

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

February 19, 2013

3:00 p.m.

**MEMBERS PRESENT**

Representative Pete Higgins, Chair  
Representative Wes Keller, Vice Chair  
Representative Benjamin Nageak  
Representative Lance Pruitt  
Representative Lora Reinbold  
Representative Geran Tarr

**MEMBERS ABSENT**

Representative Paul Seaton

**COMMITTEE CALENDAR**

PRESENTATION: TRIBAL BEHAVIORAL HEALTH DIRECTORS COMMITTEE

- HEARD

PRESENTATION: ALASKA STATE HOSPITAL AND NURSING HOMES  
ASSOCIATION

- HEARD

**PREVIOUS COMMITTEE ACTION**

No previous action to record

**WITNESS REGISTER**

TINA WOODS, Chair  
Tribal Behavioral Health Directors (TBHD)  
Anchorage, Alaska

**POSITION STATEMENT:** Testified and answered questions during a  
PowerPoint presentation titled, "Tribal Behavioral Health  
Directors Committee (TBHDC)."

CHANDA ALOYSIUS, Vice Chair  
Tribal Behavioral Health Directors (TBHD)  
Anchorage, Alaska

**POSITION STATEMENT:** Testified and answered questions during a PowerPoint presentation titled, "Tribal Behavioral Health Directors Committee (TBHDC)."

JANICE HAMRICK  
SouthEast Alaska Regional Health Consortium  
Sitka, Alaska

**POSITION STATEMENT:** Answered questions during the TBHDC presentation.

MIKE POWERS, CEO  
Fairbanks Memorial Hospital  
Fairbanks, Alaska

**POSITION STATEMENT:** Testified and answered questions during a PowerPoint presentation titled "Overview of Alaska's Hospitals and Nursing Homes."

LAURIE DOTAS  
Prestige Care, Inc.  
Anchorage, Alaska

**POSITION STATEMENT:** Testified and answered questions during a PowerPoint presentation titled "Overview of Alaska's Hospitals and Nursing Homes."

ANDREW MAYO, MD  
North Star Behavioral Health  
Anchorage, Alaska

**POSITION STATEMENT:** Testified and answered questions during a PowerPoint presentation titled "Overview of Alaska's Hospitals and Nursing Homes."

#### **ACTION NARRATIVE**

[3:00:38 PM](#)

**CHAIR PETE HIGGINS** called the House Health and Social Services Standing Committee meeting to order at 3:00 p.m. Representatives Higgins, Reinbold, and Tarr were present at the call to order. Representatives Pruitt, Nageak, and Keller arrived as the meeting was in progress.

#### **Presentation: Tribal Behavioral Health Directors Committee**

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CHAIR HIGGINS announced that the first order of business would be a presentation by the Tribal Behavioral Health Directors committee.

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TINA WOODS, Chair, Tribal Behavioral Health Directors (TBHD), said that she was with the Aleutian-Pribilof Islands Association, and that she was originally from St. Paul Island. Directing attention to the PowerPoint presentation, "Tribal Behavioral Health Directors Committee," she pointed to slide 1 and shared that the Behavioral Health Directors Committee was created in 2005, as part of the Tribal Health System, and was approved by the Alaska Native Health Board in 2008. She reported that there were 24 members from throughout the state, and they met quarterly. She noted that there were 800 employees in the Tribal Behavioral Health system, offering both rural and urban services.

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CHANDA ALOYSIUS, Vice Chair, Tribal Behavioral Health Directors (TBHD), said that she was an Athabascan Indian and Yupik Eskimo from Holy Cross. She spoke about slide 3, "Statewide Tribal Behavioral Health Services," and said that some of the services were provided through State of Alaska grants, private grants, and funding from the Indian Health Service (IHS). These providers offered a wide range of services and trainings, including outpatient, group therapy, prevention and intervention with suicide, trauma based training, residential treatment programming, family wellness warriors, and statewide crisis response.

MS. WOODS directed attention to slide 4, "The Behavioral Health Aide Model," explaining that this model was federally recognized through the Community Health Aide Program. She noted that currently there were 134 Behavioral Health aides in Alaska with a variety of certifications and trainings for a broad range of behavioral health services. She emphasized that the behavioral health aides kept individuals out of the residential treatment facilities, and that often, the aides were raised in the communities for which they provided services.

