ALASKA STATE LEGISLATURE
SENATE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE
April 8, 2009
1:36 p.m.

MEMBERS PRESENT

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE BILL NO. 66
"An Act relating to a mental health patient grievance procedure."
HEARD AND HELD

SENATE BILL NO. 168
"An Act relating to state certification and designation of trauma centers; creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers; and providing for an effective date."
HEARD AND HELD

SENATE BILL NO. 169
"An Act appropriating $5,000,000 to the uncompensated trauma care fund; and providing for an effective date."
HEARD AND HELD

PREVIOUS COMMITTEE ACTION

BILL: SB 66
SHORT TITLE: MENTAL HEALTH PATIENT GRIEVANCES
SPONSOR(s): SENATOR(s) DAVIS

01/21/09	(S)	READ THE FIRST TIME - REFERRALS
01/21/09	(S)	HSS, FIN
04/01/09	(S)	HSS AT 1:30 PM BUTROVICH 205
04/01/09	(S)	Bills Previously Heard/Scheduled
04/08/09	(S)	HSS AT 1:30 PM BELTZ 211

04/08/09	(S)	Heard & Held
04/08/09	(S)	MINUTE(HSS)

BILL: SB 168
SHORT TITLE: TRAUMA CARE CENTERS/FUND
SPONSOR(s): HEALTH & SOCIAL SERVICES BY REQUEST

03/27/09	(S)	READ THE FIRST TIME - REFERRALS
03/27/09	(S)	HSS, FIN
04/08/09	(S)	HSS AT 1:30 PM BELTZ 211

BILL: SB 169
SHORT TITLE: APPROP: TRAUMA CARE FUND
SPONSOR(s): HEALTH & SOCIAL SERVICES BY REQUEST

03/27/09	(S)	READ THE FIRST TIME - REFERRALS
03/27/09	(S)	HSS, FIN
04/08/09	(S)	HSS AT 1:30 PM BELTZ 211

WITNESS REGISTER

TOM OBERMEYER
Staff to Senator Davis
Alaska State Legislature
Juneau, AK
POSITION STATEMENT: Commented on SB 66, SB 168 and SB 169.

BRENDA KNAPP, Program Administrator
Treatment and Recovery
Division of Behavioral Health
Department of Health and Social Services (DHSS)
POSITION STATEMENT: Supported the concept of SB 66, but had many concerns.

JEAN MISCHEL, Attorney
Legislative Legal Services
Legislative Affairs Agency
State Capital
Juneau, AK.
POSITION STATEMENT: Answered questions on SB 66.

JAMES GOTTSTEIN, President/CEO
Law Project for Psychiatric Rights (Psych Rights)
POSITION STATEMENT: Strongly supported SB 66.

FAITH MEYERS, speaking for herself
POSITION STATEMENT: Supported SB 66.

DARENCE COLLINS, representing himself
POSITION STATEMENT: Supported SB 66.

RON ADLER, Director
Alaska Psychiatric Institute
Department of Health and Social Services (DHSS)
POSITION STATEMENT: Commented on SB 66.

DR. JAY BUTLER, Chief Medical Officer
Department of Health and Social Services (DHSS)
POSITION STATEMENT: Neutral stance on SB 168.

ROD BETIT, President/CEO
Alaska State Hospital and Nursing Home Association (ASHNHA)
POSITION STATEMENT: Supported the concept of SB 168.

MARK JOHNSON, former chief of Emergency Medical Services
POSITION STATEMENT: Supported SB 168.

ACTION NARRATIVE

1:36:32 PM
CHAIR BETTYE DAVIS called the Senate Health and Social Services Standing Committee meeting to order at 1:36 p.m. Present at the call to order were Senators Paskvan, Thomas, Dyson and Davis.

SB 66-MENTAL HEALTH PATIENT GRIEVANCES

1:37:01 PM
CHAIR DAVIS announced consideration of SB 66.

