERMAN, Staff to Senator Olson, affirmed that the new fiscal note had been distributed.

[9:43:36 AM](#)

Co-Chair Stedman observed that the fiscal note accompanying this legislation would be the largest one advanced by the Committee to date this session. While assistance to the State's seniors and the needy is important, this legislation in essence "is going counter" to the Legislature's effort to control the growth of the operating budget this year.

JANET CLARKE, Assistant Commissioner, Finance and Management Services, Department of Health and Social Services, explained that the \$17.4 million fiscal note "is a comprehensive fiscal note for the cost of Senior Care program" in that it includes administrative costs in addition to the benefits paid to recipients. The annual costs associated with the existing Senior Care Program, which has existed for approximately three years, has been approximately 12 million dollars.

Ms. Clarke reviewed the Analysis information on page 3 of the fiscal note. It depicted the monetary benefits estimated to be paid at each of the three different income levels. These payments which are estimated to amount to \$16.6 million, would account for the "bulk" of the program expenses. The balance would address the cost of administering the program. Additional staff would be required to administer this program since it is more complex than the previous Senior Care program. The previous Senior Care program allotted single cash payments of \$120 per month to program recipients as opposed to the three tiered payment approach proposed in this bill.

[9:47:28 AM](#)

Co-Chair Stedman asked whether, instead of increasing staffing levels, computer programs could be enhanced to address this effort.

[9:47:46 AM](#)

Ms. Clarke explained that staffing was based on caseload levels. The number of people who would be eligible for this assistance is anticipated to increase.

Co-Chair Stedman asked the Department to testify to the accuracy of its calculations.

[9:48:29 AM](#)

ELLIE FITZJARRALD, Director, Division of Public Assistance, Department of Health and Social Services, stated that approximately 7,000 seniors are currently enrolled in the Senior Care program. "This bill would increase that number to 8,800". Two additional staffers would be required to manage the additional caseloads as each application must be reviewed to determine eligibility and the information on each eligible individual must be entered into the Department's computer system. In addition, the Department's computer system must be upgraded to ensure that payments are made in a timely matter.

Ms. Clarke pointed out that one time costs, such as the computer upgrades, have been identified and could be eliminated from the program expenses, once completed.

Co-Chair Stedman advised that it is much easier to control expenses when things such as one-time expenses are identified early on in the budget process. Otherwise the tendency is to expand the program to absorb that funding.

Co-Chair Stedman also thought that the FY 2012 expenses depicted in the fiscal note were an underestimation in light of the fact that the number of program recipients might increase as the State's population ages. To that point, he asked whether the Department had studied the State's "aging trends" and the affect of that beyond the timeframe specified in this bill.

Ms. Clarke affirmed that aging trends were analyzed. The determination was that the State's senior population growth rate would be "fairly flat" for the next eight to ten years and then would experience a significant level of growth. That information was utilized in developing the new fiscal note.

Ms. Clarke explained that the new fiscal note depicts a zero expense for FY 2012 as the program is proposed to terminate in 2011.

[9:51:18 AM](#)

In response to a question from Senator Thomas, Ms. Fitzgarrald expressed that the Department had conducted a survey of program recipients to determine why the prescription drug component had been under-utilized. The determination was that the program "was not what they needed" as other prescription drug programs were

available to them through other insurance programs, pension benefits, or the new Medicare Part "D" program.

Senator Thomas asked what consideration had been given to those who had utilized the program.

Ms. Fitzgarrald specified that approximately 140 seniors were currently utilizing the drug benefit. Senator Olson had addressed this issue in this bill by revising the income test levels and increasing the benefit levels.

[9:53:24 AM](#)

Senator Elton agreed with Co-Chair Stedman's remarks that once a program is established, it is often difficult to curtail or disband. To that point, he asked the Department to provide an estimate of the program expenses were it continued to the year 2020, particularly as the senior population "bubble" was yet to come. In addition, he asked whether the fiscal note was developed in consideration of future changes in the federal poverty level.

Ms. Fitzgarrald affirmed that the fiscal note did reflect the fact that federal poverty guideline levels would increase each year.

[9:54:55 AM](#)

Co-Chair Stedman asked for further clarification about the staffing levels required to support the program.

Ms. Clarke specified that four staffers currently manage the Senior Care program. Two additional staff would be required to support the program proposed in this bill.

Co-Chair Stedman understood therefore that the program would be supported by a total of six staffers.

Senator Olson moved to report Version "C" from Committee with individual recommendations and new Department of Health and Social Services fiscal note.

There being no objection, CSSB 4(FIN) was REPORTED from Committee with the new \$17,398,900 fiscal note, dated April 3, 2007 from the Department of Health and Social Services.

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**ADJOURNMENT**

Co-Chair Bert Stedman adjourned the meeting at [9:56:51 AM](#).