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REPRESENTATIVE NAGEAK commented that many people with mental health problems were sent away, and the communities had asked to

bring these people back to the community. He shared that, in order for those people to heal, they needed to be around family. He pointed out that there were no centers in rural areas for mental health patients. He declared that a change was evident in the patients when they were allowed to come home.

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MS. WOODS moved on to slide 5, "The Alaska Tribal Health System," which pinpointed the behavioral health aides around Alaska. She expressed her agreement with Representative Nageak that facilities which were culturally responsive needed to be built; however, while each organization was looking for funding, some organizations were still trying to build basic clinics. She moved on to slide 6, "How does the State benefit from working with Tribal Behavioral Health?" She pointed out that the State of Alaska was eligible for 100 percent reimbursement from the federal government for Tribal Health Behavioral provided services statewide. She stated her pride that these services were offered in a culturally responsive way.

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MS. ALOYSIUS pointed out that the Federal Medical Assistance Percentage was cost neutral to the State of Alaska. She stated that the behavioral health aides, working in partnership with psychologists, clinicians, and psychiatrists, did help keep people in the village and out of the emergency rooms and in-patient units in urban areas. She emphasized that the behavioral health aide was often the sole behavioral health provider in a village.

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REPRESENTATIVE REINBOLD asked if e-medicine or face to face technology were used to help reduce costs.

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MS. ALOYSIUS replied that although some facilities were equipped for video conferencing, the cost of the facilities, the lack of bandwidth, and the interruptions from weather were all factors to overcome. She detailed that even though there was training for many of the providers outside the village, they still often did not understand the difficulty for obtaining resources and medications in the villages.

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CHAIR HIGGINS asked if the behavioral health aide and the community health aide were the same.

MS. WOODS replied that it was the same model.

CHAIR HIGGINS asked if this was the same person in a village.

MS. ALOYSIUS, in response, said that these were different people. She explained that the behavioral health aide model was based on that of the community health aide, but that the behavioral health aide was a para-professional, and was usually Native Alaskan from that same village.

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MS. WOODS, in response to Chair Higgins, said that the behavioral health aide training was given throughout the state, including the University of Alaska Fairbanks.

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JANICE HAMRICK, SouthEast Alaska Regional Health Consortium, in response to Chair Higgins, said that training was done through [indisc] and through essential learning in the community.

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MS. WOODS commented on slide 7, "Tribal Behavioral Health Directors Committee Current Priorities," and listed the three priorities for the current year: Access to Care, Shortage in Services, and State Requirements. She explained slide 8, "Priority #1: Access to Care," and stated that there were many barriers for an individual when entering treatment, including discussion of personal issues with a stranger. She relayed that there were even more issues for the Alaska Native population. She pointed out that there was a high rate of social issues, but a low utilization of mental health services. She remarked that the behavioral health aide program worked because individuals were comfortable speaking with a person from their own community. She declared that the documentation requirements, which were culturally invasive and daunting, resulted in many Alaska Native elders not seeking services. She said there were 5-8 hours of paperwork to process prior to the initial individual therapy session and that this was a huge barrier. She stated that the venue requirements did not support

culturally responsive options such as in-home assessments, as the elder had to come to the clinic for service. She pointed out that there was not the ability to bill for reimbursement for behavioral health aide services.

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MS. ALOYSIUS stated that it required courage to walk into a service center and ask for help, and that "when they're greeted with a binder of information thicker than the books behind you on your shelf, it's a barrier in itself." She pointed to the importance of face to face interaction for understanding, and that it was important for Alaska Native people to know "why they're hurting, in their hearts, and in their minds, and in their bodies." She emphasized that it was necessary to bring wellness to that level in the communities, and to simplify the documentation, or Alaska would continue to lead the nationwide indicators for suicide, substance use, and sexual assault.

MS. ALOYSIUS, in response to Chair Higgins, said that the documentation was for the State of Alaska's new, extensive Medicaid regulations. She said it could take four to eight hours to complete the documents, and only then could they begin the assessments.

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MS. WOODS said that often people would not return after sitting through lengthy paperwork. She asked that the State of Alaska offer another category for service, a brief intervention category. She shared that there was currently a one-time crisis intervention, and she suggested allowing a culturally responsive intervention to individuals in order to build a relationship of trust for engagement with the system.