1:37:13 PM
TOM OBERMEYER, staff to Senator Davis, sponsor of SB 66, read the sponsor statement. He explained that SB 66 replaces a one-paragraph mental health grievance procedure under AS 47.30.184(7) with a much more comprehensive process. It recognizes and protects to a much greater extent the constitutional right of due process to an aggrieved patient who is undergoing treatment at a public or private evaluation facility or mental health unit.

Because of the exceptional circumstances under which such patients are admitted and treated, due process requires special safeguards. SB 66 provides a reasonable opportunity for informal or formal resolution of concerns or grievances with timely written complaints, responses and appeals, department review,

maintenance of records and reporting. It covers all state and private mental health facilities or hospital mental health units licensed in this state. New procedure requires detailed complaint forms, written answers by an impartial body within five days, three levels of appeal including response to urgent grievances within 24 hours. The timelines are strict because many patients are only in mental health facilities for a matter of days and grievances or appeals cannot be heard before discharge. A grievance may be filed at any time, but there is a statutory limitation of year after being discharged from the facility or unit.

1:38:39 PM
SB 66 provides notice of the grievance procedure upon admission to the facility, easy access to grievance forms and a secure complaint box in which to deposit the forms. The contents of the complaint box are to be read each day, and the original copy of the form must be kept in the patient record. The department is charged with reviewing all grievances and responses. Facilities and units must file quarterly reports of the number and type of grievance and the resolution including litigation. SB 66 prevents mental health facilities or units from "front loading" or asking patients to go through an informal complaint process before filing a grievance. In this way grievances in the past were reportedly were seldom heard and there is no written record of a grievance on which to file an appeal.

The bill allows for personal representatives to act in the interest of the patient in the grievance process as well as providing an appointed patient advocate in the mental health facility or unit.

He noted that the department sent over some suggestions that include adding a definition of "grievance." He said typically there is no record of what is going on and many of the people who are involved in the process are denied due process because they are mentally ill. He explained that due process involves deprivation of life, liberty or property, and the main problem here is a lack of liberty, particularly in those who are in forced civil commitments. The department has said maybe this bill should only apply to those, but they are trying to recognize that this state doesn't have a procedure or standard form that allows these patients to have routine issues dealt with in a timely way.

Finally, three levels of appeal have been set up. The first two levels go up to the commissioner; no response is needed. If they

want to appeal to the third level – the administrative hearing officer, the department is asked to intervene. This means that the hearing officer would make a determination, and then it would be turned over to the commissioner to accept or make some other determination. At that point, the administrative process is over and the next step would be court. This does not anticipate that the process of criminal law will not apply should the police be called, but it ensures that there will be a record of what goes on throughout the process.

1:42:51 PM
SENATOR PASKVAN moved to adopt the proposed committee substitute (CS) to SB 66, labeled 26-LS0239\E, as the working document. There being no objection, version E was before the committee.

SENATOR ELLIS joined the meeting.

1:44:07 PM
CHAIR DAVIS asked Mr. Obermeyer to explain the changes in the CS.

MR. OBERMEYER said essentially the CS ties up some loose ends. "Formal grievance" was replaced with "grievance" on page 2, line 2, and "written" was added before "notice" on page 3, line 2, and "appeal" before "procedure" on line 9. On page 3, lines 12-14 added "a written response to the grievance on the form required by one of the subsection within five days after receipt of the grievance and after each level of requested review."

The written response is supposed to include a list of options to resolve the grievance including a level-3 appeal. It also changed the time frame to appeal from 20 days to 30 in subsection 5(c) on page 3, line 30. Page 4, lines 1-4 adds "the hearing officer shall make findings and recommendations to the commissioner who shall make a final written decision on or before the 5th day after the commissioner receives the recommendations." This is to give the department an opportunity to resolve the matter at the lowest level, and if it is determined it can't be resolved the patient can go to court.

MR. OBERMEYER said that the hearing process has many more formalities and it is truly an independent body. One of the big concerns in the process is that impartiality is almost impossible unless you do get to an impartial administrative hearing officer; however, the biggest problem is that most grievances are not ever heard and there is no documentation that they ever occurred.