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MS. ALOYSIUS moved on to slide 9, "Priority #2: Shortage in Services," and offered an anecdote about the shortage for statewide crisis response. She declared that it was important for the State of Alaska to partner with the villages, in order to know the community leaders for response to crises. She pointed out that providers get compassion fatigue, but there was not anyone to relieve them. She asked that the state have a fund to support necessary travel for crisis response. She asked who would respond if there was an incident similar to the shooting incidences in the schools in the Lower 48, and

suggested that a reasonable, responsible, simple emergency response plan be developed.

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MS. ALOYSIUS stated that Alaska had a shortage of providers, especially in the rural areas. As there are no resources in a village, a professional fills many roles, and they get no relief from all the requirements for documentation. She asked for state help with loan repayments for service in rural villages.

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REPRESENTATIVE NAGEAK shared his story for the difficulty to the loss of a loved one by suicide.

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MS. ALOYSIUS asked the committee to continue to seek funding for follow up programs.

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MS. ALOYSIUS shared slide 10, "Priority #3: State Requirements," and the need for balance between provision of a quality service and accountability. She said that the new Medicaid regulations had an unfunded mandate for all behavioral health providers to receive accreditation from certain recognized associations. She offered a personal anecdote regarding the accreditation of a small clinic in her district.

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MS. WOODS indicated slide 10, and suggested that an Integrated Healthcare Structure would encourage the integration among behavioral health and primary care, as the current structure prevented billing options for behavioral health in the primary care setting.

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MS. ALOYSIUS continued the discussion of slide 10, and explained that the mandated electronic data base system used by the State of Alaska did not interface with other electronic health records systems.

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MS. ALOYSIUS, in response to Representative Reinbold, explained that the Health Information Technology for Economic and Clinical Health (HITECH) Act was a mandated federal act for health care systems to have a certified electronic medical record. She explained that this rewarded organizations with funding for the prompt integration of electronic medical records, which included specific certification requirements.

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MS. WOODS presented slide 11, "In Summary" and stated that the Tribal Behavioral Health Directors Committee maintained partnerships with the State of Alaska and the Alaska Mental Health Trust Authority for a variety of items. She declared that it was an underfunded system, and that behavioral health was "always the last to be considered for anything." She explained that the regional health organizations were all different, and had different operational approaches. She emphasized that behavioral health was the root of the entire mind, body, and spirit.

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REPRESENTATIVE REINBOLD asked if the request for funding had been through the Department of Health and Social Services.

MS. WOODS explained that that there were areas in the presentation where support had been requested. She described the "state plan amendment" which would create billing codes for behavioral health aide services, as these services were not currently admissible for billing. She stated that this had been in discussion since 2008, and noted that this would resolve some of the priority issues, which included brief intervention therapy instead of complete assessments.

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REPRESENTATIVE REINBOLD asked if these were the diagnostic codes, if the Patient Protection and Affordable Care Act would have any effect, and when would the Centers for Medicare and Medicaid Services (CMS) act on this.

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MS. ALOYSIUS, in response, stated that these diagnostic codes had been sent to CMS by the State of Alaska, but she had no

knowledge of its current status. She opined that the Patient Protection and Affordable Care Act would have no bearing on this.

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CHAIR HIGGINS asked who funded the 800 employees.

MS. ALOYSIUS replied that it was primarily funded by the Indian Health Services (IHS), but there were also some private and State of Alaska grant funds.

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CHAIR HIGGINS expressed his understanding that, for something to work, the villages had to endorse and accept it.

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The committee took a brief at-ease.

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CHAIR HIGGINS brought the committee back to order at 3:53 p.m.

**Presentation: Alaska State Hospital and Nursing Homes Association**

[3:53:42 PM](#)

CHAIR HIGGINS announced that the final order of business would be a presentation by the Alaska State Hospital and Nursing Home Association.

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MIKE POWERS, CEO, Fairbanks Memorial Hospital, stated that he represented a community hospital with an attached long-term care facility, a common relationship for continuum of care in Alaska. He lauded the long-term care programs in Alaska.

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MR. POWERS, offering a PowerPoint, "Overview of Alaska's Hospitals and Nursing Homes," directed attention to slide 3, "Alaska is Beyond Rural when compared to other States," and pointed out the staggering difference of bed density in Alaska

compared to most other states. He explained that this lack of beds brought difficulties which included getting patients to the hospital during the golden hour, recruiting to the state, and creating centers of excellence. He declared a need, and a challenge, for Alaska to recruit highly trained, certified, competent, skilled providers with high technological training.