1:47:56 PM

MR. OBERMEYER said language on page 5, lines 6-7, says the facility or unit shall make a good faith effort to mail a response to a grievant that has been discharged from the facility. The facility is defined to mean "hospital or clinic in which mental health patients receive evaluation or treatment and for which public funds are provided" on page 5, line 26. Page 6, lines 2-3 describes a unit as "a discrete portion of facility dedicated to the treatment or evaluation of mental health patients."

1:50:07 PM

BRENDA KNAPP, Program Administrator, Treatment and Recovery, Division of Behavioral Health, Department of Health and Social Services (DHSS), said they support the spirit of the bill and share the legislature's desire to ensure that mental health patients in the state are treated fairly, receive appropriate treatment and that their concerns, when they have them, are heard. But they do have some concerns with the bill as written and those are in a memo.

She advised that first of all, there are already grievance policies in place. Certainly the hospital facilities with designated evaluation and treatment facilities and stabilization facilities are all accredited by the joint commission are required to have and follow grievance procedures. But within the community system, which would also be impacted by this bill, any grantee is required as part of their RFP procedure to provide a copy of their grievance procedure for consumer complaints. That has to be approved by the department in order for them to receive funding. She said her experience is that having the grievances resolved at the lowest level does work. If it can't be resolved, the department is already required in AS 47.36.060 to investigate and respond to complaints made by a patient or an interested party on behalf of a patient.

Although the current bill sets forth some new requirements - one of them being the three levels of review - the third one requiring department intervention, it does nevertheless require that copies of all grievance activity and the resolutions of those complaints be provided to the department. This would be a huge volume of documentation, and the department would be required to review all grievance documents that are provided for compliance with the section.

1:53:41 PM

MS. KNAPP said although they might only be required to intervene on the third level, all levels would require review for compliance. Certainly if something was found to be mishandled they would have an obligation to investigate and follow through. So it raises a level of work for the department that has been handled at the local level. They deal mostly in communities with non-profits or with municipal or tribal entities that do have their own governing boards where grievances of any sort are resolved. "We have that that works."

The bill also requires a specific form to be used for grievances. At this time the community programs have to design a form and submit it to the department for approval. They are given models they can use and have some latitude within their own structure to tailor it to their own needs as long as some of the core elements are there. Certainly the Joint Commission has standards regarding what the grievance procedure and policy would look like for the inpatient facilities. The state would like to move toward accreditation of community facilities but that represents a lot of money to providers.

Another concerning aspect of the bill is the broad definition of grievance. Currently it is a concern or a complaint that is unresolved. This bill broadens it to include "suggestions" which widens the arena. It is too broad.

1:56:37 PM
MS. KNAPP pointed out that there are other venues for patients and recipients of community based services to express their concerns without having to fill out a form and wait for a formal procedure - organizations such as the State Mental Health Board, the Mental Health Trust Authority, the Disability Law Center, Office of Public Advocacy and the Ombudsman. She concluded by saying they are very willing to work with the committee on this bill.

1:58:29 PM
CHAIR DAVIS asked how many grievances have come before the department per year.

MS. KNAPP answered probably about five actual grievances in the past five years.

CHAIR DAVIS asked if that doesn't seem odd to her.

1:59:10 PM

MS. KNAPP said that was not surprising, because she has worked in the community system for many years and knows how grievances are handled. It doesn't surprise her that they are resolved at the level in which they occur. If a grievance involves a criminal act, of course, it is referred to law enforcement.

SENATOR DYSON said he thought this bill changes what "grievance" means and that more things might fall into it now.

MS. KNAPP agreed.

SENATOR DYSON asked her to help him understand the down side of this from the department's perspective.

MS. KNAPP said if grievances can be successfully handled at the level at which they occur, it seems appropriate to do that, and to require that the department be copied on all documents surrounding that seems like an unnecessary administrative burden. They want staff to focus on real problems.

SENATOR DYSON asked if, in her profession, there is a possibility of people using the grievance process inappropriately out of spite.