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MR. POWERS indicated slide 4, "Alaska has 40 Hospitals and Nursing Homes," which listed the membership of the association.

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REPRESENTATIVE REINBOLD asked about the shortage of medical personnel and asked if there were any teaching institutions in Alaska.

MR. POWERS identified the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) collaborative medical school program and its relationship with Providence Alaska Medical Center and the University of Alaska. He said that outlying areas of Alaska had area health education centers associated with medical schools.

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LAURIE DOTAS, Prestige Care, Inc., said that the nursing homes were instrumental for training nurses and nurse's aides during their clinical rotations, and this participation would grow the workforce.

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ANDREW MAYO, MD, North Star Behavioral Health, said that his clinic had affiliations with 12 higher education institutions in many disciplines.

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MR. POWERS said that these partnerships were the most cost effective way to recruit during the building of an academic center. He moved on to slide 5, "Health Care is a Major Employer in Alaska," which indicated the growth opportunities for health care in Alaska, currently about 31,000 jobs. Noting slide 6, "Half of all Health Care Employment is in Hospitals & Nursing Homes," he said that physicians, outpatient care, and home health programs were all important. Explaining slide 7,

"Health care employment is throughout the State," he noted the challenge for assuring appropriate certifications for a level of competence to all Alaskans.

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CHAIR HIGGINS reflected that the health care profession was the second or third largest employer in the State of Alaska, and expressed his agreement with Mr. Powers that health care was an economic anchor in the state.

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MR. POWERS reviewed slide 8, "Alaska Costs Compared to Comparison States," and stated that the cost of living in Alaska was 30 percent higher than the U.S., and that hospital costs were 38 percent higher. He attributed this to the higher labor costs for hard to recruit positions. He spoke about a recent training program for surgical nurses in Alaska.

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REPRESENTATIVE REINBOLD asked who were the comparison states in slide 8.

MR. POWERS replied that this was the Northwest rural areas.

MR. POWERS said that rotating travelling nurses into Alaska was a good way to gauge interest for permanent positions.

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MR. POWERS moved on to slide 9, "Cost Drivers Impacting the Cost of Care in Alaska."

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MS. DOTAS, in reference to slide 9, stated that her company was owned and operated by a company in the Lower 48, and that Prestige Care was its only Alaska center. She expressed her envy for competitors in the Lower 48 for free shipping of equipment, food, and other products. She stated that this did impact costs in Alaska.

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DR. MAYO voiced his support for the military population, but he pointed out that this was often a transient population which affected recruiting and hiring. He offered an anecdote about the high cost of food in Alaska.

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MR. POWERS considered slide 10, "Alaska Pays more for health care practitioners than 8 comparison state," which graphed the state wage comparisons between Alaska and other western states, and reflected that Alaska wages were 20 percent above the U.S. average.

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MR. POWERS commented on slide 11, "Hospital must serve all who need care," stating that health care finance "is a strange beast" with the complexity of uncompensated care. He reported that although everyone who came to the emergency room received care, the cost for any uncompensated care was shifted to other payers. He declared that the health care industry was supportive of Medicaid expansion, as more than 40,000 Alaskans would be covered in the next 10 years, it would bring \$1.1 billion of federal funding to Alaska, \$1.2 billion of additional salaries in Alaska, and \$2.5 billion of increased economic activity. He recognized the possibility for the future loss of federal sharing. He noted that there had been suggestions for a co-pay system, so that patients would have "skin in the game." He declared that the Medicaid expansion could have a tremendous economic benefit for the state.

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REPRESENTATIVE REINBOLD asked if he would advocate for a copay system and for what percentage.

MR. POWERS expressed his agreement with a copay system, and he suggested that it be "some kind of tiered mechanism." He established that this would offer a reasonable sense of accountability.

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REPRESENTATIVE REINBOLD offered her belief that a co-pay system would make people show up.

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MR. POWERS called attention to slide 12, "2011 distribution of Hospital Charges by Primary Pay Source," and stated that 32 percent of payments came from Medicare, 20 percent from Medicaid, 30 percent from commercial insurance, and about 17 percent from self-pay.

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MR. POWERS offered a snapshot of Fairbanks Memorial Hospital, slide 13, "Fairbanks Memorial Hospital," and slide 14, "Who Do We Serve." He stated that the hospital was a sole community provider, with a close relationship with the Native and military communities, and that the majority of its patients came from within a 30 mile radius. He said the top diagnoses were normal deliveries, psychosis, and alcohol.