MS. KNAPP replied that is true in any field, but all complaints merit review.

2:03:16 PM
SENATOR DYSON asked since she said she appreciated the spirit of the legislation if she was inferring that improvements could be made to the system.

MS. KNAPP said that if there is the perception of a problem, there is a problem. So it is important to look at the concerns of those who perceive the problem and find what the reasons might be.

SENATOR DYSON asked if this department had been audited in regard to this issue in recent history.

MS. KNAPP said she did not know.

CHAIR DAVIS asked her to find out.

CHAIR DAVIS said Jean Mischel, drafting attorney for this legislation, and they should ask her to address the change in definition of "grievance" with her.

2:05:41 PM
MR. OBERMEYER commented that the definition of "grievance" was intentionally put into the statute because many of the issues that come before these facilities are often changed from what might be a grievance to a suggestion or a complaint. So it gives the facility the opportunity to talk the individual out of what they are doing. This recognizes the problem of "front loading" and making a grievance disappear.

2:07:39 PM
JEAN MISCHEL, Attorney, Legislative Legal Services, said the definition used here is very broad. Alaska statue has no other definition of grievance; so lacking that, the courts would apply the dictionary definition. This change goes beyond that, and it is a policy call for the legislature.

2:09:10 PM
JAMES GOTTSTEIN, President/CEO, Law Project for Psychiatric Rights (Psych Rights), said he was on the Mental Health Board and strongly supported SB 66. The board pushed through standards for grievances and he wrote a letter to the Chair on 2/16/09 on this issue. He said the administration didn't appreciate the way mental health clients are marginalized just by being classified as mental health clients. So whatever they do can easily be dismissed and disregarded unless safeguards are in place. So it is very important that this bill puts those safeguards in place.

Also, when he was still on the board they pushed for putting the requirements they had negotiated with the department into regulations so that they would be more permanent.

In line with what he said before about people being marginalized, they are often really coerced into accepting things, and that's another reason why there really should be oversight of the process.

MR. GOTTSTEIN said it is interesting that the administration would complain about the huge amount of paperwork if this were enacted and at the same time say that there were only five grievances in five years. It strains credulity to say only five grievances were unresolved to the satisfaction of clients in five years. He thought the current process was suppressing the elimination of the problems that are going on.

2:13:24 PM

FAITH MEYERS, speaking for herself, supported SB 66. The current psychiatric patient grievance procedure statute, AS 47.30.847, does not adequately protect patients and their rights.{ As a former psychiatric patient, she said she had been in acute care psychiatric facilities, evaluation units and had received treatment as an out-patient. As an advocate, she has talked to former psychiatric patients and their newsletter includes results of a recent survey that shows dissatisfaction with current psychiatric patient procedures.

She stated that 10 different categories of clients receiving services from the DHSS who are not satisfied can file an appeal with the department or with an administrative law judge. Alaska may be the only state that does not allowing psychiatric patients to file an appeal to a higher level. Even individuals in prisons or jails can file an appeal with the Department of Corrections, but as of now all psychiatric patients do not have a clear path to file an appeal either with DHSS or an administrative law judge. Either would be acceptable.

MS. MEYERS said the loopholes in the current statute allow psychiatric facilities to deny patients their right to file a grievance at the time of their choosing. It is important that patients receive a written copy of the grievance procedure and associated rules, get a written response in a timely manner, be able to file a grievance when they choose instead of having to through the facility informal complaint resolution process first, be able to appeal to a higher authority when dissatisfied with the resolution, and to have grievance reporting that will be looked at by more than one person within 24 hours for an emergency grievance. These are all rights given by SB 66.

2:17:40 PM
DARENCE COLLINS, representing himself, supported SB 66. In Maine, he said, people sued their DHSS equivalent to force improvements in the state psychiatric patient grievance procedure. In the state of Georgia, the legislature stepped in, in 2008 and revised the grievance procedure statute after it was shown that their equivalent of DHSS was not properly investigating psychiatric patient complaints or keeping records of them.