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MR. POWERS concluded with slide 15, "Economic Impact," slide 16, "Fairbanks Memorial Hospital," and slide 17, "Going Forward." He reported that the hospital had 1350 employees, with \$107 million in salary and benefits, and \$360 million in gross revenues. He pointed to some of the challenges which included the impact for niche providers, chronic inebriates, assisted living, and adolescent behavioral health services. He noted the sources of pride to include the native and military partnerships, and the recruitment of 70 physicians in the last 6 years.

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DR. MAYO introduced the North Star Behavioral Health facility, slide 18, and slide 19, "Who do we Serve," reporting that it was a 76 bed acute facility, with the only child and preteen acute mental health units in Alaska. He said there were a semi-secure level 5 treatment center, and a locked level 6 unit. He noted that it was the only facility for military children needing residential care in Alaska, and that they worked closely with Alaska Psychiatric Institute (API). He shared that 30 percent of admissions came from outside the Anchorage Bowl. He reported that the primary diagnoses were mood disorders, substance related disorders, post-traumatic stress disorder, and developmental disabilities. He listed the demographics of the patients, noting that 48 percent were Caucasian and 30 percent Native Alaskan.

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DR. MAYO assessed slide 20, "Economic Impact," and reported that there were five facilities, and the salaries and benefits were about \$22 million for 425 part-time and full time employees. He stated that they spent about \$700,000 in contract services, about \$900,000 in purchased services, and about \$2.3 million in supplies, all from local vendors.

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DR. MAYO explained that the challenges for the facility included nursing recruitment, continuity of care with outpatient providers to keep the recidivism rate low, low cost telemedicine, specialty care populations, and effective prevention strategies, slide 21. He expressed his pride in the distribution of suicide prevention training plans in the schools, the stability of the medical staff, and the scientifically based and statistically significant outcome data for the children they had in their care.

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DR. MAYO concluded with slide 22, "Going Forward," and said that he foresaw continued growth in specialty services, so children could stay close to their families, as well as a continuum of care for adults. He expressed a desire for an expansion of the telemedicine program, continued recruitment for doctors for outpatient services, and continued training and education for mental health issues in Alaska.

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MS. DOTAS introduced "Prestige Care," slide 23, and reported that Prestige had taken over the nursing home facility in July, 2009. She stated that they were one of two long term care and sub-acute providers in Anchorage, slide 24, "Who Do We Serve." She reported that 97 percent of the admissions came directly from acute care, usually after an injury or acute illness. She said the average length of stay was 946 days, and there was a fine balance between a medical facility and a home. She said they strive to make it a comfortable place to live. For the HMO and Medicare rehabilitation patients, the average length of stay was 58 days. She noted that 85 percent of the patients were long term, while 45 percent of the residents had dementia or short term impaired cognition.

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MS. DOTAS called attention to slide 25, "The Silver Tsunami," and stated that the senior population in Alaska would double by 2020 and would almost triple by 2030. As most of the facilities were already close to full occupancy, there was going to be a bed issue for long term care. She pointed out that 90 percent of long term care service in Alaska was paid by Medicaid, slide 26, "Long Term Care."

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MS. DOTAS briefed the committee about slide 27, "Residents Activities of Daily Living Levels," stating that most patients were admitted after some sort of traumatic event, a fracture or neurological event, and had not planned for admission. She reported that 26 percent of the patients required a mechanical lift, or a lot of manpower, to move and take care of them. She moved on to slide 28, "Economic Impact" and relayed that Prestige Care employed 144 people, had an all-time low turnover rate of 30 percent, and annual salary and benefit costs of \$8.1 million, which included the contract therapy services. She said there were gross revenues of \$12.6 million. She noted that they had just received approval to add 12 beds, for a total of 102 beds. She shared that Prestige Care, Inc. had recently purchased the facility, and this was the first time that this facility had been owned and operated by the same firm. She declared that "it had a huge impact, for my residents and for my staff alike. It was a big day, the day that financing went through ... to say we own it was a big pride factor."

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MS. DOTAS announced that Prestige Care had won the Bronze Quality Award by the American Health Care Association in 2012, was a recipient of Mountain-Pacific Quality Health's Excellence in Care & Quality Award, and was the only five star rated center for Quality Ratings, slide 29, "Sources of Pride."

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#### **ADJOURNMENT**

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:39 p.m.