At ease at 2:18 p.m.

MR. COLLINS said the Alaska Psychiatric Institute (API) that is managed by DHSS in a 2006 report showed 256 complaints filed by patients in a 12-month period; not one was considered a

grievance, and not one person received a written response, which is a federal requirement. The loophole and inadequacy in the current grievance procedure statute allowed API to treat all complaints informally. He enumerated complaints included safety, sexual abuse, and medications. API has made some improvements, but nothing stops them from going back to their old habits and 50 other facilities are still doing the same type of thing.

2:22:19 PM
MR. COLLINS said two reports from the Ombudsman's Office were critical of DHSS because they did not want to keep statistics. SB 66 will require DHSS to keep statistics. The same report indicated that DHSS has not investigated a psychiatric complaint in many years even though they are required to do so by AS 47.30.660. The department cannot by law delegate its responsibility of investigating a patient's complaint to a non-state entity, but that is exactly what DHSS is doing. He said that revising and updating psychiatric patient procedure statutes is a national trend as is making them uniform.

2:25:08 PM
SENATOR PASKVAN asked if an internal peer review process had been performed at API, which is confidential.

RON ADLER, Director, Alaska Psychiatric Institute, Department of Health and Social Services (DHSS), said, "We are always in a continuous state of continuous quality improvement." All complaints and grievances are review by both himself and the medical director; they have a Patients' Rights and Ethics Committee that reviews these and looks at trends and documents them as they are relevant. The medical staff at API has a peer review process that is confidential.

SENATOR PASKVAN asked how many of those processes have been completed on average per year.

MR. ADLER responded that he could get that data for him.

SENATOR PASKVAN said he wanted to see if any of the 256 complaints were addressed in the 2006 review.

MR. ADLER stated that API deals with a number of people who have disturbances of thoughts, and he takes exception to anyone who says x number of people complain of sexual misconduct or violence, whatever. That is just the kind of thing they hear from people who are incapacitated at time of admission. Once they stabilize, they will frequently either retract their

complaint or not acknowledge that it was going on out of embarrassment.

2:29:34 PM
CHAIR DAVIS asked him to provide that information to her office.

SENATOR DYSON asked when someone has been involuntarily been committed, has a guardian ad litem been appointed.

MR. ADLER answered that a "court visitor" and a public defender come in and work with the patient and represent him in any legal proceedings that are relevant to commitment status and medication orders.

SENATOR DYSON said he worries about an organization that is far less professional than API, that is just warehousing folks and may not be properly caring for people. If that organization was not being professional, how would an outside person ever find out and "blow the whistle?"

2:31:40 PM
MR. ADLER replied that the federally funded authority in the state is the Disability Law Center that is headquartered in Anchorage, but has offices in Juneau and Fairbanks. They are very active with API; their telephone number is at each treatment unit, and if there is any allegation of violation of human rights they are quick to investigate. The scope of the Center's authority goes beyond that of the state hospital and includes the private sector.

SENATOR DYSON asked who has oversight of conduct at the 50 other facilities.

MR. ADLER responded that his impression is that Alaska is a very small state; the Mental Health Board conducts quarterly meetings in various parts of the state and spends a great deal of time taking public testimony and/or holding town halls to get input from the local constituents to see how the system can be improved. It's always been amazing to him when a consumer of services makes a statement that things aren't right without going into detail. And then after testimony has closed, a number of people who are involved in the system engage the person to see what is wrong and a subcommittee is established to make changes. That is the same process that started when Faith Meyers brought complaints about her treatment at API.

MR. ADLER said he thinks Alaska has a very transparent and collaborative process; it is very difficult for any type of misconduct to occur. The things that need to be changed have already been changed through a process of oversight and collaboration through the variety of stakeholder meetings and public testimonies that go on throughout the year.

2:35:32 PM
MS. KNAPP added that within the community system of 50 or so grantee programs, these are voluntary programs; people are not "committed" to them. If a person is deemed not competent to manage her own affairs, a guardian would be appointed. If they might be a danger to themselves they might be committed for a period of time so they are not actually locked down. Family members are often the guardians.

2:36:53 PM
SENATOR DYSON said the inference is that some of the people who are complaining, if indeed it was bad, they could leave. He assumed that people who are involuntarily committed are not free to leave.

MS. KNAPP replied yes; that would be if they are in the psychiatric unit under commitment at Bartlett Hospital, which is the designated evaluation and treatment facility. But at the community program like Juneau Alliance for Mental Health they are free to leave.

SENATOR PASKVAN asked if the results of the medical review or joint accreditation are confidential.

MR. ADLER answered that the joint commission review is public; the peer and medical reviews are confidential.

2:38:52 PM
CHAIR DAVIS asked Ms. Knapp for a list of grantees and to identify the levels of care provided by the grantees and hospitals. She advised that the bill will probably not get another hearing this session, but she was going to appoint a subcommittee. Her feeling is that there is a reason for the bill, and she appreciated the department's willingness to work with her on it.

MS. KNAPP agreed.

SENATOR DYSON asked for any audits.

2:41:19 PM
CHAIR DAVIS said if one wasn't available, she may have to request one. She closed public testimony and held SB 66 in committee.

SB 168-TRAUMA CARE CENTERS/FUND

2:42:09 PM
CHAIR DAVIS announced consideration of SB 168.

TOM OBERMEYER, staff to Senator Davis, sponsor of SB 168, read the sponsor statement. It is about state certification and designation of trauma centers, creating the uncompensated trauma care fund to offset uncompensated trauma care provided at certified and designated trauma centers and providing for an effective date.

SB 168 addresses the urgent need for a comprehensive statewide trauma center system coordinating and integrating the efforts of emergency medical services, public safety agencies, air medical services and health care facilities to insure that patients receive the most efficient and effective care from time of injury through rehabilitation. Trauma care systems have been shown to reduce death from injury by as much as 25 percent and are recognized as an integral part of the state's EMS and disaster response system. Only eight states have fully functioning systems and 15 states have no system.

Trauma is any life threatening occurrence either accidental or intentional that causes injuries. The leading causes of trauma are motor vehicle accidents, falls and assaults; trauma is the leading cause of death among Americans under 44 years of age.

A trauma center is a hospital, clinic or other certified entity equipped to provide comprehensive emergency medical services to patients suffering traumatic injuries. They were established by the medical establishment in response to traumatic injuries that often require complex and multi-disciplinary treatment including surgery in order to give the victim the best possible chance for survival and recovery.

2:43:57 PM
Section 1 in SB 168 adds subsection (c) to emergency medical services to address the state certification and designation of trauma centers. It creates the uncompensated trauma care fund under section 2 to offset uncompensated trauma care provided at

certified and designated trauma centers and provides for an immediate effective date.

The bill requires the commissioner to establish special designations in regulation of levels of 1-4 of certified trauma centers that shall be used to set compensation eligibility and the amounts under the uncompensated trauma care fund. Although current Alaska statutes revised in 1993 require certification of hospitals, clinics or other entities representative of trauma centers, they do not require or provide incentives for participation. The uncompensated trauma care fund will provide the needed incentives for hospitals for clinics and other entities to seek certification as trauma centers.

Since the state's statutes and regulations in this area were enacted over 15 years ago, only 3 of 24 eligible Alaska hospitals reportedly have successfully completed the verification and certification process as trauma centers. In order to qualify as a trauma center, a hospital must meet certain criteria established by the American College of Surgeons. Trauma centers vary in their specific capacities and are identified by levels 1-4; 1 being the highest. Higher levels of trauma centers will have trauma surgeons available including those trained in such specialties as neurosurgery, orthopedic surgery, as well as highly sophisticated medical diagnostic equipment and specialized treatment units. Lower levels of trauma centers may only be able to provide initial care and stabilization of a traumatic injury and arrange for transfer of the victim to a higher level trauma care.

2:45:52 PM
MR. OBERMEYER said under the Alaska trauma center system, it is anticipated that tertiary hospitals designated as higher level trauma centers will insure the availability of critical care specialists 24 hrs/day, 7 days/wk. The Alaska Native Medical Center is a level 2 trauma center; Yukon Kuskokwim and Norton Sound Regional Hospitals are level 4. It is believed that there are adequate medical resources to establish more level 2 trauma centers in Anchorage, and it is considered feasible to establish level 3 and 4 centers throughout the state. Because of long transport times trauma centers at all levels are necessary to improve patient outcomes. Level 1 trauma centers have critical care specialists in the hospital or on call at all times.

The closest level 1 trauma center is Harborview Medical Center in Seattle. The operation of a trauma center is extremely expensive. Some areas are underserved by trauma centers because

of this expense. For instance, Harborview is the only level 1 trauma center to serve the entire states of Washington, Idaho, Montana, and Alaska.

He said that patient traffic at trauma centers can vary widely as there is no way to schedule the need for emergency services. A variety of different methods have been developed for dealing with this. Halifax Health in Daytona Beach, Florida, reportedly is employing a pod system to be provided by several different small emergency departments at different hospitals rather than one large trauma center.

It is anticipated that Alaska, likewise, will have to develop a trauma center system which is best suited to its needs. It is anticipated that persons critically injured in remote areas of Alaska will be transported directly to a distant trauma center by plane and helicopter for faster and better care than if they had been transported to a closer hospital, which is not designated a trauma center.

The designation, coordination and funding of a trauma center in Alaska as provided under SB 168 will save time and lives. It will also provide the financial incentives for more participation by hospitals, clinics and other certified trauma care entities which are not available under present law.

He drew the committee's attention to the attachments and documents that indicate that in Alaska the leading cause of death in persons ages 1 to 44 is trauma; the average number of fatalities from trauma is 400 each year, and for every injury death, 11 people are hospitalized for trauma-related injuries. For every trauma death that occurs in the hospital, there are an estimated 3 people discharged with permanent disability. On average, more than 800 Alaskans are hospitalized annually with central nervous system injury (spinal cord or brain injuries). In 2004 motor vehicles were the leading cause of injury death (117), followed by firearm injuries (116). In 2004, the economic cost of hospital stays for trauma patients in Alaska was estimated at over $73 million; 1 in 4 of those hospital admissions were uncompensated.

CHAIR DAVIS set SB 168 aside.

SB 169-APPROP: TRAUMA CARE FUND

2:49:14 PM

CHAIR DAVIS asked Mr. Obermeyer to provide a brief overview of SB 169.

MR. OBERMEYER explained that SB 169 is the appropriation bill that asks the state to fund the uncompensated trauma fund at $5 million.

SB 168-TRAUMA CARE CENTERS/FUND

CHAIR DAVIS returned attention to SB 168 to continue taking testimony.

2:50:46 PM
DR. JAY BUTLER, Chief Medical Officer, Department of Health and Social Services (DHSS), said Alaska's trauma death rate has declined over the last 30 years thanks to prevention efforts, but it is still significant. The department took a neutral stance on SB 168.

DR. BUTLER said, "A better job can be done with the medical management of trauma victims." To begin a systematic approach to improving trauma care in Alaska, the DHSS hosted the American College of Surgeons' Committee on trauma system evaluation and planning this past November. The committee noted that Alaska has no trauma system and the report included over 70 recommendations for improving trauma care and creating a statewide trauma system. Among the priority recommendations was a recommendation to require all acute care hospitals to seek trauma center designation appropriate to their capacity within the next two years to improve the quality of medical care for trauma victims and improve outcomes.

DR. BUTLER said SB 168 provides an incentive for hospitals to become certified trauma centers rather than creating a mandate. It creates a fund for reimbursement of trauma care that would be provided for care to uninsured or underinsured patients. There are a number of potential sources of funds, and the department has been working to develop the sources further. However, he said because of the uncertainty involving funding, the administration is taking a neutral stance on SB 168.

2:53:07 PM
SENATOR DYSON asked if the administration requested this bill.

CHAIR DAVIS replied no; it was requested by others than the department.

2:54:10 PM
ROD BETIT, President/CEO, Alaska State Hospital and Nursing Home Association (ASHNHA), said they support the concept of SB 168. The detailed report from the College of Surgeons prescribes a mandatory approach, which he didn't think would be well received for a variety of reasons. This is a priority that his members selected to work on in 2009, and he understands it is one of the department's priorities, too. The trauma system needs to be improved; the reasons why it hasn't happened need to be understood why it hasn't happened before. Some of those include the availability of physicians and their willingness to serve because there are very significant and time sensitive requirements around each classification level in the trauma scheme, and the costs to do that. And since there is clear evidence that if you have trauma centers, they attract more uncompensated care that has to be dealt with as well as what levels are care should be in each community.

He understood that Alaska has five designated facilities, four of those are tribal. The one with the highest level designation is Alaska Native Medical Center. Those are staff model hospitals where the physicians work for those hospitals. One private facility that is certified at the lowest level is co-located in a community with one of those tribal facilities. The rest have struggled with ways to meet the conditions of certification - being private hospitals with physicians who do not work for them and having a shortage of some of the types of physicians needed and the ability to make sure the physicians will be there within the time response required. This is one issue they don't know how to solve at this point, but a group within the AHNSHA is working on it. This is a great approach to try to pull more facilities in and get them designated. Clearly, uncompensated care is one way to do that, but unless they can figure out some of the logistical problems around physician availability, they won't get as far as the committee would like with this piece of legislation.

2:57:49 PM
SENATOR PASKVAN asked, if it were funded at the $5 million level, what range of hospitals would want to participate in the plan.

MR. BETIT answered that since this deals with "a half a glass" and deals with uncompensated care, but not with the physician cost or availability, none said they would be willing to move forward to get the designation. It's a step in the right direction, but maybe the $5 million could be matched through

some disproportionate sharing funding that Medicaid makes available that the state hasn't fully capitalized on. Maybe some of that could also go into offsetting some of the increased costs for the physician on call and recognizing that they have to have the right physicians available to be on call. He hoped to work with the department on these issues over the next few months.

2:59:09 PM
MARK JOHNSON, former chief of Emergency Medical Services, said during that time that he served, he worked very hard to develop an EMS system in Alaska and made a lot of progress. One of the issues they worked on was to improve the trauma system in Alaska where they made some limited progress. In the 1990s with the use of some federal grant funds, his office co-sponsored American College of Surgeon reviews of eight different hospitals in Alaska that created reports on their strengths and weaknesses. Some hospitals have been reviewed multiple times. The report that the college came out with addressed some issues mentioned by Mr. Betit as well as going into a lot more detail on how to solve some of the problems.

It's been said for many years, that trauma systems require commitment, and unless the medical community and the hospitals are willing to provide it, they aren't going to solve the problem, Mr. Johnson said, and he's been dealing with it for decades. The reality is that Alaska's hospitals are not meeting national standards in trauma care, and the public is not well served by that. Harris polls indicate that nationwide, people actually think they live in a community with a trauma system, but in fact in many places it doesn't exist.

MR. JOHNSON said reducing complications and lengths of stay can produce better outcomes and more lives saved, and these can all result in downstream long term savings. One of the biggest problems in this state is on-call. Sometimes a surgeon is needed immediately, but they must be called to find somebody available. Those calls take time and that sometimes results in bad outcomes. That should be pre-planned and pre-arranged; and that's what this is about.

3:02:55 PM
SENATOR DYSON said "commitment" sounds like money.

MR. JOHNSON said to some extent that is true, but other things can be done that don't cost much. You look at creative solutions, and some are in this report.

CHAIR DAVIS said this bill will come back next session. [SB 168 was held in committee.]

3:04:11 PM

There being no further business to come before the committee, she adjourned the meeting at 3:04 p.m.